NHS
Wirral Community Health and Care
NHS Foundation Trust

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

WUTH AND WCHC BOARD OF DIRECTORS IN PUBLIC

WUTH AND WCHC BOARD OF DIRECTORS IN PUBLIC

4 June 2025

09:00 GMT+1 Europe/London

AGENDA

1. WUTH AND WCHC BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 DRAFT Board of Directors in Public Minutes - 7 May.pdf
- 3.1 DRAFT Public Board of Directors minutes 230425 v2.pdf
- 4 Action Log - Public Board.pdf
- 4. FINAL WCHC_matters arising_Public Board_April 2025 v2.pdf
- 7 Joint Chief Executive Officer Report.pdf
- 8 IPR.pdf
- 8.1 WUTH IPR Dashboard - May 2025 - Intro.pdf
- 8.2 WUTH IPR Dashboard - May 2025 - 1 COO.pdf
- 8.3 WUTH IPR Dashboard - May 2025 - 2 MD.pdf
- 8.4 WUTH IPR Dashboard - May 2025 - 3 CN.pdf
- 8.5 CN Commentary - for May 2025 BoD.pdf
- 8.6 WUTH IPR Dashboard - May 2025 - 4 CPO.pdf
- 8.7 CPO Commentary - for May BoD.pdf
- 9. WCHC Integration Performance Report April 2025_AH.pdf
- 11. DRAFT Lead Governor Report - June 2025.pdf
- 12 Audit and Risk Comm.pdf
- 13 FBPAC Committee Report May25 MC.pdf
- 14. FINAL_Audit Committee Chair's Report - April 2025.pdf

- 15. FINAL_ May QSC Chair's Report.pdf
- 17 Quarterley Maternity & Neonatal Report June 2025 Final Final.pdf
- 18 WUTH IPR Dashboard - May 2025 - 5 CFO.pdf
- 18.1 CFO Commentary M1 25-26 280525.pdf
- 19 COO report for Apr 25.pdf
- 20 WCHC Learning from Deaths Report Q4 2024-25.pdf
- 21 Staff Survey Results.pdf
- 21.1 Appendix 1 Trust wide Staff Survey Action Plan 2025.pdf
- 21.2 Appendix 2 RY7-benchmark-2024.pdf
- 22a. FTSU Cover Sheet 2025 PS.pdf
- 22b. FTSU Annual Report April 2024 - March 2025.pdf
- 23a Cover Sheet Social Value annual report 2024-25.pdf
- 23b. Social Value Annual Report 2024-25.pdf
- 24a. Cover sheet Organisational Strategy 22-27.pdf
- 24b. Year3_2024-25_strategy update Board June 2025.pdf
- 25 Modern Slavery Statement report.pdf
- 26a. cover sheet modern slavery v2.pdf
- 26b. Modern Slavery 2025 v1.pdf
- 27 BAF Quarter 1 25-26.pdf
- 28a. WCHC BAF cover sheet - June 2025 v2.pdf
- 28b. WCHC_BAF_appendix 1 strategic risks summary table - June 2025 v3.pdf
- 28c. BAF Strategic risks QSC oversight_ID01-ID02 March 2025.pdf

29 Board Report Charitable Funds June 25.pdf

30 EPRR Report Cover Sheet FINAL.pdf

30.1 EPRR Report Appendix A - G.pdf

31 FINAL WCHC Cover Sheet 2025 - Comms & Marketing Report.pdf

31.1 FINAL Comms & Marketing Report Q4 2024_25.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community Health and Care NHS Foundation Trust

Notice of Meeting

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

Meeting	WUTH and WCHC Board of Directors in Public
Date	Wednesday 4 June 2025
Time	09:00 – 12:00
Location	Hybrid

Page		Agenda Item	Lead	Presenter
	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
7	3.	Minutes of Previous Meetings • WUTH – 7 May 2025 • WCHC – 23 April 2025	Sir David Henshaw	
25	4.	Action Logs • WUTH – 7 May 2025 • WCHC – 23 April 2025	Sir David Henshaw	
	5.	Patient Story	Sam Westwell	
	Standing Items			
	6.	Joint Chair Update – **Verbal**	Sir David Henshaw	
29	7.	Joint Chief Executive Officer Report	Janelle Holmes	
35	8.	WUTH Integrated Performance Report	Executive Directors	
56	9.	WCHC Integrated Performance Report	Executive Directors	
	10.	WUTH Report from the Lead Governor – **Verbal**	Sheila Hillhouse	
59	11.	WCHC Report from the Lead Governor	Lynn Collins	
	Chairs Reports			
61	12.	WUTH Audit and Risk Committee	Steve Igoe	
63	13.	WUTH Finance Business Performance Committee	Sue Lorimer	

65	14.	WCHC Audit Committee	Meredydd David	
67	15.	WCHC Quality and Safety Committee	Professor Chris Bentley	
	16.	WCHC Staff Voice Forum – **Verbal**	Ali Hughes	
	WUTH Strategic Objective: Outstanding Care			
69	17.	Quarterly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
	WUTH Strategic Objective: Continuous Improvement			
76	18.	Chief Finance Officer Report	Mark Chidgey	
81	19.	Chief Operating Officer Report	Hayley Kendall	
	WCHC Strategic Objective: Populations			
89	20.	Learning from Deaths Report Q4 2024/25	Dr Eddie Roche	
	WCHC Strategic Objective: People			
99	21.	Staff Survey Results 2024	Debs Smith	
251	22.	Freedom To Speak Up Annual Report	Paula Simpson	Alison Jones
	WCHC Strategic Objective: Place			
278	23.	Social Value End of Report 2024-25	Tony Bennett	Dave Hammond
	Strategy			
305	24.	WCHC Organisational Strategy Year 3 Report	Tony Bennett	
	Governance and Assurance			
356	25.	WUTH Modern Slavery Statement	David McGovern	Cate Herbert
359	26.	WCHC Modern Slavery Statement	Debs Smith	
363	27.	WUTH Board Assurance Framework (BAF)	David McGovern	
389	28.	WCHC Board Assurance Framework (BAF)	Alison Hughes	
410	29.	WCHC Charitable Funds Annual Report	Robbie Chapman	

414	30.	WCHC Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Jo Chwalko	Mick Blease
527	31.	WCHC Communications & Marketing Report Q4 2024/25	Alison Hughes	
	Closing Business			
	32.	Questions from Governors and Public	Sir David Henshaw	
	33.	Meeting Review	Sir David Henshaw	
	34.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 3 September, 09:00 – 12:00			

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 7 May 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SR	Dr Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
JH	Janelle Holmes	Chief Executive
RM	Dr Ranj Mehra	Deputy Medical Director
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer & Interim Deputy CEO
SW	Sam Westwell	Chief Nurse

In attendance:

JC	Jo Chwalko	Director of Integration and Delivery
CM	Chris Mason	Chief Information Officer
DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
TC	Tony Cragg	Public Governor
SLa	Sharon Landrum	Head of People Experience – item 14

Apologies:

NS	Dr Nikki Stevenson	Medical Director & Deputy CEO
SI	Steve Igoe	SID & Deputy Chair

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting**	

	The minutes of the previous meeting held on the 2 April were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story highlighting the experience of the emergency services and the experience of corridor care from the perspective of a patient's next of kin. The video story described the difficult circumstances of corridor care, including the issues with communication, timeliness of care and dignity. Despite this the patient's next of kin praised the thoroughness of care provided by doctors and nurses. SW stated corridor care had reduced since this patient's experience and ambulance handover times including waiting times had reduced. SW added privacy screens were now available in circumstances of corridor care to maintain patient dignity. HK explained the ambition was to reduce corridor care by 50% this year and actions were in place to achieve this. Members discussed the number of Emergency Department (ED) attendances and how this could be reduced by patients seeking appropriate treatment in another environment. Members acknowledged a number of urgent and emergency care initiatives were underway, including call before convey, identifying high intensity users, working with care homes and reviewing GP hours in the walk in centre to extend to out of hours. After due discussion members agreed to hold a half day meeting, which would be expanded to include WCHC Board members and a Primary Care Network GP to discuss in more detail alternative methods for reducing the number of ED attendances. Members thanked SW for providing the video story, suggesting it should be shared more widely and thanked staff who continued to work in the challenging circumstances. The Board **NOTED** the video story.	Janelle Holmes/Jo Chwalko
6	**Chair's Update** DH provided an update on recent matters and highlighted the interviews for the Joint Non-Executive Director position between WUTH and WCHC had taken place, and an applicant had been successful.	

	DH added the appointment was subject to final checks and Nominations Committee and Council of Governors approval which would be sought imminently. The Board **NOTED** the update.	
7	**Chief Executive Officer Report** JH summarised the recent meeting of the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board in April, referencing the work taken place by the ICB and providers in respect of 2025/26 planning. JH noted the 2024-25 Annual Report of the Director of Public Health for Wirral had been published and provided an in-depth look at the key health challenges facing the Wirral. JH highlighted Cathy Elliot had been appointed as the Chief Executive of Cheshire & Merseyside ICB to replace Graham Urwin who departs later this year. JH reported in March there were three Reporting of Injuries, Diseases and Dangerous Occurrences reported to the Health and Safety Executive and one Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH referenced the new NHS England Chief Executive letter to all Trusts and ICBs on 1 April which provided an update on the 2025/26 planning and other priority areas of focus for the year ahead. JH also referenced the new Board member appraisal framework had been launched and would be used for this year's appraisals. JH stated the ICB Associate Director of Nursing Care had carried out a site visit in March as part of the Paediatric Audiology Improvement Programme. No immediate concerns were raised and the clinical teams were praised for their hard work. JH highlighted a ceremony was held on 11 April whereby IncuBabies, a charity dedicated to supporting the care of newborns, donated £300,000 to help refurbish the Neonatal Unit at Arrowe Park Hospital. JH explained the Trust had been shortlisted for a prestigious National Institute for Health and Care Research West Coast Award and added that in April, Lisa Byrne and Switchboard Team won the Patient Care Award and Amanda Cook won the Named Employee of the Month – Patient Care. The Board **NOTED** the report.	
8	**Integrated Performance Report**	

	RM highlighted the number of patients recruited to NIHR studies was below trajectory, however the Research and Innovation Team were focussed on high quality research studies and commercial research opportunities. SW stated C Diff remains above the target of 6 per month, indicating there were 11 incidents in March. SW added there were 3 category 3 hospital acquired pressure ulcers in March against a target of 0. SR queried about the risk of patients experiencing pressure ulcers while waiting on the corridor to receive care. SW stated patients were at a greater risk of pressure ulcers in this environment and stressed the importance of nursing staff having strong attention to detail. SW highlighted the Friends and Family Test for ED was 75.5%, Outpatients 94.5%, Maternity and inpatients exceeded the 95% of those that responded were either satisfied or very satisfied with the service. SW explained the number of level 1 concerns raised with the Trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff was below the agreed threshold. SW reported except for Clinical Support Worker (CSW) day fill rates, Registered Nurse and CSW staffing fill rates were above the threshold of 90%. DS stated sickness absence had improved in March but remains above target at 5.76% and continues to be an area of concern and focus. Turnover had risen above target in March to 1.12%, which was due to an increase in retirements. Appraisal compliance had decreased to 87.06% and feedback suggests this decline is due to increased annual leave in March. The Board **NOTED** the report.	
9	**Chairs Report – Quality Committee** SR alerted members that the Committee discussed the internal audit review into Local Safety Standards for Invasive Procedures, which gave limited assurance and understood the relevant recommendations from the review were being progressed at pace. SR also alerted members that several patients had made direct complaints about the care they had received direct to the Care Quality Commission. Committee heard about the plans already underway to oversee a review of the governance of complaints.	

	SR further alerted members to the small number of long-standing actions from past Care Quality Commission inspections. The Committee has asked for an update at its next meeting outlining a clear plan to complete these actions or modify them appropriately, as well as understanding how any risks are mitigated. SR summarised the various "Advise" and "Assure" matters from the Committee meeting on 26 March. The Board **NOTED** the report.	
10	**Chairs Report – People Committee** LD alerted members that the Committee discussed exit interviews for staff leaving the Trust and that this continues to be an area for improvement particularly in the development of a central recording system. LD explained due to other commitments taking priority it is unlikely that the team will be able to review why staff leave the Trust, beyond the standard information recorded in ESR until 2026 at the earliest. LD summarised the various "Advise" and "Assure" matters from the Committee meeting on 3 April. DH queried about the nursing staff group and the opportunities available regarding recruitment, retention, and turnover. SW stated a workforce plan for this staff group had not been developed due to the establishment review being completed earlier this year, however acknowledged there were opportunities which would be explored. SW added this staff group also had a low turnover rate due to staff living and working locally in the area. DS also advised that staff turnover was within planned levels and not an area of concern. CC noted the issue regarding exit interview data and queried if exit interviews were taking place when a member of staff was leaving. DS stated this was not being carried out consistently but acknowledged that generally when staff have a negative experience, they seek an exit interview with a HR representative. The Board **NOTED** the report.	
11	**Chairs Report – Estates and Capital Committee** MS alerted members that the Trust cannot fully demonstrate that it is fully compliant in terms of periodic inspection and maintenance across its asset base.	

	MS also alerted members that matters relating to violence and aggression continue to be a concern and it was agreed that a report should come to Board to discuss how the Trust can improve in this area. MS further alerted members that work is required in relation to fire safety training compliance, although work continues to resolve infrastructure issues such as the recent enhancement of dry risers. MS summarised the various "Advise" and "Assure" matters from the Committee meeting on 10 April. SL commented that the estates and facilities improvement presentation given to Committee had been well received by members. DH agreed and requested this be communicated more widely across the Trust and suggested it be used at the Annual Members' Meeting later in the year. DS agreed to ask Adam Doyle to liaise with Kathryn McDermott to progress this. SR queried about the progress to ensure the Trust was fully compliant regarding asset documentation. MS stated the Trust had a CAFM system to document assets and as part of the 2025/26 capital programme a bid had been made to upgrade the system to give greater functionality for enhanced reporting. The Board **NOTED** the report.	Debs Smith
12	**Chairs Reports – Finance Business Performance Committee** SL alerted members that the Trust ended the financial year with a deficit of £15.6m. After adjustments for items excluded from the control total, the deficit came down to £9.7m which is an adverse variance from plan of £3.1m. The Trust also made cost improvement savings of circa £20m during the year, this reflected continuous improvement and was £8m behind plan. SL also alerted members that cash continues to be a very significant risk an area requiring focus and close management with payroll requirements remaining top priority. The Better Practice Payment Code has not been achieved. SL further confirmed to members that the 25/26 plan Trust is now compliant for RTT performance through a 5% improvement as required in the national planning guidance and in line with other Acute providers in the North West.	

	SL summarised the various “Advise” and “Assure” matters from the Committee meeting on 23 April. SL requested an update on the CIP workshop planned for the week following the Committee meeting and the progress that had been made. HK confirmed that progress had been made and a further meeting was planned for this week. HK emphasised that Divisional teams were aware of the importance of transacting cost improvement programme schemes at pace. The Board **NOTED** the report.	
13	**Monthly Maternity and Neonatal Services Report** SW provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise for March. SW added there were no Patient Safety Investigation Incidents (PSIIs) declared in March for Maternity or Neonatal Services. SR commented he took part in a walkabout of Maternity and Neonatal Services on 11 April and observed a positive team committed to improvement and heard of good feedback from patients. **The Board:** • **NOTED** the report; and • **NOTED** the Perinatal Clinical Surveillance Assurance report.	
14	**Employee Experience Update** SLa gave a presentation summarising the 2024 NHS Staff Survey results, indicating the response rate was 47% compared to a median response rate of 49%. SLa set out the response rates by Division, noting Acute declined by 8% and Estates and Facilities increased by 26%. SLa highlighted overall the Trust scored broadly in line with the average results for each of the 9 People Promise elements. SLa explained the key highlights and areas for improvement. The areas for improvement identified improvement for all, staff safety and reporting concerns. DS commented about the questions relating to the care of patients being the organisation’s top priority, explaining the Board had	

	agreed patient care was a priority despite the financial challenges and questions whether this message has been received by staff which was a concern. LD commented it was disappointing to see that staff did not feel after having an appraisal it helped them improve how to do their job, noting the Trust scored below the average result for this. LD suggested this implied the appraisal framework was not impactful enough or development led. DS stated a review of the appraisal framework was underway and explained there were enhanced controls in place regarding staff development due to the financial position. SL commented it was also disappointing to see that staff would not be happy to recommend this Trust to friends or relatives for treatment, noting the Trust also scored below the average result for this as well. DS agreed and proposed in the biannual People Experience Report provided to Workforce Steering Board and People Committee include a focus on questions 25a, c and d. SR suggested it may be beneficial in the appraisal meeting for managers and staff to discuss the results of appraisal to prompt further discussion. CC queried about the 8% reduction in the response rate for the Acute Division, adding this was disappointing given the continued focus on health and wellbeing in this area. The Board **NOTED** the report.	Sharon Landrum
15	**Chief Finance Officer Report** MC reported at the end of March, month 12, the Trust was reporting a deficit of £15.6m which included an impairment of the Trust estate of £5.8m and which was excluded from the Trust's control total. MC advised after adjusting for this impairment, the Trust was reporting a deficit of £9.7m, an adverse variance against plan of £3.1m. The variance was in line with forecasts previously shared with the Board and advised to the ICB earlier in the year. MC set out the key drivers of the variance, indicating these related to underperformance in respect of the elective activity plan, expenditure on urgent care in excess of within planned levels and delivering planned integration benefits. MC reported that the deficit position continued to place significant pressure on both the Trust's cash position and compliance with the	

	Better Payment Practice Code. This was the most immediate finance risk to the Trust and is driven by the continuation of an underlying deficit position. MC confirmed that the request for additional cash in March was not approved but the Trust submission in April had been partially approved for £8m. As this is less than requested it will only partially mitigate the cash risk in quarter 1 2025/26. MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency and cash were amber, and agency spend, and capital was green. The Board: • **NOTED** the report; • **NOTED** the detailed mitigations implemented in year as described in the appendix; and • **APPROVED** the £3.1m variance to plan.	
16	**Chief Operating Officer Report** HK highlighted in March the Trust attained an overall performance of 98.90% against plan for outpatients and an overall performance of 101% against plan for elective admissions. HK indicated the Trust underachieved plan for outpatient new appointments, however overachieved plan for both outpatient procedures and for elective/day case. HK summarised the referral to treatment standard and current performance against this, reporting the Trust had 34 65-week waiters at the end of March against a standard to have no patients waiting 65 weeks by March. HK set out the 34 patients were due to either mutual aid patients, patient choice, or Ophthalmology graft patients. HK explained the overall referral to treatment waiting list had increased from 47,438 to 49,009 during the month and the Trust was undertaking a 'validation sprint' in quarter 1 as part of the national initiative to reduce the overall waiting list size. HK further summarised cancer performance against trajectories and the Faster Diagnostic Standard. HK highlighted in March type 1 unscheduled care performance was 47.21% and remained below the planned improvement trajectory, however, acknowledged there had been a 3% improvement compared to the previous month. HK added the Trust was continuing to deliver a range of improvements across the urgent and emergency care pathways to support patient flow and improve the quality and timeliness of care.	

	HK reported the Trust had a 37-minute average ambulance handover time resulting in achieving the 50-minute target. HK stated the number of patients not meeting the criteria to reside continued to reduce, currently at 13.9% against a trajectory of 10%. The Board **NOTED** the report.	
17	**Registers of Interest, Gifts and Hospitality Annual Update** DM provided the year-end updates on the register of interests, the register of gifts and hospitality, noting this had been provided to Audit and Risk Committee in April. The Board **NOTED** the Register of Interests at Appendix 1 and 2, the Register of Gifts at Appendix 3 and Hospitality at Appendix 4.	
18	**Annual Report of the Board of Directors, including Effectiveness Review** DM provided an overview of the outcome following the effectiveness review, noting all responses to the survey returned positive results and the self-assessment of the Terms of Reference found no areas recommended for amendment. The Board: • **APPROVED** the statement of effectiveness found at section 1.3; and • **NOTED** both the outcomes of the effectiveness survey, and the self-assessment against the Terms of Reference.	
19	**Board Assurance Framework (BAF) Annual Close Down** DM provided an update on the management of strategic risks through the BAF and the year-end position for each strategic risk for 2024/25. DM highlighted of the 12 strategic risks 4 were high (red) and set out the rationale for this. DM summarised the remaining 8 risks and their relevant score changes throughout the year and commentary for each. DM commented there was a Board Seminar in the afternoon to discuss risk appetite and to confirm the strategic risks for 2025/26. The Board: • **NOTED** the report; and • **APPROVED** the end of year position in relation to the BAF in 2024/25	
20	**Cycle of Business**	

	The Board **NOTED** the report.	
21	**Questions from Governors and Public** TC commented it was disappointing the Acute Division experienced an 8% reduction in the staff survey response rate and queried this. HK agreed that it was disappointing and stated there were several factors and these were in the process of being addressed.	
22	**Meeting Review and BAF Review** Members had no further comments in relation to the BAF.	
23	**Any other Business** No other business was raised.	

(The meeting closed at 11:20)

Wirral Community Health and Care NHS Foundation Trust

TRUST BOARD OF DIRECTORS MEETING
(Community Centre, St Catherine's Health centre)

DRAFT MINUTES OF MEETING

WEDNESDAY 23 APRIL 2025 at 2.00PM

Members:

Mr Tony Bennett	Chief Strategy Officer	(TB)
Prof Chris Bentley	Non-Executive Director	(CB)
Dr Jo Chwalko	Chief Operating Officer / Director of Integration and Delivery / Interim Deputy Chief Executive	(JC)
Mr Meredydd David	Non-Executive Director	(MD)
Sir David Henshaw	Chair	(SDH)
Mrs Janelle Holmes	Chief Executive	(JH)
Mrs Alison Hughes	Director of Corporate Affairs	(AH)
Mr Steve Igoe	Joint Non-Executive Director	(SI)
Ms Debs Smith	Chief People Officer	(DS)
Mr Dave Miles	Interim Chief Finance Officer	(DM)
Mr Dave Murphy	Chief Digital Information Officer	(DMu)
Dr Eddie Roche	Interim Medical Director	(ER)
Mrs Paula Simpson	Chief Nurse	(PS)

In Attendance;

Mr Robbie Chapman	Deputy Chief Finance Officer (WUTH) - observer	(RC)
Ms Lynn Collins	Lead Governor	(LC)
Mrs Cathy Gallagher	Senior Assistant (minute taker)	(CG)
Mr Paul O'Higgins	CQC Observer (on Teams)	(PO)
Ms Emma Robinson	Associate Non-Executive Director	(ERob)
Ms Lyndsey Costello	Service Director (agenda item 1 only)	(LCo)

Reference	Minute
1. WCT25/26-01	**Journey of Care** PS introduced the Journey of Care which focussed on the Fit Club service. The service user and her mum described the health benefits of using the service and how it had significantly improved their overall health. The advice and support from Phil Rhodes, Senior Health and Wellbeing Advisor had dramatically improved both their lifestyles. The Board of Directors welcomed and appreciated the story shared and extended thanks to the service. LCo also agreed an action to provide further information to the Board of Directors on the number of children that were referred to the service per annum, the uptake on referrals and the number that did not attend their appointment *(see action log status).*
2.	**Apologies for Absence**

WCT25/26-02	Tony Bennett, Chief Strategy Officer, Steve Igoe, Joint Non-Executive Director.
3. WCT25/26-03	**Declaration of Interests** The members of the Board confirmed standing declarations of interest, and it was noted that there was nothing on the agenda that required further action in respect of standing or new interests.
4. WCT25/26-04	**Minutes of the previous meeting - 19 February 2025** The Board of Directors approved the minutes of the meeting held on 19 February 2025, as a true and accurate record.
5. WCT25/26-05	**Matters Arising - 19 February 2025** The Board of Directors reviewed the status and noted any outstanding items. *(See separate actions/matters arising tracker.)*
6. WCT25/26-06	**Chair's Report** SDH presented a verbal Chair's Report noting the following points; • Both Trust Boards met together formally at the end of March 2025 and agreed the Partnership Agreement which allows both FTs to jointly exercise functions and facilitates joint decision-making on specific delegated matters. • Significant interest was received in the Joint Non-Executive Director role for both Trusts and interviews would be held on 2 May 2025. • Thanks, and best wishes to Dave Miles, interim CFO who would leave the Trust at the end of April 2025 to take up a new position at Mersey Care NHS FT. • Steve Igoe had been appointed Interim Non-Executive Director of the Trust by the Council of Governors, following the departure of Beverley Jordan at the end of March 2025. Steve was unable to join the meeting today but had already chaired his first Finance & Performance Committee, and a short report was included in the papers. The Board of Directors received the report with no further questions or comments.
7. WCT25/26-07	**Lead Governor's Report** LC presented the report as included in the pack, summarising recent work of the Council of Governors. • Governors were delighted with the positive response to the first Joint NED recruitment campaign. • Together with governor colleagues from WUTH, governors were pleased to have the opportunity to come together with representatives from both Trusts and Sir David in March 2025, to receive updates on the programme of integration between the organisations. The Board of Directors received the report with no further questions or comments.
8. WCT25/26-08	**Chief Executive's Report** JC presented the report which highlighted key issues of local, regional and national importance. The following key points were highlighted; • In March 2025, the Boards of Directors of WCHC and WUTH came together to sign a Partnership Agreement. This agreement enables joint decision-making on the future direction of travel, the development of a joint strategy and the opportunities for greater collaboration to improve clinical pathways and patient outcomes. • Excellent progress is already being made across a number of clinical services, in particular with work happening in urgent care, the virtual frailty ward and the community response teams. The MSK services will also soon to be co-located in the community bringing benefits to patients, staff and the wider health economy. • Following confirmation in February 2025 of the publication of the planning guidance for 2025-26 the Trust completed all of the required submissions including financial, workforce and operational plans to the ICB and NHSE. • New guidance had been published by NHSE outlining expectations and

	recommendations in the completion of board member appraisals. It has been developed in service of board effectiveness and to ensure a consistent and standard approach to appraisal, recognising that there would be requirement to adapt depending on the type of organisation and between Executive and Non-Executive Directors. • Cathy Elliot has been appointed as the Chief Executive of Cheshire & Merseyside ICB to replace Graham Urwin who departs in June 2025. • The Executive Teams at WCHC and WUTH were now meeting jointly on a weekly basis. JC also referred to the 2-hour Urgent Community Response Service and the ED integration which would improve patient pathways and have greater accessibility to therapies in the community. The members of the Board noted the update provided and there were no further questions or comments.
9. WCT25/26-09	**Reports from the committees of the Board** **Quality & Safety Committee - 12 March 2025** CB provided a verbal report highlighting the following key areas: • The Chief Nurse provided an update from System / Place Quality and Performance Group which focussed on Primary Care using the Patient Safety Incident Response Framework (PSIRF) formula. • The Cheshire & Merseyside Chief Nurse Forum had carried out some work with other partners on clinical risks associated with urgent and emergency care. • The Chief Nursing Officer had responded to concerns expressed by CNs across England regarding maintaining safe staffing levels. • A presentation around using remote clinical monitoring (Isla Care) had been shared with committee for assurance. • The Quality Strategy Delivery Plan 2024-25 was on track to deliver. • The Draft Quality Goals for 2025-26 had been developed to support the Trust quality strategy and strategy objectives. • The MIAA audit report on PSIRF resulted in Substantial Assurance. • The Patient Led Assessment of Care Environments (PLACE) scoring for the Community Intermediate Care Centre (CICC) was the 3rd highest score in the country. • A review of the Shanley Report for Greater Manchester Mental Health Trust had identified 7 of the 11 recommendations as transferrable to the Trust. The Trust was fully compliant with these recommendations and no gaps had been identified. **Finance & Performance Committee - 9 April 2025** SDH noted apologies from SI as new interim Chair of the Committee. It was confirmed that there were no items to raise by exception. **People & Culture Committee - 9 April 2025** MD provided a verbal report as interim Chair of the Committee, highlighting the following key areas; • The People Strategy - Year 4 Delivery Plan Report was deferred so that both Trust strategies could be aligned to ensure collaborative working. • The Workforce Sharing Agreement underpinning the programme of integration would be taken to the first meeting of the Integration Management Board. • People performance indicators were positive and although sickness absence was high, levels had reduced. • The NHS Staff Survey results 2024 had been published. The response rate was slightly lower than the previous year at 51% and of the 9 themes, 2 had improved including staff reporting incidents and harassment from colleagues, 4 themes for

	continued improvements included staff morale, staff feeling safe and healthy, flexible working and career progression. • The Sexual Safety update provided assurance of the work that had taken place by the task and finish group. • Risk ID07 in the BAF was currently under review to be rescored. • The Internal MIAA Audit report had provided substantial assurance on ESR / payroll and procedures. • The Policy Schedule update included a three-month extension to Partnership and Recognition Policy which was approved. **Briefing from Informal Board - 19 March 2025** AH provided a verbal briefing from the informal board session held on 19 March 2025 noting that the Annual Planning submission including Finance, Workforce and Board Assurance Checklists and the final submission timetable was shared with members of the board. AH noted that briefings were also shared on the new governance arrangements on CIP, the Transformation programme 2024-25, the 2-Year Delivery Plan to support integration of WCHC and WUTH and the 100 Day Plan. **Staff Voice Forum - 25 March 2025** AH gave a verbal update from the Staff Voice Forum on 25 March 2025, noting the main topic of discussion was integration and communication.
10. WCT25/26-10	**Integrated Performance Report** JH introduced the report which provided a summary of performance across the Trust during March and April 2025, noting that a detailed analysis of performance was completed in the oversight groups reporting to the Integrated Performance Board (IPB). ***Operational Performance*** JC highlighted the following position for operational performance: • There were a total 91 KPIs; 76 green KPIs, 7 amber and 8 red and good progress had been made to increase performance with action plans in place for all red KPIs. • Performance against the four-hour target in the Walk-in-Centre and Urgent Treatment Centre remained high at 96.8%. • Bed occupancy in the Community Intermediate Care Centre (CICC) was at 94.4%. The median length of stay was currently 18 days (v's target under 21 days). • Referrals to the HomeFirst service were at 162 (v's target of 170). • Urgent Community Response 2-hour and 2-day performance continued to exceed the 70% target at 89.0% which demonstrated the huge demand for community services. • The UCAT 15-minute response was at 62.0% and UCAT 30-minute response was at 94.7%. • The CAS 20-minute response times trend was 78.9% and 2-hour 64.9% in month which continued to improve, and NHS 111 Service was at 48.8%. • RTT - Patients seen within 18 weeks was 100% compliant. • DM01 - Patients waiting with a wait under 6 weeks was 100% compliant. SDH reflected the significant demand on ED noting that approx. 30% of those attending did not require treatment and would benefit from receiving treatment elsewhere. JC recognised this and advised that the work now underway to review Urgent Care Services across both acute and community, and working with primary care and the VCSFE sector aimed to address this and reduce number attending ED. SDH recognised it as a wicked issue and suggested that transformation thinking, and approaches were needed. JH agreed to take an action to discuss further opportunity with JC.

	Workforce Performance DS highlighted the following position for workforce performance: • Staff turnover was at 8.9% below the target of 10%. Turnover may increase this year which would be mapped to match the Workforce Plan. • Mandatory training compliance was at 94.9% above the 90% target. • Agency usage was at 0.9% below the cap of 3.2% • Contracted FTE vacancies in month was at 5.5%. ***Quality Performance*** PS highlighted the following position for quality performance: • QUAL 02 - Number of incidents reported remained in normal variation. • QUAL 03 - Patient Safety Incidents - the SPC chart indicated a shift following in the Learn from Patient Safety Event System (LFPSE) which remained under scrutiny at CRMG, IPB and the Quality & Safety Committee. • QUAL 08 - Total number of complaints YTD was at 3. YTD number of concerns was at 93. • QUAL 15 - Clostridium difficile infections resulting in moderate or severe harm with learning identified in relation to patient safety systems and QUAL 16 – MRSA infections with learning identified for the Trust had no incidents YTD resulting moderate or severe harm. • QUAL 18 - The YTD position of all incidents reported with moderate and above harm level was at 4.3%. There had been no level 4 moderate harm incident reports since July 2024. • QUAL 22 - The YTD Friends and Family Test responses was at 93.2% from over 28,000 responses. • QUAL 25 - The YTD position was at 92.4% reported to be no and low harm patient safety incidents. ***Financial Performance*** DM highlighted the following position for financial performance: • Budget performance was on plan with a surplus of £2.64m for M11. • Income was ahead of plan at £1.65m. Additional funding included contracts and training funds from NHS England. • Pay budget was over plan at £1.89m. • Non-pay was broadly on plan but there were some Estates and clinical supplies pressures. • Capital expenditure M11 was at £1.5m ahead of plan and expected to meet the capital expenditure limit of £4.7m. • Cost improvement Plan (CIP) YTD delivered £5.8m efficiency against a plan of £5.6m. • Better Payment Practice Code performance by volume was 91.9% and value at 95.5% against a target of 95%. The Board of Directors received the report noting the performance reported across all performance domains.
11. WCT25/26-11	**Board Assurance Framework (BAF) 2024-25 - Year-end position** AH presented the updated position in relation to strategic risks managed through the BAF following detailed review by the committees during March and April 2025. The year-end position for 2024-25 was noted with 2 new strategic risks on the BAF which related to the achievement and potential consequences of the challenging financial plan 2025-26. Through each of the committees of the Board it had also been acknowledged that a cross-reference between WCHC strategic risks and WUTH strategic risks would be

	important during 2025-26 to include appropriate mitigations based on partnership working for key strategic risks. The Board of Directors was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board and approved the strategic risks 2024-25 year-end position including 2 new risks for 2025-26.
12.	**Organisational Strategy 2022-27 - Year 3 Progress Report** SDH noted that this item would be deferred as apologies had been received from the Chief Strategy Officer. This was supported on the basis that the agenda item was not time critical and would be presented to the Board at the next meeting.
13. WCT25/26-13	**Mortality Report - Learning from Deaths Q3 2024-25** ER presented the Mortality Report - Learning from Deaths Q3 October 2024 - December 2024. There was a total of 13 reported unexpected deaths including 7 child deaths all of which were reviewed using SUDIC methodology. During Q3 there were 0 deaths which met the criteria for StEIS reporting. Of the total deaths reported in Q3, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Learning was identified as a result of a safety systems review which was discussed and shared at service level and reported to Clinical Risk Management and Mortality Review groups in addition to being shared with teams both internal and external to the trust. The Board of Directors approved Appendix 1 for publication on the Trust's website.
14. WCT25/26-14	**Staff Voice Forum** The minutes from the meeting of Staff Voice Forum on 21 January 2025 were received and noted.
15. WCT25/26-15	**Council of Governors** The minutes of the Joint Council of Governors meeting on 21 March 2025 were received and noted.
16. WCT25/26-16	**Any Other Business** JH advised that the two provider collaboratives at ICB level - Cheshire & Mersey Acute Specialist Trust Alliance (CMAST) and the Mental Health Learning Disability Community would become one provider collaborative during 2025-26. A further update would be provided in due course including the governance arrangements to support the new collaborative.
17. WCT25/26-17	**Items for Risk Register** There were no new risks identified for the risk register.
18. WCT25/26-18	**Invitation for Public Comments:** None.
19. WCT25/26-19	**Summary of actions and decisions** AH provided a summary of actions and decisions taken during the Board of Directors meeting.
20. WCT25/26-20	**Meeting Review** There were no further comments on the review of the meeting.
Date and Time of Next Meeting:	

The next formal Trust Board meeting will take place on **Wednesday 4 June 2025 at 9.00am, Community Centre, St Catherine's Health Centre.**			
Board - Chair Approval			
Name:		**Date:**	
Signature:			

The meeting finished at 15:59.

Action Log
Board of Directors in Public
4 June 2025

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 March 2025	9	To incorporate as part of the integration programme the development of a one Wirral number telephony system for patients to access information by dialling one number	Matthew Swanborough	In progress. Due August 2025.	August 2025
2.	2 April 2025	8	To provide at a future Board Seminar different approaches to address sickness absence, taking examples from internal and external to the NHS	Debs Smith	In progress. Due July 2025.	July 2025
3.	7 May 2025	5	To consider a Wirral-wide initiative to address the burden and demand on ED; immediate and longer-term opportunities to affect significant change	Janelle Holmes/Jo Chwalko	In progress. A verbal update will be provided at the June meeting.	June 2025
4.	7 May 2025	11	To ask Adam Doyle to liaise with Kathryn McDermott to progress with publicising the estates and facilities improvement journey presentation	Debs Smith	Complete.	June 2025
5.	7 May 2025	14	To include in the biannual People Experience Report provided to Workforce Steering Board and People Committee a focus on questions 25a, c and d	Sharon Landrum	Complete. Information to be incorporated into report to Workforce Steering Board/People Committee in September.	September 2025

Wirral Community Health and Care NHS Foundation Trust

Board of Directors - Matters Arising 2024-25 and 2025-26

Actions from meeting held on **19 June 2024** have been completed and archived**.**

Actions from meeting held on **21 August 2024.**

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
Board Assurance Framework	WCT24/25-067	Provide an overview of the governance supporting the PDAF at Wirral Place through informal board session	A.Hughes	November 2024	**Complete.** The references to PDAF risks are included in regular BAF reports to the committees of the Board and the Board of Directors.

There were no actions from the meeting on **16 October 2024**.

Actions from meeting held on **11 December 2024.**

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
Committee Assurance Reports	WCT24/24-117	The approach to CIP 25-26 to be shared and discussed at a future board / informal board meeting.	T.Bennett	~~February 2025~~ March 2025	**Complete.** The CIP programme including governance arrangements was shared at informal board in March 2025 and FPC in April 2025.
Integrated Performance Report	WCT24/24-119	Include the tracking of non-RTT services in the TIG performance dashboard	B.Palin	January 2025	**Complete.**
		Share future commissioning plans for the	T.Bennett	January	**Complete.**

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
		Long Covid service		2025	
Freedom To Speak Up Bi-annual Report	WCT24/25-126	In future FTSU reports include reference to demographic data related to FTSU raised across the Trust	P.Simpson	June 2025	**Complete.** Demographic on age and ethnic origin is included. From 01/04/2025 a Quality Improvement has been instigated to improve the number and quality of the demographic data captured and how this is used to support all staff members to speak up.
Any Other Business	WCT24-25-129	Share the revised CQC statement of purpose with members of the Board	P.Simpson	December 2024	**Complete.**

Actions from meeting held on **19 February 2025**

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
Journey of Care	WCT24-25-134	Schedule a follow up with the family members to provide members of the board with an update on the work complete to address the concerns and learnings identified.	P.Simpson	June 2025	This action is in progress to coordinate availability with all parties.
Integrated Performance Report	WCT24-25-143	Complete an assessment of UCR service potential and impact	B.Palin	April 2025	**Complete.** The UCR assessment of service potential and impact has been incorporated into the Urgent and emergency Care

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
					integration work between WUTH & WCHC. Achievements to date include • UCR team now re located - on site in ED • Developing operational and quality performance metrics • Development of system impact metrics • Service review of outcomes, to inform new ways of integrated working

Actions from meeting held on **23 April 2025**

Topic Title	Minute Reference	Action Points	Lead	Due Date	Status
Integrated Performance Report	WCT25/26-10	Provide an update on the uptake / no. of contacts for the Risk and Resilience service.	J.Chwalko	June 2025	An update will be provided in the Integrated Performance Report.
		Consider a Wirral-wide initiative to address the burden and demand on ED; immediate and longer-term opportunities to affect significant change.	J.Holmes J.Chwalko	June 2025	Verbal update to be provided.

Board of Directors in Public **Item 7**
4 June 2025

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

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

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

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

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

1	**Narrative**
1.1	**Local News and Developments** **Cheshire and Merseyside Trusts form new Provider Collaborative**

The two Cheshire & Merseyside provider collaboratives have come together to form the Cheshire and Merseyside Provider Collaborative (CMPC) from 1 May 2025.

Both Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST), and the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC) will be working together to share the opportunity for provider engagement, improvement and transformation across the health and care system.

CMPC will focus on aligning in-hospital and out-of-hospital services to improve patient care and ensure these services are streamlined and efficient. This will support the NHS plan to shift activity from hospital to home , recognising the interdependence between acute and community services.

Cheshire and Merseyside Provider Collaborative (CMPC) Update

The CMPC Leadership Board met on Friday 2 May. This was the first single provider collaborative meeting for Cheshire and Merseyside. This inaugural meeting discussed several system wide issues and included Trust CEOs and Chairs.

The Leadership Board received an update on the work being progressed by the ICB with NHSE on the system's financial plan and additional provider and ICB actions required to reduce current system expenditure plans to the available financial envelope. A revised plan had been shared with NHSE with further discussions at a regional and national level expected. Additional scrutiny and intervention is expected, and further control and standardisation was relayed as necessary.

The Board was introduced to Mandy Nagra, who has been appointed as Cheshire and Merseyside System Improvement Director. Mandy commented on an amount of good work going on within C&M. This message was coupled with a wider expectation of more and continuous improvement financial efficiencies and delivery at pace.

Further areas of discussion related to a quarterly review of improvement programme delivery and discussion on the work plans for each of the programmes in the year ahead..

Update papers were also provided on the following areas:

- System financial report
- System performance update

NHS Cheshire and Merseyside publishes Green Plan for 2025-2028

On Earth Day (22 April), NHS Cheshire and Merseyside launched its refreshed Green Plan – a bold, practical blueprint for how it will decarbonise healthcare, boost resilience, and create healthier communities across the region. The refreshed Green Plan reinforces a commitment to a sustainable, net zero NHS that supports both people and planet, and revolves around three key priorities for 2025 and beyond:

- Expanding natures role in health
- Climate adaptation
- Heat decarbonisation

The full Green Plan can be found on the sustainability section of this website.

Care Quality Commission (CQC) Unannounced Inspection

The CQC commenced an unannounced inspection of Arrowe Park Hospital on the 12th May. The inspection focused on Urgent and Emergency Care and Medicine. The onsite inspection took place over 3 days, initial feedback from the CQC was provided on day 3 and WUTH responded to the feedback on the 21st May 2025.

CQC submitted a data request to the Trust on Monday 19th May with a deadline for submission of Tuesday 27th May. We remain in inspection period until the first draft of the CQC report is received, expected on the 7th August 2025

Inspectors heard of positive examples of integrated working between the acute hospital and community services. They also consistently heard positive feedback from patients and their families. Patients told them that staff were attentive and responsive.

Staff also reported they felt supported within their teams. Interactions among staff showed teams had a strong culture of support and evidence of strong working relationships.

There were areas for improvement highlighted and we are working with staff to ensure we have robust processes in place to address these areas and respond to the CQC.

GIRFT Breast Surgery Gateway Review: Cheshire and Merseyside Cancer Alliance

WUTH with other providers in Cheshire and Merseyside participated in the Getting It Right First Time (GIRFT) review of the Cheshire and Merseyside Cancer Alliance (CMCA). GIRFT aimed to identify and reduce unwanted variations to improve quality of care, patient outcomes and efficiency in NHS breast surgery services.

At a regional level several key strengths were observed, including implementation of Contrast Enhanced Spectral Mammography (CESM), recruitment into clinical trials, Advanced Nurse Practitioners (ANP's) supporting urgent clinics and post op wound clinics to reduce pressures on community services.

In WUTH the review identified that 35% of patients were over age 70 which was above national average and 22.8% were in most deprived group. Key strengths included being a high performer for the 62-day cancer standard and having below average length of stay for implant-based reconstructions.

Community Paediatrics Neurodevelopment Pathway Update

Neurodevelopment (ND) diagnostic pathway demand continues to outstrip capacity, leading to paediatric patients waiting on average >2 years to be assessed for Attention-Deficit/Hyperactivity Disorder (ADHD) or Autism (ASD).

A joint WCHC and WUTH business case was developed in 2024/25 and submitted to the ICB for consideration during 2025/26 planning. The 3-year plan was designed to address the backlog of patients waiting within the service and enable the implementation of the new pathway.

The ICB communicated in April 2025 that the joint WCHC and WUTH business case

	had now been considered. However, due to the current financial position across the NHS the business case had not been approved for funding within 2025/26. Work is underway to review what efficiencies can be made within existing resource, although this will not significantly reduce the waiting times. **WCHC Interim Chief Finance Officer** Robbie Chapman took up the position of Interim Chief Finance Officer (CFO) at Wirral Community Health and Care (WCHC) as of 1 May 2025. Robbie has been Deputy Chief Finance Officer at Wirral University Teaching Hospital (WUTH) since October 2020 and replaces Dave Miles who was the previous interim CFO at WCHC. Dave Miles left WCHC to start a new position at Mersey Care NHS Foundation Trust as their Deputy Director of Finance and we wish him all the very best in his new role and extend our thanks for his valuable contribution and commitment to the Trust.
1.2	**WUTH Health and Safety** There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in April. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There were no Patient Safety Incident Investigations (PSII) opened in April under the Patient Safety Incident Response Framework (PSIRF).
1.3	**Published Reports of Interest** The following are some reports recently published and of interest to members of the Board, staff and public. • ***Consultation on the draft NHS Performance and Assessment Framework.*** *NHS England is consulting on the draft NHS Performance and Assessment Framework, focussed on the proposed approach and methodology for assessing the performance of integrated care boards and NHS trusts and foundation trusts. The consultation will run until 30 May 2025 and feedback will help refine the framework's approach to oversight across the NHS ahead of publication and implementation later this year* – NHS England » Consultation on the draft NHS Performance and Assessment Framework • **Patient safety healthcare inequalities reduction framework.** This framework sets out five key principles to reduce patient safety healthcare inequalities across the NHS. It outlines opportunities that local teams and integrated care boards (ICBs) can implement, as well as the work NHS England is taking nationally to support and enable this – NHS England » Patient safety healthcare inequalities reduction framework • **The role of young people at the centre of service design.** The latest report in the Providers Deliver series aims to share and celebrate the work of NHS trusts and foundation trusts, showcasing new and innovative initiatives to support children and young people to access the care they need. Wirral Community Health and Care NHS Foundation Trust worked with teenagers to develop a sexual health service that meets the needs of people aged 13 to 19.

1.4	**Communications and Engagement** **Chief Executive visit to Community Nursing** The Birkenhead and Claughton Community Nursing Teams welcomed me during a visit in May. The visit was an opportunity to showcase the incredible work being done every day by our dedicated community nurses. Along with sharing some of the challenges and successes they experience on the front line, the team also discussed ideas with me how improving self-care for the patient would release more capacity and time to deliver care. The team appreciated the opportunity to speak openly about their work and ask questions about the future. Further visits from me and Trust Chair, Sir David Henshaw are planned with other services across the Trust. **Celebrating Our Nurses – International Nurses Day 2025** WUTH and WCHC marked International Nurses Day on 12 May with celebrations across both Trusts, thanking our amazing nurses for their compassion, care, and dedication. Chief Nurse, Paula Simpson at Wirral Community Health and Care NHS Foundation Trust and Chief Nurse, Sam Westwell at Wirral University Teaching Hospital provided a joint pledge which was shared with staff across both Trusts. *"This International Nurses Day, we want to recognise the outstanding contribution of our nurses across Wirral University Teaching Hospital and Wirral Community Health and Care NHS Foundation Trust. This year's national theme, Caring for Nurses, is a timely reminder of how vital it is to support those who spend their days caring for others.* *Across both Trusts, our nurses are there day in, day out - in hospitals, clinics, and in the community - providing care that truly matters.* *Whether it's delivering clinical care, sharing knowledge, or being there through the toughest moments, your impact is felt by so many across the Wirral.* *As our two organisations continue to work more closely together, our shared commitment to you remains central.* *Caring for nurses means making sure you feel supported, heard, and valued, not just today, but throughout your careers.* *We're proud of the difference you make, and we're proud to work alongside you.* *Thank you for everything you do, each and every day, to care for our community."*

WUTH Team of the Month Winners – Children's Ward team, including Emily Thomas and Dr Elizabeth Thompson

The Children's Ward won Team of the Month were nominated for making a significantly positive impact on the young person's emotional and physical health. Kindness and compassion were shown by every staff member (including nurses, play specialists, student nurses and hotel services staff). The team met her emotional needs, she was happy, smiling and singing when she was sad - they provided comfort and care.

WUTH Employee of the Month – Support Services Winner Joshua Ang, Business Intelligence Support Assistant

Joshua Ang, Business Intelligence Support Assistant won Employee of the Month - Support Services. Josh is part of a new team, with limited access to an established network of contacts, and he used his initiative to self-start with a calm and organised approach. The project was highly complex and will greatly benefit cancer patients, enabling our radiology teams to make best use of their capacity to prioritise patients for a faster diagnosis of cancer.

WCHC April Standout Winner – Cheryl Manning, Knowsley 0-25 North Team

Cheryl is a dedicated Health Visitor in the Knowsley 0-25 North Team and is incredibly innovative in devising better ways of working and improving processes to streamline services.

Cheryl is an integral part of the team and goes above and beyond to support the service and families she works with. Her generous, funny, and kind presence is inspirational, and she lifts the team morale even on the most challenging of days. Cheryl treats everyone with kindness, compassion and fairness.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8**

04 June 2025

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

Executive Summary and Report Recommendations
This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of April 2025. It is recommended that the Board: • Note performance to the end of April 2025.

Key Risks
This report relates to the key risks of: • Quality and safety of care • Patient flow management during periods of high demand

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

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

1	**Narrative**
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

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

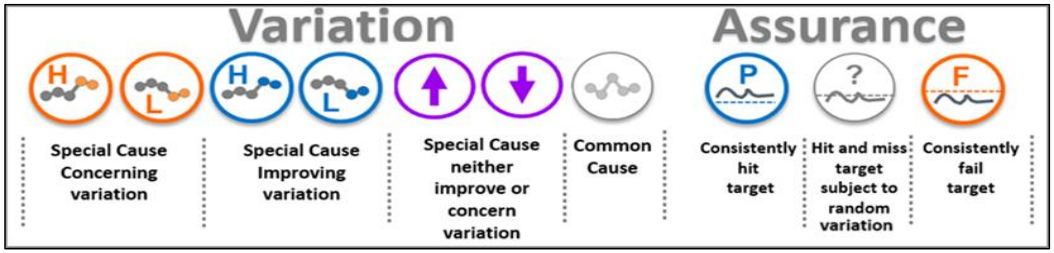
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - May 2025

Approach

The metrics for inclusion have been reviewed with the Executive Director team.
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 their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Key to SPC Charts:



Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	2	3	5
All Domains	16	27	43

Issues / limitations

SPC charts should only be used for 15 data points or more.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

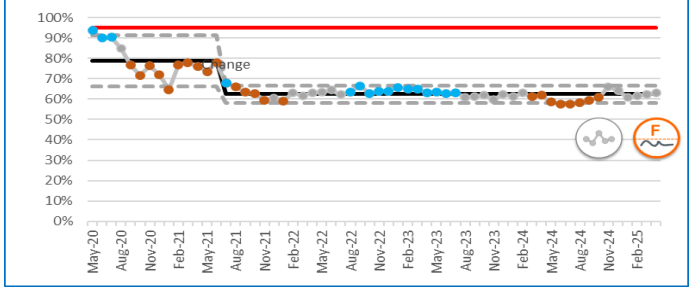
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	National threshold target for 2024/25 is not yet confirmed - internal maximum set at 108 cases for the year.

Chief Operating Officer (1)

CQC Domain : Responsive

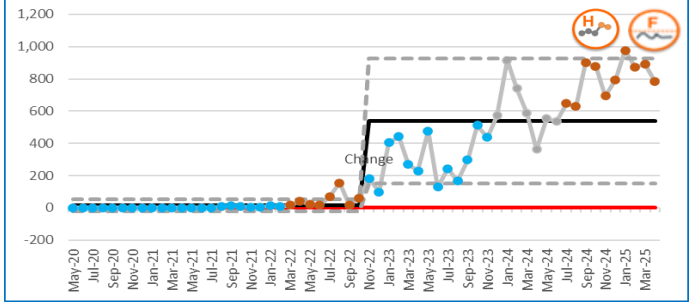
4-hour Accident and Emergency Target (including APH UTC)



Apr-25
63.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

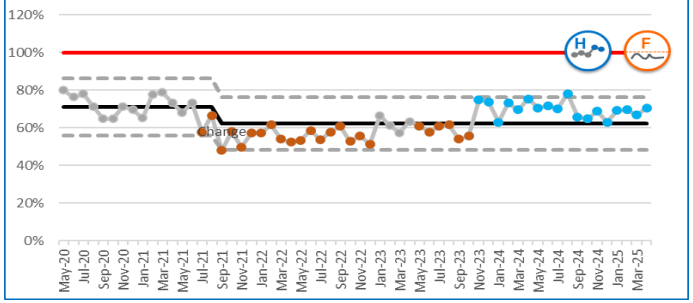
Patients waiting longer than 12 hours in ED from a decision to admit



Apr-25
783
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

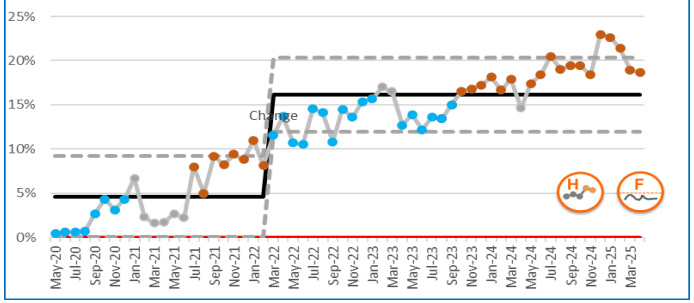
Time to initial assessment for all ED patients - % within 15 mins



Apr-25
70.6%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

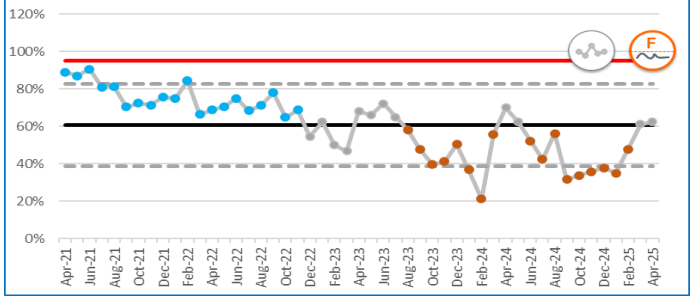
Proportion of patients more than 12 hours in ED from time of arrival



Apr-25
18.7%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

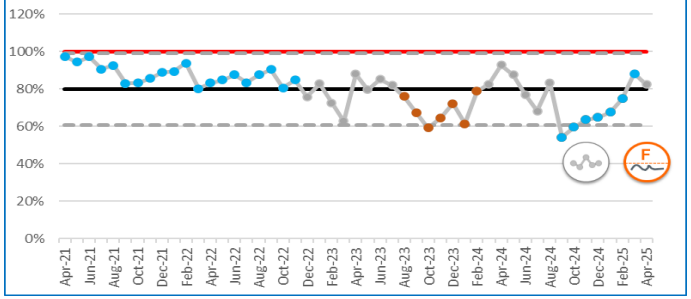
Ambulance Handovers: % < 30 mins



Apr-25
62.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

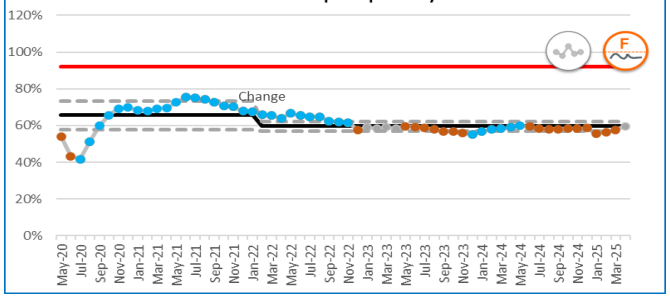


Apr-25
82.3%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

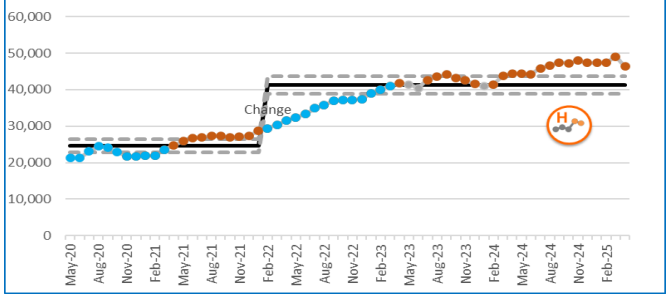
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Apr-25
59.74%
Variance Type
Common cause variation
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

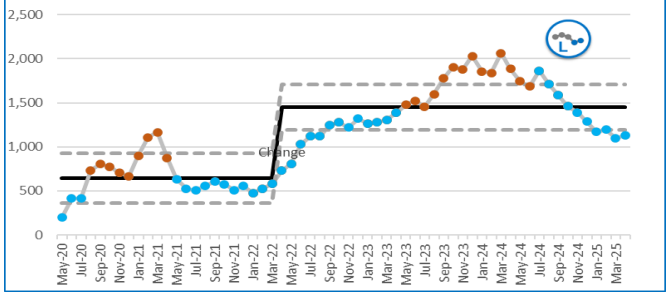
Referral to Treatment - total open pathway waiting list



Apr-25
46400
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

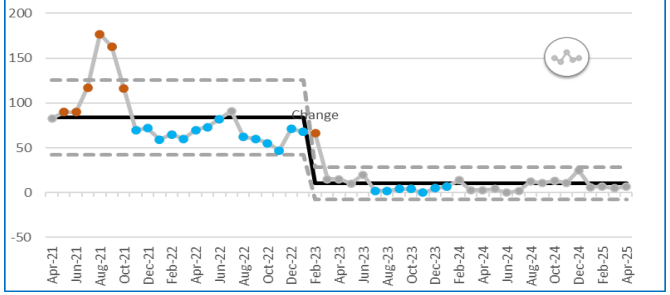
Referral to Treatment - cases exceeding 52 weeks



Apr-25
1128
Variance Type
Special cause variation - improving
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

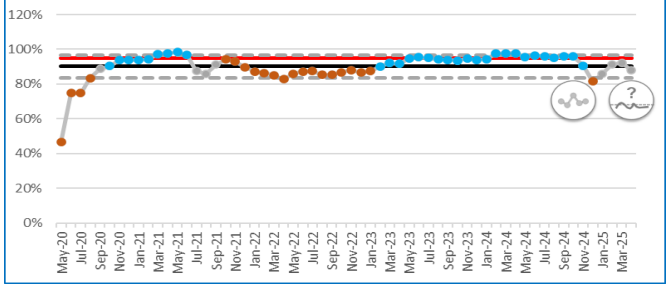
Referral to Treatment - cases waiting 78+ wks



Apr-25
7
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

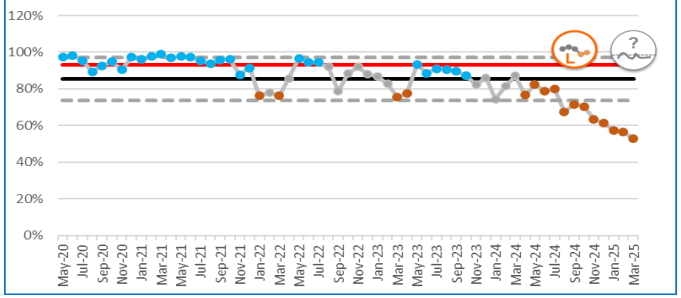


Apr-25
87.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

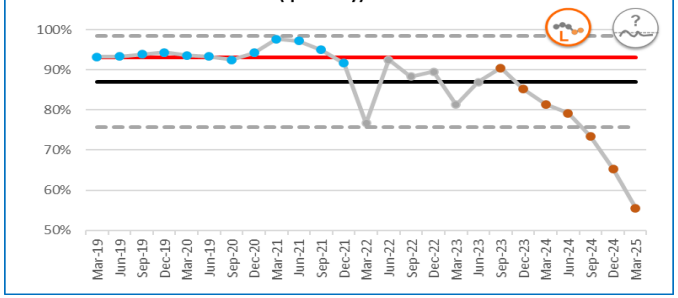
Cancer Waits - 2 week referrals (monthly)



Mar-25
52.9%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

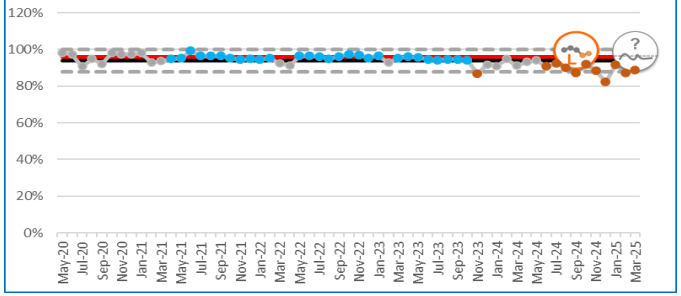
Cancer Waits - 2 week referrals (quarterly)



Mar-25
55.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

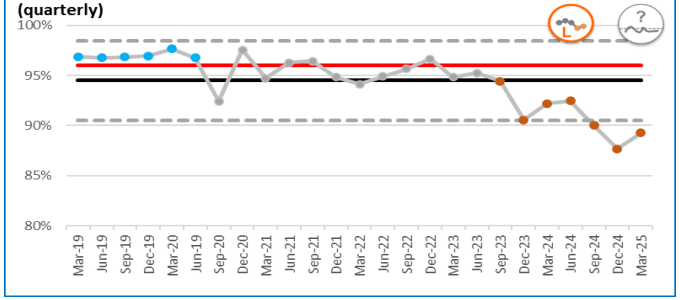
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Mar-25
88.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

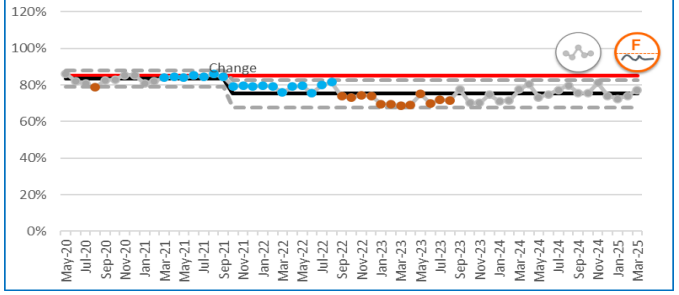
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Mar-25
89.3%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

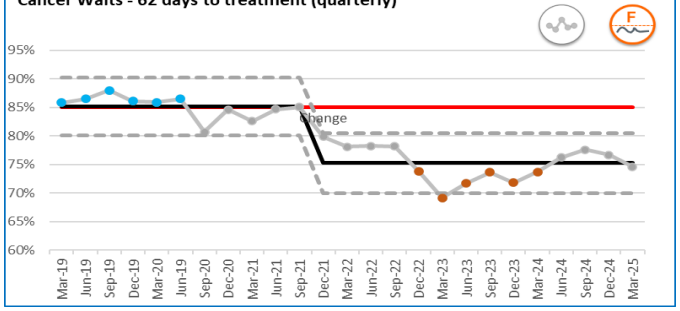
Cancer Waits - 62 days to treatment (monthly)



Mar-25
77.4%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Cancer Waits - 62 days to treatment (quarterly)

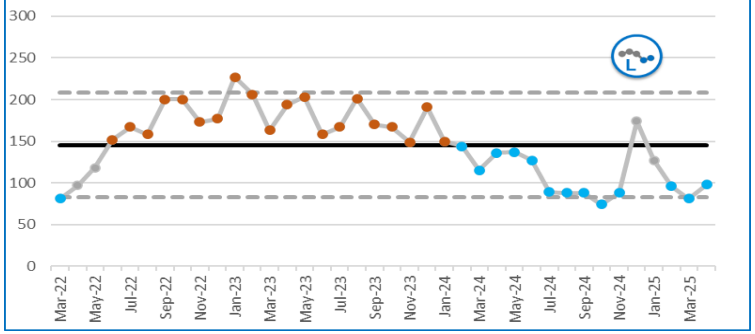


Mar-25
74.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (4)

CQC Domain : Responsive

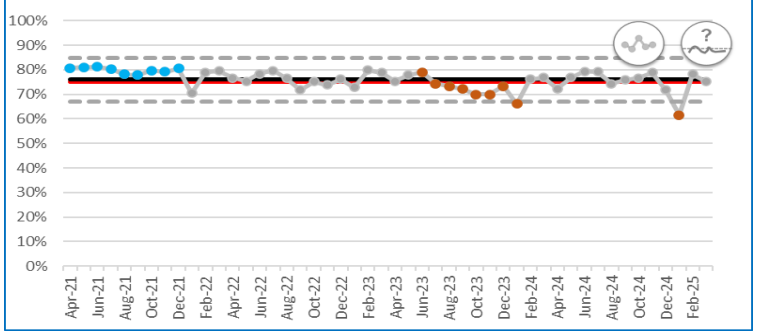
Cancer Waits - reduce number waiting 62 days +



Apr-25
98
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

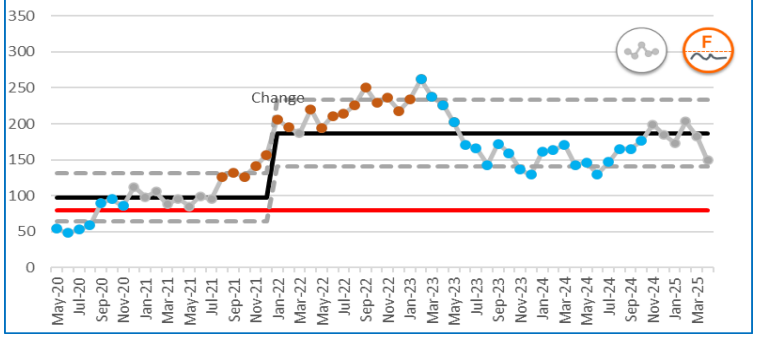
Cancer - Faster Diagnosis Standard



Mar-25
75.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

CQC Domain : Effective

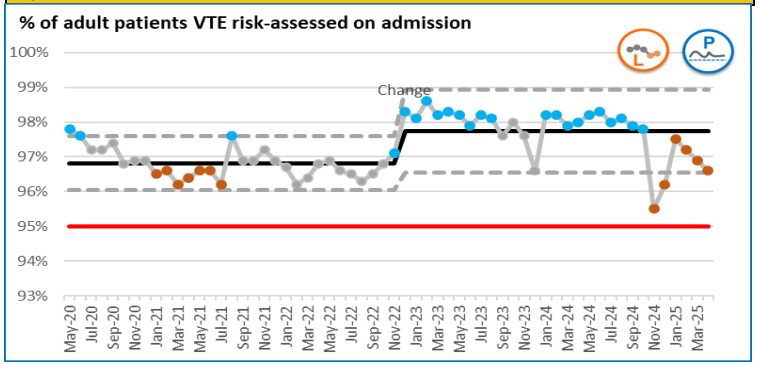
Long length of stay - number of patients in hospital for 21 or more days



Apr-25
149
Variance Type
Common cause variation
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

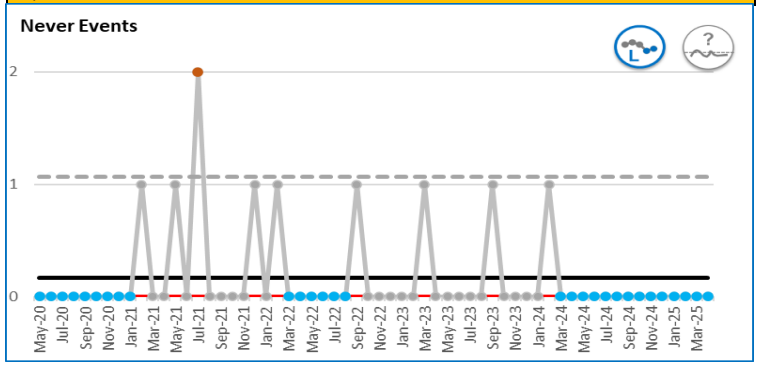
Medical Director

CQC Domain : Safe



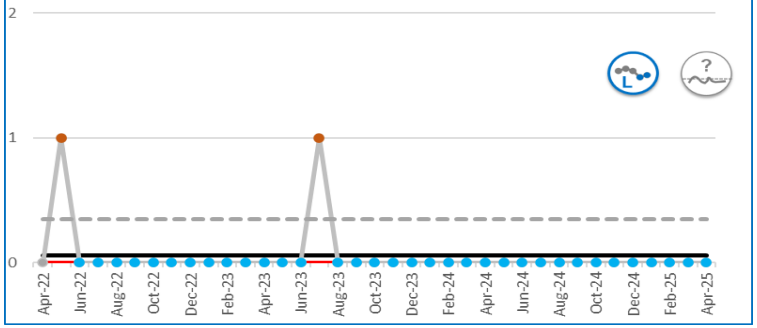
Apr-25
96.6%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



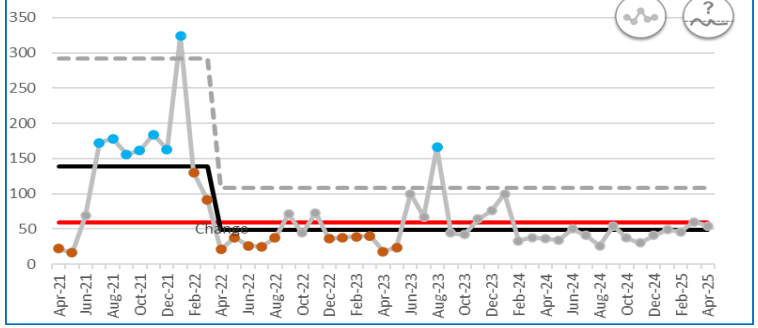
Apr-25
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



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

CQC Domain : Well-led

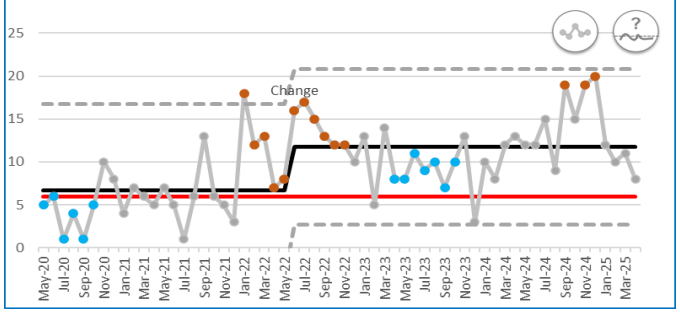


Apr-25
54
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

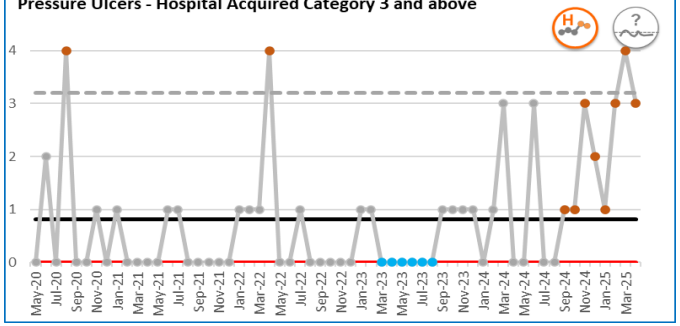
Clostridioides difficile (healthcare associated)



Apr-25
8
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

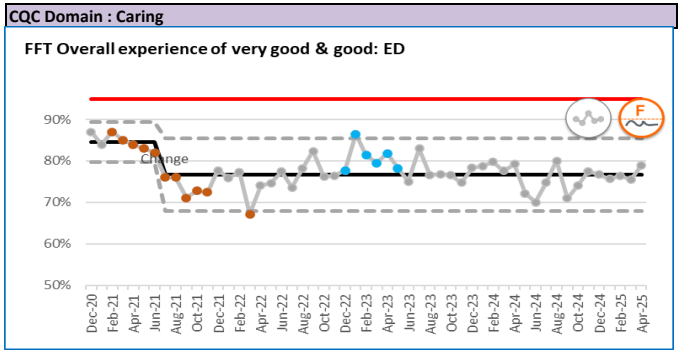
Pressure Ulcers - Hospital Acquired Category 3 and above



Apr-25
3
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

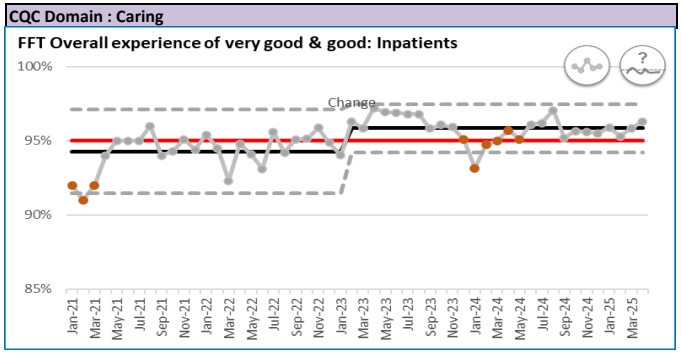
FFT Overall experience of very good & good: ED



Apr-25
79.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

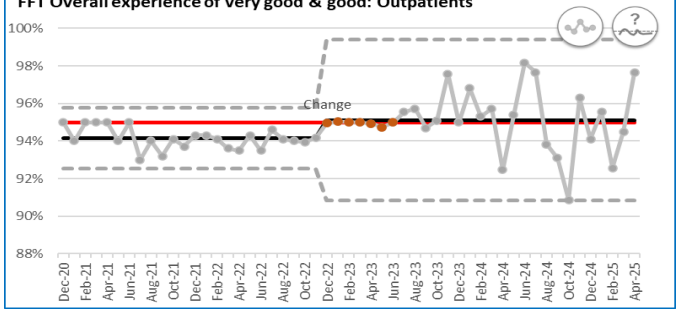
FFT Overall experience of very good & good: Inpatients



Apr-25
96.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

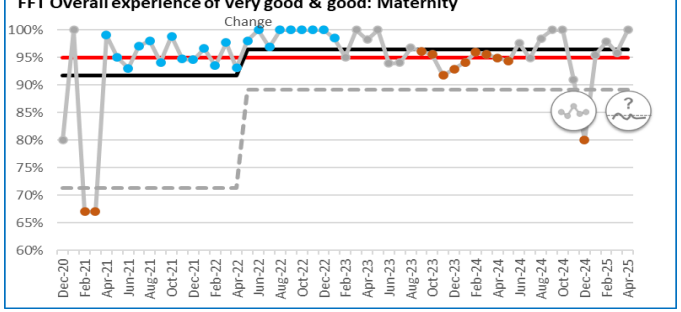
FFT Overall experience of very good & good: Outpatients



Apr-25
97.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity

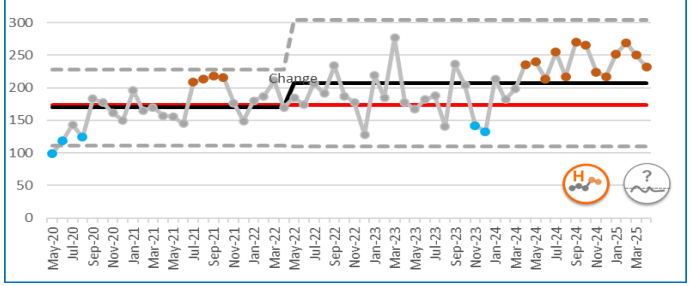


Apr-25
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

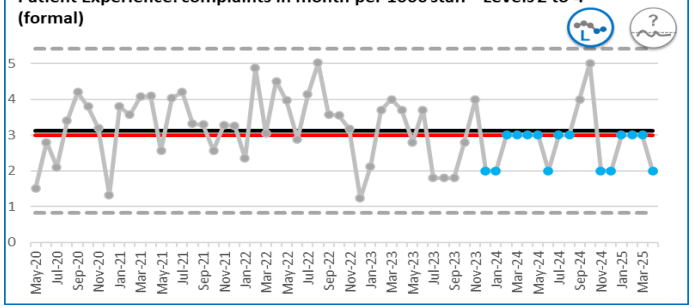
Patient Experience: concerns received in month - Level 1 (informal)



Apr-25
232
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

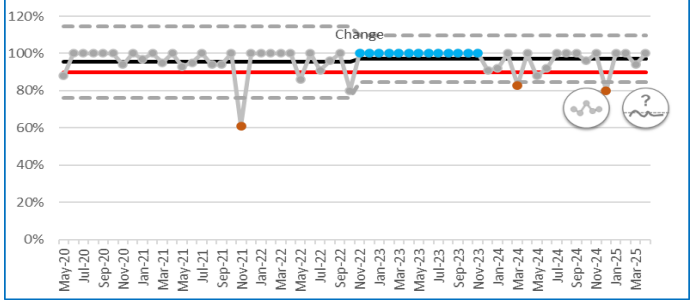
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Apr-25
2
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

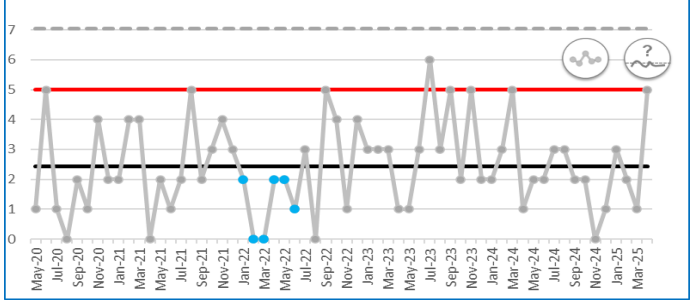
Formal Complaint acknowledged within 3 working days



Apr-25
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

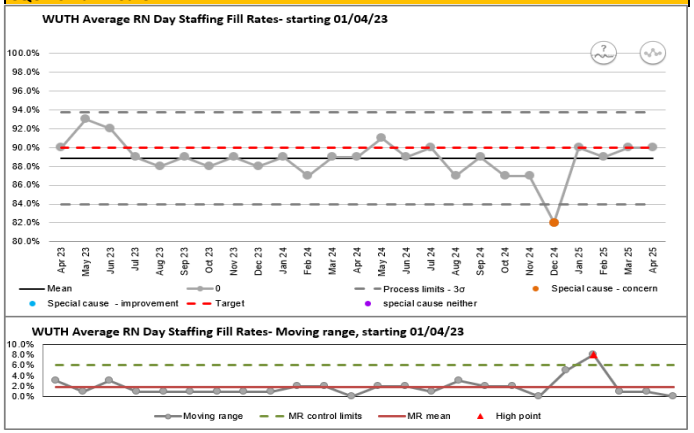
Number of re-opened complaints



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

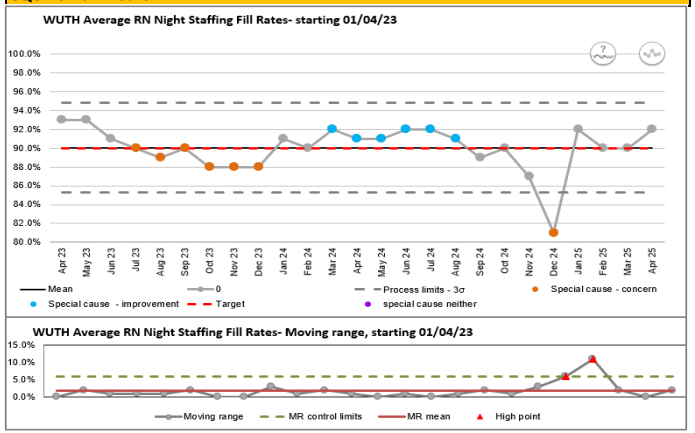
Chief Nurse (3)

CQC Domain : Safe



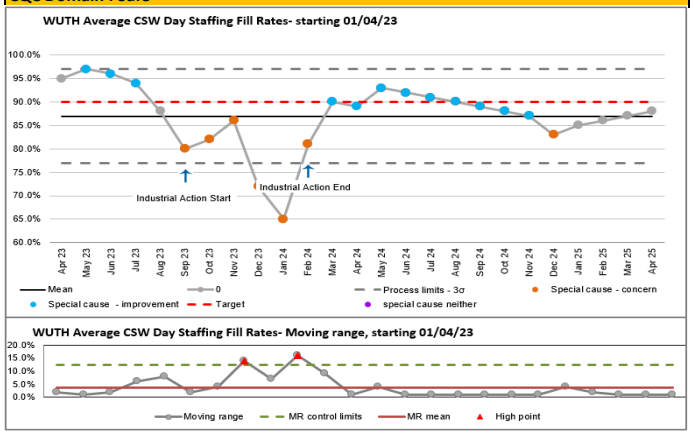
Apr-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



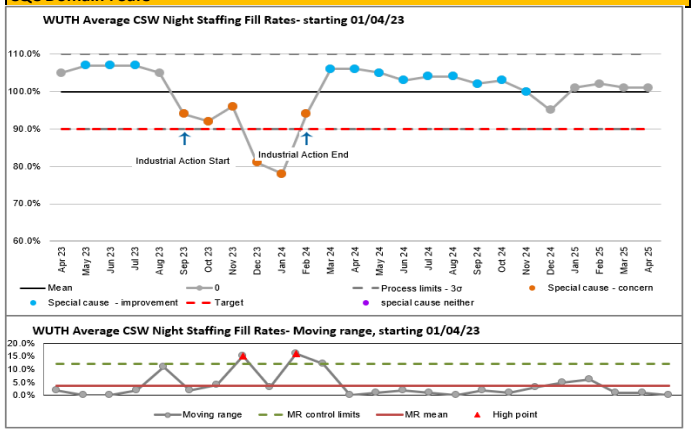
Apr-25
92.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



Apr-25
88.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



Apr-25
101.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse – for May 2025 BoD

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation in month.

C Difficile there were 8 incidents in April 2025.

There was 5 category 3> hospital acquired pressure ulcer in March 2025 against a target of 0.

Friends and family test for ED 79%, Outpatients, Maternity and inpatients exceeded the 95% of those that responded were either satisfied or very satisfied with the service.

The number of level 1 concerns raised with the trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff was below the agreed threshold.

With the exception of CSW day fill rates, RN and CSW staffing fill rates were above the threshold of 90%.

Infection Prevention and Control

Narrative:
The trust diagnosed 8 patients with CDT in April, of those reported there were 5 Hospital-onset health care associated (HOHA) and 3 Community onset healthcare associated (COHA).

This continues to show a downward trend since Dec 24

Infection Prevention & Control is one of the 3 quality priorities for the Trust in 2025/26 and the IPC plan going forward will further explore the key strategies to reduce patients diagnosed with *Clostridioidies difficile* and Gram negative bacteraemia.

Collaborative working with the Community Trust continues with further engagement with the ICB being explored.

Actions:
Completed or in place.

- Ongoing use of a decant ward to facilitate bay movements to allow for HPV to take place following a patient identified with CD Toxin/Equivocal results.
- Ongoing IPC visibility to wards and department offering expert advice and guidance.

- Robust process embedded to pick up weekend results.
- Senior nurse walk rounds focusing on IPC basics, including cleanliness, hand hygiene, bare below the elbows, decluttering and estates issues.
- Collaborative monthly meeting with WUTH IPC and the Community IPC team
- C&M IPC collaboration group focusing on CDT
- IPC daily review of all side rooms, including those with en-suite facilities in the medical division to identify who can be moved out should a side room with en-suite facilities be needed for a patient with loose stools.
- Place based AMR champion funded by public health being progressed.
- Review of patients that relapse to identify common themes.

Risks to position

High site occupancy levels

Patients with competing needs for isolation

FFT Overall experience of very good and good.

Narrative:

The NHS Friends and Family Test (FFT) was created to help service providers, and commissioners understand if patients are satisfied with the service provided, or where improvements are needed. It's a quick anonymous way for patients to provide their views. The trust monitors FFT across a range of care settings, with a target rating of a minimum 95% for good or very good.

ED score was 79%. Analysis of the patient comments for ED identifies waiting times and communication, as the main reasons for attributing negative ED response.

Actions:

- Proactively respond to feedback, making immediate rectifications when able to do so.
- Continued focus on providing people with access to provide feedback via FFT.
- Feedback to local teams' themes from FFT to identify areas of improvement.
- Regular announcements on waiting times within ED.
- Introduce new ways of working to enable a smoother patient journey.
- Rounding the department to check patients' needs are met.

Risks to position and/or actions:

- Bed occupancy is impacting on the length of time patients remain within ED. Processes are in place operationally to enable earlier egress from ED.
- Reduction in administrative support to deliver the patient experience strategy, due to current vacancy controls. Work being priorotised to mitigate risks to the strategy

Complaints

Narrative

In April 2025, the Trust logged 10 formal complaints (level 2) and 232 informal concerns (level 1).

While the level 1 concern numbers were similar to the 2024/25 monthly average of 240 (a 3% fall), there was a large (44%) fall in the number of formal complaints (for which the 2024/25 monthly average was 18).

Divisional Breakdown

- Medicine received the highest number of both formal complaints (6) and informal concerns (70).
- Emergency Care received 4 formal complaints.
- Each of the other divisions logged 1 formal complaint, with the exception of Estates, Facilities & Capital, for which none was logged.
- After Medicine (70), Surgery received the highest number of informal concerns (62), followed by Women's & Children's (43), Emergency Care (38), Diagnostics & Clinical Support 30), Corporate Departments (15), and Estates, Facilities & Capital (7).

Key Themes

The most frequently reported themes across all concerns and complaints remained:

1. **Communication (27%)**: Primarily due to communication failures rather than staff attitude.
2. **Access and Admission (25%)**: Predominantly related to delays and cancellations.
3. **Treatment and Procedure (19%)**: Largely centred on delays in care delivery.

The departments most frequently referenced were Emergency Department (ED) and Community Child Health.

Timeliness and Case Progress

The average response time to formal complaints in April was 52 working days (which was an improvement from 58 working days in March, and the full-year average of 60 working days in 2024/25), with 58% of responses sent within 40 working days – again, a marked improvement from 2024/25 (30%).

At the end of April, there were 41 formal complaints in progress, of which 13 had exceeded the 40-working-day target, below the 2024/25 highpoint of 77 and 24 (in November).

Actions

- Daily performance reports and weekly divisional meetings with the Complaints Team ensure continuous oversight, structured guidance and escalation where necessary.

Nurse Staffing Fill Rates

Narrative:

Registered nurse and care support working fill rates should be reported to the board on a monthly basis to ensure compliance with NHSE developing workforce safeguards 2018 and the national quality board safe sustainable and productive staffing 2017. A ward level dashboard should also be available to demonstrate safe effective care is being delivered. Fill rate threshold is currently set at 90% day and night CSW and RN. March saw adequate fill rates for RN day and Night and CSW night shift. Agency ceased in April in both ED and Theatres.

Actions:

Review of vacancies across the organisation, to fully understand the risk and impacts and determine the most effective recruitment process ie; speciality based recruitment events. Including ED.

Second acuity review completed with new safer nursing care tool, data currently being analysed.

Assurance re effectiveness of absence management.

Weekly roster oversight review meetings undertaken by DCN/CN to review use of bank and agency, and roster KPI's

Roster/establishment/ESR alignment project under way.

Proposal regarding the approach to maternity leave backfill in development.

ED recruitment to new establishment underway, staff being temporarily redeployed to ED from wards to maintain safety, impacting on the wards.

Retention group reinitiated.

Risks to position and/or actions:

- High sickness absence rates.
- Staffing temporary escalation areas ie; ED corridor.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:
WUTH has a zero tolerance on Hospital Acquired Pressure Ulcers (HAPU) category 3 and above.
During April we have seen an increase in the development of category 3 & 4 pressure ulcers all validated by the tissue viability team.
Five patients sustained pressure damage in April, four category 3 and one category 4.

Breakdown:

Medicine & Acute
Category 3 - heel x 1(Ward 19), buttocks x 2 (Ward 19 & AMU) and Category 4 x 1 Finger (Ward 19).

Surgery
Category 3 heel x 1 due to plaster cast (Ward 10)

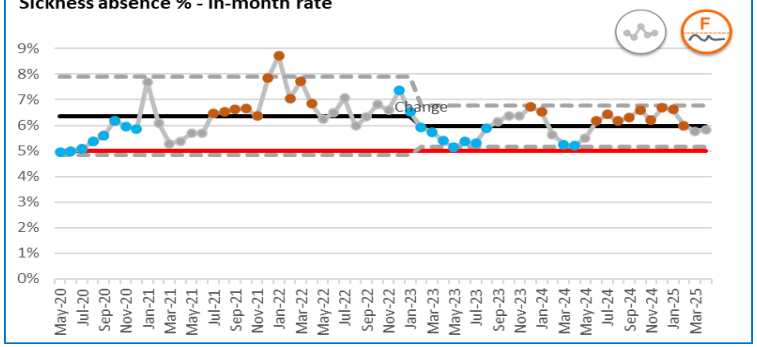
Actions:
- Deep dive undertaken within Medicine & Acute division regarding increase.
- Rapid evaluations of care undertaken on all pressure ulcers with lesson learnt.
- Further training arranged for Ward managers and matrons on completing clinical incidents and validation of pressure ulcers.
- Monthly pressure ulcer training arranged for all staff by Tissue Viability Team on classification of pressure ulcer and aSSKINg model of care.
- Ad – hoc ward training.
- Introduction of tissue viability educational boards within surgery.
- Divisional harms meetings arranged weekly and monthly.

Risks to position and/or actions:
- Part time leadership within the tissue viability team.

Chief People Officer

CQC Domain : Safe

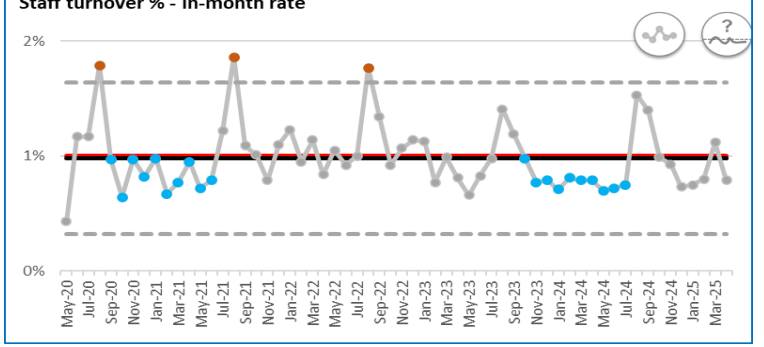
Sickness absence % - in-month rate



Apr-25
5.84%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

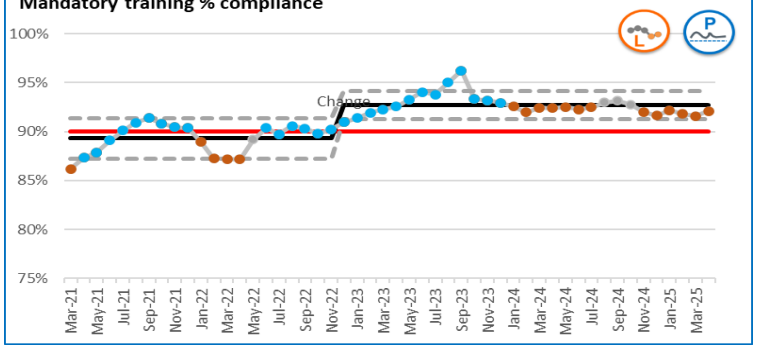
Staff turnover % - in-month rate



Apr-25
0.79%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

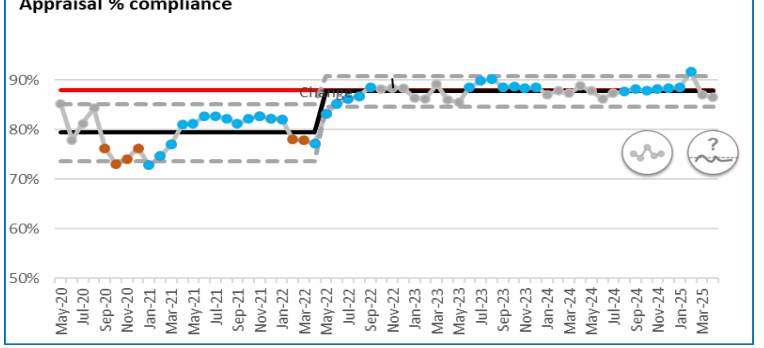
Mandatory training % compliance



Apr-25
92.11%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Apr-25
86.60%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for May 2025 BoD

Overall position commentary

- The Trust's People KPIs for mandatory training is on target at 92.11%.
- Sickness absence has improved over recent months however it remains above target at 5.84% and an area of concern and focus.
- Turnover is on target in April at 0.79%.
- Appraisal has decreased to 86.60%.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For April 2025 the indicator was 5.84% and demonstrates special cause variation - concerning.

The majority of absences relate to short term sickness. Gastrointestinal illnesses remains the highest cause of sickness followed by anxiety/depression and Cold/Flu, these three reasons account for 50% of all absences in April 2025.

In January 2025 a deep dive presentation to Audit Committee highlighted Additional Clinical Services, Nursing and Midwifery, and Estates and Ancillary staff groups as key areas of focus. Since then, significant improvements have been made in Additional Clinical Services and Nursing and Midwifery.

Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy.

Actions:

Proactively supporting Physical Health & Wellbeing

- Proactive promotion of the EAP Active Care Support for Stress-Related Absences
- Wellbeing surgeries in place with a focus on mental health
- International nurses and midwives' day celebration events
- Road map to wellbeing developed in conjunction with Surgical division
- EAP on site presence to increase uptake
- Trainee OHA and OHP vacancies out to advert
- Burn out sessions lead by the Trusts psychotherapist
- Second MHFA support session held in April

Managing Absence

- 44 managers trained this month in Attendance Management via the Managers Essentials or standalone sessions
- HR Drop-In sessions running each weekday for managers to have direct access to 1:1 support from HR team
- HR team implemented a targeted approach to sickness absence management, enabling more effective resource allocation and focused support where it is most needed.
- Audits of application of policy remain ongoing; reports shared with divisional triumvirates as part of improvement measures and ensuring consistent application of policy.
- Monitoring of the sickness absence KPI and associated actions are ongoing via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.

Risks to position and/or actions:

The local risk (397) score is 15 and BAF risk is 12, the increased risk position remains in month to reflect the impact that current sickness levels are having upon the organisation.

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR Team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels, financial controls and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The negative impact of both sickness absence and presenteeism on the workforce and patient care are well known and understood across the Trust. Work to ensure consistent and robust application of the policy is underway, led by HR Team work continues to review sickness and target support at areas of highest need.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of April 2025 compliance has dropped in month from 87.06% in March to 86.60%.

While Medicine and Women and Children's Divisions remain compliant, all areas except for Estates, facilities & Capital, Surgery and Women & Children's have seen a further reduction in compliance for April. Initial engagement with Divisional HR business partners suggests that a peak in annual leave during March has impacted compliance. The OD team are working with HR business partners and operational leaders to fully understand this as a key action to address.

Appraisal compliance was discussed at Workforce Steering Board on 30th April, prior to the release of April's Workforce data. Discussions also focused on the length of paperwork. It was agreed that divisions would each nominate a member of staff to contribute to a review of the Appraisal and Check in paperwork and a quick turnaround is anticipated.

Actions:

- The OD team are reviewing the Appraisal and Check-in paperwork via focus group with divisional representatives to streamline this further.
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team continue to contact all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process, note this is in addition to ESR automatic messages which are also issued.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and 'on-demand' learning resources that brief staff and managers on the new process.
- The appraisal portlet makes recording appraisals easier for managers with a short step by step video to assist them in recording appraisals.

Risks to position and/or actions:

- Ongoing system pressures continue to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness, in a format and at a time which works around operational commitments, for teams / services that are particularly lower in compliance.

Public Board of Directors **Item 9**

04 June 2025

Title	Integrated Performance Report - April 2025
Lead Director	Janelle Holmes, Chief Executive
Author	Dave Murphy, Chief Digital Information Officer
Report for	Information

Executive Summary and Report Recommendations

The Integrated Performance Report provides a summary of performance across operational, quality, workforce and financial metrics.

The report provides an in-month and YTD position.

The Integrated Performance Board met on 28th May 2025 to review performance up to and including M01.

The Integrated Performance Dashboard will be presented 'live' at the meeting of the Board of Directors to provide an update on Trust performance across all domains. This report should be considered alongside the briefings from the Chairs of the committees of the Board.

It is recommended that the Board:

- Receive the report live from TIG and be assured on the monitoring of performance across the Trust for M01, 2025-26

Key Risks

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

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

Contribution to WCHC strategic objectives:	
Populations	

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Every meeting of the Board of Directors.	Public Board.	IPR	The report is presented live from TIG and received for assurance on performance across all domains.

1	**Narrative**
1.1	The development of a published version of the IPR remains in progress. This responds to a recommendation from the Trust's external auditors and previous updates reported to the Board of Directors. This work is also being considered in collaboration with WUTH to ensure alignment and consistency where relevant and appropriate. A review is currently underway in partnership with Directors / portfolio leads, to agree measures and KPIs in full accordance with Insightful Board guidance. A first draft of the report will be tabled at the Board of Directors meeting on the 2 July 2025 for discussion and approval.

2	**Implications**
2.1	**Quality/Inclusion** Not applicable
2.2	**Finance** None identified.
2.3	**Compliance** The development of a published version of the IPR will respond to a recommendation from auditors

3	**The Trust Social Value Intentions**

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

Wirral Community Health and Care NHS Foundation Trust

Lead Governor Report

Joint NED recruitment

The members of the Remuneration Committee of the Council of Governors were pleased to support the recruitment of the first joint NED with WUTH. The number of applications received was extremely high and following shortlisting, six candidates were invited to interview.

Together with colleagues from WUTH and both Non-Executive and Executive Directors from each Trust, governors were involved in the final selection process on 2 May 2025.

The quality of candidates was extremely high, and a recommendation for appointment was provided to the Council of Governors at both WCHC and WUTH which was subsequently supported.

All pre-employment checks including Fit and Proper Persons checks are now underway and we look forward to being able to confirm the appointment very soon and welcoming our first Joint NED to Wirral later in the summer.

Council of Governor Meeting

The members of the CoG held a formal meeting on 28 May 2025, and we were interested to receive updates from the Trust on the delivery of the 100-day plan following the Wirral Review in 2024, and on the 2-year integration plan which will support the Trust's coming together to maximise the benefits of integration.

Other useful updates were provided on the new NHSE guidance on Board member appraisals, the year-end audit programme and the Trust's Financial Plan 2025-26.

Deputy Lead Governor

We are now seeking Expressions of Interest from governors for the Deputy Lead Governor role, and I look forward to being able to confirm appointment at the next public Board meeting.

PLACE assessment

As governors we were delighted to be part of the PLACE assessment again for 2024 and for the Trust to have been placed third in the country across the 8 assessed metrics, with an overall score of 98.22%.

The assessment completed in October 2024 which included governor colleagues, assessed the three wards at the Community Intermediate Care Centre. Our thanks to all those who supported the assessment and to all staff across the Trust who work hard to achieve these standards every day.

Further information can be found on the NHSE website - Patient-Led Assessments of the Care Environment (PLACE), 2024 - England - NHS England Digital

WCHC and WUTH Councils of Governor Development

We are looking forward to our next joint development session with WUTH governors on 9 July 2025.

Wirral Community Health and Care NHS Foundation Trust

Your Voice

The members of the Your Voice group came together on 29 May 2025 with a varied and engaging agenda. The members of the group were interested in the programme of integration between the Trust and WUTH and welcomed the update provided by the Trust's Chief Strategy Officer. An interesting update on the recent SEND inspection in Wirral was also provided, together with an opportunity for members to contribute to a patient information leaflet on washable continence products.

As a standing agenda item, the group also received an update on patient experience and learning from feedback received.

The Your Voice group will meet again on 15 July 2025 at 10.30am.

Lynn Collins
Lead Governor (public governor, Wirral West)

29th May 2025

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
4 June 2025

Item No 12

Report Title	Chairs Report – Audit and Risk Committee
Date of Meeting	22 April 2025
Author	Steve Igoe, Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ There remains a risk as a result of challenges to timely clinical coding. The risk arises as a result of vacancies and the impact of system downtime during the recent cyber incident. A short-term mitigation plan is being developed however the Committee were not assured yet that the potential financial and clinical risks have yet been mitigated.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Trust approved the Anti-Fraud plan presented by MIAA for 2025/26. ○ The Trust remains on track to resolve issues raised during Internal Audit reviews during the year. ○ The Committee approved the final Internal Audit plan presented by MIAA for 2025/26. ○ The Committee reviewed, discussed and approved the schedule of material management estimates to be used in constructing the year end accounts for the Trust for 2024/25 year.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Trust continues to meet and exceed payment metrics. ○ The Trust highlighted green ratings against the Government counter fraud standard for each of the 12 components. ○ Recent Internal Audit reviews provided substantial assurance following examination of controls in relation to the patient safety incident response framework and transfer to a new payroll provider. ○ The Trust received positive assurance on its overall approach to Governance, Risk Management and Internal Control. ○ The Trust received an opinion of “Substantial Assurance” from Internal Audit as a result of their work during the year. This indicates that the Trust has a good system of internal control designed to meet the

	organisation's objectives and that these controls are generally being applied consistently.
Review of Risks	• The Committee discussed the risk relation to Outstanding Care SO1.It was felt that in this constrained environment there would be more pressure to innovate when it came to clinical care. As a result, it would be necessary to have a greater risk appetite. Discussion also covered risk SO3 relating to continuous improvement and again noted the need for innovation and perhaps a more risk aware approach.
Other comments from the Chair	None

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
7 May 2025

Item No 13

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	28 May 2025
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust ended month 1 with a deficit of £ 0.9m which is in line with plan. However, that is after the inclusion of £1.6m non-recurrent mitigations which offset a corresponding shortfall in recurrent CIP. ○ The full year value of CIP identified to date is £27.2m against a target of £32m. After adjusting for risk the CIP reduces to £18.1m, a gap of £13.9m. This is an area of concern as we enter month 3 of the financial year. Addressing this risk requires project development to progress at pace. Executives were asked to bring to the next committee meeting a plan for speeding up delivery and reducing the risk. ○ Cash continues to be an area requiring focus and currently it is forecast that cash support will be needed before Q3. NHSE has announced stricter controls for the allocation of support. All options for releasing cash will continue to be considered through the year. ○ Loss of external income through the Aseptic Pharmacy now presents an income risk as contribution from external sales has ceased temporarily due to the required estates upgrades. ○ The elective activity plan was achieved in full for month 1.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Contracts for the provision of primary and revision hips and knees orthopaedic implants valued at £1.678m were approved for submission to the Board of Directors. ○ A full business case for UECUP Phase 3 Enabling Works was approved for submission to the Board of Directors on the basis that the clinical and estates issues within the case are scrutinised through the broader skill set of the full board. ○ The business case for the refurbishment of the Aseptic Unit was not completed in time for the meeting and remains outstanding.

Assure	• The Committee wish to assure members of the Board of Directors that:
	  ○ The Committee received the PWC Action Plan Closure Report and was assured that all actions but one were complete and the outstanding action was being progressed.
	  ○ An update on 2025/26 plan assurance was received through which the 3 year capital budget was endorsed and confirming two reviews linked to the plan.
	  ○ There is a focus on maximising delivery and identifying opportunities led by the ICB Chief Delivery Officer, including NHSE initiated assurance of (a) CIP delivery and (b) financial plans.

Review of Risks	• Cash remains an operational and reputational risk to the Trust as suppliers are being paid outside of the BPPC to preserve cash. This is being managed closely by the Finance Department. • NHS contracts with NHSE and C&M ICB are due for agreement by the 29th May 2025. Final signature was yet to be completed as of the date of the meeting but anticipated to be completed shortly after. • Trust-wide engagement on the challenging CIP target remains a risk and a multidisciplinary meeting was planned with the executive team to progress delivery.
Other comments from the Chair	• The committee noted the full engagement of the Trust with the various elements of NHSE plan assurance activity.

Board of Directors in Public
4 June 2025

Item No 14

Report Title	Chairs Reports – Audit Committee
Date of Meeting	30th April 2025
Author	Meredydd David, Chair of Audit Committee

Alert	• The Audit Committee wish to alert members of the Board of Directors that: ○ Internal Audit programme is progressing well and on track to be completed within agreed timeframe. ○ External Audit work is progressing well and off to a good start although early days. ○ Initial headline financial and remuneration report have been submitted within agreed timeframe.
Advise	• The Audit Committee wish to advise members of the Board of Directors that: ○ The Audit Plan and Anti-Fraud work plan for 25/26 were discussed and approved. ○ The draft Annual Governance Statement and Annual report for 24/25 are still work in progress due to the need to consider the outcome of the review of 0-19 contracts and its possible impact. The DRAFT Annual Report and AGS will go to the Board for review in May 2025, before sharing with the external auditors. ○ The Board of Directors will meet on 18 June 2025 to receive the final Annual Report & Accounts following completion of the audit. ○ Two tender waivers reported to committee due to the need to align timing due to the partnership approach with WUTH
Assure	• The Audit Committee wish to assure members of the Board of Directors that: ○ Head of Internal Audit Opinion for 2024-25 confirmed substantial assurance in all areas audited. ○ Counter/Anti-Fraud annual report received with no issues or concerns to note. A new framework is being introduced nationally and the committee will be briefed in the Autumn ○ Audit tracker report evidenced very good progress on delivering the audits and implementing recommendations ○ Review of all high-level risks confirmed assurance of all being well managed

Review of Risks	○ BAF risks to be reviewed and appropriate risks carried forward with two possible new risks to be considered– delivery of the financial plan and service transformation ○ Discussed and agreed the need for the strategic risks and BAF's to be aligned between WUTH and WCHCT over the next 12 months ○ No significant risks identified regarding VFM
Other comments from the Chair	Board will take accountability for final approval of Annual Governance Statement, Financial Statement and Annual Report

Board of Directors in Public **Item No 15**
4 June 2025

Report Title	Chairs Report - Quality and Safety Committee
Date of Meeting	7th May 2025
Author	Professor Chris Bentley – Committee Chair

Alert	QSC wish to alert members of the Board that the committee: • Received information from operational IPB of concerns raised through the Local Area SEND Partnership Board (LASPB) that 2/10 priority areas remain following the SEND inspection report and still require Priority Action. With ICB not agreeing to fund the Business Case for Neuro-Diversity pre-diagnosis pathway, review of impact and possible mitigations is urgently underway. (See Risks section below) • Triangulation of a range of strategic action plans has identified weaknesses in the lines of assurance for some components of the Operational Programmes. For QSC, some of these arose in the Quality and Safety and Inclusion enabling strategies. While proceeding in development through Programme Oversight Group with QEIA oversight, in implementation and outcome terms they were not reporting for governance and assurance through QSC to Board. Chief Nurse is exploring how best to correct this, by drawing in periodic reporting alongside the Quality Strategy Delivery Plan for committee scrutiny, and inclusion of elements in the Annual Account. This will also strengthen assurance processes in relation to a testing CIP.
Advise	QSC wish to advise members of the Board that the committee: • Reviewed and discussed the **Draft Quality Account**, prior to it coming to Board. It was found to be a full account celebrating a very productive year. Advised inclusion of some details of Operational Programmes drawn from the Quality Strategy • Approved the **2 QSC assigned risks from the BAF** to be forwarded as part of the BAF report to Board • Reviewed in detail the **quarterly Mortality - Learning from Deaths Report.** None reflecting concern over WCHC care. A query being pursued about relative child death numbers across Places. Agreed onward reporting to Board and statutory quarterly report posted on Trust website • Final review of the **Emergency Preparedness Resilience and Response (EPRR) Annual Report.** Noted the very positive MIAA assignment report and its Substantial rating. Also reassured by the extensive programme of exercises and training described. Approved extension of remaining actions to July. Approved the **Major Incident Plan for 2025/26.** Approved for both to come to Board.

	• Reviewed the **Freedom to Speak Up Annual Report** and commended the excellent work of Alison Jones and the 135 FTSU champions. (Detail to be found in the Quality Account) and agreed onward reporting to Board.
Assure	QSC wish to assure members of the Board that it signed off: • **Quality Strategy Delivery Plan 2024/25** report, closely monitored throughout a difficult year, but achieving the majority of what aimed for. Full credit to a strong leadership driving it led by Claire Wedge. 4 components carried forward. Key outcomes captured in the Quality Account. After review discussion approved the **draft Quality Goals for 2025/26 and Q1 plan**. • **Annual Claims Report** from which learning was noted but no actions. (Only 1 claim was made in the reporting year). • **Infection, Prevention and Control Assurance Quarterly Report** reported that the IPC BAF showed 6/10 elements rated green, and 4 amber. The amber actions were all mitigated, and 2 were requiring extensions to September to enable consideration as part of integration plans with WUTH. • End of year report for the **Clinical Audit Programme 2024/25** showed high quality performance and impact. 64/68 audits were completed and 4 deferred to 25/26 with mitigations. The committee had requested a few short case studies, and these helped illustrate the impact being achieved. **Audit Programme for 2025/26** had been developed in line with the Trust's PSIRF framework, and in collaboration with WUTH. This was accepted and now goes on for monitoring against key themes by Audit Committee.
Review of Risks	High-level risks which had been discussed at the (operational) IPB were brought to QSC for information and discussion in accordance with the Risk Policy: • Risk ID 3125. (L4XC4) Inability to deliver the pre-diagnostic elements of the ND pathway. ICB had not agreed to fund the business case. Impact being considered and partnership response being developed. Consider risk score increase. • Risk ID 2830. (L5XC3) Commission resource unable to meet demand to assess and deliver for children with EHCP need. Caseload review; raised at LASPB; developing business case • Risk ID 3147 (L5XC3) Problems with delays in structure changes to the SAFE reporting system, resulting in certain dashboard errors. Negotiations described as underway with Ideagen, the provider, to pressure timescales for resolution. • Risk ID 3137 (L4XC4) Call bell system on Bluebell ward of CICC. Installation timing agreed. Strong mitigations in place; no patient safety incidents
Other comments from the Chair	At start of new planning year much discussion about balancing forward plans while approving e.g. BAF components; Quality Goals; Audit plans. Need plans and governance systems resilient to change as: Trust integration processes develop at pace; safeguarding of unique community elements and developments aware of Neighborhood Health Guidelines and coming 10 Year Plan; severe financial constraints affecting realistic feasibility of targets.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 17**

04 June 2025

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

Report Purpose and Recommendations

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

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

This paper provides a specific update regarding MIS Year 6 and 7, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Midwifery staffing update, Maternity Continuity of Carer (MCoC) together with an progress updates on MPOP, UNICEF, MNVP, NNU expansion and visit

It is recommended: -

- Note the report and associated appendices.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position with the Maternity Incentive Scheme Year 6 and launch of Year 7 requirements.
- Note the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI).
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the PMRT reports.
- Note the progress with the Maternity Portal Online Programme.
- Note the position with the Maternity Self Assessment Tool.
- Note the progress with the UNICEF accreditation.
- Note the progress with the NNU expansion and visit held in December 2024.

Key Risks

This report relates to these key Risks:

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

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

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

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

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (April 2025) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months on review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other

	providers. A further set of clinical quality metrics has been provided by Cheshire and Mersey LMNS and the reporting pack has been challenged in terms of accuracy and relevance of the measures. There have been no further datasets shared or any feedback provided.

2	**Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in April 2025 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there are three active cases. There were no Patient Safety Investigation Incidents (PSII's) declared in April 2025 for Neonatal services.

3	**Maternity Incentive Scheme (MIS) Year 6/7**
	The declaration for MIS Year 6 was submitted as approved by the Board of Directors in January 2025 to NHSR. As advised by MBBRACE and NHS Resolution Safety Action 1 was declared as non-compliant in the first instant, with a view to a review of the position when the external verification is undertaken. Whilst reassurance was provided by NHS Resolution and MBRRACE and an appeal process WUTH have been declared non complaint with Safety Action 1 of the CNST Maternity Incentive Scheme (MIS) Year 6. The PSQM includes As a result, we have been invited to apply for the opportunity of discretionary funding. Now in its seventh year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2** in line with the revised updates to the scheme published in April 2025 at **Appendix 3 and 4**. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the next maternity quarterly update report utilising the audit tool.

	Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB.

4	PMRT Reports
	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 5 and 6**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 3 and Quarter 4 24/25 period. .

5	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 31st December 2024 the Trust achieved 91% compliance against the 6 elements included at **Appendix 7**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper. Quarter 4 evidence has been submitted and under review by the LMNS for compliance.

6	Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. A full review has been undertaken and the gap analysis is included at **Appendix 8** and remains in the same RAG rated position as fully compliant.

7	Three Year Delivery Plan – Maternity and Neonatal
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 9** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support

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

8	Midwifery Workforce and update on Maternity Continuity of Carer Model (MCoC)
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has five maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. There are no further teams planned to be launched and a continued focused approach to deliver the model of care to enhanced women/birthing people. As previously presented to Board of Directors a full workforce review is required to be undertaken every 3 years in line with Ockenden utilising the Birth Rate + workforce tool. The report was received in March 2025 and the maternity workforce report with recommendations for consideration is included at **Appendix 10**.

9	MPOP
	There is a requirement by the LMNS to report the progress of the Maternity Portal Online Programme (MPOP) to the Board of Directors and it is included at **Appendix 11.**

10	Maternity Self Assessment Tool
	There is a requirement by NHSE and the Care Quality Commission (CQC) to report the Maternity Self-Assessment tool 6 monthly to the Board of Directors included at **Appendix 12**. .

11	UNICEF Accreditation
	There is a requirement to report to the Board of Directors the status of UNICEF accreditation and is at **Appendix 13 and 14** is the detail of the maternity reassessment. Neonatal unit will be applying for accreditation status in 2025 and are working towards the requirements.

12	Maternity and Neonatal Voices Partnership
	In line with Safety Action 7 WUTH has a well embedded Maternity and Neonatal Voices Partnership collaboration and infrastructure in place. The Board of Directors can have assurance the Board Safety Champions meet with the perinatal leadership team at a minimum of bi-monthly and any support required by the Trust Board if identified will be escalated and implemented.

13	NNU Annual Visit
	An annual visit was hosted by WUTH on 6th December 2024 for the North West Neonatal Operation Network (NWODN). The feedback was very positive with suggested actions and is included at **Appendix 15**. A further visit is scheduled for 6th June 2025.

14	NNU Expansion
	From 2018/19 to present, the Trust Charity, along with Incubabies Charity, have fundraised approximately £1m for the redevelopment of the Neonatal Unit at Arrowe Park Hospital. Across 2023 and 2024, the Estates Team, with the support of Day Architectural examined a range of design options to support the redevelopment of the unit. A development option has been approved to expand the Neonatal footprint to comply with the British Association of Perinatal Medicine (BAPM) due to commence in June 2025.

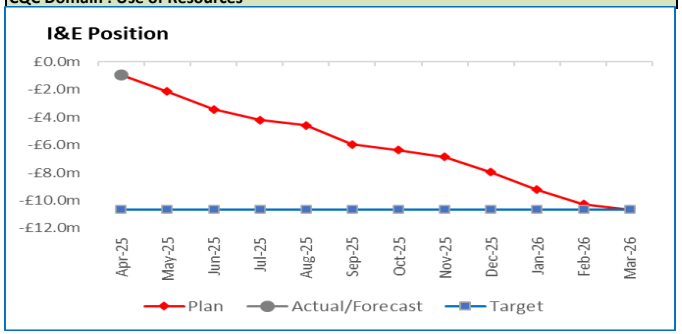
15	Conclusion
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

16	Implications
16.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
16.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 9 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. Safety Action 1 noncompliance has no impact on quality and safety of maternity services and is a data transcription error. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care.

	• Progress with sustainability of Ockenden. • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
16.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity workforce is required and funding options continue to be explored. A paper will be submitted to BDISC for approval to increase establishment and maintain compliance with Safety Action 5. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels.
16.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

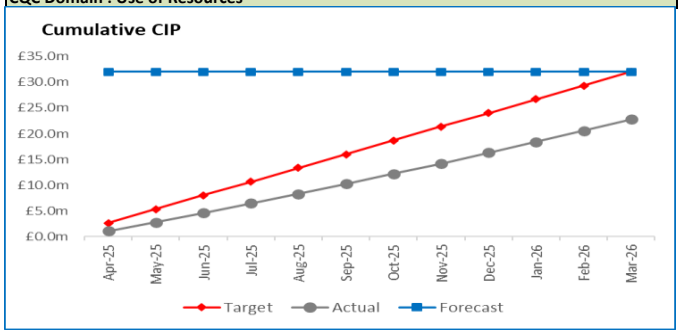
Chief Finance Officer

CQC Domain : Use of Resources



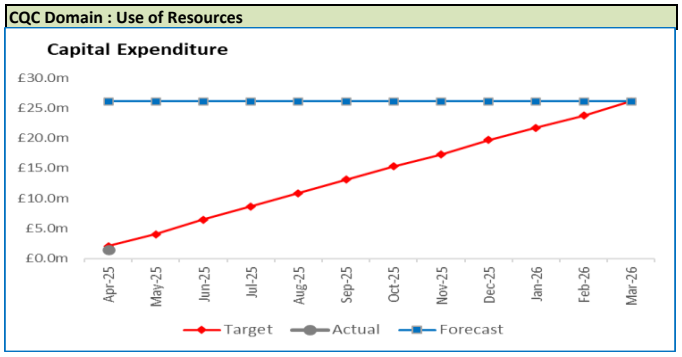
Apr-25
-£0.9m
Variance
Position equal to plan
Target
-£10.6m

CQC Domain : Use of Resources



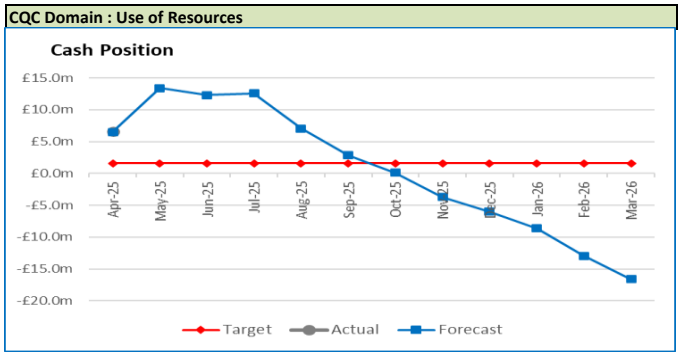
Apr-25
£1.1m
Variance
Position worse than plan
Target
£2.7m

CQC Domain : Use of Resources



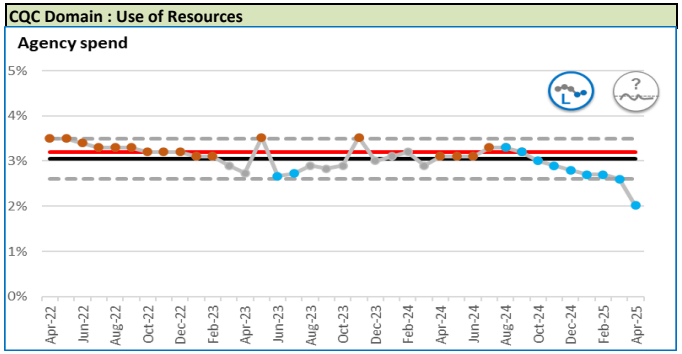
Apr-25
£1.5m
Variance
Position meets the plan
Target
£2.1m

CQC Domain : Use of Resources



Apr-25
£6.6m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Apr-25
2.02%
Variance
Position better than threshold
Threshold
3.2%

Executive Summary

At the end of April 2025 (M1) the Trust is reporting a deficit of £0.89m which is in line with the M1 plan. In M1 the Trust has transacted 13.3% of the annual CIP benefits which is £1.6m ahead of plan. The Trust identified 4 key risks to the plan which are:

- Full CIP delivery – This is the primary risk to achieving the 2025–26 financial position. Whilst the Trust is ahead of plan at M1, the risk adjusted annual forecast is below the required target.
- Activity / Casemix – The M1 income plan has been met.
- Aseptic Pharmacy – This risk is materialising with a significant reduction in income resulting from production compliance changes.
- Run-rate – 80% of targeted run-rate reductions have been identified.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). The cash balance at the end of M1 was £6.563m which results from a contract payment profile which will be revised in May i.e. this level of cash balance will not be sustained.

Management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy.

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

Statutory Financial Targets	RAG (M1)	Section within this report / associated chart
Financial Stability		I&E Position
Agency Spend		I&E Position
Financial Sustainability		N/A (quarterly update)
Financial Efficiency		Cumulative CIP
Capital		Capital Expenditure
Cash		Cash Position

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

The Board is asked to:

- Note the report.
- Note that the Trust's most immediate risk remains the cash position.
- Note the risks to delivering the recurrent £32m CIP target.
- Approve the 3 year capital budget including £1.1m charitable funding for the Neonatal unit redevelopment scheme.

I&E Position

Narrative:

The table below summarises the M1 position:

	In Month		
Cost Type	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£39.7m	£39.8m	£0.1m
Other Operating Income	£2.8m	£2.5m	-£0.4m
Total Income	**£42.6m**	**£42.3m**	**-£0.2m**
Employee Expenses	-£31.7m	-£32.1m	-£0.4m
Operating Expenses	-£13.0m	-£12.3m	£0.6m
Non Operating Expenses	-£0.4m	-£0.3m	£0.1m
CIP	£1.6m	£1.6m	-£0.1m
Total Expenditure	**-£43.5m**	**-£43.2m**	**£0.3m**
24-25 Final Position	**-£0.9m**	**-£0.9m**	**£0.0m**

Key variances within the YTD position are:

Clinical Income – £0.1m positive variance relates to overperformance across Surgery, Medicine and W&C divisions in respect of elective activity.
Employee Expenses - £0.4m adverse variance relates to use of bank, agency and undelivered vacancy factors in month 1.
Operating expenses – £0.6m positive variance relates to underspends on clinical supplies, drugs and other operating expenditure.
Cost Improvement Programme – On plan in month - the Trust has transacted 13.3% of the annual CIP benefits which is £1.6m ahead of plan

The Trust's agency costs were 2% of total pay bill for the month, which is below the NHSE threshold of 3.2% of total staff costs.

Cumulative CIP

Narrative:

The Trust has transacted CIP with a part year effect of £12.9m at M1. Overall the Trust has identified recurrent CIP with a full year effect of £27.2m, a shortfall against target of £4.8m however, this figure reduces to £22.1m once risk adjusted, reflecting a risk to full delivery of £9.9m.

Review of the CIP position is ongoing through weekly CIP Assurance and monthly Productivity Improvement Board.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £8.9m in M1, a positive variance of £0.3m. This is primarily driven by overperformance in respect of the Surgical division (UGI, Urology and Colorectal) and the Medicine division (Gastro).

Capital Expenditure

Narrative:

The table below confirms the Trust's proposed capital budget for 2025/26 to 2027/28:

Funding Source	Budget Holder	25/26 (Plan)	26/27 (Plan)	27/28 (Plan)	3 Year Plan
Internally Funded (Depreciation)	CFO	£9.77m	£9.77m	£9.77m	**£29.30m**
ICB/PDC/WCHC	CFO	£15.21m			**£15.21m**
Charitable Funds	CFO	£1.10m			**£1.10m**
Total Funding Sources		**£26.07m**	**£9.77m**	**£9.77m**	**£45.60m**
Estates, Facilities & EBME	CSO	£3.76m	£5.00m	£5.00m	**£13.76m**
Operational Delivery (COO) *	COO	£8.44m	£2.75m	£2.75m	**£13.94m**
Digital BAU *	CIO	£0.75m	£0.90m	£0.90m	**£2.55m**
Medical Education **	MD	£0.08m	£0.08m	£0.08m	**£0.23m**
Transformation **	CE	£0.25m	£1.00m	£1.00m	**£2.25m**
Contingency	CFO	£0.00m			**£0.00m**
UECUP *	COO	£7.80m	£0.04m	£0.04m	**£7.88m**
Approved Pipework Programme	CSO	£0.00m			**£0.00m**
PDC commitments	Various	£0.30m	£0.00m	£0.00m	**£0.30m**
ICB Hosted	CFO	£3.59m			**£3.59m**
Charitable Funds ***	CSO	£1.10m	£0.00m	£0.00m	**£1.10m**
Total Expenditure Budgets		**£26.07m**	**£9.77m**	**£9.77m**	**£45.60m**
Uncommitted/(Overcommitted)		**£0.00m**	**£0.00m**	**£0.00m**	**£0.00m**

Expenditure at M1 totals £1.462m which is £0.591m below the planned level.

It is confirmed to the Board that each Executive budget holder has set out their 3 year plan and that assurances will be provided to Estates and Facilities committee and Audit and Risk Committee of the alignment between these plans and the risk register.

The £1.10m of Charitable Funds is to fund the Neonatal unit redevelopment scheme of which £0.30m has been donated by IncuBabies and £0.80m from WUTH Charitable funds. Tenders have been evaluated and the contract will be awarded within budget.

Cash Position

Narrative:

The cash balance at the end of M1 was £6.563m which results from a contract payment profile which will be revised in May i.e. this level of cash balance will not be sustained. Current modelling shows that the Trust will need to seek additional cash support from Q3. However, NHSE has announced stricter controls in relation to the allocation of this deficit support so this could bring forward the requirement for cash support to as early as Q2.

Mitigations include:

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

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 19**
4 June 2025

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Director of Operations Alistair Leinster, Divisional Director – Performance and Planning
Report for	Information

Executive Summary and Report Recommendations

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

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

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

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

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. In addition cancer services and many surgical specialities have seen unexpected levels of increases in demand. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by AQuA and Emergency Care Intensive Support Team (ECIST) on improving the 4 and 12 hour performance standards.

2	Planned Care
2.1	**Elective Activity** In April 2025, the Trust attained an overall performance of 104% against plan for outpatients (101% for new outpatient attendances), and an overall performance 105% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for April	Actual for April	Performance
Out pt New	10,818	10,946	101.2%
Out pt Follow up	23,153	24,687	106.6%
Out pt procedures	3,455	3,429	99.3%
Total Out pts	37,426	39,062	104.4%
Day case	4,113	4,305	104.7%
Inpatients	506	547	108.1%
Total	4,619	4,852	105.0%

The Trust overachieved plan for outpatient new appointments and for elective / daycase (on the back of overachievement of daycase plan), with small under delivery for outpatient procedures.

Overachievement of new outpatient attendance plan was attributed to the Diagnostics and Clinical Support, with Medicine achieving 98% of plan, Surgery 99% and Women's

	and Children's 100%. All divisions over-achieved plan for daycase / elective overnight admissions.
2.2	**Referral to Treatment (RTT)** The way Trusts are monitored on RTT performance has changed from April and the key metrics are covered in the table below. The Trust's performance at the end of April 2025 against RTT metrics was as follows *(RAG rated versus monthly trajectories from Trust planning submission)*:

	Apr-25	May-25	Jun-25
Total Caseload	46,400		
% RTT	59.74%		
52 weeks	1,128		
52 weeks % of caseload	2.43%		
104+ Week Wait Performance	0		
78+ Week Wait Performance	7		
65+ Week Wait Performance	24		

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

The overall RTT waiting list decreased in size in April 2025 by -5.5% to 46,400 (-2,699 patients) due to the impact of the 'validation sprint'. The national validation sprint focuses on reduction of RTT waiting lists through additional validation carried out locally, across quarter one.

Of the 7 x patients waiting 78+ weeks at the end of April 2025, all 7 patients were Gynaecology. 4 x were as a result of patient choice, 1 x was due to capacity and 2 were complex.

The number of patients waiting 65+ weeks has continued to decrease to 24 patients. Of the 24 patients waiting, 4 x were complex, 2 x were mutual aid patients, 7 x were patient choice and 2 x were Ophthalmology graft patients and 8 were due to capacity. It is predicted that these will reduce to minimal numbers from June 2025.

2.3 **Cancer Performance**

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 4:

Quarter	4
Period	01/01/2025 - 31/03/2025

National Standards:

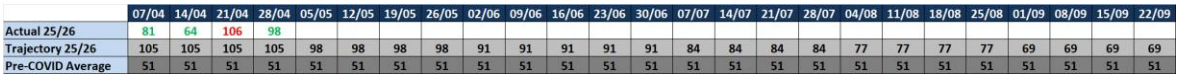
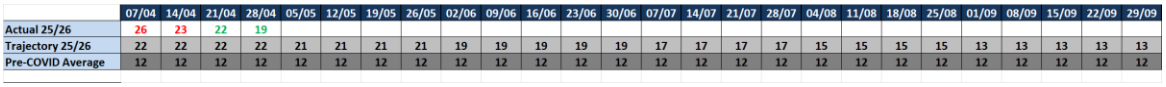
Standard	Indicator	Threshold	January-25	February-25	March-25	Quarter 4
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Can	75.00%	61.57%	78.22%	75.18%	71.59%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.74%	87.27%	88.63%	89.26%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	72.33%	73.95%	77.37%	74.61%

Sub Standards:

Standard	Indicator	Threshold	January-25	February-25	March-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	61.57%	78.22%	75.18%
28 Day Wait	Breast >=90%	90.00%	59.55%	89.76%	88.51%
28 Day Wait	Skin >=90%	90.00%	89.74%	91.55%	90.83%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	72.33%	73.95%	77.37%

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	January-25	February-25	March-25
14 Day Wait	GP USC Referral to First Appointment	93.00%	57.43%	56.41%	52.91%

	• *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for March 2025. This was due to two specialities increasing waiting times for outpatients and diagnostics. • *62-day treatment* - For 2024/25, the 62 day treatment standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory to achieve 77% performance by March 2025. The Trust underachieved local trajectory in January and February 2025, due to the impact of the cyber incident on 28-day performance, but achieved trajectory for March 2025. • *62-day waiters* – the number of waiters increased April 2025, compared to March 2025. Trajectory has been rebased to see reduction in 62-week waiters to 20 by March 2026.  • *104-day long waiters* – the number of waiters reduced in April 2025. Trajectory has been rebased to see reduction to 4 by March 2026.  Additional measures have been put in place to increase monitoring of cancer performance. This includes the development of tumour site level trajectories to support improved monitoring of performance and identification of issues, development of a tumour site level cancer improvement plans for 2025/26 which sets out key challenges / corresponding actions / pathway improvement, and a new monthly cancer specific performance meeting. There are significant capacity challenges in three specialities that's driving under performance across the standards.
2.4	**DM01 Performance – 95% Standard** At the end of March 2025 87.8% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01. This saw performance below the revised national standard of 95%, and the requirement for Trusts to achieve 90% by March 2025. Non-obstetric ultrasound remains the area of greatest pressure despite increased capacity and the use of mutual aid. Reduction had been seen in the backlog created by the cyber incident, but pressure on the service has been exacerbated by a significant increase in referrals (pressures also see in other Cheshire and Merseyside hospitals). A recovery plan is in place with additional capacity created in May and June.
2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue. The main areas of concern are recovery of cancer performance and delivering 0 x 65 weeks and 78 weeks waiters. Cancer improvement plans are being drafted for 2025/26 by divisions, including tumour site level trajectories, as well as plans to address more immediate performance issues.

3.0 Unscheduled Care

3.1 Performance

In April, Type 1 performance was reported at 49.13%, with a combined performance across all Wirral sites reaching 74.43%, reflecting continued efforts to improve access and flow across urgent and emergency care services.

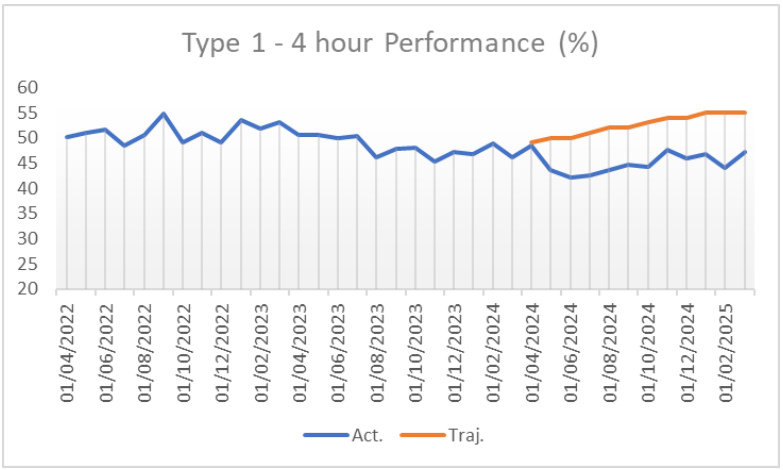
Type 1 ED attendances:	Type 3 ED attendances:
• 7,845 in March (avg. 253/day) • 7,369 in April (avg. 245/day) • 6% decrease from previous month	• 3,510 in March (avg. 113/day) • 3,157 in April (avg. 105/day) • 10% decrease from previous month

Urgent and Emergency Care (UEC) performance in April remained below the planned trajectory however, Type 1 performance improved by 2% compared to March, indicating some early positive movement despite continued pressure across the system.

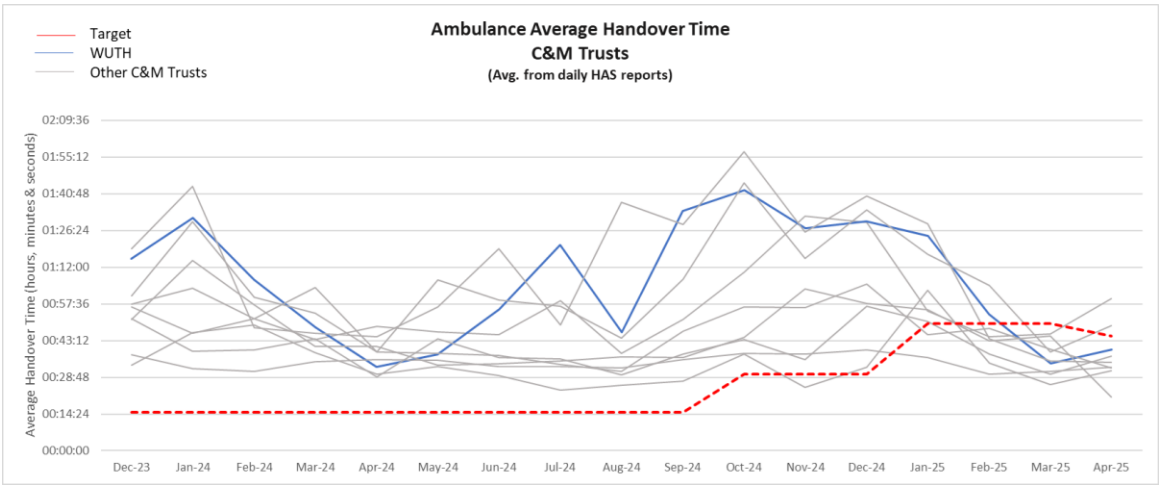
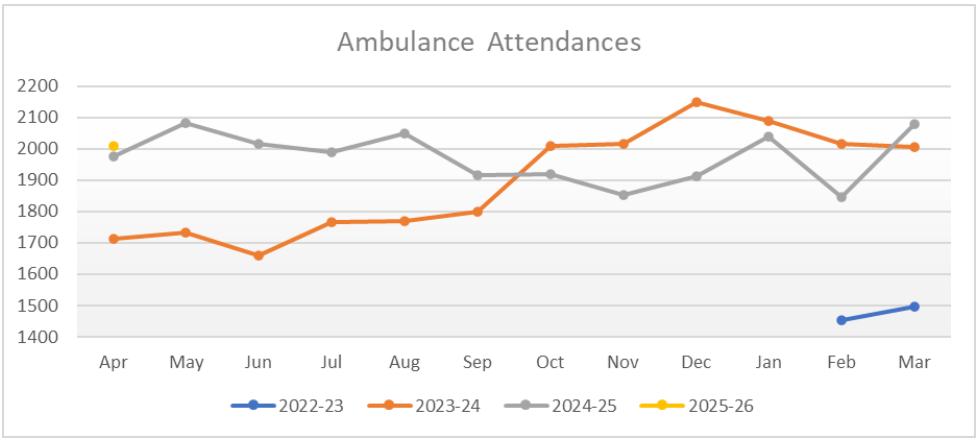
The Trust continues to face significant challenges with 12-hour decision-to-admit breaches, which remain a key area of operational concern. This will be a core focus of the 2025/26 UEC Improvement Plan, with a range of actions planned to reduce delays.

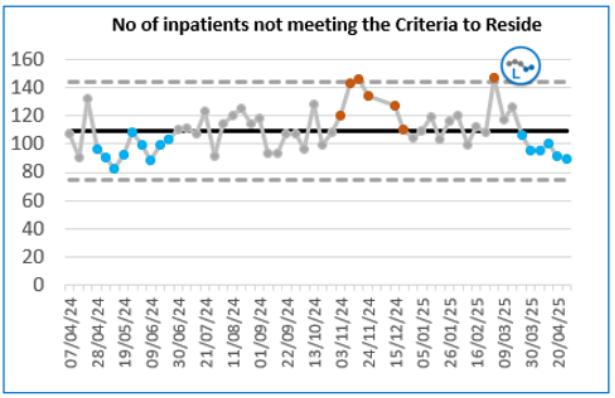
These include strengthened internal escalation processes, increased clinical oversight of patient flow, and greater utilisation of same-day emergency care and alternative pathways to ease pressure on the Emergency Department. UEC Improvement plans also include improvements aligned to the local integration programme.

Despite ongoing demand, the Trust remains fully committed to driving improvement across urgent and emergency care services. Several UEC schemes are already underway, with clinical and operational teams working closely together to support improved flow, reduce delays, and enhance patient and staff experience.



The 'call before convey' service is now embedded within urgent care pathways, with direct access to the Urgent Medical Assessment Centre (UMAC) now available to NWAS crews. However, utilisation remains variable and continues to be closely monitored through regular system meetings with oversight from NHSE and the System Control Centre (SCC). Ongoing engagement is in place to encourage consistent use of the pathway and ensure clinically appropriate alternatives to ED conveyance are maximised.

	Frailty Same Day Emergency Care (SDEC) continues to demonstrate positive impact, with consistent streaming of referrals from ED and low admission conversion rates. A planned increase in capacity from late May is expected to support a higher volume of direct moves from ED, helping to reduce long waits, improve patient outcomes, and improve the overall experience for frail patients. The local community provider Trust urgent care teams have now relocated to the acute site, enabling more integrated working and joint decision-making. Work is already underway to strengthen UEC pathways, including rapid in-reach from the Urgent Community Response (UCR) team into ED when ambulance arrivals are identified as suitable for community alternatives. The plan is for this to develop and will see a reduction in unnecessary admissions and improve system responsiveness. The Trust is currently working on the improvement plans to sustain improvements with ambulance handovers for 2025/26. Ambulance handover performance remained strong throughout the month, consistently performing below the expected trajectory.  Ambulance attendances are slightly above previous years activity levels: 
3.2	**Transfer of Care Hub development and no criteria to reside (NCTR).** The number of No Criteria to Reside (NCTR) patients continued to reduce in April. Work continues with ECIST to review the capacity and demand for Wirral, which will allow focus at pathway level on reducing the number of patients in acute beds to achieve the 10% target.



The Trust performance for NCTR remained in a strong position in comparison to other Trusts in Cheshire & Merseyside. The most recent position shows a performance of 11.9%:

	Trust	Trajectory	Current	Var
1	Wirral		11.9%	
2	Mid Cheshire		17.9%	
3	Countess of Chester		18.5%	
4	Warrington & Halton		20.4%	
5	Mersey and West Lancs		20.6%	
6	LUHFT		20.9%	
7	East Cheshire		22.7%	
	Total		19.1%	

3.3 Mental Health

The Trust continues to experience sustained pressure related to the number of patients presenting to the Emergency Department in mental health crisis.

In April, the Trust participated in a regional review of mental health provision led by NHS England, alongside Mental Health Providers, Merseyside Police, the Voluntary Sector, and other Acute Trusts. This collaborative exercise aimed to assess current system capacity and identify opportunities for improvement. The outcome report is expected in June and will support the identification of priority areas for joint action.

The outcome of the national capital funding bid to support the development of a dedicated Mental Health Crisis Hub for Wirral is still awaited.

3.4 Risks and mitigations to improving urgent care performance

The Trust continues to make steady progress in delivering the actions outlined within the Urgent and Emergency Care (UEC) Improvement Plan, with a clear focus on achieving key quality standards. Performance is being closely monitored through the UEC Improvement Group, with Place leads and the System Control Centre (SCC) providing oversight of sentinel metrics to support assurance and drive delivery.

However, several operational pressures remain. Increased patient acuity, sustained demand for inpatient beds, and high levels of admissions continue to impact flow and present challenges to the delivery of planned improvements. Strengthening nursing capacity within the Emergency Department—particularly to support timely ambulance handovers and ensure appropriate care in corridor areas—remains a key priority.

	Demand for mental health support also continues to place additional pressure on ED capacity and workforce, contributing to wider flow constraints across the system. These risks are being actively monitored, with mitigation plans under development as part of ongoing system resilience efforts.

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

5	Conclusion
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements continue in reducing long waiting times.

Public Board of Directors **Item 20**

04 June 2025

Title	Mortality Report: Learning from Deaths Framework Quarter 4: 01 January 2025 – 31 March 2025
Lead Director	Eddie Roche, Interim Medical Director
Author	Eddie Roche, Interim Medical Director
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this paper is to assure the Board of Directors of quality governance systems regarding learning from deaths and to seek approval in relation to the publication of the learning from deaths appendix on the Trust website.

This quarterly report provides evidence that learning from deaths is embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from Deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q4 2024/25, along with a summary of any thematic learning identified during investigation into these cases.

All deaths reported to the Trust in Q4 2024/25 have flowed through the Trusts governance processes. There were no deaths that were associated with gaps or omissions in care delivery. Learning was identified and actions plan developed in lines with safety systems learning. Attached as an appendix, is a Q4 summary report for publication on the Trust website

It is recommended that the Board:

- To be assured by the report and approve Appendix 1 to be published on the public facing website.

Key Risks

This report relates to the following key risks:

Strategic Risk ID01- Failure to deliver services safely and responsively to inclusively meet the needs of the population.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7th May 2025	Quality and Safety Committee	Mortality Report: Learning from Deaths Framework Quarter 4: 01 January 2025 – 31 March 2025	Approved

1	Narrative
1.1	The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. During Q4 there were a total of 11 reported deaths. This includes a total of 6 child deaths, all of which were reviewed using SUDIC methodology. During Q4 there were 0 deaths which met the criteria for StEIS reporting. Each unexpected death reported during Q4 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

	Of the total deaths reported in Q4, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Learning was identified as a result of safety systems review; this was discussed and shared at service level and reported to Clinical Risk Management and Mortality Review Groups, with any learning shared wider as appropriate.
1.2	**<u>Background</u>** Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users. The National Quality Board (NQB) Learning from Deaths framework (2017) exists with the specific aim to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people. The key findings of the CQC report were as follows: • Families and carers are not treated consistently well when someone they care about dies. • There is variation and inconsistency in the way that system partners become aware of deaths in their care. • Trusts are inconsistent in the approach they use to determine when to investigate deaths. • The quality of investigations into deaths is variable and generally poor. • There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these. Since 2017 the focus on learning from preventable deaths and unexpected deaths has continued to strengthen and the NHSE developed the Patient Safety Strategy in 2019 which describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. The National Safety Strategy has been pivotal introducing a Patient Safety syllabus, Patient Safety Specialists, and Patient Safety Partners. All of which have been embedded within the governance of the Trust. Patient Safety and Incident Reporting Framework (PSIRF) is embedded within our Trust. It sets out the NHS approach for effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is embedded within our Clinical Risk Management group and Mortality Review group. Learning From Patient Safety Events (LFPSE) is designed to capture events where: • A patient was harmed or could have been harmed • there has been a poor outcome, but it is not yet clear whether an incident contributed or not

	• risks to patient safety in the future have been identified • good care has been delivered that could be learned from to improve patient safety.
1.3	**<u>WCHC Learning from deaths governance framework</u>** **Policies** <u>Learning from Deaths Policy (GP58)</u>; It provides a framework for how the Trust will evaluate those deaths that form part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms. <u>Incident Management Policy (GP08).</u> This cross-references the Learning from Deaths Policy, ensuring a consistent approach to implementation, and includes the process to follow in the event of an unexpected death of a patient. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths.
1.4	**Process** All reported deaths which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Safety Incident Review Group (SIRG) and the fortnightly Clinical Risk Management Group (CRMG). Further investigations are commissioned based on the events surrounding the death and the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group. The Mortality Screening Tool considers whether a variety of factors were present. Examples include: • Receipt of an End-of-Life advance care plan (PACA) • Presence of a DNACPR form • Association with failed visits • Association with rescheduled visits • Concerns raised by any party regarding the care provided prior to death • The involvement of other services involved prior to death • Medical Cause of death (if known) Commissioned investigations are monitored at CRMG against progress and timelines. Any investigation reports and associated action plans are approved at CRMG. This includes cases which are under investigation by the coroner. Thematic learning from Learning from Deaths cases is reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director and who is responsible for the Learning from Deaths agenda. Minutes from the Mortality Review Group are submitted to the Quality and Safety Committee and to the Board by exception.

	A report is produced which summarises the details of the unexpected deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers. This includes working with the UK Health Security Agency and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.
1.5	**<u>Child Deaths</u>** Given the extensive geography that WCHC delivers Children and Young People's services, there are now robust processes in place which enable every unexpected child death to be identified within all the places we deliver care. This includes Wirral, East Cheshire, St Helens & Knowsley. The membership of the Mortality Review Group includes the Trust's Child Death Overview Panel (CDOP) representative and the Trust's Head of Safeguarding enabling, the visibility of any thematic learning across the whole of Cheshire and Mersey. The membership is regularly reviewed to ensure it contains a variety of skills and knowledge to maximise the identification of learning. The Trust has links with each Place-based Child Death governance structures, which facilitates the identification of themes over a large geography and then uses this data to reflect on how WCHC can continuously improve the delivery of its Children and Young People services. Services. The Trusts Named CDOP representative is an active participant of the multi-agency Place-based Sudden Unexpected Death in Childhood (SUDIC) meetings and feeds any intelligence and learning into the Mortality Review Group. When our representative has any concerns then these are escalated and raised with system partners. The Mortality Review Group will receive the Child Deaths Annual reports when they become available.
1.6	**<u>Bereaved Families</u>** Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

	Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison. Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations.
1.7	**National Medical Examiners** Medical Examiner officers at hospital trusts now provide independent scrutiny of almost all non-coronial deaths occurring in hospitals. All deaths in England and Wales are independently reviewed either by a Medical Examiner or a coroner. Medical Examiners provide an important safeguard. The Department for Health and Social Care (DHSC) published details of the death certification reforms and are now in place since April 2024. Primary legislation was commenced on 1 October 2023. The new death certification process requires all deaths in England and Wales to be independently reviewed either by a medical examiner or a coroner. **Our local NHS host trust for this function i**s Wirral University Teaching Hospital NHS Trust. We have created agile and secure access for medical records to allow the Medical Examiner to fulfil their role.
1.8	**Q4 2024/25 WCHC Reported deaths (Datix incident reporting)** During Q4 there were a total of 11 reported deaths. This includes 6 child deaths. During Q4 there were 0 deaths which met the criteria for StEIS reporting

Structured Judgement Reviews:	
Total Number of Deaths in scope	11
There are no outstanding cases from the previous quarter (Q3)	
Total Number of Deaths considered to have more than 50% chance of being avoidable	0
LeDeR reviews: - Please note that these are undertaken by the mental health trust	
Total Number of Deaths in scope	0
Total Deaths reviewed through LeDeR methodology	0
Total Number of deaths considered to have been potentially avoidable	0
SUDIC reviews:	
Total Number of Child Deaths	6
Total Deaths reviewed through SUDIC methodology	6

1.9 **Summary of thematic / other Learning for Q4**

Each unexpected death reported during Q4 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

There were no trends or themes identified during the review of deaths. Of the total deaths reported in Q4, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Each death was reviewed at service level and via the Clinical Risk Management Group (CRMG), and Mortality Review Group. Learning opportunities were highlighted, discussed and shared. This included:

- Review of programme of training for relevant staff around recognition of the deteriorating patient
- Strengthen patient safety systems and review of the working environment for staff working in remote telephone assessment in Urgent Community Response.
- Explore opportunity for automation of alerts of NEWS2 scores to team members.
- Strengthen pathway for step up escalation processes for staff including therapists and Health Care Assistants.

1.10 **Further discussion / actions from the Mortality Review Group**

- Discussed the application of a cross-organisation MOU for Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm
- Further discussion on data from reports into deaths from child drowning, Asthma and Anaphylaxis, and deaths of Children in Need. Information has been shared with relevant services/teams.
- Medical Director to look at the reporting of learning from deaths that are not in the scope of this report, to ensure it is having the maximal impact.

1.11 **Data – Quarter 4: 2024/2025**

Child incidents coded as Unexpected Death, per service area: Q4 2024/25

Q4	Jan 2025	Feb 2025	Mar 2025	Total Q4
Wirral 0 -19	0	0	0	0
Cheshire East	2	0	0	2
St Helens 0 - 19	1	0	2	3
Knowsley 0 -25	0	1	0	1
Total Unexpected child deaths	3	1	2	6

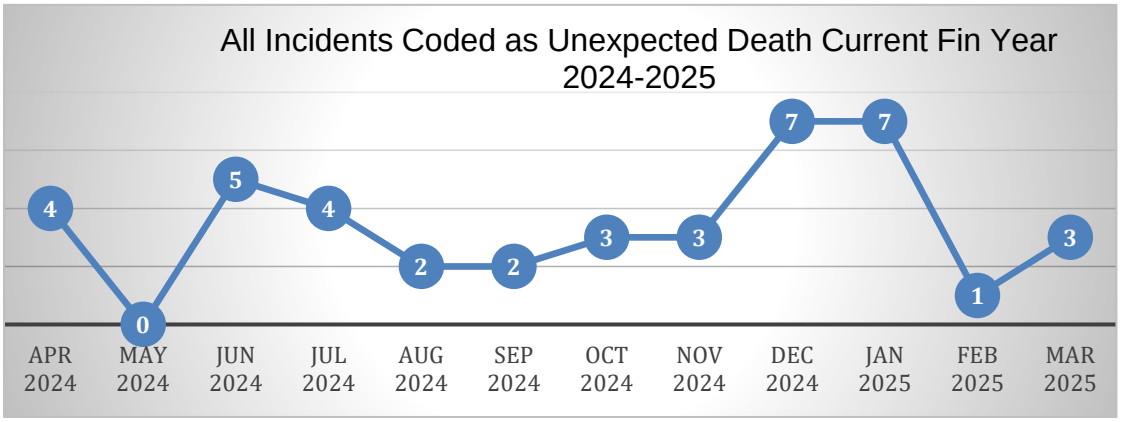
Adult incidents coded as Unexpected Death, per service area: Q4 2025/25

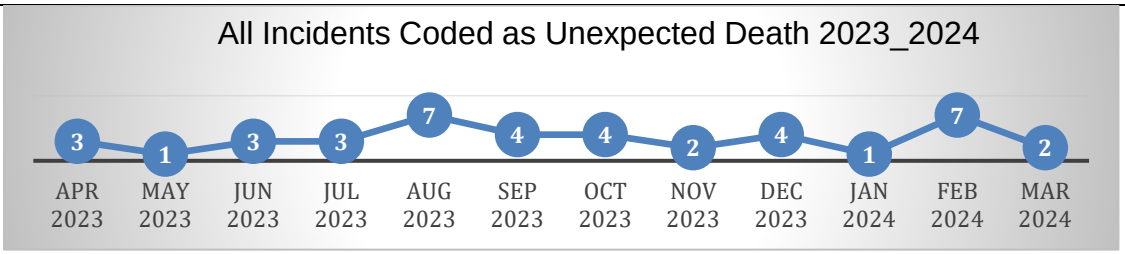
Q4	Jan 2025	Feb 2025	Mar 2025	Total Q4
Community Nursing Wallasey	1	0	0	1
Community Nursing Birkenhead	1	0	0	1
Community Integrated Response Team	2	0	1	3
Total Unexpected Adult Deaths	4	0	1	5

Q1 – Q4 Incidents coded as Unexpected Death (Financial year 2024/2025)

	Apr 24	May 24	Jun24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
CN Birkenhead	1	0	0	0	1	0	0	0	1	1	0	0	**4**
CN Wallasey	0	0	0	0	0	0	0	0	0	1	0	0	**1**
CN Night service	0	0	0	1	0	0	0	0	1	0	0	0	**2**
Wheelchair Service	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Community Integrated Response Team - CIRT	0	0	1	0	0	0	0	0	0	2	0	1	**4**
Community Intermediate Care Centre - CICC	1	0	0	0	0	0	2	0	1	0	0	0	**4**
GPOOH	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Community Dental	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Total Adult	**2**	**0**	**2**	**1**	**1**	**1**	**2**	**0**	**4**	**4**	**0**	**1**	**18**
Wirral 0-19	1	0	0	1	1	0	0	1	1	0	0	0	**5**
Cheshire East	1	0	3	1	0	1	1	0	2	2	0	0	**11**
Knowsley 0-25	0	0	0	1	0	0	0	0	0	0	1	0	**2**
St Helens 0-19	0	0	0	0	0	0	0	2	0	1	0	2	**5**
Total Child	**2**	**0**	**3**	**3**	**1**	**1**	**1**	**3**	**3**	**3**	**1**	**2**	**23**
Total Unexpected Deaths	**4**	**0**	**5**	**4**	**2**	**2**	**3**	**3**	**7**	**7**	**1**	**3**	**41**

1.12 **Graphical representation / trend of all reported unexpected deaths between 01/04/24 – 31/03/25, compared below with the previous 12 months**





2	Implications
2.1	**Quality/Inclusion** The contents of the report do not relate to equality and inclusion matters. Quality of care is considered through the PSIRF processes.
2.2	**Finance** There are no finance and resource implications
2.3	**Compliance** This report supports our compliance with the National Quality Board Learning from Deaths Framework

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: **Community engagement and support** ☐ **Purchasing and investing locally for social benefit** ☐ **Representative workforce and access to quality work** ☐ **Increasing wellbeing and health equity** ☒

Appendix 1

Learning from Deaths Q4 24/25 Report ***(for publication on Trust website)***

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 4 2024/25.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

There were 5 adult, and 6 child deaths reported during this quarter, which followed the appropriate investigation processes.

All deaths reported to the trust have been reviewed in accordance with Trust policy. Of the deaths reported in Q4, after investigation, none of these were within scope of this report as none were caused by gaps or omissions in care provided by the trust. Learning was identified and discussed and shared with relevant teams and services. Duty of Candour was not applicable to any of these cases.

We continue to promote shared learning in, and outside of our organisation and work collaboratively with our system partners to improve care within all the communities in which we provide services, focusing on addressing health inequalities on a population-based approach.

Dr Eddie Roche

Interim Executive Medical Director
Wirral Community Health and Care NHS Foundation Trust

30 April 2025

Public Board of Directors **Item 21**

04 June 2025

Title	Staff Survey Results
Lead Director	Debs Smith, Chief People Officer
Author	Carla Burns, Deputy Director of HR and OD
Report for	Approval

Executive Summary and Report Recommendations

This report provides the Public Board with an overview of the analysis of the results of the 2024 NHS National Staff Survey along with the corresponding actions to support delivery of improvements. This report is provided for assurance and approval.

The final response rate for the Trust was 51% which was lower than the NHS Community Trust average and higher than the national NHS response rate of 50%. This was a decrease from 2023 when the Trust's response rate was 60%. A total of 927 staff completed the survey.

Overall, the survey results showed a steady position in all 7 themes and a declined in 2 themes; '*We are always learning*' and '*Morale'*.

'*We are always learning'*: access to development opportunities and improvement to appraisal quality is required.

'*Morale'*: work pressures and burnout require focused attention to drive improvement.

In comparison to the benchmark Community Trusts WCHC had below average scores for 8 out of the 9 indicators. In comparison to the whole NHS scores the Trust scored above average for 8 out of 9 indicators.

Some examples of positive performance include:

- Most improved scores in the areas of staff reporting of incidents and not experiencing harassment from colleagues.
- Immediate manager valuing staff work Trust has scored consistently above average for 3 years and had one of the highest scores for Community Trusts.
- Improved perception of staff relating to recognition for good work.
- Staff feeling trusted to do their job.

Results have been shared with the Joint Union of Staff Side (JUSS) and separate sessions will be held with the BAME and Ability Staff networks to explore inclusion related scores further.

In response to the 2024 staff survey results there will be a number of actions including:

- Delivering sessions to managers on how to understand their results and to enable the development and delivery of local actions.
- Triangulation of survey results with other data sources to prioritise actions.
- Results will continue to be shared with stakeholders and all teams will develop local action plans with the aim of improving staff experience at local level which will contribute to improving the overall position
- Development of a Trustwide action plan (appendix 1)

At an organisational level the themes for improvement have been identified as:

- Morale
- We are safe and healthy – burnout scores
- We work flexibly
- Career progression and development

The workforce inclusion scores will be further reviewed as there is a need to focus on the experience of disabled staff and staff from a BME background to understand why their experience is worse than others.

Local action plans will be developed and monitored and will be reviewed in light of quarterly Pulse survey data.

It is recommended that the Board:

- Review the analysis provided and receive assurance on the outlined areas for priority focus and proposed actions.

Key Risks
This report relates to the following key risks: • Related BAF Risks include ID07, ID08 and ID10.

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

Contribution to WCHC strategic objectives:	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	Yes
People	
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	

Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Yes
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
09 April 2025	People and Culture Committee	Staff Engagement	Approved the Trustwide action plan

Appendix 1

Trust Staff Survey Action Plan 2025 (based on 2024 survey)

Action Plan

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Assurance provided

No	Actions required	Completion date	Person responsible	Change stage	Description of current position	Evidence of completion % associated measurable outcomes
	Communications					
1	High level sharing of results	2023/4 Q4	Director of HR and OD	4	Complete	Meeting notes and Communications
2	Sharing of results with key stakeholders, Staff Voice Forum and JUSS	2023/4 Q4	Head of HR (E&W)	4	Complete	
3	Sharing of results in key management meetings	2023/4 Q4	Head of HR (E&W)	4	Complete	
4	Celebrate areas of success in the results	2024/25 Q1	Head of HR (E&W)	2	In train	
	Flexible working	**Completion date**	**Person responsible**	**Change stage**	**Description of current position**	**Evidence of completion % associated measurable outcomes**
5	Analysis of flexible working over last 12 months and comparison to previous 12 months, Approvals, part approvals and rejections, Learning from appeals	Q1	Head of HR (E&W)/ People Promise Manager			

Appendix 1

6	Case study from areas of good practice for advertising and sharing of best practice	Q1	Head of HR(E&W) / People Promise Manager			
7	Explore use of health roster to support more effective flexible working	Q2	Health Roster Team & Head of HR (W&R)			
	Feeling safe and healthy	**Completion date**	**Person responsible**	**Change stage**	**Description of current position**	**Evidence of completion % associated measurable outcomes**
9	Identify actions to support teams where high levels of burnout have been identified with input from Health and Safety Manager	Q1	MDT approach between People Team and Health & Safety			
10	Identify which areas of the organisation have staff experiencing harassment from patients and develop support to reduce incidences of this nature.	Q2	MDT approach between People Team, LSMS Lead, Nursing and Operations			
	Morale	**Completion date**	**Person responsible**	**Change stage**	**Description of current position**	**Evidence of completion % associated measurable outcomes**
12	Review of reward and recognition across the trust to establish what is valued by staff	Q1	Head of Communications/ Head of HR (E&W)			
13	Peer review to establish shared learning opportunities with WUTH People Team	Q3	Head of HR (E&W)			

Appendix 1

	We are always learning	Completion date	Person responsible	Change stage	Description of current position	Evidence of completion % associated measurable outcomes
14	Review of survey results to understand the demographics of the data e.g. Staff groups, ethnicity, length of service, departments	Q1	L&D Manager			
15	Focus on targeted actions based on the analysis and other feedback sources	Q3	Deputy Director of HR and OD			
	Team action plans	**Completion date**	**Person responsible**	**Change stage**	**Description of current position**	**Evidence of completion % associated measurable outcomes**
16	Local actions identified and improve staff experience – plan in place and progress monitored	Q1	Line managers			

Survey Coordination Centre

NHS

Wirral Community Health and Care NHS Foundation Trust

NHS Staff Survey Benchmark report 2024

Contents

Survey Coordination Centre

NHS

Introduction

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this report

This benchmark report for Wirral Community Health and Care NHS Foundation Trust contains results for the 2024 NHS Staff Survey, and historical results back to 2020 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations.

Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34a-b and Q35 are not weighted or benchmarked because these questions ask for demographic or factual information.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two themes (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and sub scores are related and mapped to individual survey questions.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q24f, Q26d, Q31b

Report structure

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Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, the themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, with the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note: where there are fewer than 10 responses for a question, this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes.

Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2023 vs 2024.
- Guidance on data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Using the report

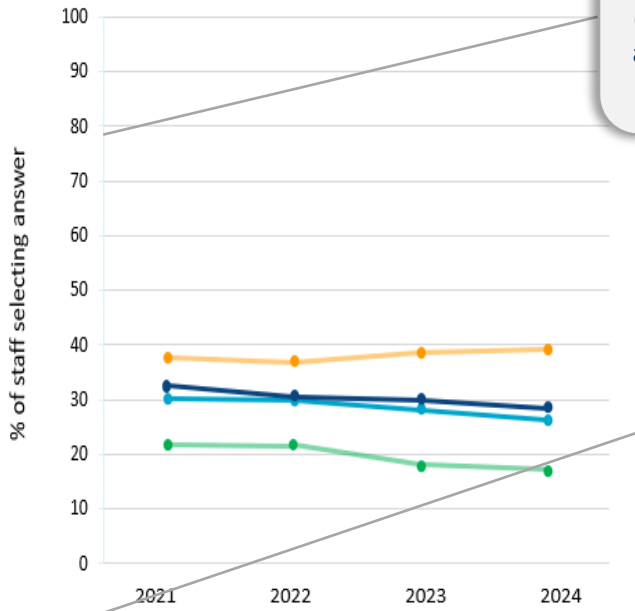
Survey Coordination Centre NHS

Note this is example data

Key features

Question number and text (or summary measure) specified at the top of each slide.

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

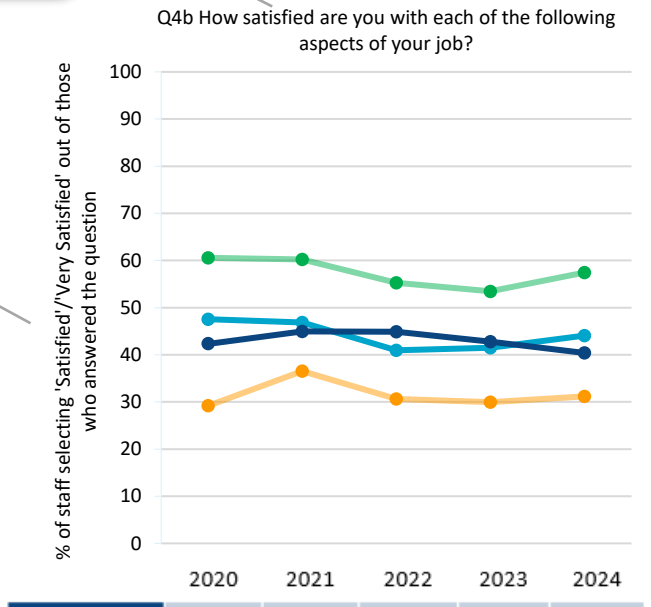


	2021	2022	2023	2024
Your org	32.6%	30.6%	30.0%	28.5%
Best result	21.8%	21.7%	18.0%	17.1%
Average result	30.2%	29.8%	28.1%	26.4%
Worst result	37.6%	36.9%	38.5%	39.2%
Responses	480	500	515	520

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

'Best result', 'Average result', and 'Worst result' refer to the **benchmarking group's** best, average and worst **results.**

Tips on how to read, interpret and use the data are included in the Appendices



	2020	2021	2022	2023	2024
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	55.3%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Note: Charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2022, 2023 and 2024 portions of the chart and table.

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NHS

Organisation details

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Organisation details

Survey Coordination Centre NHS

Wirral Community Health and Care NHS Foundation Trust

2024 NHS Staff Survey

Organisation details

Completed questionnaires 927

2024 response rate 51%

Survey details

Survey mode Online

This organisation is benchmarked against:

Community Trusts

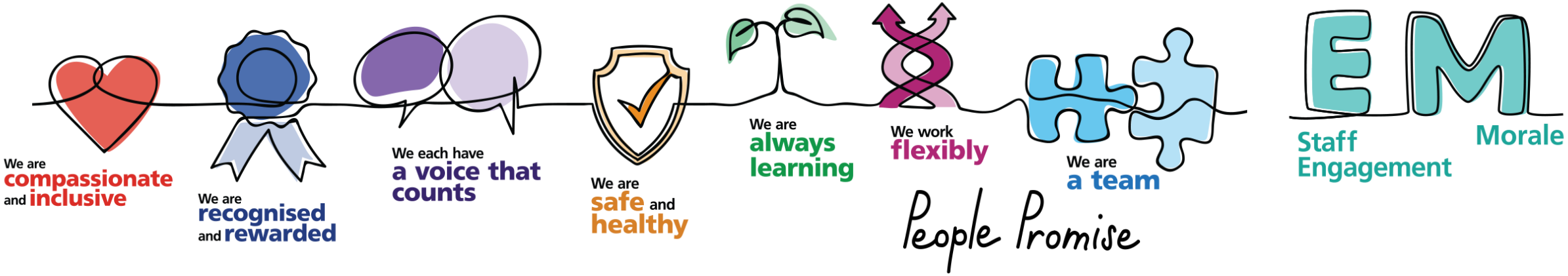
2024 benchmarking group details

Organisations in group: 14

Median response rate: 62%

No. of completed questionnaires: 28109

For more information on benchmarking group definitions please see the Technical document.



People Promise elements, themes and sub-score results

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

NHS

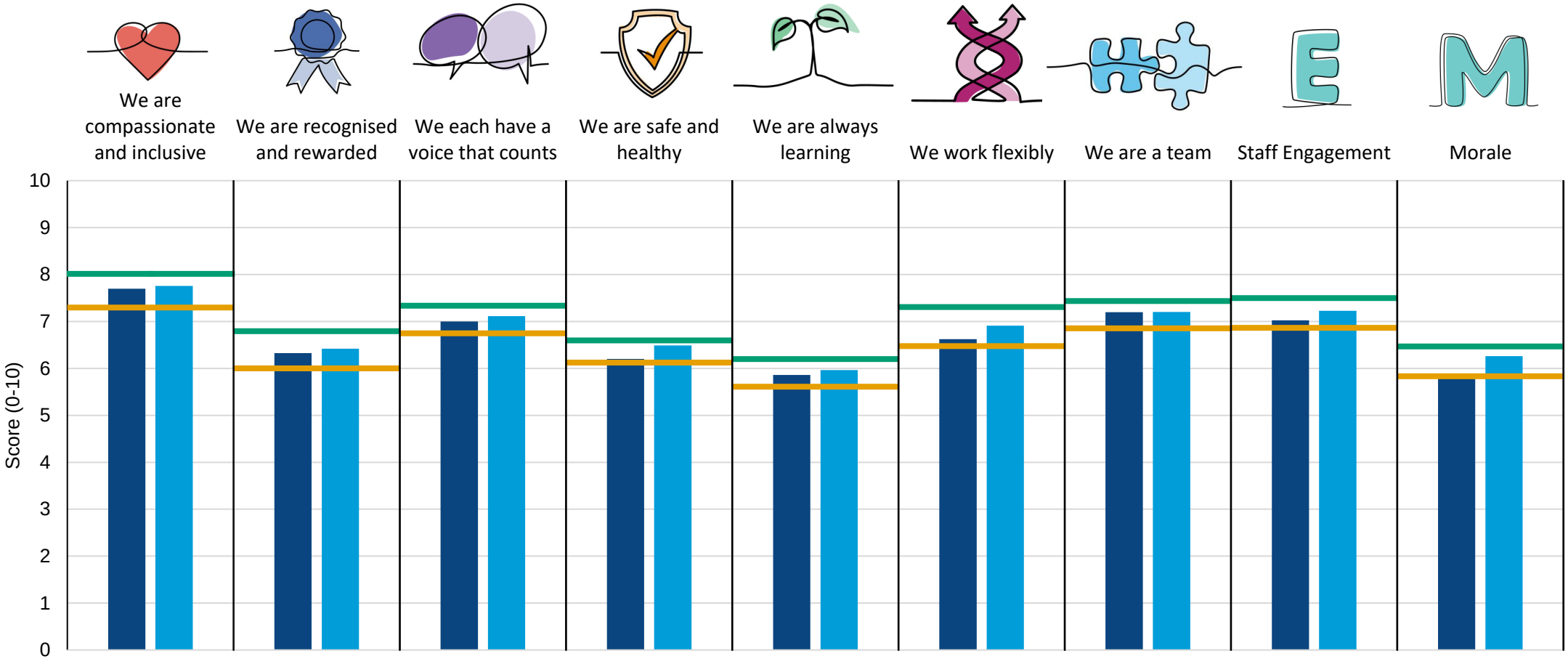
People Promise elements, themes and sub-scores: Overview

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



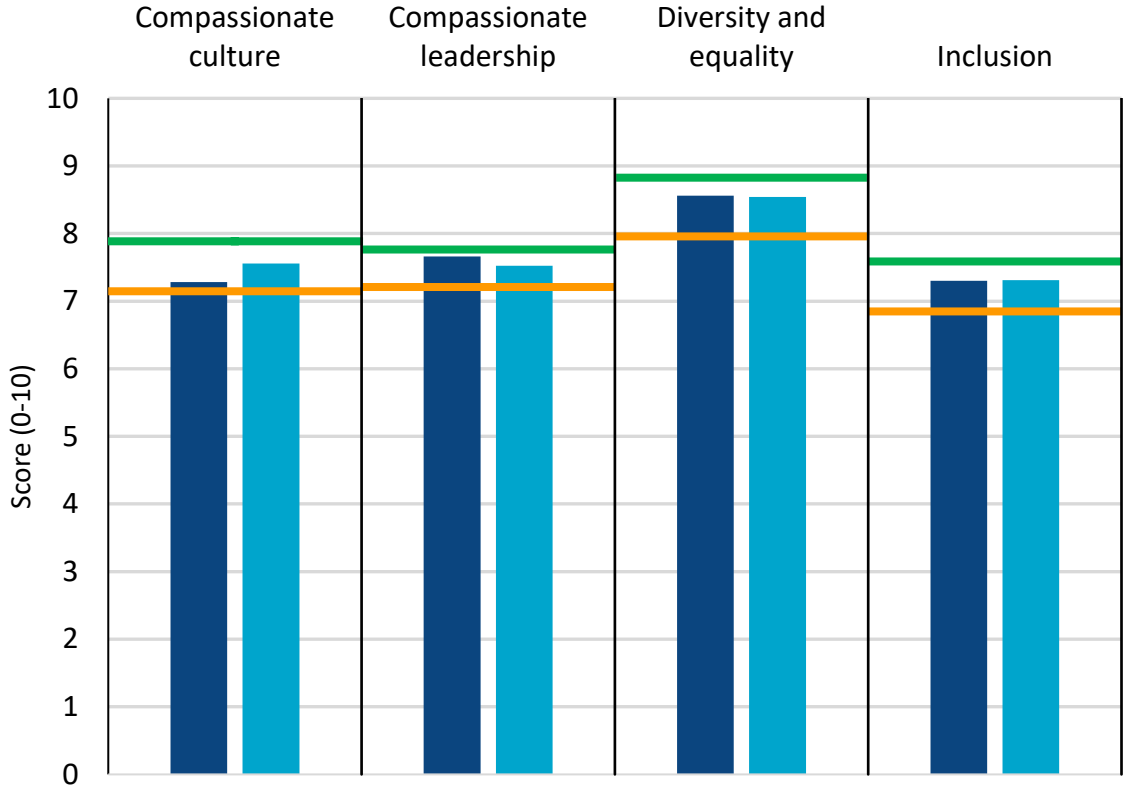
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.70	6.32	7.00	6.20	5.86	6.63	7.20	7.02	5.84
Best result	8.01	6.79	7.34	6.60	6.20	7.31	7.44	7.50	6.47
Average result	7.76	6.42	7.11	6.49	5.97	6.91	7.20	7.23	6.26
Worst result	7.30	6.00	6.75	6.12	5.61	6.48	6.85	6.87	5.83
Responses	925	925	918	921	901	922	925	926	927

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

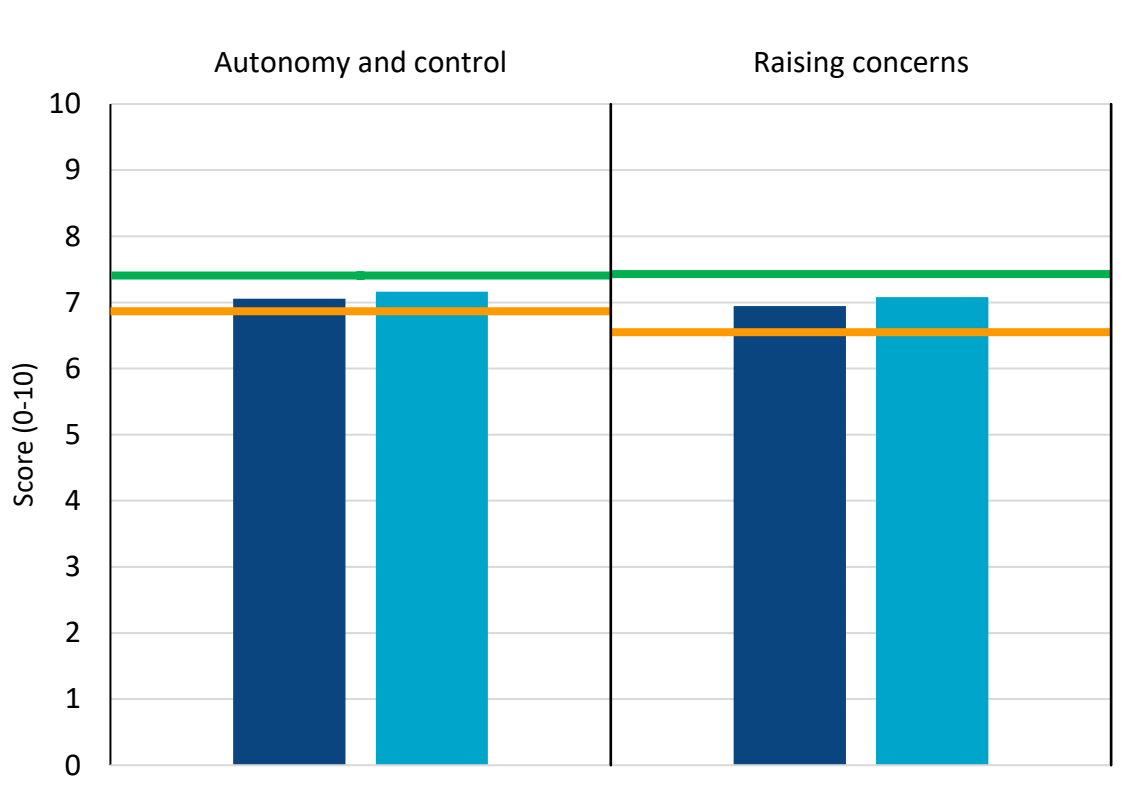
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.28	7.66	8.56	7.30
Best result	7.89	7.76	8.83	7.59
Average result	7.56	7.53	8.54	7.31
Worst result	7.15	7.21	7.96	6.85
Responses	923	925	922	923

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.05	6.94
Best result	7.41	7.43
Average result	7.16	7.08
Worst result	6.87	6.55
Responses	926	919

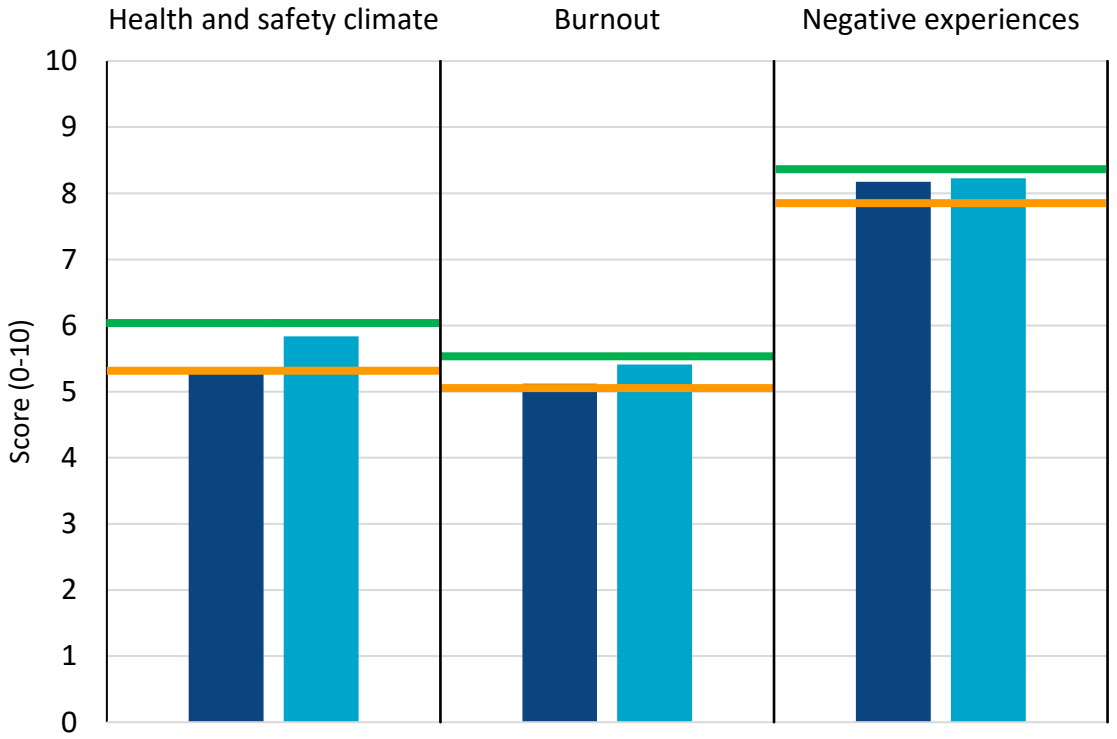
Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

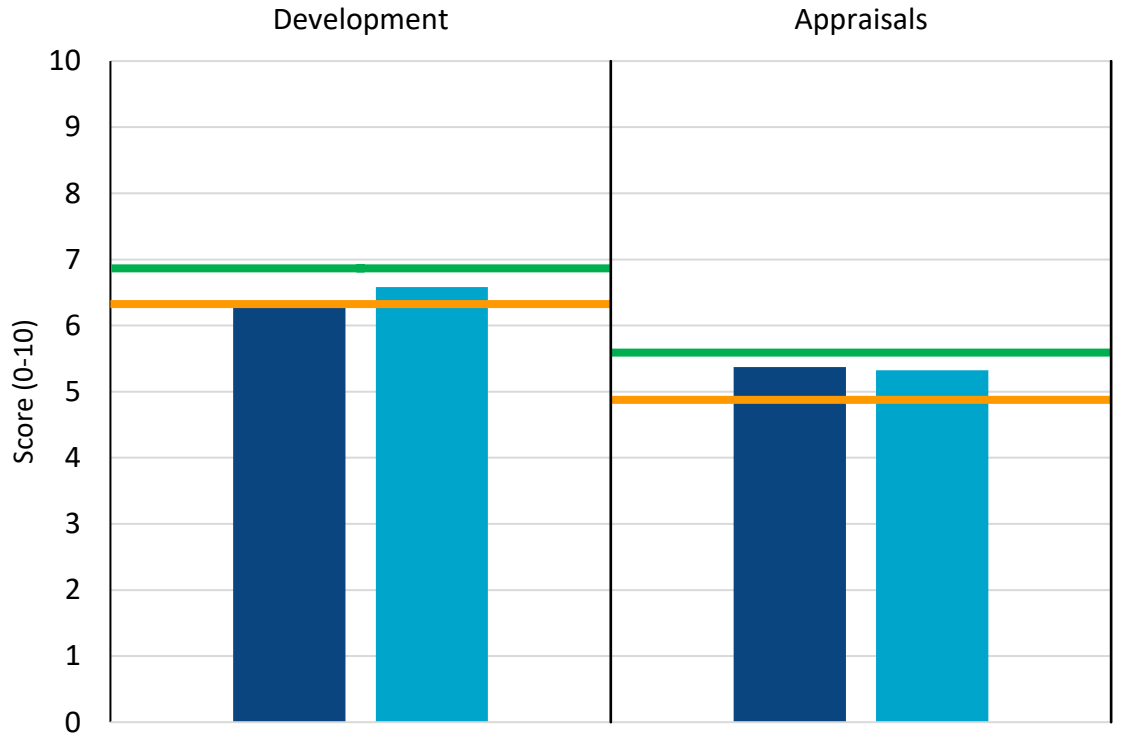
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.32	5.12	8.17
Best result	6.04	5.53	8.36
Average result	5.84	5.41	8.23
Worst result	5.32	5.05	7.85
Responses	926	926	923

Promise element 5: We are always learning



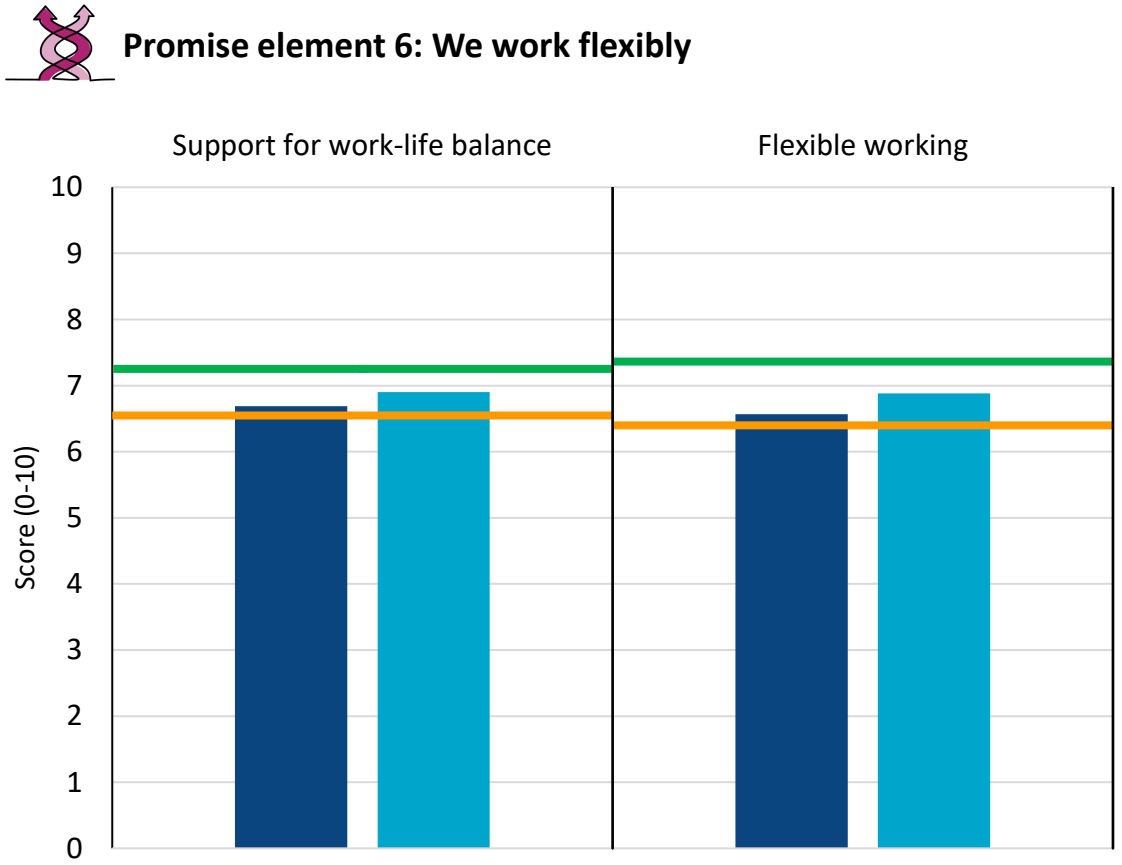
	Development	Appraisals
Your org	6.33	5.37
Best result	6.86	5.59
Average result	6.58	5.32
Worst result	6.32	4.88
Responses	924	902

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

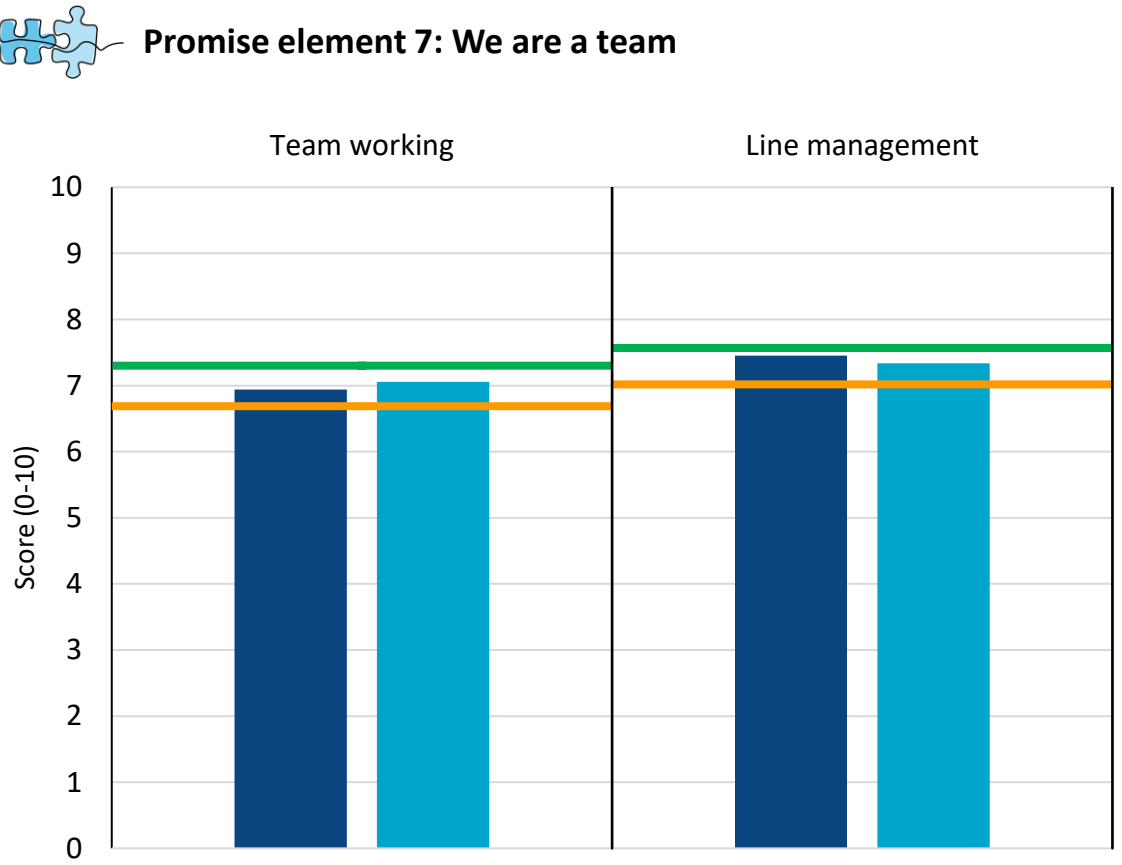
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.69	6.57
Best result	7.25	7.36
Average result	6.90	6.88
Worst result	6.55	6.40
Responses	927	922

Promise element 7: We are a team



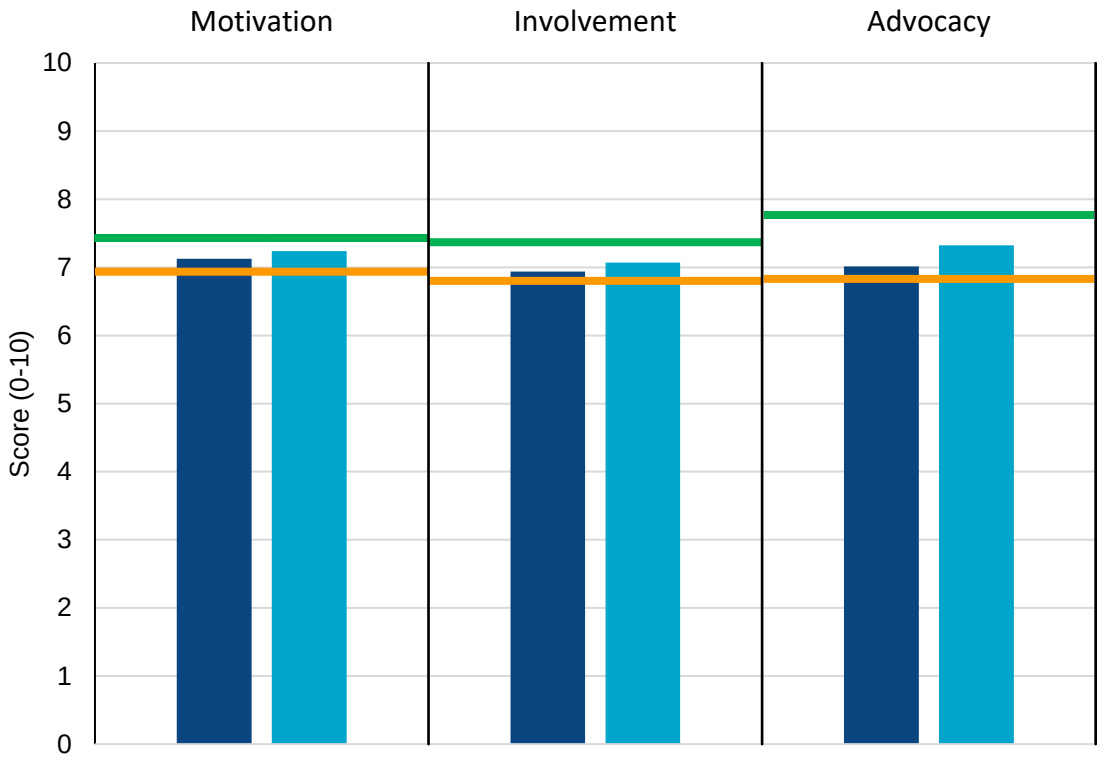
	Team working	Line management
Your org	6.94	7.45
Best result	7.30	7.57
Average result	7.06	7.34
Worst result	6.69	7.02
Responses	925	926

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

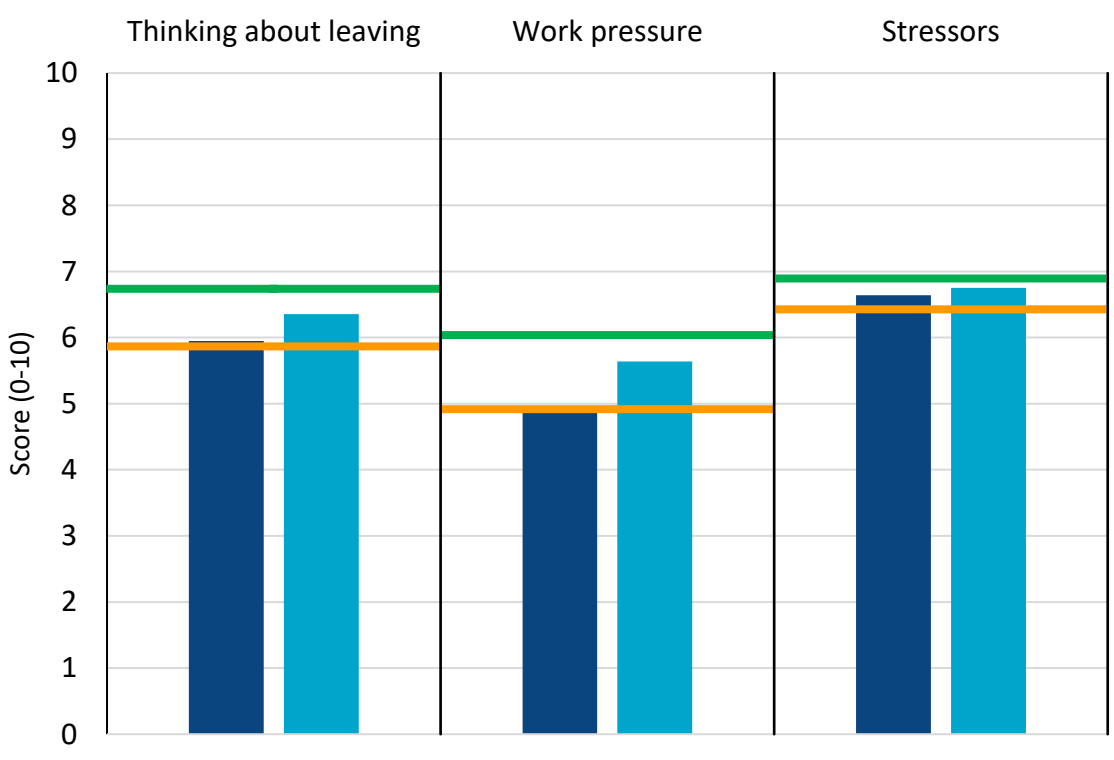
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.13	6.94	7.01
Best result	7.43	7.37	7.77
Average result	7.24	7.07	7.32
Worst result	6.94	6.80	6.83
Responses	918	926	923

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.95	4.92	6.64
Best result	6.74	6.04	6.89
Average result	6.35	5.64	6.75
Worst result	5.87	4.92	6.43
Responses	925	926	926

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores: Trends

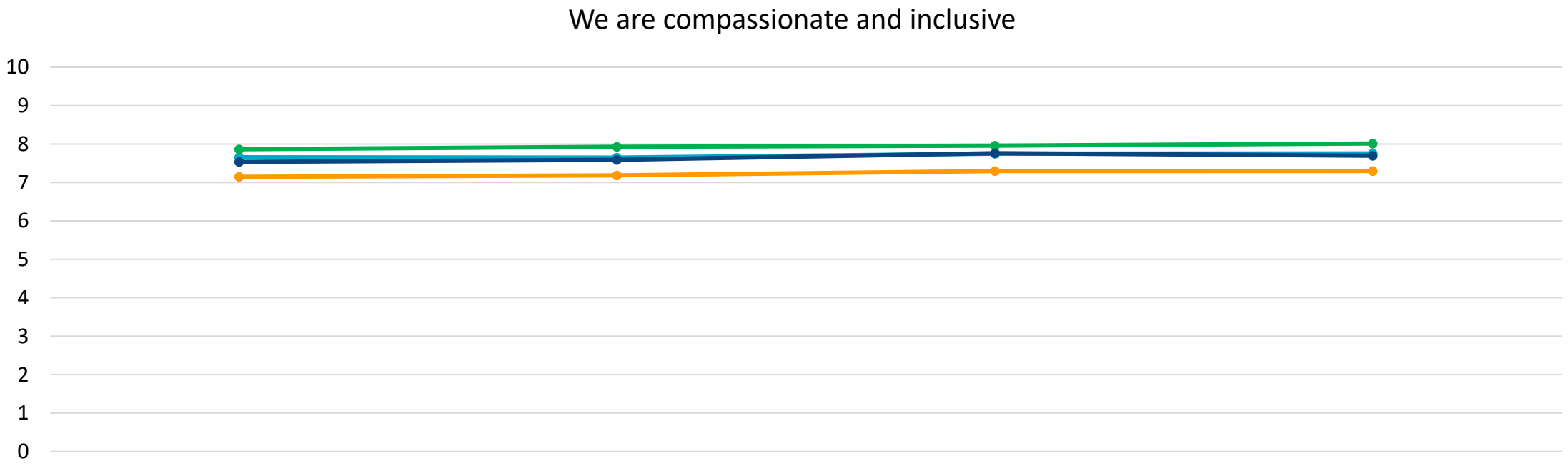
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022	2023	2024
Your org	7.54	7.59	7.76	7.70
Best result	7.87	7.93	7.96	8.01
Average result	7.65	7.65	7.75	7.76
Worst result	7.15	7.19	7.30	7.30
Responses	961	918	1047	925

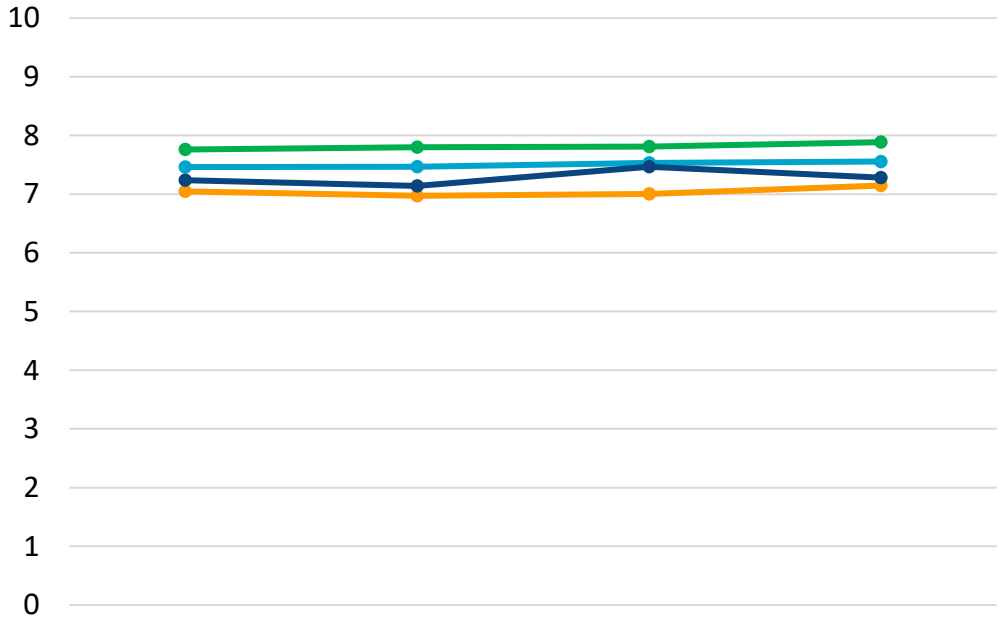
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

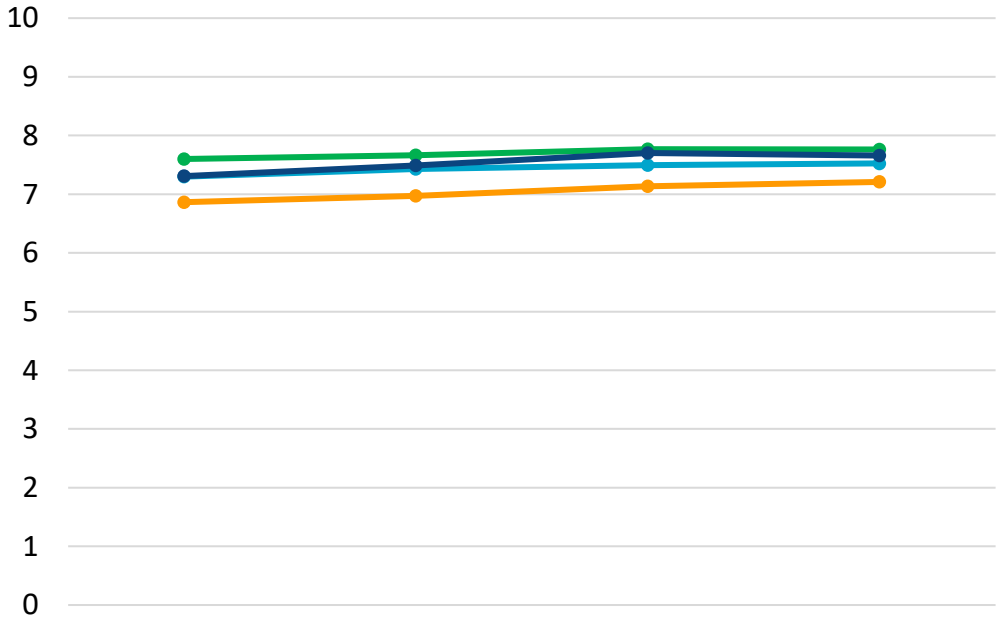
Promise element 1: We are compassionate and inclusive (1)

Compassionate culture



	2021	2022	2023	2024
Your org	7.24	7.14	7.47	7.28
Best result	7.76	7.80	7.81	7.89
Average result	7.46	7.46	7.53	7.56
Worst result	7.05	6.97	7.00	7.15
Responses	950	918	1044	923

Compassionate leadership



	2021	2022	2023	2024
Your org	7.31	7.49	7.70	7.66
Best result	7.60	7.66	7.77	7.76
Average result	7.30	7.43	7.50	7.53
Worst result	6.86	6.97	7.13	7.21
Responses	961	918	1047	925

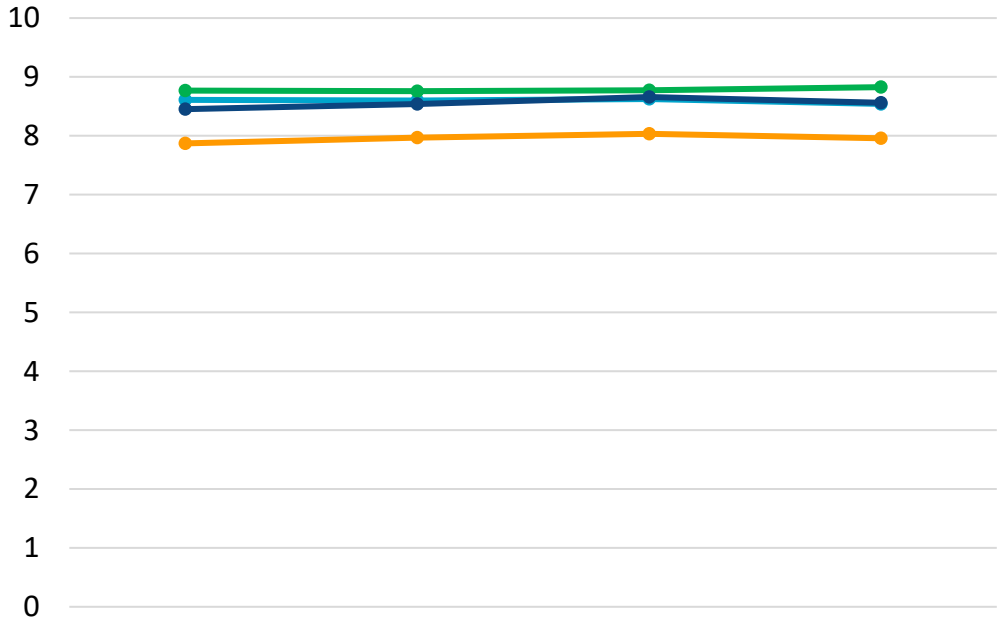
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

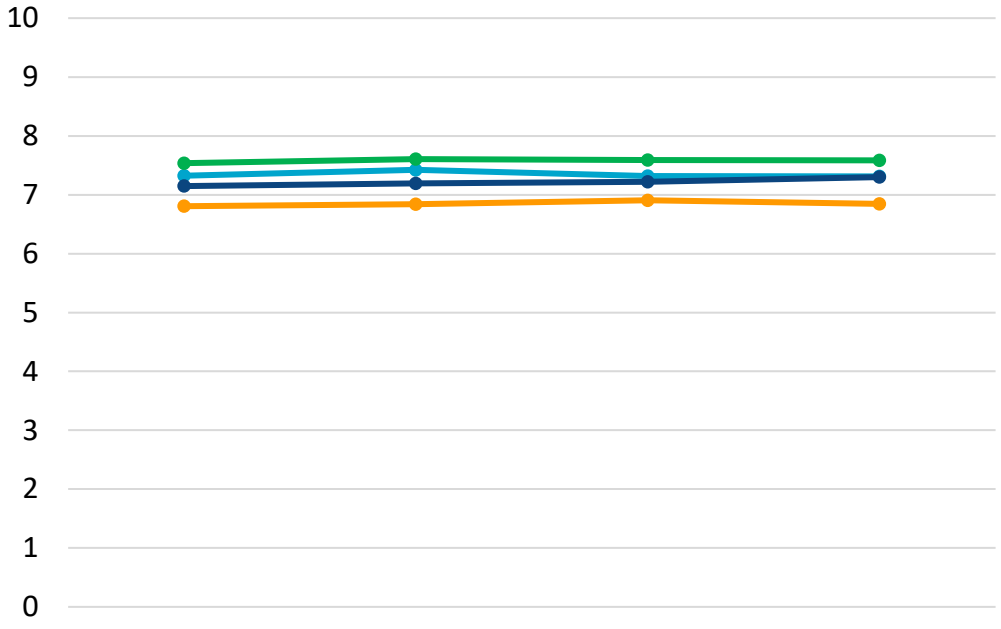
Promise element 1: We are compassionate and inclusive (2)

Diversity and equality



	2021	2022	2023	2024
Your org	8.45	8.54	8.66	8.56
Best result	8.77	8.76	8.77	8.83
Average result	8.61	8.60	8.62	8.54
Worst result	7.87	7.97	8.03	7.96
Responses	961	913	1047	922

Inclusion



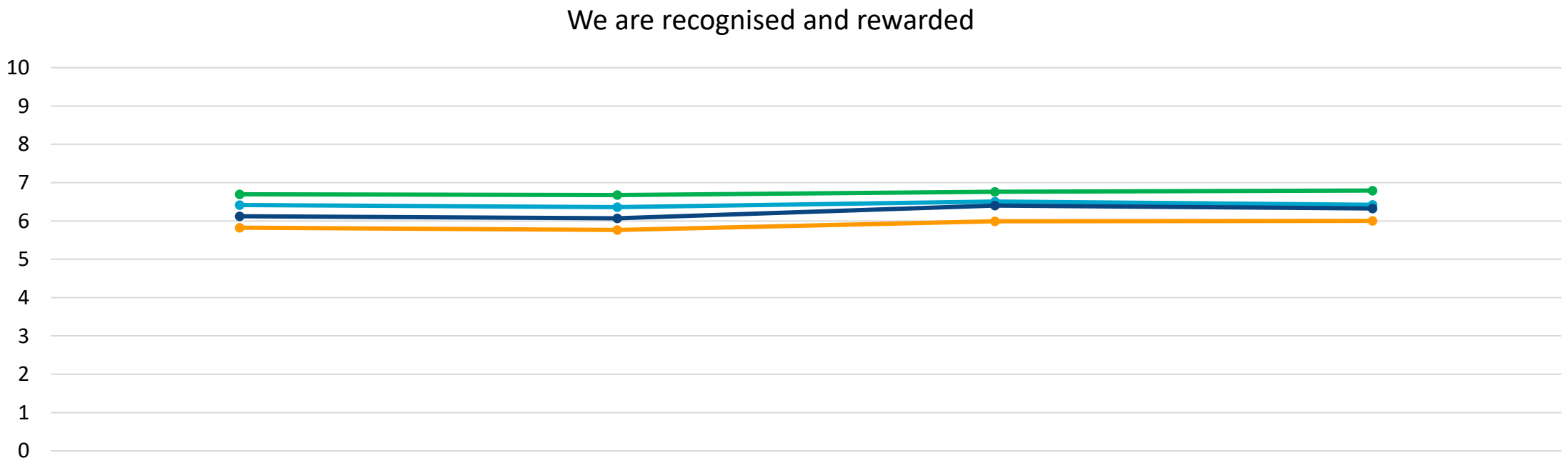
	2021	2022	2023	2024
Your org	7.15	7.19	7.22	7.30
Best result	7.54	7.61	7.59	7.59
Average result	7.32	7.42	7.32	7.31
Worst result	6.81	6.84	6.91	6.85
Responses	964	918	1047	923

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded



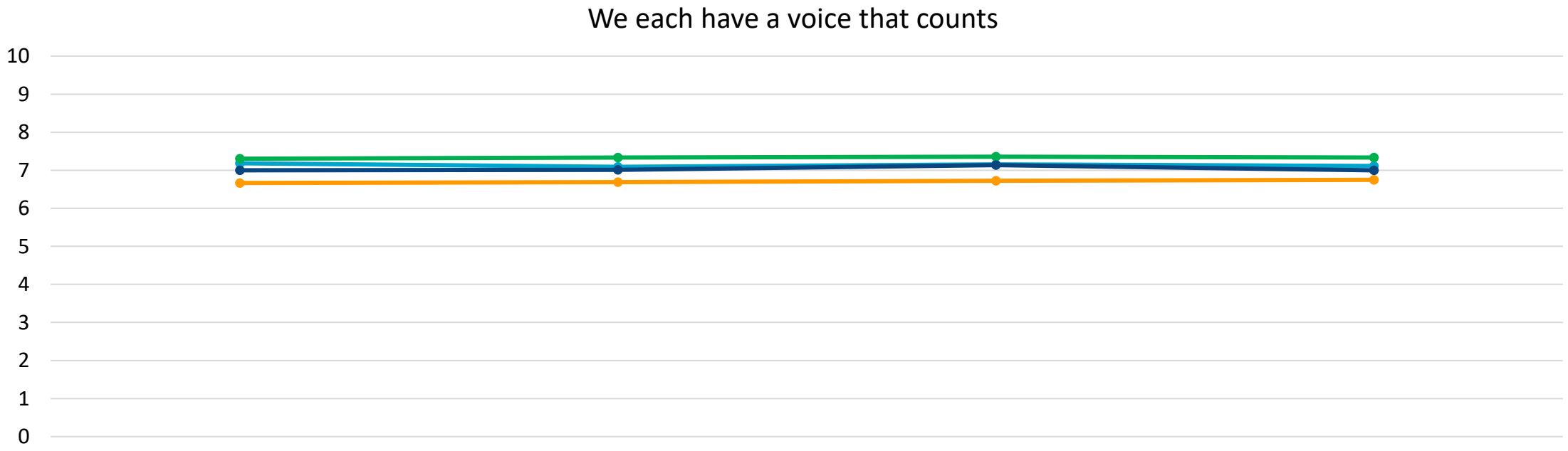
	2021	2022	2023	2024
Your org	6.12	6.07	6.40	6.32
Best result	6.70	6.68	6.76	6.79
Average result	6.42	6.36	6.51	6.42
Worst result	5.83	5.76	5.99	6.00
Responses	975	918	1045	925

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022	2023	2024
Your org	7.00	7.01	7.14	7.00
Best result	7.30	7.33	7.36	7.34
Average result	7.18	7.09	7.16	7.11
Worst result	6.67	6.69	6.73	6.75
Responses	947	918	1041	918

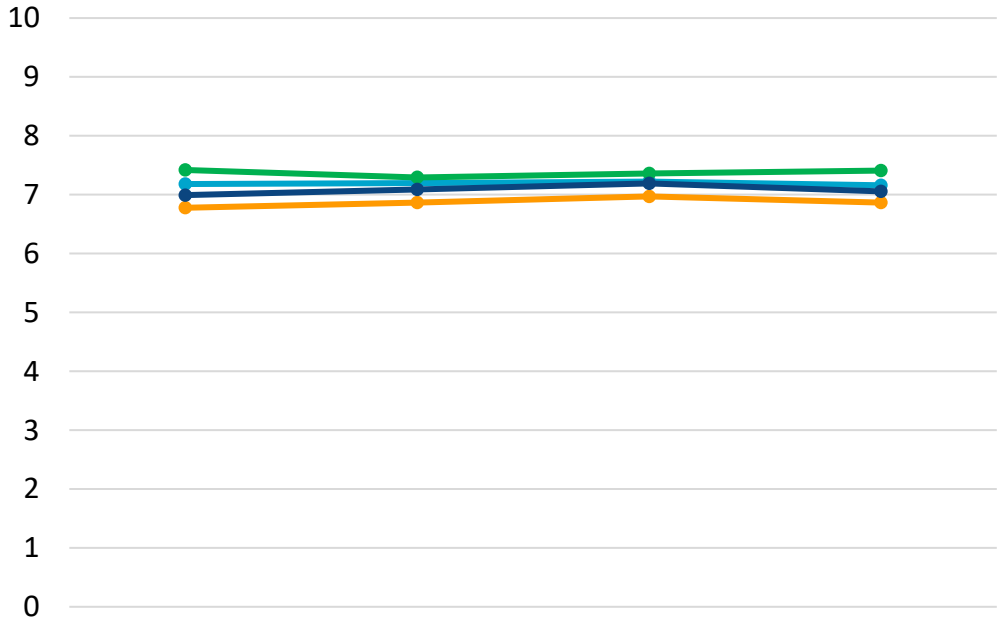
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

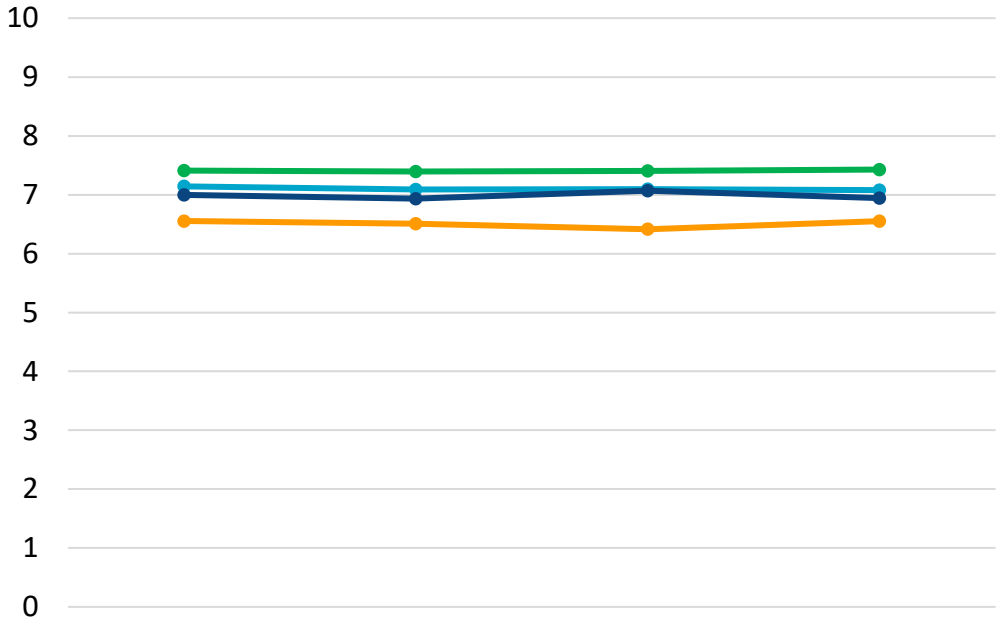
Promise element 3: We each have a voice that counts

Autonomy and control



	2021	2022	2023	2024
Your org	6.99	7.09	7.19	7.05
Best result	7.42	7.29	7.36	7.41
Average result	7.18	7.20	7.22	7.16
Worst result	6.78	6.86	6.97	6.87
Responses	977	918	1047	926

Raising concerns



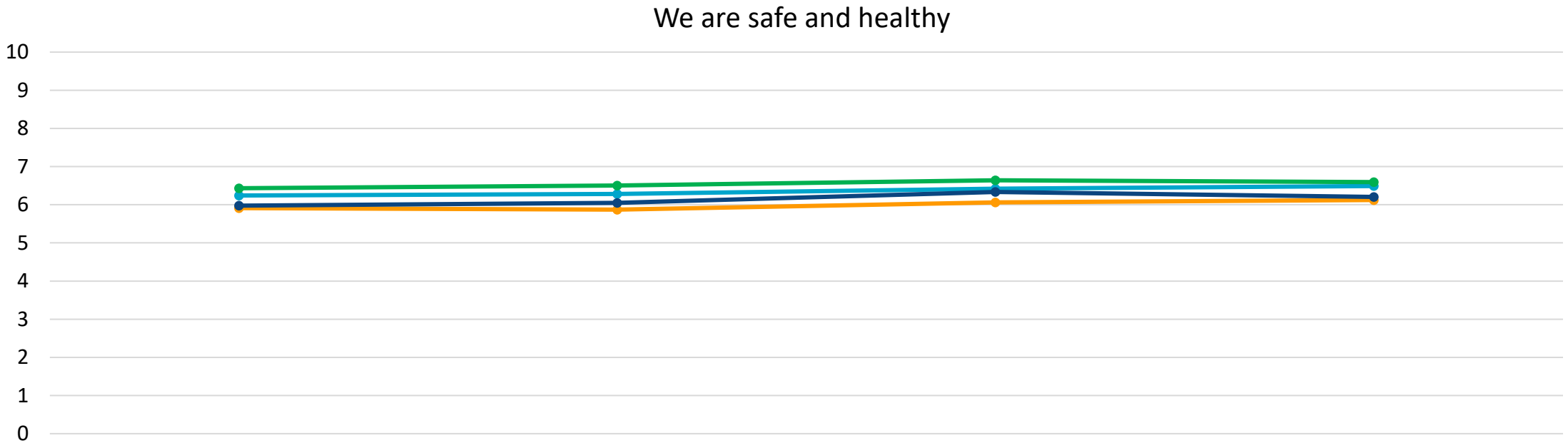
	2021	2022	2023	2024
Your org	7.00	6.93	7.07	6.94
Best result	7.41	7.40	7.41	7.43
Average result	7.14	7.09	7.10	7.08
Worst result	6.55	6.51	6.41	6.55
Responses	947	918	1041	919

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	2021	2022	2023	2024
Your org	5.98	6.05	6.33	6.20
Best result	6.43	6.50	6.64	6.60
Average result	6.24	6.28	6.42	6.49
Worst result	5.91	5.87	6.06	6.12
Responses	964	913	1013	921

Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

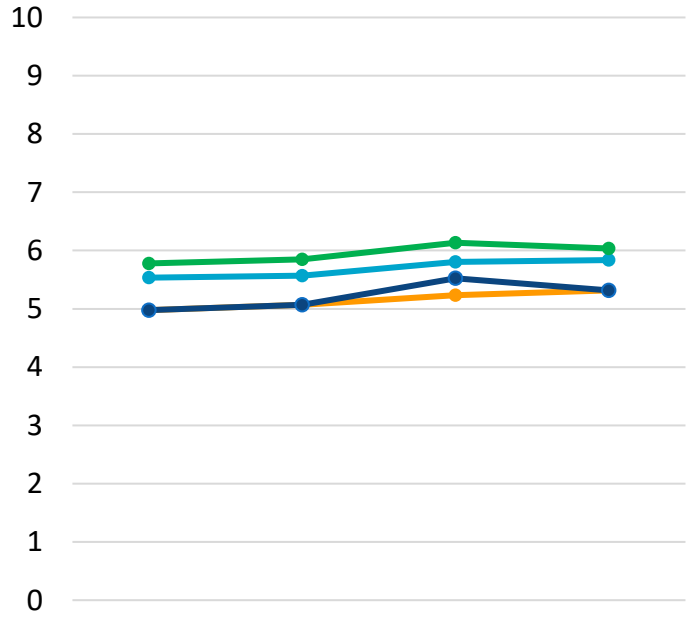
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

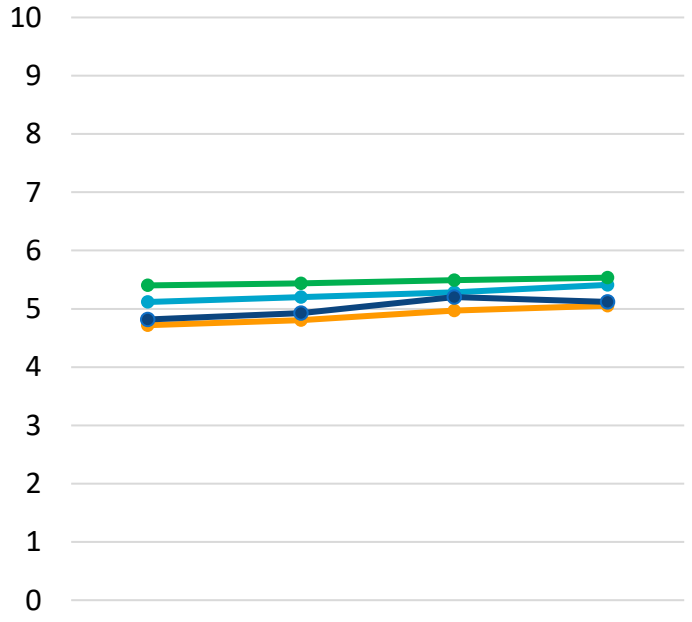
Promise element 4: We are safe and healthy

Health and safety climate



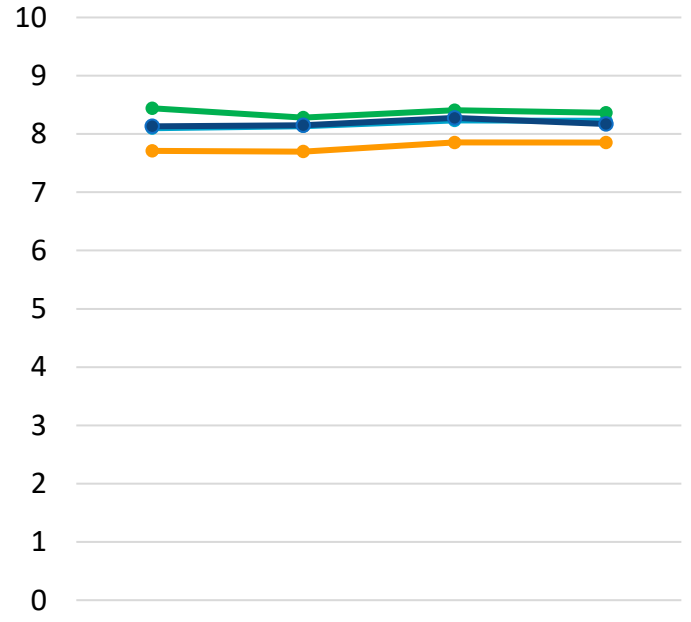
	2021	2022	2023	2024
Your org	4.98	5.07	5.52	5.32
Best result	5.78	5.85	6.13	6.04
Average result	5.54	5.57	5.80	5.84
Worst result	4.98	5.07	5.23	5.32
Responses	977	918	1016	926

Burnout



	2021	2022	2023	2024
Your org	4.82	4.93	5.20	5.12
Best result	5.40	5.44	5.49	5.53
Average result	5.12	5.20	5.28	5.41
Worst result	4.72	4.81	4.97	5.05
Responses	964	917	1047	926

Negative experiences



	2021	2022	2023	2024
Your org	8.13	8.15	8.28	8.17
Best result	8.44	8.28	8.41	8.36
Average result	8.10	8.13	8.23	8.23
Worst result	7.71	7.70	7.86	7.85
Responses	964	914	1013	923

Note: 2023 results for 'Health and safety climate' and 'Negative experiences' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning

	2021	2022	2023	2024
Your org	5.48	5.62	6.13	5.86
Best result	6.17	6.08	6.32	6.20
Average result	5.77	5.86	6.04	5.97
Worst result	4.93	5.29	5.54	5.61
Responses	937	887	1026	901

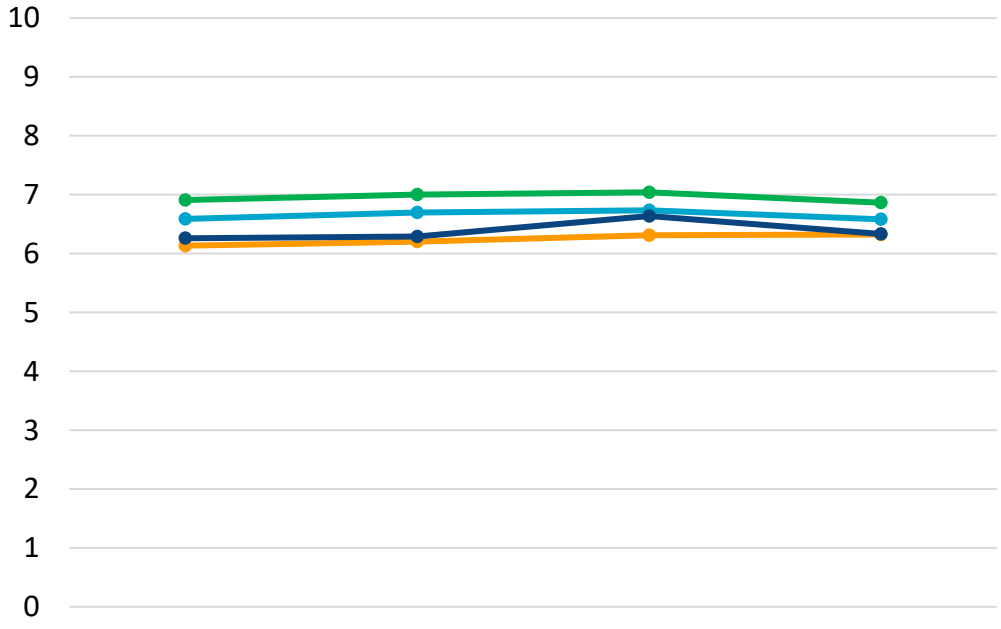
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

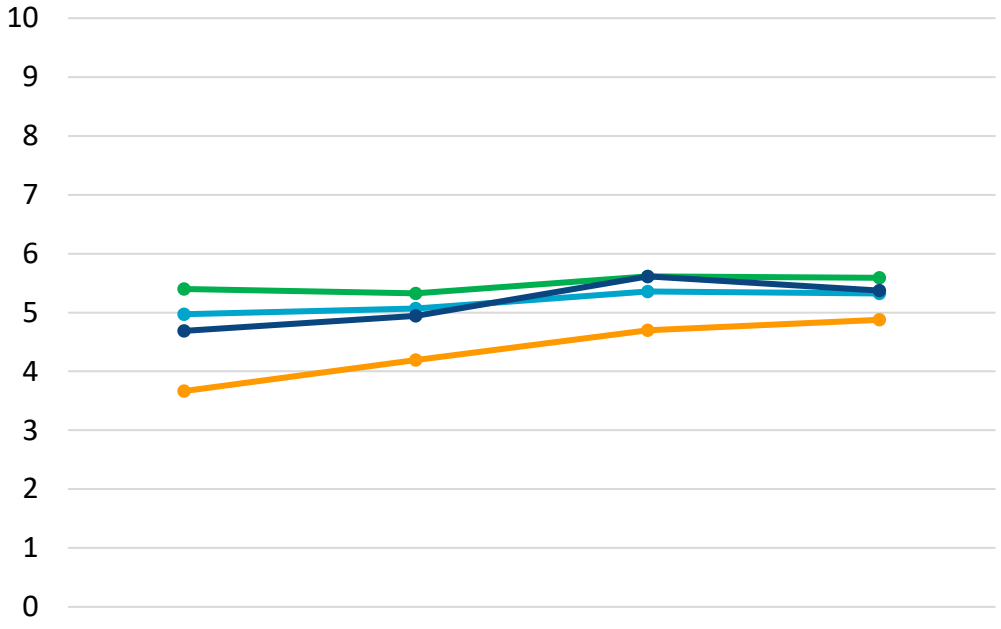
Promise element 5: We are always learning

Development



	2021	2022	2023	2024
Your org	6.26	6.29	6.64	6.33
Best result	6.91	7.00	7.04	6.86
Average result	6.59	6.70	6.73	6.58
Worst result	6.13	6.20	6.31	6.32
Responses	956	913	1047	924

Appraisals



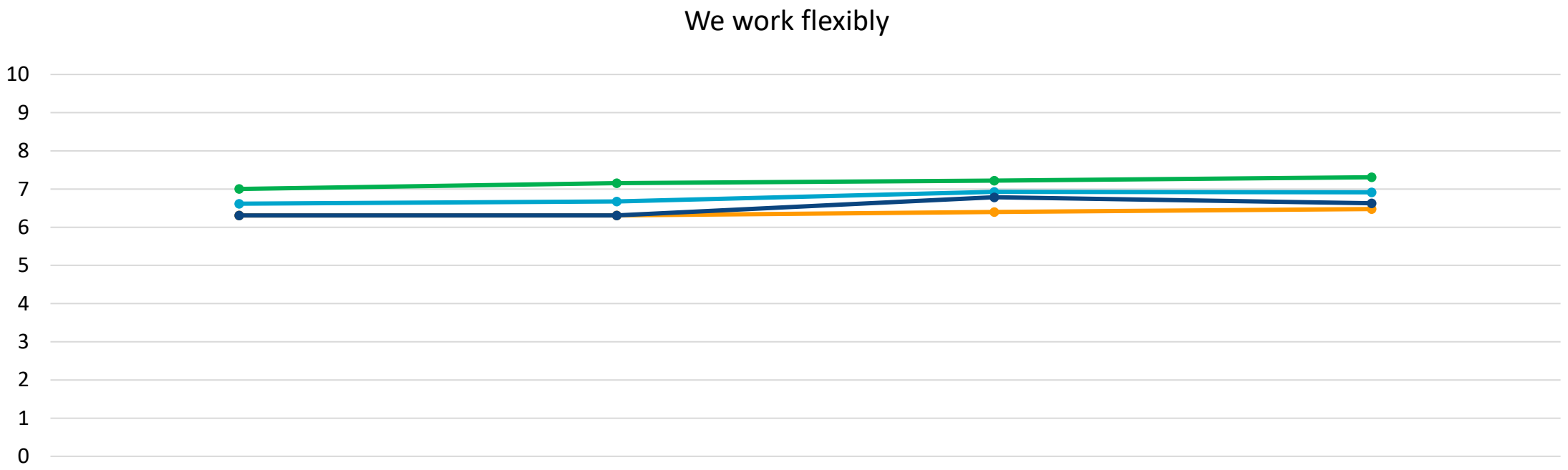
	2021	2022	2023	2024
Your org	4.69	4.95	5.61	5.37
Best result	5.40	5.33	5.61	5.59
Average result	4.97	5.07	5.36	5.32
Worst result	3.67	4.19	4.70	4.88
Responses	942	892	1026	902

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	2021	2022	2023	2024
Your org	6.31	6.31	6.78	6.63
Best result	7.00	7.16	7.22	7.31
Average result	6.62	6.68	6.93	6.91
Worst result	6.31	6.31	6.40	6.48
Responses	970	916	1042	922

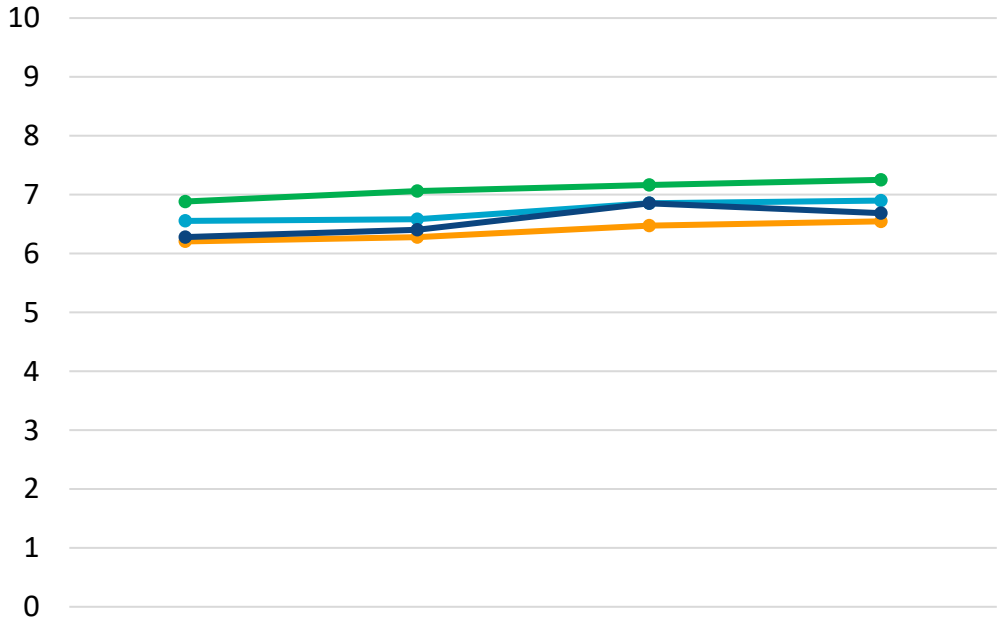
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

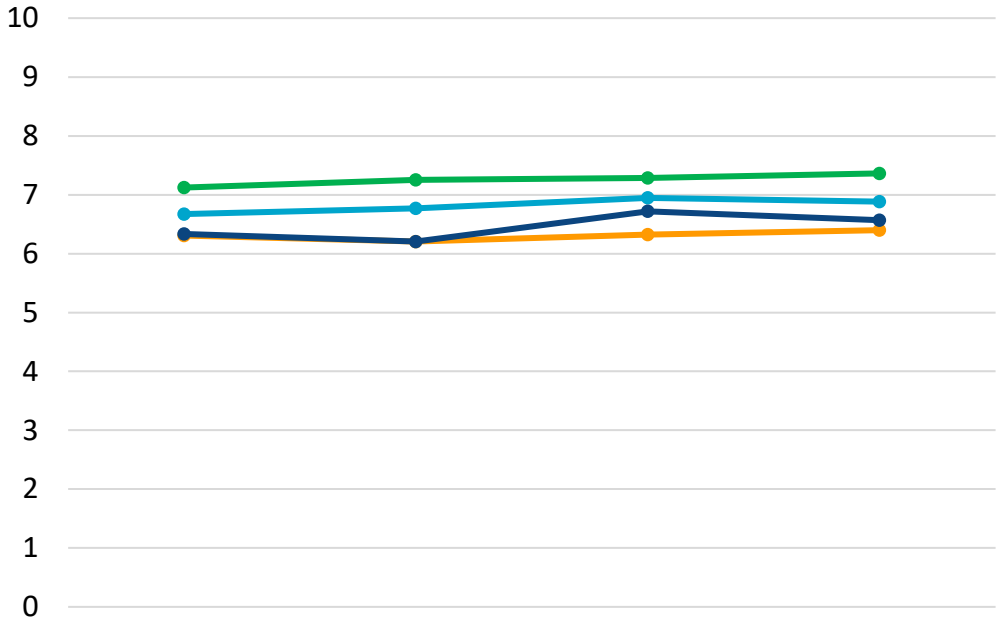
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022	2023	2024
Your org	6.28	6.41	6.85	6.69
Best result	6.88	7.06	7.16	7.25
Average result	6.55	6.58	6.85	6.90
Worst result	6.21	6.28	6.47	6.55
Responses	972	917	1046	927

Flexible working



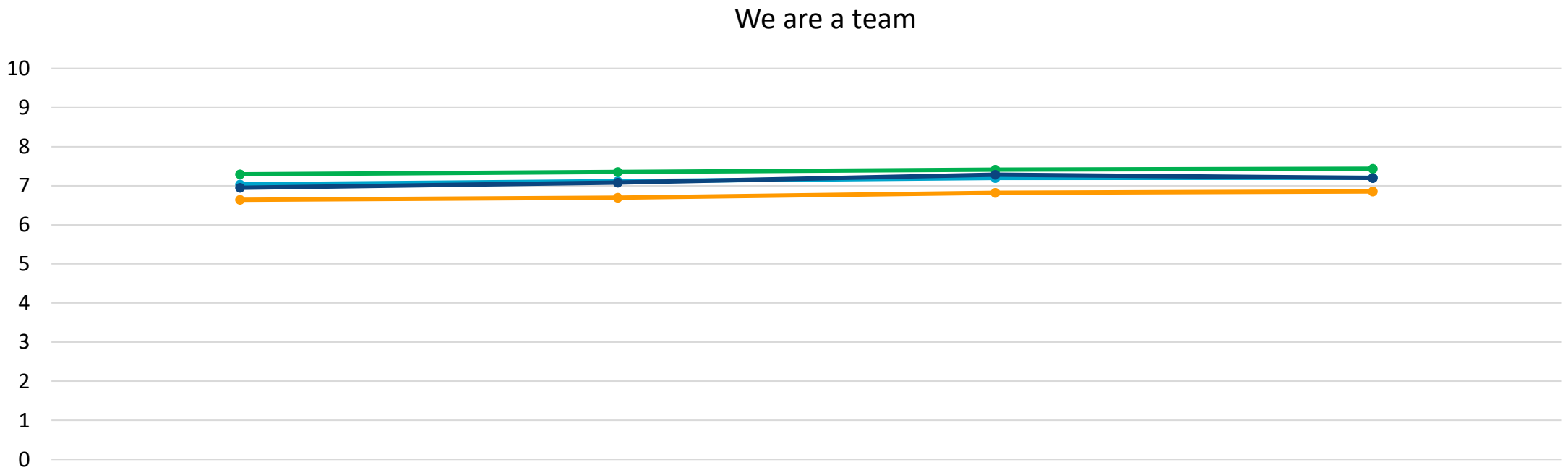
	2021	2022	2023	2024
Your org	6.34	6.21	6.72	6.57
Best result	7.12	7.26	7.28	7.36
Average result	6.67	6.77	6.95	6.88
Worst result	6.31	6.21	6.33	6.40
Responses	973	917	1043	922

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



	2021	2022	2023	2024
Your org	6.95	7.08	7.28	7.20
Best result	7.29	7.35	7.41	7.44
Average result	7.03	7.12	7.20	7.20
Worst result	6.64	6.70	6.82	6.85
Responses	962	918	1047	925

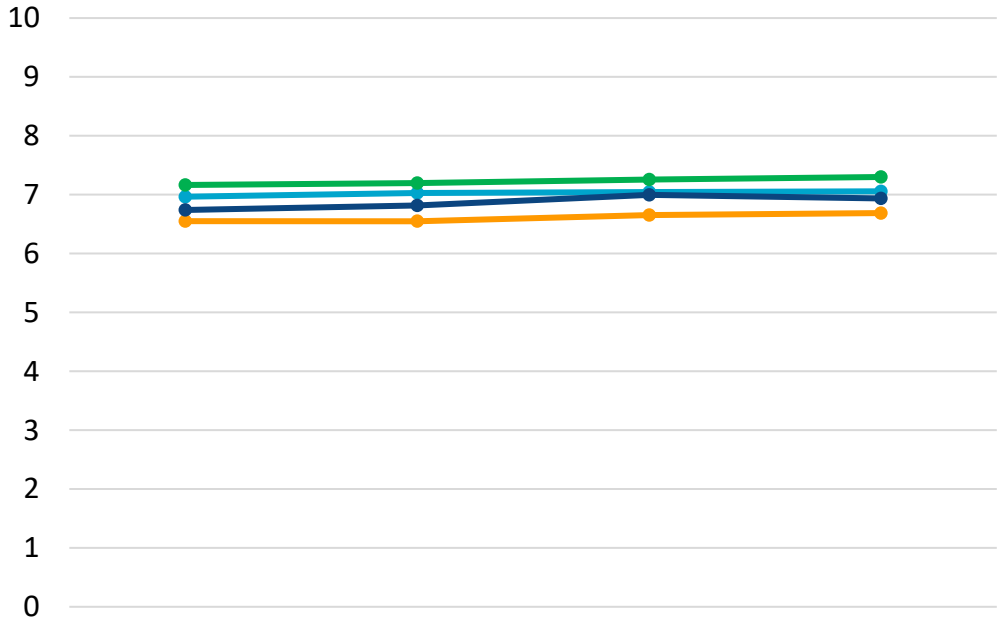
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

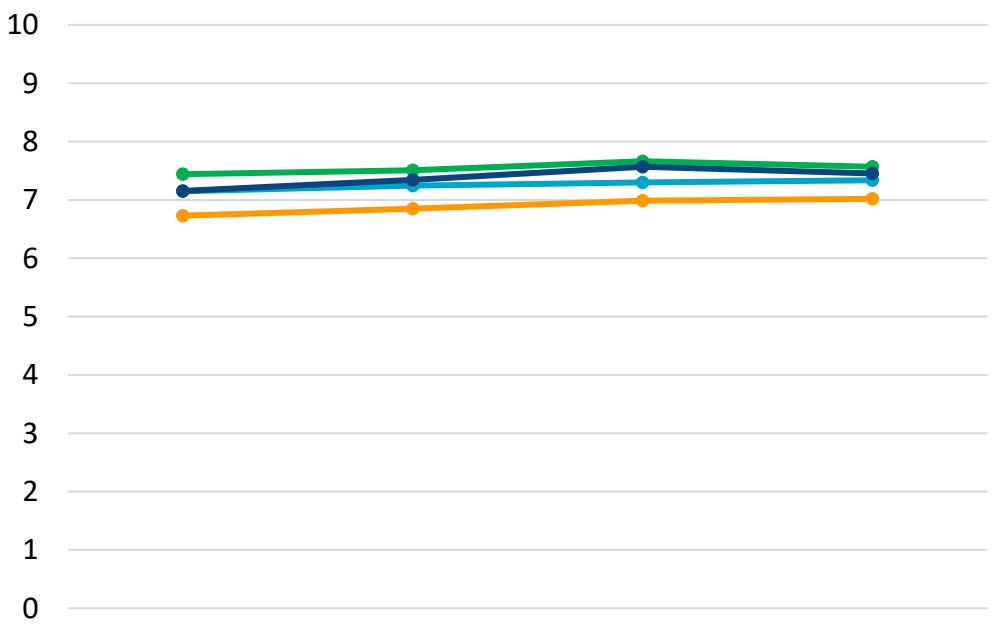
Promise element 7: We are a team

Team working



	2021	2022	2023	2024
Your org	6.74	6.82	7.00	6.94
Best result	7.16	7.20	7.26	7.30
Average result	6.97	7.03	7.04	7.06
Worst result	6.55	6.55	6.65	6.69
Responses	968	918	1047	925

Line management



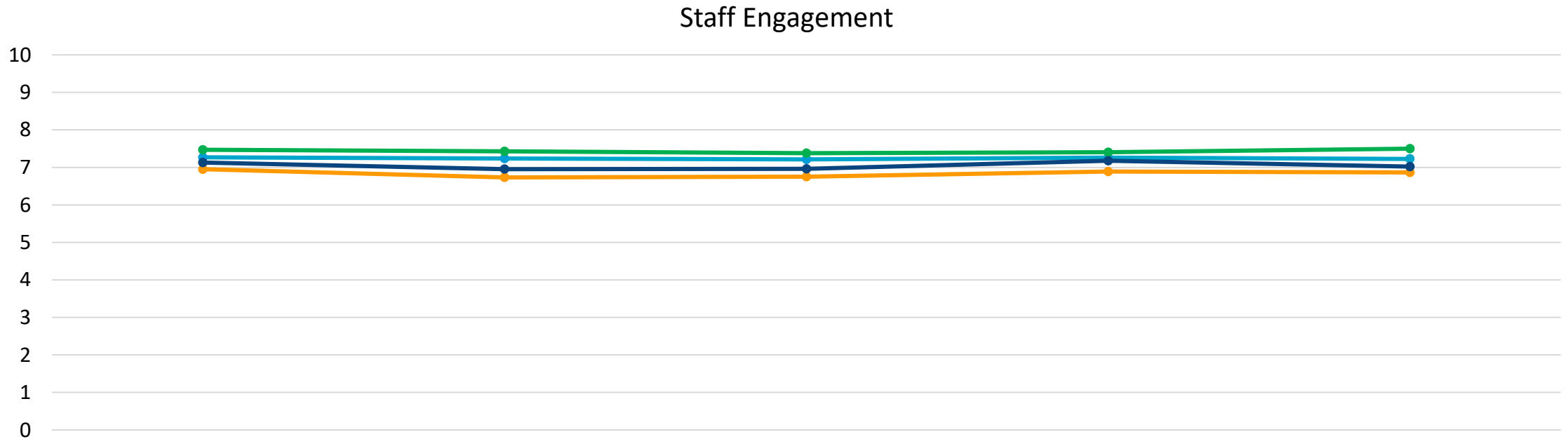
	2021	2022	2023	2024
Your org	7.15	7.34	7.57	7.45
Best result	7.44	7.51	7.66	7.57
Average result	7.15	7.24	7.30	7.34
Worst result	6.73	6.85	6.99	7.02
Responses	962	918	1047	926

People Promise elements and themes: Trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



	2020	2021	2022	2023	2024
Your org	7.13	6.95	6.96	7.18	7.02
Best result	7.47	7.43	7.38	7.40	7.50
Average result	7.27	7.24	7.21	7.26	7.23
Worst result	6.95	6.73	6.75	6.89	6.87
Responses	825	976	918	1047	926

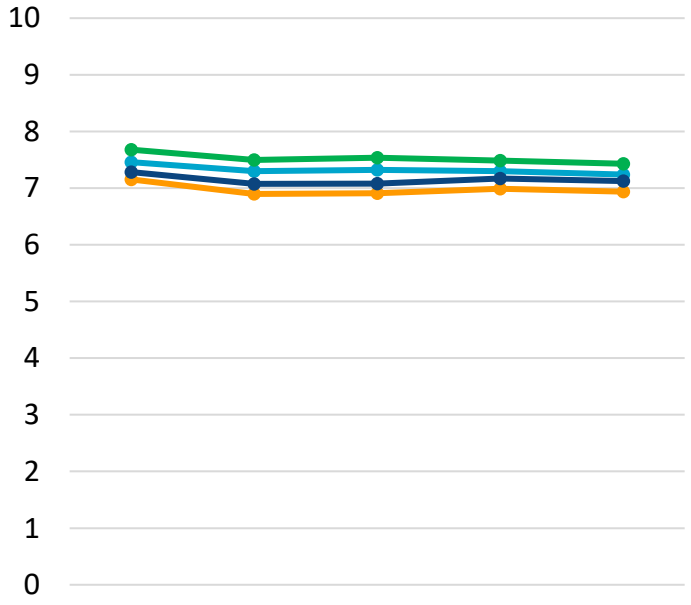
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement

Motivation

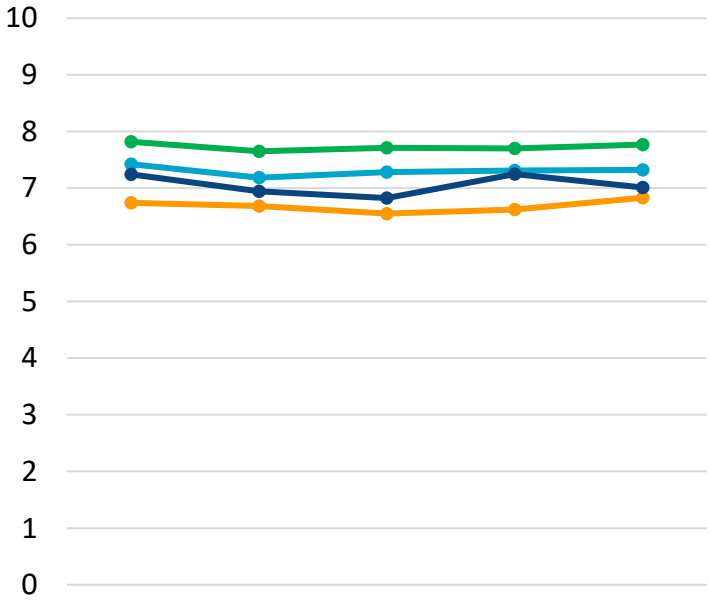


	2020	2021	2022	2023	2024
Your org	7.28	7.08	7.08	7.17	7.13
Best result	7.68	7.50	7.54	7.49	7.43
Average result	7.46	7.30	7.32	7.30	7.24
Worst result	7.15	6.90	6.91	6.99	6.94
Responses	821	973	905	1041	918

Involvement

	2020	2021	2022	2023	2024
Your org	6.87	6.85	6.98	7.13	6.94
Best result	7.29	7.37	7.27	7.31	7.37
Average result	7.02	7.06	7.10	7.13	7.07
Worst result	6.72	6.62	6.71	6.87	6.80
Responses	825	977	918	1047	926

Advocacy



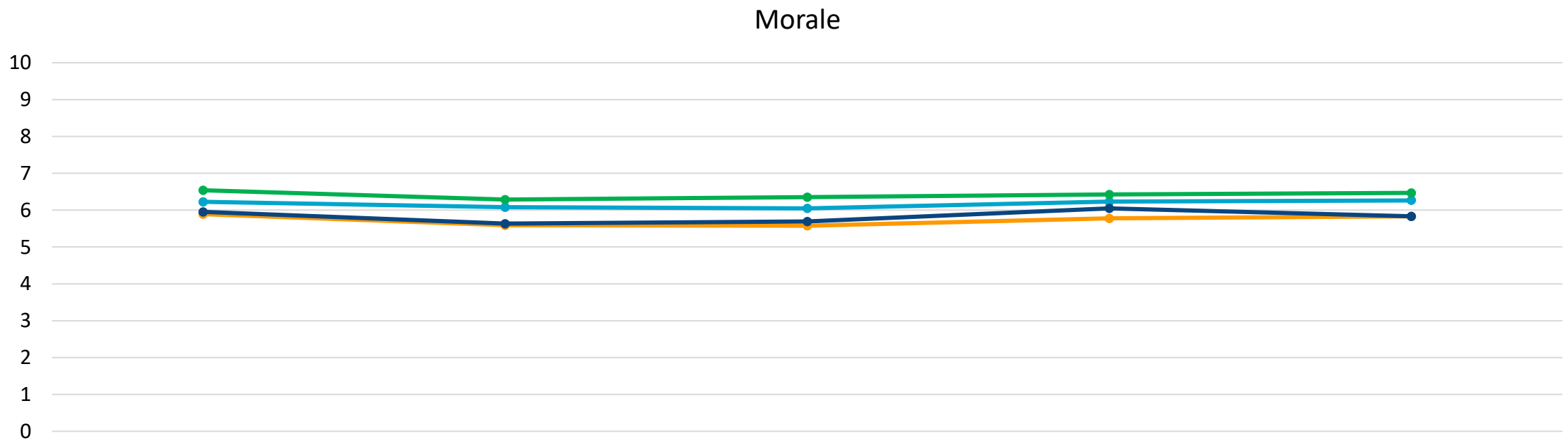
	2020	2021	2022	2023	2024
Your org	7.24	6.94	6.82	7.25	7.01
Best result	7.82	7.65	7.71	7.70	7.77
Average result	7.42	7.18	7.28	7.31	7.32
Worst result	6.74	6.68	6.55	6.62	6.83
Responses	822	950	918	1044	923

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



	2020	2021	2022	2023	2024
Your org	5.95	5.64	5.69	6.05	5.84
Best result	6.54	6.29	6.36	6.42	6.47
Average result	6.22	6.08	6.05	6.23	6.26
Worst result	5.89	5.59	5.58	5.78	5.83
Responses	824	975	918	1047	927

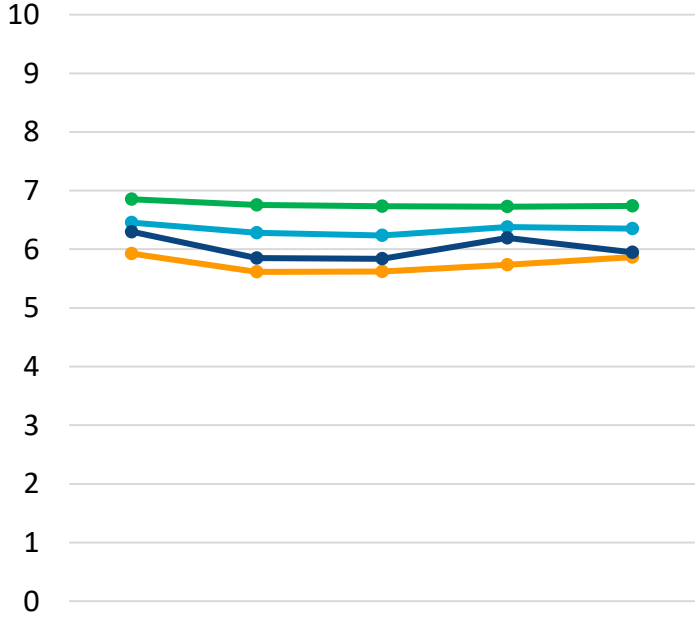
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

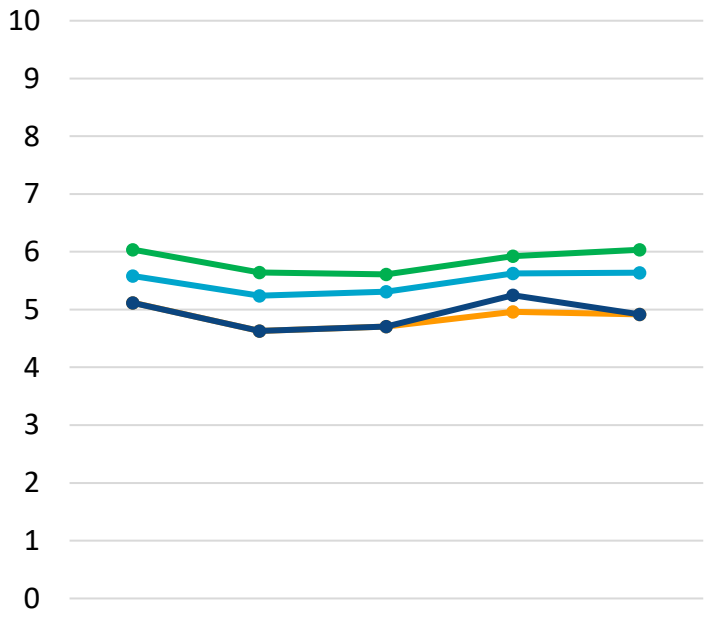
Theme: Morale

Thinking about leaving



	2020	2021	2022	2023	2024
Your org	6.30	5.85	5.84	6.19	5.95
Best result	6.85	6.75	6.73	6.73	6.74
Average result	6.45	6.28	6.23	6.38	6.35
Worst result	5.93	5.61	5.62	5.74	5.87
Responses	822	946	917	1045	925

Work pressure



	2020	2021	2022	2023	2024
Your org	5.12	4.63	4.70	5.25	4.92
Best result	6.04	5.64	5.61	5.93	6.04
Average result	5.58	5.24	5.31	5.63	5.64
Worst result	5.12	4.63	4.70	4.96	4.92
Responses	824	977	918	1047	926

Stressors

	2020	2021	2022	2023	2024
Your org	6.47	6.44	6.55	6.71	6.64
Best result	6.85	6.76	6.85	6.89	6.89
Average result	6.69	6.64	6.67	6.77	6.75
Worst result	6.38	6.24	6.33	6.43	6.43
Responses	820	975	917	1045	926

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive

Questions included:

Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

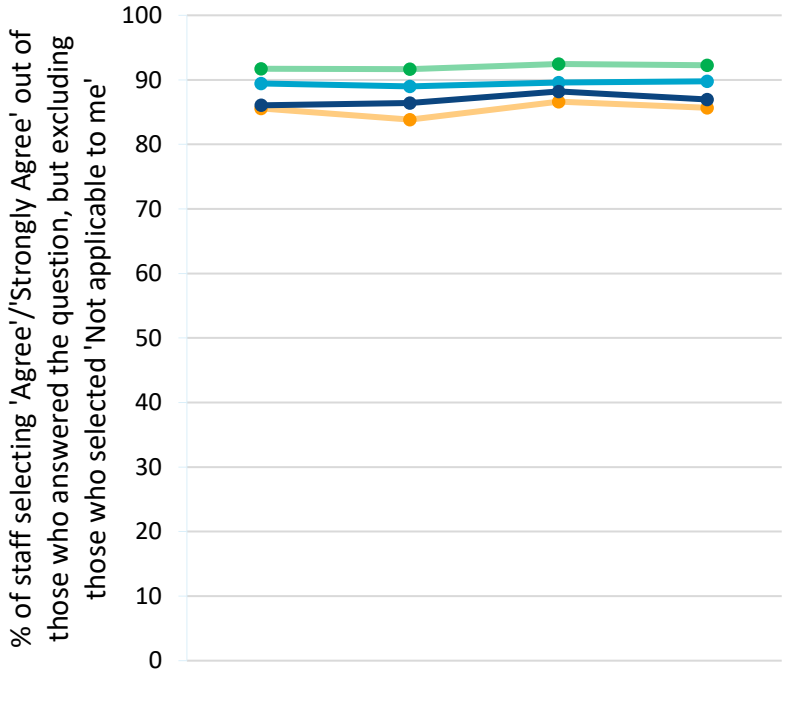
Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

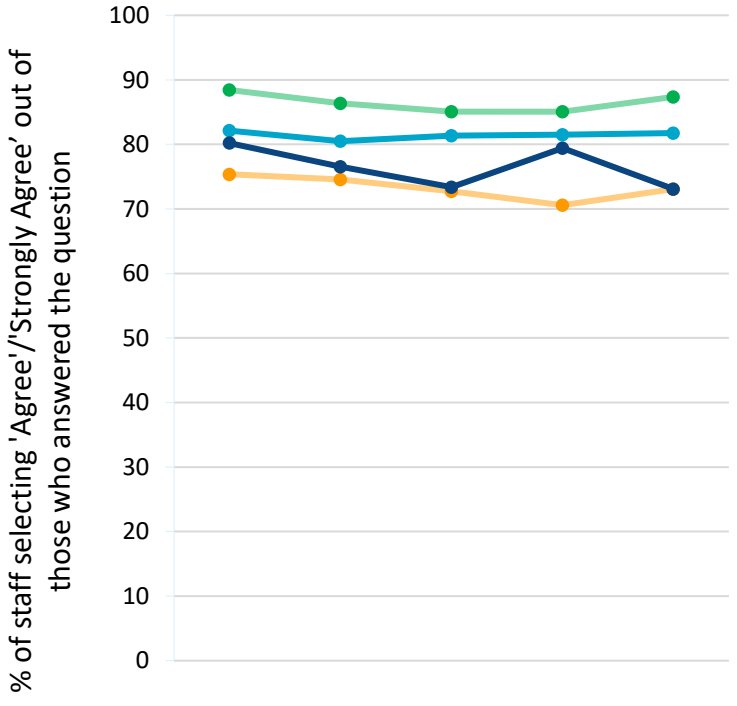
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6a I feel that my role makes a difference to patients / service users.



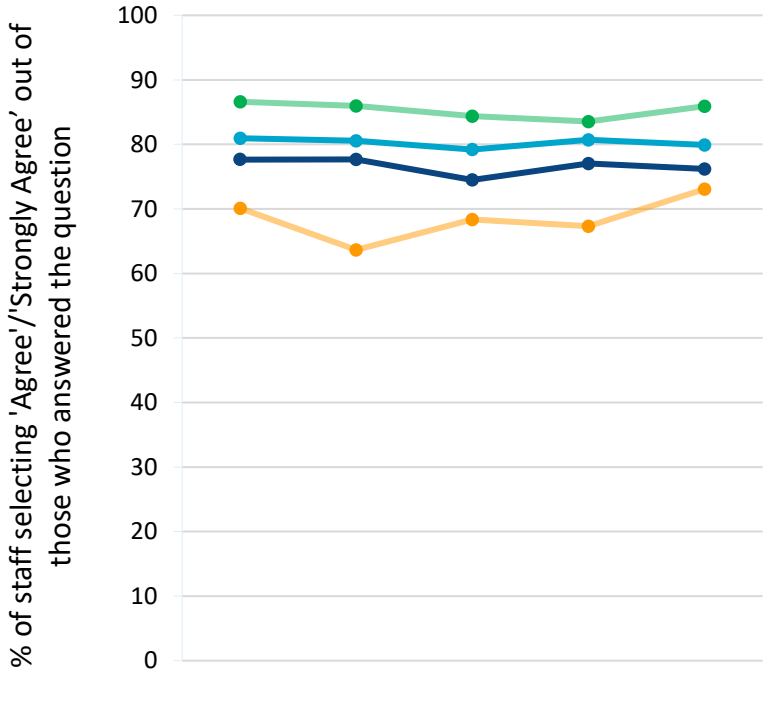
	2021	2022	2023	2024
Your org	86.06%	86.42%	88.21%	86.95%
Best result	91.71%	91.66%	92.46%	92.28%
Average result	89.42%	88.99%	89.58%	89.77%
Worst result	85.59%	83.84%	86.63%	85.65%
Responses	952	890	1013	900

Q25a Care of patients / service users is my organisation's top priority.



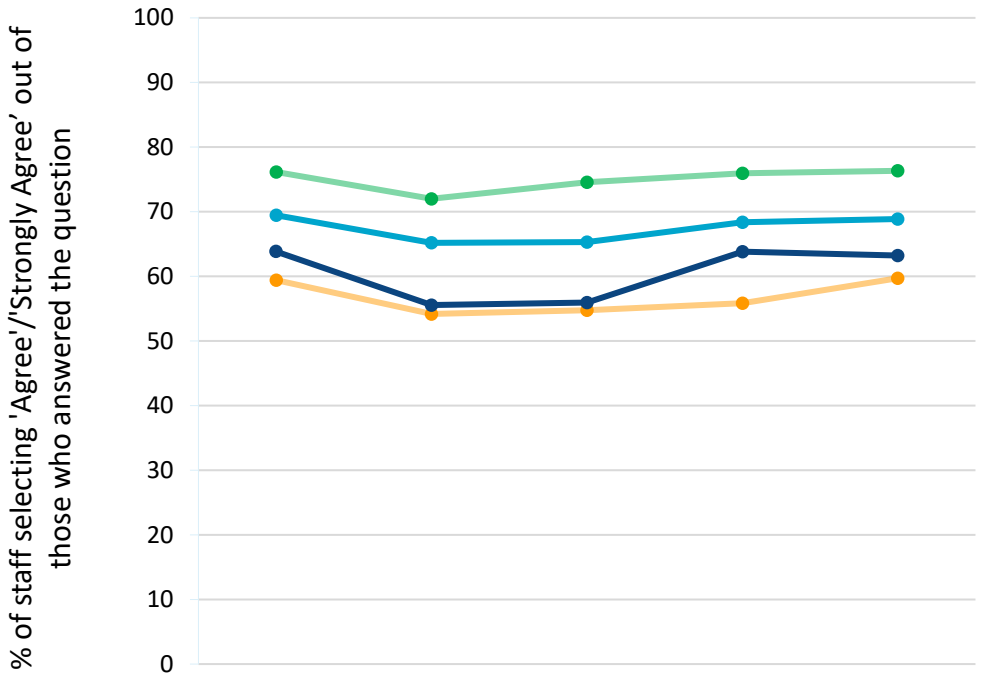
	2020	2021	2022	2023	2024
Your org	80.19%	76.52%	73.35%	79.45%	73.09%
Best result	88.43%	86.38%	85.08%	85.07%	87.34%
Average result	82.13%	80.49%	81.33%	81.53%	81.76%
Worst result	75.38%	74.57%	72.73%	70.58%	73.09%
Responses	821	950	917	1043	922

Q25b My organisation acts on concerns raised by patients / service users.



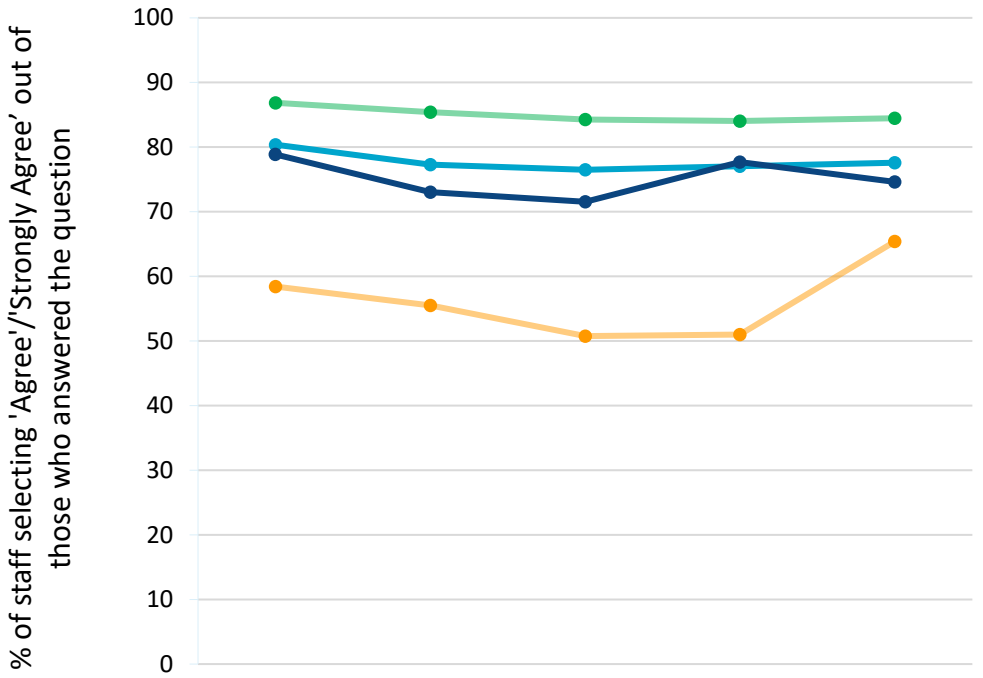
	2020	2021	2022	2023	2024
Your org	77.66%	77.67%	74.49%	77.06%	76.21%
Best result	86.60%	85.97%	84.39%	83.55%	85.94%
Average result	80.95%	80.55%	79.20%	80.71%	79.93%
Worst result	70.12%	63.66%	68.35%	67.31%	73.07%
Responses	819	950	917	1043	923

Q25c I would recommend my organisation as a place to work.



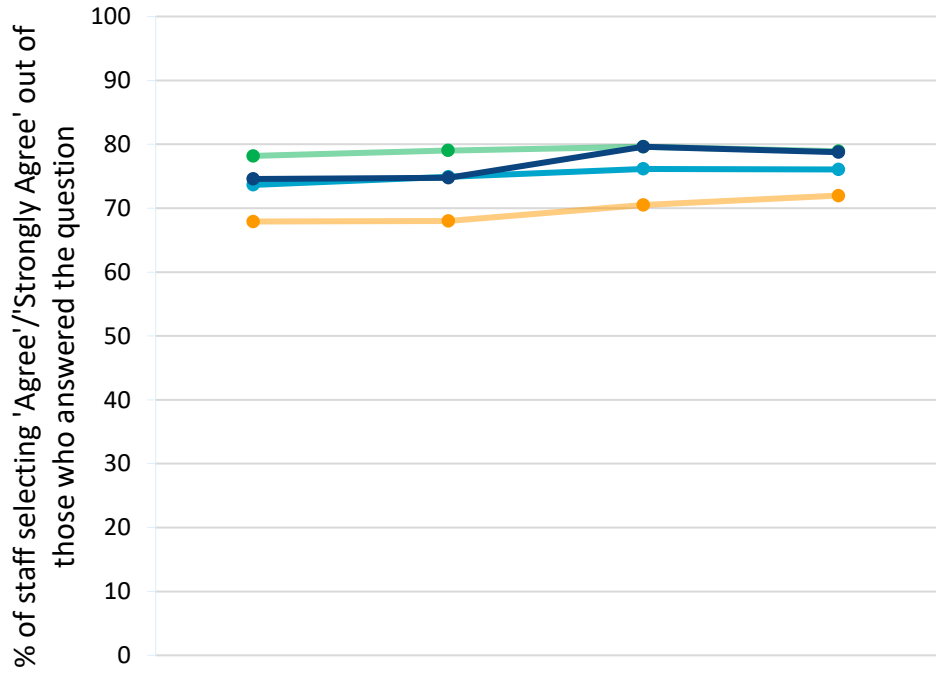
	2020	2021	2022	2023	2024
Your org	63.83%	55.57%	55.95%	63.81%	63.21%
Best result	76.15%	72.01%	74.57%	75.97%	76.34%
Average result	69.46%	65.19%	65.31%	68.36%	68.89%
Worst result	59.42%	54.18%	54.75%	55.86%	59.71%
Responses	821	949	918	1043	923

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



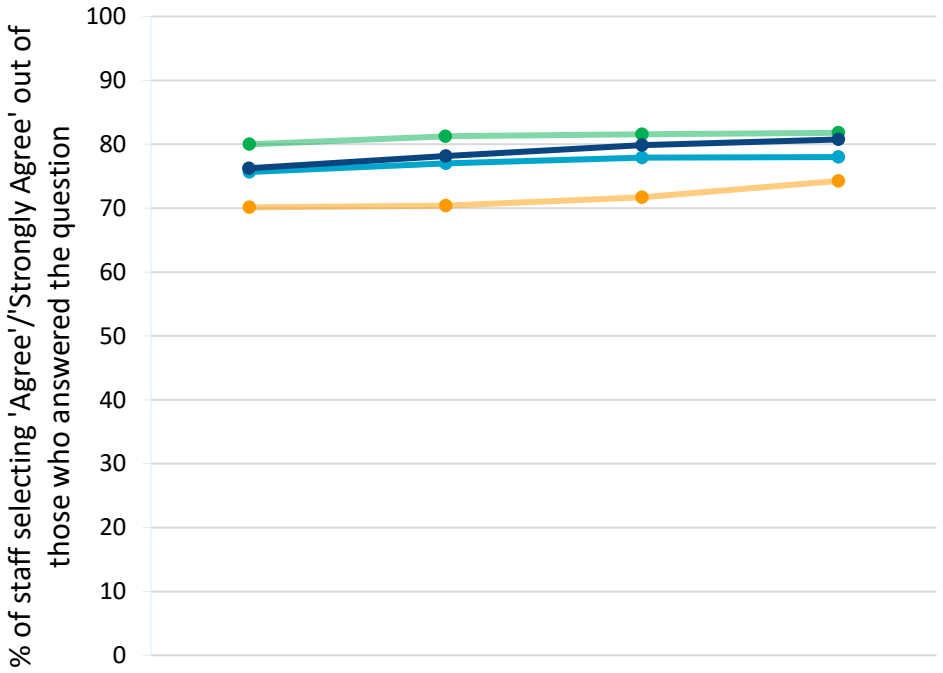
	2020	2021	2022	2023	2024
Your org	78.87%	73.02%	71.54%	77.70%	74.64%
Best result	86.86%	85.39%	84.27%	84.05%	84.46%
Average result	80.38%	77.29%	76.50%	77.06%	77.59%
Worst result	58.43%	55.52%	50.76%	50.99%	65.41%
Responses	820	949	918	1042	922

Q9f My immediate manager works together with me to come to an understanding of problems.



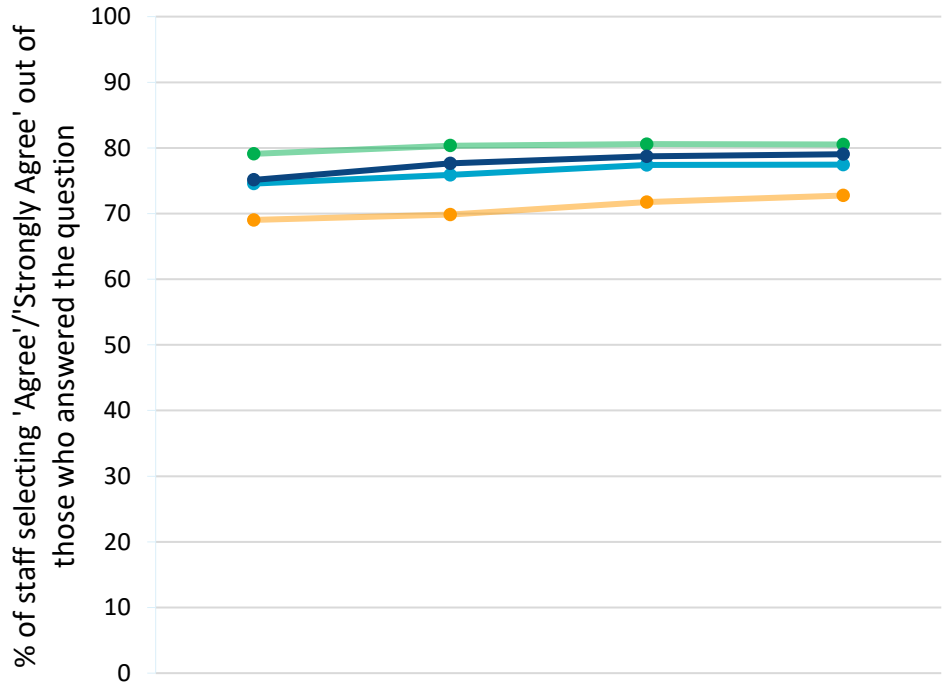
	2021	2022	2023	2024
Your org	74.57%	74.76%	79.61%	78.78%
Best result	78.18%	79.03%	79.61%	78.91%
Average result	73.64%	74.89%	76.14%	76.05%
Worst result	67.91%	68.01%	70.47%	71.97%
Responses	959	918	1042	926

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



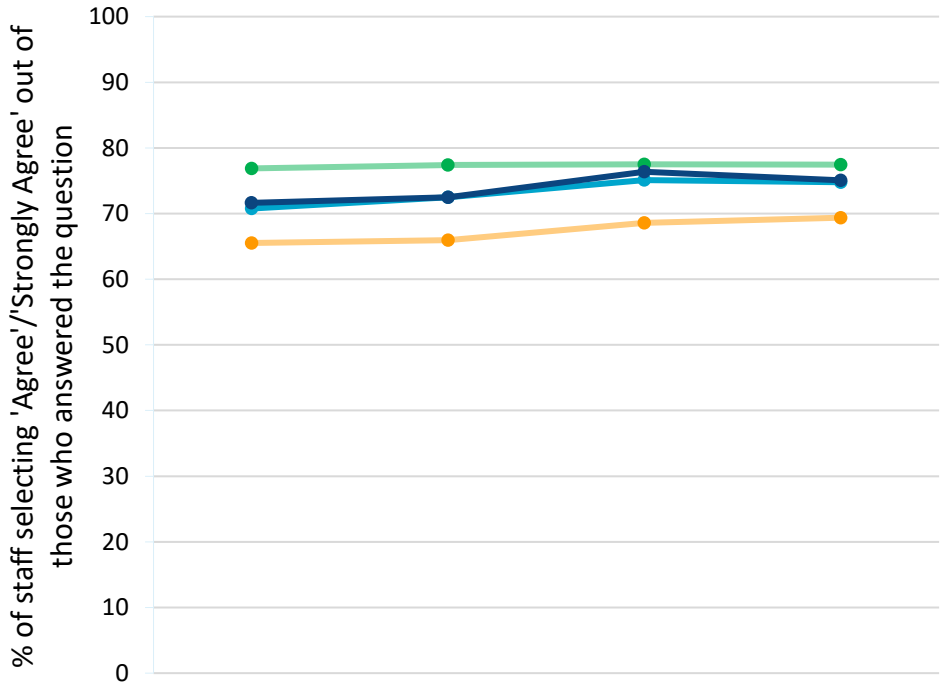
	2021	2022	2023	2024
Your org	76.25%	78.15%	79.89%	80.75%
Best result	79.99%	81.24%	81.58%	81.79%
Average result	75.66%	77.02%	77.92%	78.00%
Worst result	70.13%	70.40%	71.70%	74.26%
Responses	960	918	1044	924

Q9h My immediate manager cares about my concerns.



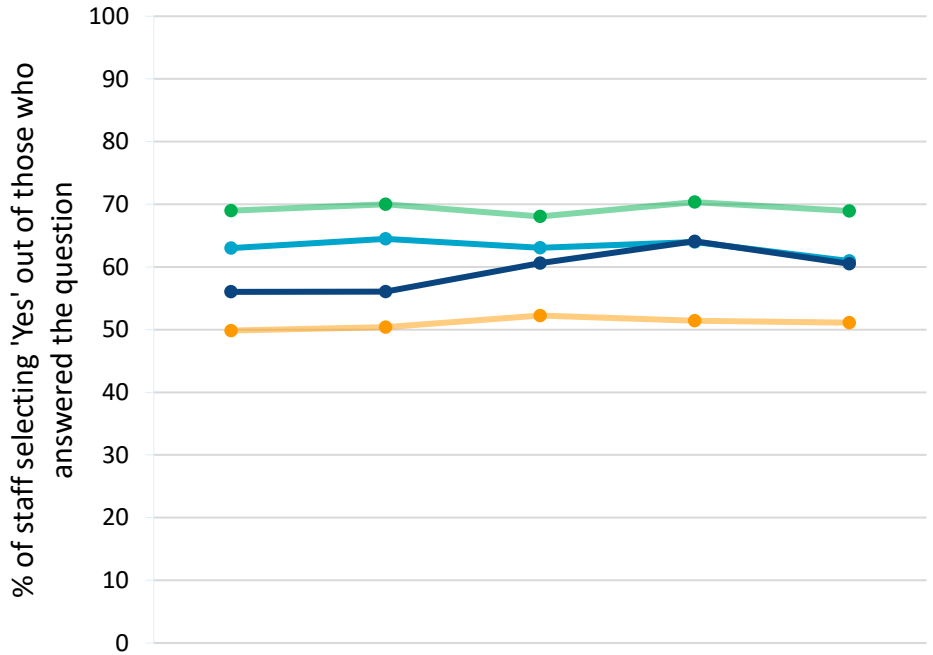
	2021	2022	2023	2024
Your org	75.12%	77.64%	78.70%	79.04%
Best result	79.10%	80.33%	80.58%	80.53%
Average result	74.57%	75.89%	77.40%	77.45%
Worst result	69.03%	69.87%	71.77%	72.75%
Responses	958	916	1046	924

Q9i My immediate manager takes effective action to help me with any problems I face.



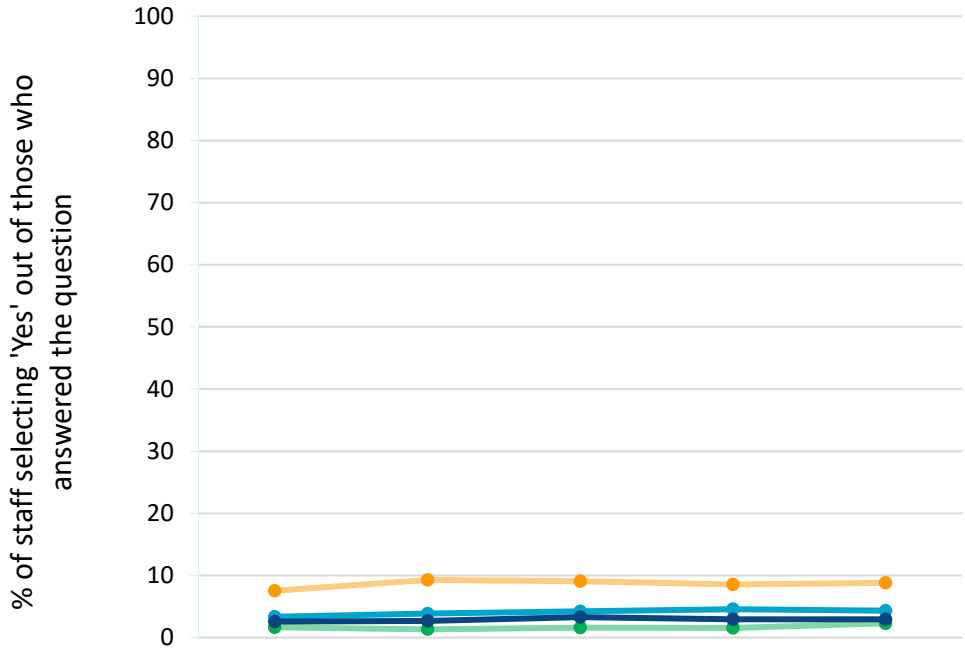
	2021	2022	2023	2024
Your org	71.63%	72.50%	76.36%	75.04%
Best result	76.88%	77.39%	77.50%	77.45%
Average result	70.77%	72.49%	75.10%	74.78%
Worst result	65.52%	65.94%	68.56%	69.37%
Responses	960	915	1043	924

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



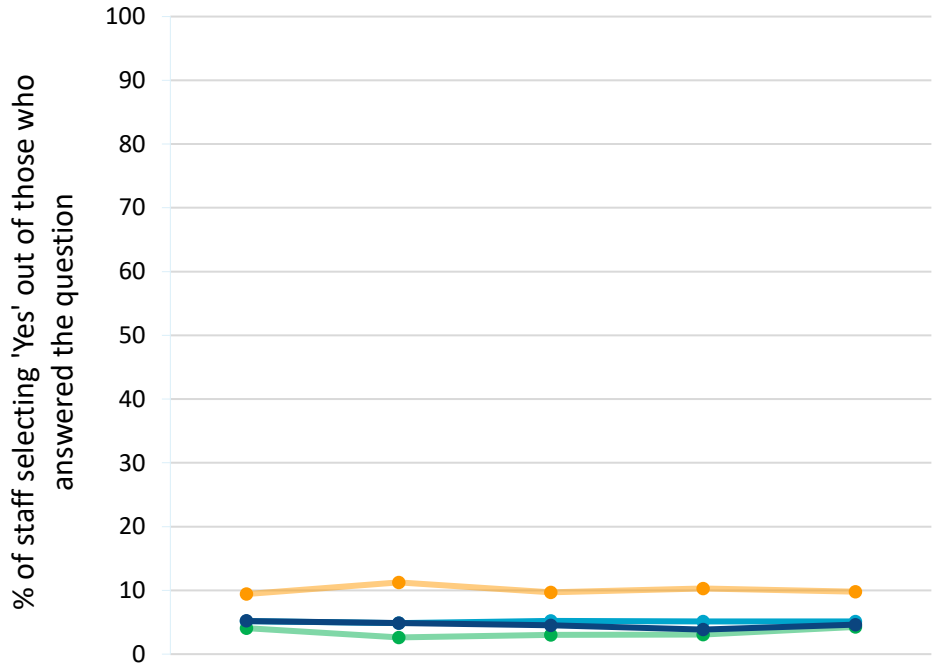
	2020	2021	2022	2023	2024
Your org	56.02%	56.08%	60.63%	64.10%	60.50%
Best result	68.96%	70.00%	68.06%	70.34%	68.92%
Average result	63.01%	64.48%	63.06%	63.96%	60.95%
Worst result	49.86%	50.40%	52.24%	51.43%	51.09%
Responses	819	957	900	1035	918

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



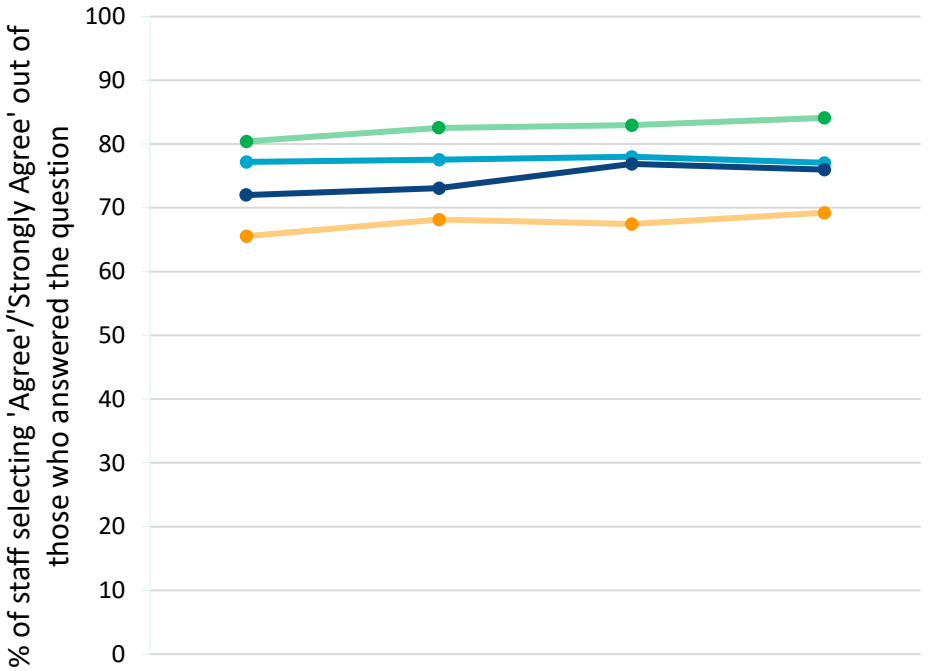
	2020	2021	2022	2023	2024
Your org	2.57%	2.67%	3.29%	2.92%	2.94%
Best result	1.67%	1.32%	1.59%	1.57%	2.29%
Average result	3.35%	3.87%	4.20%	4.56%	4.34%
Worst result	7.53%	9.29%	9.09%	8.53%	8.81%
Responses	820	958	911	1045	920

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



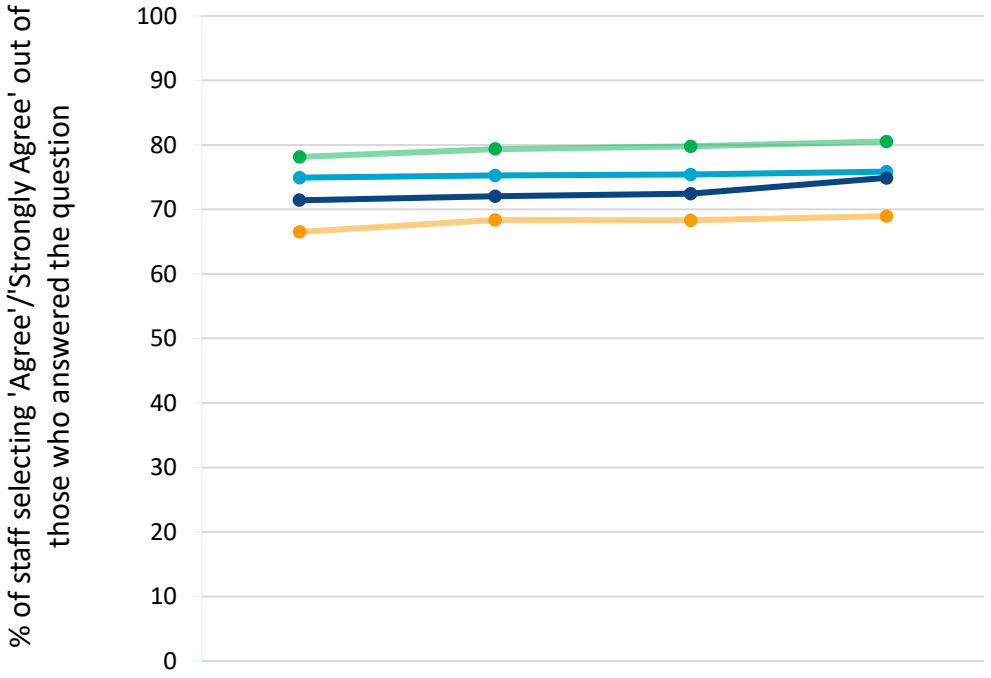
	2020	2021	2022	2023	2024
Your org	5.19%	4.87%	4.54%	3.85%	4.61%
Best result	4.08%	2.62%	3.03%	3.07%	4.26%
Average result	5.19%	4.86%	5.21%	5.13%	5.12%
Worst result	9.42%	11.25%	9.69%	10.28%	9.80%
Responses	819	959	910	1036	913

Q21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).



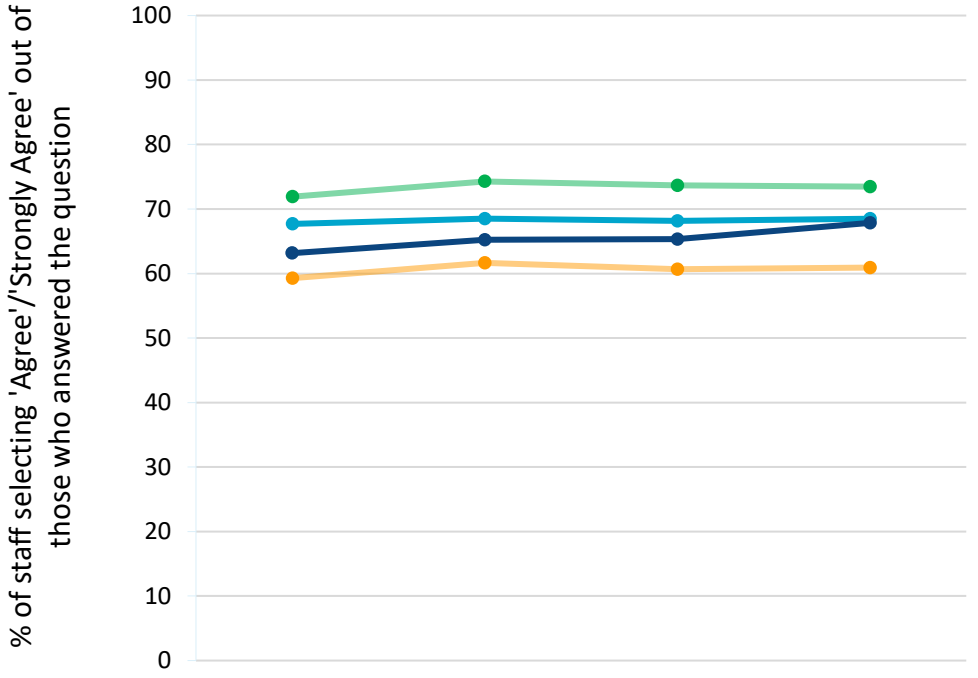
	2021	2022	2023	2024
Your org	72.00%	73.07%	76.89%	75.99%
Best result	80.42%	82.54%	82.96%	84.11%
Average result	77.22%	77.55%	78.01%	77.07%
Worst result	65.56%	68.17%	67.45%	69.23%
Responses	960	915	1045	924

Q7h I feel valued by my team.



	2021	2022	2023	2024
Your org	71.41%	72.06%	72.42%	74.90%
Best result	78.14%	79.35%	79.81%	80.55%
Average result	74.93%	75.27%	75.43%	75.86%
Worst result	66.52%	68.37%	68.31%	68.96%
Responses	968	914	1044	922

Q7i I feel a strong personal attachment to my team.

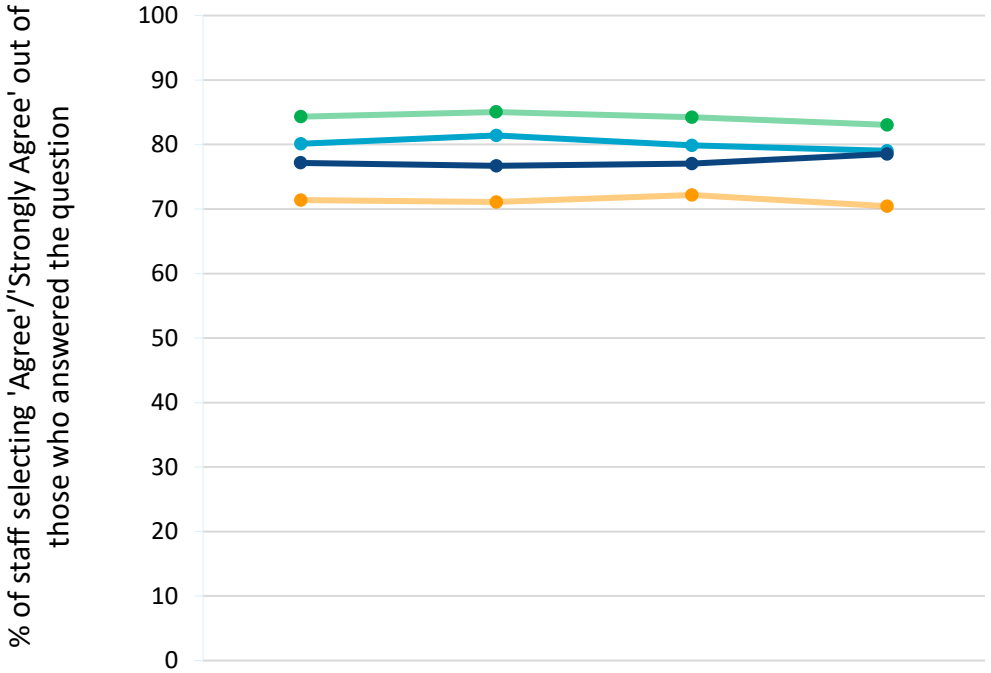


	2021	2022	2023	2024
Your org	63.16%	65.26%	65.33%	67.86%
Best result	71.92%	74.27%	73.68%	73.47%
Average result	67.70%	68.49%	68.19%	68.50%
Worst result	59.28%	61.65%	60.69%	60.90%
Responses	966	918	1046	922

Survey Coordination Centre

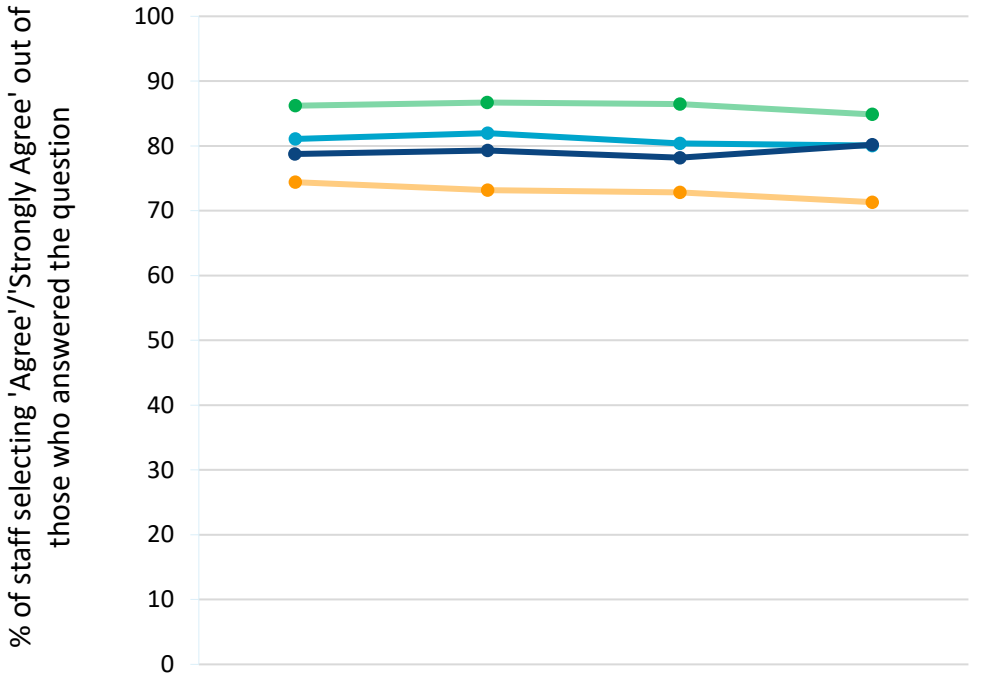
NHS

Q8b The people I work with are understanding and kind to one another.



	2021	2022	2023	2024
Your org	77.16%	76.70%	77.04%	78.54%
Best result	84.32%	85.04%	84.25%	83.05%
Average result	80.10%	81.41%	79.85%	79.04%
Worst result	71.39%	71.09%	72.18%	70.44%
Responses	964	918	1046	924

Q8c The people I work with are polite and treat each other with respect.



	2021	2022	2023	2024
Your org	78.75%	79.30%	78.18%	80.17%
Best result	86.21%	86.70%	86.47%	84.86%
Average result	81.08%	81.97%	80.40%	80.06%
Worst result	74.41%	73.16%	72.84%	71.32%
Responses	964	916	1046	924

Survey Coordination Centre

NHS

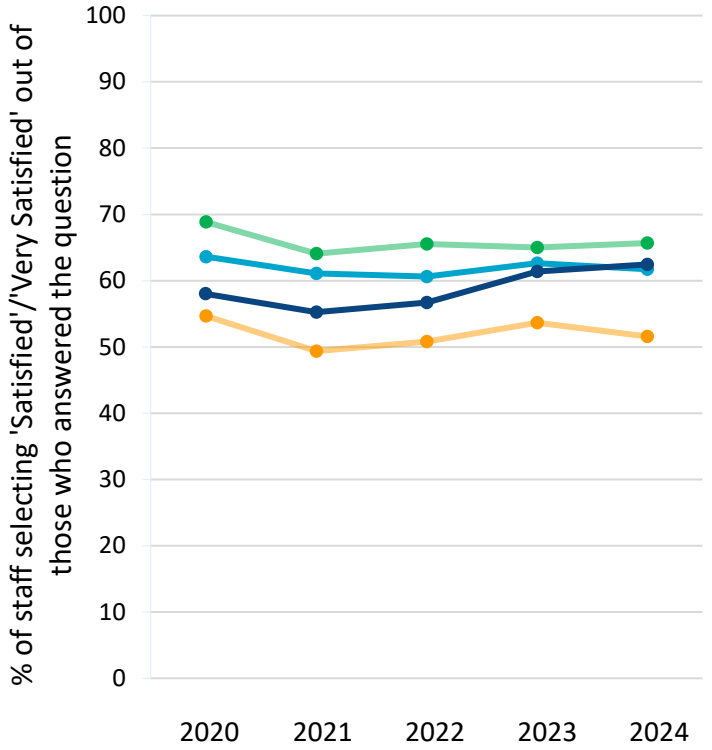
People Promise element – We are recognised and rewarded

Questions included:

Q4a, Q4b, Q4c, Q8d, Q9e

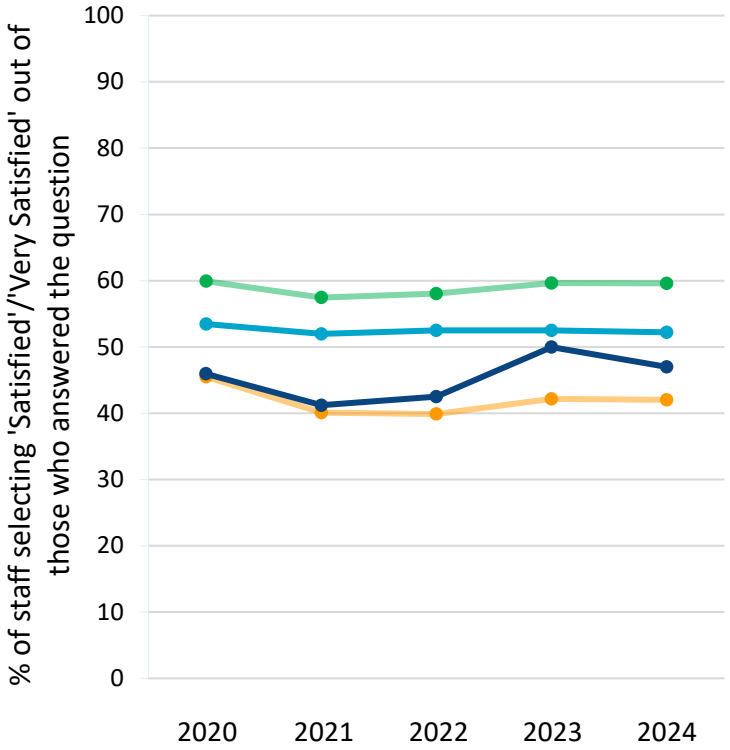
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



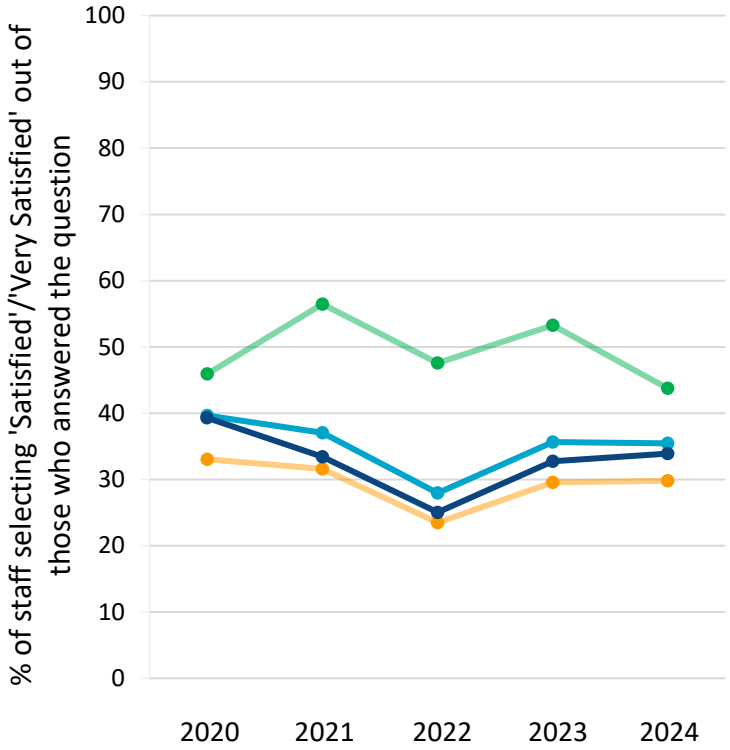
	2020	2021	2022	2023	2024
Your org	58.01%	55.25%	56.68%	61.36%	62.46%
Best result	68.85%	64.08%	65.53%	65.01%	65.67%
Average result	63.62%	61.11%	60.63%	62.63%	61.70%
Worst result	54.67%	49.38%	50.83%	53.66%	51.59%
Responses	823	975	918	1045	925

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



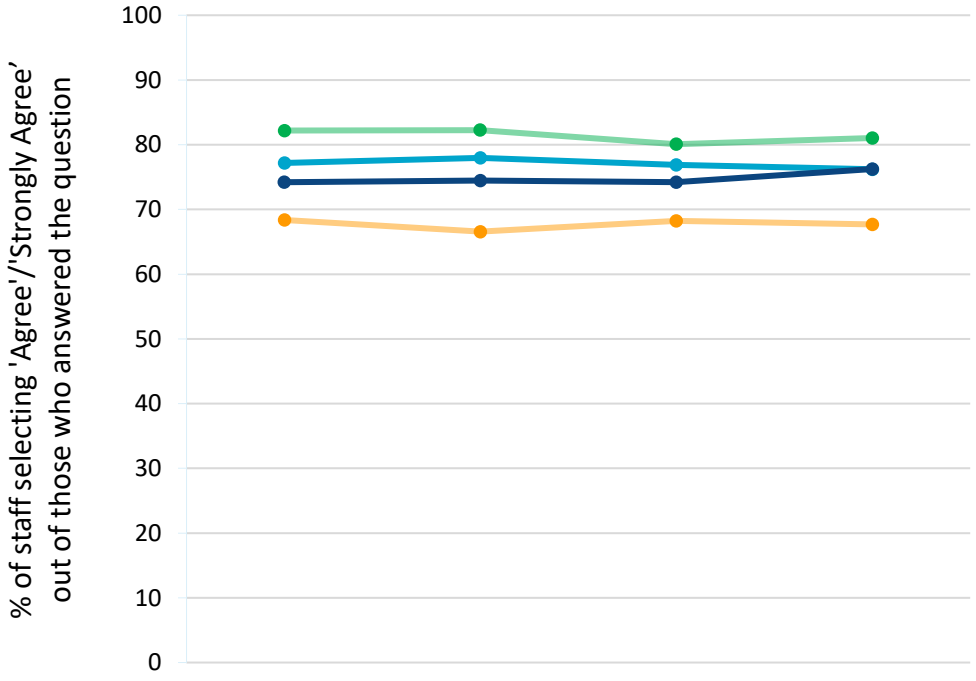
	2020	2021	2022	2023	2024
Your org	45.96%	41.21%	42.49%	49.98%	46.99%
Best result	59.92%	57.45%	58.04%	59.66%	59.58%
Average result	53.46%	51.97%	52.52%	52.50%	52.21%
Worst result	45.49%	40.11%	39.88%	42.14%	42.04%
Responses	821	972	917	1042	924

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



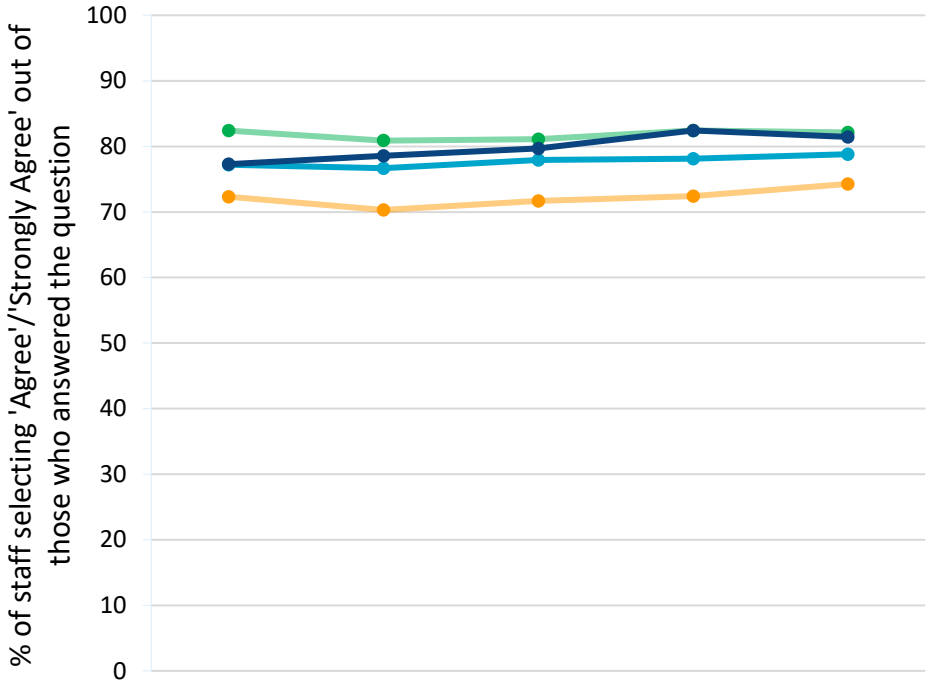
	2020	2021	2022	2023	2024
Your org	39.30%	33.42%	25.04%	32.77%	33.92%
Best result	45.94%	56.47%	47.58%	53.28%	43.74%
Average result	39.65%	37.07%	27.95%	35.64%	35.47%
Worst result	33.06%	31.60%	23.49%	29.58%	29.79%
Responses	821	972	918	1044	925

Q8d The people I work with show appreciation to one another.



	2021	2022	2023	2024
Your org	74.20%	74.48%	74.22%	76.24%
Best result	82.19%	82.25%	80.08%	81.02%
Average result	77.16%	77.96%	76.87%	76.21%
Worst result	68.37%	66.58%	68.25%	67.67%
Responses	964	918	1044	924

Q9e My immediate manager values my work.



	2020	2021	2022	2023	2024
Your org	77.29%	78.58%	79.69%	82.43%	81.43%
Best result	82.41%	80.88%	81.10%	82.43%	82.12%
Average result	77.22%	76.67%	77.93%	78.12%	78.81%
Worst result	72.32%	70.30%	71.70%	72.44%	74.27%
Responses	819	961	916	1045	924

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

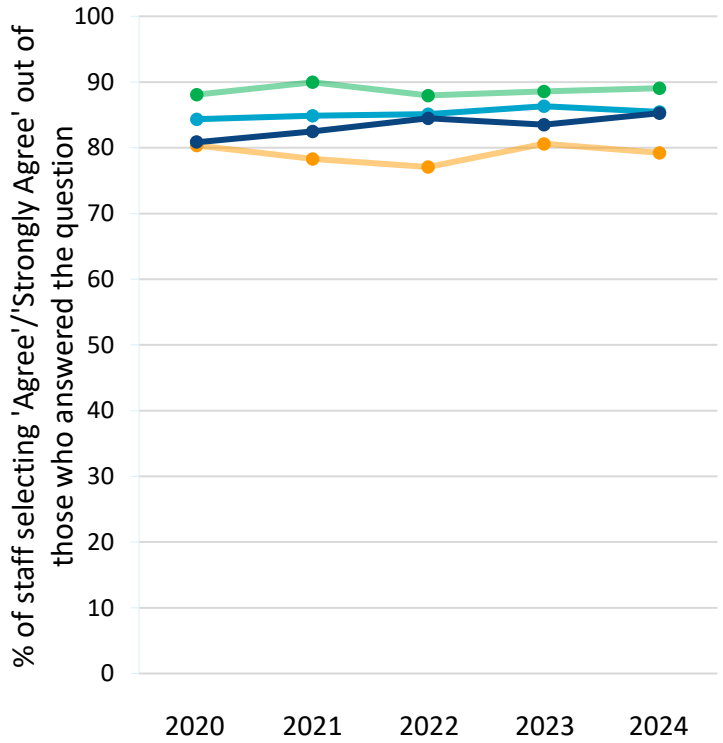
Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

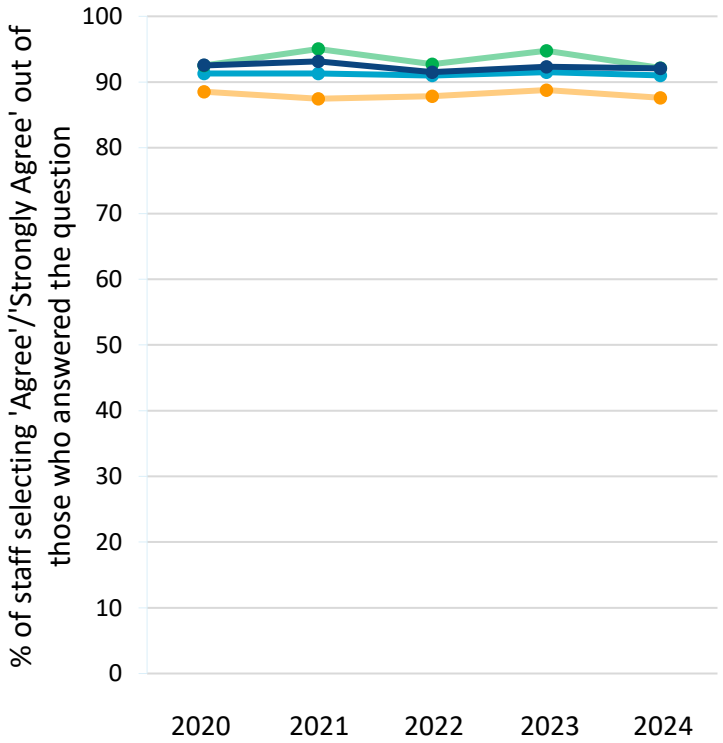
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3a I always know what my work responsibilities are.



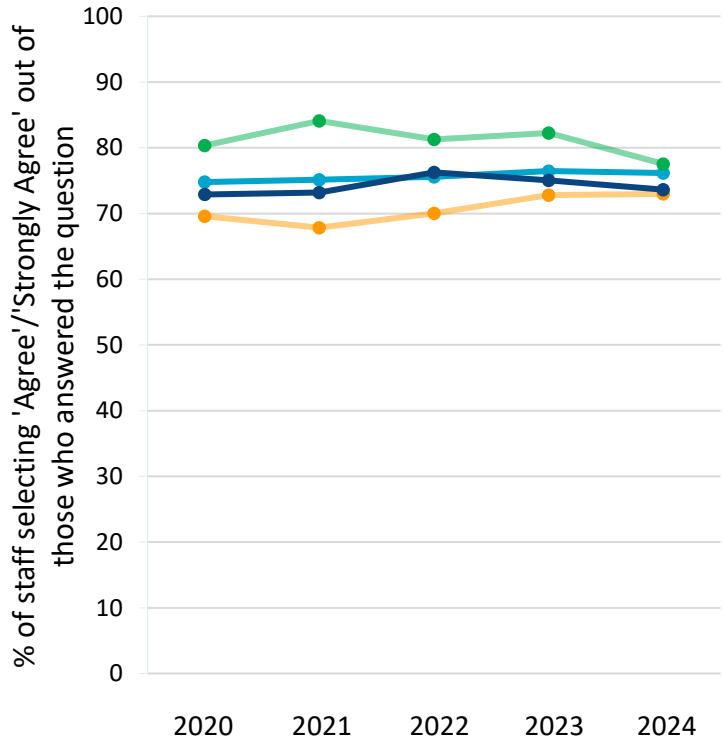
	2020	2021	2022	2023	2024
Your org	80.84%	82.48%	84.46%	83.51%	85.26%
Best result	88.11%	89.97%	87.96%	88.60%	89.08%
Average result	84.35%	84.86%	85.14%	86.32%	85.44%
Worst result	80.37%	78.30%	77.07%	80.61%	79.25%
Responses	820	977	916	1047	927

Q3b I am trusted to do my job.



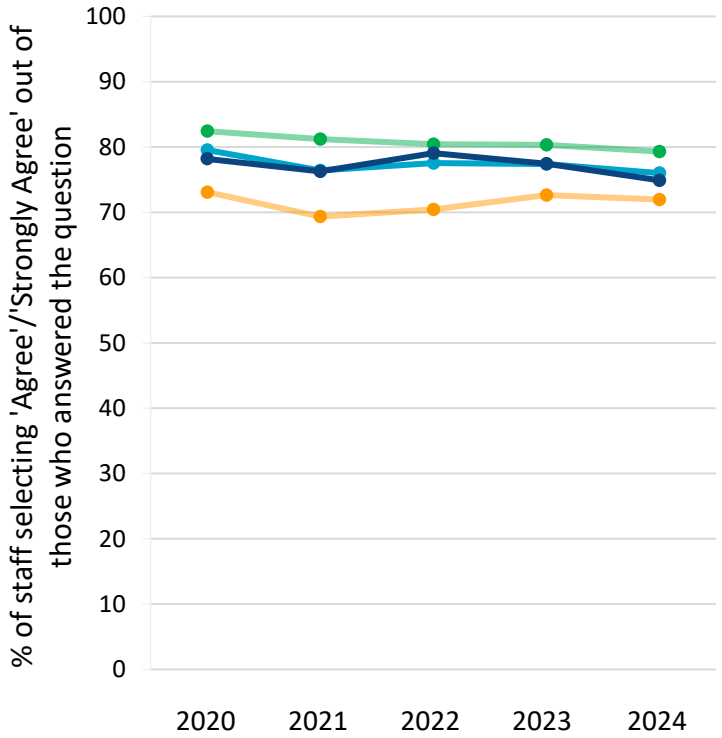
	2020	2021	2022	2023	2024
Your org	92.53%	93.15%	91.51%	92.34%	92.10%
Best result	92.53%	95.03%	92.73%	94.76%	92.15%
Average result	91.31%	91.32%	90.99%	91.51%	91.00%
Worst result	88.54%	87.46%	87.83%	88.78%	87.59%
Responses	817	976	913	1045	924

Q3c There are frequent opportunities for me to show initiative in my role.



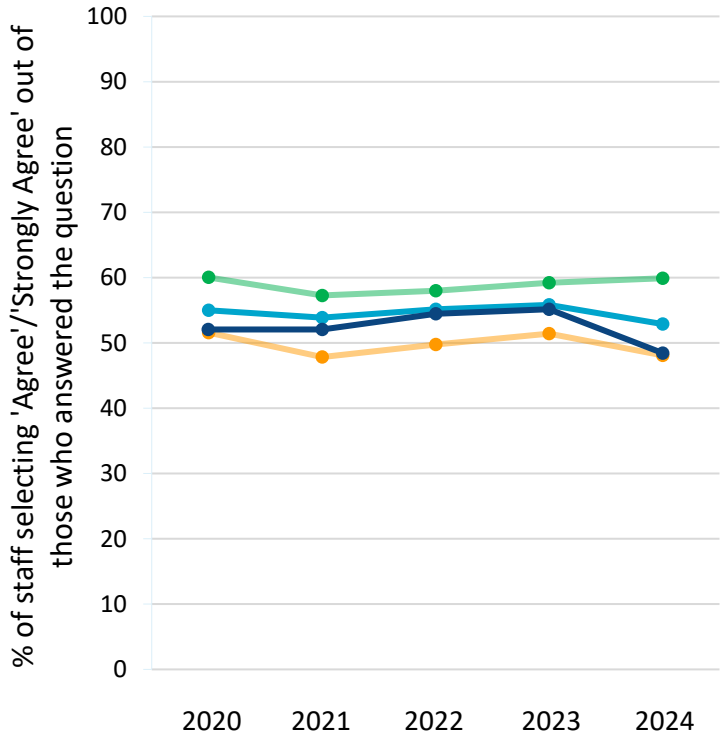
	2020	2021	2022	2023	2024
Your org	72.89%	73.19%	76.25%	75.05%	73.65%
Best result	80.35%	84.09%	81.27%	82.24%	77.55%
Average result	74.78%	75.12%	75.57%	76.46%	76.14%
Worst result	69.60%	67.84%	70.05%	72.78%	72.97%
Responses	825	974	915	1046	924

Q3d I am able to make suggestions to improve the work of my team / department.



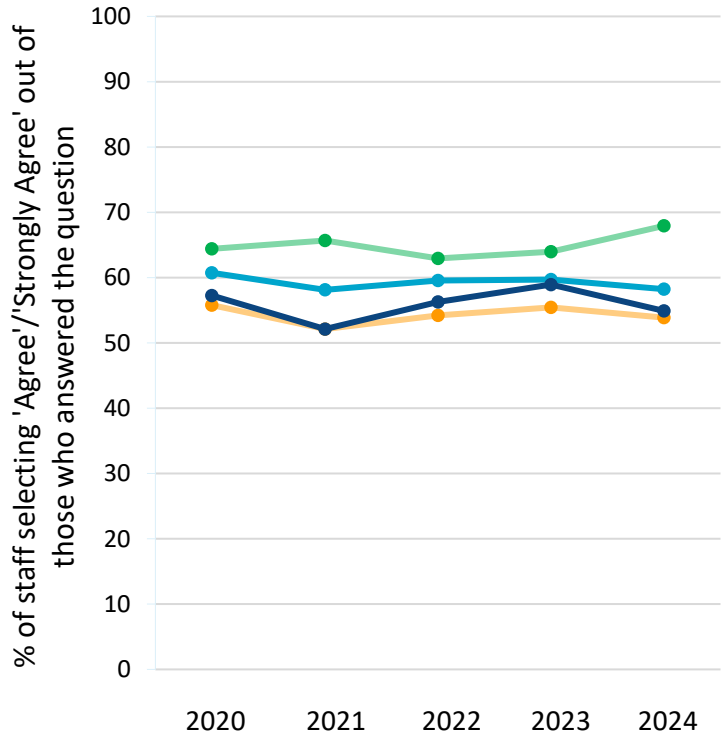
	2020	2021	2022	2023	2024
Your org	78.20%	76.26%	79.06%	77.46%	74.90%
Best result	82.42%	81.22%	80.45%	80.35%	79.30%
Average result	79.53%	76.40%	77.53%	77.41%	76.01%
Worst result	73.09%	69.34%	70.44%	72.63%	71.96%
Responses	824	977	917	1047	925

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



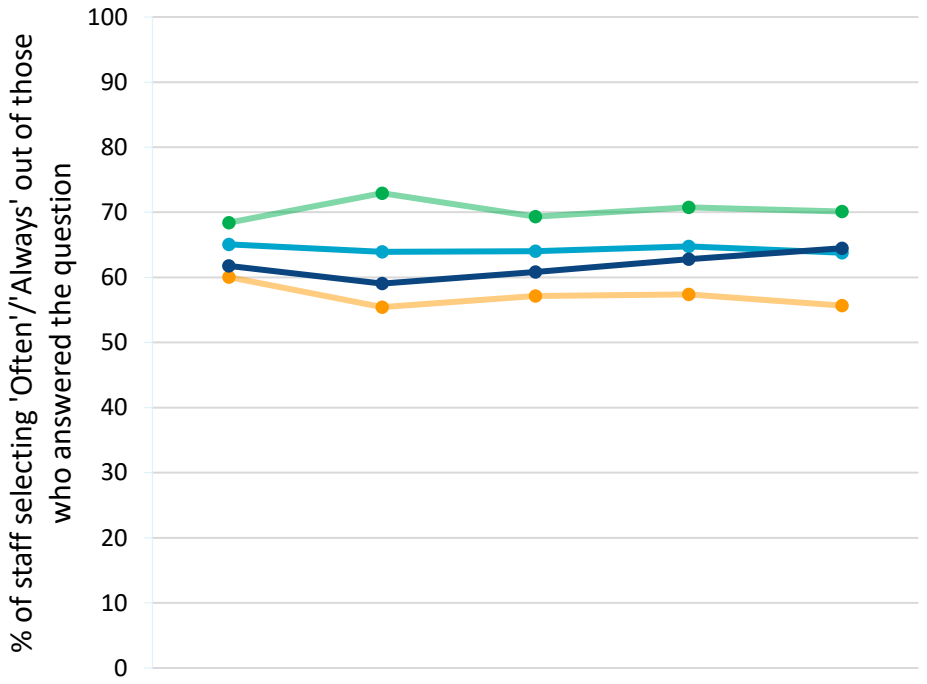
	2020	2021	2022	2023	2024
Your org	52.04%	52.06%	54.47%	55.16%	48.44%
Best result	60.02%	57.27%	58.00%	59.20%	59.89%
Average result	55.00%	53.89%	55.16%	55.82%	52.88%
Worst result	51.57%	47.84%	49.76%	51.41%	48.09%
Responses	821	977	917	1043	926

Q3f I am able to make improvements happen in my area of work.



	2020	2021	2022	2023	2024
Your org	57.23%	52.12%	56.27%	58.93%	54.89%
Best result	64.38%	65.70%	62.94%	63.95%	67.92%
Average result	60.73%	58.12%	59.56%	59.71%	58.24%
Worst result	55.78%	52.12%	54.20%	55.42%	53.87%
Responses	816	975	916	1047	922

Q5b I have a choice in deciding how to do my work.

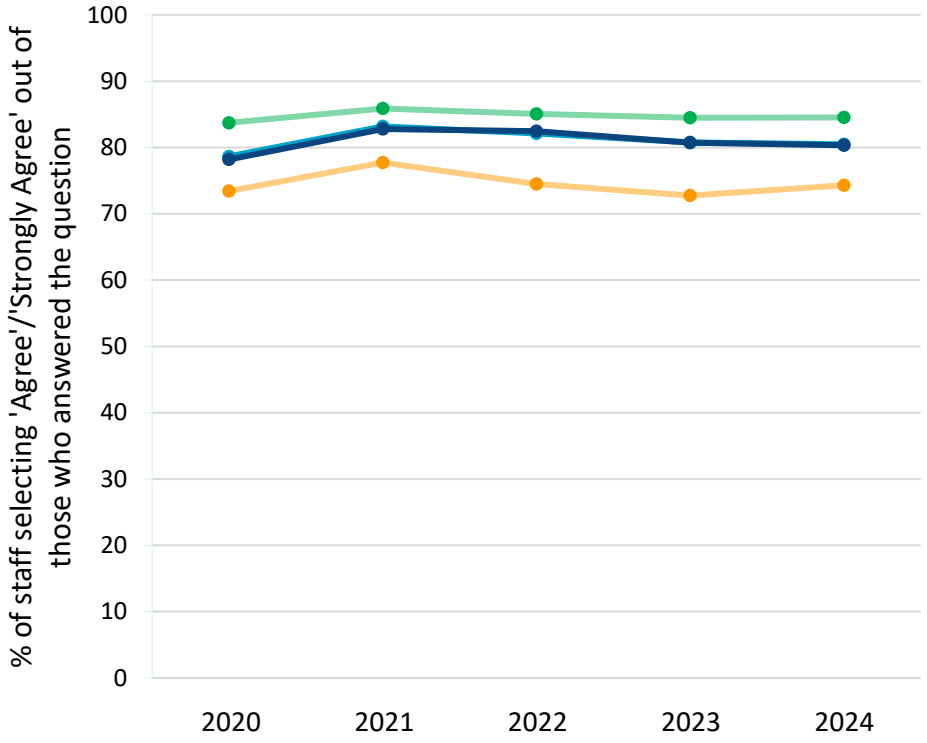


	2020	2021	2022	2023	2024
Your org	61.74%	59.05%	60.85%	62.81%	64.48%
Best result	68.41%	72.94%	69.34%	70.74%	70.12%
Average result	65.08%	63.95%	64.05%	64.77%	63.79%
Worst result	60.05%	55.44%	57.15%	57.41%	55.65%
Responses	816	974	917	1044	926

Survey Coordination Centre

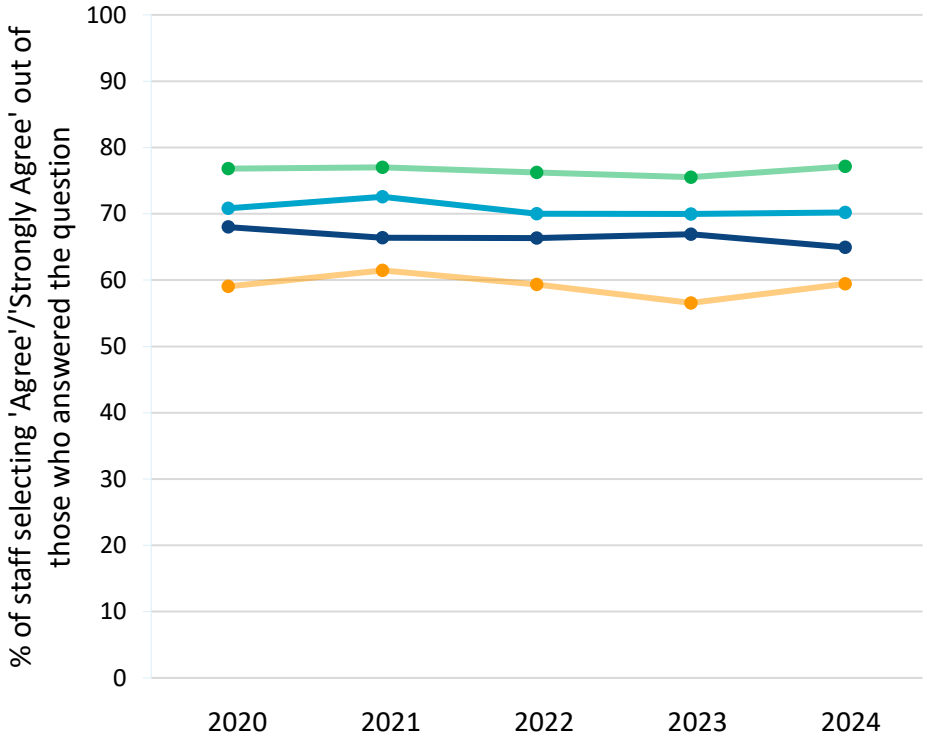
NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



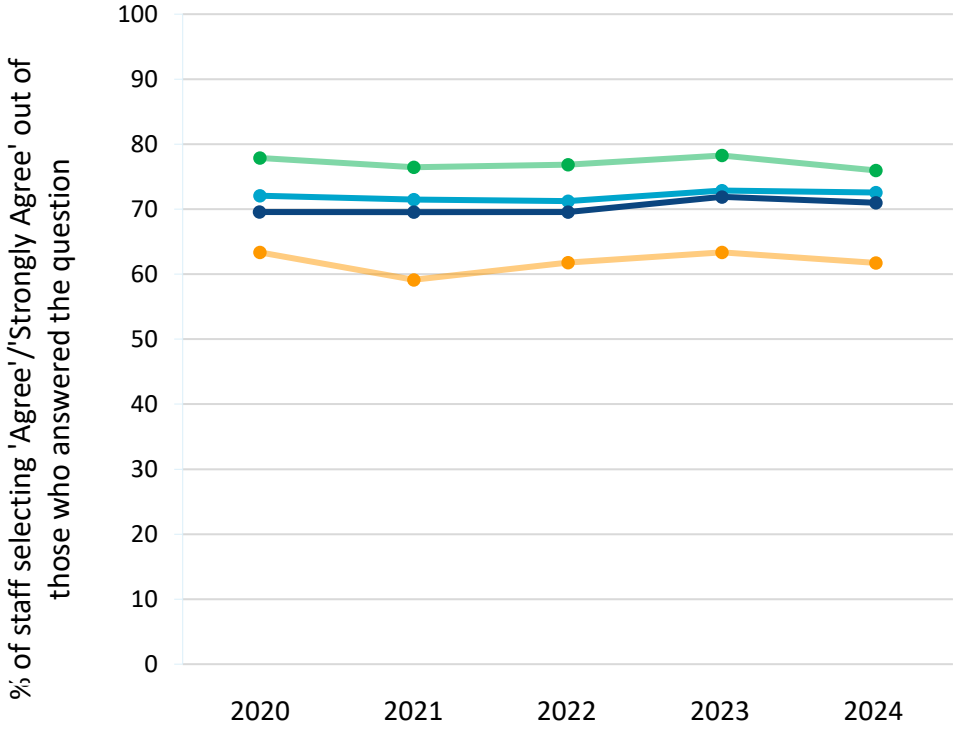
	2020	2021	2022	2023	2024
Your org	78.19%	82.78%	82.47%	80.73%	80.35%
Best result	83.73%	85.88%	85.05%	84.49%	84.55%
Average result	78.67%	83.18%	82.13%	80.79%	80.46%
Worst result	73.41%	77.73%	74.51%	72.75%	74.30%
Responses	820	959	917	1045	921

Q20b I am confident that my organisation would address my concern.



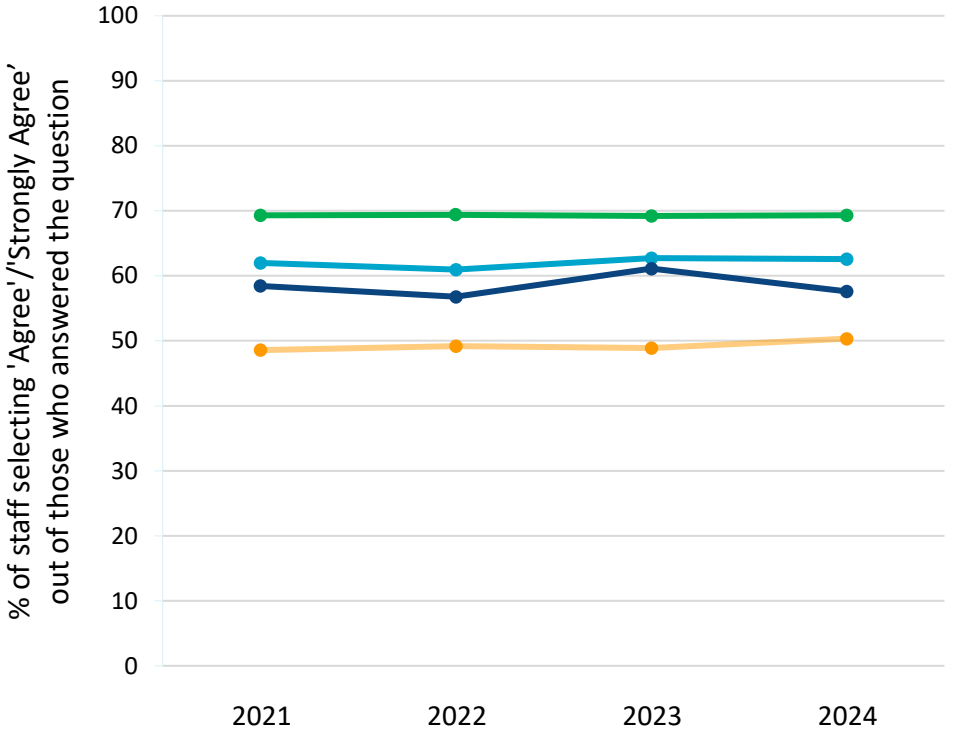
	2020	2021	2022	2023	2024
Your org	67.99%	66.38%	66.36%	66.90%	64.93%
Best result	76.80%	77.01%	76.22%	75.53%	77.14%
Average result	70.81%	72.56%	69.99%	69.98%	70.18%
Worst result	59.05%	61.46%	59.34%	56.56%	59.46%
Responses	821	959	918	1044	919

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023	2024
Your org	69.56%	69.54%	69.55%	71.90%	71.01%
Best result	77.90%	76.47%	76.85%	78.26%	75.96%
Average result	72.09%	71.47%	71.24%	72.87%	72.55%
Worst result	63.35%	59.14%	61.76%	63.35%	61.75%
Responses	818	950	915	1042	923

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024
Your org	58.42%	56.79%	61.12%	57.58%
Best result	69.31%	69.38%	69.21%	69.30%
Average result	61.97%	60.96%	62.73%	62.58%
Worst result	48.57%	49.18%	48.88%	50.33%
Responses	950	918	1036	923

Survey Coordination Centre

NHS

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

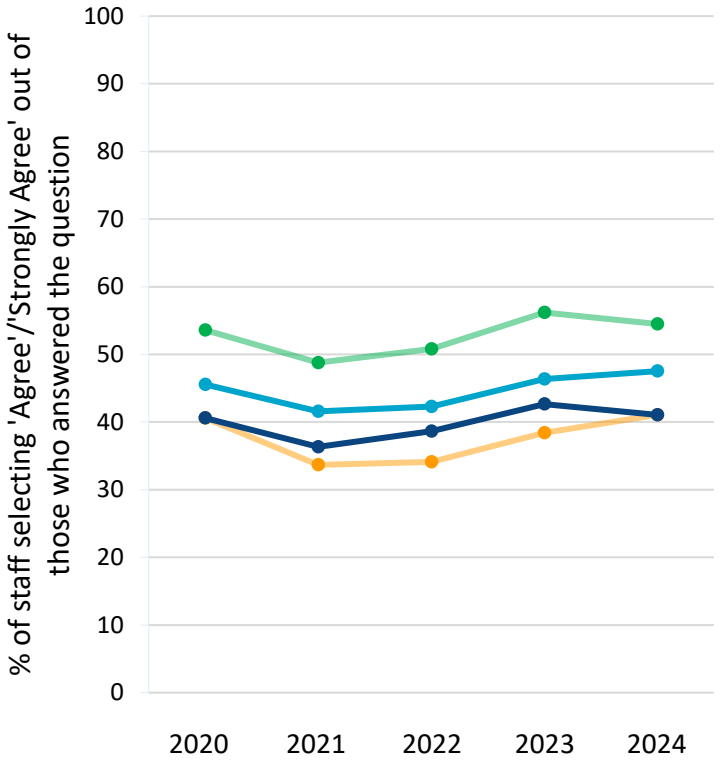
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Other questions:* Q17a, Q17b, Q22

*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

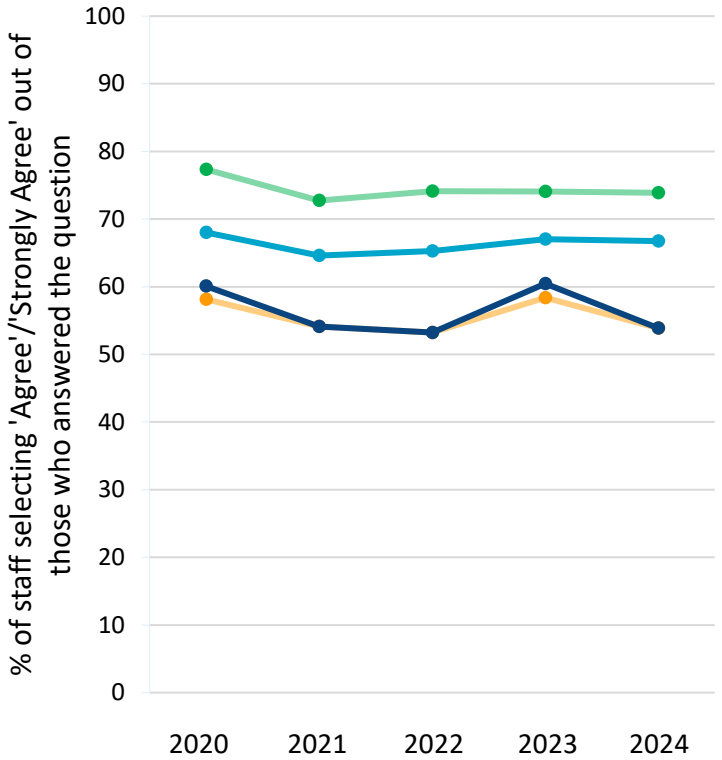
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3g I am able to meet all the conflicting demands on my time at work.



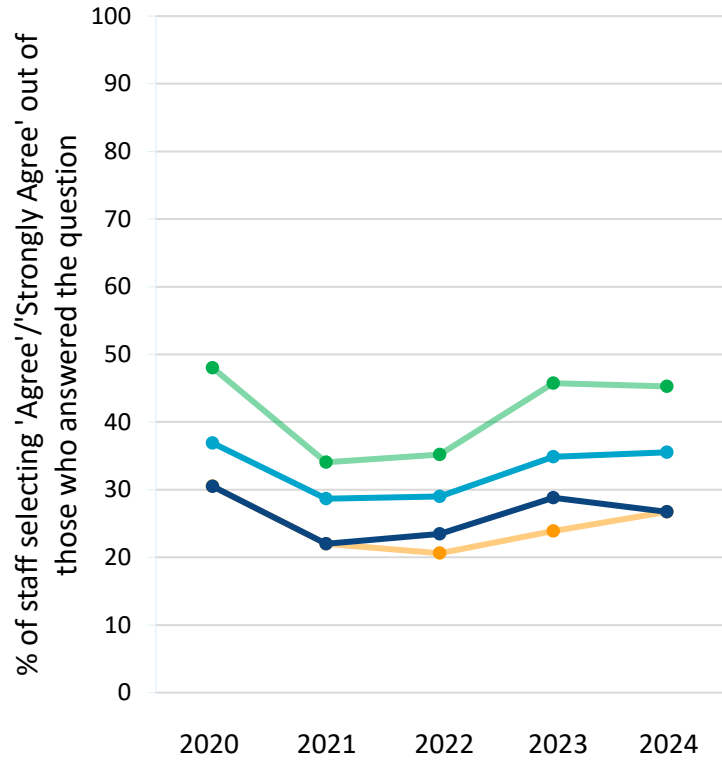
	2020	2021	2022	2023	2024
Your org	40.59%	36.33%	38.64%	42.64%	41.07%
Best result	53.58%	48.78%	50.80%	56.19%	54.51%
Average result	45.57%	41.58%	42.30%	46.34%	47.52%
Worst result	40.59%	33.67%	34.13%	38.42%	41.07%
Responses	822	974	916	1044	926

Q3h I have adequate materials, supplies and equipment to do my work.



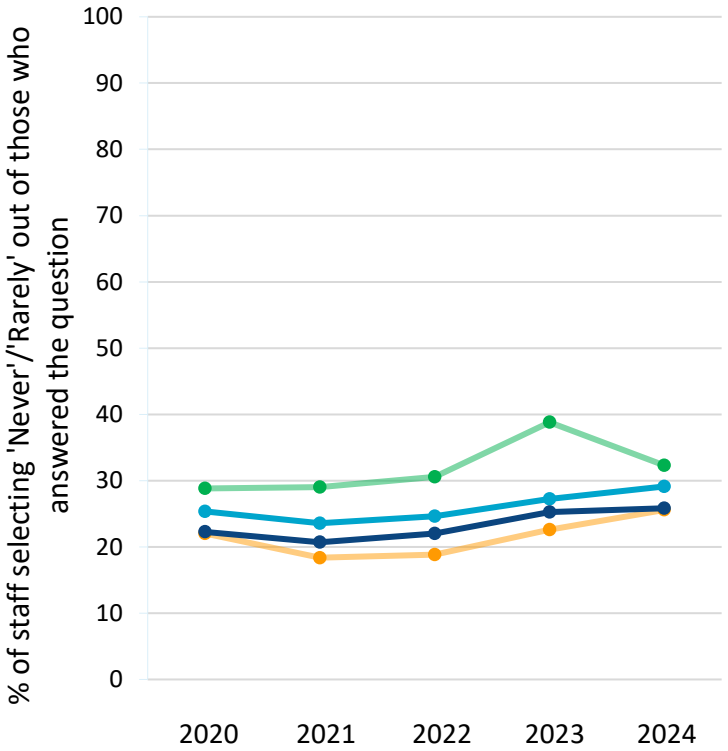
	2020	2021	2022	2023	2024
Your org	60.09%	54.11%	53.23%	60.46%	53.88%
Best result	77.34%	72.74%	74.14%	74.05%	73.89%
Average result	68.02%	64.61%	65.27%	67.04%	66.73%
Worst result	58.15%	54.11%	53.23%	58.38%	53.88%
Responses	820	976	917	1042	924

Q3i There are enough staff at this organisation for me to do my job properly.



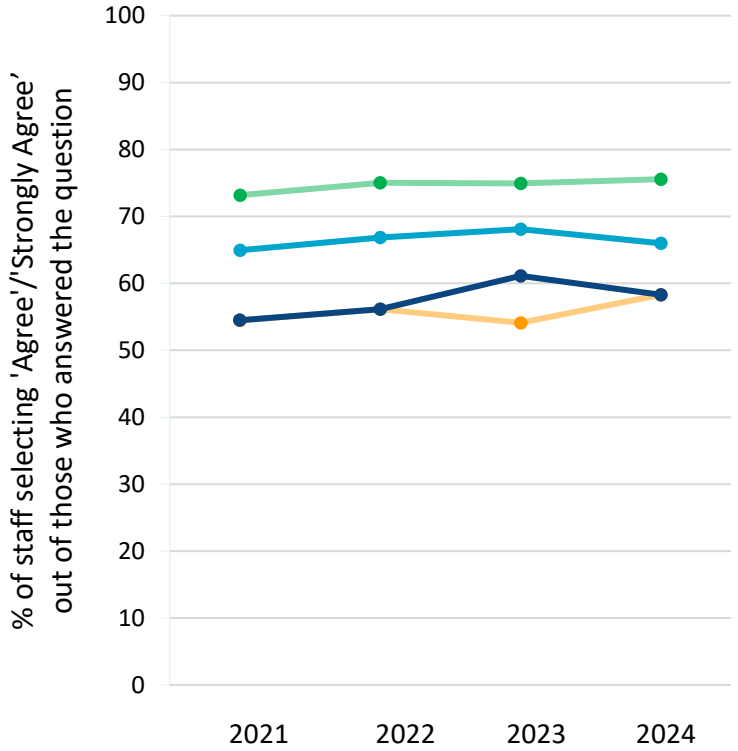
	2020	2021	2022	2023	2024
Your org	30.49%	22.00%	23.45%	28.78%	26.74%
Best result	48.02%	34.05%	35.18%	45.76%	45.26%
Average result	36.89%	28.67%	28.97%	34.87%	35.53%
Worst result	30.49%	22.00%	20.60%	23.88%	26.74%
Responses	818	975	917	1044	926

Q5a I have unrealistic time pressures.



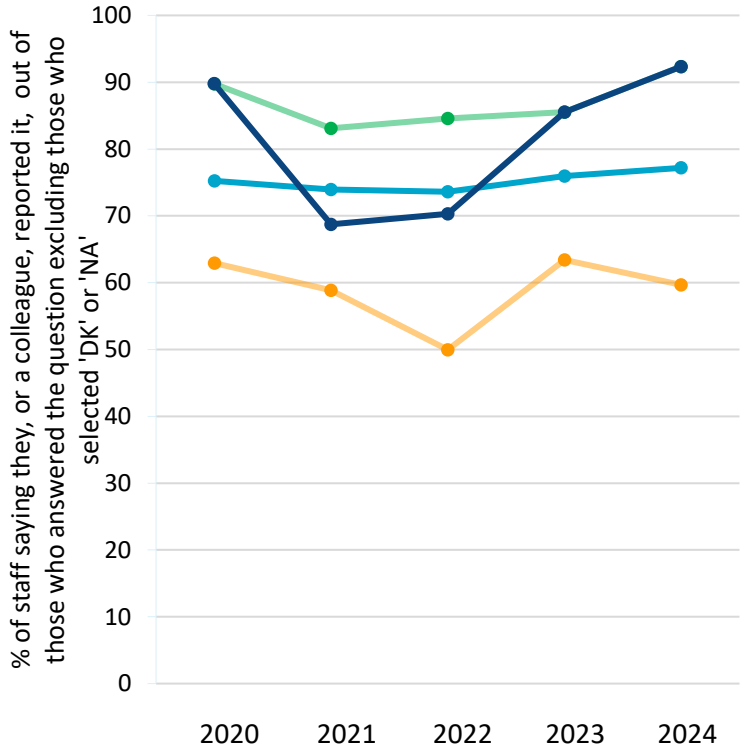
	2020	2021	2022	2023	2024
Your org	22.27%	20.70%	22.00%	25.28%	25.83%
Best result	28.82%	29.01%	30.58%	38.81%	32.30%
Average result	25.34%	23.58%	24.65%	27.22%	29.13%
Worst result	22.05%	18.38%	18.84%	22.62%	25.57%
Responses	820	974	916	1045	926

Q11a My organisation takes positive action on health and well-being.



	2021	2022	2023	2024
Your org	54.49%	56.16%	61.12%	58.31%
Best result	73.18%	75.03%	74.94%	75.57%
Average result	64.95%	66.86%	68.10%	66.01%
Worst result	54.49%	56.16%	54.11%	58.31%
Responses	951	906	1043	925

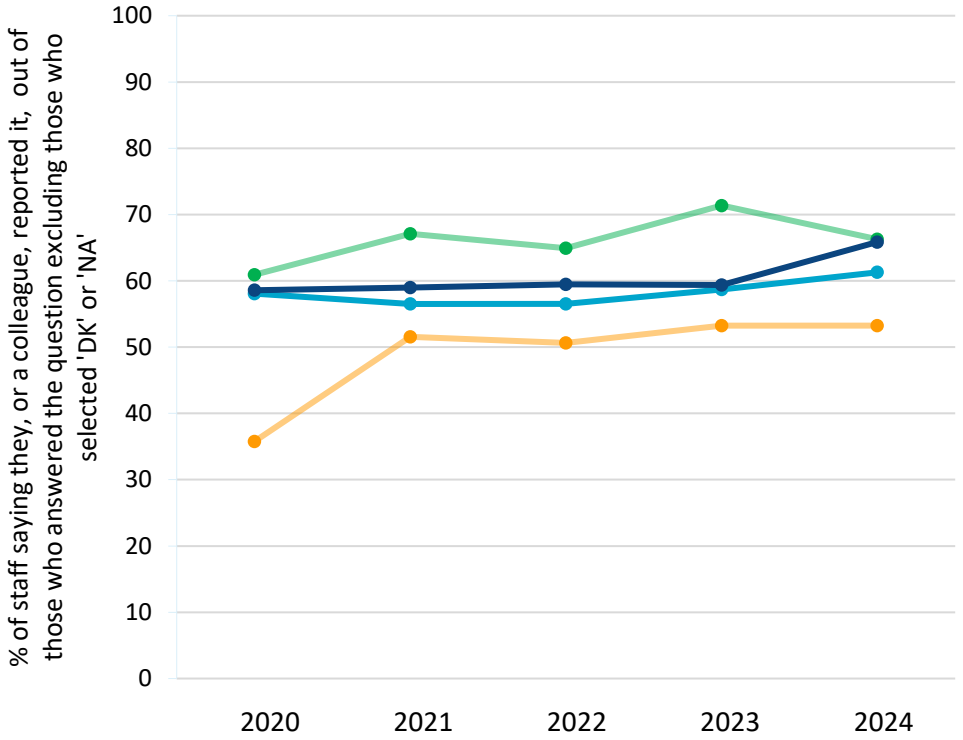
Q13d The last time you experienced physical violence at work, did you or a colleague report it?



	2020	2021	2022	2023	2024
Your org	89.75%	68.73%	70.28%	85.53%	92.34%
Best result	89.75%	83.10%	84.56%	85.53%	92.34%
Average result	75.26%	73.93%	73.61%	75.96%	77.18%
Worst result	62.94%	58.84%	49.96%	63.40%	59.65%
Responses	14	32	42	55	50

Note: 2023 results for Q13d are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

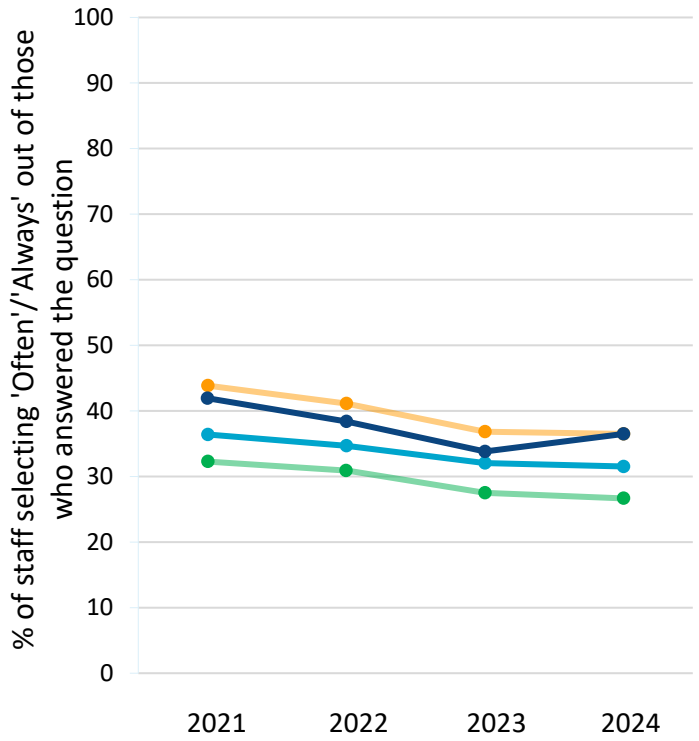
Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



	2020	2021	2022	2023	2024
Your org	58.58%	59.00%	59.45%	59.36%	65.86%
Best result	60.92%	67.11%	64.93%	71.37%	66.27%
Average result	58.08%	56.51%	56.55%	58.71%	61.29%
Worst result	35.78%	51.55%	50.66%	53.23%	53.25%
Responses	201	238	227	238	226

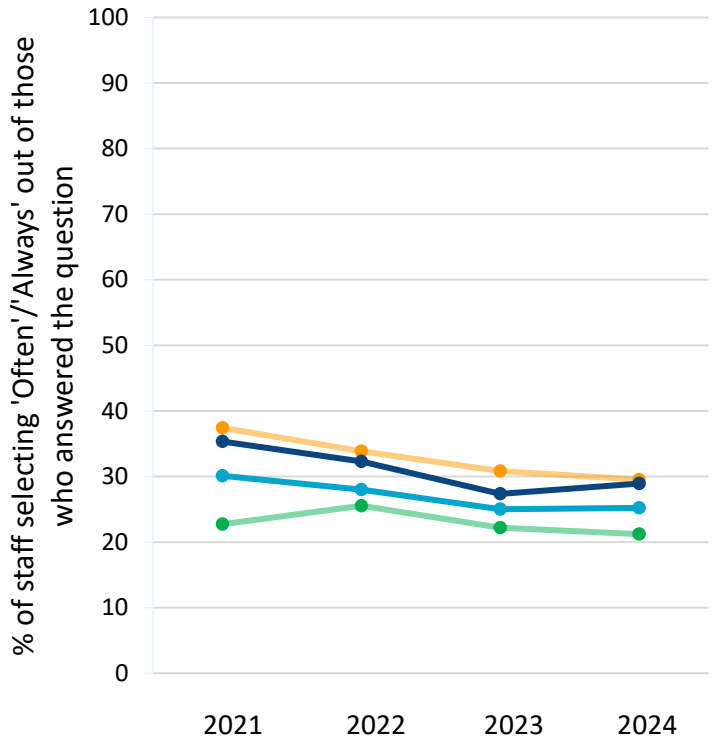
Note: 2023 results for Q14d are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Q12a How often, if at all, do you find your work emotionally exhausting?



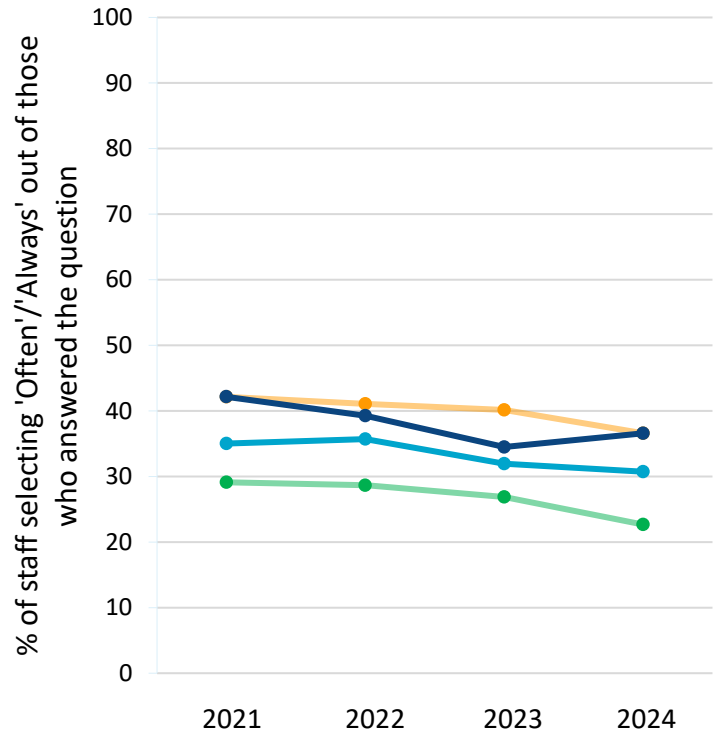
	2021	2022	2023	2024
Your org	41.93%	38.37%	33.81%	36.50%
Best result	32.27%	30.90%	27.50%	26.66%
Average result	36.40%	34.68%	32.07%	31.53%
Worst result	43.86%	41.12%	36.81%	36.50%
Responses	963	917	1047	925

Q12b How often, if at all, do you feel burnt out because of your work?



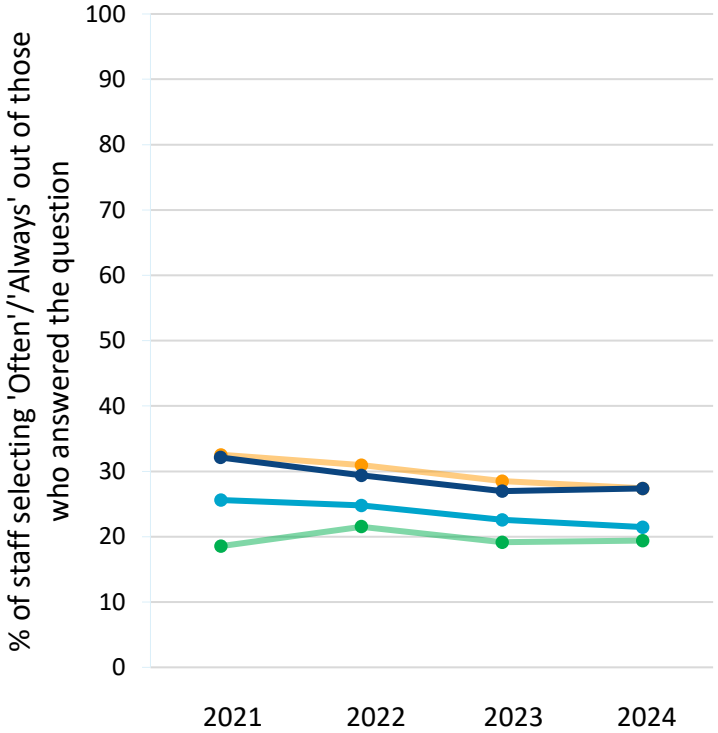
	2021	2022	2023	2024
Your org	35.33%	32.28%	27.35%	28.92%
Best result	22.72%	25.54%	22.18%	21.21%
Average result	30.10%	28.00%	25.00%	25.22%
Worst result	37.42%	33.84%	30.83%	29.52%
Responses	964	917	1046	925

Q12c How often, if at all, does your work frustrate you?



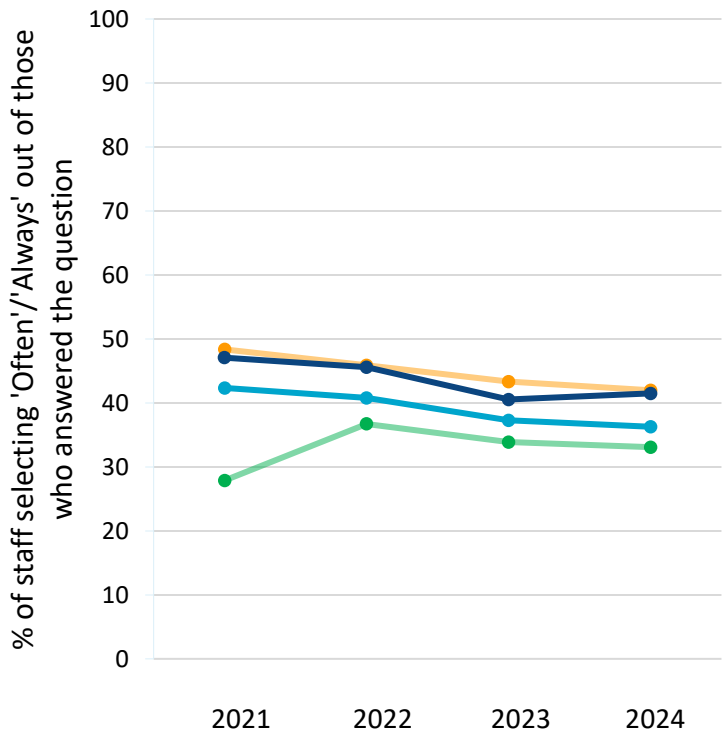
	2021	2022	2023	2024
Your org	42.15%	39.25%	34.50%	36.60%
Best result	29.11%	28.67%	26.89%	22.67%
Average result	35.03%	35.70%	31.93%	30.73%
Worst result	42.15%	41.07%	40.12%	36.60%
Responses	964	917	1046	923

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



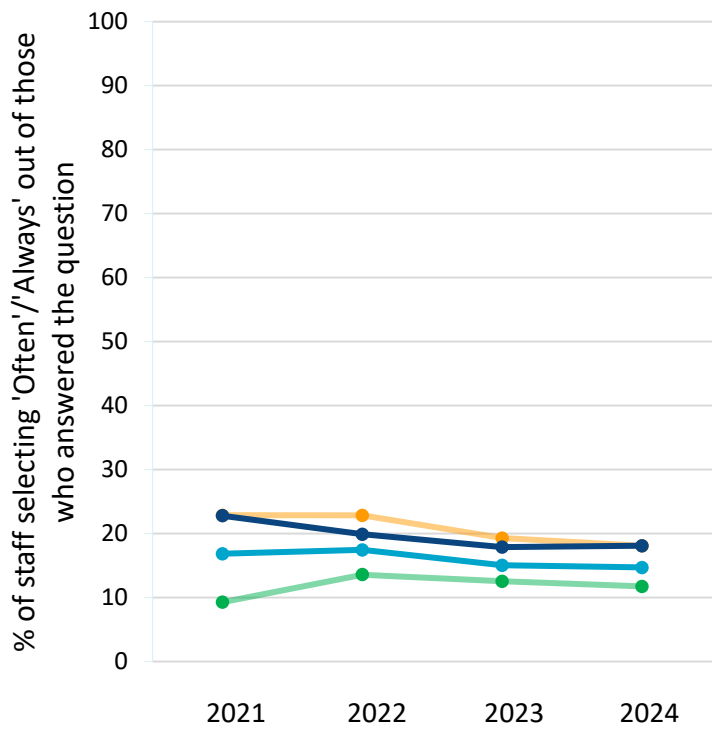
	2021	2022	2023	2024
Your org	32.11%	29.41%	26.97%	27.40%
Best result	18.54%	21.51%	19.14%	19.38%
Average result	25.60%	24.76%	22.60%	21.47%
Worst result	32.55%	30.96%	28.51%	27.40%
Responses	963	917	1043	922

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



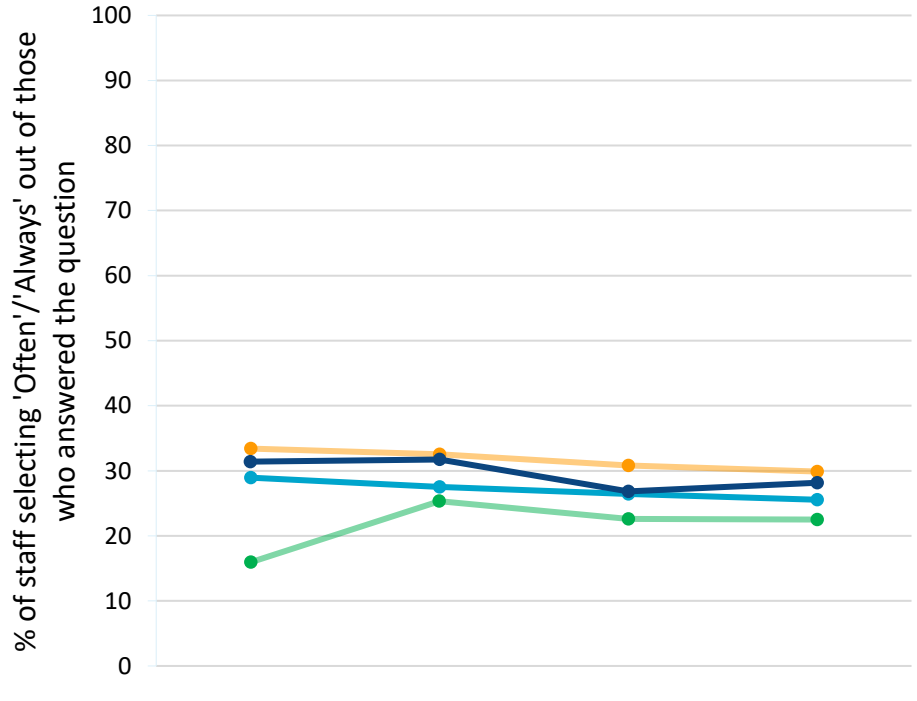
	2021	2022	2023	2024
Your org	47.07%	45.60%	40.54%	41.48%
Best result	27.88%	36.70%	33.89%	33.09%
Average result	42.34%	40.79%	37.27%	36.27%
Worst result	48.37%	45.87%	43.36%	41.98%
Responses	962	916	1046	926

Q12f How often, if at all, do you feel that every working hour is tiring for you?



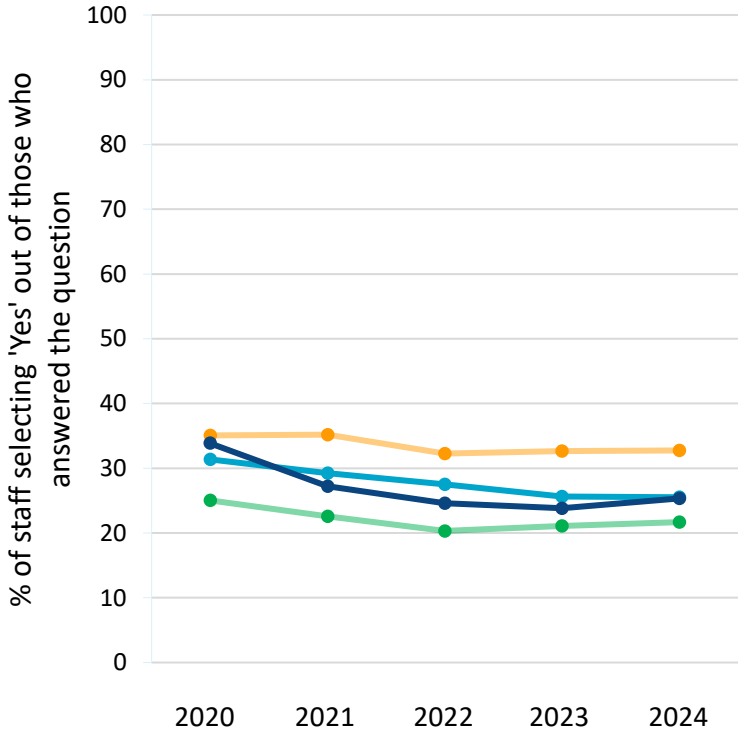
	2021	2022	2023	2024
Your org	22.78%	19.90%	17.88%	18.09%
Best result	9.27%	13.56%	12.57%	11.76%
Average result	16.83%	17.46%	15.06%	14.72%
Worst result	22.87%	22.84%	19.29%	18.09%
Responses	962	917	1045	925

Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?



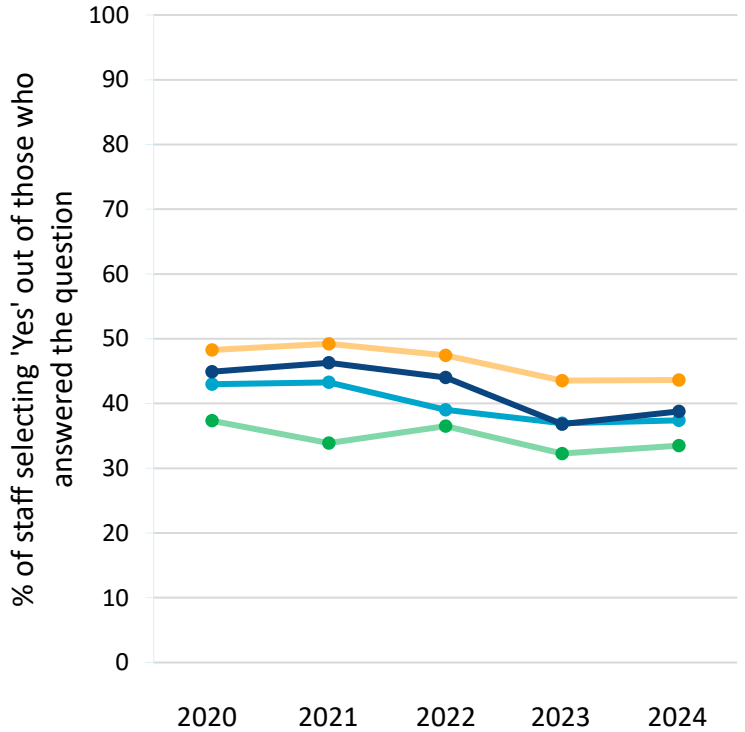
	2021	2022	2023	2024
Your org	31.39%	31.74%	26.83%	28.14%
Best result	15.94%	25.32%	22.59%	22.51%
Average result	28.94%	27.52%	26.42%	25.55%
Worst result	33.41%	32.54%	30.83%	29.89%
Responses	963	916	1046	925

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



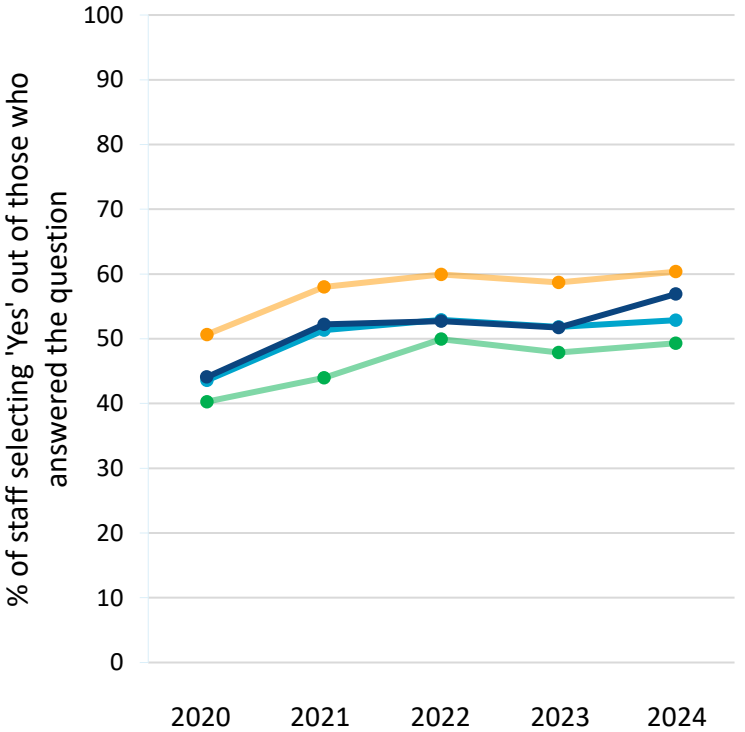
	2020	2021	2022	2023	2024
Your org	33.84%	27.21%	24.60%	23.83%	25.35%
Best result	25.03%	22.57%	20.32%	21.10%	21.68%
Average result	31.37%	29.23%	27.52%	25.64%	25.53%
Worst result	35.07%	35.19%	32.27%	32.66%	32.78%
Responses	817	964	916	1046	925

Q11c During the last 12 months have you felt unwell as a result of work related stress?



	2020	2021	2022	2023	2024
Your org	44.90%	46.29%	44.05%	36.82%	38.79%
Best result	37.33%	33.91%	36.49%	32.28%	33.48%
Average result	42.99%	43.26%	39.02%	36.95%	37.41%
Worst result	48.26%	49.23%	47.41%	43.54%	43.64%
Responses	819	962	918	1045	923

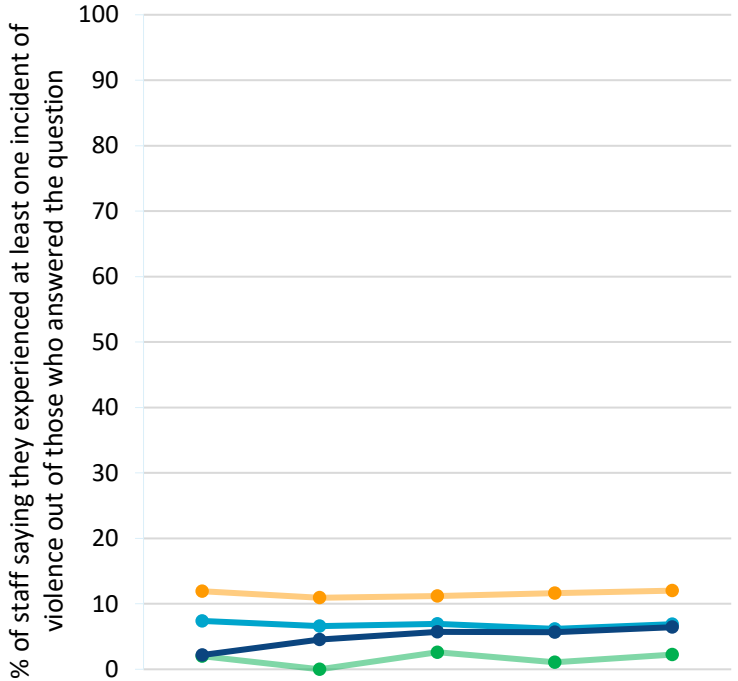
Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2020	2021	2022	2023	2024
Your org	44.08%	52.22%	52.71%	51.71%	56.91%
Best result	40.29%	43.96%	49.93%	47.86%	49.29%
Average result	43.57%	51.32%	52.92%	51.82%	52.88%
Worst result	50.67%	58.03%	59.95%	58.69%	60.36%
Responses	822	964	918	1046	925

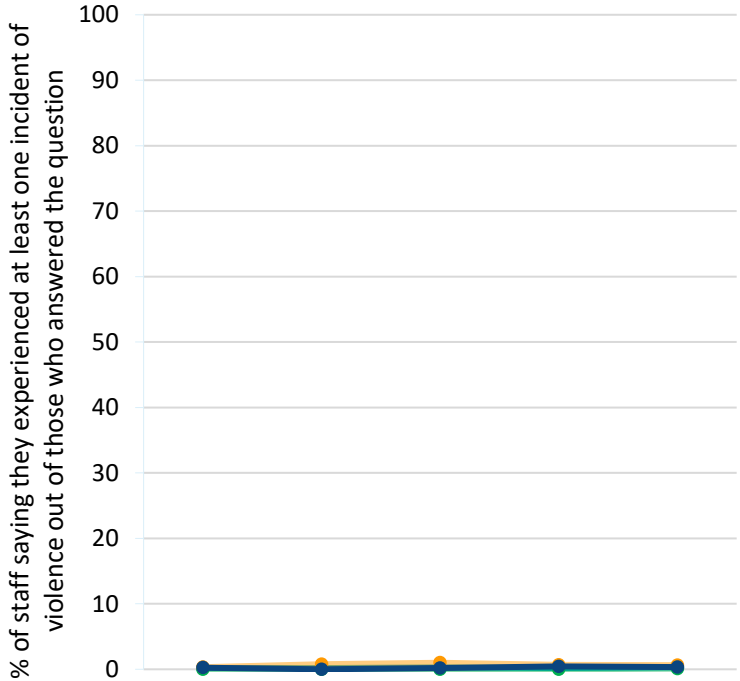
Survey Coordination Centre NHS

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



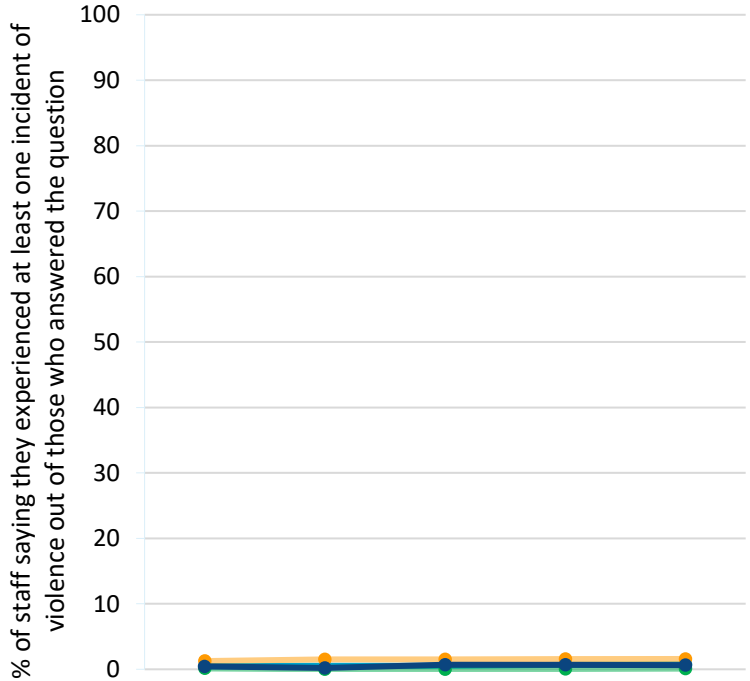
	2020	2021	2022	2023	2024
Your org	2.18%	4.56%	5.73%	5.68%	6.43%
Best result	2.02%	0.00%	2.61%	1.08%	2.26%
Average result	7.39%	6.60%	6.93%	6.18%	6.87%
Worst result	11.91%	10.93%	11.20%	11.63%	12.02%
Responses	821	964	916	1013	923

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2020	2021	2022	2023	2024
Your org	0.26%	0.00%	0.22%	0.44%	0.35%
Best result	0.00%	0.00%	0.00%	0.00%	0.10%
Average result	0.19%	0.19%	0.28%	0.19%	0.29%
Worst result	0.32%	0.79%	1.00%	0.70%	0.66%
Responses	819	963	908	997	910

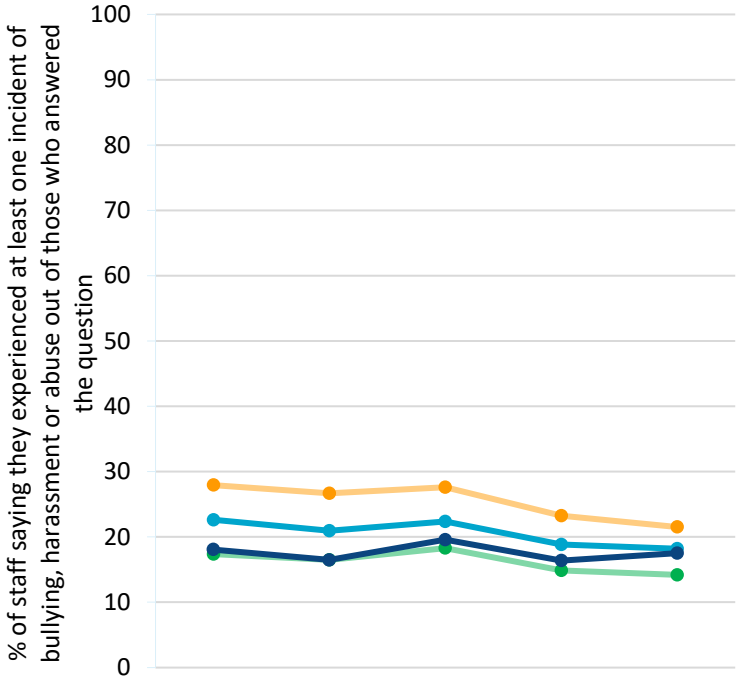
Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



	2020	2021	2022	2023	2024
Your org	0.43%	0.21%	0.69%	0.66%	0.66%
Best result	0.12%	0.00%	0.00%	0.06%	0.11%
Average result	0.47%	0.53%	0.53%	0.66%	0.74%
Worst result	1.26%	1.53%	1.54%	1.54%	1.58%
Responses	811	960	899	993	894

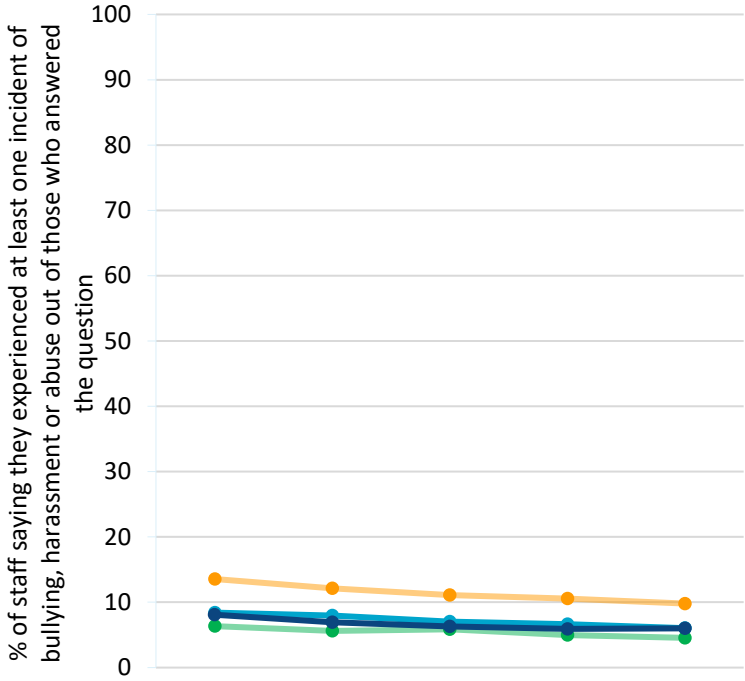
Note: 2023 results for Q13a-c are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



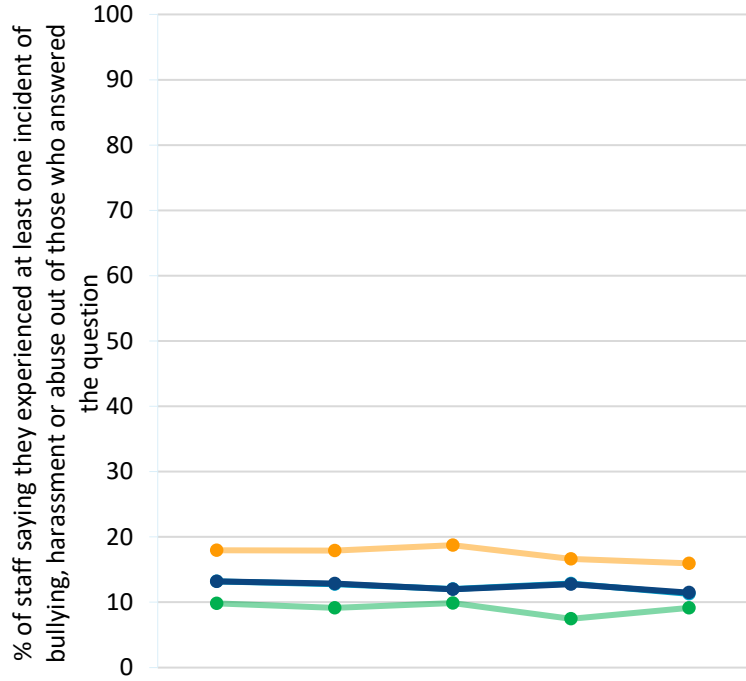
	2020	2021	2022	2023	2024
Your org	18.08%	16.47%	19.59%	16.38%	17.50%
Best result	17.35%	16.47%	18.28%	14.86%	14.20%
Average result	22.63%	20.96%	22.36%	18.86%	18.20%
Worst result	27.93%	26.70%	27.60%	23.27%	21.52%
Responses	821	907	917	1013	923

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2020	2021	2022	2023	2024
Your org	8.09%	6.96%	6.28%	5.92%	6.01%
Best result	6.34%	5.62%	5.85%	5.00%	4.55%
Average result	8.42%	7.97%	7.01%	6.64%	6.03%
Worst result	13.56%	12.11%	11.10%	10.55%	9.80%
Responses	819	904	906	1005	913

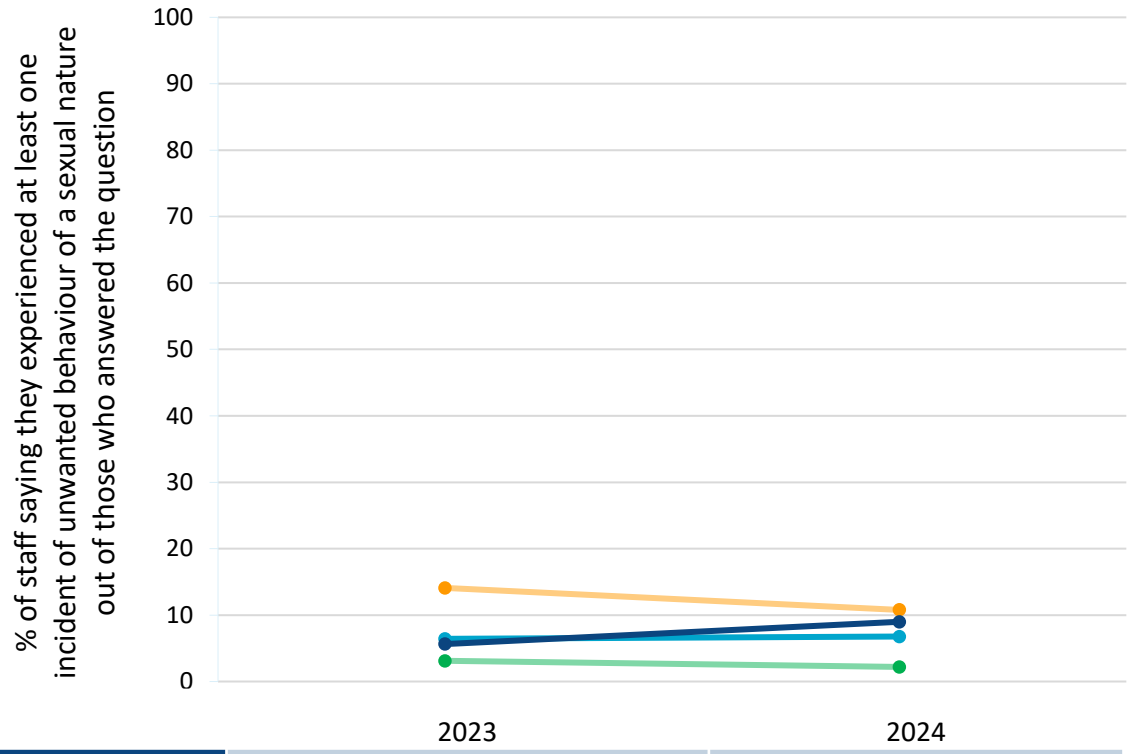
Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



	2020	2021	2022	2023	2024
Your org	13.20%	12.88%	11.99%	12.75%	11.47%
Best result	9.84%	9.12%	9.88%	7.47%	9.15%
Average result	13.20%	12.77%	12.04%	12.85%	11.29%
Worst result	17.97%	17.93%	18.74%	16.64%	15.96%
Responses	813	901	904	1002	910

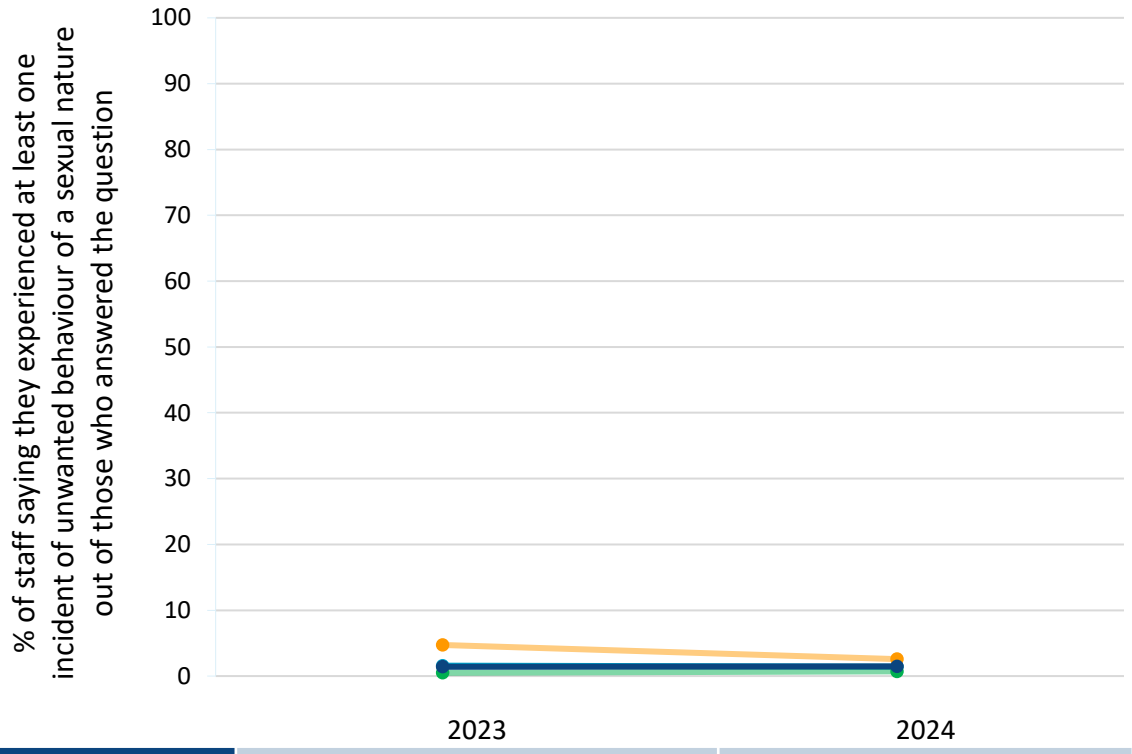
Note: 2023 results for Q14a-c are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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



	2023	2024
Your org	5.63%	8.99%
Best result	3.12%	2.20%
Average result	6.43%	6.77%
Worst result	14.09%	10.78%
Responses	1046	925

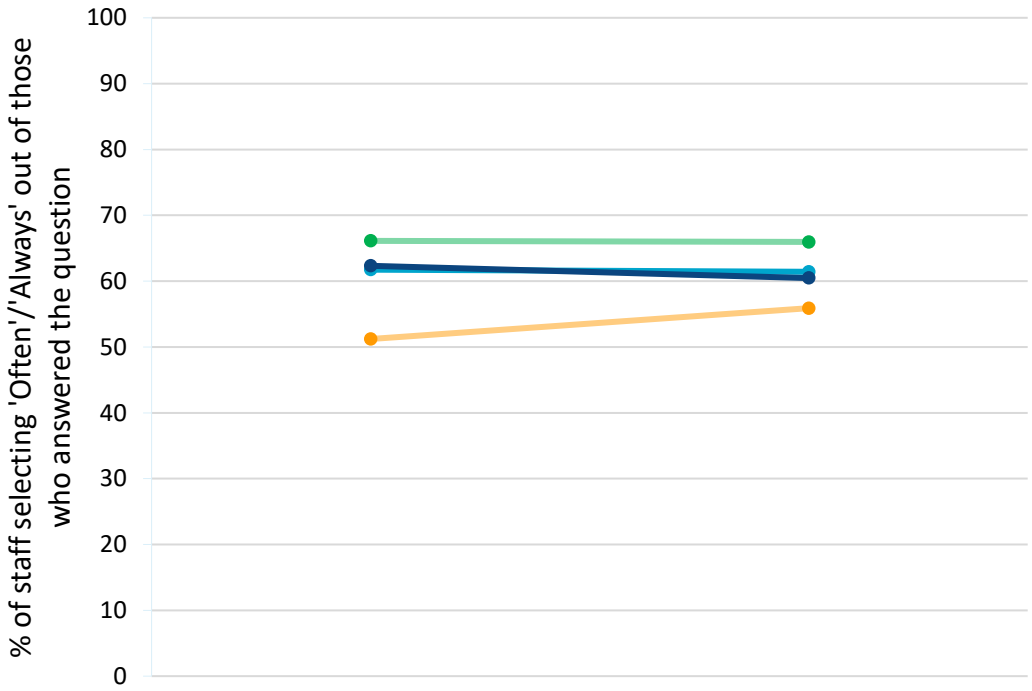
Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues



	2023	2024
Your org	1.41%	1.47%
Best result	0.50%	0.71%
Average result	1.58%	1.43%
Worst result	4.72%	2.58%
Responses	1042	920

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Q22 I can eat nutritious and affordable food while I am working



	2023	2024
Your org	62.33%	60.47%
Best result	66.12%	65.96%
Average result	61.74%	61.42%
Worst result	51.21%	55.90%
Responses	1047	925

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:

Development – Q24a, Q24b, Q24c, Q24d, Q24e

Appraisals – Q23a*, Q23b, Q23c, Q23d

Other questions** - Q24f

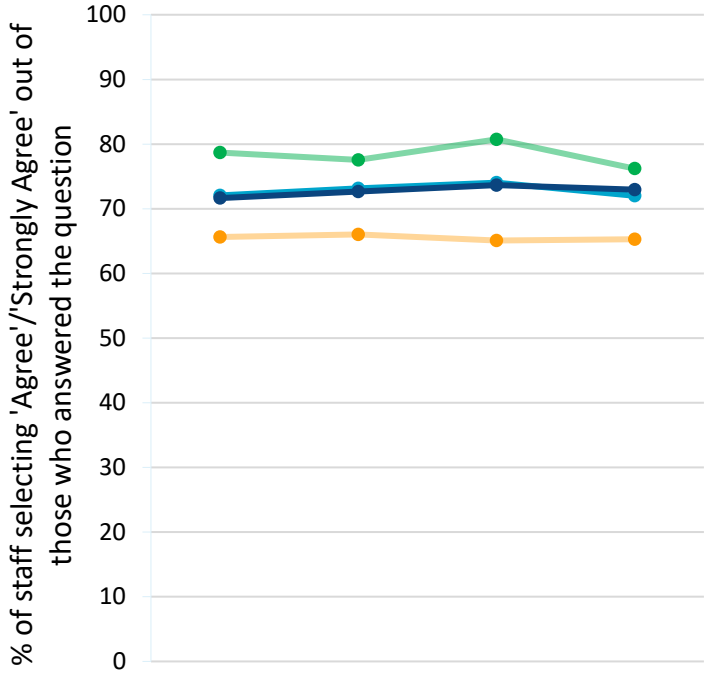
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

**Q24f does not contribute to the calculation of any scores or sub-scores.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

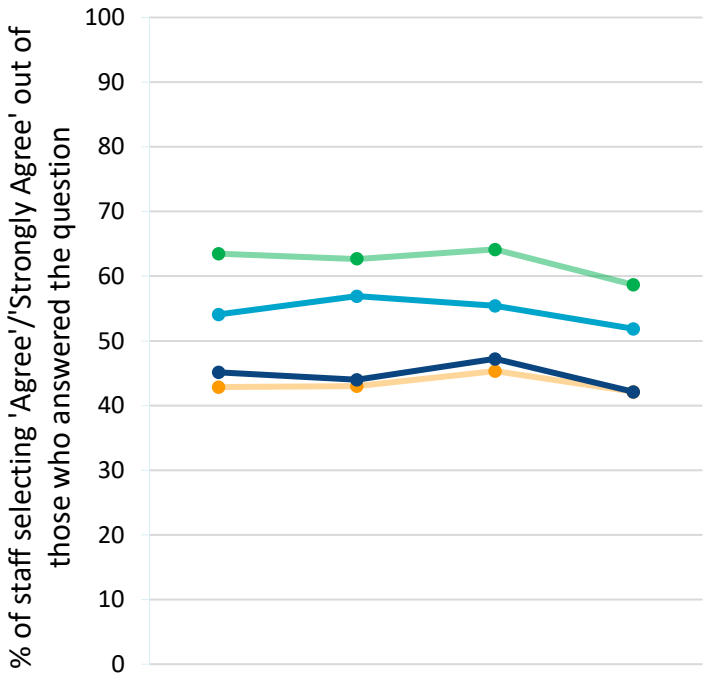
Survey Coordination Centre NHS

Q24a This organisation offers me challenging work.



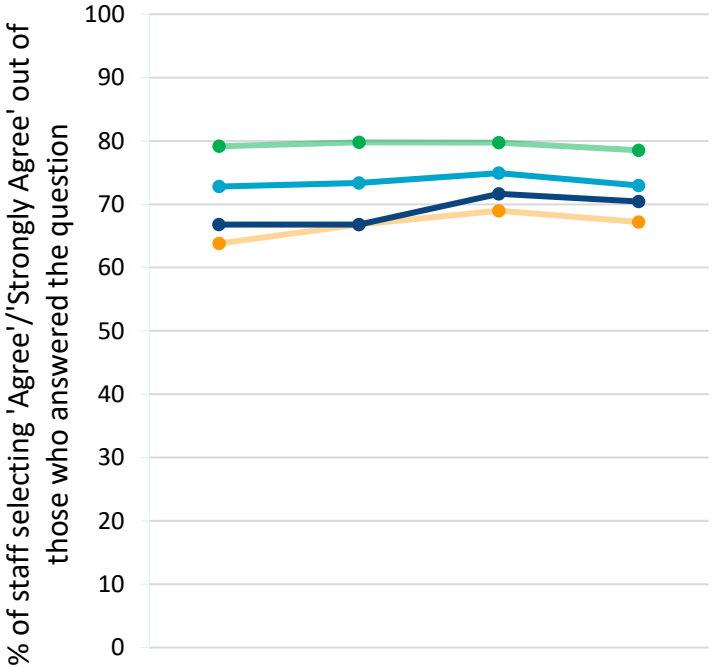
	2021	2022	2023	2024
Your org	71.65%	72.68%	73.66%	72.97%
Best result	78.69%	77.56%	80.73%	76.20%
Average result	72.05%	73.14%	74.03%	72.00%
Worst result	65.65%	66.03%	65.09%	65.30%
Responses	956	913	1046	922

Q24b There are opportunities for me to develop my career in this organisation.



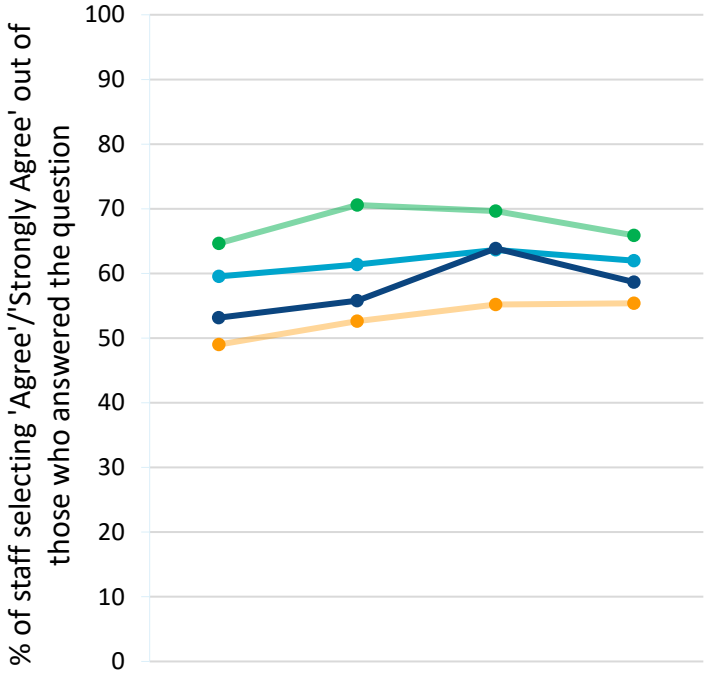
	2021	2022	2023	2024
Your org	45.12%	43.99%	47.23%	42.12%
Best result	63.48%	62.65%	64.15%	58.67%
Average result	54.10%	56.92%	55.42%	51.87%
Worst result	42.87%	43.00%	45.32%	42.12%
Responses	956	913	1046	923

Q24c I have opportunities to improve my knowledge and skills.



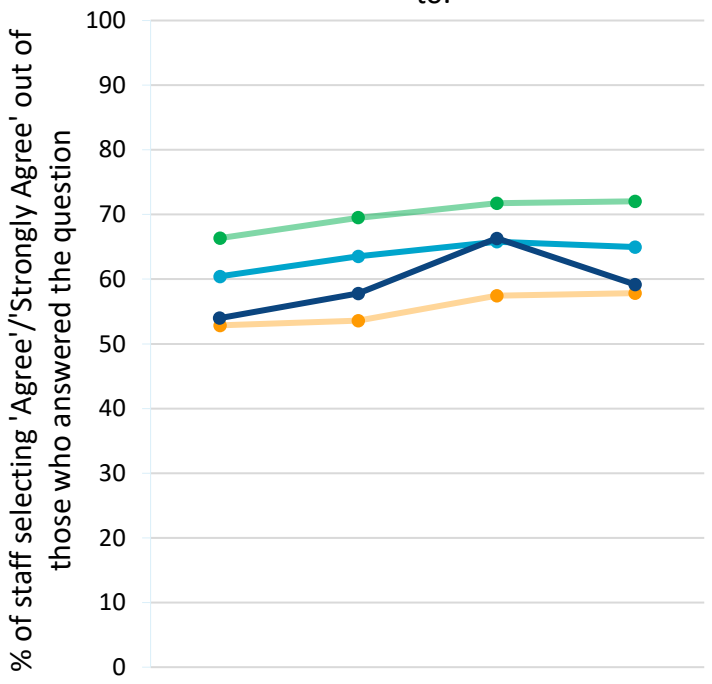
	2021	2022	2023	2024
Your org	66.79%	66.79%	71.65%	70.43%
Best result	79.15%	79.78%	79.75%	78.52%
Average result	72.79%	73.35%	74.91%	72.96%
Worst result	63.81%	66.79%	68.98%	67.21%
Responses	954	912	1045	925

Q24d I feel supported to develop my potential.



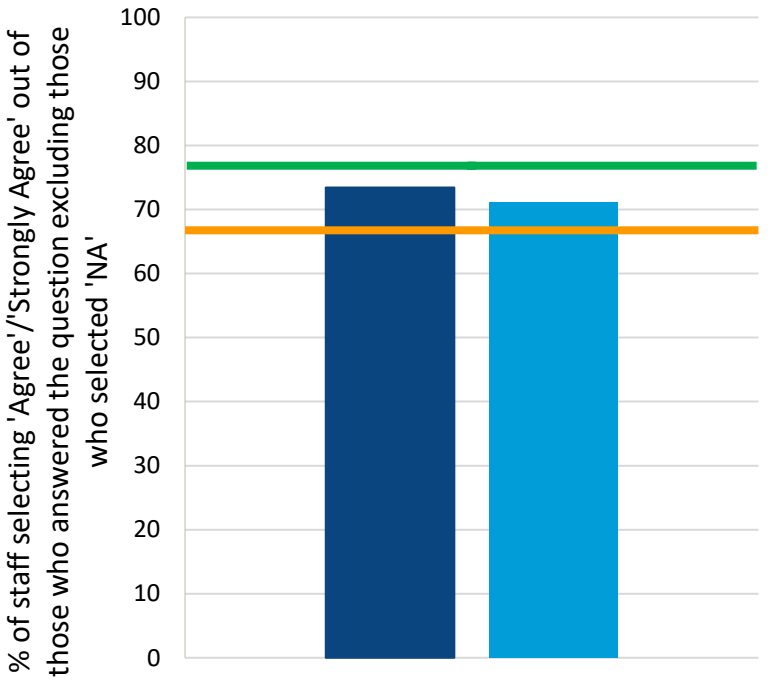
	2021	2022	2023	2024
Your org	53.16%	55.81%	63.87%	58.67%
Best result	64.67%	70.59%	69.67%	65.89%
Average result	59.54%	61.39%	63.64%	61.97%
Worst result	49.00%	52.62%	55.21%	55.39%
Responses	956	911	1045	922

Q24e I am able to access the right learning and development opportunities when I need to.



	2021	2022	2023	2024
Your org	53.98%	57.81%	66.33%	59.19%
Best result	66.34%	69.49%	71.75%	72.04%
Average result	60.44%	63.55%	65.79%	64.95%
Worst result	52.86%	53.59%	57.46%	57.84%
Responses	956	913	1044	925

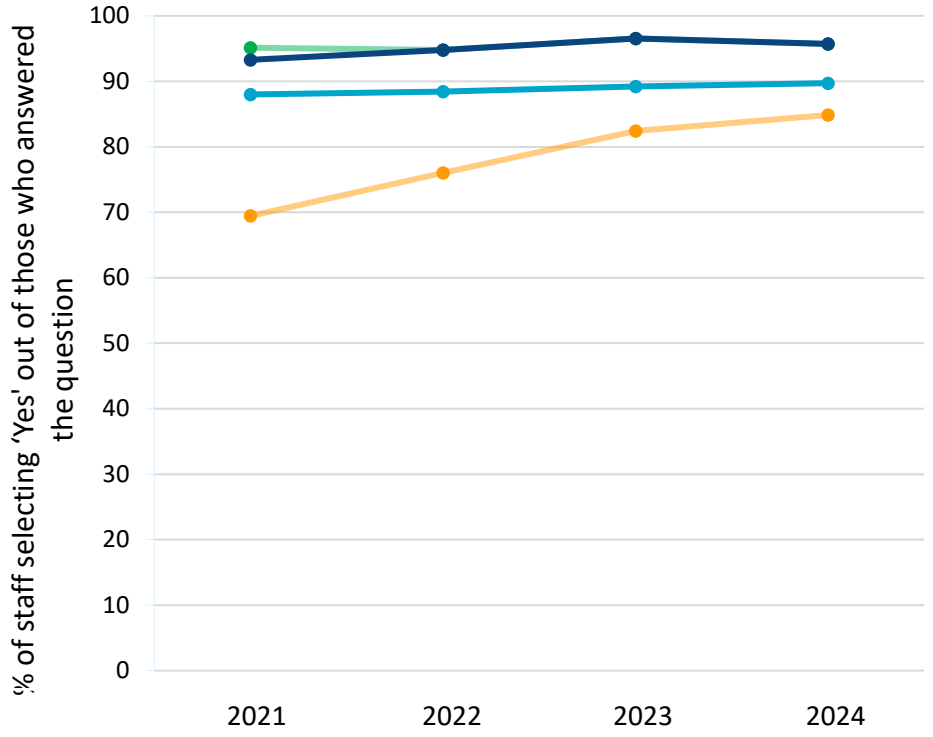
Q24f* I am able to access clinical supervision opportunities when I need to.



	2024
Your org	73.44%
Best result	76.84%
Average result	71.14%
Worst result	66.75%
Responses	787

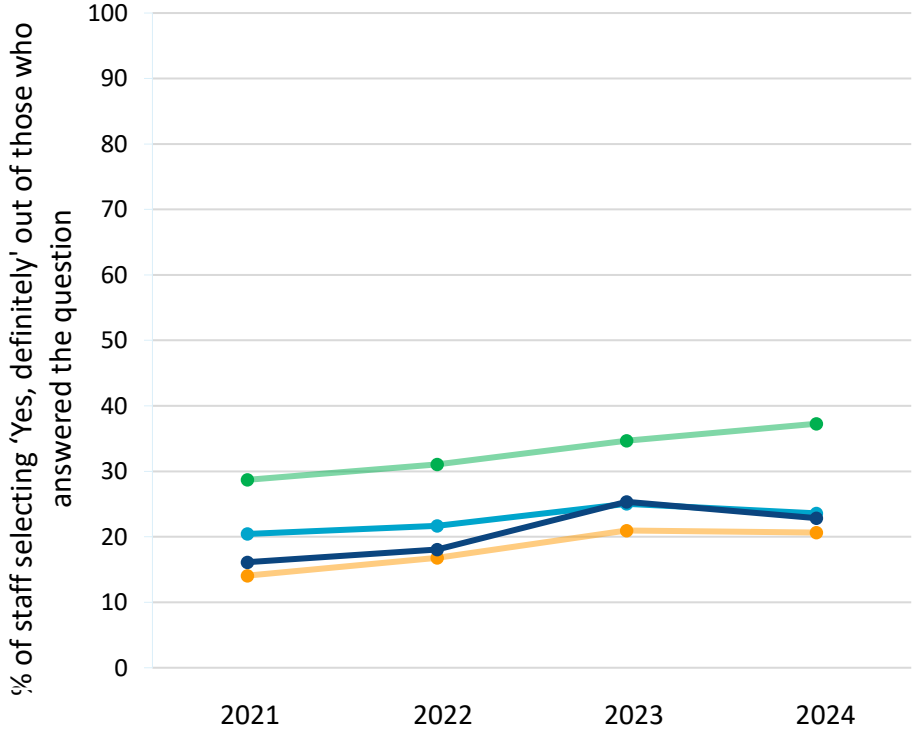
*Q24f was introduced in 2024 and does not currently contribute towards any People Promise element score, theme score or sub-score to protect trend data over five years.

Q23a* In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2021	2022	2023	2024
Your org	93.29%	94.79%	96.55%	95.73%
Best result	95.15%	94.79%	96.55%	95.73%
Average result	88.00%	88.46%	89.22%	89.72%
Worst result	69.45%	76.00%	82.42%	84.86%
Responses	958	913	1034	919

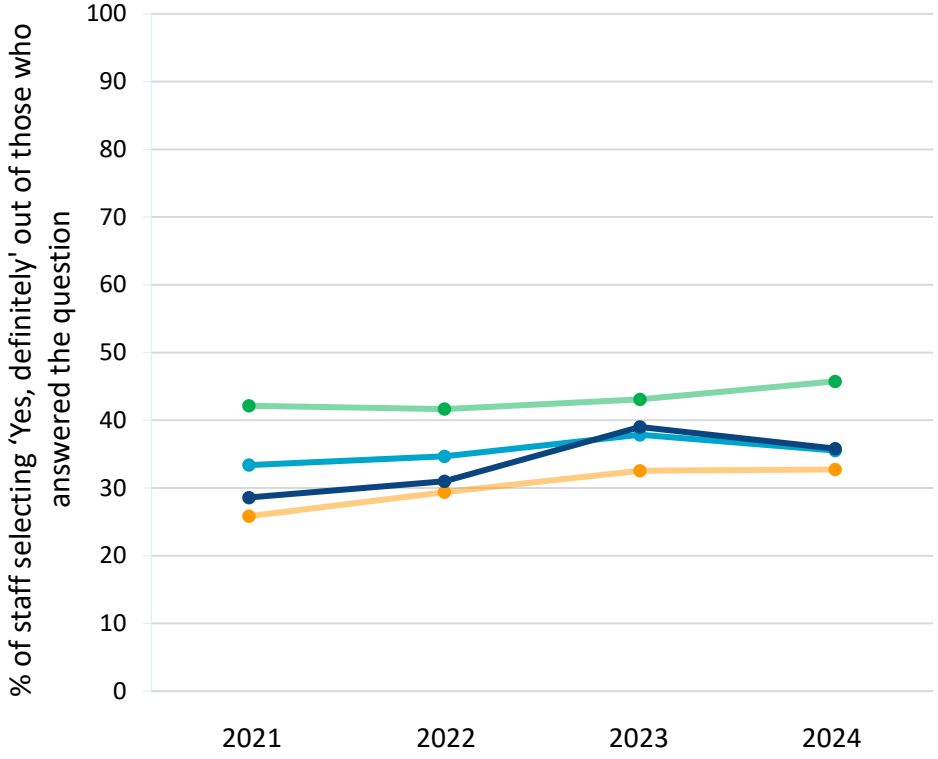
Q23b It helped me to improve how I do my job.



	2021	2022	2023	2024
Your org	16.12%	18.06%	25.35%	22.86%
Best result	28.70%	31.07%	34.66%	37.27%
Average result	20.43%	21.68%	25.03%	23.56%
Worst result	14.07%	16.81%	20.96%	20.65%
Responses	888	860	996	871

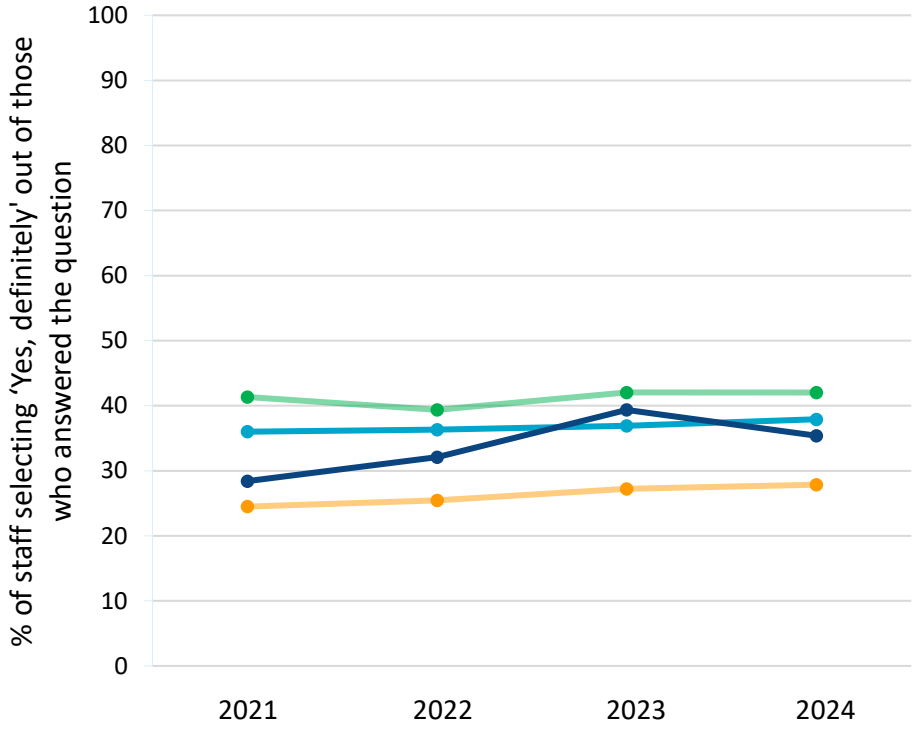
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

Q23c It helped me agree clear objectives for my work.



	2021	2022	2023	2024
Your org	28.60%	30.96%	39.00%	35.82%
Best result	42.13%	41.64%	43.08%	45.74%
Average result	33.38%	34.65%	37.86%	35.53%
Worst result	25.84%	29.36%	32.57%	32.73%
Responses	889	861	998	872

Q23d It left me feeling that my work is valued by my organisation.



	2021	2022	2023	2024
Your org	28.41%	32.09%	39.35%	35.37%
Best result	41.32%	39.37%	42.04%	42.01%
Average result	36.00%	36.30%	36.91%	37.92%
Worst result	24.49%	25.44%	27.24%	27.85%
Responses	889	860	996	870

Survey Coordination Centre

NHS

People Promise element – We work flexibly

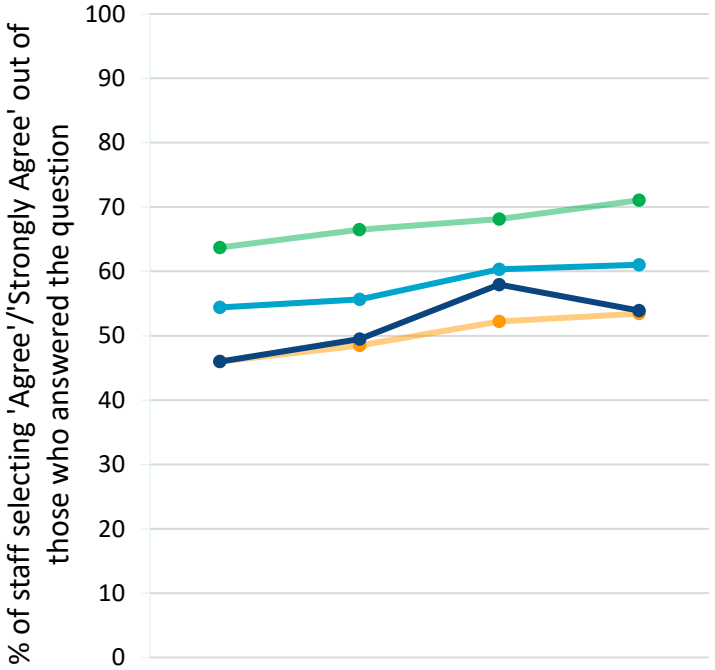
Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

Flexible working – Q4d

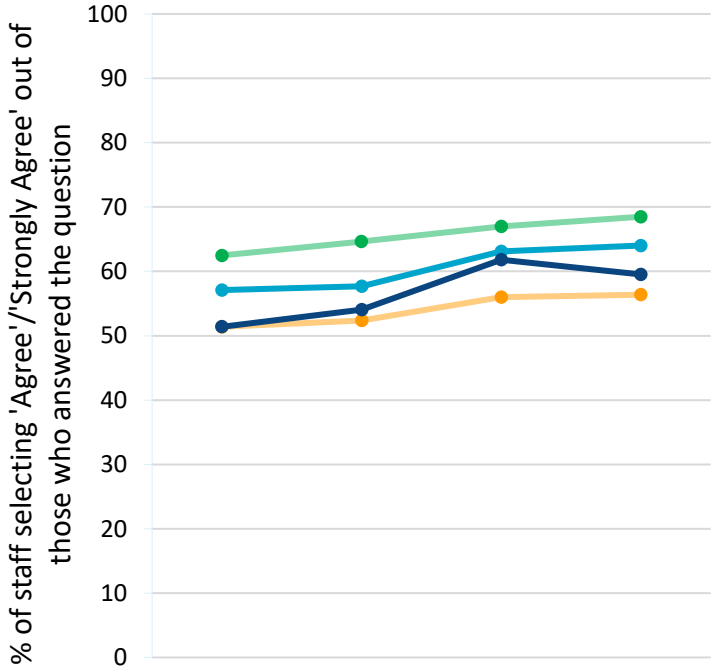
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6b My organisation is committed to helping me balance my work and home life.



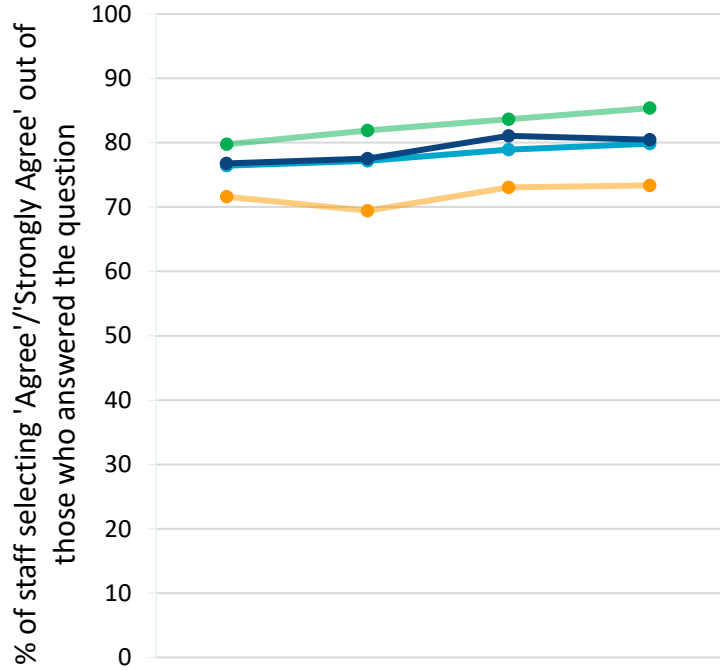
	2021	2022	2023	2024
Your org	45.98%	49.46%	57.95%	53.90%
Best result	63.71%	66.48%	68.13%	71.05%
Average result	54.39%	55.62%	60.32%	61.03%
Worst result	45.98%	48.46%	52.21%	53.43%
Responses	971	916	1044	927

Q6c I achieve a good balance between my work life and my home life.



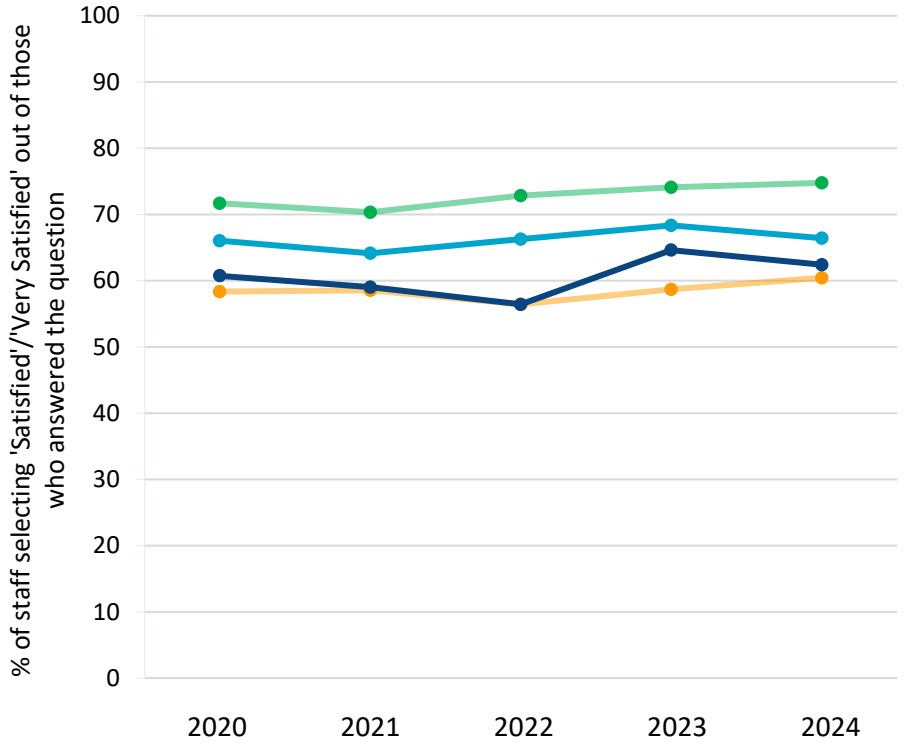
	2021	2022	2023	2024
Your org	51.38%	54.07%	61.81%	59.53%
Best result	62.48%	64.63%	66.97%	68.49%
Average result	57.10%	57.71%	63.11%	64.02%
Worst result	51.38%	52.36%	55.97%	56.37%
Responses	972	916	1045	925

Q6d I can approach my immediate manager to talk openly about flexible working.



	2021	2022	2023	2024
Your org	76.78%	77.53%	81.06%	80.48%
Best result	79.75%	81.90%	83.64%	85.37%
Average result	76.43%	77.18%	78.90%	79.84%
Worst result	71.62%	69.42%	73.05%	73.37%
Responses	972	917	1046	927

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.

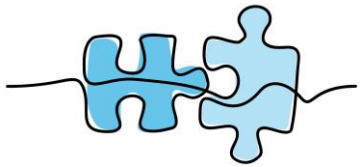


	2020	2021	2022	2023	2024
Your org	60.74%	59.04%	56.44%	64.62%	62.43%
Best result	71.69%	70.34%	72.83%	74.12%	74.78%
Average result	66.05%	64.14%	66.27%	68.36%	66.42%
Worst result	58.38%	58.56%	56.44%	58.68%	60.45%
Responses	821	973	917	1043	922

Survey Coordination Centre

NHS

People Promise element – We are a team



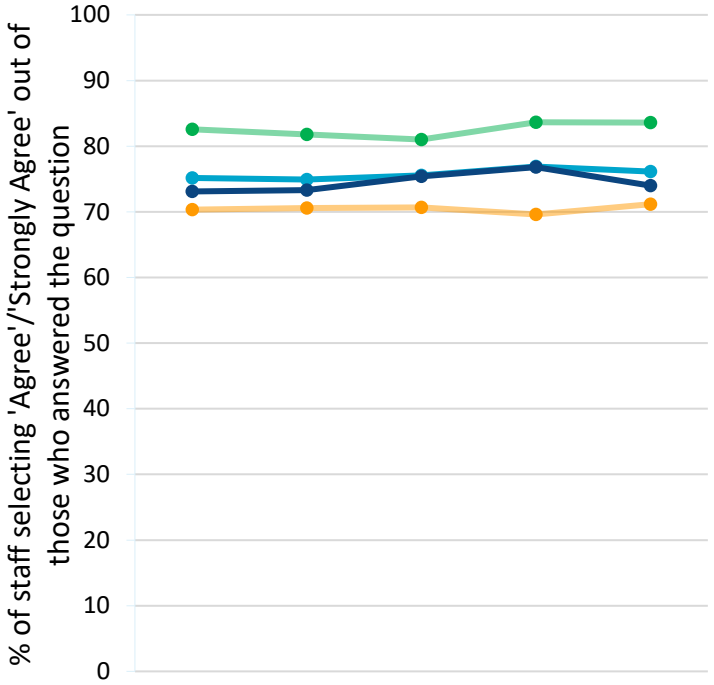
Questions included:

Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

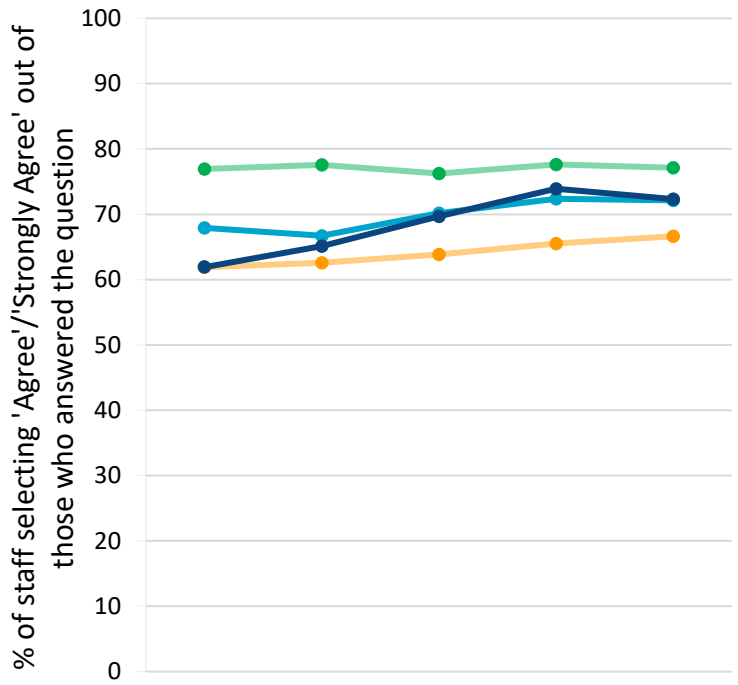
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q7a The team I work in has a set of shared objectives.



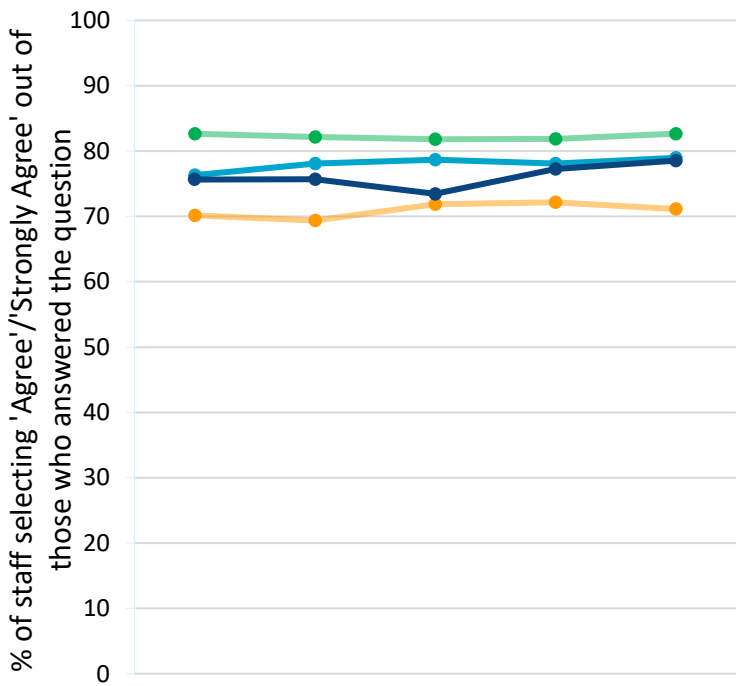
	2020	2021	2022	2023	2024
Your org	73.11%	73.32%	75.41%	76.81%	73.97%
Best result	82.55%	81.80%	81.01%	83.64%	83.62%
Average result	75.15%	74.92%	75.54%	76.89%	76.11%
Worst result	70.32%	70.60%	70.69%	69.60%	71.16%
Responses	820	967	917	1046	923

Q7b The team I work in often meets to discuss the team's effectiveness.



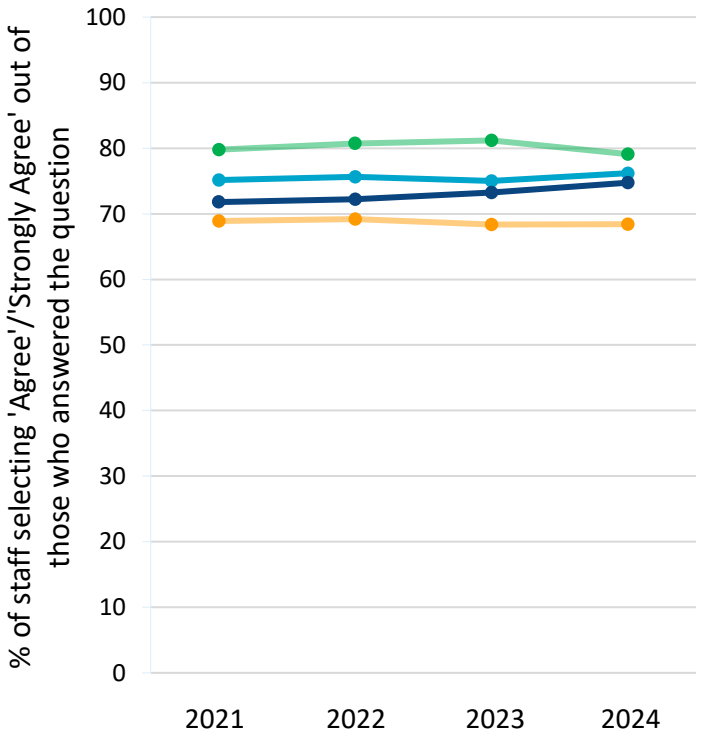
	2020	2021	2022	2023	2024
Your org	61.91%	65.15%	69.69%	73.92%	72.34%
Best result	76.92%	77.59%	76.24%	77.63%	77.15%
Average result	67.92%	66.72%	70.18%	72.38%	72.12%
Worst result	61.91%	62.58%	63.86%	65.51%	66.64%
Responses	822	967	916	1045	924

Q7c I receive the respect I deserve from my colleagues at work.



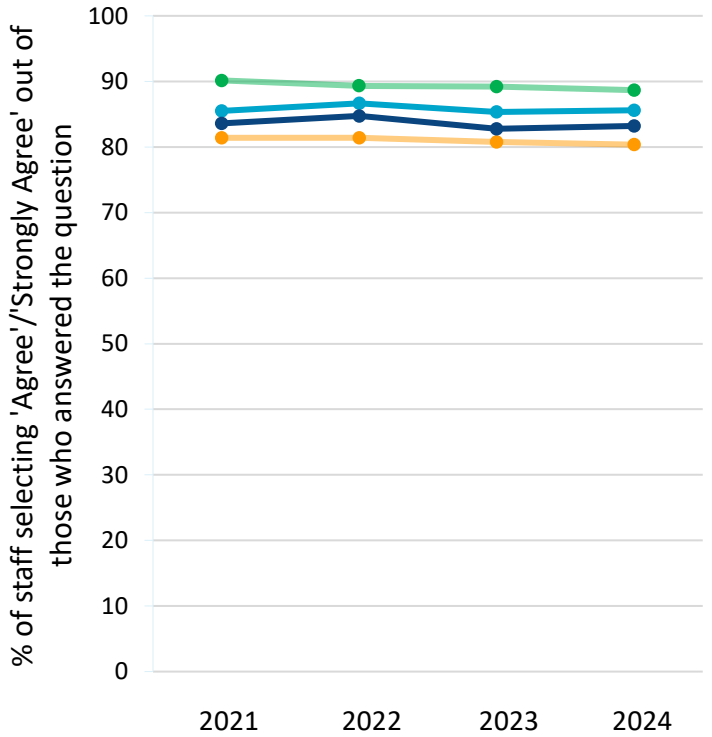
	2020	2021	2022	2023	2024
Your org	75.65%	75.69%	73.46%	77.27%	78.55%
Best result	82.64%	82.15%	81.82%	81.86%	82.67%
Average result	76.32%	78.11%	78.66%	78.07%	78.97%
Worst result	70.16%	69.38%	71.87%	72.16%	71.15%
Responses	820	967	918	1047	925

Q7d Team members understand each other's roles.



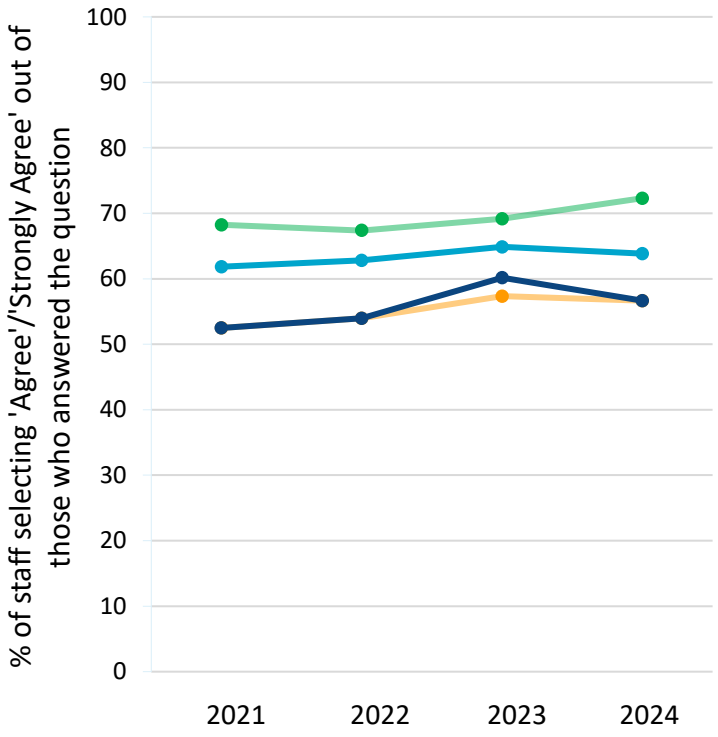
	2021	2022	2023	2024
Your org	71.79%	72.23%	73.27%	74.75%
Best result	79.79%	80.73%	81.20%	79.10%
Average result	75.17%	75.63%	75.01%	76.20%
Worst result	68.89%	69.20%	68.36%	68.41%
Responses	968	916	1047	923

Q7e I enjoy working with the colleagues in my team.



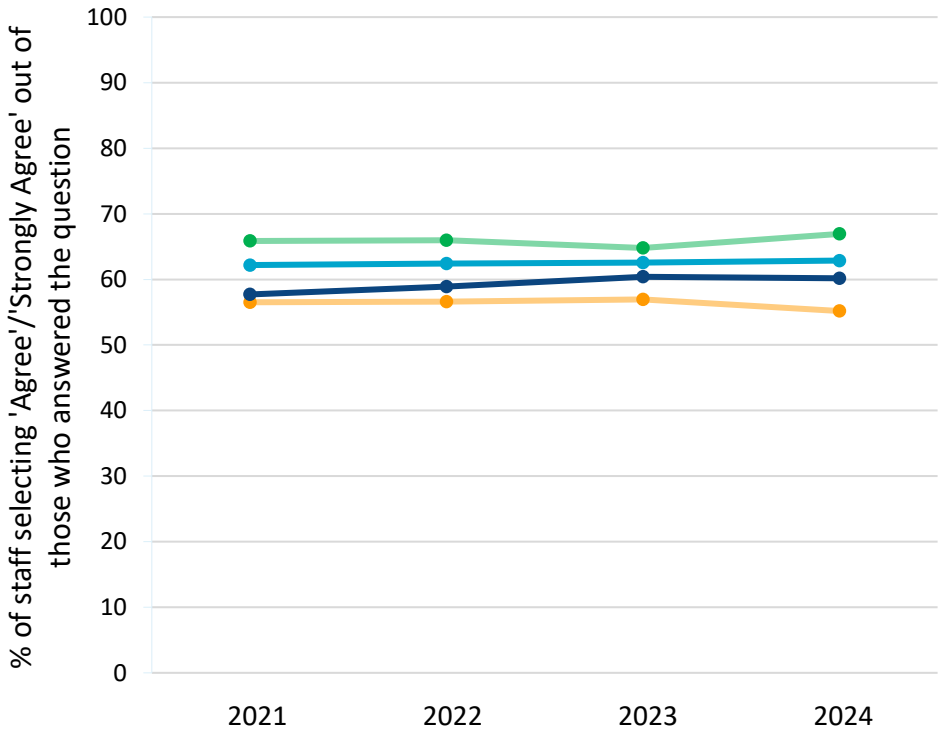
	2021	2022	2023	2024
Your org	83.60%	84.75%	82.78%	83.19%
Best result	90.15%	89.32%	89.20%	88.67%
Average result	85.48%	86.66%	85.34%	85.60%
Worst result	81.39%	81.41%	80.78%	80.36%
Responses	963	917	1042	923

Q7f My team has enough freedom in how to do its work.



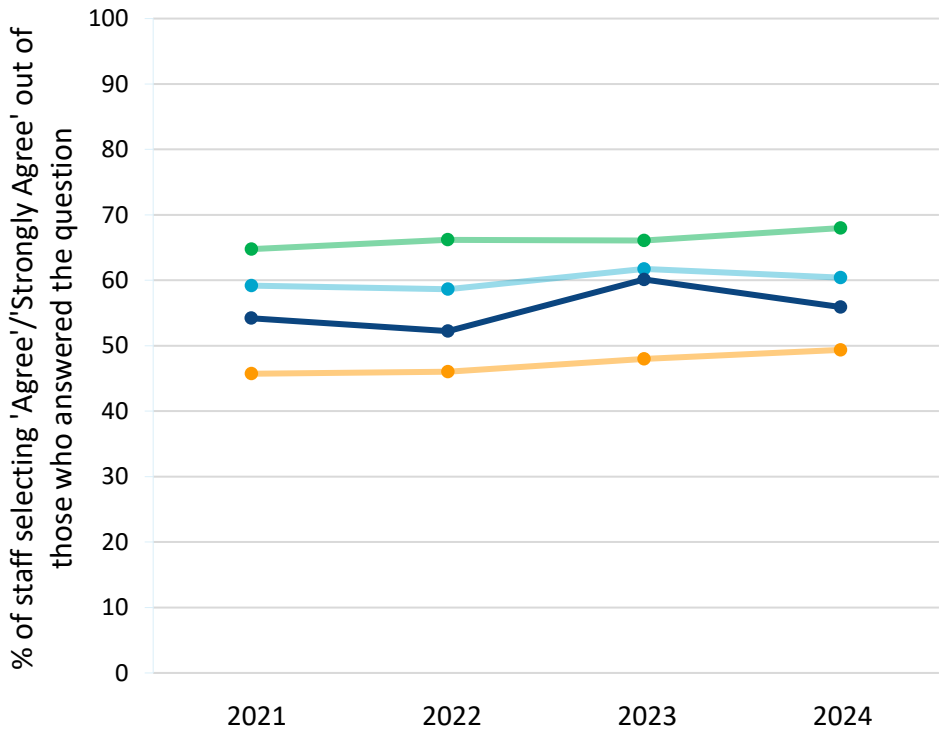
	2021	2022	2023	2024
Your org	52.49%	53.98%	60.17%	56.66%
Best result	68.25%	67.36%	69.16%	72.31%
Average result	61.85%	62.80%	64.88%	63.84%
Worst result	52.49%	53.98%	57.35%	56.66%
Responses	965	918	1045	923

Q7g In my team disagreements are dealt with constructively.



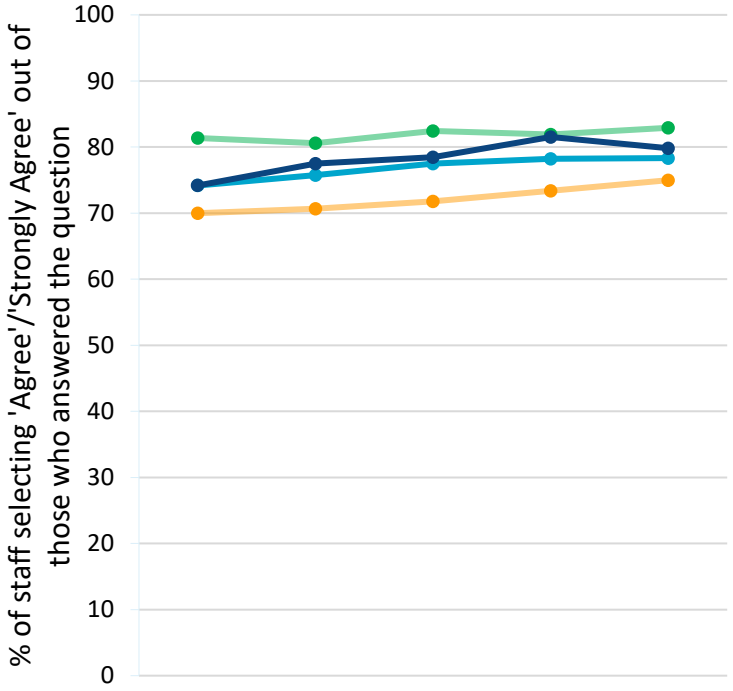
	2021	2022	2023	2024
Your org	57.71%	58.89%	60.39%	60.15%
Best result	65.86%	65.97%	64.79%	66.93%
Average result	62.19%	62.42%	62.57%	62.87%
Worst result	56.53%	56.63%	56.95%	55.18%
Responses	965	914	1043	922

Q8a Teams within this organisation work well together to achieve their objectives.



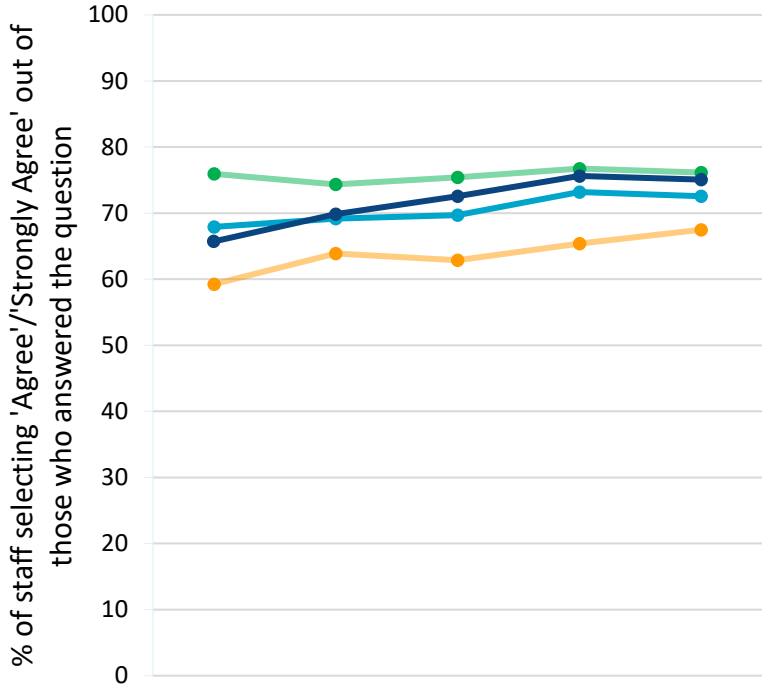
	2021	2022	2023	2024
Your org	54.22%	52.23%	60.13%	55.92%
Best result	64.76%	66.19%	66.09%	67.98%
Average result	59.21%	58.64%	61.74%	60.43%
Worst result	45.72%	46.05%	47.98%	49.37%
Responses	964	918	1047	924

Q9a My immediate manager encourages me at work.



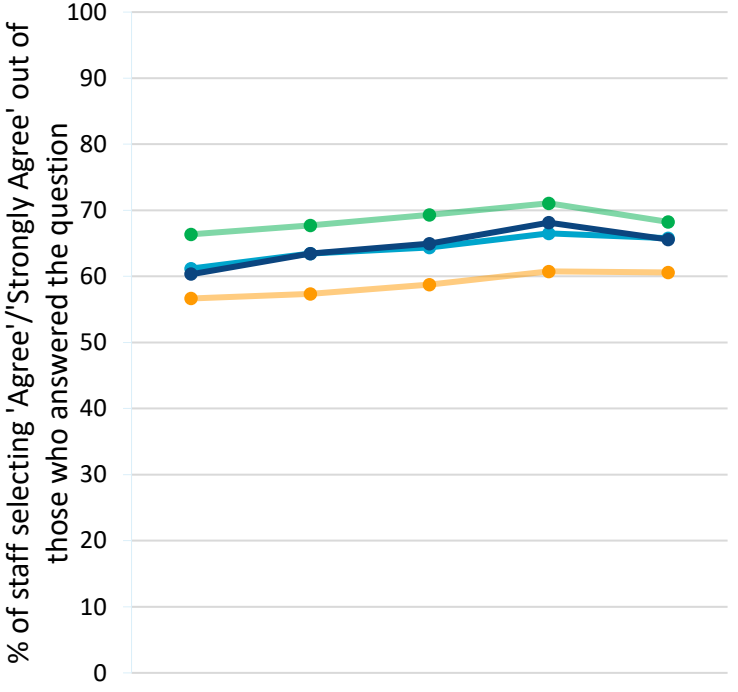
	2020	2021	2022	2023	2024
Your org	74.18%	77.50%	78.48%	81.52%	79.80%
Best result	81.39%	80.58%	82.43%	81.88%	82.91%
Average result	74.18%	75.77%	77.50%	78.24%	78.33%
Worst result	69.99%	70.67%	71.78%	73.39%	74.99%
Responses	822	962	918	1047	926

Q9b My immediate manager gives me clear feedback on my work.



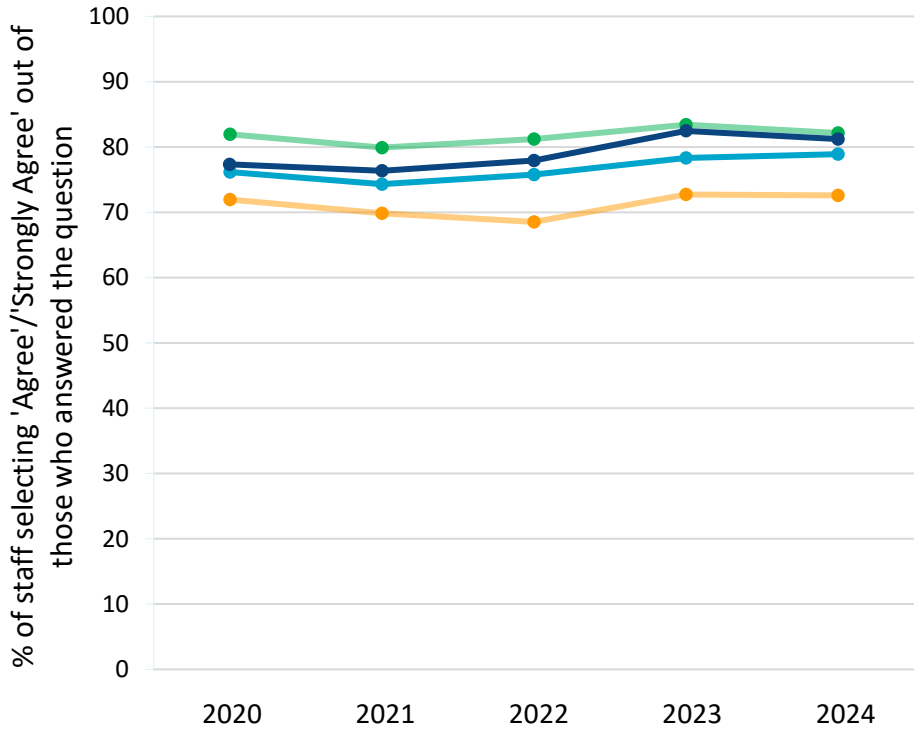
	2020	2021	2022	2023	2024
Your org	65.72%	69.82%	72.53%	75.62%	75.07%
Best result	75.95%	74.34%	75.39%	76.74%	76.15%
Average result	67.91%	69.17%	69.71%	73.19%	72.54%
Worst result	59.24%	63.88%	62.85%	65.40%	67.48%
Responses	817	962	916	1041	924

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2020	2021	2022	2023	2024
Your org	60.32%	63.47%	64.95%	68.13%	65.57%
Best result	66.37%	67.72%	69.33%	71.07%	68.27%
Average result	61.19%	63.45%	64.37%	66.51%	65.76%
Worst result	56.66%	57.36%	58.76%	60.76%	60.62%
Responses	818	962	917	1047	925

Q9d My immediate manager takes a positive interest in my health and well-being.



	2020	2021	2022	2023	2024
Your org	77.34%	76.36%	77.93%	82.46%	81.21%
Best result	81.95%	79.91%	81.22%	83.41%	82.17%
Average result	76.17%	74.31%	75.78%	78.33%	78.90%
Worst result	71.95%	69.85%	68.53%	72.72%	72.58%
Responses	820	962	918	1047	926

Survey Coordination Centre

NHS

Theme – Staff engagement

Questions included:

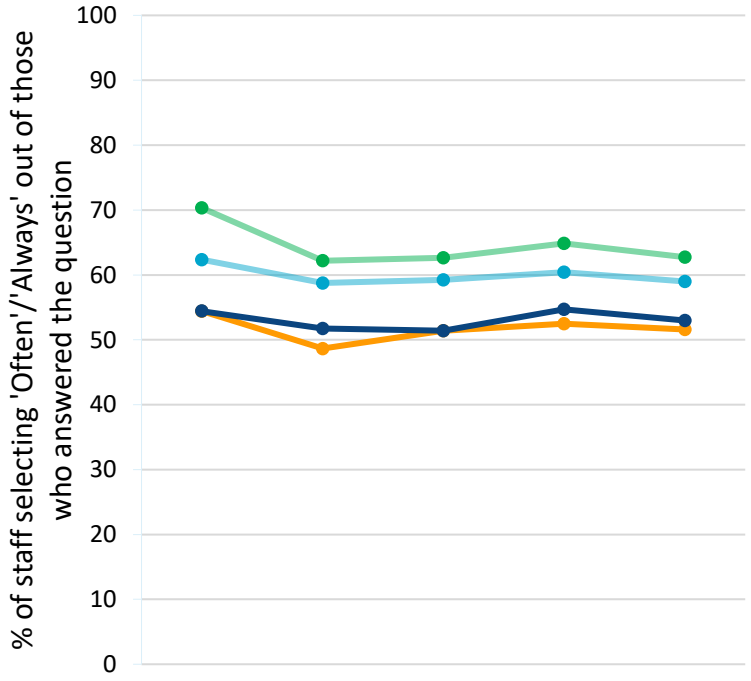
Motivation – Q2a, Q2b, Q2c

Involvement – Q3c, Q3d, Q3f

Advocacy – Q25a, Q25c, Q25d

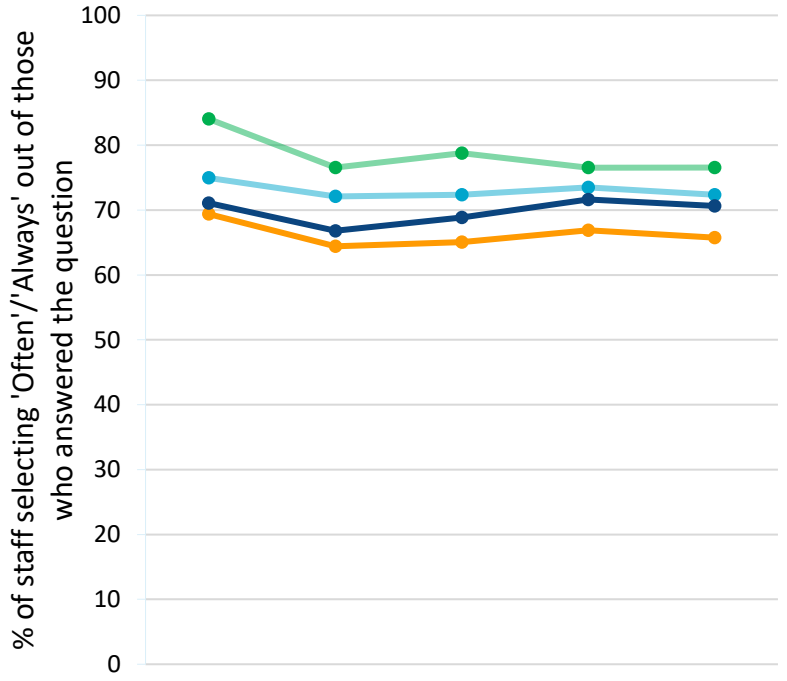
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q2a I look forward to going to work.



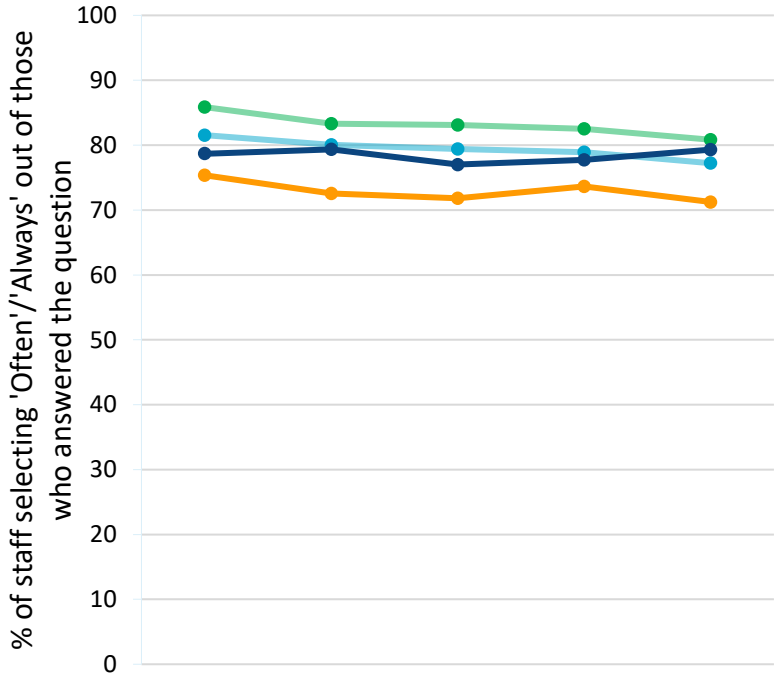
	2020	2021	2022	2023	2024
Your org	54.42%	51.73%	51.40%	54.69%	52.98%
Best result	70.32%	62.18%	62.65%	64.86%	62.75%
Average result	62.35%	58.76%	59.22%	60.44%	58.99%
Worst result	54.42%	48.66%	51.40%	52.47%	51.61%
Responses	820	979	911	1042	921

Q2b I am enthusiastic about my job.



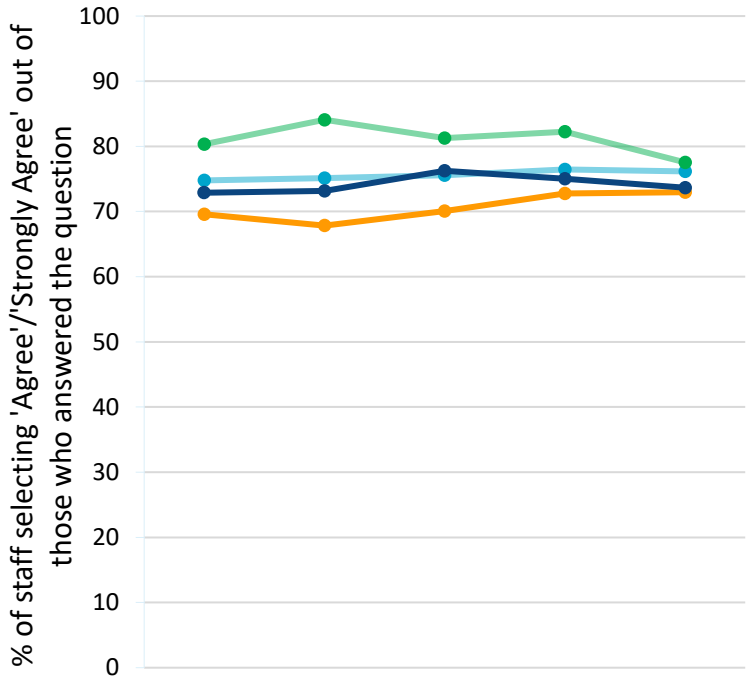
	2020	2021	2022	2023	2024
Your org	71.07%	66.81%	68.85%	71.63%	70.62%
Best result	84.03%	76.54%	78.78%	76.52%	76.52%
Average result	74.95%	72.09%	72.34%	73.47%	72.35%
Worst result	69.38%	64.41%	65.05%	66.90%	65.77%
Responses	818	973	907	1042	918

Q2c Time passes quickly when I am working.



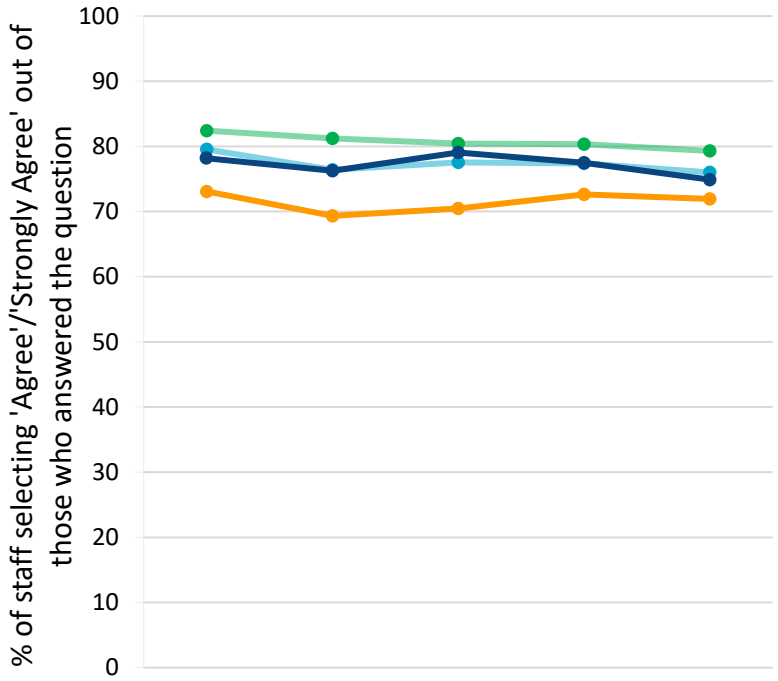
	2020	2021	2022	2023	2024
Your org	78.68%	79.35%	77.01%	77.72%	79.32%
Best result	85.86%	83.29%	83.09%	82.50%	80.84%
Average result	81.54%	80.06%	79.43%	78.93%	77.22%
Worst result	75.36%	72.55%	71.82%	73.61%	71.24%
Responses	820	975	907	1042	920

Q3c There are frequent opportunities for me to show initiative in my role.



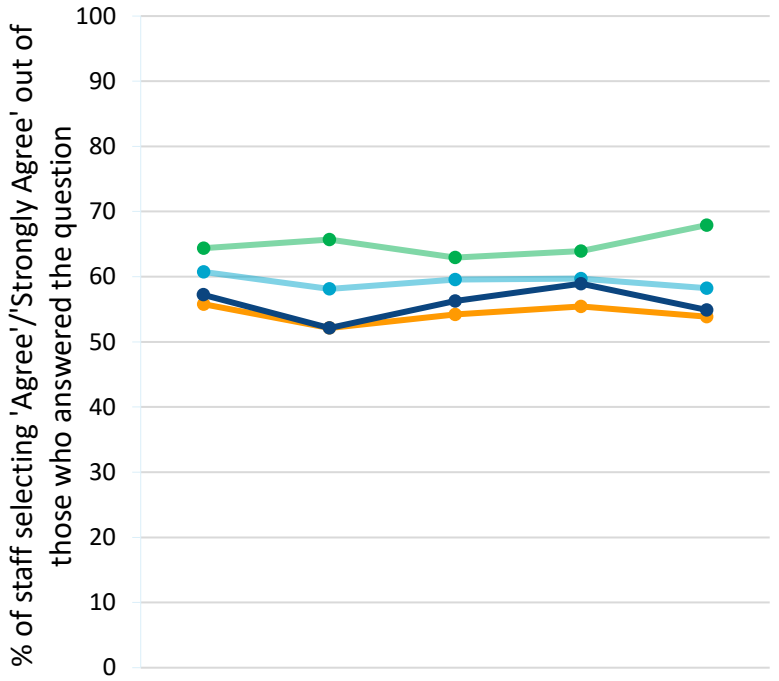
	2020	2021	2022	2023	2024
Your org	72.89%	73.19%	76.25%	75.05%	73.65%
Best result	80.35%	84.09%	81.27%	82.24%	77.55%
Average result	74.78%	75.12%	75.57%	76.46%	76.14%
Worst result	69.60%	67.84%	70.05%	72.78%	72.97%
Responses	825	974	915	1046	924

Q3d I am able to make suggestions to improve the work of my team / department.



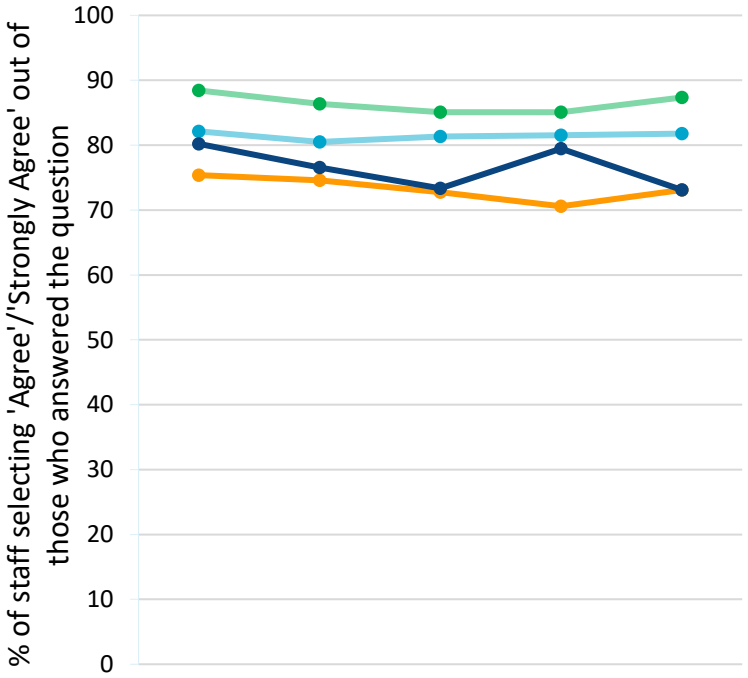
	2020	2021	2022	2023	2024
Your org	78.20%	76.26%	79.06%	77.46%	74.90%
Best result	82.42%	81.22%	80.45%	80.35%	79.30%
Average result	79.53%	76.40%	77.53%	77.41%	76.01%
Worst result	73.09%	69.34%	70.44%	72.63%	71.96%
Responses	824	977	917	1047	925

Q3f I am able to make improvements happen in my area of work.



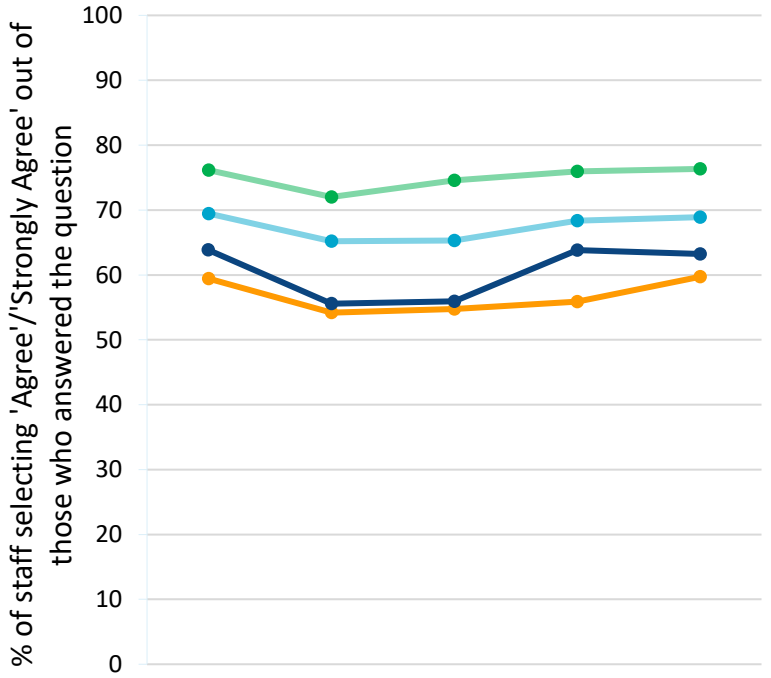
	2020	2021	2022	2023	2024
Your org	57.23%	52.12%	56.27%	58.93%	54.89%
Best result	64.38%	65.70%	62.94%	63.95%	67.92%
Average result	60.73%	58.12%	59.56%	59.71%	58.24%
Worst result	55.78%	52.12%	54.20%	55.42%	53.87%
Responses	816	975	916	1047	922

Q25a Care of patients / service users is my organisation's top priority.



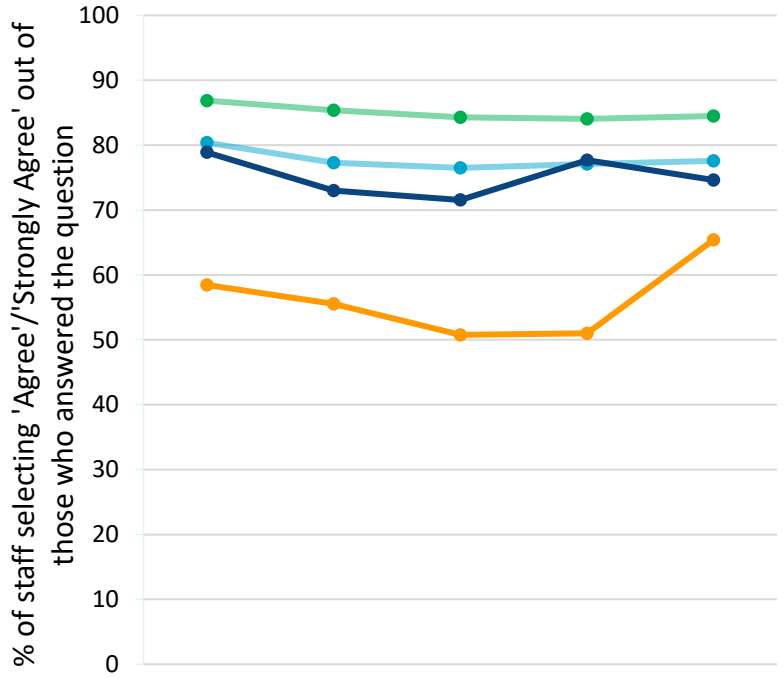
	2020	2021	2022	2023	2024
Your org	80.19%	76.52%	73.35%	79.45%	73.09%
Best result	88.43%	86.38%	85.08%	85.07%	87.34%
Average result	82.13%	80.49%	81.33%	81.53%	81.76%
Worst result	75.38%	74.57%	72.73%	70.58%	73.09%
Responses	821	950	917	1043	922

Q25c I would recommend my organisation as a place to work.



	2020	2021	2022	2023	2024
Your org	63.83%	55.57%	55.95%	63.81%	63.21%
Best result	76.15%	72.01%	74.57%	75.97%	76.34%
Average result	69.46%	65.19%	65.31%	68.36%	68.89%
Worst result	59.42%	54.18%	54.75%	55.86%	59.71%
Responses	821	949	918	1043	923

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2020	2021	2022	2023	2024
Your org	78.87%	73.02%	71.54%	77.70%	74.64%
Best result	86.86%	85.39%	84.27%	84.05%	84.46%
Average result	80.38%	77.29%	76.50%	77.06%	77.59%
Worst result	58.43%	55.52%	50.76%	50.99%	65.41%
Responses	820	949	918	1042	922

Survey Coordination Centre

NHS

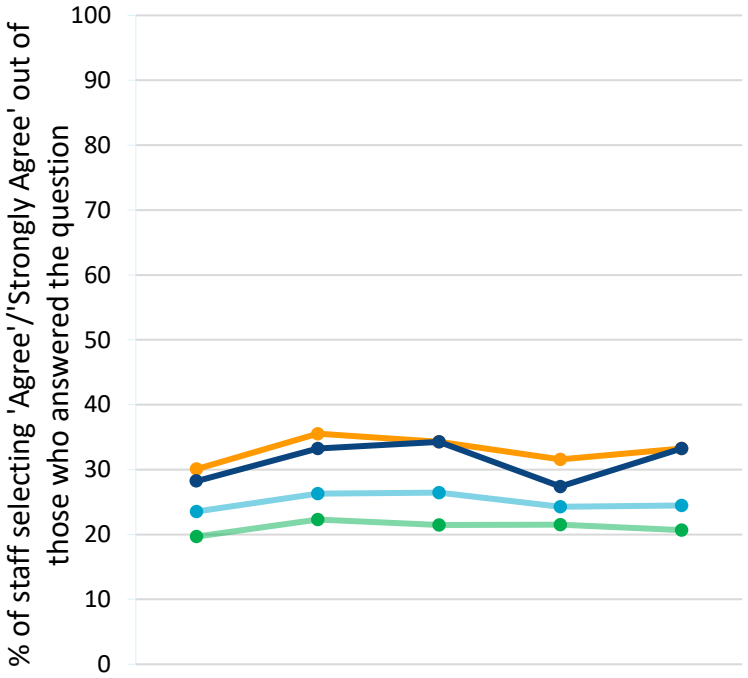
Theme - Morale

Questions included:

Thinking about leaving – Q26a, Q26b, Q26c
Work pressure – Q3g, Q3h, Q3i
Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

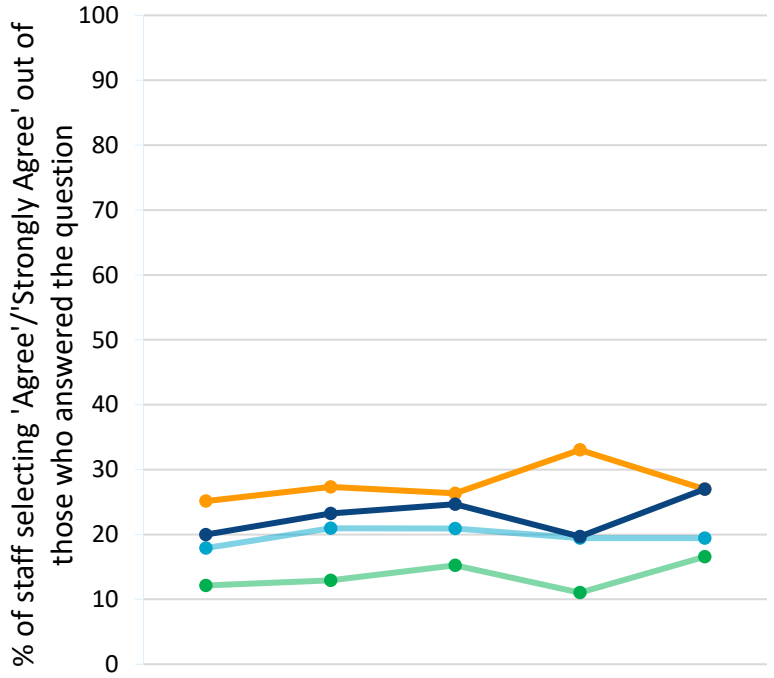
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q26a I often think about leaving this organisation.



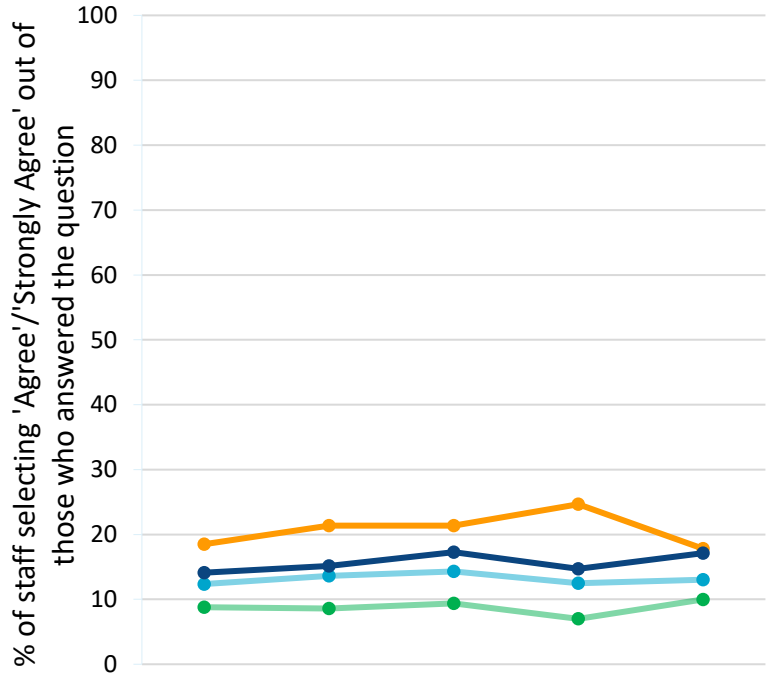
	2020	2021	2022	2023	2024
Your org	28.24%	33.26%	34.27%	27.39%	33.23%
Best result	19.68%	22.30%	21.48%	21.51%	20.68%
Average result	23.54%	26.30%	26.45%	24.29%	24.48%
Worst result	30.07%	35.53%	34.27%	31.55%	33.23%
Responses	822	947	916	1045	925

Q26b I will probably look for a job at a new organisation in the next 12 months.



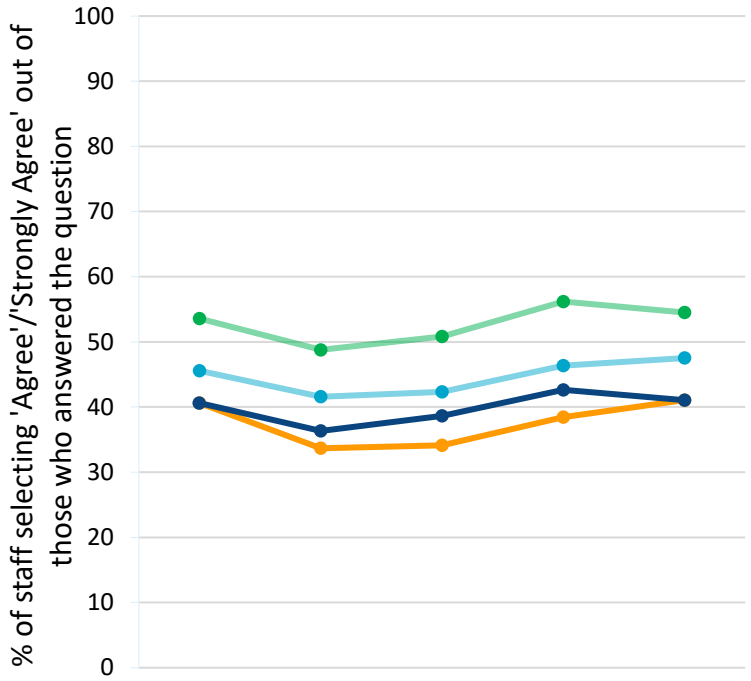
	2020	2021	2022	2023	2024
Your org	19.97%	23.23%	24.68%	19.68%	26.99%
Best result	12.15%	12.93%	15.22%	11.03%	16.56%
Average result	17.90%	20.95%	20.93%	19.42%	19.45%
Worst result	25.14%	27.34%	26.35%	33.03%	26.99%
Responses	821	945	917	1045	925

Q26c As soon as I can find another job, I will leave this organisation.



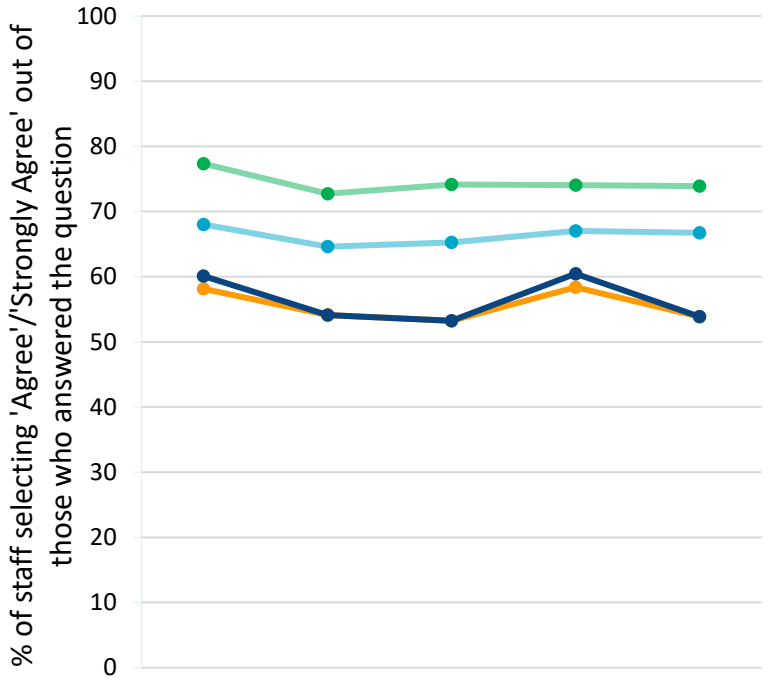
	2020	2021	2022	2023	2024
Your org	14.11%	15.15%	17.27%	14.72%	17.13%
Best result	8.81%	8.60%	9.37%	7.00%	9.99%
Average result	12.36%	13.60%	14.30%	12.47%	13.01%
Worst result	18.49%	21.36%	21.37%	24.66%	17.81%
Responses	817	946	917	1043	924

Q3g I am able to meet all the conflicting demands on my time at work.



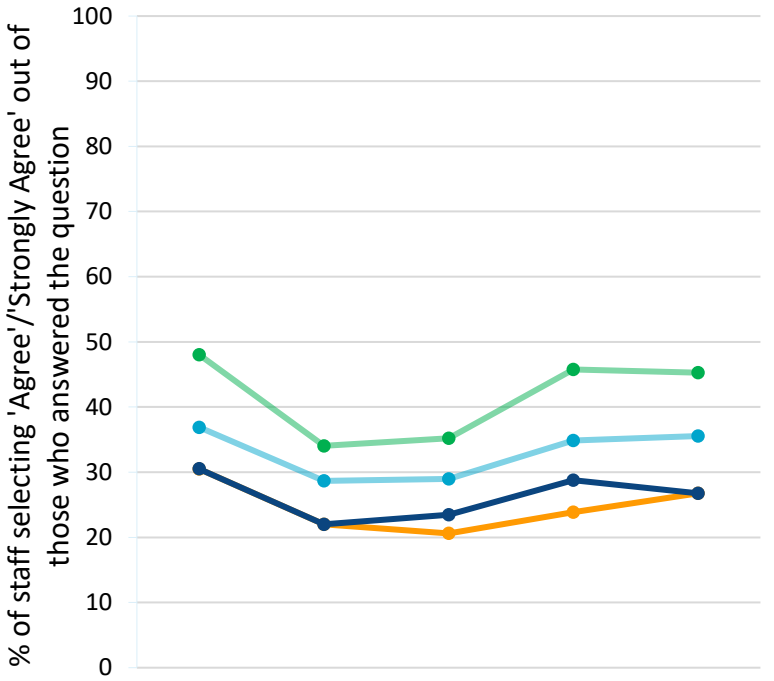
	2020	2021	2022	2023	2024
Your org	40.59%	36.33%	38.64%	42.64%	41.07%
Best result	53.58%	48.78%	50.80%	56.19%	54.51%
Average result	45.57%	41.58%	42.30%	46.34%	47.52%
Worst result	40.59%	33.67%	34.13%	38.42%	41.07%
Responses	822	974	916	1044	926

Q3h I have adequate materials, supplies and equipment to do my work.



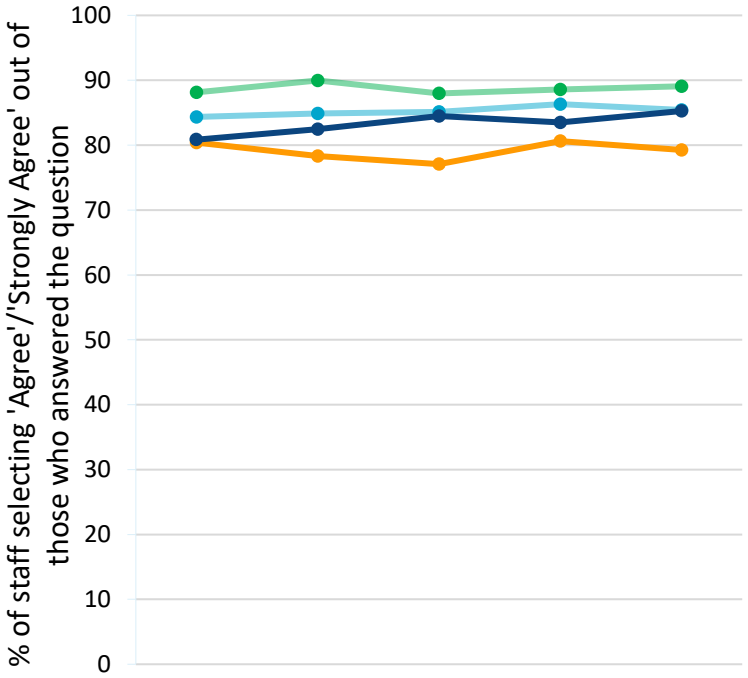
	2020	2021	2022	2023	2024
Your org	60.09%	54.11%	53.23%	60.46%	53.88%
Best result	77.34%	72.74%	74.14%	74.05%	73.89%
Average result	68.02%	64.61%	65.27%	67.04%	66.73%
Worst result	58.15%	54.11%	53.23%	58.38%	53.88%
Responses	820	976	917	1042	924

Q3i There are enough staff at this organisation for me to do my job properly.



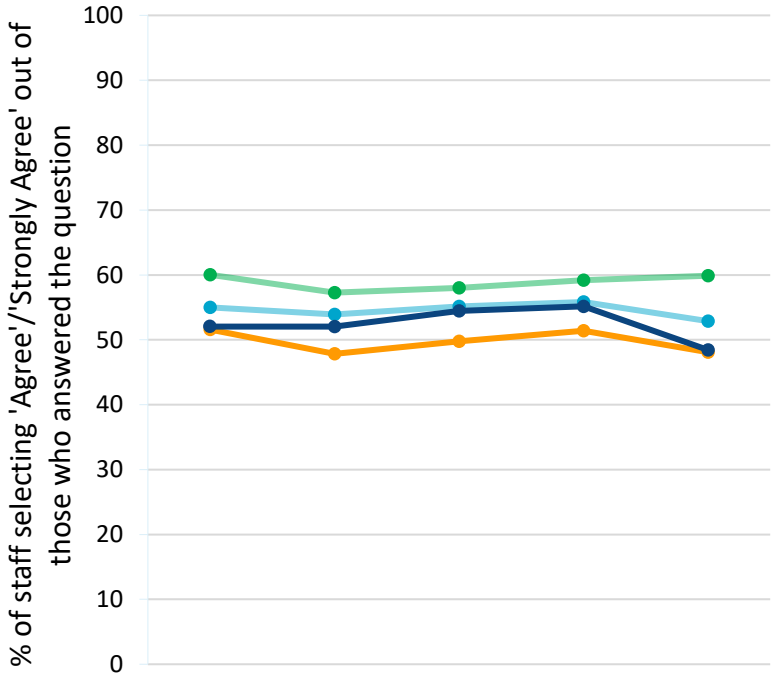
	2020	2021	2022	2023	2024
Your org	30.49%	22.00%	23.45%	28.78%	26.74%
Best result	48.02%	34.05%	35.18%	45.76%	45.26%
Average result	36.89%	28.67%	28.97%	34.87%	35.53%
Worst result	30.49%	22.00%	20.60%	23.88%	26.74%
Responses	818	975	917	1044	926

Q3a I always know what my work responsibilities are.



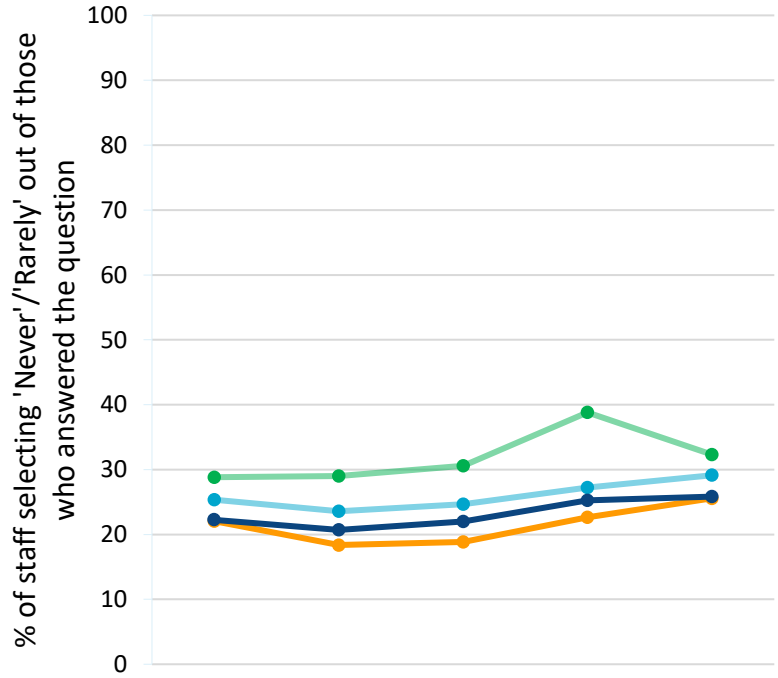
	2020	2021	2022	2023	2024
Your org	80.84%	82.48%	84.46%	83.51%	85.26%
Best result	88.11%	89.97%	87.96%	88.60%	89.08%
Average result	84.35%	84.86%	85.14%	86.32%	85.44%
Worst result	80.37%	78.30%	77.07%	80.61%	79.25%
Responses	820	977	916	1047	927

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



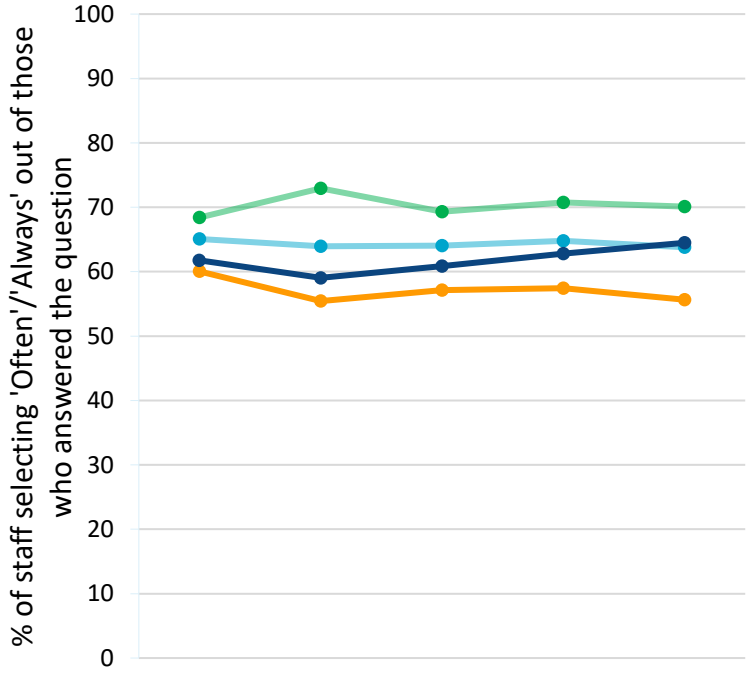
	2020	2021	2022	2023	2024
Your org	52.04%	52.06%	54.47%	55.16%	48.44%
Best result	60.02%	57.27%	58.00%	59.20%	59.89%
Average result	55.00%	53.89%	55.16%	55.82%	52.88%
Worst result	51.57%	47.84%	49.76%	51.41%	48.09%
Responses	821	977	917	1043	926

Q5a I have unrealistic time pressures.



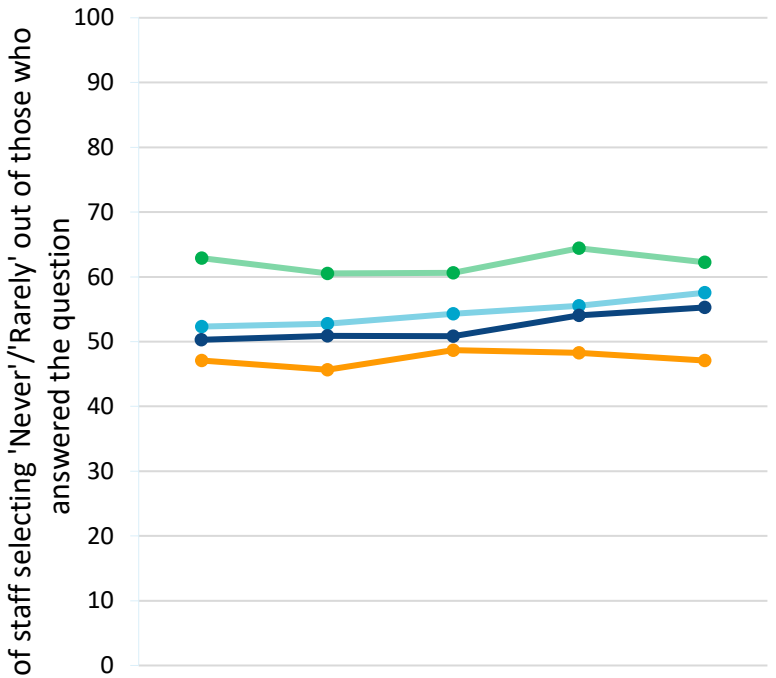
	2020	2021	2022	2023	2024
Your org	22.27%	20.70%	22.00%	25.28%	25.83%
Best result	28.82%	29.01%	30.58%	38.81%	32.30%
Average result	25.34%	23.58%	24.65%	27.22%	29.13%
Worst result	22.05%	18.38%	18.84%	22.62%	25.57%
Responses	820	974	916	1045	926

Q5b I have a choice in deciding how to do my work.



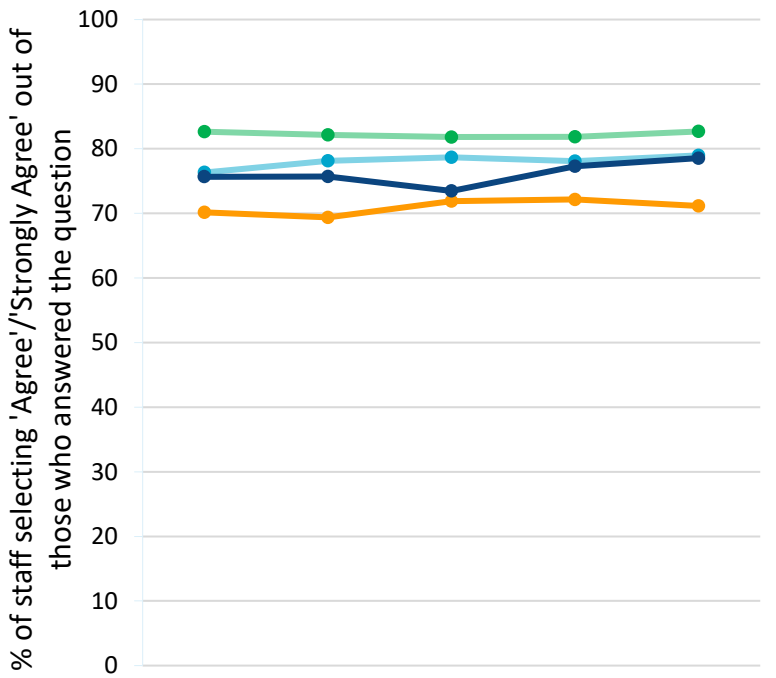
	2020	2021	2022	2023	2024
Your org	61.74%	59.05%	60.85%	62.81%	64.48%
Best result	68.41%	72.94%	69.34%	70.74%	70.12%
Average result	65.08%	63.95%	64.05%	64.77%	63.79%
Worst result	60.05%	55.44%	57.15%	57.41%	55.65%
Responses	816	974	917	1044	926

Q5c Relationships at work are strained.



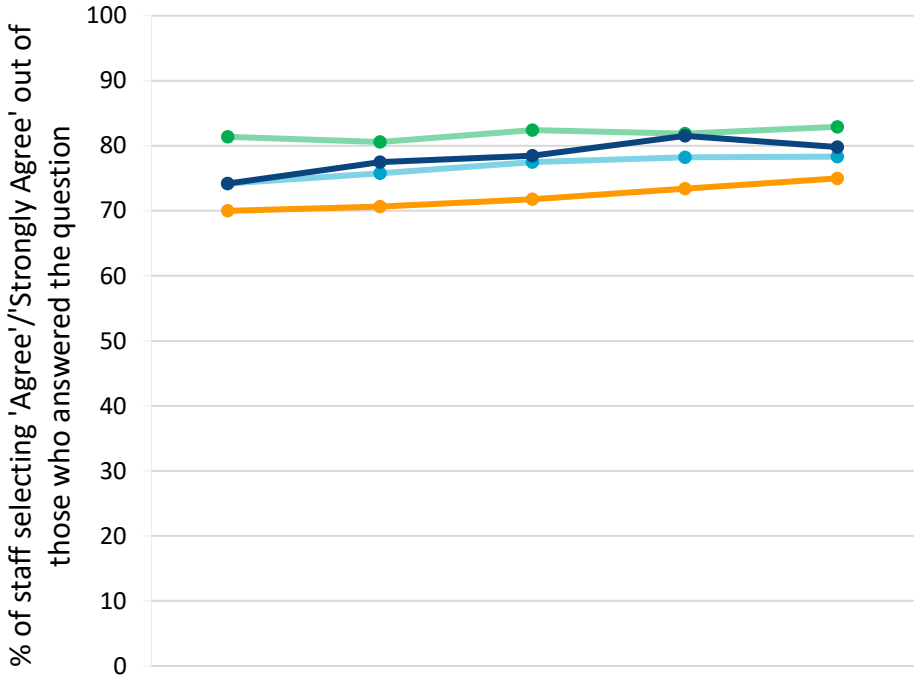
	2020	2021	2022	2023	2024
Your org	50.29%	50.91%	50.86%	54.07%	55.27%
Best result	62.92%	60.54%	60.64%	64.41%	62.24%
Average result	52.33%	52.78%	54.32%	55.53%	57.55%
Worst result	47.08%	45.66%	48.68%	48.28%	47.07%
Responses	818	975	916	1043	925

Q7c I receive the respect I deserve from my colleagues at work.



	2020	2021	2022	2023	2024
Your org	75.65%	75.69%	73.46%	77.27%	78.55%
Best result	82.64%	82.15%	81.82%	81.86%	82.67%
Average result	76.32%	78.11%	78.66%	78.07%	78.97%
Worst result	70.16%	69.38%	71.87%	72.16%	71.15%
Responses	820	967	918	1047	925

Q9a My immediate manager encourages me at work.



	2020	2021	2022	2023	2024
Your org	74.18%	77.50%	78.48%	81.52%	79.80%
Best result	81.39%	80.58%	82.43%	81.88%	82.91%
Average result	74.18%	75.77%	77.50%	78.24%	78.33%
Worst result	69.99%	70.67%	71.78%	73.39%	74.99%
Responses	822	962	918	1047	926

Questions not linked to People Promise elements or themes

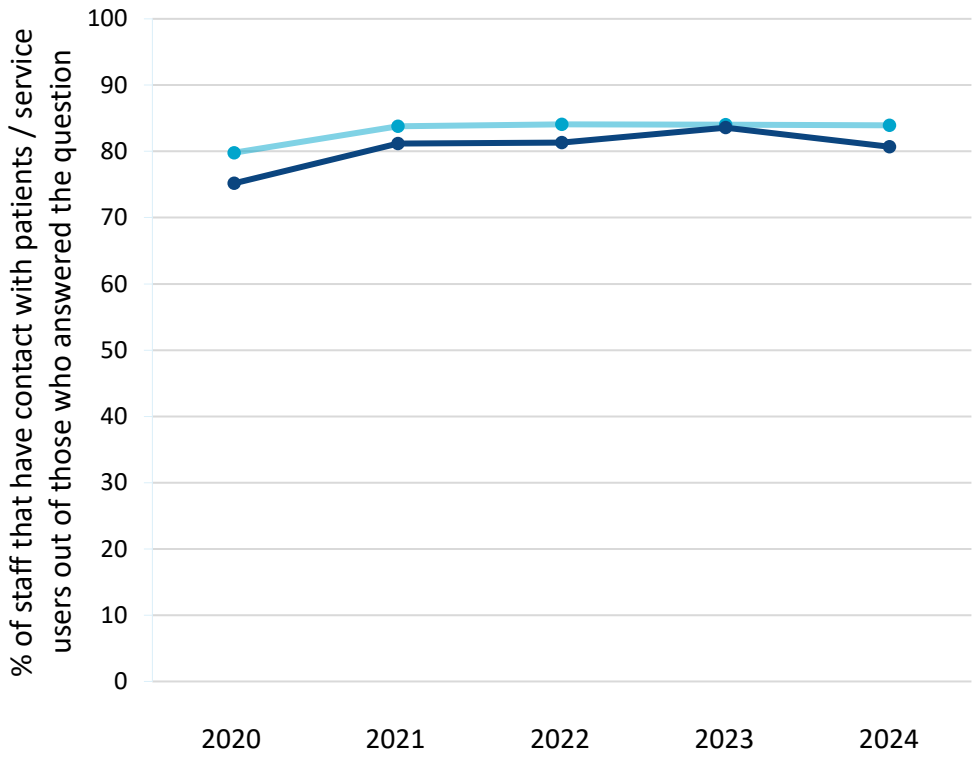
Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. The results for Q24f are reported in the section for People Promise element 5: We are always learning. These questions do not contribute to any score or sub-score calculations.

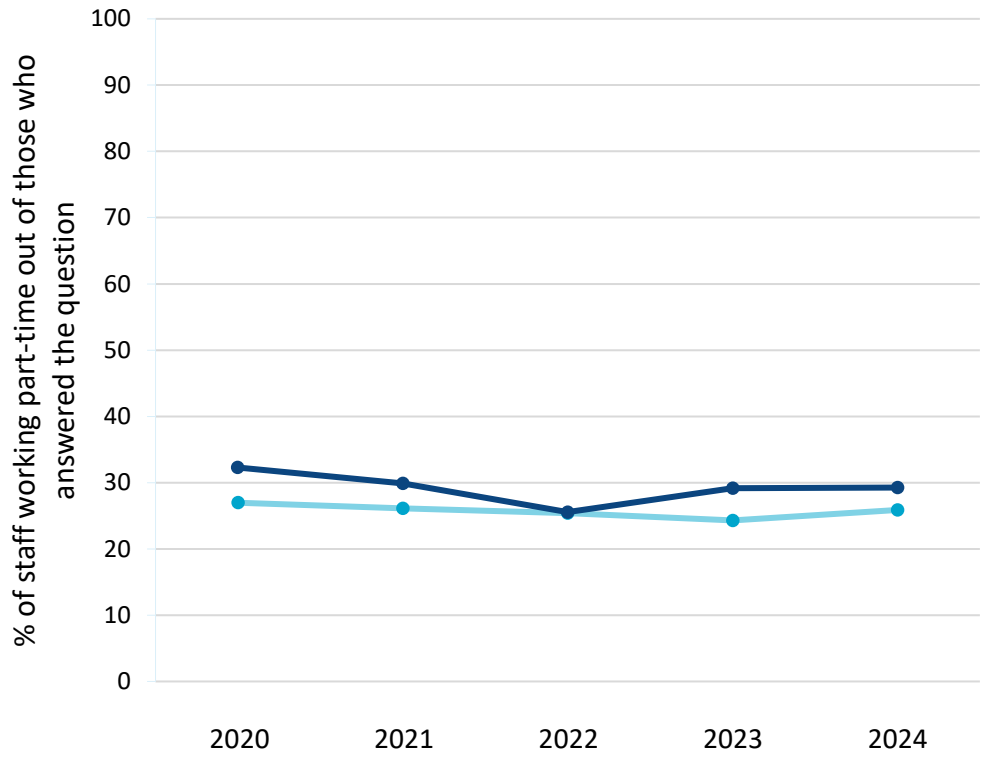
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



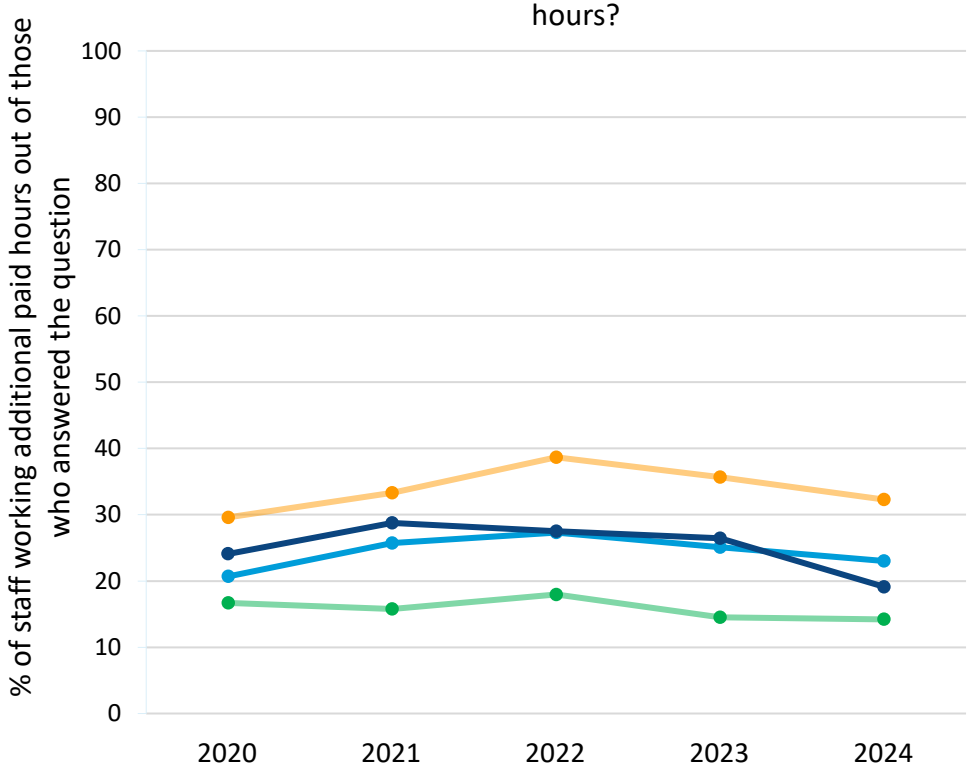
	2020	2021	2022	2023	2024
Your org	75.18%	81.19%	81.32%	83.57%	80.67%
Average	79.80%	83.78%	84.08%	84.05%	83.95%
Responses	822	978	910	1041	921

Q10a How many hours a week are you contracted to work?



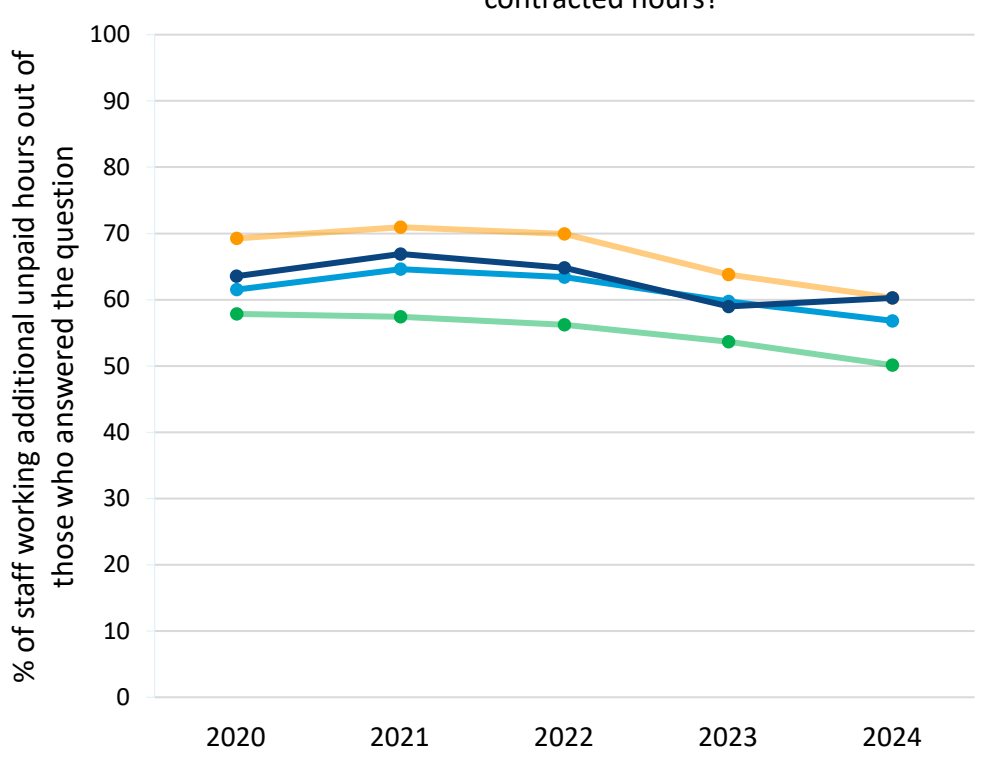
	2020	2021	2022	2023	2024
Your org	32.28%	29.88%	25.56%	29.14%	29.26%
Average	26.97%	26.14%	25.40%	24.30%	25.89%
Responses	762	937	892	1026	909

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



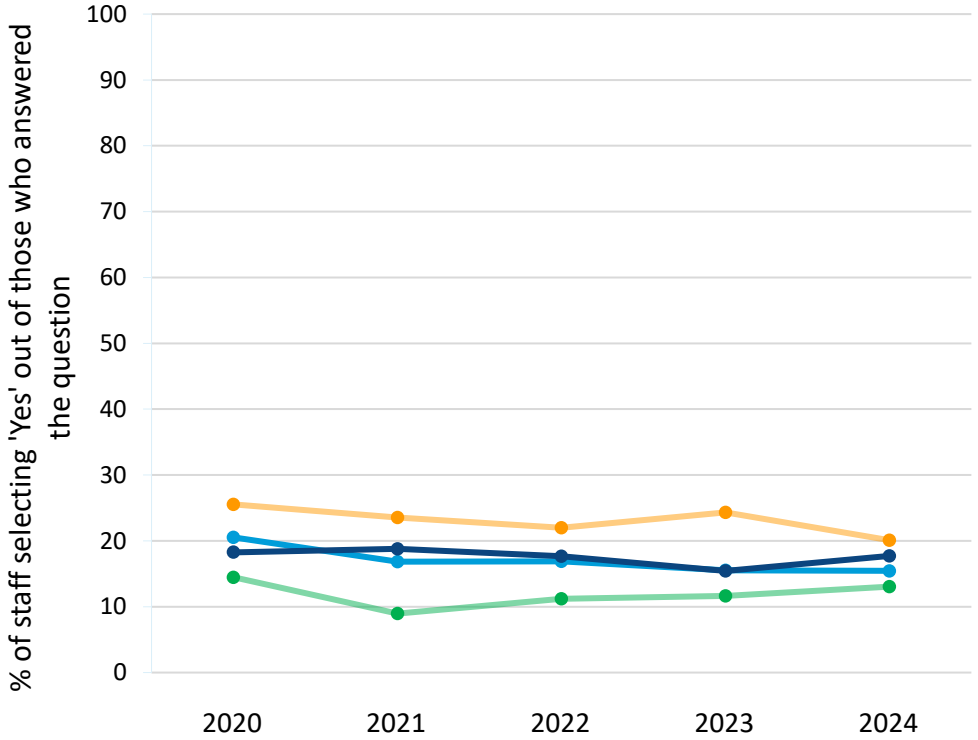
	2020	2021	2022	2023	2024
Your org	24.10%	28.76%	27.53%	26.46%	19.13%
Lowest	16.71%	15.76%	17.97%	14.54%	14.21%
Average	20.69%	25.72%	27.30%	25.08%	23.02%
Highest	29.60%	33.28%	38.67%	35.67%	32.28%
Responses	793	958	912	1044	924

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



	2020	2021	2022	2023	2024
Your org	63.54%	66.90%	64.81%	58.99%	60.29%
Lowest	57.86%	57.44%	56.24%	53.64%	50.11%
Average	61.52%	64.61%	63.41%	59.76%	56.81%
Highest	69.26%	70.95%	69.91%	63.82%	60.29%
Responses	809	960	913	1035	921

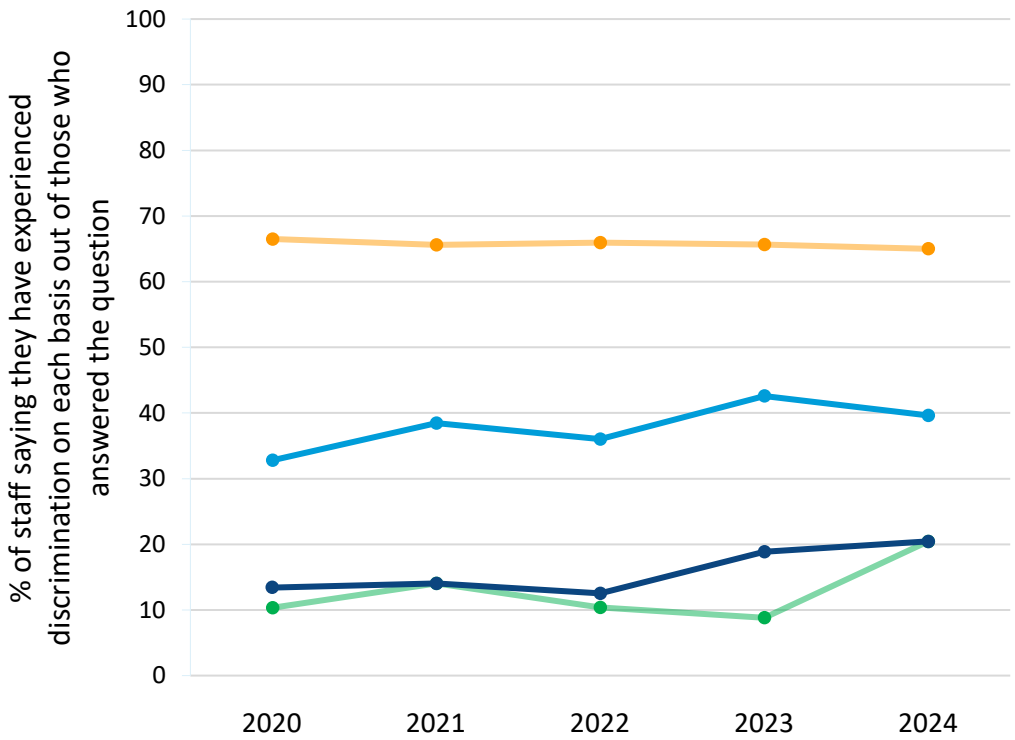
Q11e* Have you felt pressure from your manager to come to work?



	2020	2021	2022	2023	2024
Your org	18.25%	18.79%	17.69%	15.44%	17.72%
Best result	14.48%	8.95%	11.22%	11.63%	13.05%
Average result	20.53%	16.84%	16.90%	15.54%	15.45%
Worst result	25.54%	23.53%	22.00%	24.30%	20.10%
Responses	367	511	485	543	516

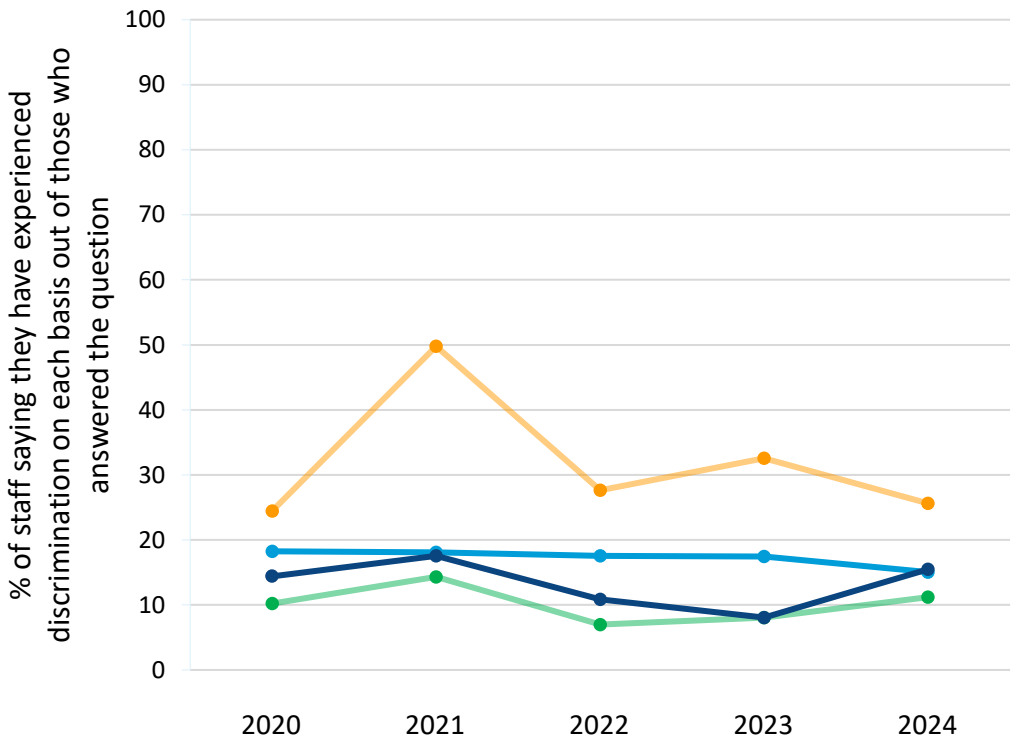
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.



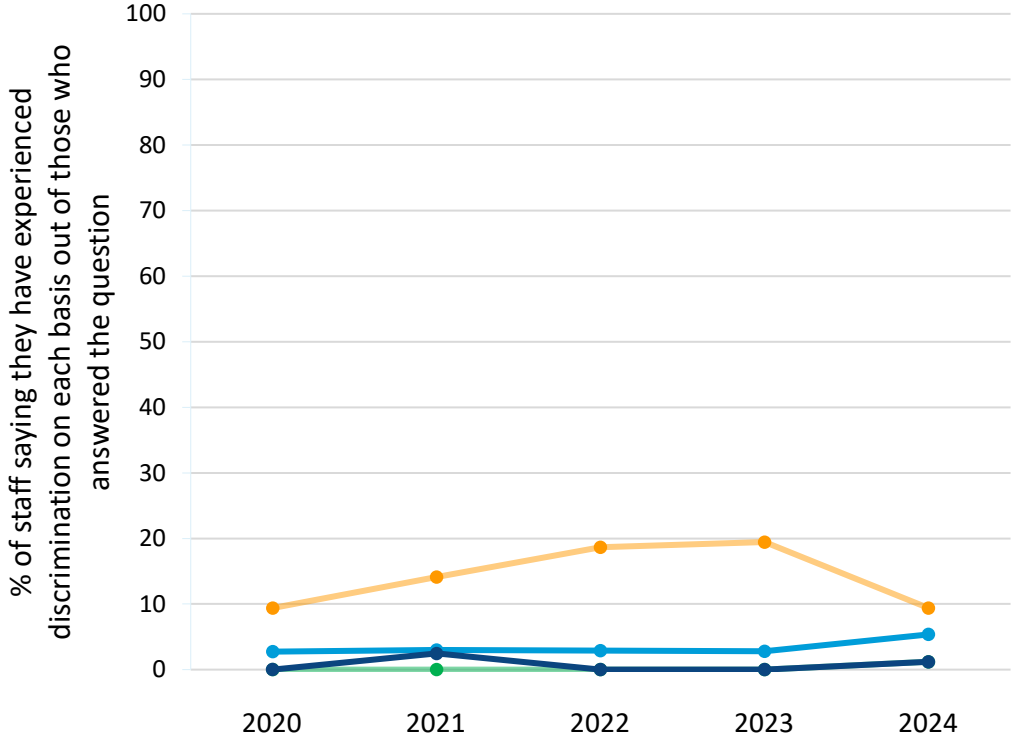
	2020	2021	2022	2023	2024
Your org	13.42%	14.03%	12.53%	18.85%	20.45%
Best result	10.34%	14.03%	10.39%	8.81%	20.45%
Average result	32.79%	38.47%	36.01%	42.58%	39.64%
Worst result	66.50%	65.62%	65.95%	65.67%	65.00%
Responses	55	65	60	63	65

Q16c.2 On what grounds have you experienced discrimination? – Gender.



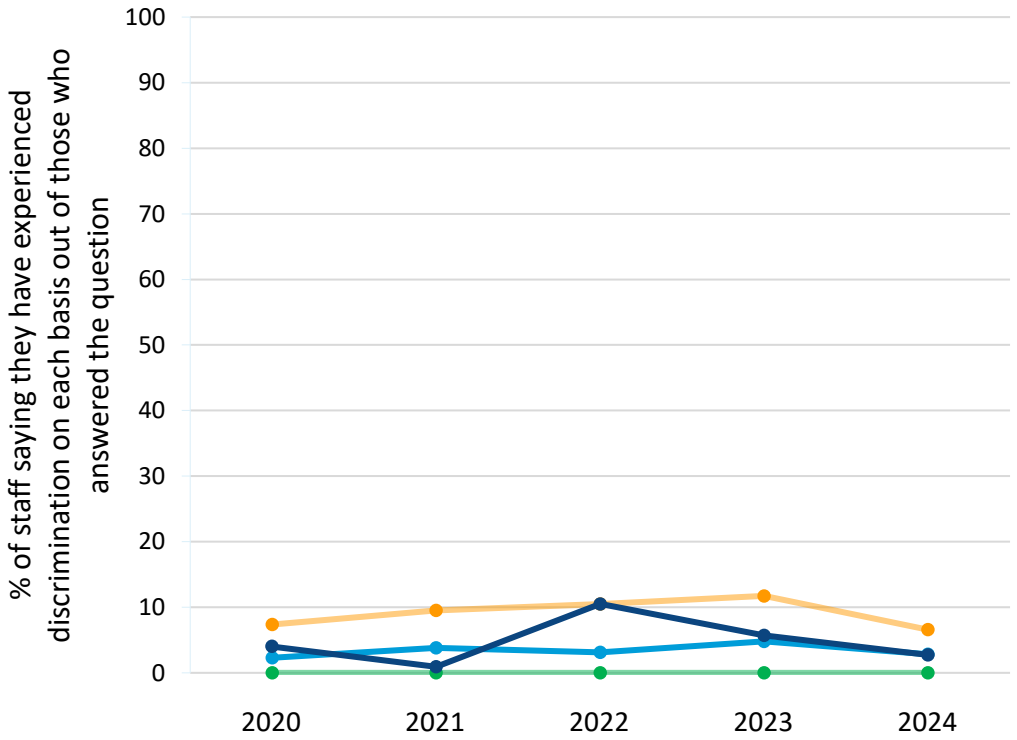
	2020	2021	2022	2023	2024
Your org	14.41%	17.54%	10.85%	8.06%	15.45%
Best result	10.23%	14.32%	6.98%	8.06%	11.20%
Average result	18.25%	18.08%	17.57%	17.45%	15.05%
Worst result	24.46%	49.77%	27.64%	32.54%	25.60%
Responses	55	65	60	63	65

Q16c.3 On what grounds have you experienced discrimination? – Religion.



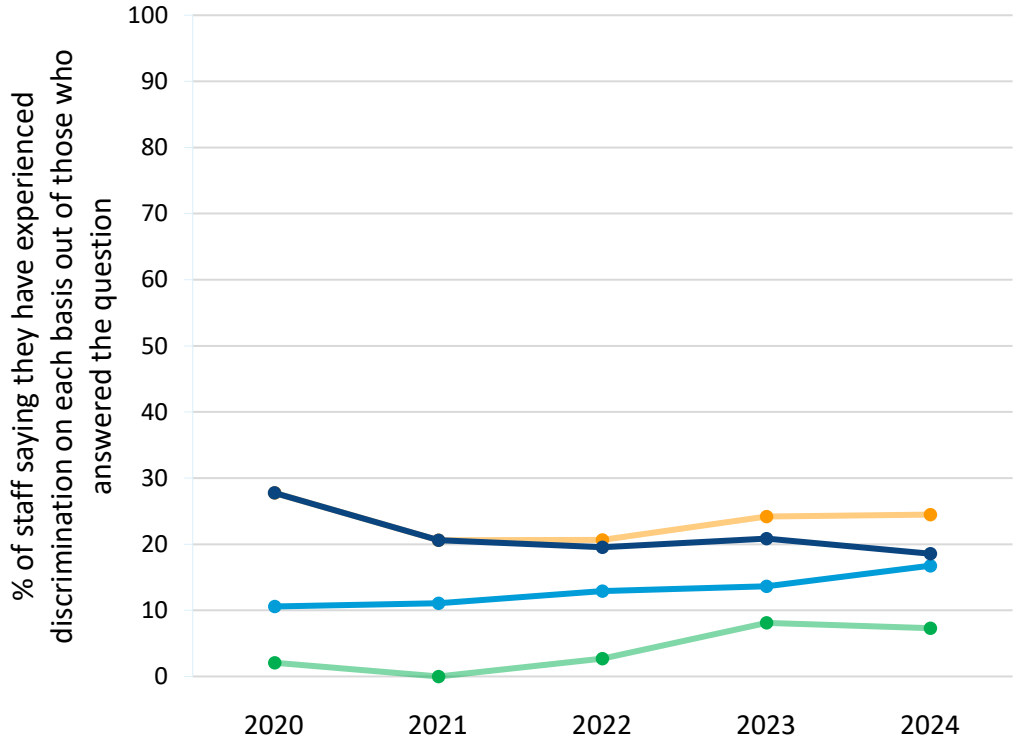
	2020	2021	2022	2023	2024
Your org	0.00%	2.47%	0.00%	0.00%	1.20%
Best result	0.00%	0.00%	0.00%	0.00%	1.20%
Average result	2.74%	3.01%	2.89%	2.81%	5.36%
Worst result	9.40%	14.13%	18.64%	19.45%	9.38%
Responses	55	65	60	63	65

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



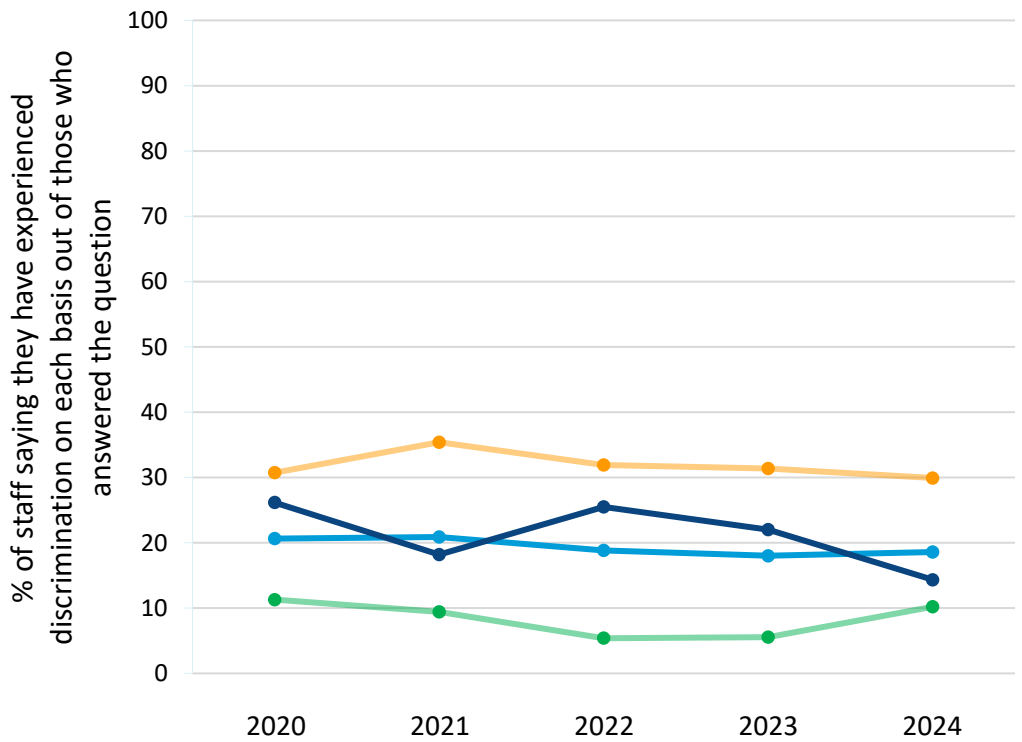
	2020	2021	2022	2023	2024
Your org	4.03%	0.92%	10.51%	5.69%	2.75%
Best result	0.00%	0.00%	0.00%	0.00%	0.00%
Average result	2.30%	3.80%	3.12%	4.80%	2.85%
Worst result	7.39%	9.51%	10.51%	11.74%	6.58%
Responses	55	65	60	63	65

Q16c.5 On what grounds have you experienced discrimination? – Disability.



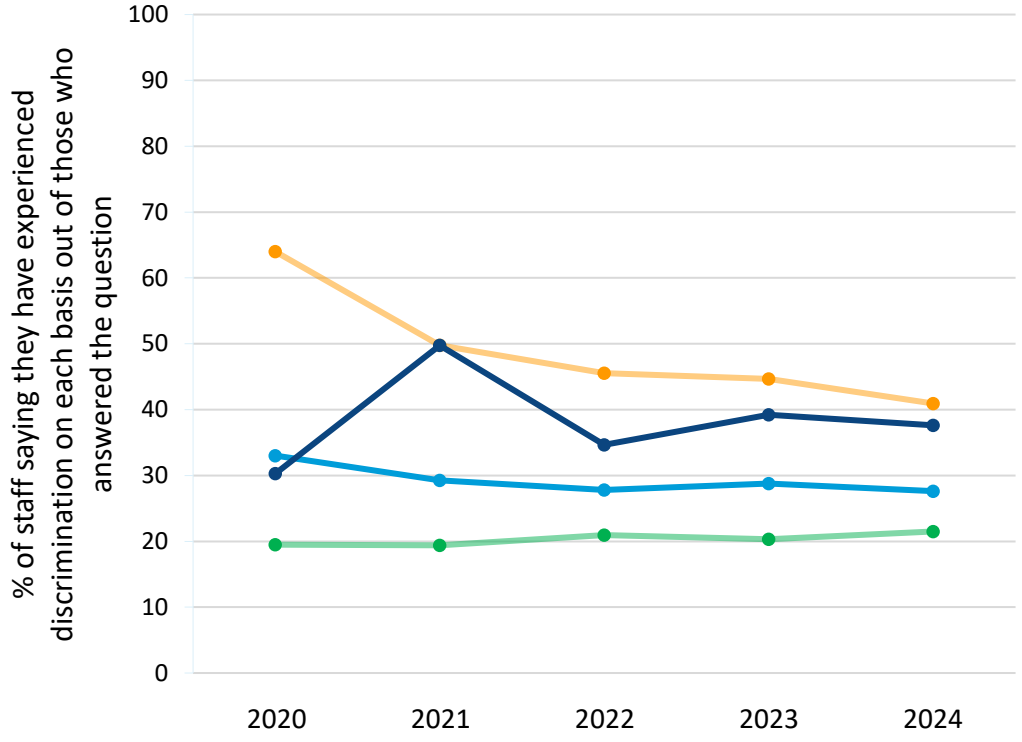
	2020	2021	2022	2023	2024
Your org	27.75%	20.60%	19.55%	20.83%	18.56%
Best result	2.07%	0.00%	2.69%	8.10%	7.28%
Average result	10.59%	11.10%	12.91%	13.62%	16.76%
Worst result	27.75%	20.60%	20.65%	24.17%	24.49%
Responses	55	65	60	63	65

Q16c.6 On what grounds have you experienced discrimination? – Age.



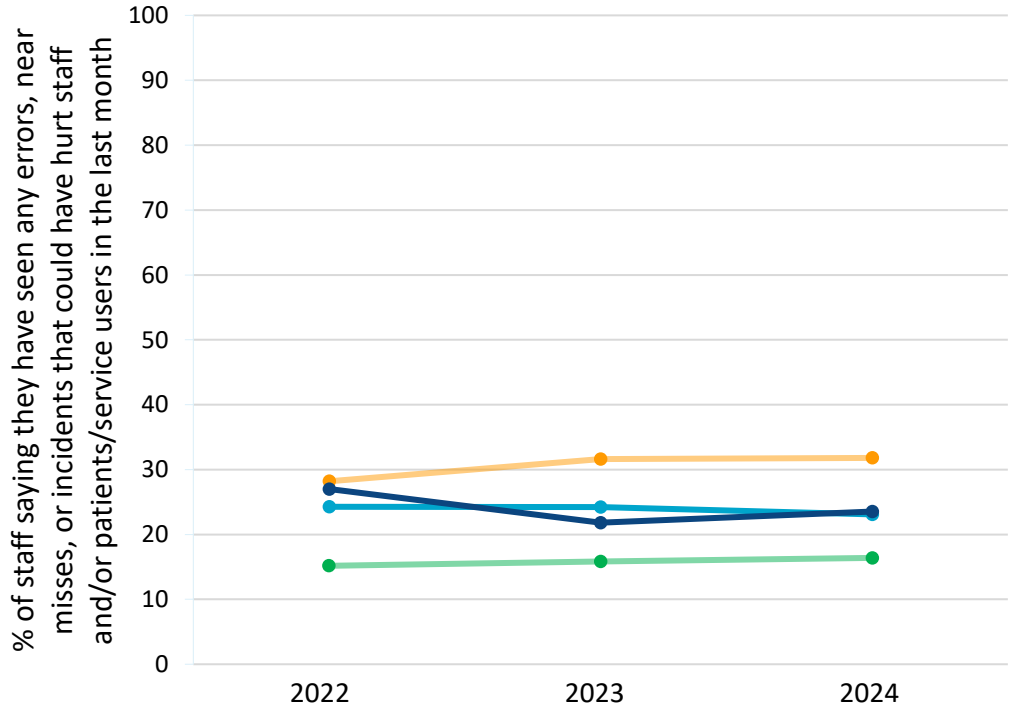
	2020	2021	2022	2023	2024
Your org	26.15%	18.18%	25.48%	22.02%	14.34%
Best result	11.30%	9.42%	5.38%	5.55%	10.23%
Average result	20.67%	20.89%	18.83%	18.02%	18.60%
Worst result	30.75%	35.40%	31.90%	31.39%	29.93%
Responses	55	65	60	63	65

Q16c.7 On what grounds have you experienced discrimination? – Other.



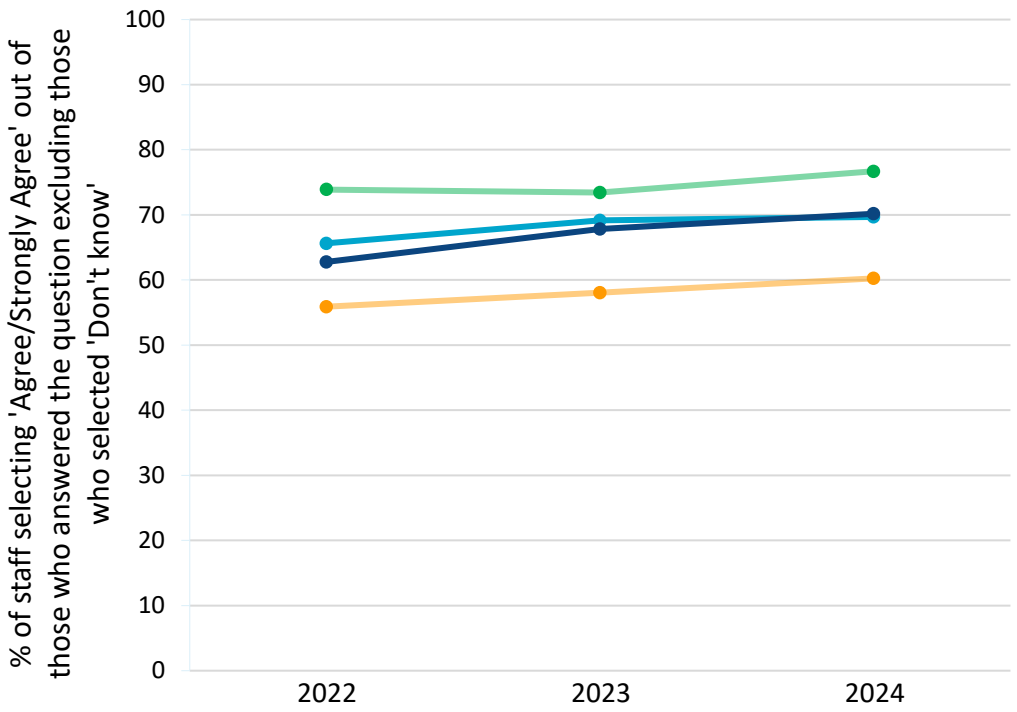
	2020	2021	2022	2023	2024
Your org	30.28%	49.75%	34.64%	39.24%	37.60%
Best result	19.51%	19.40%	20.96%	20.34%	21.50%
Average result	33.02%	29.24%	27.79%	28.77%	27.62%
Worst result	64.01%	49.75%	45.52%	44.65%	40.93%
Responses	55	65	60	63	65

Q18 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



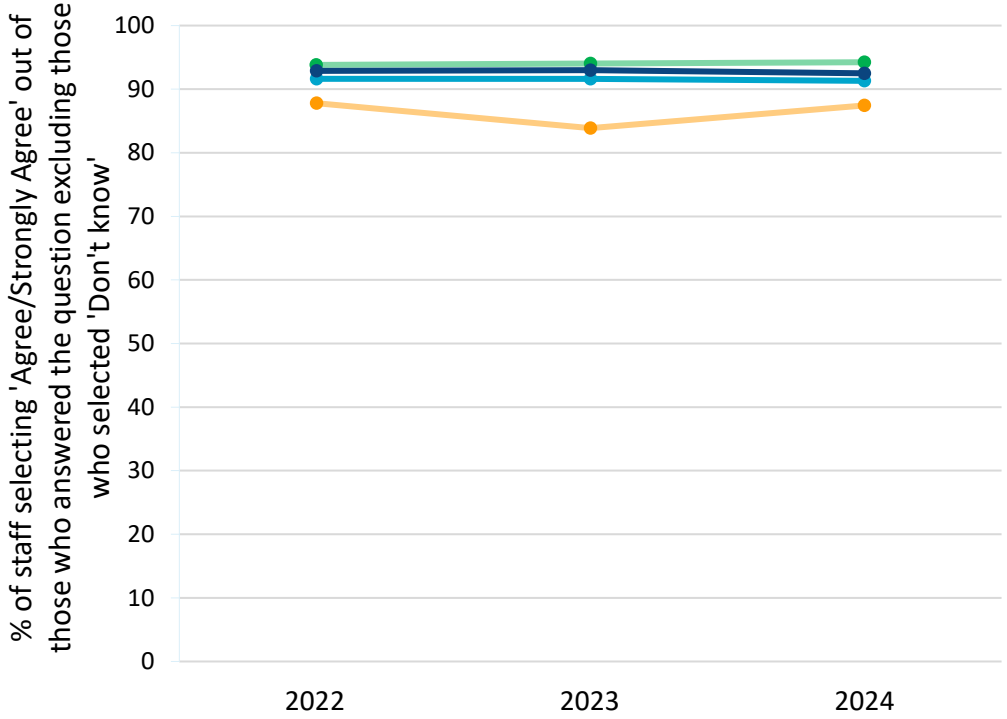
	2022	2023	2024
Your org	27.00%	21.82%	23.55%
Best result	15.17%	15.84%	16.39%
Average result	24.27%	24.21%	23.09%
Worst result	28.20%	31.62%	31.79%
Responses	898	1027	915

Q19a My organisation treats staff who are involved in an error, near miss or incident fairly.



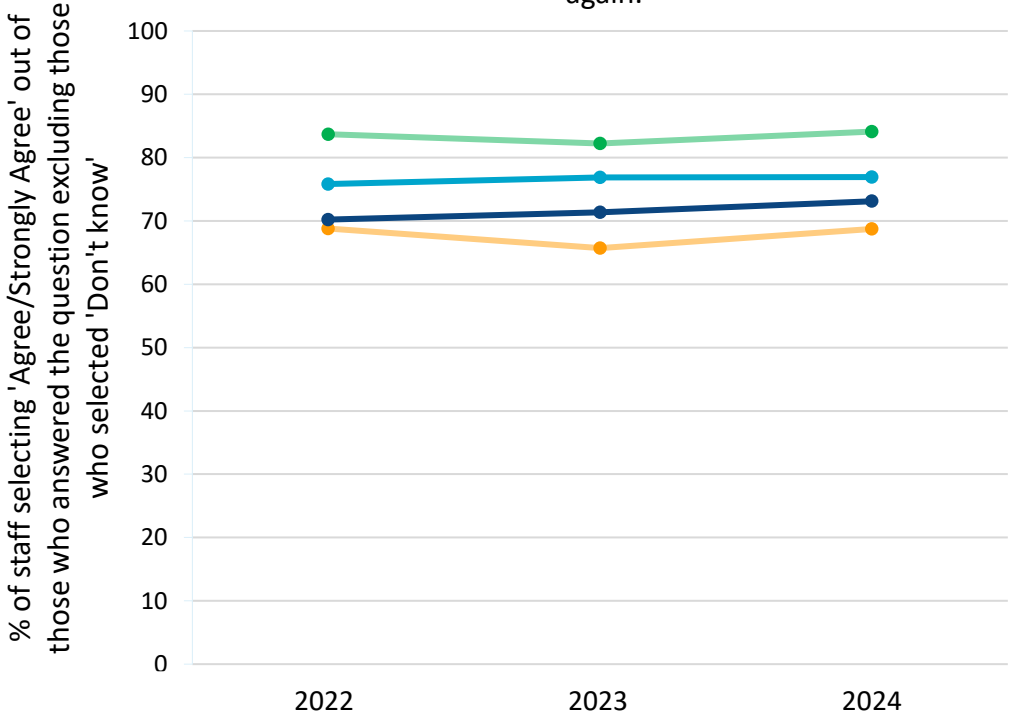
	2022	2023	2024
Your org	62.78%	67.84%	70.17%
Best result	73.90%	73.43%	76.70%
Average result	65.64%	69.15%	69.69%
Worst result	55.90%	58.06%	60.25%
Responses	709	809	711

Q19b My organisation encourages us to report errors, near misses or incidents.



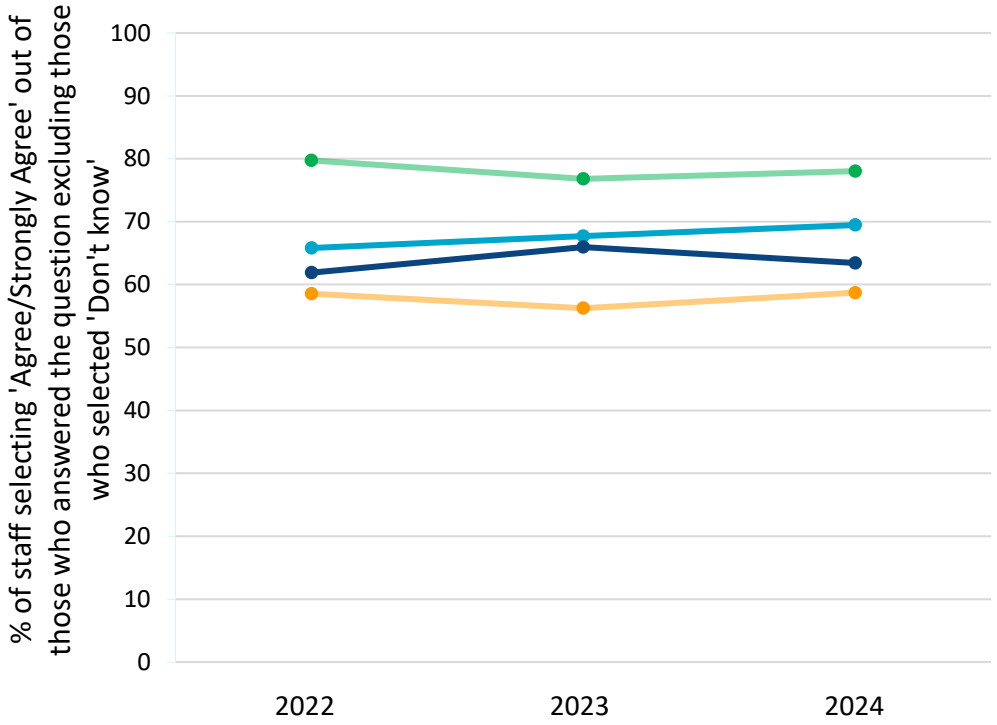
	2022	2023	2024
Your org	92.88%	92.99%	92.49%
Best result	93.81%	94.01%	94.23%
Average result	91.63%	91.61%	91.31%
Worst result	87.79%	83.87%	87.45%
Responses	892	1015	900

Q19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



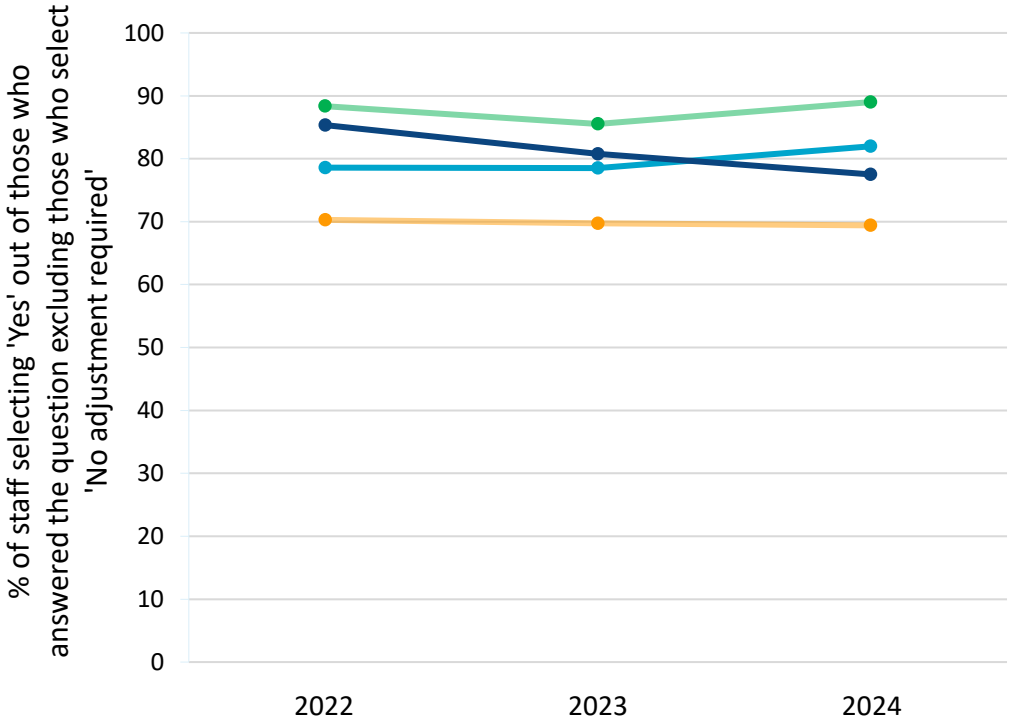
	2022	2023	2024
Your org	70.22%	71.38%	73.11%
Best result	83.67%	82.23%	84.11%
Average result	75.83%	76.87%	76.93%
Worst result	68.80%	65.71%	68.75%
Responses	800	915	825

Q19d We are given feedback about changes made in response to reported errors, near misses and incidents.



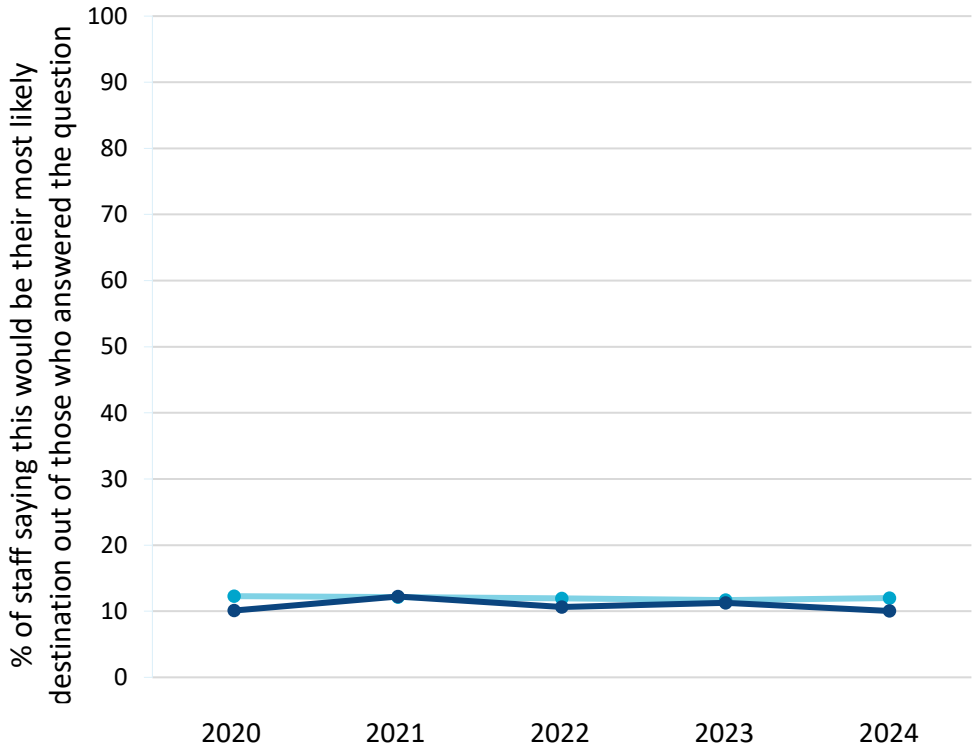
	2022	2023	2024
Your org	61.90%	65.96%	63.41%
Best result	79.74%	76.81%	78.01%
Average result	65.82%	67.71%	69.47%
Worst result	58.57%	56.24%	58.72%
Responses	815	952	836

Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work?



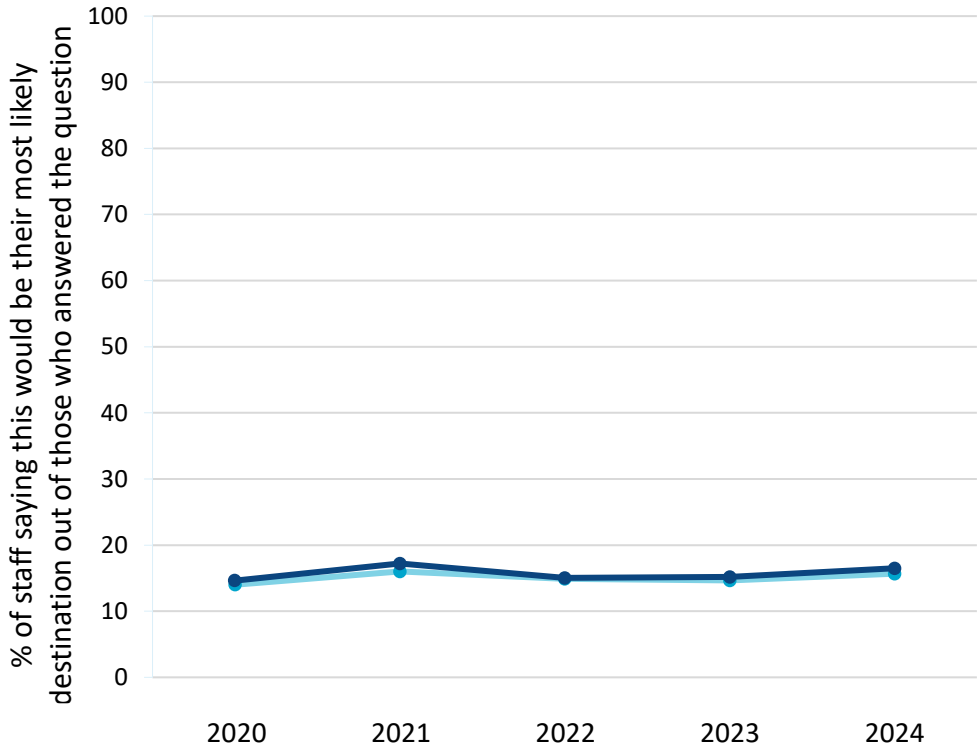
	2022	2023	2024
Your org	85.35%	80.78%	77.51%
Best result	88.38%	85.53%	89.01%
Average result	78.59%	78.52%	81.98%
Worst result	70.29%	69.73%	69.42%
Responses	162	198	183

Q26d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



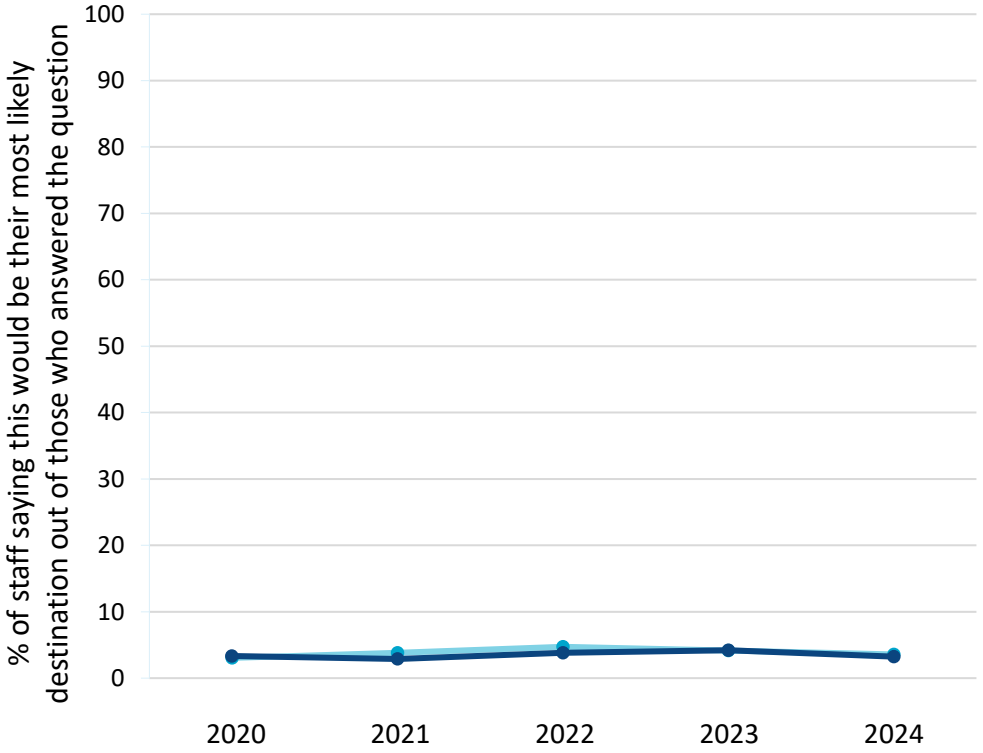
	2020	2021	2022	2023	2024
Your org	10.11%	12.22%	10.66%	11.27%	10.03%
Average	12.28%	12.16%	11.94%	11.68%	12.01%
Responses	752	900	863	976	867

Q26d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.



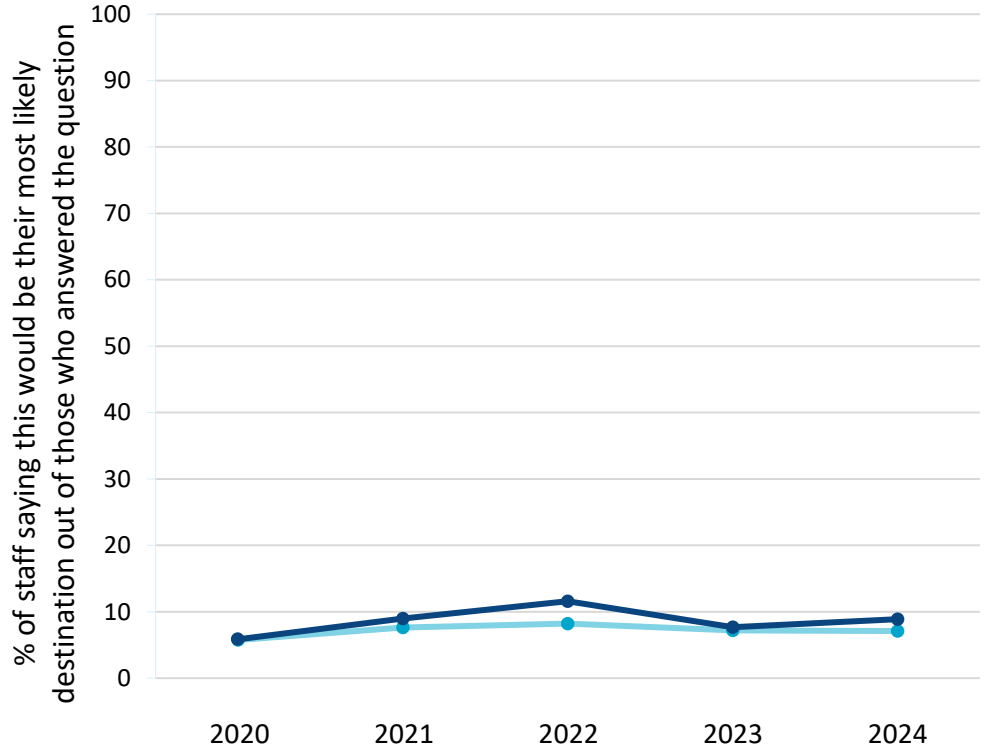
	2020	2021	2022	2023	2024
Your org	14.63%	17.22%	15.06%	15.16%	16.49%
Average	14.01%	16.02%	14.89%	14.65%	15.68%
Responses	752	900	863	976	867

Q26d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



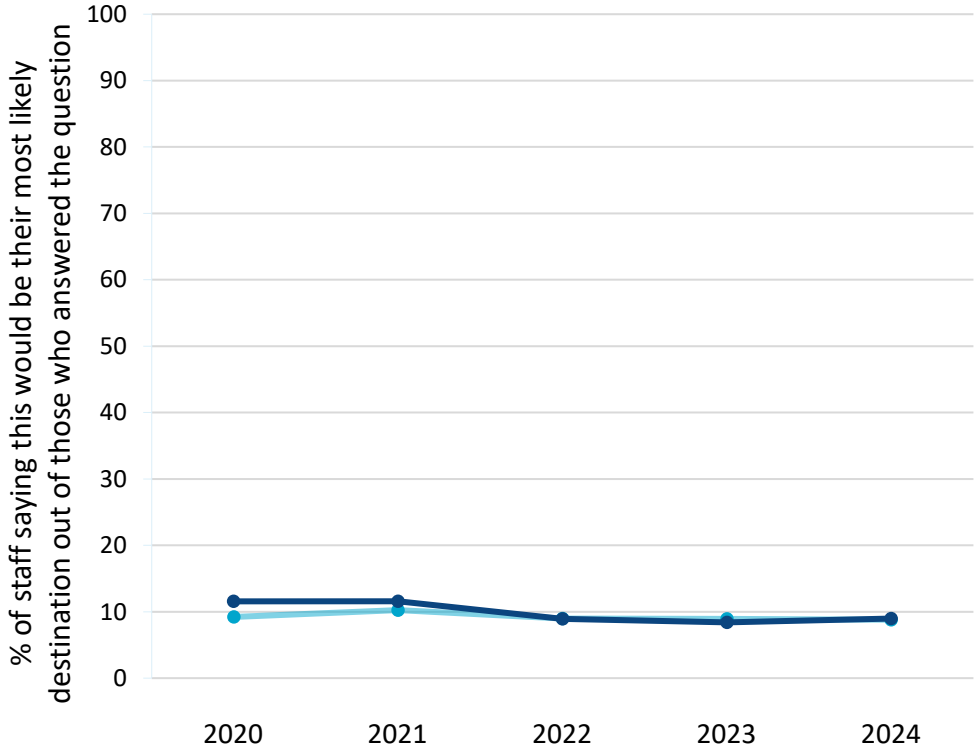
	2020	2021	2022	2023	2024
Your org	3.32%	2.89%	3.82%	4.20%	3.23%
Average	3.05%	3.84%	4.72%	4.15%	3.57%
Responses	752	900	863	976	867

Q26d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.



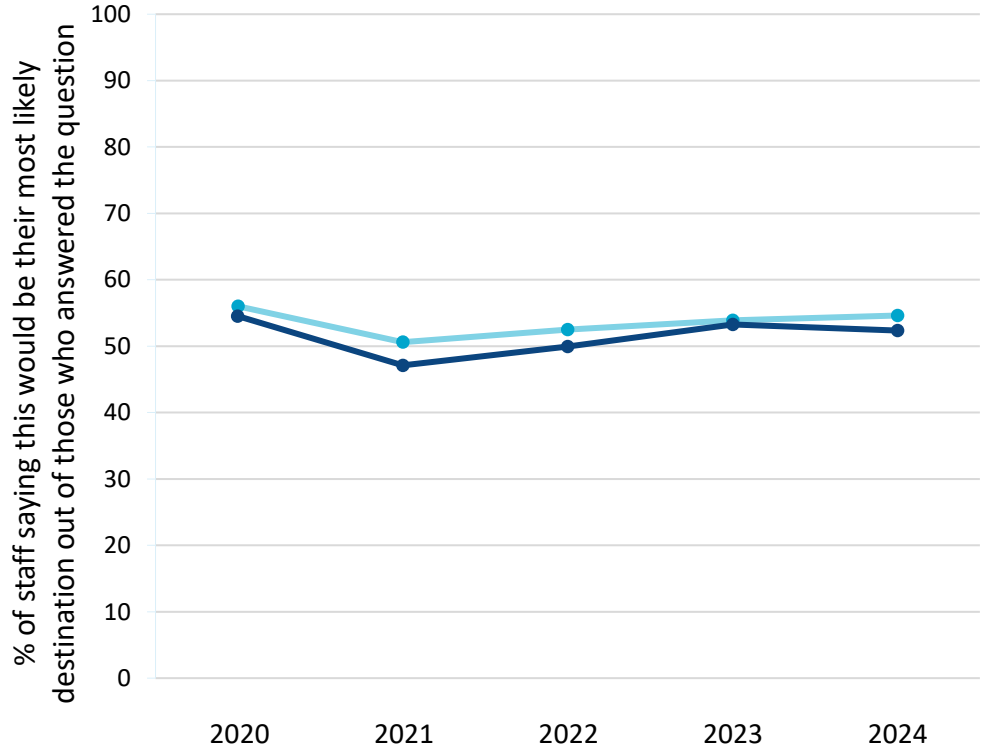
	2020	2021	2022	2023	2024
Your org	5.85%	9.00%	11.59%	7.68%	8.88%
Average	5.75%	7.62%	8.22%	7.20%	7.10%
Responses	752	900	863	976	867

Q26d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2020	2021	2022	2023	2024
Your org	11.57%	11.56%	8.92%	8.40%	9.00%
Average	9.20%	10.25%	8.99%	8.91%	8.80%
Responses	752	900	863	976	867

Q26d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2020	2021	2022	2023	2024
Your org	54.52%	47.11%	49.94%	53.28%	52.36%
Average	56.01%	50.60%	52.49%	53.91%	54.60%
Responses	752	900	863	976	867

Survey Coordination Centre

NHS

Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Equality Standards

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2020-2024 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey metrics used in the Workforce Disability Equality Standard (WDES). It includes the 2020-2024 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was changed to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Metric	Qu No	Workforce Disability Equality Standard
		For each of the following metrics, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

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Workforce Race Equality Standards (WRES)

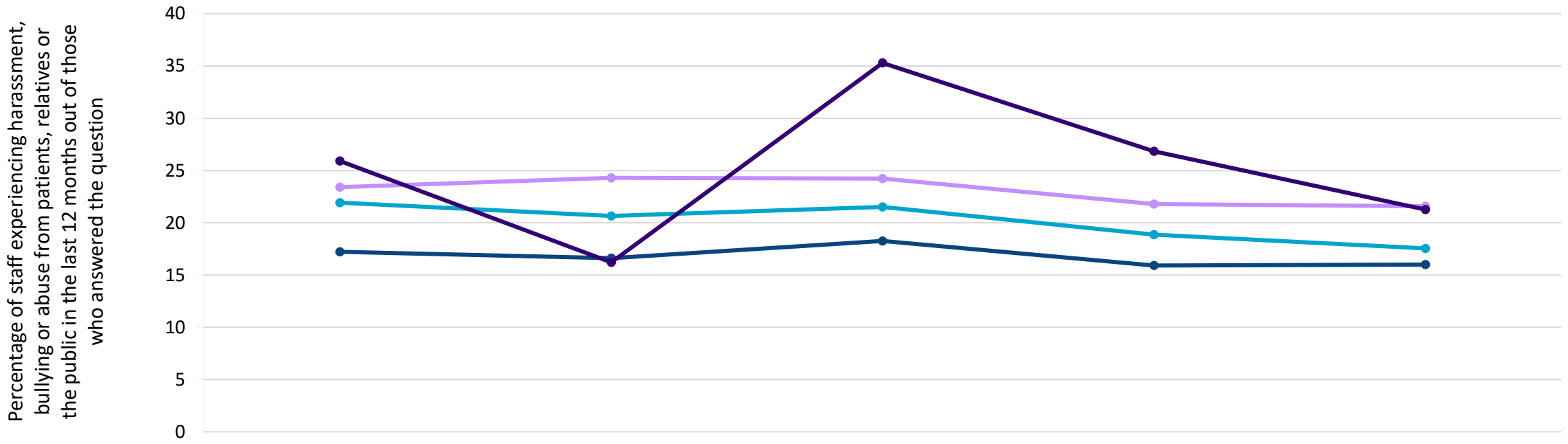
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



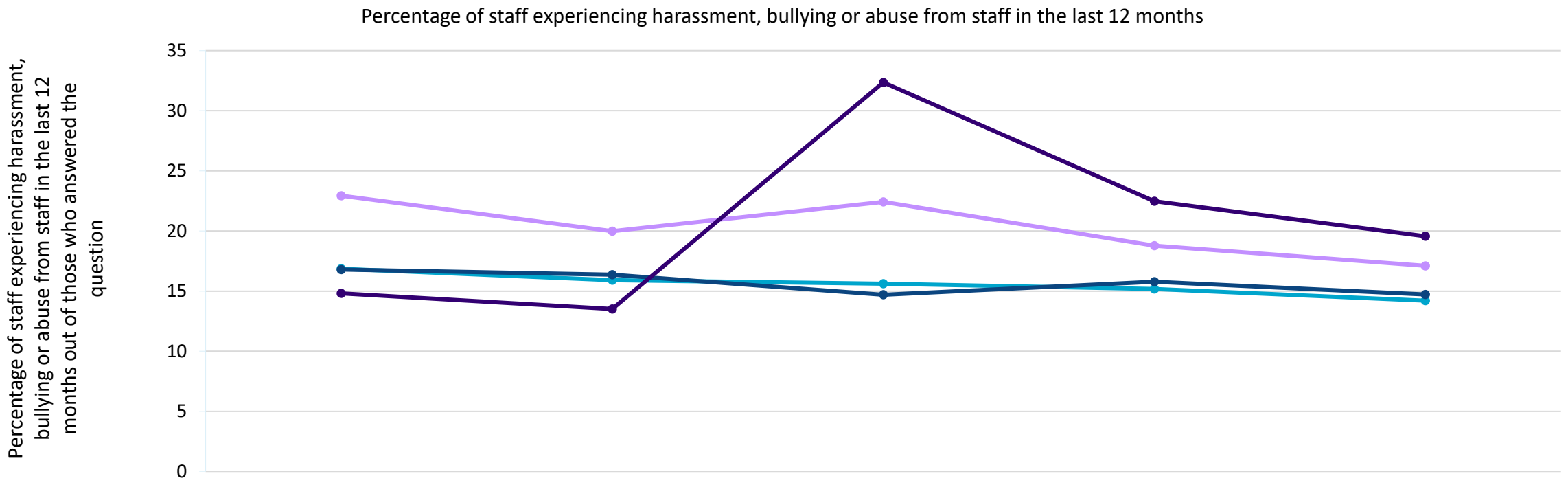
	2020	2021	2022	2023	2024
White staff: Your org	17.22%	16.61%	18.26%	15.91%	16.01%
All other ethnic groups*: Your org	25.93%	16.22%	35.29%	26.83%	21.28%
White staff: Average	21.93%	20.65%	21.52%	18.86%	17.55%
All other ethnic groups*: Average	23.41%	24.30%	24.24%	21.80%	21.59%
White staff: Responses	784	843	876	954	868
All other ethnic groups*: Responses	27	37	34	45	47

*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 5 (Q14a) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



	2020	2021	2022	2023	2024
White staff: Your org	16.79%	16.37%	14.70%	15.77%	14.71%
All other ethnic groups*: Your org	14.81%	13.51%	32.35%	22.47%	19.57%
White staff: Average	16.86%	15.91%	15.62%	15.19%	14.21%
All other ethnic groups*: Average	22.94%	19.99%	22.42%	18.79%	17.10%
White staff: Responses	786	843	871	954	870
All other ethnic groups*: Responses	27	37	34	45	46

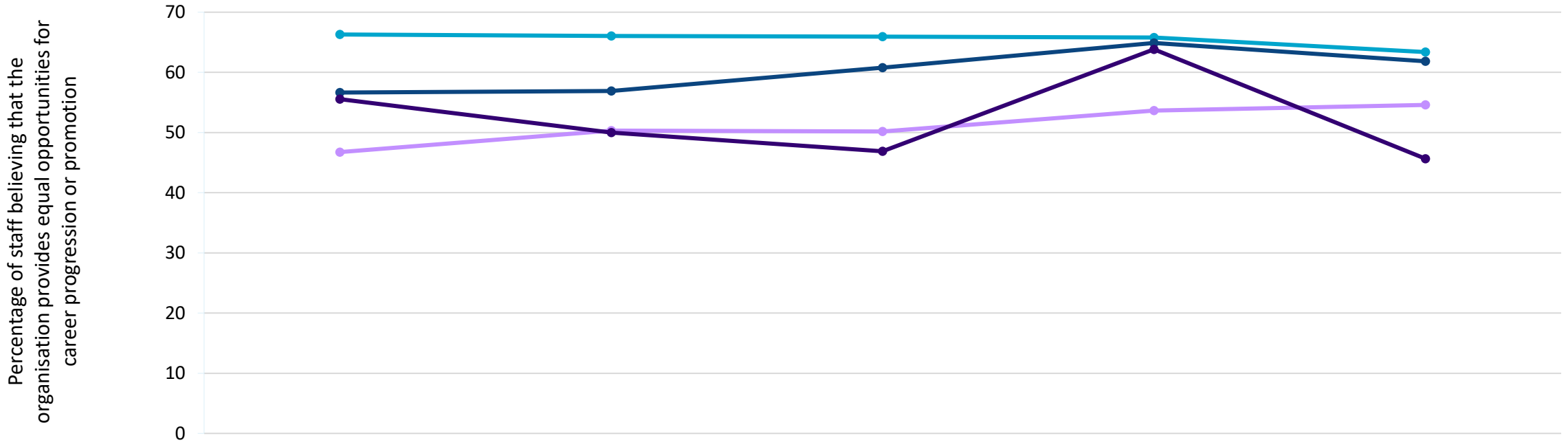
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 6 (Q14b & Q14c) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



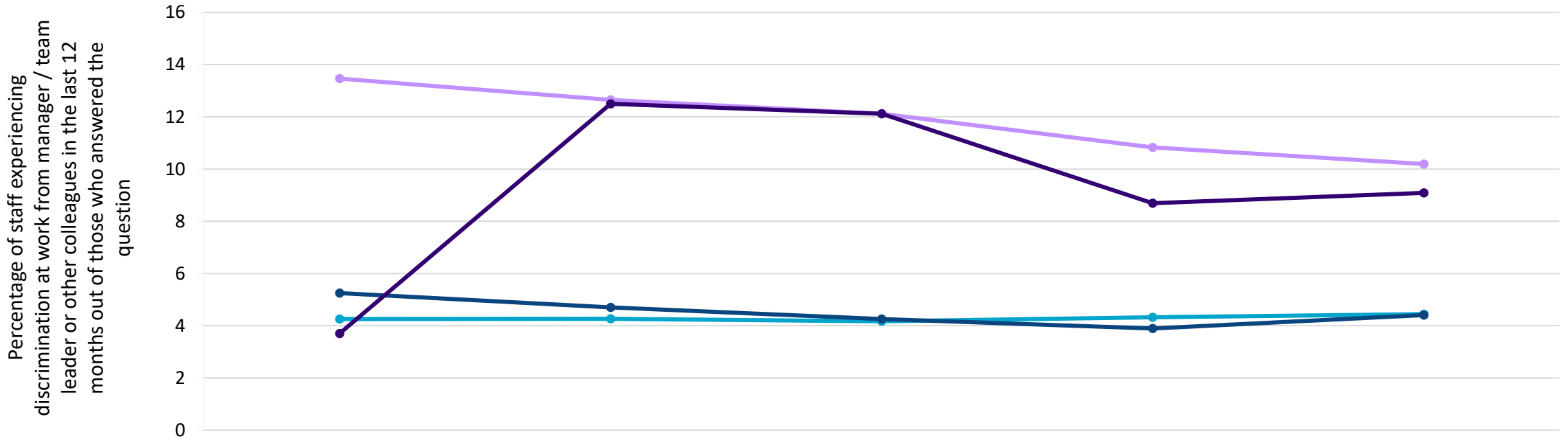
	2020	2021	2022	2023	2024
White staff: Your org	56.65%	56.90%	60.79%	64.89%	61.85%
All other ethnic groups*: Your org	55.56%	50.00%	46.88%	63.83%	45.65%
White staff: Average	66.30%	66.05%	65.92%	65.80%	63.37%
All other ethnic groups*: Average	46.75%	50.31%	50.18%	53.66%	54.59%
White staff: Responses	782	891	862	974	865
All other ethnic groups*: Responses	27	40	32	47	46

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2020	2021	2022	2023	2024
White staff: Your org	5.25%	4.70%	4.26%	3.89%	4.41%
All other ethnic groups*: Your org	3.70%	12.50%	12.12%	8.70%	9.09%
White staff: Average	4.26%	4.26%	4.17%	4.33%	4.44%
All other ethnic groups*: Average	13.46%	12.65%	12.12%	10.83%	10.19%
White staff: Responses	781	893	869	976	862
All other ethnic groups*: Responses	27	40	33	46	44

*Staff from all other ethnic groups combined

Survey Coordination Centre

NHS

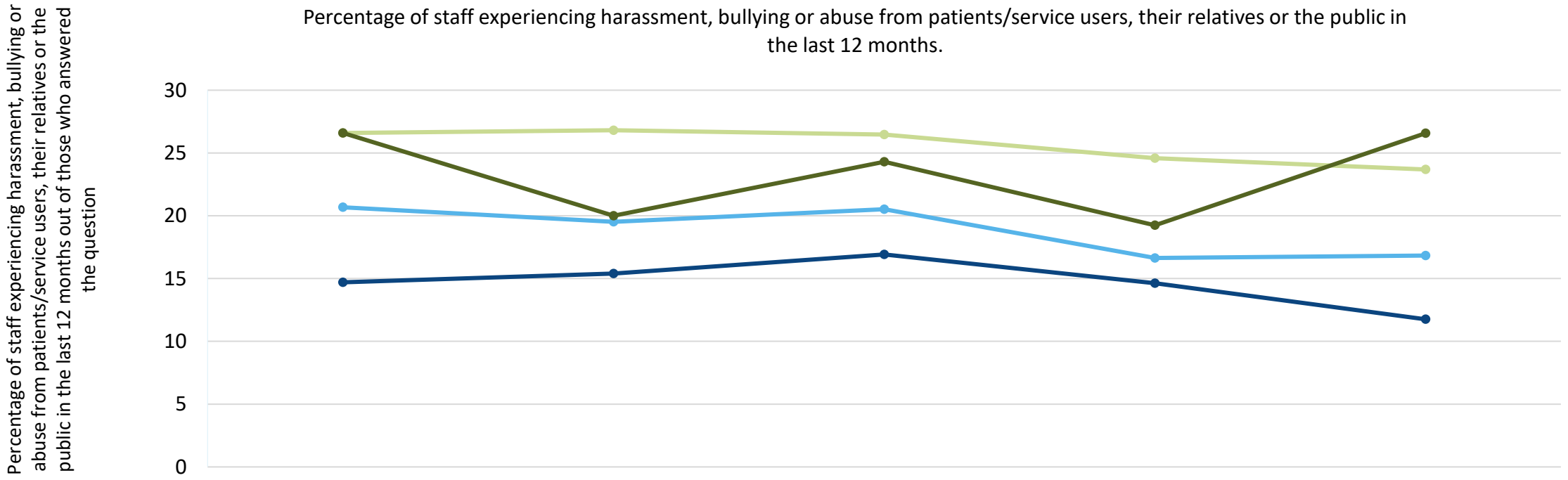
Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

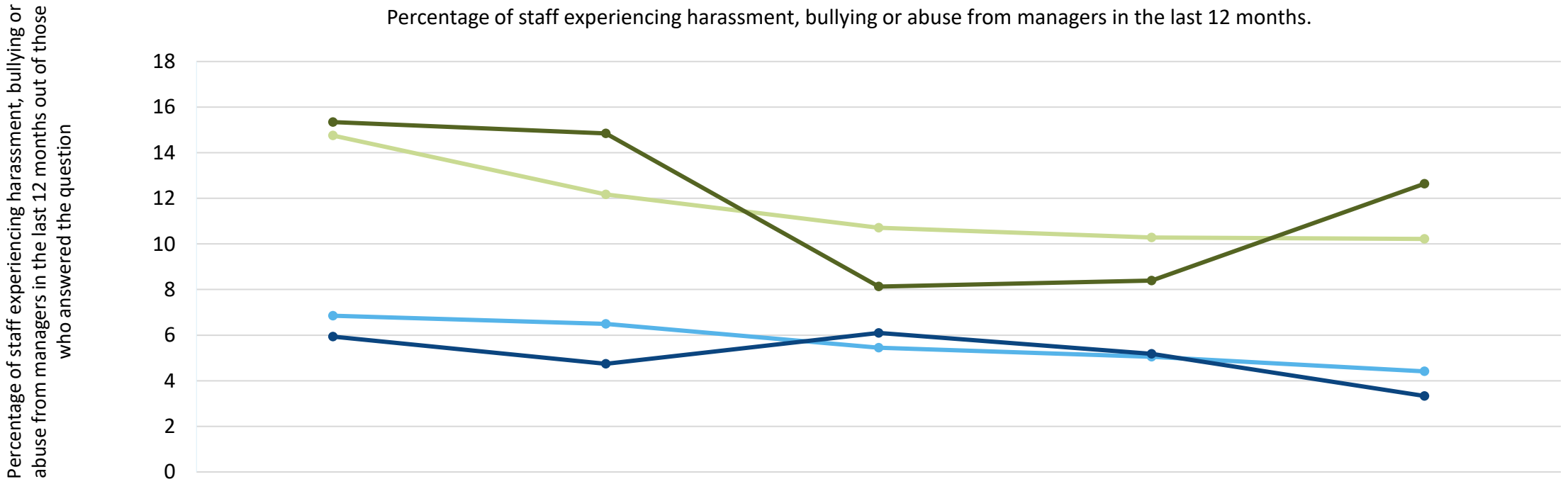


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	26.60%	20.00%	24.30%	19.24%	26.57%
Staff without a LTC or illness: Your org	14.70%	15.40%	16.92%	14.63%	11.76%
Staff with a LTC or illness: Average	26.60%	26.81%	26.46%	24.59%	23.69%
Staff without a LTC or illness: Average	20.67%	19.53%	20.51%	16.64%	16.83%
Staff with a LTC or illness: Responses	188	230	251	303	271
Staff without a LTC or illness: Responses	626	656	662	680	638

Note: 2023 results for WDES metric 4a (Q14a) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

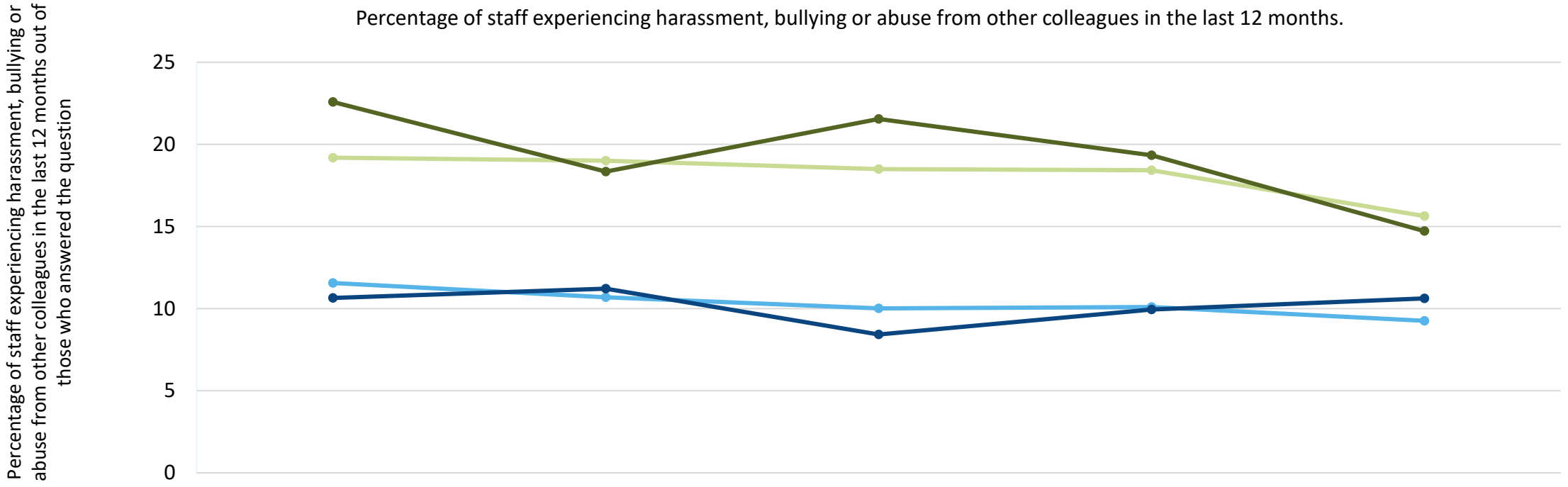


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	15.34%	14.85%	8.13%	8.39%	12.64%
Staff without a LTC or illness: Your org	5.94%	4.74%	6.10%	5.18%	3.33%
Staff with a LTC or illness: Average	14.75%	12.17%	10.71%	10.28%	10.22%
Staff without a LTC or illness: Average	6.85%	6.49%	5.45%	5.05%	4.41%
Staff with a LTC or illness: Responses	189	229	246	298	269
Staff without a LTC or illness: Responses	623	654	656	677	630

Note: 2023 results for WDES metric 4b (Q14b) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

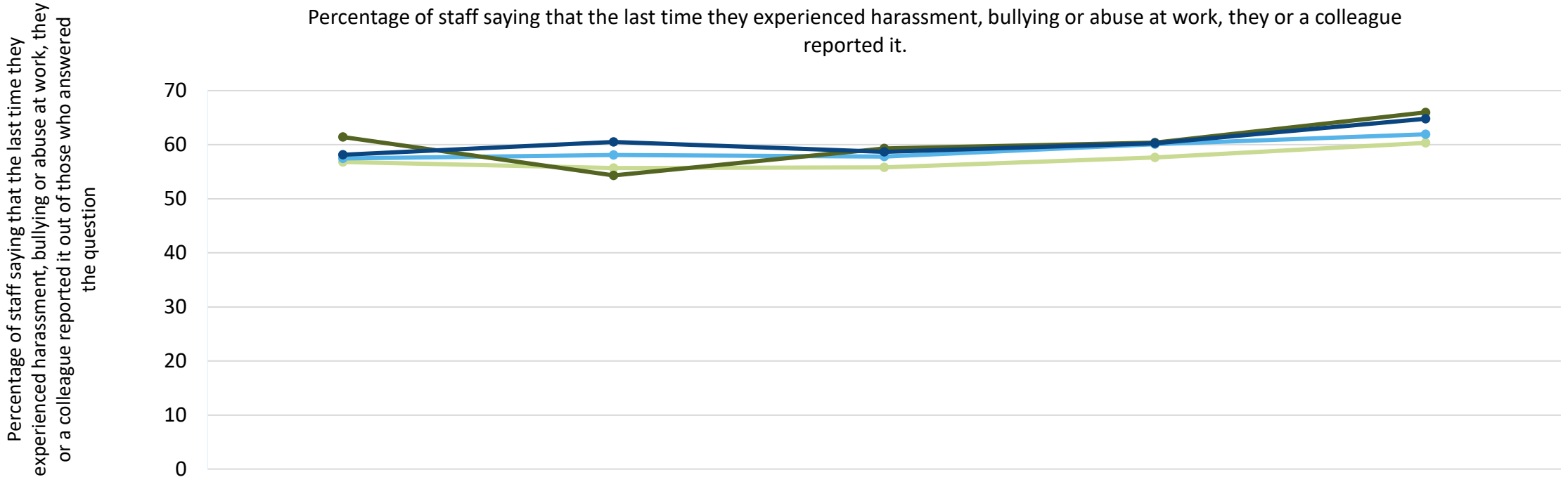


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	22.58%	18.34%	21.54%	19.34%	14.72%
Staff without a LTC or illness: Your org	10.65%	11.21%	8.42%	9.94%	10.62%
Staff with a LTC or illness: Average	19.19%	19.00%	18.49%	18.43%	15.63%
Staff without a LTC or illness: Average	11.56%	10.69%	10.01%	10.10%	9.26%
Staff with a LTC or illness: Responses	186	229	246	296	265
Staff without a LTC or illness: Responses	620	651	653	676	631

Note: 2023 results for WDES metric 4c (Q14c) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

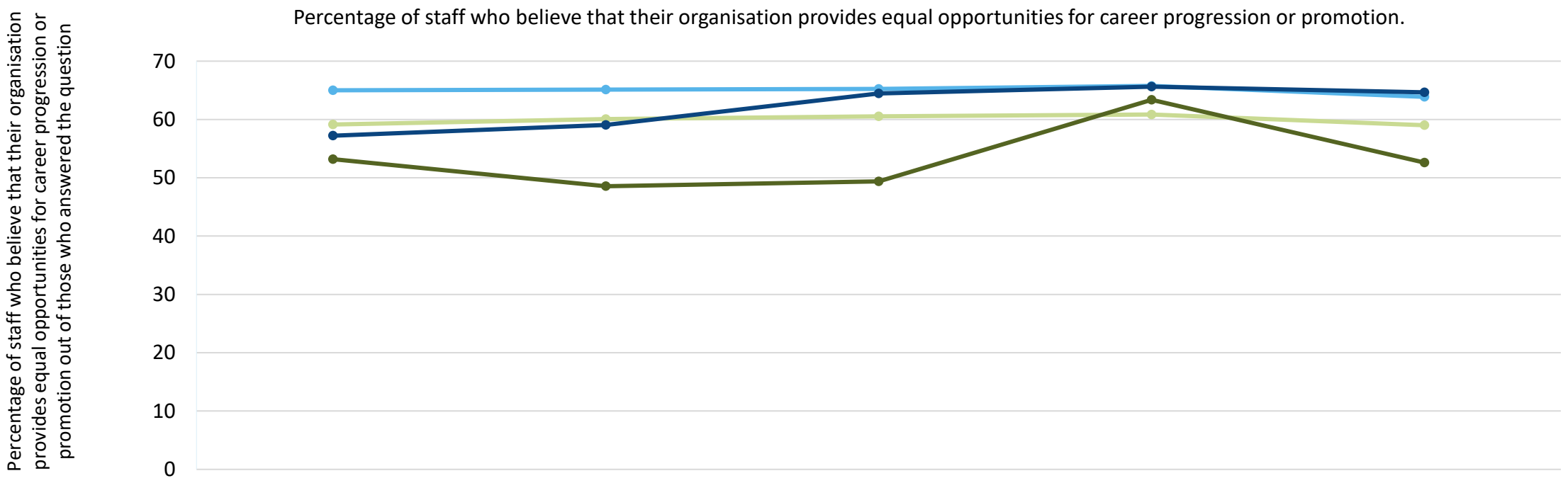


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	61.43%	54.32%	59.30%	60.39%	65.98%
Staff without a LTC or illness: Your org	58.14%	60.53%	58.70%	60.25%	64.80%
Staff with a LTC or illness: Average	56.81%	55.68%	55.80%	57.63%	60.34%
Staff without a LTC or illness: Average	57.46%	58.08%	57.82%	60.10%	61.93%
Staff with a LTC or illness: Responses	70	81	86	91	97
Staff without a LTC or illness: Responses	129	152	138	138	125

Note: 2023 results for WDES metric 4d (Q14d) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

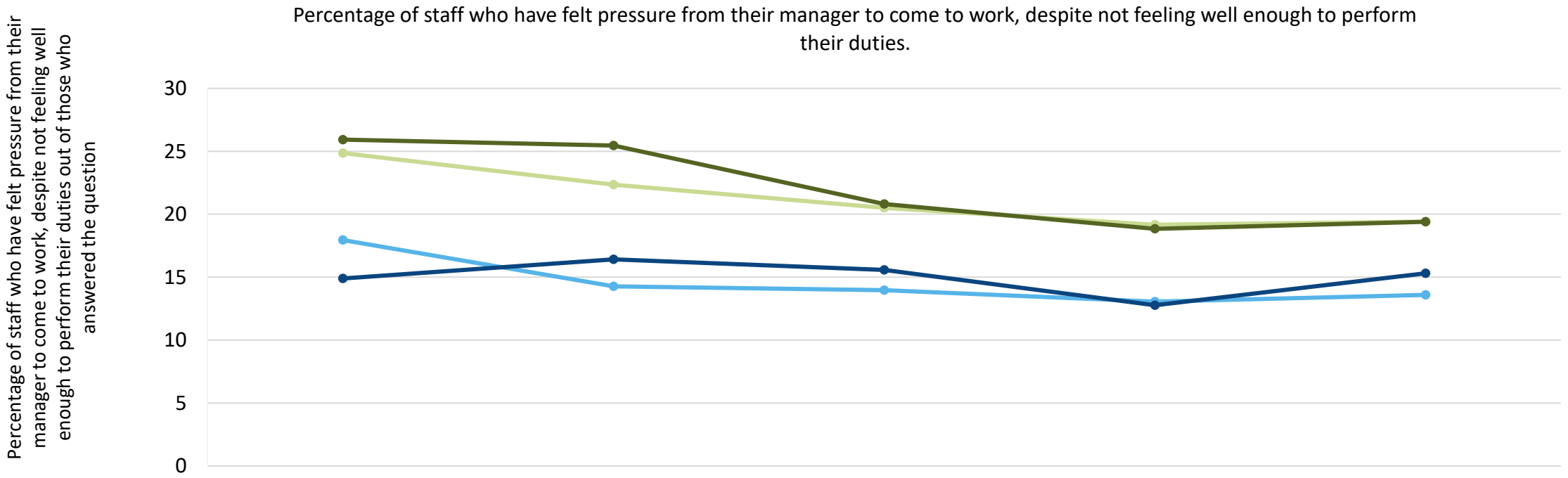


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	53.19%	48.55%	49.39%	63.37%	52.59%
Staff without a LTC or illness: Your org	57.21%	59.05%	64.46%	65.62%	64.67%
Staff with a LTC or illness: Average	59.15%	60.09%	60.54%	60.85%	59.01%
Staff without a LTC or illness: Average	65.01%	65.12%	65.22%	65.75%	63.87%
Staff with a LTC or illness: Responses	188	241	247	303	270
Staff without a LTC or illness: Responses	624	696	650	701	634

Workforce Disability Equality Standards

Survey Coordination Centre NHS

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



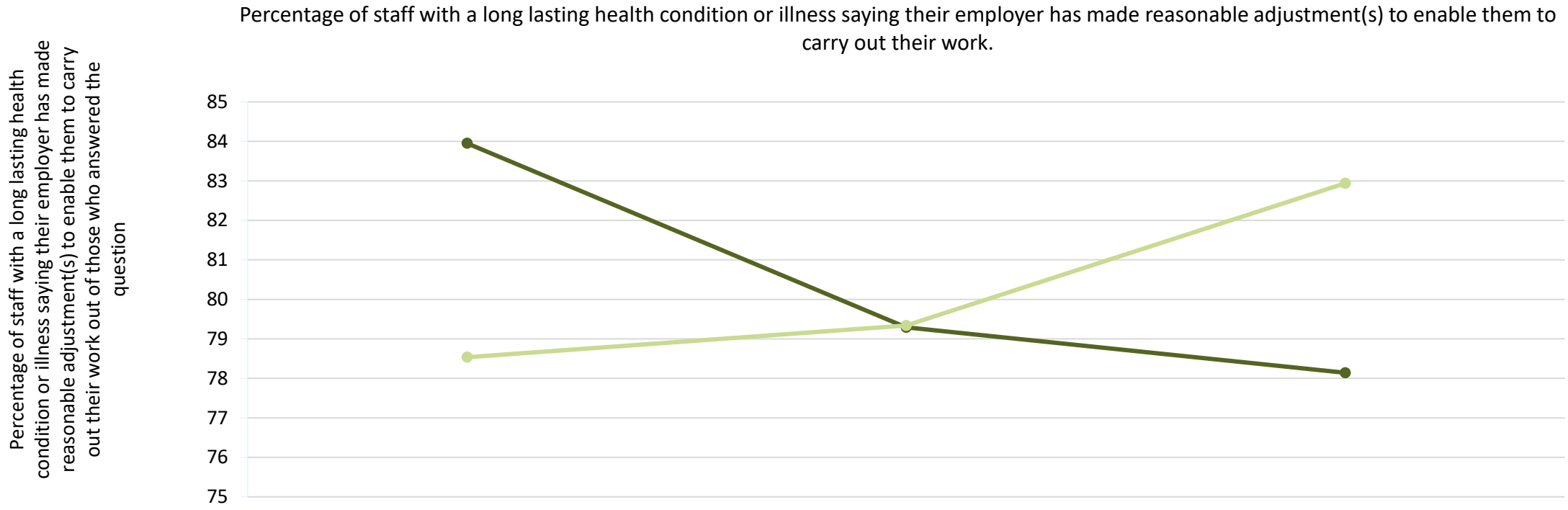
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	25.93%	25.45%	20.81%	18.84%	19.40%
Staff without a LTC or illness: Your org	14.90%	16.42%	15.58%	12.77%	15.31%
Staff with a LTC or illness: Average	24.86%	22.35%	20.51%	19.16%	19.41%
Staff without a LTC or illness: Average	17.95%	14.27%	13.97%	13.06%	13.60%
Staff with a LTC or illness: Responses	108	165	173	207	201
Staff without a LTC or illness: Responses	255	335	308	321	307

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	42.55%	34.85%	38.65%	42.48%	34.93%
Staff without a LTC or illness: Your org	48.40%	44.13%	45.23%	52.62%	52.04%
Staff with a LTC or illness: Average	47.49%	42.95%	44.69%	46.35%	43.85%
Staff without a LTC or illness: Average	56.14%	54.16%	54.77%	56.49%	54.36%
Staff with a LTC or illness: Responses	188	241	251	306	272
Staff without a LTC or illness: Responses	626	698	661	705	638

Workforce Disability Equality Standards

Survey Coordination Centre NHS

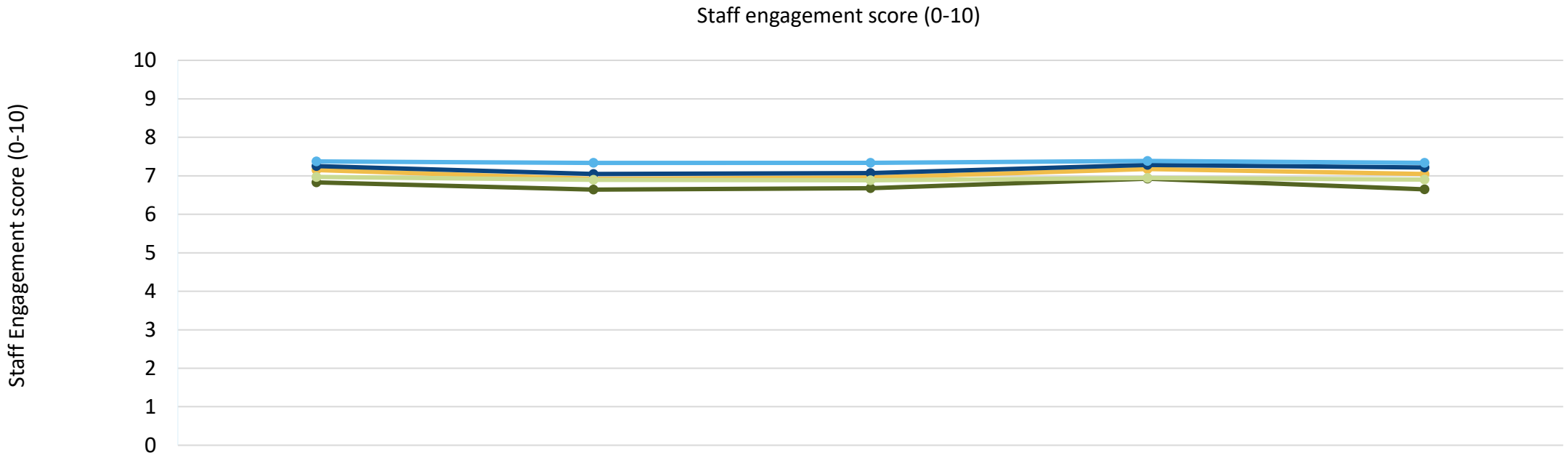
Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022	2023	2024
Staff with a LTC or illness: Your org	83.95%	79.29%	78.14%
Staff with a LTC or illness: Average	78.54%	79.34%	82.94%
Staff with a LTC or illness: Responses	162	198	183

Workforce Disability Equality Standards

Survey Coordination Centre NHS



	2020	2021	2022	2023	2024
Organisation average	7.15	6.92	6.95	7.18	7.05
Staff with a LTC or illness: Your org	6.83	6.64	6.68	6.93	6.65
Staff without a LTC or illness: Your org	7.25	7.05	7.07	7.28	7.22
Staff with a LTC or illness: Average	6.97	6.89	6.88	6.95	6.90
Staff without a LTC or illness: Average	7.37	7.34	7.34	7.39	7.34
Staff with a LTC or illness: Responses	189	243	251	307	272
Staff without a LTC or illness: Responses	628	698	662	709	640

Note: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

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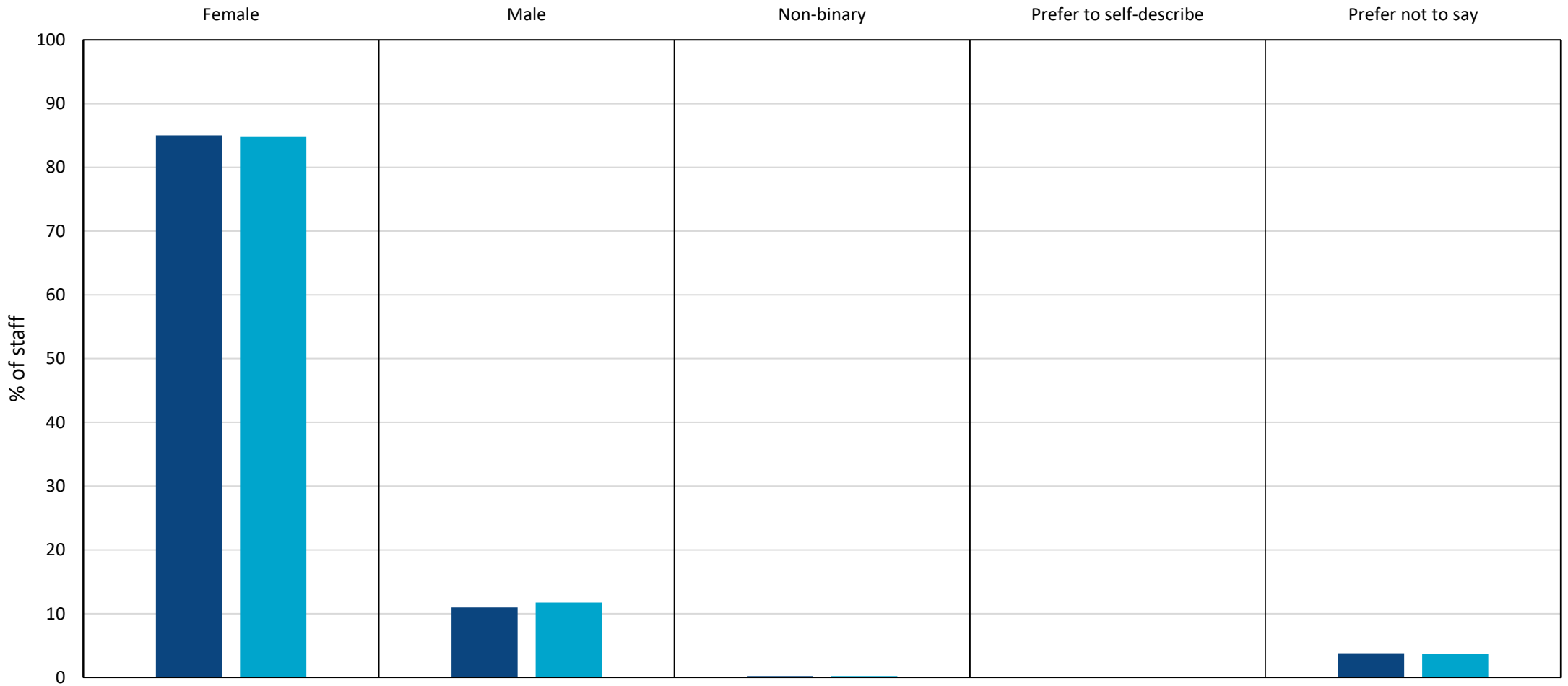
NHS

About your respondents

This section shows demographic and other background information for 2024.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	85.03%	10.95%	0.22%	0.00%	3.80%
Average	84.75%	11.72%	0.21%	0.08%	3.66%
Responses	922	922	922	922	922

Background details – Is your gender identity the same as the sex you were registered at birth?

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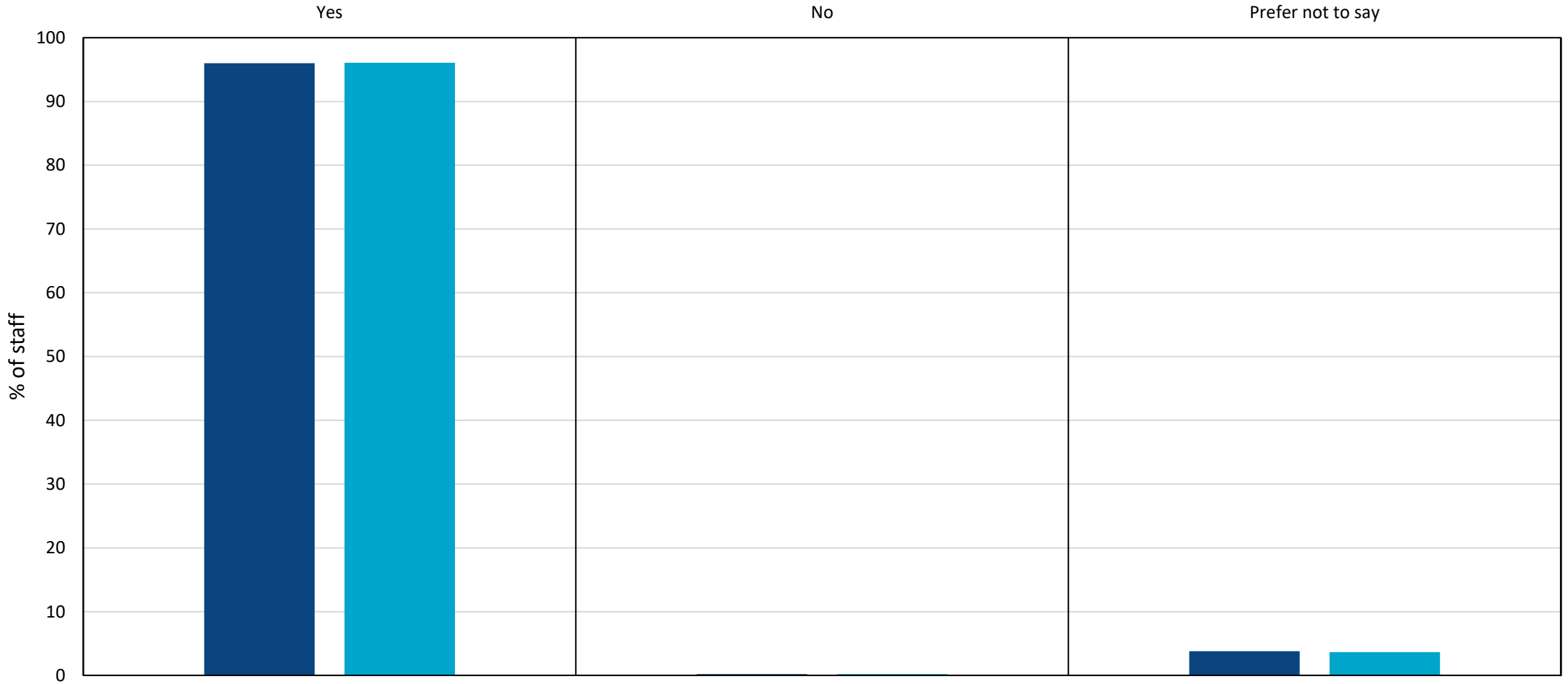
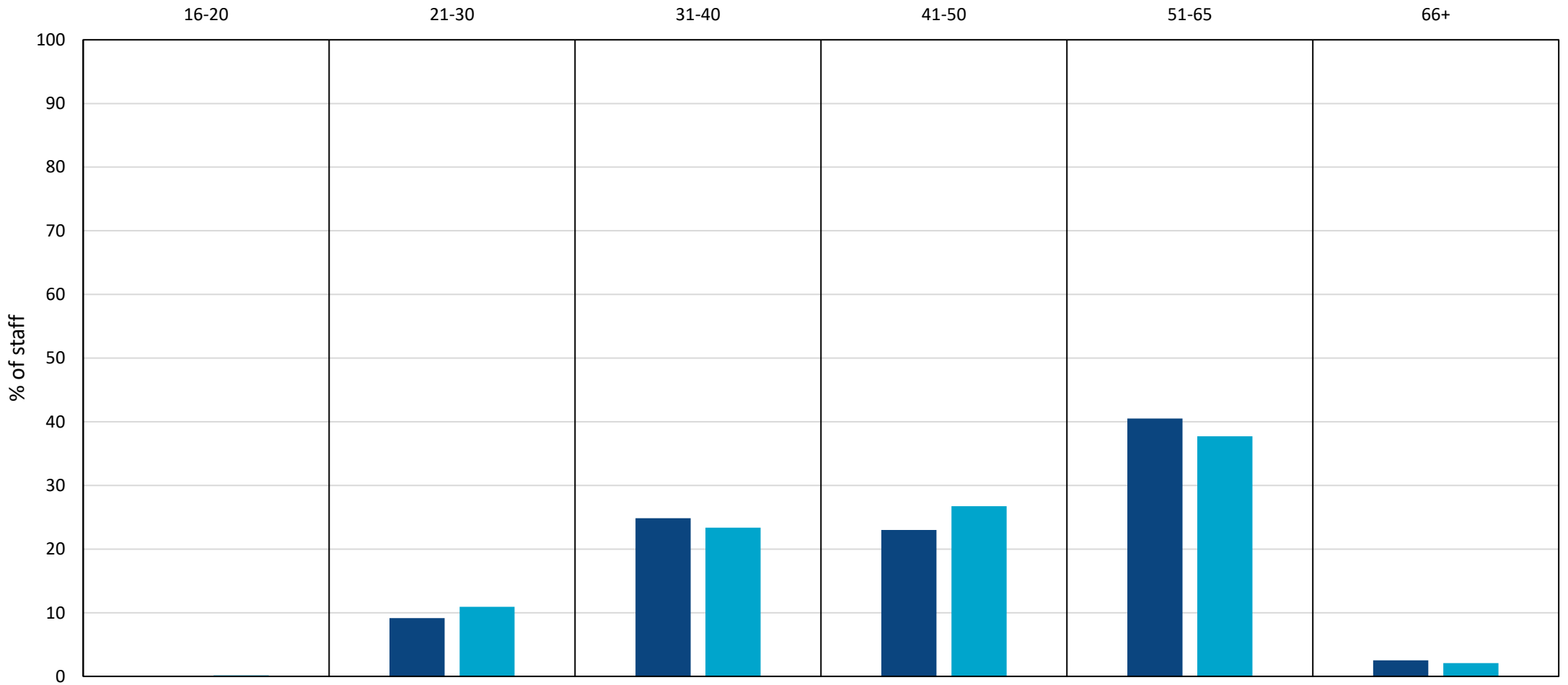


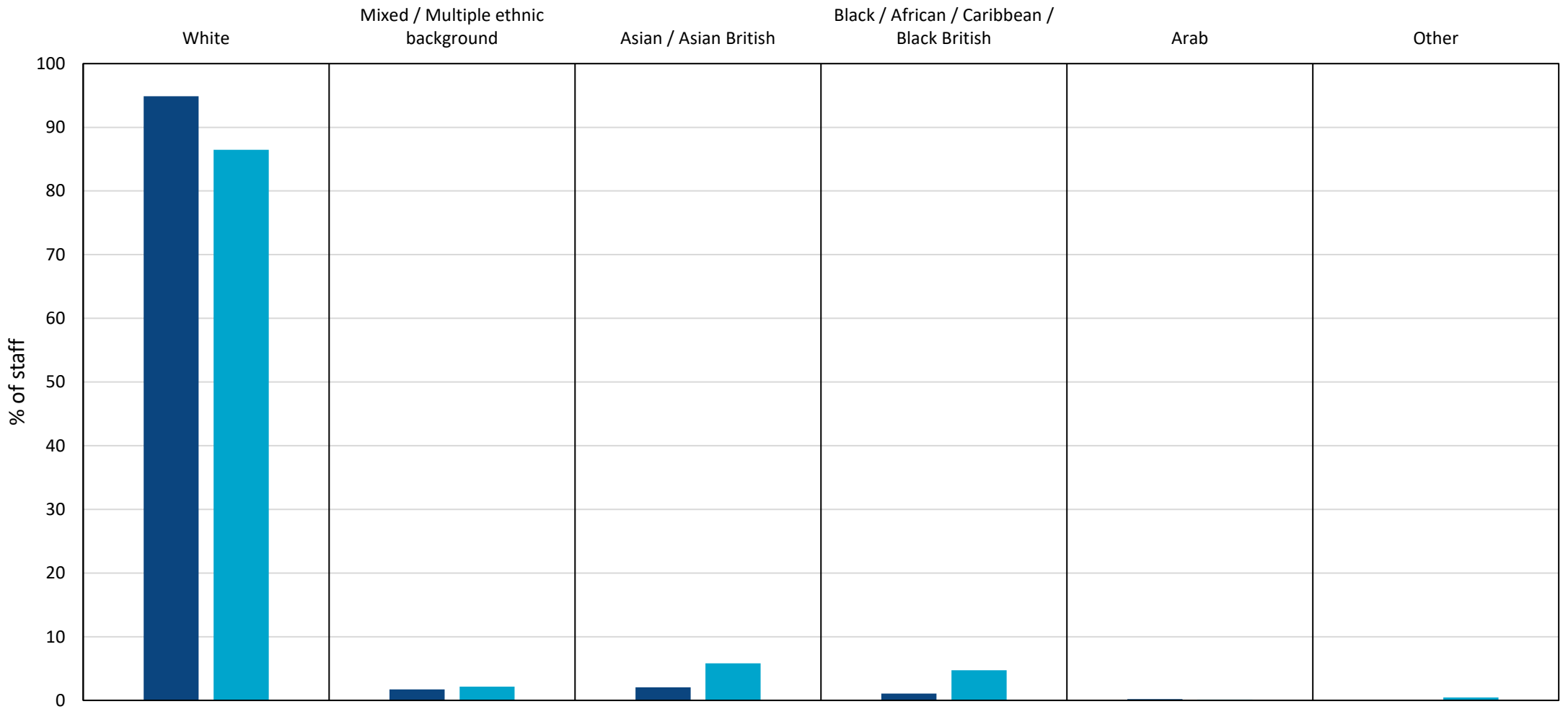
	Yes	No	Prefer not to say
Your org	95.99%	0.22%	3.79%
Average	96.06%	0.19%	3.65%
Responses	923	923	923

Background details - Age



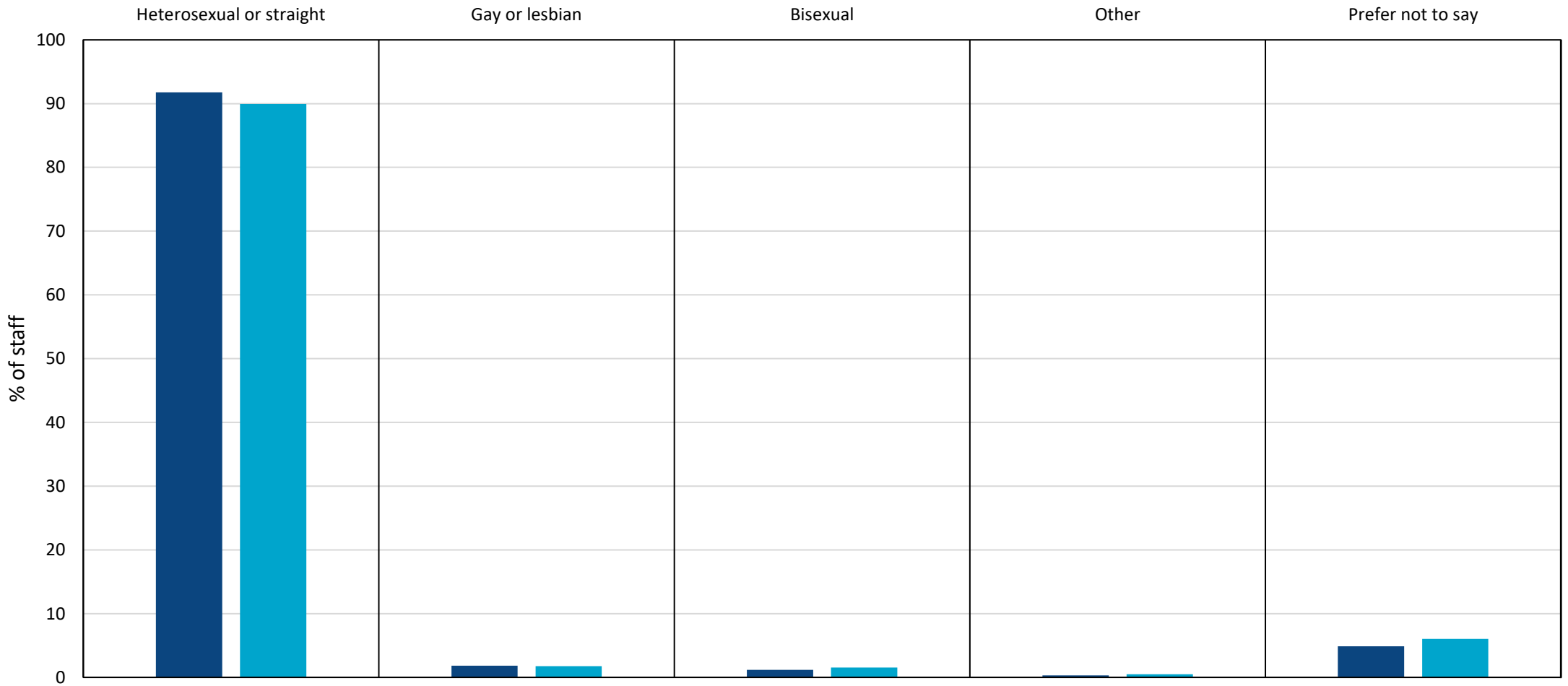
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.00%	9.15%	24.84%	22.98%	40.52%	2.51%
Average	0.18%	10.94%	23.36%	26.74%	37.73%	2.09%
Responses	918	918	918	918	918	918

Background details - Ethnicity



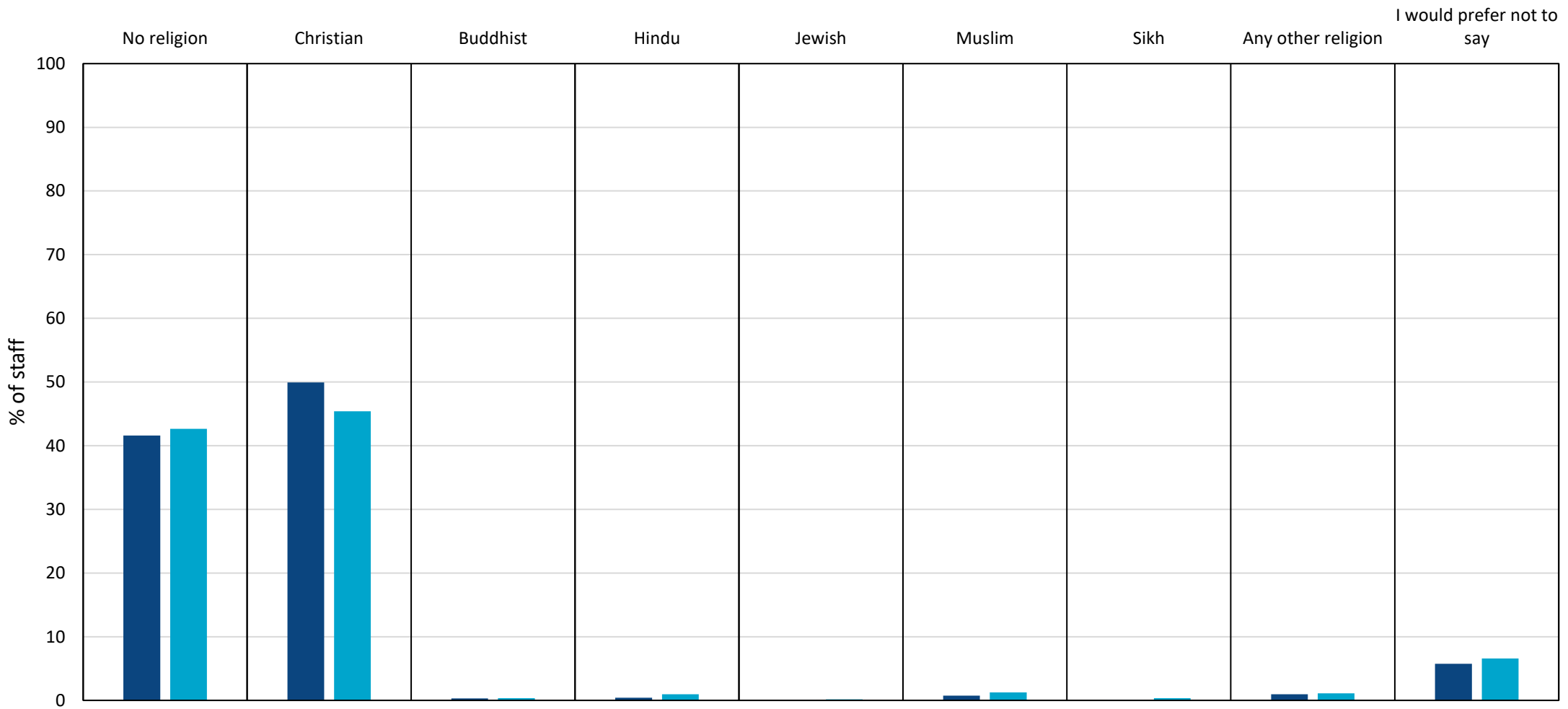
	White	Mixed / Multiple ethnic background	Asian / Asian British	Black / African / Caribbean / Black British	Arab	Other
Your org	94.89%	1.74%	2.07%	1.09%	0.22%	0.00%
Average	86.48%	2.14%	5.83%	4.74%	0.13%	0.46%
Responses	919	919	919	919	919	919

Background details – Sexual orientation



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	91.77%	1.84%	1.19%	0.33%	4.88%
Average	89.93%	1.76%	1.56%	0.49%	6.04%
Responses	923	923	923	923	923

Background details - Religion



	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	41.59%	49.95%	0.33%	0.43%	0.11%	0.76%	0.11%	0.98%	5.75%
Average	42.63%	45.39%	0.34%	0.97%	0.15%	1.27%	0.34%	1.12%	6.59%
Responses	921	921	921	921	921	921	921	921	921

Background details – Long lasting health condition or illness

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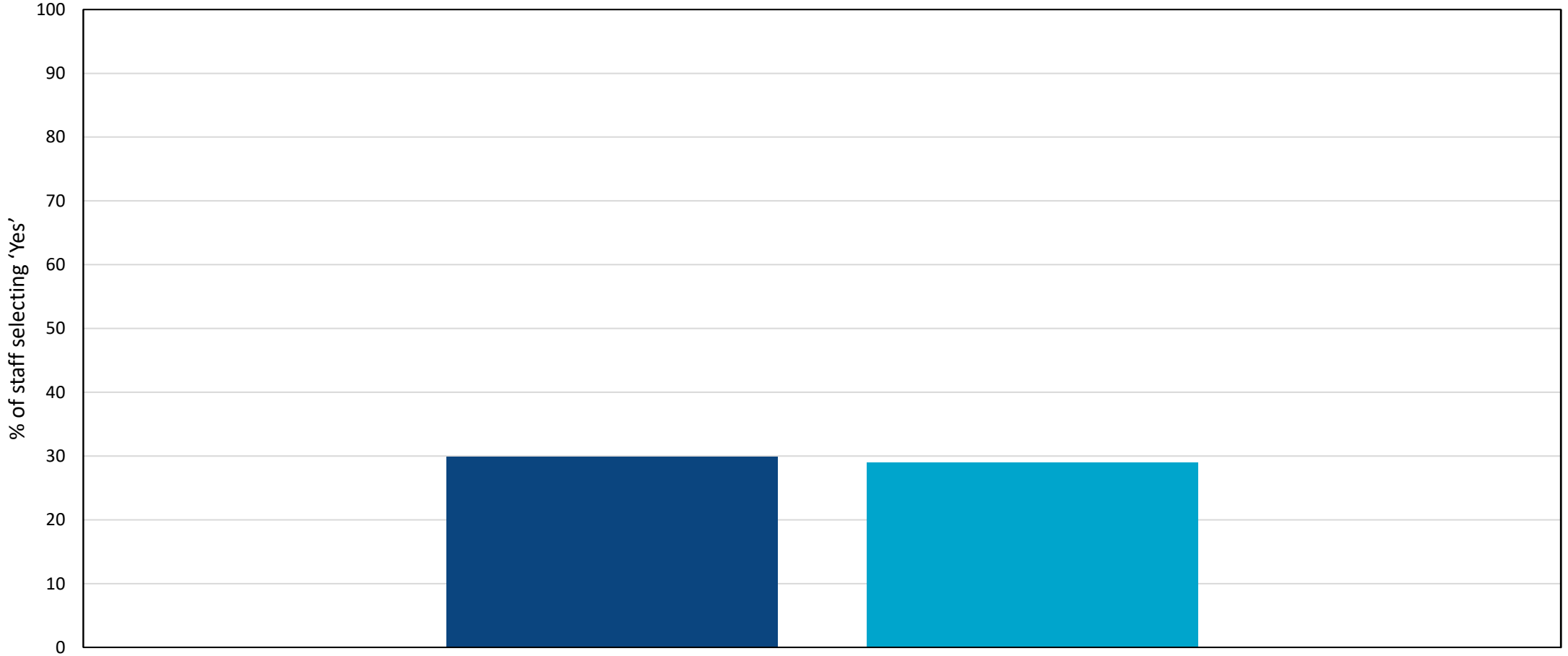
Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



Your org	29.90%
Average	28.90%
Responses	913

Background details – Parental / caring responsibilities

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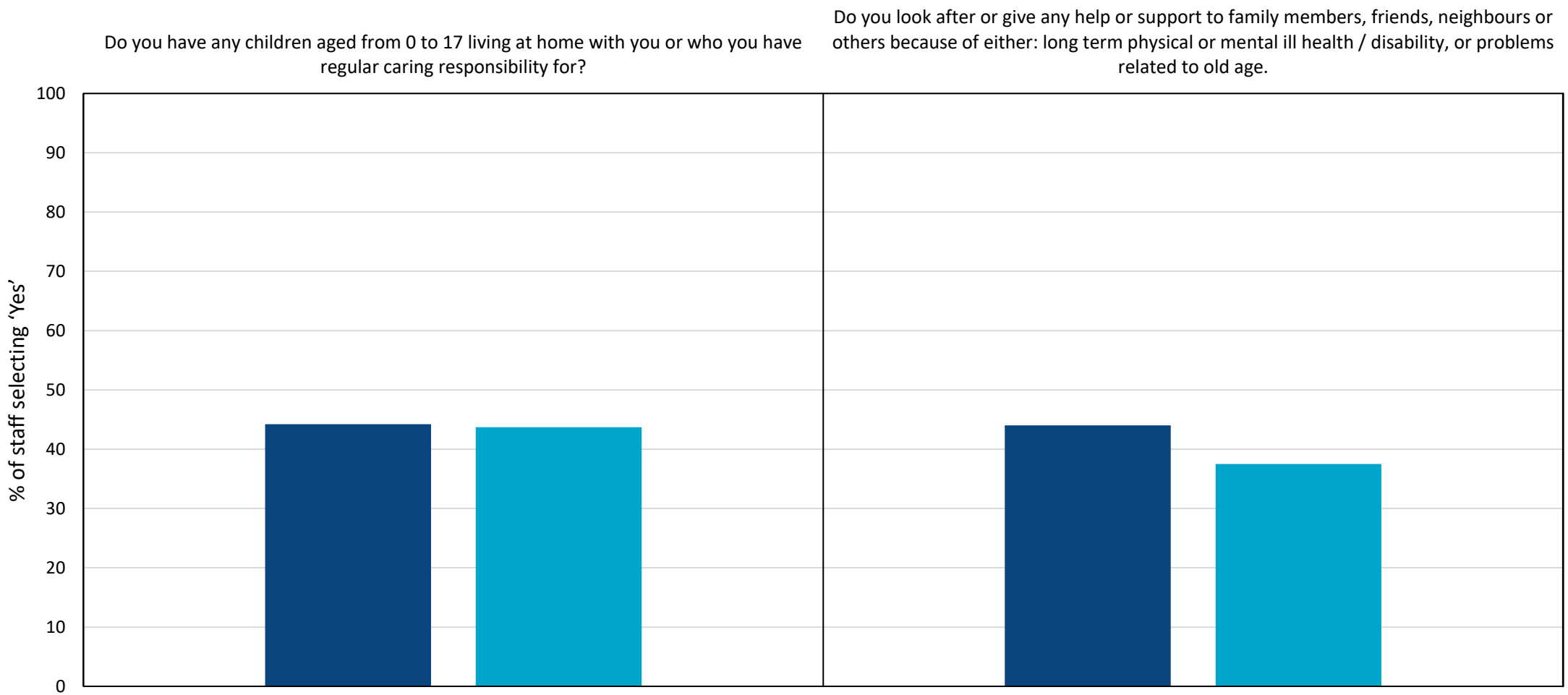
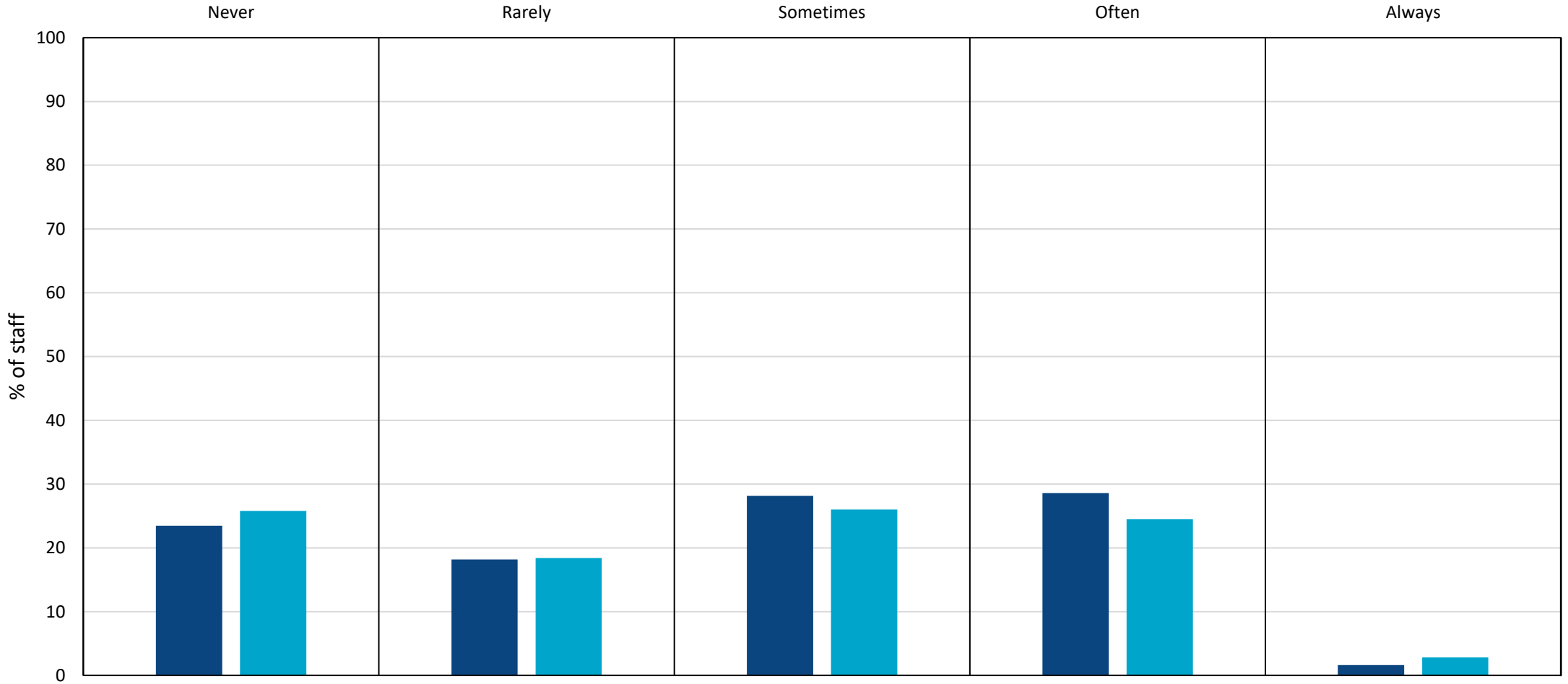


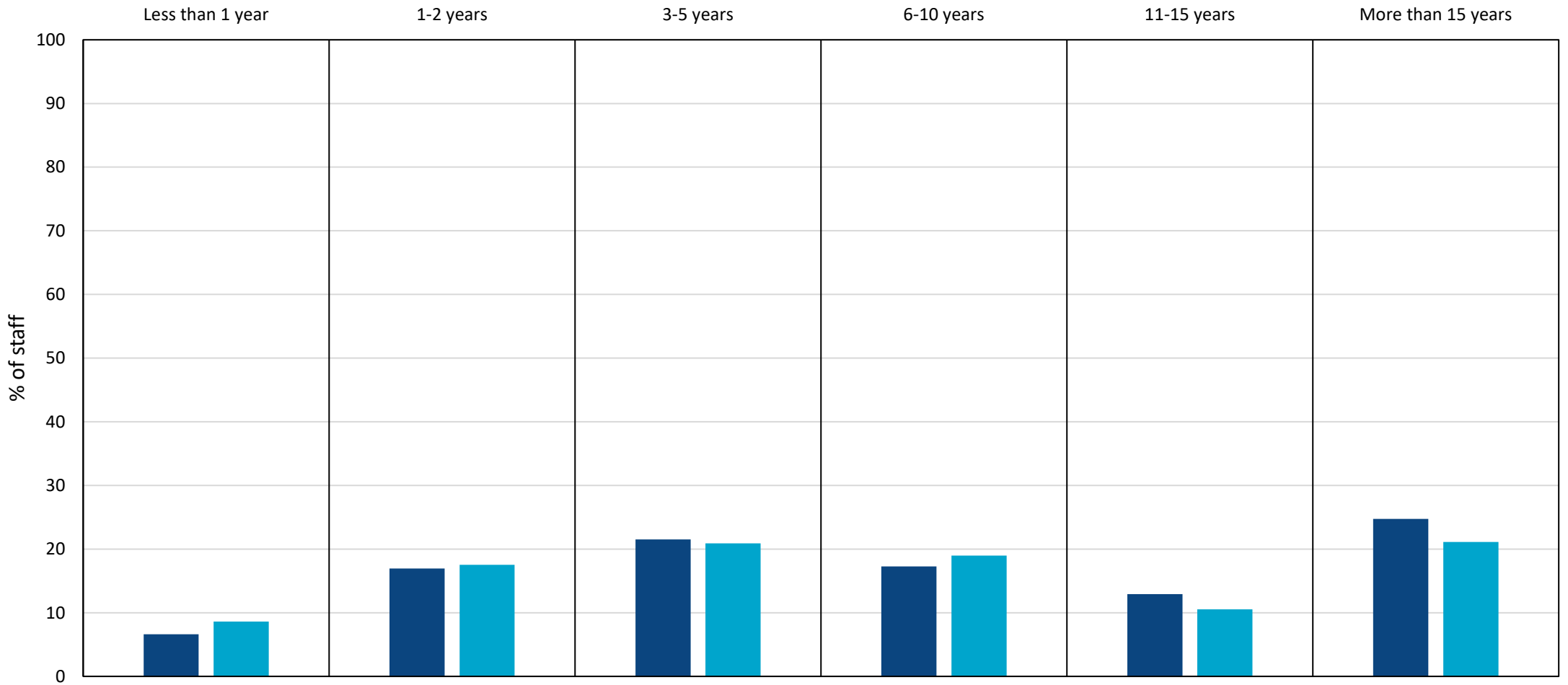
Your org	44.23%	44.02%
Average	43.72%	37.50%
Responses	918	920

Background details – How often do you work at/from home?



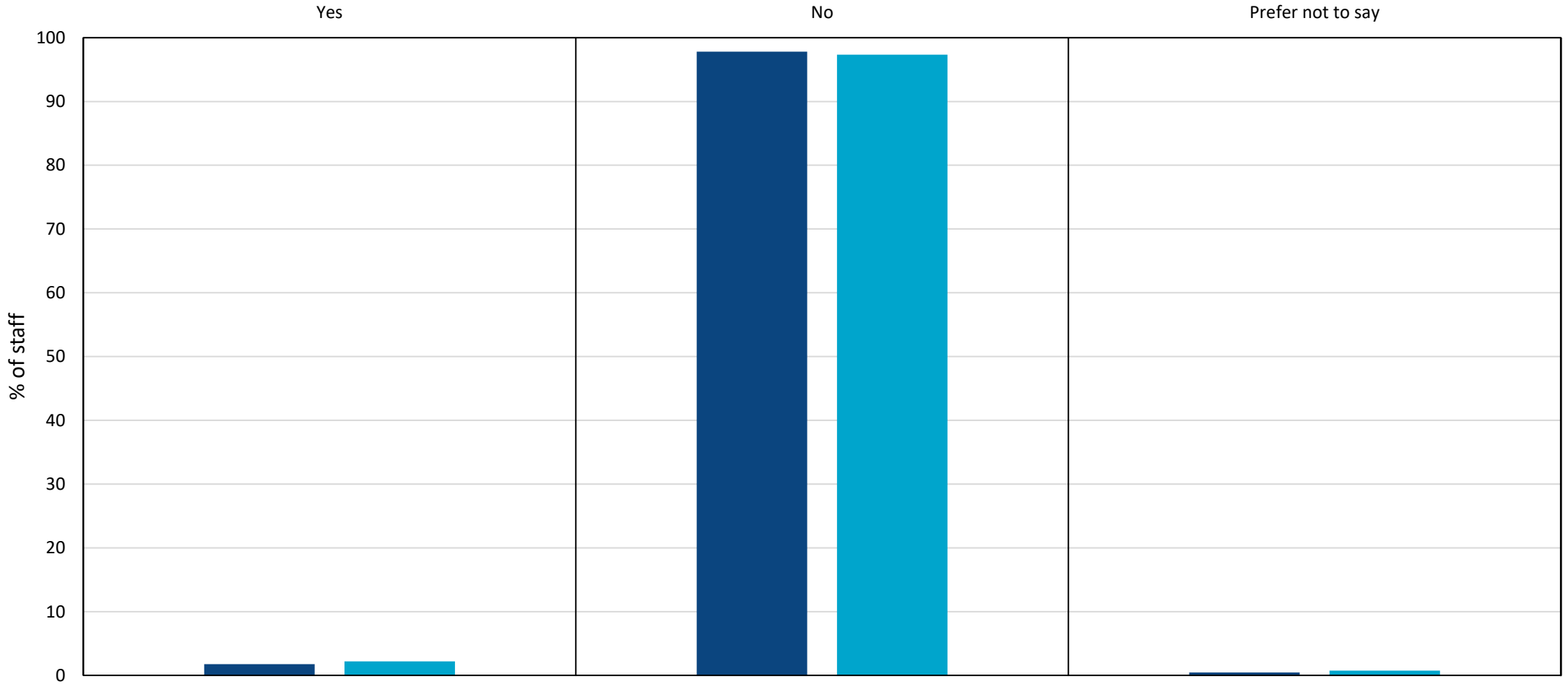
	Never	Rarely	Sometimes	Often	Always
Your org	23.48%	18.18%	28.14%	28.57%	1.62%
Average	25.78%	18.41%	26.02%	24.48%	2.80%
Responses	924	924	924	924	924

Background details – Length of service



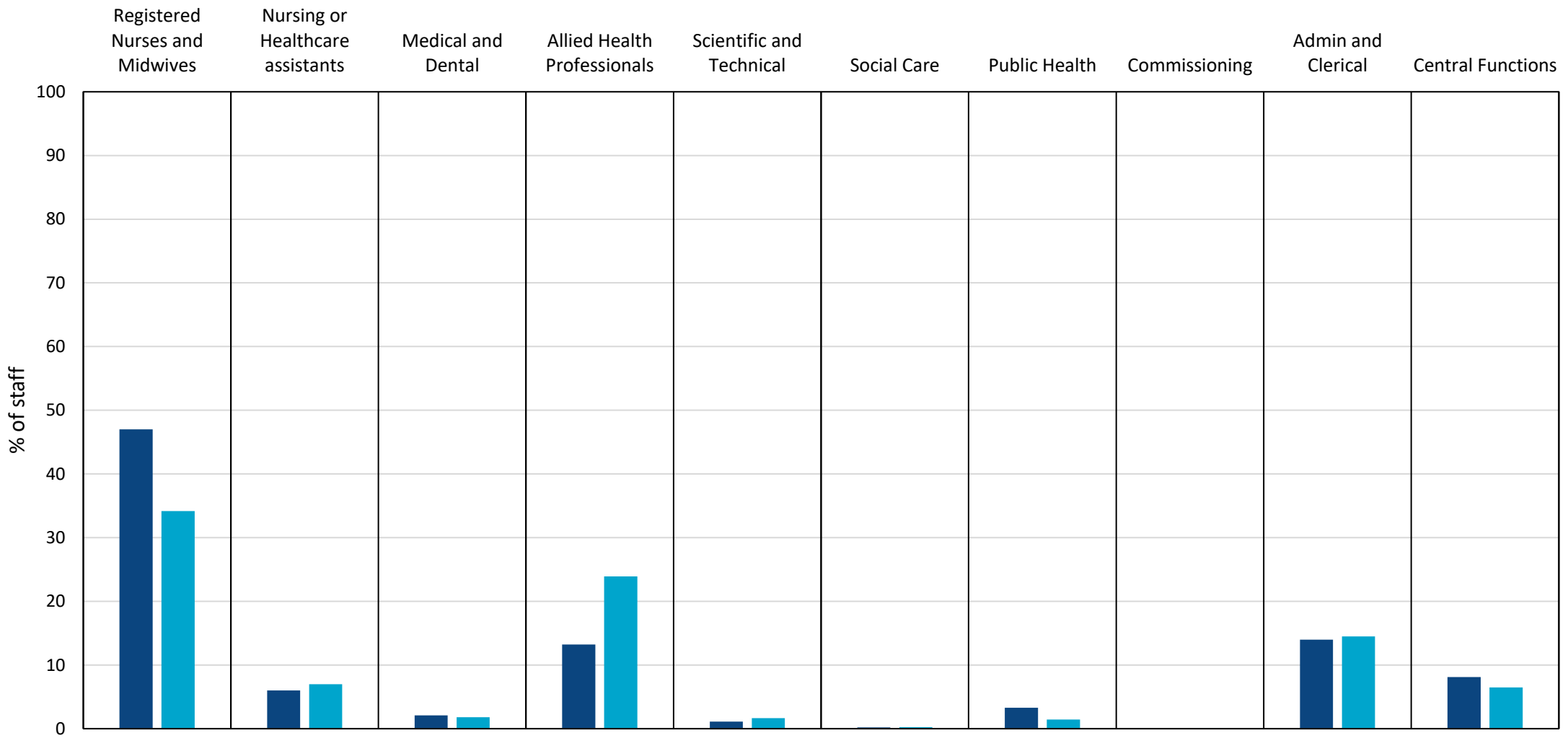
	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	6.62%	16.94%	21.50%	17.26%	12.92%	24.76%
Average	8.61%	17.54%	20.91%	18.96%	10.52%	21.12%
Responses	921	921	921	921	921	921

Background details – When you joined this organisation, were you recruited from outside of the UK?



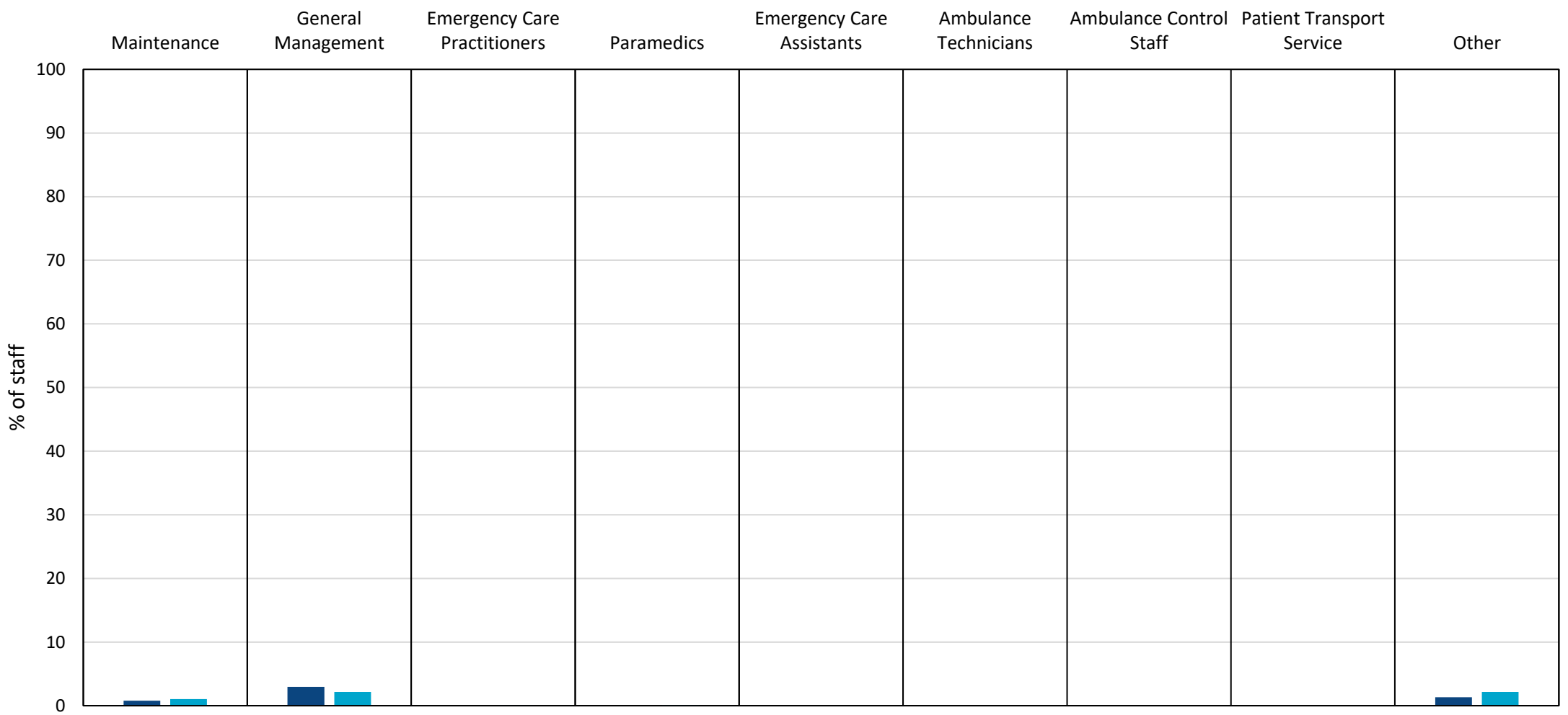
	Yes	No	Prefer not to say
Your org	1.75%	97.81%	0.44%
Average	2.20%	97.33%	0.76%
Responses	915	915	915

Background details – Occupational group



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	46.99%	6.01%	2.08%	13.22%	1.09%	0.22%	3.28%	0.00%	13.99%	8.09%
Average	34.18%	6.98%	1.81%	23.91%	1.64%	0.22%	1.44%	0.09%	14.50%	6.48%
Responses	915	915	915	915	915	915	915	915	915	915

Background details – Occupational group



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	0.77%	2.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.31%
Average	1.04%	2.16%	0.03%	0.09%	0.00%	0.00%	0.00%	0.00%	2.15%
Responses	915	915	915	915	915	915	915	915	915

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Appendices

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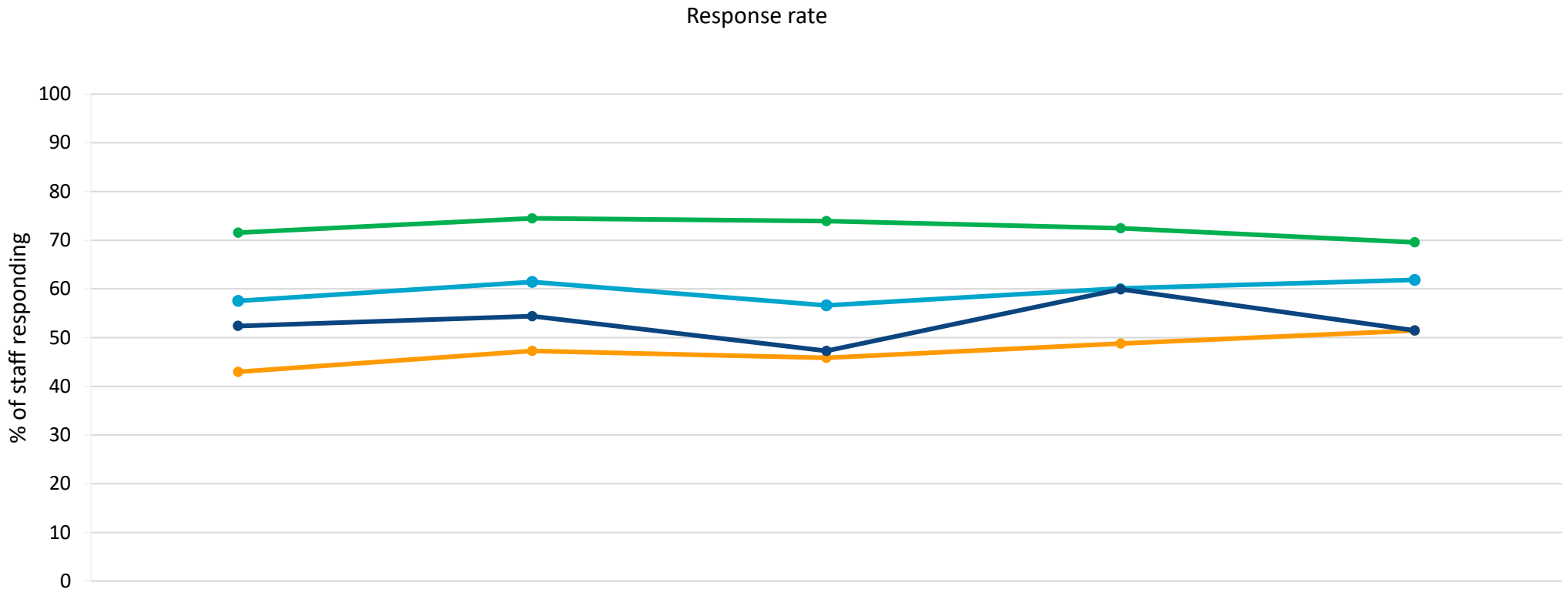
Appendix A: Response rate

Appendix A: Response rate



	2020	2021	2022	2023	2024
Your org	52.38%	54.39%	47.27%	59.93%	51.44%
Highest	71.57%	74.50%	73.93%	72.47%	69.55%
Average	57.55%	61.43%	56.61%	60.10%	61.85%
Lowest	42.97%	47.25%	45.87%	48.80%	51.44%
Responses	825	984	918	1047	927

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Appendix B: Significance testing 2023 vs 2024

Appendix B: Significance testing – 2023 vs 2024

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Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.76	1047	7.70	925	Not significant
We are recognised and rewarded	6.40	1045	6.32	925	Not significant
We each have a voice that counts	7.14	1041	7.00	918	Not significant
We are safe and healthy	6.33	1013	6.20	921	Not significant
We are always learning	6.13	1026	5.86	901	Significantly lower
We work flexibly	6.78	1042	6.63	922	Not significant
We are a team	7.28	1047	7.20	925	Not significant
Themes					
Staff Engagement	7.18	1047	7.02	926	Not significant
Morale	6.05	1047	5.84	927	Significantly lower

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

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The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data but have been included to aid users.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. The People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the technical document available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer-term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Appendix C: 1. Reviewing People Promise and theme results

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When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

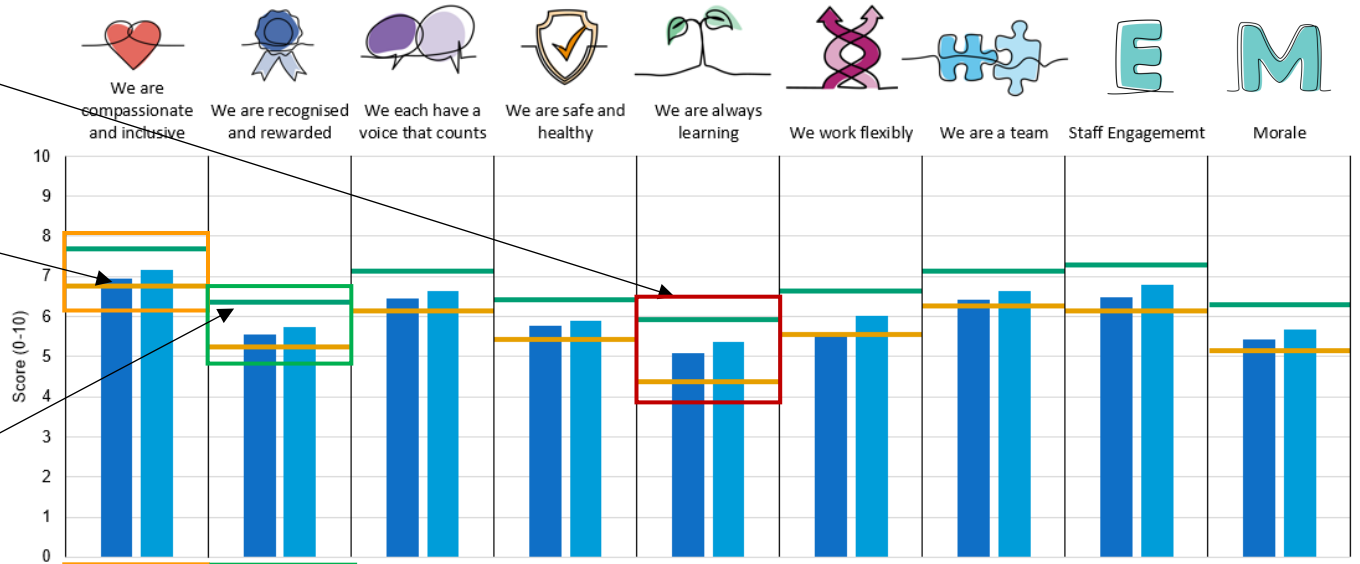
It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another point of reference.

Areas to improve

- By checking where, the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

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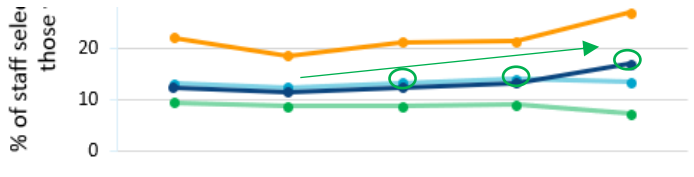
Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



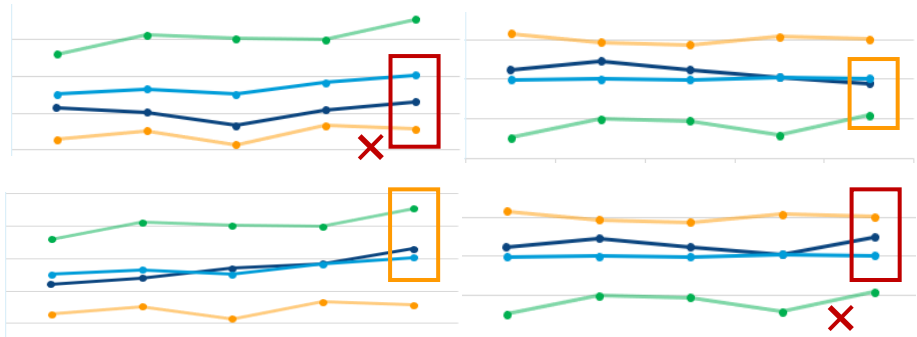
	2020	2021	2022	2023	2024
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	595

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average and worst benchmarking group result for question

Appendix C: 3. Reviewing question results

Survey Coordination Centre NHS

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

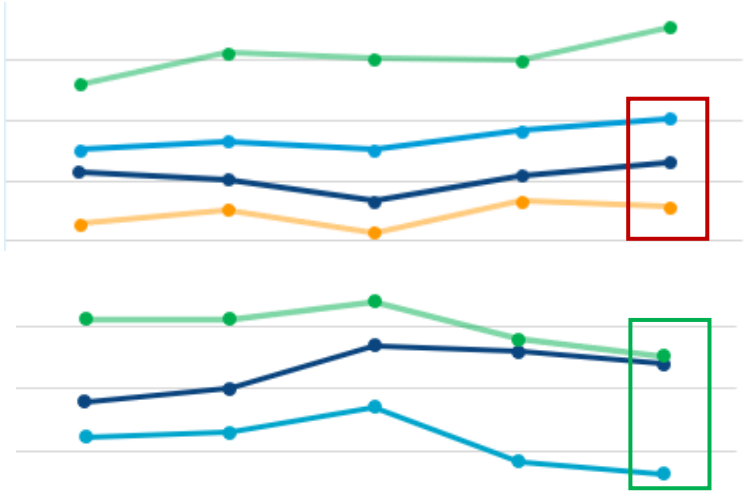
Identifying questions of interest

- **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

- **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

NHS

Appendix D: Additional reporting outputs

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

Survey Coordination Centre NHS

Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Guide: Contains technical details about the NHS Staff Survey data, including data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for Wirral Community Health and Care NHS Foundation Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Public Board of Directors **Item 22**

04 June 2025

Title	Freedom to Speak Up Annual Report
Lead Director	Paula Simpson, Chief Nurse
Author	Alison Jones, Freedom to Speak up Guardian
Report for	Approval

Executive Summary and Report Recommendations
The purpose of this report is to request approval of the Freedom to Speak Up (FTSU) Annual Report 2024/25. The report also provides assurance regarding FTSU activity and learning during the reporting period 01 April 2024 – 31 March 2025.
It is recommended that the Board: • Approve the Freedom to Speak Up Annual Report for 2024/2025

Key Risks
This report relates to the following key risks: • Whilst this does not link to any specific risk, the existence of a healthy speaking up culture remains pivotal to ensure a strong focus on safe, effective practice for both staff and people accessing 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 WCHC strategic objectives:	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	Yes

People	
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Yes
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7th May 2025	Quality and Safety Committee	Freedom to Speak up Annual Report	Approved.

1	**Narrative**
1.1	This annual report provides an overview of Freedom to Speak Up (FTSU) activity during 2024/25 and covers the following key areas: • Summary of Concerns Reported • Concerns Reported by Service • Predominant Themes identified • Outcomes and Learning • Our People - Feedback from Satisfaction Questionnaires - Monitoring information • Key successes Key priorities for 2025/26
1.2	During the reporting period, 50 FTSU Concerns were reported via the FTSU Guardian in 2024/25. This reflects a 47% increase in concerns reported from previous year and mirrors the national trend.
1.3	36 of the concerns reported (72%) were either reported openly by staff members or confidentially via the FTSU Guardian, with 14 reported (28%) reported anonymously.
1.4	The highest number of concerns reported were from Community Response Directorate, with relationships and team dynamics being the predominant theme of concerns. Extensive and focussed support has been offered to this directorate, the impact of which is currently being evaluated.
1.5	Outcomes and learning are included in the report, along with successes achieved throughout the year.
1.6	The Trust has 135 FTSU Champions across all Trust sites and available in all Staff Network Groups to support our workers to speak up safely, promote our Trust values and promote behavioural standards.

2	**Implications**
2.1	**Quality/Inclusion**

	This is an assurance report detailing Freedom To Speak Up concerns reported in the last financial year. The Speaking Up policy, which supports the governance and process of speaking up, contains the Quality & Equality Impact Assessment.
2.2	**Finance** None identified.
2.3	**Compliance** Freedom to speak up is a fundamental element of CQC well-led key inspections

3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: **Community engagement and support** ☐ **Purchasing and investing locally for social benefit** ☐ **Representative workforce and access to quality work** ☒ **Increasing wellbeing and health equity** ☒

Compassion | Open | Trust

Wirral Community Health and Care NHS Foundation Trust

Freedom To Speak Up Annual Report April 2024 – March 2025

Alison Jones : FTSU Guardian

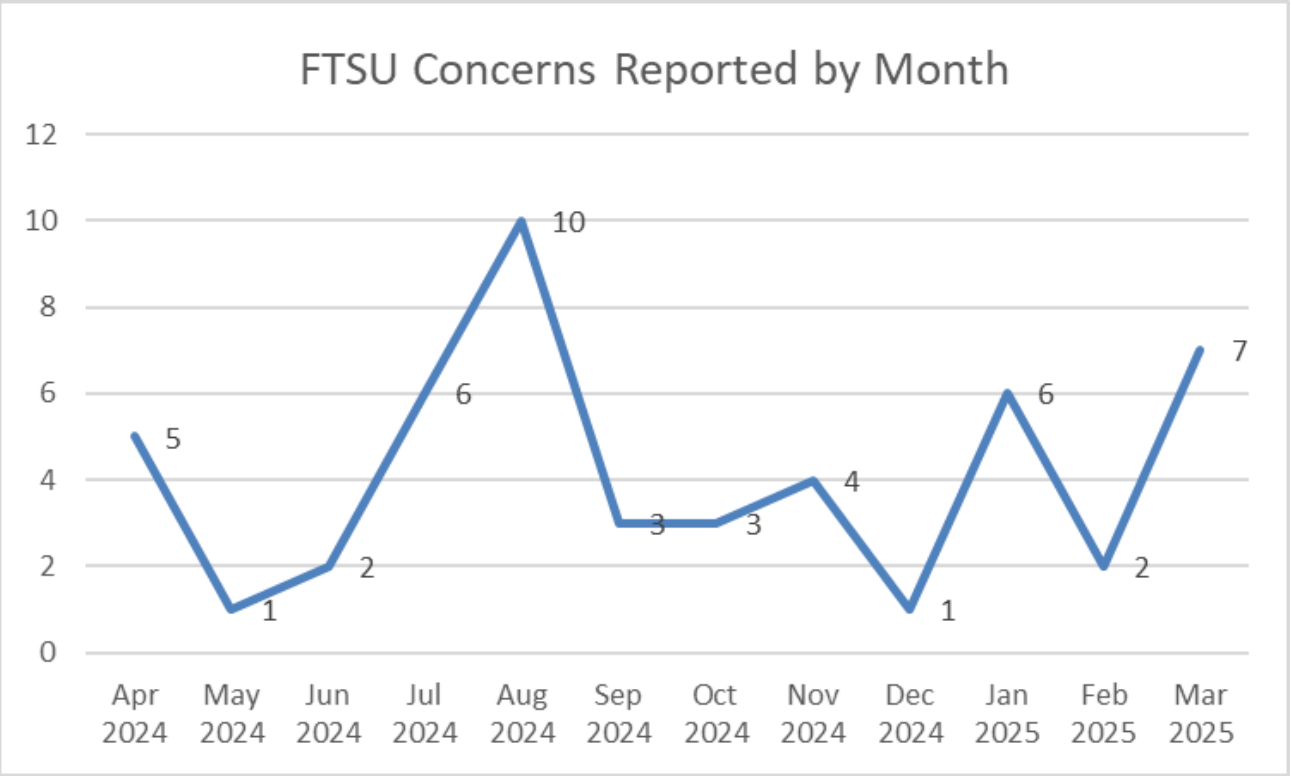
Date : May 2025

Contents of Report

Governance - How FTSU is monitored and supported

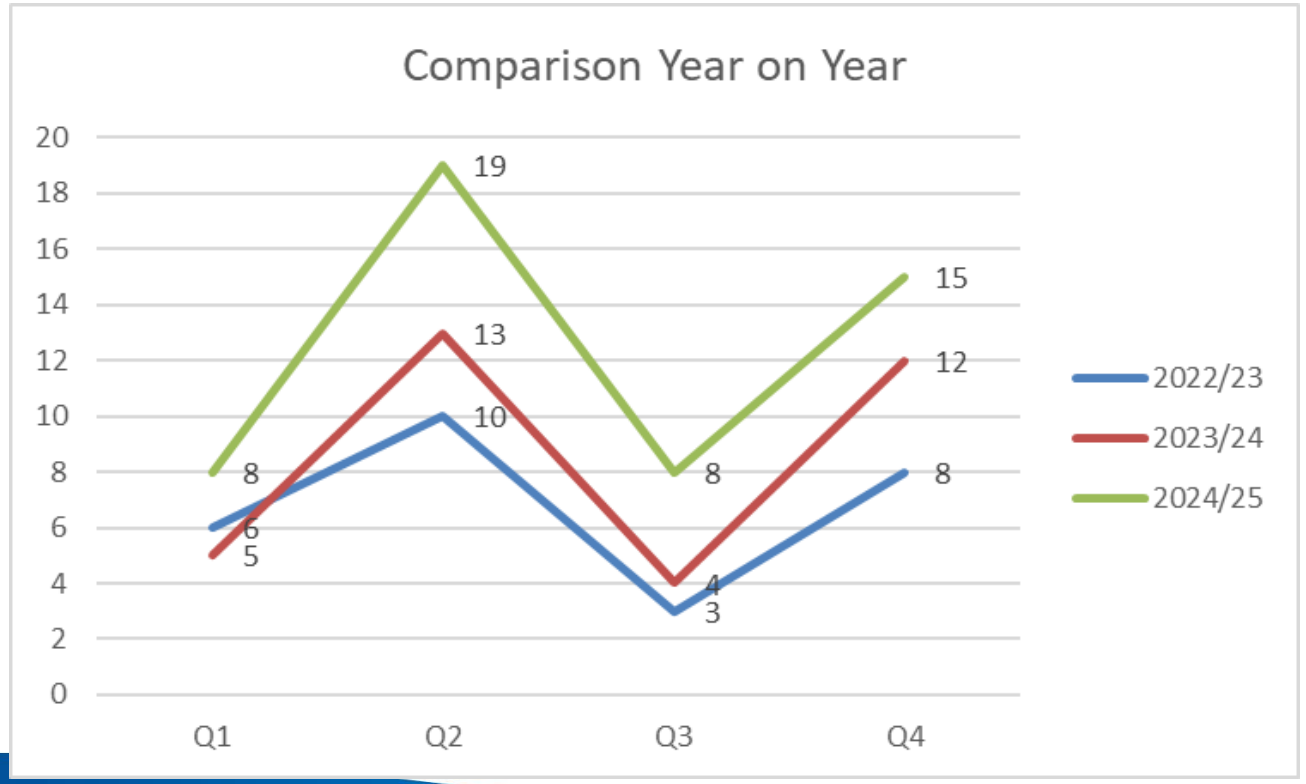
- Freedom To Speak Up Guardian who supports staff who raise concerns and promotes a culture of open reporting
- 135 FTSU Champions across the Trust promoting a speak up culture in their teams and in all staff network groups
- Speak Up policy in line with recommendations from the National Guardians Office
- Freedom To Speak Up strategic plan published in 2024
- FTSU Guardian is supported by both an Executive and Non-Executive Board member
- FTSU Guardian meets every other week with Chief Operating Officer, Chief Nurse, Chief People Office and their deputies
- Quarterly FTSU Steering Group to monitor themes and learning as well as triangulation with other sources
- FTSU Guardian presents a bi-annual report to Quality and Safety Committee and Trust Board

Concerns Reported 2024/25



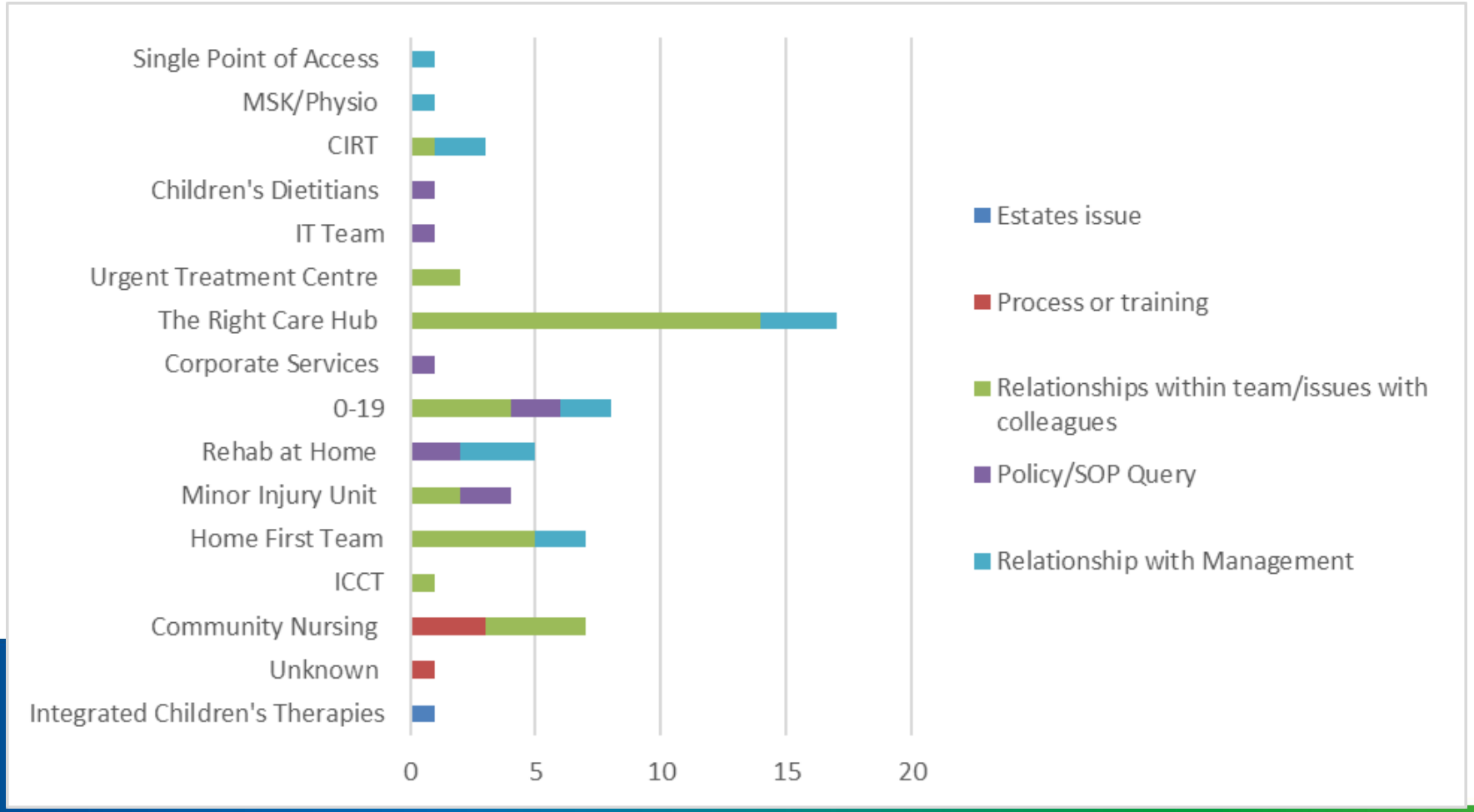
50 FTSU Concerns were reported via the FTSU Guardian in 2024/25

Concerns Reported Comparison

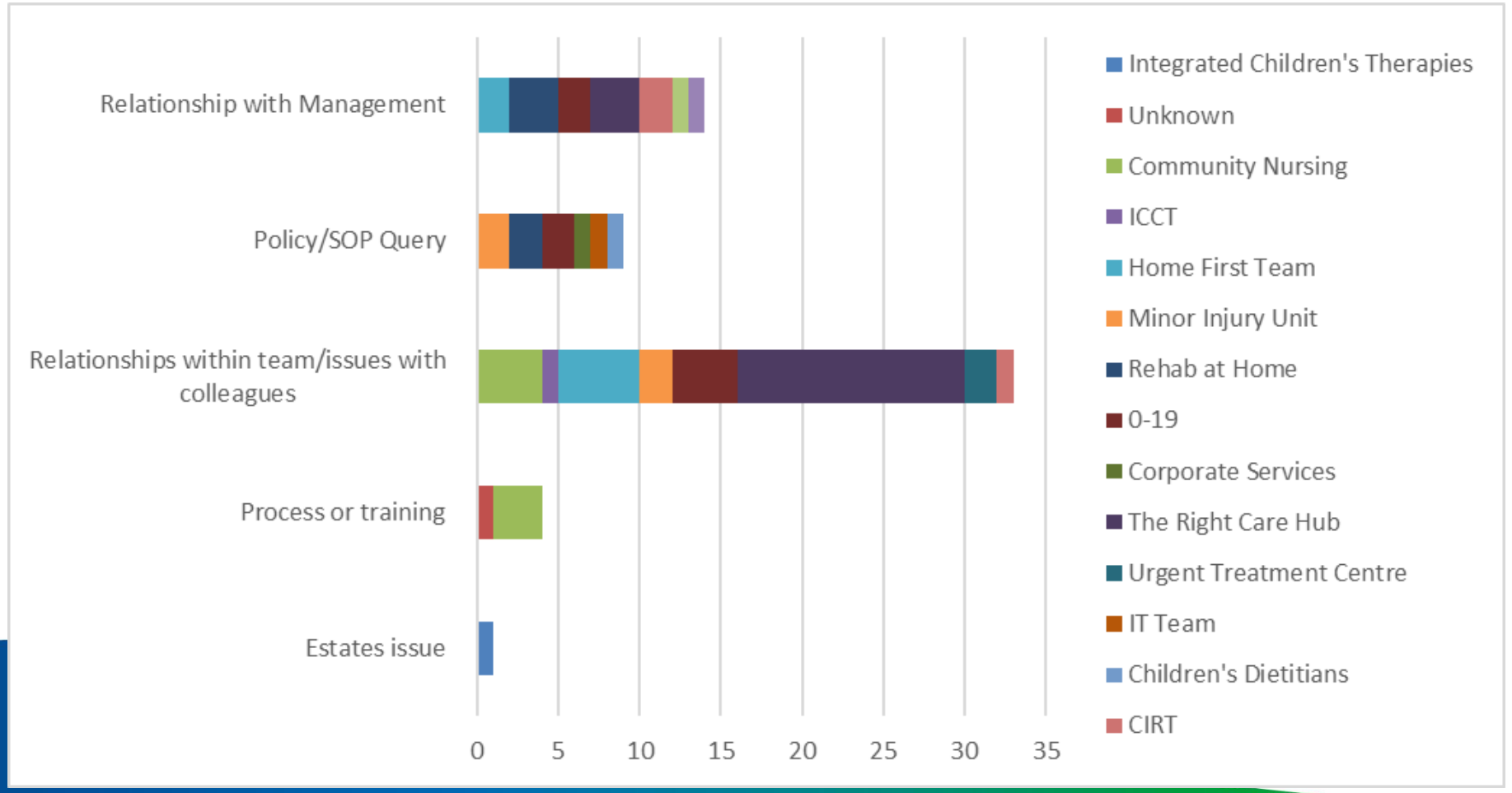


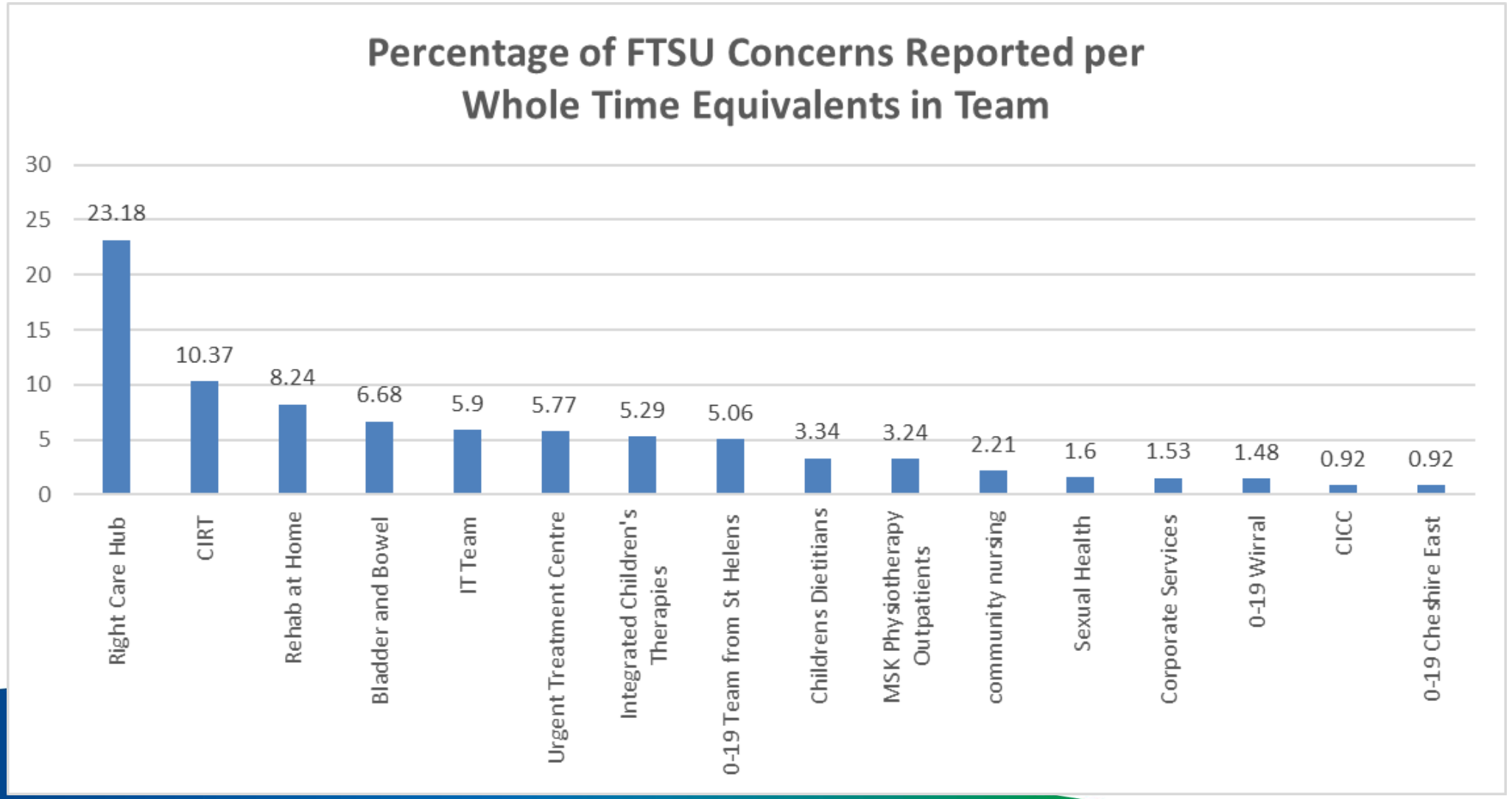
- FTSU reporting has increased year on year
- There was a 47% increase in concerns reported from previous year
- This mirrors national trends in reporting via FTSU Guardian

Concerns Reported 2024/25 by Service and Theme



Concerns Reported 2024/25 by Theme and Service




Percentage of FTSU Concerns Reported per Whole Time Equivalents in Team
30
25
20
15
10
5
0
23.18
10.37
8.24
6.68
5.9
5.77
5.29
5.06
3.34
3.24
2.21
1.6
1.53
1.48
0.92
0.92
Right Care Hub
CIRT
Rehab at Home
Bladder and Bowel
IT Team
Urgent Treatment Centre
Integrated Children's Therapies
0-19 Team from St Helens
Childrens Dietitians
MSK Physiotherapy Outpatients
community nursing
Sexual Health
Corporate Services
0-19 Wirral
CICC
0-19 Cheshire East

Summary of Concerns Reported

- Highest number of concerns reported were from Community Response Directorate
- Highest theme of concerns reported was relationships within teams and relationships with managers

Confidence in FTSU Process

- 36 of the concerns reported (72%) were either reported openly by staff members or confidentially via the FTSU Guardian
- 14 of the concerns reported (28%) were reported anonymously.
- Concern numbers have increased by 47% since the previous year
  (34 in 2023/24 compared to 50 in 2024/25)

Outcomes and Learning

- Agreement between teams and Estates for conservatory at Highfield to be a shared resource during lunch period to allow for a quiet space away from desks
- Training and support offered to all staff to support the use of the new expenses system
- Cultural review within team supported by Deputy Chief Operating Officer and Learning and Development Team
- Support provided for a new Team Leader in developing their role and additional on going support put in place
- Review of managing attendance policy to support staff members to reclaim booked annual leave when on sick leave
- Review of Standard Operating Procedures for 0-19 and additional support provided

Outcomes and Learning Continued

- Additional support provided under the protected characteristic of Veganism including Trust wide promotions and Comms
- Local resolution re appropriate behaviours in the workplace and use of Behavioural Standards Framework
- Collaborative work with Infection Prevention and Control Team to support clinical staff re needlestick injuries
- Facilitated conversation arranged between staff member and managers. Staff member supported by the return to work process
- L&OD Team provided additional training dates to support staff members who have difficulty traveling to Wirral for training

Outcomes and Learning Continued

- Review of MASH process in St Helens with improvements made to process with support from Safeguarding and Information Governance Team.
- Relationship issues within team addressed with support from Deputy Chief Operating Officer and Learning and Development Team. Ongoing action plan in place to support culture within team moving forward
- Reporters signposted to most appropriate support via HR department
- Reporter supported to meet with Service Director to discuss concerns and jointly develop a support plan
- Support provided to revisit reasonable adjustment plan and address changes

FTSU Satisfaction Questionnaires

Questionnaires are sent out to reporters when a FTSU Concern has been closed

- The answers from the questionnaires are used to support the promotion of Speaking Up for everyone in the Trust
- As part of our compliance with the National Guardians Office we upload the percentage answer to the question Would you speak up again on a quarterly basis
- This information is used by the National Guardians Office to gauge satisfaction with speaking up processes
- In 2024/25 90% of the questionnaires returned stated that the reporter would speak up again. 5% answered Maybe and 5% answered Don’t know
- The reporters who returned questionnaires also had the opportunity to add feedback comments

What Our People Tell US

Feedback from satisfaction questionnaires

The matter was dealt with efficiently and in a timely manner. I am really pleased I took the opportunity to speak up

Kept informed and issue resolved

I had a great communication following my FTSU and was kept informed at all stages of their enquiries

I felt that the Guardian took my concerns seriously and has kept it confidential to the extent that I wanted her to

I felt that although I had had discussions with management previously in the past over other concerns, sometimes it didn't feel like they were actually taking on board what was being said. On this occasion my concern was with management and I felt 'lost' with how to discuss it. By speaking to the Guardian I felt like I was taken seriously and listened to.

Very supported they were kind, considerate and never gave their own opinion or advised of what to do, they would wait until you came up with your conclusion and then guide you to right policy's and gave supportive advice.

What Our People Tell US Continued

Feedback from satisfaction questionnaires

Concerns were listened to. Communications were excellent and actions were swift. Overall a great experience

I would definitely speak up again as the FTSU Guardian I told my experiences to listened to me, supported me and treated me with kindness and compassion. I felt she understood what I had gone through and presented an accurate report to senior management detailing my experiences I had encountered whilst working for a previous team

I was listened to without judgement. Freely able to discuss own issues and others concerns

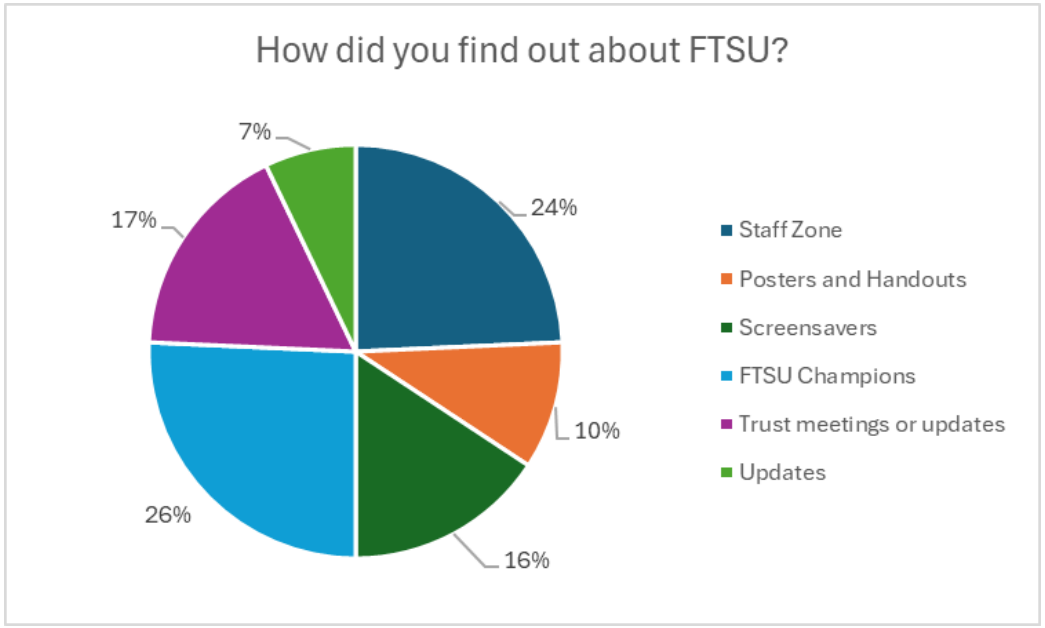
We felt we were listened to and issues were addressed in a timely and appropriate manner

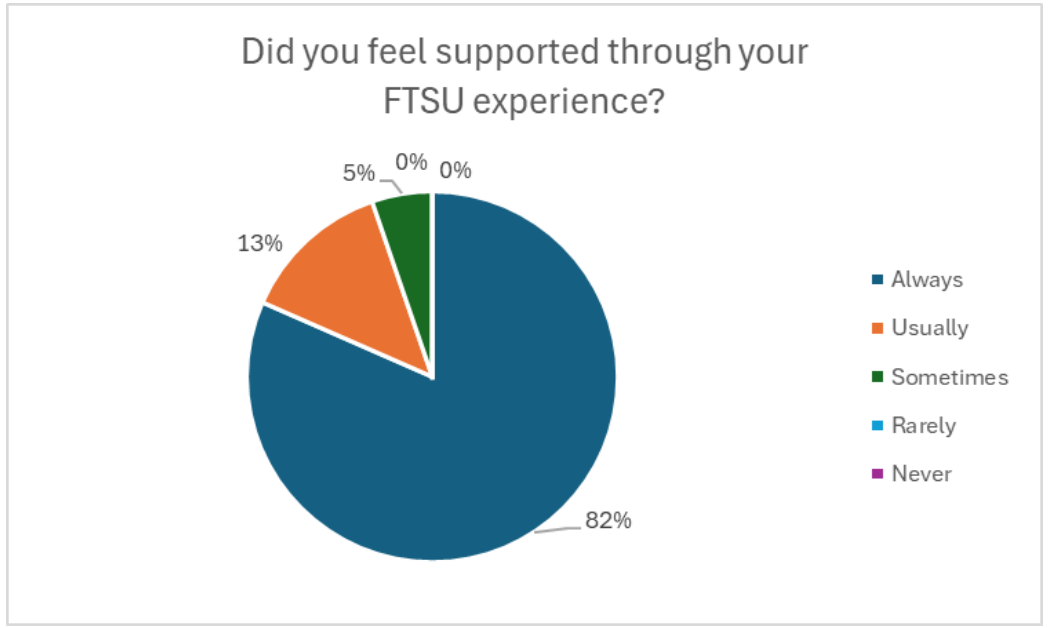
The Guardian was kind and listened to my concerns she was able to put my concerns in a cohesive time line and did not rush or interrupt when I was speaking.

Very supportive gave me space to think next steps and when next had been decided they were there to fully support my options.

FTSU Satisfaction Questionnaires

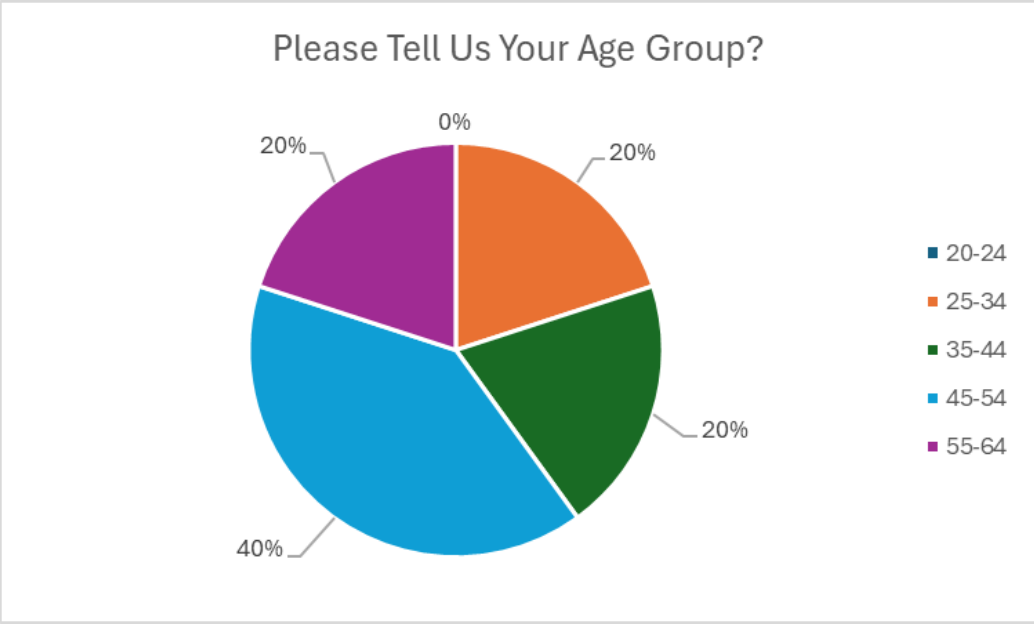
Information provided from reporters who returned satisfaction Questionnaires

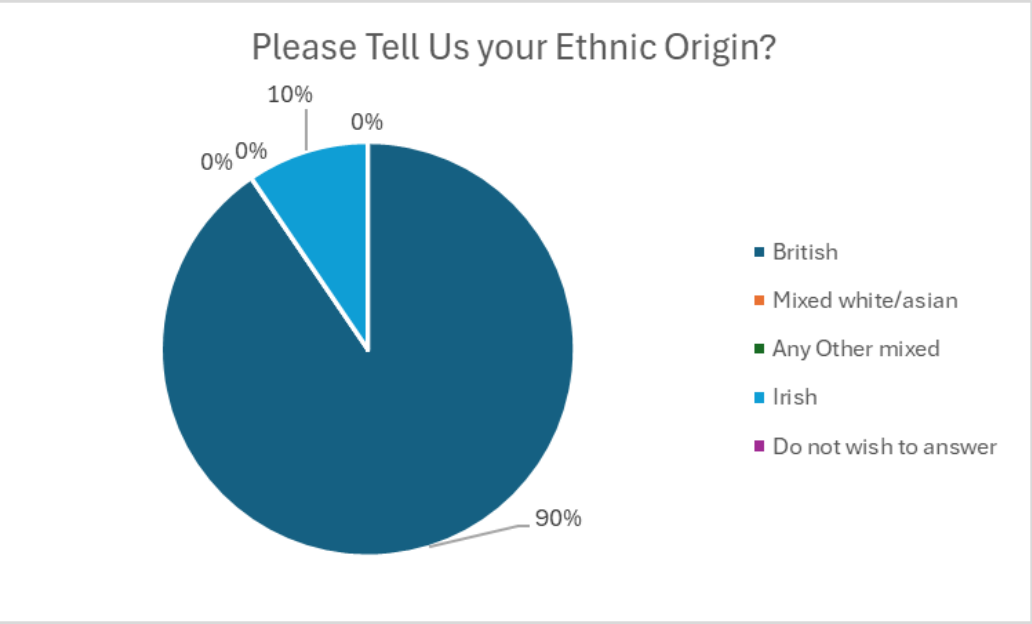




FTSU Satisfaction Questionnaires

Information provided from reporters who returned satisfaction Questionnaires

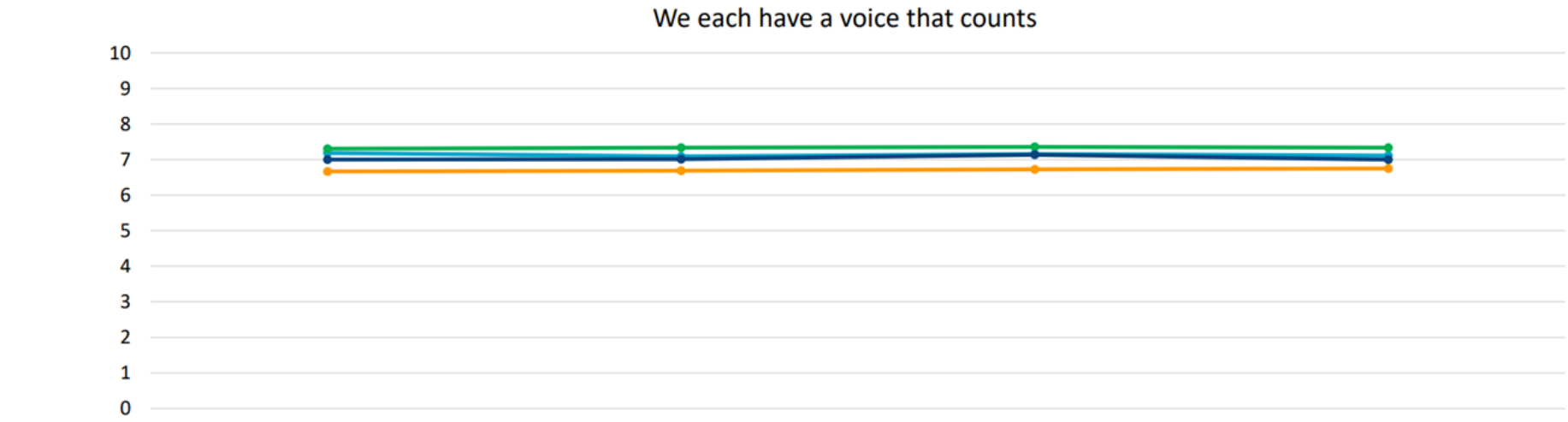




NB : From 01/04/2025 a Quality Improvement has been instigated to improve the number and quality of the demographic data captured and how this is used to support all staff members to speak up

Staff Survey 2024

Promise element 3: We each have a voice that counts



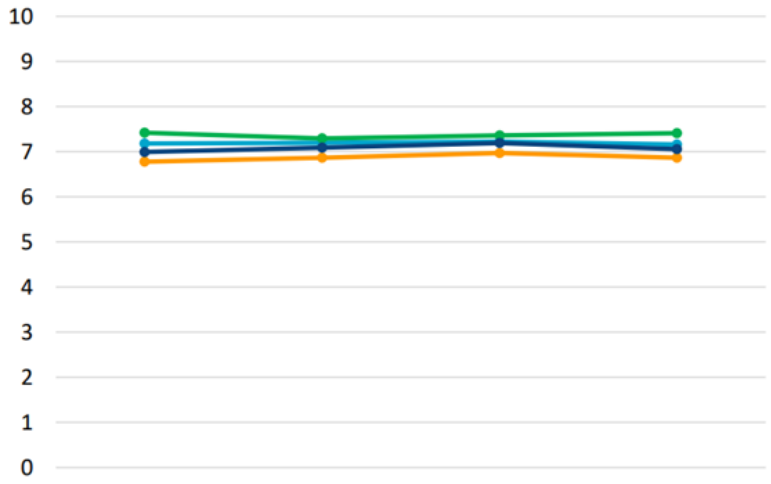
	2021	2022	2023	2024
Your org	7.00	7.01	7.14	7.00
Best result	7.30	7.33	7.36	7.34
Average result	7.18	7.09	7.16	7.11
Worst result	6.67	6.69	6.73	6.75
Responses	947	918	1041	918

Wirral Community Health and Care NHS Foundation Trust Benchmark report

Staff Survey 2024

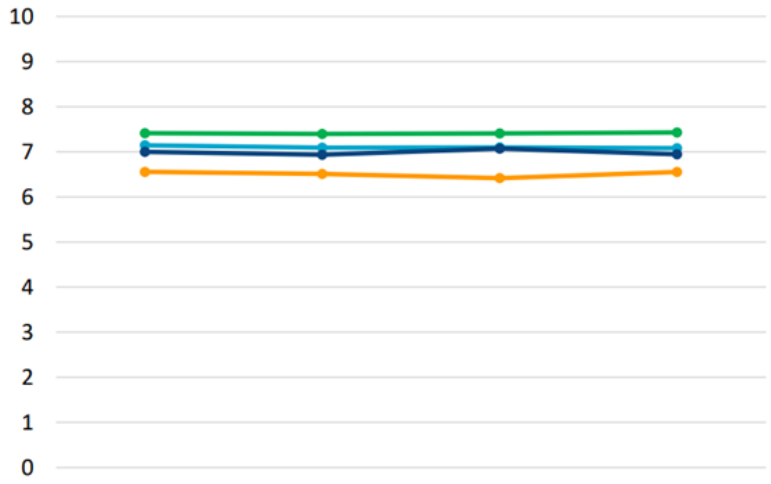
Promise element 3: We each have a voice that counts

Autonomy and control



	2021	2022	2023	2024
Your org	6.99	7.09	7.19	7.05
Best result	7.42	7.29	7.36	7.41
Average result	7.18	7.20	7.22	7.16
Worst result	6.78	6.86	6.97	6.87
Responses	977	918	1047	926

Raising concerns



	2021	2022	2023	2024
Your org	7.00	6.93	7.07	6.94
Best result	7.41	7.40	7.41	7.43
Average result	7.14	7.09	7.10	7.08
Worst result	6.55	6.51	6.41	6.55
Responses	947	918	1041	919

Successes

- The FTSU strategic plan was launched outlining the Trust's commitment and vision to support our staff to speak up
- We currently have 135 FTSU Champions across all Trust sites and available in all Staff Network Groups to support our workers to speak up safely, promote our Trust values and promote behavioural standards
- All Champions had access to additional FTSU Refresher training in 2024/25 to support them in their role
- We achieved 94.46% compliance in the Speak Up, Listen Up, Follow Up role essential training, exceeding our 90% target
- Improvements were made in the gathering of demographic information to give a higher statistical sample

Key priorities for 2025/26

- Greater collaborative working with FTSU Team at Wirral University Teaching Hospital
- Development of triangulation tool to be monitored at Quarterly FTSU Steering Group
- Improvement in the monitoring of demographic information to support all Trust staff to speak up freely and openly

National Speak Up Month October 2024

A celebration of Speaking Up and raising awareness

30 Staff Facebook posts
13 Inspirational Quotes about The Power of Listening
8 messages from Champions
7 Items in the Update
4 Screen Savers
4 Poems written by our staff
1 Wear Green Wednesday
1 Special Addition of the Update
1 Wordsearch
1 Quiz

Multiple localised team events hosted by our 135 wonderful FTSU Champions across the Trust promoting, supporting and signposting

National Speak Up Month October 2024

A celebration of Speaking Up and raising awareness

Public Board of Directors **Item 23**

04 June 2025

Title	Social Value Annual Report, 2024/25
Lead Director	Tony Bennett, Chief Strategy Officer
Author	David Hammond, Deputy Chief Strategy Officer
Report for	Approval

Executive Summary and Report Recommendations

WCHC's Social Value report for 2024/25 highlights areas of progress against WCHC's five social value themes and the We Will statements in the Social Value and Partnerships section of the Organisational Strategy (2022-27).

Notable areas of development relate to 'Community Engagement and support' (particularly Marine Place). With regard to the three We Will statements, one has been assessed as 'Met' and two as 'Partially met'.

Those 'Partially met' are related to delivering the Trust's Green Plan and Focus on Employment and Procurement. The former because, despite positive development in 24/25, the last available reported year shows an increase in CO2e emissions. The latter because the loss of external funding led to a significant reduction in activity related to Widening Participation.

Nevertheless, there are many examples of good practice provided and WCHC can demonstrate significant progress in all areas of its Social Value Framework

It is recommended that the Board:

- To agree the draft Social Value report for 2024/25.

Key Risks

This report relates to the following key risks:

N/A

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
20 May 2025	Executive Group	Social Value Annual Report	Approved to progress to Board

1	Narrative
1.1	To approve the draft Social Value report for 2024/25.

2	Implications
2.1	**Quality/Inclusion** N/A
2.2	**Finance** N/A
2.3	**Compliance** N/A

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply:

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

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NHS
Wirral Community Health and Care
NHS Foundation Trust

Social Value

Annual report, 2024/25

SOCIAL VALUE QUALITY MARK

LEVEL 1

Social Value report 2024/25

Our role as a community health and care provider goes beyond service provision. Maximising our social value is a key part of our Organisational strategy (2022-27).

We were the first NHS Trust in the country to achieve the Social Value Quality Mark at Level 1.

We have signed up to both the Cheshire and Merseyside Anchor Institution Charter Principles and the Cheshire and Merseyside Social Value Charter.

This report highlights some of our work during 2024/25.

Social value aims from WCHC's 5 year strategy (2022-27):

- Expanding and delivering our social value agenda with a focus on employment and procurement
- Deliver the Trust Green Plan, improving processes for the effective management of the Trust's environmental impacts, increasing employee engagement and reducing direct carbon emissions throughout the Trust's value chain
- Collaborate with local partners to improve health outcome through increasing social value

WCHC's Social Value framework

WCHC's Social Value Framework has five themes.

Each contains sub themes with metrics that are tracked through our Oversight Groups.

These are derived from the themes of the Anchor Institution Charter Principles and the Cheshire and Merseyside Social Value Charter.

In 2024/25 we have made progress in all areas with a particular focus on Increasing Wellbeing and Health Equity, Reducing Environmental Impact, and Community Engagement and Support.

Purchasing and investing for social benefit

Our purchasing power supports the local economy.
We use suppliers committed to increasing social value.

In 2024/25 we spent **£8.1m** (ca. 20% of total) in the local supply chain (ie within Cheshire & Merseyside), comparable to recent years.

100% of the contracts (3) we awarded included social value as part of tender evaluation.

Our suppliers have demonstrated their social value commitments through the tender process, e.g.

- **Net zero direct carbon emissions by 2030**
- **Maintaining an accredited Ultra Low Emission Vehicle (ULEV) fleet**
- **Annual employee volunteer days**
- **Local recruitment and employment**
- **Support for local VCFSE organisations**
- **More environmentally friendly packaging**

Representative workforce and access to quality work

We are ensuring our workforce fully represents our communities and provides opportunities for more people to gain access to good quality jobs.

This means:

- Making sure people know about jobs in the NHS
- Inspiring people to follow a career in healthcare, and supporting their development
- Removing unnecessary barriers to seeking and applying for jobs

Expanding horizons

Team WCHC supported the Liverpool City Region (LCR) **NHS Careers Event** hosted by NHS England at Hope University.

Over 250 Year 9 children from schools across the region applied to attend the event and attended workshops hosted by NHS staff on different areas of work within the NHS.

Our team worked with other trusts to showcase digital and procurement careers.

Staff from the Knowsley 0-25 Service attended the **Liverpool John Moores University careers events 2025** to promote our organisation and share the job opportunities and support available to new staff.

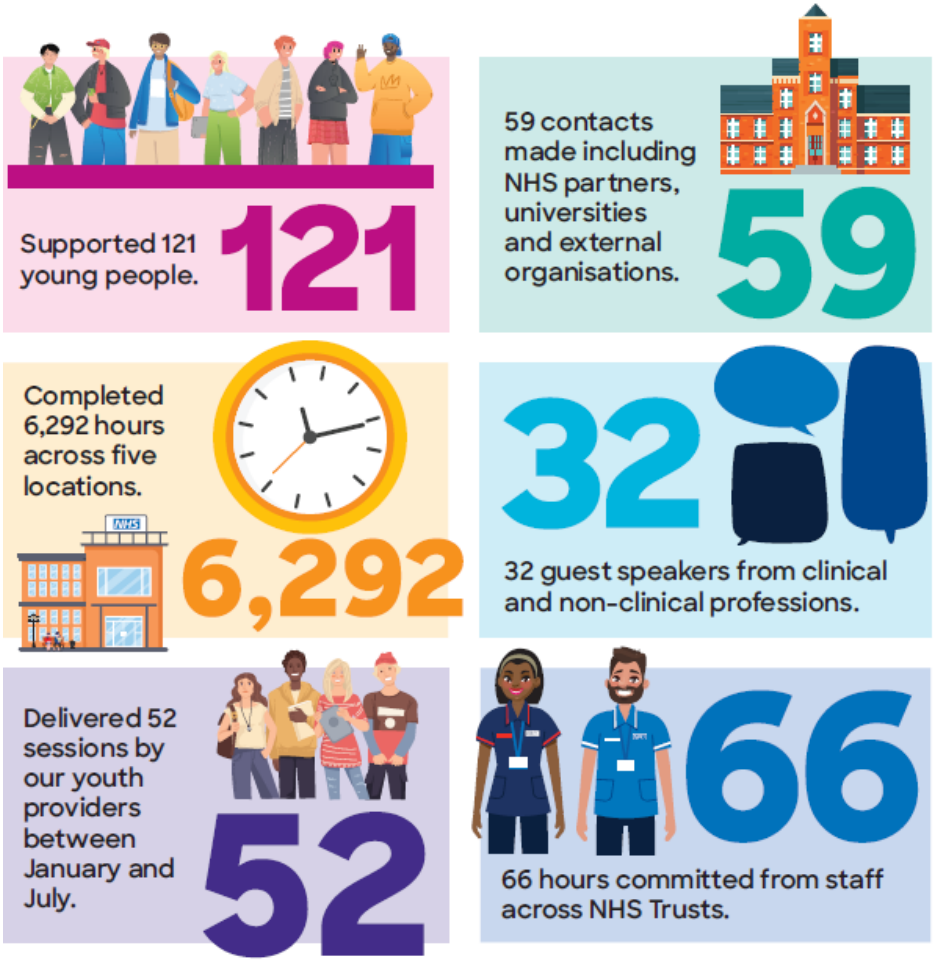
NHS Cadets

The Trust was the first NHS Community Trust to partner with NHSE and St John's Ambulance to deliver the NHS Cadets Programme.

During 2024-25, the programme was **expanded to St Helens and Knowsley**. This enabled even more young people to particate and develop their leadership skills and volunteer in the NHS.

In August 2024, the NHS Cadets came together to **celebrate their achievements**.

Whilst we lost our external funding for NHS Cadets in 2024/25, we are proud to have helped drive and improve this national programme.



Apprenticeships

In 2024/25, we continued to encourage staff to develop through apprenticeships.

WCHC supported **66 staff**, equivalent to **3.6%** of our substantive workforce, on an apprenticeship. An increase of 0.6% compared to 2023/24.

24 new apprenticeships started in 2024/25, and 15 staff successfully completed.

The social value of the apprenticeships at levels 2, 3 and 4 was **over £100k.**

Increasing wellbeing and health equity

We work to increase wellbeing and health equity for both our staff and the wider communities we serve.

We continued to prioritise Wellbeing Conversations, with **118 staff** trained in Wellbeing Conversations during 2024/25, adding to the 150+ trained previously.

The training "…renewed focus on my own wellbeing as well as supporting colleagues and feeling more confident in initiating conversations."

Throughout the year, we put focus on different wellbeing topics, promoted through staff communications and events, including:

- financial wellbeing
- men's health
- menopause
- mental health
- nutrition
- physical activity

MENTAL HEALTH FOUNDATION
MENTAL HEALTH AWARENESS WEEK

Health & Wellbeing Celebration & Sharing Event

On 19 June 2024 we held a Staff Health and Wellbeing event, well attended by staff, VCFSE partners and members of the public. It showcased services available to both staff and the public, adding to the wellbeing campaigns run throughout the year.

Staff Networks

We have continued the support and development of our staff network groups, BAME, Pride, Ability, Working Careers and the menopause group. In total our staff networks have **nearly 120 members** from across the organisation, who regularly attend a network meeting every 4-6 weeks.

Each of the staff networks has an identified executive sponsor, helping us make the Trust an inclusive and welcoming place to work and receive care through inclusive senior leadership.

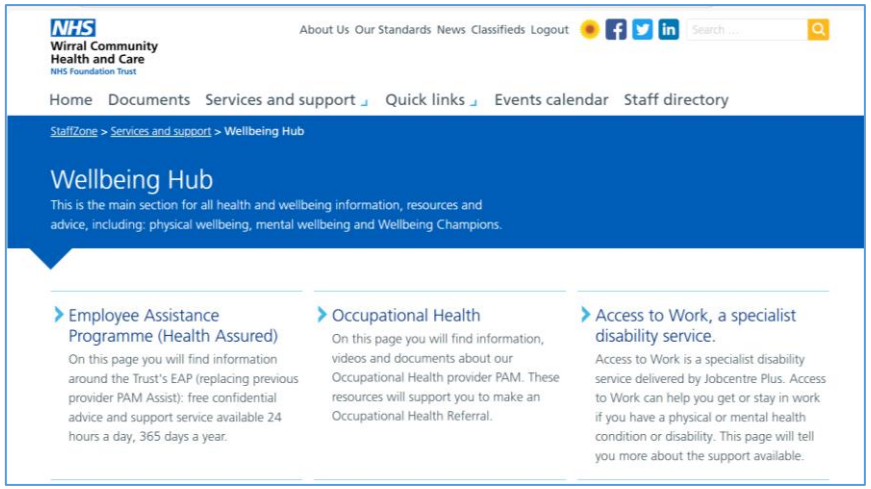
"It is important as a member of the Board we understand people's lived experiences and take that learning to make a positive difference for our staff and people we serve."

Executive Staff Network Sponsor

StaffZone Wellbeing Hub

We launched the Wellbeing Hub, so that staff can find practical help and support related to Wellbeing all in one place. It features:

- Occupational Health / Employee Assistance Programme
- Access to work
- Financial Wellbeing
- Wellbeing Conversation Training
- Mental Wellbeing
- Health and Wellbeing Champions
- Working Carers support
- Menopause and support available
- Booking a team visit by Spartacus our therapy dog



Spartacus, Trust Therapy Dog

This year, our therapy dog Spartacus and his handler Eileen, visited **over 30 services** and met hundreds of staff, service users and patients along the way.

His impact has been felt most deeply with children in our 0-19+ / 0-25 services and with older patients at our Community Intermediate Care Centre (CICC).

Spartacus and Eileen were recognised by the BBC's The One Show for going the extra mile to help others in their community. This was aired on BBC One in April.

> *"One unforgettable moment was when a patient who hadn't spoken in weeks began talking the moment she saw Spartacus… These moments are both humbling and inspiring."*
>
> *Spartacus' handler, Eileen*

Spartacus, Eileen and Laura from WCHC, with BBC's The One Show Pete Wicks

Sustainability

We aim to reduce our environmental impact, both directly and across our supply chains. Our Green Plan for 2025-2028 sets out the Trust strategy for reducing environmental impact, focusing on:

Energy - continue to strive to achieve Net Zero Carbon by 2040 by reducing carbon emissions year on year, and apply for decarbonisation project funding

Waste - achieve a waste segregation target of 20% incineration / 20% infectious / 60% offensive. Separating waste reduces disposal costs and energy use.

Adaptation - produce climate adaptation plans to account for anticipated disruption caused by unpredictable weather events, and higher temperatures

Waste, energy and water

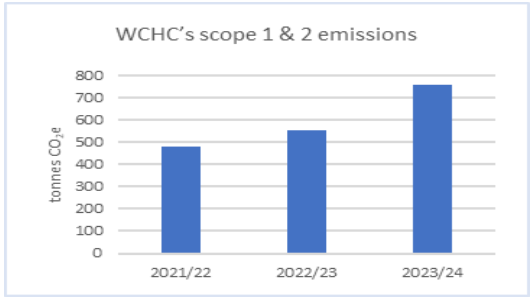
Maintaining our commitment to reducing greenhouse gas emissions, WCHC implemented a **major upgrade of its Building Management System** for St Catherine's Health Centre in 2024/25

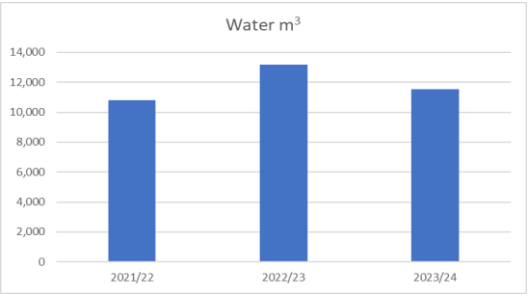
This means that the Estates team can now more easily change temperatures, balance heating and cooling systems, diagnose faults and provide information to contractors.

This will counteract increases in emissions over the three years to 2023/24 (last reported data) due to increased footprint and service recovery post-covid. Positively, whilst energy use increased, we saw **less water used**.

Our increased footprint includes a new building in West Kirby, which achieved **high sustainability standards** for its design and construction.

BREEAM Very Good

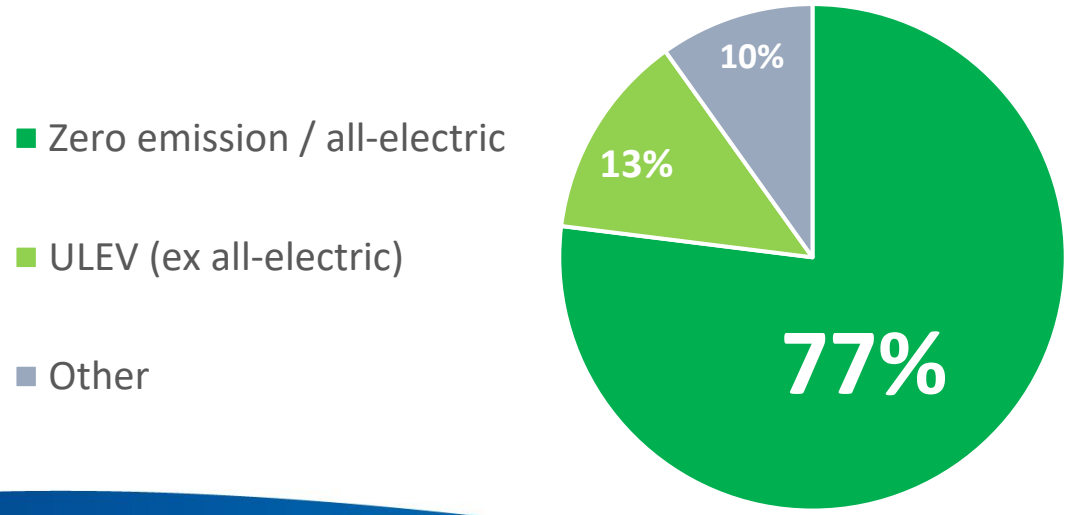




Ultra Low Emissions Vehicle (ULEV) growth

By promoting salary sacrifice car lease, we have seen a positive shift in the proportion of our salary sacrifice car fleet (152) that is made up of Ultra Low Emission Vehicles (ULEV), mostly all-electric cars.

At the end of 2024/25, **77% of salary sacrifice cars were all electric and zero emission at point of use**, with 90% overall ULEV.



Community engagement and support

We engage with patients and other members of the public, and the wider voluntary, community, faith and social enterprise (VCFSE) sector, to:

- create better links and understanding across teams
- Maximise the benefit that the VCFSE can deliver

We **commissioned Autism Together** for part of our Tier 2 Oliver McGowan training, learning from people with lived experience of Autism and Learning Disability.

118 staff have already had this Tier 2 training.

Our patient engagement groups, Your Voice and INVOLVE, have continued to help improve the experiences of people who access Trust services.

yourvoice
listening • supporting • shaping

Community engagement

In 2024/25 we have worked with other organisations including Healthwatch Wirral , WUTH, CWP, One Wirral CIC, Carers Alliance and Wired to deliver events and support including:

Community Carers Event (June 2024) at Arrowe Park Hospital providing information on a wide range of services relevant to carers, carers rights information, health & wellbeing advice and resources, support, and social activities available to carers locally.

New Brighton Pride (August 2024) supported by our LGBTQ+ staff network and our Sexual Health Wirral service, celebrating the diversity in our communities and our workforce, showing positive allyship to our LGBTQ+ colleagues, friends, families and communities.

Winter Wellness Event (November 2024) at Arrowe Park Hospital promoting good hand hygiene, hydration and vaccinations for Flu, Covid-19 and Pneumococcal. Therapists also advised on general mobility and core strength to maintain fitness, core stability and prevent falls.

Marine Place

Marine Place, a community café in our health and wellbeing centre in West Kirby, has gone from strength to strength in delivering social value through community engagement.

It's offer to patients and members of the public has included

- Information and Advice sessions, including Benefit Advice
- Falls prevention
- Carer support
- IAPT (mental health) drop in sessions
- Partnership days, involving Community Connectors, Social Prescribers, Alzheimer's Society, Wirral Society for the Blind Partially Sighted, Dementia Together Wirral

Advice sessions provide an average saving or increase in benefit of £150 per client

Marine Place's social value return on investment averages £7,410/month, or £88,928/year

The 'Cathy'

Continuing to work in partnership with Age UK Wirral and building on the success of Marine Place, a community café in our health and wellbeing centre in West Kirby, a similar set up launched in St Catherine's Health Centre in 2024.

Based on the social value principles of Marine Place, the community cafés have **18 regular volunteers** who have contributed **over 3000 hours** of volunteering time to date.

"Volunteering gives me a reason to get out and a sense of purpose now that I'm retired. I enjoy being part of a team and knowing that I'm giving something back to the community."

Social Value – We Will… 1

Expand and deliver our social value agenda with a focus on employment and procurement	**Partially met**	✓ Social value in all WCHC tenders ✓ Active support for career sessions with local education providers ✓ Apprenticeships (£100+k social value, levels 2-4) ✓ NHS Cadets celebration event — Loss of funding to continue NHS Cadets programme — Loss of funding meant unable to deliver additional Widening Participation programme as planned

Social Value – We Will… 2

Deliver the Trust Green Plan, improving processes for the effective management of the Trust's environmental impacts, increasing employee engagement and reducing direct carbon emissions throughout the Trust's value chain	**Partially met**	✓ Procurement processes encouraging reduced environmental impact from suppliers ✓ Investment in Building Management System upgrade for improved efficiency ✓ Increase in ULEV cars via salary sacrifice scheme ✓ Reduction in water usage in last reported year — Increase in overall emissions in last reported year

Social Value – We Will… 3

Collaborate with local partners to improve health outcomes through increasing social value	✓ **Met**	✓ Marine Lake and The Cathy delivering high social value, including volunteering opportunities ✓ Collaborative work with partners to support wide range of groups and events ✓ Commissioning local VCFSE organisation to support staff training ✓ Your Voice and INVOLVE group supporting improvement in patient experience

Summary

WCHC continues to drive and promote social value aligned to our strategic intent.

The report demonstrates key social value return in all areas with plans for further progress.

Over the coming year, these plans include bringing together our social value work with that of Wirral University Teaching Hospital to create even greater impact together.

Public Board of Directors **Item 24**

04 June 2025

Title	Organisational Strategy 2022-27 Year 3 Progress Report
Lead Director	Tony Bennett, Chief Strategy Officer
Author	Tony Bennett, Chief Strategy Officer, David Hammond, Deputy Chief Strategy Officer
Report for	Information

Executive Summary and Report Recommendations

The Five-Year Organisational Strategy (2022 - 2027) was approved by Board in April 2022. Each section includes 'We Will…' statements against which delivery can be measured. The strategy was reviewed and a revised version, with changes to some of the We Will statements, was approved in April 2024.

This update provides an overview of key achievements against each of the following sections:

- Operational development
- Quality & innovation
- Inclusion
- People
- Digital

The end of year three position shows significant achievement across every strategy area, delivering against all the We Will statements planned for 2024/5.

Highlights are identified in the presentation, including significant progress in development integrated teams for Population Health Management, extending the responsiveness and scope of admissions avoidance capacity with Urgent Community Response's Call Before Convey and revised Virtual Frailty Ward model, and reshaping the Trust's Centralised Booking Service to improve efficiency and quality of service

It is recommended that the Board:

- Be assured with regard to progress against delivery of the Organisational Strategy (2022 - 2027)

Key Risks

This report relates to the following key risks:

N/A

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
No reporting history.			

1	Narrative
1.1	To assure Board of progress against delivery of the third year (2024/25) of the Five Year Organisational Strategy (2022-2027) by providing an end of year update with an overview of key achievements against the We Will statements from the Organisational Strategy in each of its key sections.

2	Implications
2.1	**Quality/Inclusion** N/A
2.2	**Finance** N/A
2.3	**Compliance** N/A

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: Community engagement and support ☒ Purchasing and investing locally for social benefit ☒ Representative workforce and access to quality work ☒ Increasing wellbeing and health equity ☒ Reducing environmental impact ☒

NHS
Wirral Community Health and Care
NHS Foundation Trust

Organisational Strategy, end of 2024/25 update

Tony Bennett, Chief Strategy Officer
Wednesday 23 April 2025

Purpose

To assure Board of progress towards delivery of the Five Year Organisational Strategy (2022-2027) by providing an update against Year 3 of the Strategy.

- Report gives an overview of key achievements against the We Will statements from the Organisational Strategy in each of its key sections.
- Enabling strategies (Quality, People, Digital) report through committees against strategy delivery plans, therefore highlights are presented in this report.

Strategy delivery assurance routes

- Enabling strategy updates go to relevant committees, therefore this update identifies highlights for each enabling strategy, with more detail for Operational development.
- Projects supporting Operational development priorities have reported at Programme Oversight Group.
- Actions in strategy updates are mapped against We Will statements from the Organisational Strategy for detailed assurance against delivery plans.

Strategy	Committee(s)
Quality & Innovation	Quality & Safety
Inclusion and Health Inequalities	
People	People & Culture
Digital	Finance & Performance

Operational development

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25 "We Will" Statements	Key deliverables	Action Ownership
Develop integrated care models for 0-19+ services in Cheshire & Merseyside	1. Deliver the next stage of the 0-19 Centralised Contact Hub project (Phase 2), to develop the service offer and pathways from the Hub. Support the launch and delivery of Family Hubs in all Places where WCHC delivers 0-19/25 services. 2. Through the Population Health Management (PHM) project: Align ICCT staff to Wirral's PCN footprints as enabler for PHM on PCN footprint, to incorporate ICCT long term condition management into PHM model. Agree principles and models for integrated PHM teams with all Wirral PCNs and implement integrated team working with three PCNs by end Jan 24/25. 3. Continuation of collaboration with Age UK in Marine Lake and St Catherines, with social value return that exceeds the nominal rental value. 4. As part of the District Nursing Development Project, develop and agree a model for allocating resources proportionate to population health needs	1. COO 2. CN 3. CSO 4. CSO
Implement locality teams in Wirral, with proactive population health management (PHM) and care coordination...		
Build and implement a holistic model for prevention and management of Long Term Conditions, supporting Primary Care Network (PCN) and locality working		
Continue to collaborate with NHS, local authority and Voluntary, Community Faith and Social Enterprise (VCFSE) partners so that people benefit from person-centred, well-coordinated care.		
Identify how we will take a population health approach to target service delivery and deploy our workforce to meet population health need.		

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25 "We Will" Statements	Key deliverables	Action Ownership
Continue to expand our Community Integrated Response Team model for 2 hour Urgent Community Response (UCR) and, with WUTH, Virtual Frailty Ward, to prevent unnecessary hospital admissions.	5. UCR activity levels of 170/month and performance of 70+% people seen in two hours, plus maximising Virtual Frailty Ward occupancy 6. Home First pathway discharge rates target 170 people per month. 7. CICC occupancy rates above 90% and average LOS of 21 days. Development of a formal step-up pathway into CICC. 8. Right Care Hub Project (Phase 2) will integrate additional services' administrative functions within the Hub, whilst developing admission avoidance and intermediate care coordination pathways 9. Urgent & Emergency Care Upgrade Project: With WUTH, development during 24/25 of i) an agreed clinical and operational model ii) an agreed digital solution to support the model	5. COO 6. COO 7. COO 8. COO 9. COO
Continue to develop our Home First service with system partners, so that people can be supported and have their needs assessed at home after a hospital stay, improving flow.		
Develop our bed-based Community Intermediate Care Centre (CICC) pathways with step-up capability as part of comprehensive intermediate care offer.		
Continue to develop our Single Point of Access into a multidisciplinary Right Care Hub for access to urgent care services, admission avoidance and integrated care coordination.		
Implement a single front door model for urgent treatment and A&E as part of Wirral's urgent and emergency care services		

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Implement locality teams in Wirral, with proactive population health management (PHM) and care coordination... **Build and implement a holistic model for prevention and management of Long-Term Conditions, supporting Primary Care Network (PCN) and locality working**	2. Through the **Population Health Management (PHM) project:** Align ICCT staff to Wirral's PCN footprints as enabler for PHM on PCN footprint, to incorporate ICCT long term condition management into PHM model. Agree principles and models for integrated PHM teams with all Wirral PCNs and implement integrated team working with three PCNs by end Jan 24/25.	COO CNO (SRO for Ageing Well and Frailty)

Details of progress 24/25
Wirral's integrated Community Trust and Primary Care Network population health management teams are being set up to deliver proactive, coordinated care for people who most need it and who are more likely to experience unplanned hospital admissions. This brings together WCHC's matrons, frailty nurse practitioners and early intervention assistants with PCN teams, including paramedics, pharmacy teams, social prescribers and care coordinators. This work began in late 2023/24 with a fully integrated primary-community team pilot project, working on a Primary Care Network (PCN) footprint in Moreton & Meols PCN. Having confirmed during Q1&2 2024/25 that this model improved communication and care coordination on the PCN footprint, reduced duplication, and enabled focus on people most needing proactive support, we started to roll it out with other PCNs in Wirral. Every PCN in Wirral is in the process of adopting this model. Moreton & Meols and Wallasey Wellbeing PCN units are already live, alongside Arno Primary Care Alliance and North Coast Alliance, and West Wirral. All others should be in place by Q3 2025/26. The model has been shared with NHS England's national team and the National Clinical Director for Older People as a working example of Integrated Neighbourhood Teams. It has also been featured by the British Geriatric Society as an effective example of integrated proactive care.

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Continue to collaborate with NHS, local authority and Voluntary, Community Faith and Social Enterprise (VCFSE) partners so that people benefit from person-centred, well-coordinated care.	3. Continuation of collaboration with Age UK in Marine Lake and St Catherines, with social value return that exceeds the nominal rental value.	CSO

Details of progress 24/25
Age UK Wirral continue to provide café and a wider support offer in West Kirby and Birkenhead, occupying space on the basis of measurable social value, reporting high levels of social value return. The calculated social value significantly exceeds the market rental value of the space. The community garden at Marine Lake Health Centre, managed by volunteers, goes from strength to strength. The café creates opportunities for a wide range of external organisations, mainly charities, to engage with people and offer support. This includes carers, people who are socially isolated, those needing support with physical and mental health, and issues related to housing and finance. Additionally, we have actively engaged with VCFSE to strengthen the Population Health Management model on a PCN footprint, including via PCN social prescribers, ensuring people have social as well as clinical support..

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Identify how we will take a population health approach to target service delivery and deploy our workforce to meet population health need.	4. As part of the **District Nursing Development Project**, develop and agree a model for allocating resources proportionate to population health needs	COO CSO

Details of progress Q4
A model has been developed to match team district nursing capacity resources to population health needs. Implementation of new model expected Q2 25/26. Additionally, resource allocation for developing integrated frailty teams with Primary Care Networks has been informed by population health needs, evidenced by unplanned care demand and cross checked against health inequality data. Cheshire & Merseyside CIPHA (i.e. Combined Intelligence for Population Health Action) tool and related EMIS searches employed to understand levels of need and identify people with higher levels of emergency admissions.

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Continue to expand our Community Integrated Response Team model for 2-hour Urgent Community Response (UCR) and, with WUTH, Virtual Frailty Ward, to prevent unnecessary hospital admissions.	5. UCR activity levels of 170/month and performance of 70+% people seen in two hours, plus maximising Virtual Frailty Ward occupancy	COO

Details of progress 24/25
We have continued to deliver above target levels of UCR activity with 90% of patients being seen within 2 hours against target of 70% We launched Call Before Convey within UCR, which enabled paramedics to contact UCR from the patient's home, to discuss alternatives to ambulance conveyance. This prevented 235 conveyances to acute services (December 2024 - March 2025), with enhanced care pathways supporting patients to receive treatment in their own home. UCR increased NWAS referrals by 81% in December 2024 when compared to December 2023 due to the call before convey project UCR has notably higher referrals from care homes than other providers across C&M. This is due to the teletriage and UCR teams merging resulting in an enhanced service to all care home residents with access to the Frailty Virtual ward and therapy services. We revised the Virtual Ward model for September 2024 to enable higher levels of occupancy, which was enabled by the introduction of a nurse lead caseload with Geriatrician oversite. We are also in the process of expanding diagnostics available on the frailty virtual ward to include point of care testing and ECG's. This increase in occupancy has been sustained throughout Q3 and Q4 to date due to effective collaborative working with WUTH.

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Continue to develop our Home First service with system partners, so that people can be supported and have their needs assessed at home after a hospital stay, improving flow.	6. Home First pathway discharge rates target 170 people per month.	COO
Details of progress 24/25		
Home First facilitated discharges has consistently over-achieved against target for 24/25. Continue to work collaboratively with WUTH and Local Authority colleagues to maximise the HF offer and provide joined up care for complex discharges		

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Develop our bed-based Community Intermediate Care Centre (CICC) pathways with step-up capability as part of comprehensive intermediate care offer.	7. CICC occupancy rates above 90% and average LOS of 21 days. Development of a formal step-up pathway into CICC.	COO
Details of progress 24/25		
The YTD position for Median Length of stay 18 days against a 21 day target and YTD occupancy at 92%. Continue to develop step-up pathway from community and realign delivery model to maximise discharges from hospital. Commenced in-house medical model from November 2024		

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Continue to develop our Single Point of Access into a multidisciplinary Right Care Hub for access to urgent care services, admission avoidance and integrated care coordination.	8. **Right Care Hub Project (Phase 2)** will integrate additional services' administrative functions within the Hub, whilst developing admission avoidance and intermediate care coordination pathways	COO

Details of progress 24/25
Phase 2 of Right Care Hub continued through 24/25. Now planning for 25/26 where clinical triage and care navigation will become part of the Urgent Care integration project with WUTH during and align to national expectations. The Centralised Booking Service has significantly developed during 24/25. It expanded to include the administrative functions for more services (including referral input /management, call handling, appointment booking, patient communication). It now supports 11 clinical services (8 having migrated to the new CBS model during 24/25), with more scheduled to be included in 25/26. This has led to improvements in call answering (80+% now within 60 seconds), with reductions in call abandonment rate (5% reducing to 3%). Most of the 7500 calls/month are handled within 2.5minutes, with reductions in maximum call volume due to quicker resolution. Measurable benefits have been achieved in productivity, cost, performance, patient experience and staff experience and morale.

Operational Development

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Develop integrated care models for 0-19+ services in Cheshire & Merseyside	1. Deliver the next stage of the **0-19 Centralised Contact Hub project (Phase 2),** to develop the service offer and pathways from the Hub. Support the launch and delivery of Family Hubs in all Places where WCHC delivers 0-19/25 services.	COO
Details of progress 24/25		
Phase 2 of the Centralised Hub developments has been launched. Phase 2 focuses on the introduction of digital screening tools. Family Hubs have launched across all 4 localities and 0-19 are an integral partner. Action completed.		

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
Implement a single front door model for urgent treatment and A&E as part of Wirral's urgent and emergency care services.	9. **Urgent & Emergency Care Upgrade Project:** With WUTH, development during 24/25 of i) an agreed clinical and operational model ii) an agreed digital solution to support the model	COO
Details of progress 24/25		
Project continues in line with agreed timeframes. Digital solution now agreed. Now working on clinical and operational model as part of the overall Urgent Care integration plans with WUTH for 25/26		

Quality and innovation

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

	WCHC Strategic Priorities	WCHC Strategic Actions 2024/25 "We Will" Statements	Action Ownership
Quality Strategy: **Care beyond boundaries**	**Safe care and support every time**	1. Embed a framework for system-wide learning, i.e. Patient Safety Incident response Framework (PSIRF) 2. Use data to drive improvement across key clinical risk priorities 3. Embed inequalities data collection to facilitate better understanding of need 4. Establish processes for systematically hearing from people / communities - coproduction of care pathways, to improve inclusivity, reduce inequalities, and ensure we meet people's needs 5. Develop a sustainable workforce to lead innovation and research 6. Build a strong innovation and research portfolio, and establish an innovation hub with system partners	1. CNO 2. CNO 3. CNO 4. CNO 5. MD 6. MD
	People and Communities Guiding Care		
	Ground-breaking Innovation and Research		

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
1. Embed a framework for system-wide learning, i.e. Patient Safety Incident Response Framework (PSIRF)	Embed PSIRF further ensuring the principles are demonstrated throughout trust process and culture.	CNO

Details of progress 24/25
PSIRF policy and plan approved and implemented Quarterly Safety Champions meetings commenced with joint chairs Patient Safety Lead and Community Nurse Manager. Focus on appreciative enquiry and psychological safety and the role of the patient safety champions in supporting teams to embed this further. Mechanism to support the continual monitoring, understanding and evaluation of work as prescribed, perceived and work as done embedded through divisions and CRMG. PSIRF methodology embedded further by offering learning Cafes for the key principles of psychological safety, SEIPS (System Engineering Imitative for Patient Safety), and appreciative inquiry.

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
2. Use data to drive improvement across key clinical risk priorities	Deliver a minimum of 4 quality improvement programmes based on high priority clinical risks demonstrating tangible outcomes relating to safety and clinical effectiveness.	CNO

Details of progress 24/25

• Following data analysis, the following four priority clinical risk areas have been identified via triangulation of data.
  ○ Wound care improvement plan
  ○ Falls improvement plan
  ○ Medicines improvement plan
  ○ End of Life Care
  ○ Deteriorating patient – Audit and staff engagement work will guide priorities in 25/26
• Driver diagrams and associated improvement plan are monitored at the Trusts' Clinical Risk Management Group.
• Improvements have been realised in compliance with ASSKING framework relating to pressure ulcer prevention and the number of falls resulting in moderate harm at CICC.

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
3. Embed inequalities data collection to facilitate better understanding of need	Continue to develop data collection methodology in relation to Accessible Information Standards and health inequalities waiting list tool	CNO

Details of progress 24/25
Accessible Information Standards • Post MIAA Audit. Improvement action plan developed and presented to SOG September 24. • Continued improvement in AIS completion rates across services – locality completion rates range from 47% to 80%. Monitored at SOG – Qualitative and Quantitative analysis. TIG dashboard now updated to show new compliance monitoring, targets and agreed trajectories • Templates streamlined to minimise duplication between AIS inclusion template and HI waiting list tool. Go live Q4. **Health inequalities waiting tool** • PID approved at POG Q3. • Work on the questionnaires and SOP to refine the tool and remove confliction with AIS template is now complete. SOP approved at CAG. Comms plan developed • Walk through video being produced by Clinical systems team

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
4. Establish processes for systematically hearing from people / communities - coproduction of care pathways, to improve inclusivity, reduce inequalities, and ensure we meet people's needs	Delivery of - Tier 2 Oliver McGowan training - 4 co-designed care pathways - What matter to you campaign	CNO

Details of progress 24/25
Delivery of **Tier 2 Oliver McGowan training** – targeting delivery to 12% of eligible staff Implementation of the following **4 codesigned care pathways** aimed at reducing health inequalities and evidencing sustainability and spread • NPOP and referral pathway to memory clinic • Translation and interpretation (Trust-wide inclusive of children's services) • Long Covid and rehabilitation • Rehab at Home and home hazards checklist • Family Nurse Partnership (Children's services)- Improving accessibility of information for first time parents **"What matters to you"** campaign implemented. First What Matters to You campaign day was held on 25/9/24 with the campaign team visiting sites across Wirral and Cheshire East – CICC, Podiatry, MSK, Cardiology, Walk in Centres, Community Nursing, 0-19 and 0-25. Thematic analysis being completed and feedback to staff to promote a you said, we did approach Week 2 of the campaign completed November with services visited – Diabetes Smart and Community Dental. Work has commenced with Wirral Met College work experience students to support the you said we did approach

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
5. Develop a sustainable workforce to lead innovation and research	-Train a further 20% of eligible staff in QSIR methods - Develop a research enabling workforce.	MD

Details of progress 24/25
• Continued focus on engagement and awareness of staff / enhancing the culture around research, innovation, continuous improvement.
• Ratification of the Terms of Reference of the Research and Innovation Oversight Group in Q3.
• Commencement of the Research and Innovation Oversight Group (RIOG) in Q3.
• Support from North West Regional Research Delivery Network (NW RRDN) Agile Research Delivery Team to enable delivery of REACH HFpEF
• NIHR NW RRDN (Service Support Costs) Funding for 1.0 WTE Band 6 Clinical Research Practitioner
• Secondment of Band 8a Head of Research of Research and Innovation from NWRRDD for Q3/Q4.
• Research Champions identified across 7 clinical services.
• Ongoing growth of QSIR-P and QSIR-F enabled staff; 82 staff trained this year (> the 20% of eligible staff target)
• Ongoing access to degree/Masters level qualifications, that have research/innovation linked content: 2 Doctorate courses / 33 live learners at L6/7, 19 completed learners at L6/7.

Quality & Innovation

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
6. Build a strong innovation and research portfolio, and establish an innovation hub with system partners	- Increase research capability and capacity. - Establish an Innovation Hub with Wirral Met college. - Establish 2 'creativity sessions with innovation partners.	MD

Details of progress 24/25
NW RRDN Agile Research Delivery Team support has enabled ongoing recruitment to NIHR portfolio studies • Cardiology - WCHC is the largest recruiter nationally for REACH HFpEF • MSK – PANDA-S • 0-19 Further studies in set up involve Community Response and 0-19 Active board membership of the Wirral Research Collaborative, a multi provider group focused on growing the footprint of health care research in Wirral. Partner organisation of NIHR Applied Research Collaboration, Northwest Coast (ARCNWC) – focused on reducing health inequalities and improving the quality and efficiency of health and social care through connected research communities. MD attended the opening of WUTH Research and Innovation Hub (Sept 2024) MoU agreed between WCHC and the Wirral Metropolitan College for Innovation Hub (Hamilton Campus Building, Birkenhead) Creativity session (Nov 24) with Wirral Met college and WCHC staff. Opening event held in the Innovation Hub (Jan) 2025. Creativity session planned for Q4

Digital

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Priorities "We Will" Statements	WCHC Strategic Actions 2024/25	Action Ownership
1. Build on our IT core, ensure cyber security and move towards cloud-based infrastructure	1. Develop the Trusts digital infrastructure in accordance with The Digital Strategy 2022 – 25 2. Develop and implement plans to optimise use and drive benefits from the Electronic Patient Record 3. Ensure obligation to achieve 5% recurrent CIP is met 4. Produce Business Case for the procurement of the Electronic Patient Record 5. Drive digital transformation through introduction of new or existing technologies	1. CDIO 2. CDIO 3. CDIO 4. CDIO 5. CDIO
2. Complete Electronic Health Record (EHR) future state design and implementation		
3. Define and embed a strategic model for remote and assistive care, e.g. virtual consultation, wearable technology, to better support people at home		
4. Further integrate use of population health data from WCHC with associated needs assessments from the wider place-based systems to inform strategic planning and service delivery		
5. Ensure that staff are supported to develop the necessary digital skills and are empowered to lead innovation		
6. Develop a range of ways for patients to engage with services and their care, to increase choice and minimise digital exclusion		

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key Deliverables:	Action Ownership
1. Develop the Trust's digital infrastructure in accordance with Digital Strategy 2022-25	- Ensure Infrastructure is fit for purpose - Fully compliance with cyber assurance standards - Enables integration and interoperability at scale	CDIO

Details of progress 24/25
Capital workstreams delivered: • Move to hybrid cloud phase 1 • Endpoint replacement programme moved to a 4 year cycle • Complete installation and commissioning of Health & Social Care Network (HSCN) circuits to all sites • Complete rollout of Wi-Fi infrastructure across all sites including for GOVROAM • Replace Firewalls at SCHC and VCHC • Replace Uninterrupted Power Supply (UPS) at SCHC, VCHC and Marine Lake • Refurbish comms room at VCHC. Cabling, power provision Undertake assurance works to transition from Data Security & Protection Toolkit (DSPT) to Cyber Assessment Framework (CAF) Continue development of the Cyber assurance agenda with enhanced monitoring Move Home folders to OneDrive Rebuild Data Warehouse and optimise data structures and import routines

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key Deliverables:	Action Ownership
2. Develop and implement plans to optimise use and drive benefits from the Electronic Patient Record (EPR)	- Improve digital maturity - Enable transformation at scale - Enable integration / interoperabilty	CDIO

Details of progress 24/25
Achieved HIMSS (Healthcare Innovation & Management Systems Society) level 5 with areas identified for validation at level 6
Completed mapping exercise to identify key enablers
Input and support to the district nursing transformation project to optimise all aspects of the EPR
Implemented appointment text reminders across all services
Implemented Airmid (patient app for appointments, Video consultations
Initiated workstream to integrate with Labs for orders and results
Developed and agreed plan for integrated digital solution for UECUP (Urgent & Emergency Care Upgrade Programme)

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key Deliverables:	Action Ownership
3. Ensure obligation to achieve 5% recurrent CIP is met	- CIP requirements fully met, with ideas carried forward to support CIP in 2025/26	CDIO

Details of progress 24/25
Digital CIP identified and delivered, 5% recurrent including: • Review of Telephony / Unified Comms • Mobile Phones • Exit from Wirral Care Record

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key Deliverables:	Action Ownership
4. Produce Business Case for the procurement of the Electronic Patient Record	- Contract term aligned with WUTH contract for Oracle Millenium to enable single procurement campaign in 2030.	CDIO

Details of progress 24/25
Develop Strategic Outline Case and Financial Case, approved at Board May 2024
Develop Outline Business Case (OBC) approved at Board, July 2024
Develop Full Business Case, approved at Board in August 2024
Contract term aligns with WUTH EPR contract to provide flexibility for future joint procurement campaign
TPP contract signed

Digital

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key Deliverables:	Action Ownership
5. Drive and enable digital transformation through introduction of new or existing technologies	- Value for Money - Digital enablers to transformation	CDIO

Details of progress 24/25
Redesign of EPR for 0-19 services, reducing 4 units to 1
Digital support to Community Nursing transformation workstream
Purchase of Robotic Process Automation technology (BluePrism) use cases in development
Introduced Airmid as primary solution for virtual consultations, removing Attend Anywhere, AccuRX and Zoom for Business

People

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic People Priorities	WCHC Strategic Actions 2024/25 "We Will" Statements	Action Ownership
Looking after our people.	1. Train and develop managers to fully and compassionately support the well-being of their staff. 2. Improve the employee experience and our brand as an employer which will include a refreshed approach to staff engagement at all levels. 3. Develop and embed a Restorative, Just and Learning Culture where staff can bring their true selves to work and speak up, challenge, contribute and innovate in a psychologically safe environment 4. Build strong leadership and management capability through our Leadership Qualities Framework (LQF) to ensure leaders role-model our values and behaviours 5. Provide career progression opportunities and enhance staff skills, knowledge and experience through experiential and formal learning and development 6. Ensure our workforce planning meets future needs, creating a safe and sustainable workforce within the available resources. 7. Optimising our ways of working aligned to opportunities from digitisation, growing our talent, and maximising our role as an Anchor Institution.	1. CPO 2. CPO 3. CPO 4. CPO 5. CPO 6. CPO 7. CPO
Culture and belonging.		
Growing for the future.		
New ways of working.		

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
1. Train and develop managers to fully and compassionately support the well-being of their staff.	Deliver a 'Manager Essentials' programme. Deliver raining for managers to support staff mental health and wellbeing.	CPO

Details of progress 24/25
A 'Manager Essentials' programme has been developed and implemented for newly appointed managers and for those who require an update to skills. Year 1 of programme implementation has focused on establishing a platform for the programme, developing a manager induction booklet and implementing modules to develop managers as 'People Managers'. Wellbeing Conversation training has been developed and implemented, ensuring compassionate management approach via f2f sessions. Attendance Management managers training redesigned and rolling programme recommenced. Return to work interview compliance support provided to all managers to focus upon the significance of support and recording. Promotion of the benefits of the Employee Assistance Programme continued.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
2. Improve the employee experience and our brand as an employer which will include a refreshed approach to staff engagement at all levels.	Review, refresh and implement the onboarding process for new starters. Deliver People Promise Project to support reduced turnover.	CPO

Details of progress 24/25
New onboarding site refreshed, and portal expanded to review up to 18 months. People Promise Project delivered and voluntary turnover reduced by 1% District Nursing identified as an area of priority and significant engagement undertaken via Viva Engage, DN Bulletin and MS Teams sessions. Staff awareness of Flexible Retirement options identified as an area of focus. Quarterly promotions to staff (bulletin, screensavers etc), Retirement Pension Awareness sessions delivered, and Total Reward Statement access increased.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
3. Develop and embed a Restorative, Just and Learning Culture where staff can bring their true selves to work and speak up, challenge, contribute and innovate in a psychologically safe environment	Launch and embed WCHC behavioural standards framework. Develop and implement a concept/process for culture change interventions.	CPO

Details of progress 24/25
Behavioural Standards Framework (BSF) launched and embedded within all leadership activity in 24/25. BSF cards to distributed to staff across the Trust. The BSF has also been embedded into the Trust Team Development Toolkit, appraisal processes, Internal Leadership Development and appropriate policies. Culture process developed and implemented, for targeted culture work to be used when working directly with teams and departments. There has been strong promotion of the role of FTSU in raising concerns and creating a positive safety culture whilst focusing on the health and well-being of our people. The Trust has committed to the NHS Sexual Safety Charter in June 2024 and the following work has been undertaken in 24/25: • Task and Finish Group: Established to implement the charter, including HR, Safeguarding, Security, FTSU, and Risk Management. • Adoption of the new NHS national sexual misconduct policy framework. • Risk Assessment Conducted to identify potential hazards and risks, evaluate effectiveness of control measures, and incorporate additional actions. • Data Triangulation: Regular review of data to monitor sexual safety in the workplace. • Launch of the ‘Understanding Sexual Misconduct in the Workplace’ course, assigned as role essential training to all supervisory or management staff.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
4. Build strong leadership and management capability through our Leadership Qualities Framework (LQF) to ensure leaders role-model our values and behaviours	Embed and continue to evaluate and evolve the WCHC leadership forum framework Develop and implement the WCHC refreshed Team Development approach. Enhance visibility of senior leadership via Themed Conversations with execs	CPO

Details of progress 24/25
The Leadership Forum annual plan was confirmed via ELT at the start of 24/25 and has been delivered throughout the year. WCHC Team Development approach has been developed and implemented. The approach is available via Staff Zone and is currently in use with 5 teams. Evaluation to be reviewed in Q1 25/26. Executive and Senior Team service visits are in place.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
5. Provide career progression opportunities and enhance staff skills, knowledge and experience through experiential and formal learning and development	Develop and pilot a Clinical Career Pathway from entry-role through to registered Nurse utilising apprenticeships. Launch career conversations.	CPO

Details of progress 24/25
Priority area of Community Nursing identified with career pathway information for District Nursing services prepared and submitted as part of the project group to inform future workforce modelling. Further pathway mapping to be explored as part 25/26 priority setting and consider the need to explore pathway opportunities between acute and community. Successful Appraisal cycle with a 96% completion achieved, enabling developmental opportunities to be outlined. Career conversations launched, along with associated resources and tool kit. These offer opportunities for manages and staff to discuss career progression through structured sessions.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
6. Ensure our workforce planning meets future needs, creating a safe and sustainable workforce within the available resources.	Developing our people managers to further enable long term strategic workforce planning within services.	CPO

Details of progress 24/25
Exploration of internal model of Capacity and Demand modelling under review through Operational led project group. Current strategic planning influenced by NHSE one year planning. Adoption of the new E-Roster LOOP product and engagement with staff on the new facilities this provided. Enabled E-Roster direct bank worker booking access to two key operational services (CICC and Community Nursing) enabling engagement and ownership for workers.

People

Wirral Community Health and Care NHS Foundation Trust

WCHC People Ambitions 2024/25	Key deliverables:	Action Ownership
7. Optimising our ways of working aligned to opportunities from digitisation, growing our talent, and maximising our role as an Anchor Institution.	Targeted recruitment to support widening participation. Deliver Cheshire and Merseyside NHS Cadet Programme.	CPO

Details of progress 24/25
Targeted recruitment for entry level roles/career pathway initiated via the Sector Based Work Academy Programme and work experience placements. The Cheshire and Merseyside NHS Cadet Programme has been delivered and completed in July 24. Recommendations for future delivery have been shared with the ICB, NHSE and St Johns Ambulance.

Inclusion

Inclusion

	WCHC Strategic Priorities	WCHC Strategic Actions 2024/25 "We Will" Statements	Action Ownership
Inclusion and Health inequalities Strategy: **Care Beyond Boundaries**	**Removing barriers to access**	1. Embed a system for improving data collection as standard **(see Quality Strategy section)** 2. Develop the Equality, Diversity and Inclusion (EDI) skills and knowledge of our workforce 3. Take positive action to drive workforce diversity 4. Use data to better understand inequalities and inform workforce and service planning 5. Embed a culture of inclusiveness and empower positive allyship 6. Focus on our population health impact using Core20 PLUS 5 principles for these and other vulnerable groups of adults and children 7. Maximise our social value through local purchasing and employment 8. Deliver effective intelligence-led preventive programmes focussed on improving outcomes	1. CNO 2. CPO 3. CPO 4. CPO 5. CPO 6. CNO 7. CSO 8. CNO
	Focussing on experience of care		
	Improving outcomes for everyone		

Inclusion

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
2. Develop the Equality, Diversity and Inclusion (EDI) skills and knowledge of our workforce	Implement EDI development around Allyship.	CPO

Details of progress 24/25
Allyship at WCHC defined, to assist all colleagues in being allies. Supported by internal communications plan. Allyship launched via Leadership Event in November 2024. Training on Micro-aggression delivered, to inform the Allyship work, to support colleagues in being Allies in difficult circumstances.

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
3. Take positive action to drive workforce diversity	Improve assessment according to the Equality Delivery System. Maintain external accreditations.	CPO

Details of progress 24/25
Assessed and moderated outcome of 2024 EDS: • 3 out of 12 themes: Excelling • 8 out of 12 themes: Achieving • 1 out of 12 themes: Developing Continued support for and development of staff support networks e.g. Menopause network Accreditations maintained: • NHS Rainbow Pin Badge • Defence Employer Recognition Scheme • Veteran Aware • Disability Confident

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
4. Use data to better understand inequalities and inform workforce and service planning	Clear understanding of workforce and population demographics	CPO

Details of progress 24/25
Understanding of workforce demographics achieved through the delivery of annual regulatory reporting including Workforce Race Equality Standard, Workforce Disability Equality Standard and Pay Gap reporting. Associated action plans in place to address areas for development, examples include: Developed cultural awareness training Engaged staff network members in policy development

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
5. Embed a culture of inclusiveness and empower positive allyship	Definition of allyship clearly understood Anti-Racist Framework – Bronze Award	CPO

Details of progress 24/25
Allyship at WCHC defined, to assist all colleagues in being allies. Supported by internal communications plan. Allyship launched via Leadership Event in November 2024. Training on Micro-aggression delivered, to inform the Allyship work, to support colleagues in being Allies in difficult circumstances. Consultation with BAME assembly clarified that further evidence required to assure Bronze Award of the Anti-Racist Framework, therefore this will be carried over to 25/26.

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
6. Focus on our population health impact using Core20 PLUS 5 principles for these and other vulnerable groups of adults and children	Development of waiting list management tool	CNO

Details of progress 24/25
Waiting list management tool and group includes focus on health inequalities in reducing waiting lists. Development of district nursing and population health management models has included unplanned care utilisation to guide resource distribution, which correlates to Core20.

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
7. Maximise our social value through local purchasing and employment	Increasing routes into NHS employment and representative workforce. Buying locally with social benefit.	CSO

Details of progress 24/25
Local purchasing meant all relevant contracts by WCHC tendered included 10% social value weighting as a consideration in decision-making. 20% (£8.1m) of WCHC non-pay expenditure was within Cheshire & Merseyside. WCHC continued delivering work experience and pre-employment placements during early 2024/25. However, loss of external funding meant the lead for the NHS Cadets and Widening Participation programme left their posts in Q2 2024 with ceasing of associated initiatives. Exploration of joint working re widening participation/social value started with WUTH.

Inclusion

Wirral Community Health and Care NHS Foundation Trust

WCHC Strategic Actions 2024/25	Key deliverables:	Action Ownership
8. Deliver effective intelligence-led preventive programmes focussed on improving outcomes	Deliver phase 1 and 2 of the population health management project aimed at reducing the level of unplanned care need for the target group.	CNO

Details of progress 24/25
• Development and implementation of collocated teams offering proactive support to older age people with moderate / severe frailty. • ICCT resource reviewed to support delivery of the model. • Agreed principles and functionality of model with: Moreton & Meols and Wallasey Wellbeing, West Wirral PCN, Healthier Neighbourhoods PCN, Arno PCN, North Coast Alliance PCN and Brighter Birkenhead PCN. • Implemented integrated teams with: Moreton & Meols and Wallasey Wellbeing, West Wirral, Arno and North Coast Alliance. Others planned for go-live by Q3 25/26. • Cheshire & Merseyside CIPHA (i.e. Combined Intelligence for Population Health Action) tool and related EMIS searches employed to understand levels of need and identify people with higher levels of emergency admissions. • Links made with High Intensity User project to similarly identify patients where service activity suggests opportunities to improve proactive, holistic care and support. • Access, activity and outcomes dashboard functionality under discussion with CIPHA team.

Summary

- Good progress in year three of WCHC's Five Year Organisational Strategy, including work that continues to provide examples of best practice and influence nationally, regionally and locally.
- Work delivered with significant achievements against each of our We Will statements
- Enabling strategies supporting organisational vision with clear demonstration of contribution to Organisational Strategy

Our Vision

To be a population health focussed organisation specialising in supporting people to live independent and healthy lives.

Our Objectives

Populations

We will:

Support our populations to thrive by optimising wellbeing and independence.

People

We will:

Support our people to create a place they are proud and excited to work.

Place

We will:

Deliver sustainable health and care services within our communities enabling the creation of healthy places.

Our Goals

- Safe care and support every time
- People and Communities guiding care
- Ground breaking innovation and research

- Improve the wellbeing of our employees
- Better employee experience to attract and retain talent
- Grow, develop and realise employee potential

- Improve the health of our populations and actively contribute to tackle health inequalities
- Increase our social value offer as an Anchor Institution
- Make most efficient use of resources to ensure value for money

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 25**

04 June 2025

Title	Modern Slavery Statement
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with the annual update of the Modern Slavery Statement as required by the 2015 Act.

It is recommended that the Board:

- Approves the updated statement for 2025/26.

Key Risks

This report relates to these key Risks:

- Compliance with legislative requirements to publish a regularly reviewed and updated statement.

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

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

Governance journey

This is an annual report brought to the Board for approval.

1	Narrative
1.1	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The requirement for an annual statement is set out in Section 54 of the Act, specifically addressing the requirement for transparency in the supply chain. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The Act requires that the statement is approved annually by the Board of Directors. This year's statement has been updated in discussion with the Director of Corporate Affairs and the Assistant Director of Finance – Head of Procurement. The Board are asked to review the statement at section 1.2 and provide approval. Following this, it will be signed by the Chair and the CEO and published on the Trust website.
1.2	**Modern Slavery and Human Trafficking Act 2015 Annual Statement – 2025/26** Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business. The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are being taken to prevent slavery and human trafficking. Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our more than 6,200 strong workforce serves a population in excess of 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider Northwest footprint. We operate across two main sites, these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey. The Trust has well established and robust recruitment and vetting procedures and seeks to ensure that suppliers operate in accordance with the provisions of the Modern Slavery Act. The Trust has a total non-pay spend of c.£130m on goods, equipment and services. The Trust aims to achieve value for money and to promote social value through its contracting and purchasing activity, and the effective utilisation of the Trust's spend contributes significantly to the quality of the patient environment and patient care. The Trust supports the eradication of Modern Slavery through its procurement procedures and processes and is clear that it expects all potential suppliers to be fully compliant with the provisions of the Modern Slavery Act. The Trust recognises that whilst there are laws in place to punish incidents of modern slavery, there is an opportunity to use its purchasing power to help prevent, identify and manage the risks of it occurring in its supply chain by adopting new processes and procedures in both its procurement activity and supplier management.

	The Trust has adopted a number of measures already, which include: • The use of Public Sector Frameworks where there is strong awareness of and monitoring for Modern Slavery in the supply chain. • The mandatory exclusion of any bidder that has been convicted of a human trafficking offence, and the Trust's contracts include • The inclusion of terms and conditions conferring a legal responsibility on Contractors to support that same objective to eradicate slavery and human trafficking. We acknowledge that these measures can be strengthened in line with the Procurement Policy Note PPN02/2023 (Tackling Modern Slavery in Government Supply Chains) for procurements/contracts that were conducted following PCR 2015 and Procurement Policy Note PPN009 (Tackling Modern Slavery in Government Supply Chains) for procurements commenced on or after 24 February 2025 so that: • The new Procurement Act 2023 regulations that have superceded Public Contracts Regulations 2015 encourage preliminary market engagement to identify risks in the supply chain, to identify SMEs/VCSEs with the intention to encourage them to bid, and how social value themes and outcomes can be considered in each procurement • All suppliers and their supply chain will be assessed taking information from the Central Digital Platform to mitigate risk to the Trust • There is knowledge of the characteristics used to assess the risk of modern slavery in procurements including current global modern slavery risks in key sectors of concern such as cotton, PPE and polysilicon. • We identify and manage the risks when procuring new contracts using a proportionate and risk assessed approach and will implement enhanced due diligence checks in high risk procurements. • Risks are managed in existing contracts and arrangements. • Procurement staff are appropriately trained so that there is a consistent level of understanding of the issues; that they are able to recognise and effectively manage procurement activity where there is a potential risk and are able to deploy mitigating strategies to reduce the possibility of modern slavery occurring in the Trust's supply chain. Our approach will be monitored and reviewed in line with the provisions of the Trust's Procurement Strategy.

2	Implications
2.1	**Patients** • No direct impact on patients
2.2	**People** • No direct impact on staff, though ensuring that modern slavery does not exist throughout the supply chain supports an ethical approach and the fair treatment of everyone impacted by the Trust.
2.3	**Finance** • No financial implications
2.4	**Compliance** • Compliance with the requirements of the Modern Slavery Act 2015

Public Board of Directors **Item 26**

04 June 2025

Title	Modern Slavery Statement
Lead Director	Debs Smith, Chief People Officer
Author	Carla Burns, Deputy Director of HR and OD
Report for	Approval

Executive Summary and Report Recommendations
This statement provides a summary of the Trust's responsibilities in relation to the Modern Slavery Act 2015. It is a requirement to produce a statement on an annual basis and that the Board acknowledges and approves the content herein. It is provided retrospectively for the preceding financial year and has to be published within 6 months of the end of the financial year. The statement includes reference to existing safeguarding policies and procedures and applies to employment, procurement matters and supply chain contractors.
It is recommended that the Board: • Approve this statement

Key Risks
None identified at this stage

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

Contribution to WCHC strategic objectives:	
Populations	
Safe care and support every time	No
People and communities guiding care	No
Groundbreaking innovation and research	No
People	

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
N/A			

1	**Narrative**
1.1	See attached statement

2	**Implications**
2.1	**Quality/Inclusion** None identified
2.2	**Finance** None identified
2.3	**Compliance** The statement is required under the Modern Slavery Act 2015

3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: **Community engagement and support** ☒ **Purchasing and investing locally for social benefit** ☒ **Representative workforce and access to quality work** ☒ **Increasing wellbeing and health equity** ☒ **Reducing environmental impact** ☐

In accordance with the Modern Slavery Act 2015, Wirral Community Health and Care NHS Foundation Trust makes the following statement:

We are committed to having effective practices to combat slavery and human trafficking. Our procedures demonstrate our commitment to ensuring that there is no modern slavery or human trafficking in any part of our business, including services from third party suppliers.

We provide health care services to Wirral residents. Our services are local and community-based, provided from around 60 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

We are also commissioned to deliver some community services in West Cheshire, and we provide children and young adults services in Cheshire East, Knowsley and St Helens comprising health visiting, school nursing, family nurse partnership and breastfeeding support services.

We have inpatient beds in our Community Integrated Care Centre, providing a rehabilitation pathway to patients discharged from hospital. We also provide in-reach support into the local acute trust, residential and nursing homes across Wirral.

The Trust's guidance on modern slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider human trafficking and modern slavery issues when making procurement decisions
- Develop an awareness of human trafficking and modern slavery within our workforce

The Trust has robust recruitment policies and procedures in place which are compliant with national NHS Employment checks and CQC standards and has controls in place to ensure compliance with employment legislation, including regular audits and oversight of policies and procedures by relevant Trust Committees.

Modern slavery is incorporated within safeguarding policies and included within mandatory training programmes for all staff employed by the Trust. Training in relation to Modern Day Slavery has been delivered to all staff through our mandatory e-learning training as part of Safeguarding Adults Training level 1 and further training is provided to staff working with children and vulnerable adults. Training compliance is monitored through local governance meetings and overseen by the Trust Board.

The Trust adheres to NHS Terms and Conditions relating to Supply of Goods & Services, minimising the risk of slavery practices. This requires suppliers to (i) comply with all relevant Law and Guidance and use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify

the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

Sir David Henshaw,
Chair

Janelle Holmes
Chief Executive

XX June 2025

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 1 2025/26

Item 27

Contents

1. Introduction

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. We have adopted a '3 lines of defence' approach which highlights the levels of control in place and assurance obtained, both internally and externally, along with clear identification of those accountable for further actions to be taken in order to reduce risk.

The successful and sustained achievement of your organisation's mission and objectives are reliant on robust governance, risk management and assurance.
processes. This means the board needs to be clear about what it wants to achieve, knows what the measures of success will look like, is open and honest. in its dealings and alive to the key risks being faced within and outside of its operating environment, both at strategic and operational level.

Baker Tilly 2021

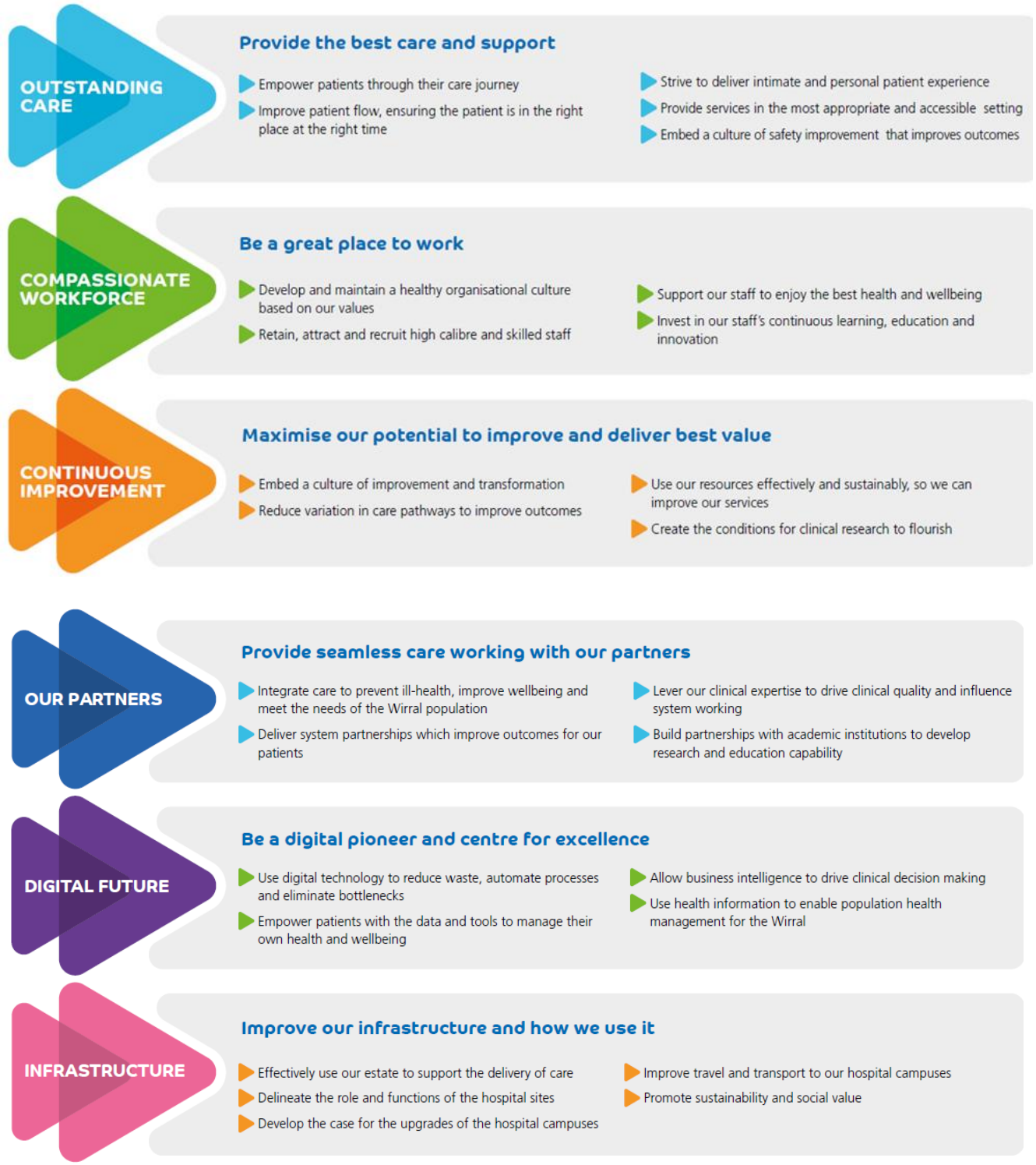
2. Vison, Strategy and Objectives

2.1 Our Vision

For us to realise our ambition it is essential that all business and work programmes are clearly aligned to our Vision, Values, Strategic and Corporate Objectives. Clear lines of sight from these down to individual objectives will support all staff in identifying how to contribute to overall achievement. Our Vision is:

2.2 Our Strategic Objectives

The BAF is derived from our overarching six strategic objectives and priorities which demonstrate our intension to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. We will be a Hospital Trust that patients, families, and carers recommend, and staff are proud to be part of.



3. Our Risk Appetite

3.1 Risk Appetite Statement

The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

The Trust recognises that its long term sustainability and success depends on the delivery of its strategic objectives and, its relationships with service users and families, the public and strategic partners. Patient and staff safety is paramount however such risks have to be tolerated within specific boundaries. Risks which impact on regulatory compliance and reputation will not be accepted and will be managed through robust risk management mechanisms.

The Trust wishes to maximise opportunities for developing and improving its activity by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Trust Strategy.

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some risks where there is a requirement to mitigate risks to patient safety or quality of care. We will ensure that all such responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an **OPEN** risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept and have an **OPEN** appetite in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and productivity.

		The Trust Board has a **MINIMAL** appetite for any risks that affect sound financial control and management.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an **OPEN** risk appetite and is eager to pursue infrastructure options which will benefit the efficiency and effectiveness of services.

4. Operational Risk Management

4.1 Operational Risk Management

The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities and threats. Uncertainty of outcome is how risk is defined. The Trust's approach to Risk management includes identifying and assessing risks and responding to them. The Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

The Trust's governance framework is supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

The overall purpose of risk management at the Trust is to:

- Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
- Ensure the Trust complies with all relevant statutory provisions.
- Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

The Trust has established an effective risk management system which ensures that:

- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust.
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management.

- Management is held to account for the effective operation of controls.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across divisions, directorates and within corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust shall achieve this by:

- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process.
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations.
- Providing training to keep risk under prudent control.
- Investigating thoroughly, learning and acting on defects in care.
- Liaising with enforcing authorities, regulators and assessors.
- Effective oversight of risk management through team and committee structures.
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings.
- Effective reporting and arrangements to hold staff to account.

In order to support the Risk Management Process the Trust (via the Risk Management Committee) gives consideration to the latest set of significant risks at each meeting.

In order to further align this process the current list of significant risks is now included as an appendix to this BAF.

4.2 Risk Categorisation

All BAF Risk are further identified by the following risk categories:

- Reputational risk. **R**
- Operational risk. **O**
- Strategic risk. **S**
- Compliance risk. **C**
- Financial risk. **F**

4.3 Link to Strategic Objectives

All BAF risks are aligned to the relevant Strategic Objectives in the Corporate Plan and highlighted in the dashboard.

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members. The BAF is updated on a Quarterly basis and subject to a full refresh on an annual basis. The BAF was refreshed and discussed at a Board workshop in May 2025.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be subject to regular monitoring, it was noted that the schedule had been designed to help highlight the BAF and its content and widen engagement across the Trust. Having achieved this aim it is now proposed that the schedule will revert to that originally in place and in line with sector norms as follows:

- Is Updated on a quarterly basis.
- Reports to the Board at every meeting.
- Reports to every meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every meeting of relevant Board Committees.
- Reporting to every meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.
- Will be subject to an annual report and refresh in March each year.

6. Update Report

6.1 Purpose

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

The controls, assurance, and actions for most of the current strategic risks have been, or are being, reviewed with Executive Team members and further iterations will be reflected in future reports to Board.

6.2 Changes to the previous version

Following the annual review of the BAF the Board has approved the strategic level risk that will be monitored for the year 2025/26. Work is continuous to update previous risks and populate newer risks.

Including in the key changes for this report are as follows:

- Update to the Risk Appetite Statement as discussed at the Board workshop in May.
- Risk 2 – Change of language to focus the risk on Planned/Scheduled Care.
- Risk 5 – Addition of the word ‘Safety’.
- Risk 6 – Updating and clarification of the risk descriptor.
- Risk 9 – To note that this risk will be subject to amendment in conjunction with Community Trust Colleagues for presentation at the joint board meeting in August.
- Risk 12 – Updating and clarification of the risk descriptor.

6.3 Risk Appetite and Risk Maturity

The report includes the current position of the Trust in relation to Risk Appetite and Maturity. This includes a refreshed assessment and statement in regard to Risk Appetite following the Board workshop in May.

6.4 Recommendations

Board is asked to:

- Approve the refreshed Risk Appetite statement included in this report.
- Approve the rewording of Strategic Risks as outlined.
- Note and comment on the current version of the BAF.

12 Month – Dashboard and Current and Quarterly Trend

Impact x Likelihood

Risk No	Strategic Priority	Risk Description	Initial Score (I x L)	Target	June 24	Sept 24	Dec 24	Mar 25 Current Year End	Direction	June 25
1	Outstanding Care **R, O, C, F**	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	20 (4 x 5)	↔	20 (4 x 5)
2	Outstanding Care **R, O, C, F**	Failure to meet targets and standards in relation to Planned/Scheduled care, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
3	Outstanding Care **R, O, C, F**	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	16 (4 x 4)	↔	16 (4 x 4)
4	Compassionate Workforce **O, C, F**	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	12 (3 x 4)	↔	12 (3 x 4)
5	Compassionate Workforce **R, O, C, F**	Failure of the Trust to have the right culture, staff experience, safety and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
6	Continuous Improvement **R, O, F**	Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision.	16 (4 x 4)	8 (4 x 2)	12 (4 x 3)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	↔	20 (4 x 5)
7	Digital Future and Infrastructure **R, O, F**	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
8	Continuous Improvement **R, F**	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
9	Our Partners **R, S, F**	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability. Note to be further considered in conjunction with WCHC and as part of the Integration Program.	12 (4 x 3)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
10	Digital Future and Infrastructure **R, S, F**	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Digital Future and Infrastructure **R, O, C, F**	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	15 (5x3)	15 (5x3)	15 (5 x 3)	15 (5 x 3)	↔	15 (5 x 3)
12	Outstanding Care **R, O, C**	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.	16 (4 x 4)	9 (3 x 3)	N/A	12 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)

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

Strategic Priority	Outstanding Care				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	12 (4 x 3)

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

Gaps in Control or Assurance
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.

Action
There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post.
Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023.
System 4 hour performance response to deliver 76% in March.
External support into ED from Aqua reviewing 4 hour and 12 hour performance – recommendation report received and local action plan in development with urgent actions.
Full engagement with the national Rapid Improvement Offer (RIO) from the national ECIST.

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

Strategic Priority	Outstanding Care				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • **Impact of the Cyber-attack was significant and deteriorated the Trust's progress with recovering elective waiting times.** • 2 specialities are challenged in delivery of 65 and 75 weeks. • **One specialty is challenged in delivering 65 weeks by the end of the financial year given the impact of the cyber-attack.**

Action
Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation.
Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients.
Utilisation of the LLP to deliver the gap in recurrent capacity.
Cyber-attack recovery plan.

BAF RISK 3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.

Strategic Priority	Outstanding Care				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from PSIRF. • Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • Trust safety huddle. • Patient safety Learning Partners. • R and I Strategy. • **PSQB divisional reporting.**	• Executive Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance. • GIRFT. • AXA accreditation. • National SNAPP Audits. • Nursing and Maternity Champions. • Monthly Maternity report. • CEO Complaints sign-off. • Digital – Incident dashboard. • Programme Board. • **ACCA Accreditation.** • **NCIOP Data.**

Gaps in Control or Assurance
• Fully complete and embedded patient safety and quality strategies. • Current operational impacts and organisational pressure. • Capital availability for medical equipment. • Medical workforce gaps. • Impact of unscheduled care demand. • Significant financial controls in place. • Update required to WISE accreditation programme. • **Lack of BI capacity impacting on patient outcome data**

Action
Complete implementation, monitoring and delivery of the patient safety and quality strategies.
Monitoring Mental Health key priorities
Complete delivery of the Maternity Safety action plan
Ongoing review of IPC arrangements – SIT Review.
CQC preparedness programme and mock inspections.
Delivery of Mental Health key priorities.
Unscheduled Care Board action plan.
Trust and C and M elective recovery programme.
Wirral system strategy for CDiff.

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

Strategic Priority	Compassionate Workforce				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group. • Staff drop in sessions. • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring.

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

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

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

Strategic Priority	Compassionate Workforce				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

Gaps in Control or Assurance
• **Full understanding of the experience of Multi-Cultural staff across the Trust**

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

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

Strategic Priority	Continuous Improvement				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • Finance Gold Command implemented. • **25/26 Planning process in place.**	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • FBPAC meeting more frequently. • **24/25 risk Mitigated from 21m to 3m.** • **Board briefed on 25/26 plan and drivers of the gap to control total.** • **PWC programme in final stages and completion of handover.** • **Board considered additional actions in relation to finance and associated risk.**

Gaps in Control or Assurance
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • Mitigated forecast of 7m variance to plan. • Unmitigated forecast of 29m variance to plan. • **Significant variance for 25/26 to approved control total.**

Action
Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing.
Complete benchmarking and productivity opportunities review pack.
Develop 3 year CIP Plan to include all trust wide strategic and transformational plans.
Expand current mitigation plan to measure risk.
Exec meetings with divisions to consider additional actions to mitigate gap control total.

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

Strategic Priority	Digital Future				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	12 (4x3)	12 (4 x 3)	12 (4 x 3)	8 (4x2)

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

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

Action
Delivery of DHT annual plan.
Prioritise delivery of Digital workload with Executives.

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

Strategic Priority	Continuous Improvement				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Programme Board oversight. • Improvement team resource and oversight. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken. • **Developed and embedded improvement methodology.**	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress and delivery of improvements. • Monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings • Improvement presentations at Board Seminar on a twice yearly basis • CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required. • Annual review and approval of improvement team supported projects, aligning to Trust priorities and risks • Project completion reviews • **NHS Impact Improvement Directors Forum attendance**

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

Action
Delivery of 24/25 improvement projects to plan
Strong Governance through PMO working of all schemes, risk and outputs
Detail improvement staff training approach and programme
Implementation of Improvement for All approach and training to staff
Development of Improvement Programme for 25/26

BAF RISK 9	**Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.** Note to be further considered in conjunction with WCHC and as part of the Integration Program.

Strategic Priority	**Continuous Improvement**				
Review Date	**Q1 2025/26**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief Executive Officer**	**12 (4 x 3)**	**9 (3 x 3)**	**9 (3 x 3)**	**6 (3 x 2)**

Controls	Assurance
• WUTH senior leadership engagement in ICB and Wirral Place • WUTH Strategic intentions are aligned with the ICB. • ICB design framework. • NHS Oversight and Assessment Framework • Input of Trust CEO and Chief Strategy Officer into Outline of the Wirral Place governance. • Creation of IMB to oversee the outcomes of the Wirral Review. • Joint Chair and CEO now in place with WCHC. • Joint Chief People Officer in place with WCHC • **Provider collaborative approach agreed** • **Partnership Agreement with WCHC** • **Integration Methodology for Corporate Functions** • **Workforce agreement and strategy**	• CEO and Chief Strategy Officer updates to Board and Executive Director meetings. • CEO attendance at Wirral Place Partnership Board • Executive participation in CMAST professional network groups • Chief Strategy Officer attendance at Wirral Health and wellbeing Board • Monthly reporting to Board of Wirral System Review progress • **Recommendations of the Wirral Review** • **100 Day Integration Plan** • **Integration Management Board (Joint Committee) Terms of Reference** • **Partnership Agreement with WCHC** • **Integration Methodology for Corporate Functions** • **Workforce agreement and strategy**

Gaps in Control or Assurance
• Formal mechanisms to ensure delivery of partnership working with Wirral Place partners. • **Lack of capacity and resources in place to deliver the integration programme in line with timescales required.** • **Determination of future hosting arrangements for staff as part of Integration**

Action
Continue identification of partnership opportunities with Wirral Community Health and Care NHS Trust
Continued implementation of actions of the Wirral Review.
Refresh Governance processes at Place.
Development of Provider Collaborative approach
Stand up the WPP and IMB
Implement proposal for transaction

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

Strategic Priority	Infrastructure				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

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

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

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

Strategic Priority	Infrastructure				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)	15 (5 x 3)	10 (5x2)

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

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

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

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

Strategic Priority	Our Partners				
Review Date	Q1 2025/26	Initial Score	Last Quarter	Current	Target
Lead	All Executive Directors	16 (4x4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Wirral Place Based Partnership Board Governance Manual. • Wirral Place Target Operating Model. • ICB. • Wirral Review Terms of Reference. • **Joint Chair and CEO in place across WCHC and WUTH.**	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Unscheduled Care Board. • Wirral Place Partnership Committees and fora. • **IMB for Integration.**

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

Action
Board discussion on Phase 1 of Wirral Review.
Consider outcomes of full review.
Implement outcomes of the full review.
Board to Board sessions.
Council of Governors Joint session.
Standing up of the IMB.
Standing up of the WPP.
Refreshment of Wirral Place Governance.
Stand up Health inequalities Board.

Appendix – Risk Scoring Matrix

Table 1 – Impact scores.

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

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

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

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

Table 2 – Likelihood

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

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

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

Appendix – Risk Appetite

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

Appendix – Significant Operational Risks

Current Month Highest Scoring Risks

536	Med	Clinical, Quality, Safety and Access risks associated with poor patient flow	(4 x 5) 20	↑
1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(4 x 5) 20	⇔
2068	W+C	There is a risk to patient safety during planned lift replacement works within the Women's and Children's Hospital	(4 x 5) 20	↑
1547	Corp	Cash management	(4 x 5) 20	↓
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(4 x 5) 20	⇔
2087	Corp	Development Integration Engine not working stopping further development projects	(4 x 5) 20	★
1756	Corp	Clostridioides difficile	(4 x 5) 20	↑

Public Board of Directors **Item 28**

04 June 2025

Title	Board Assurance Framework 2025-26
Lead Director	Alison Hughes, Director of Corporate Affairs
Author	Alison Hughes, Director of Corporate Affairs
Report for	Information

Executive Summary and Report Recommendations

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

This update provides the position for the start of the new financial year, following approval by the Board in April 2025 of new strategic risks and following the meeting of the Quality & Safety Committee in May 2025.

It is noted that due to the change of date for the Board of Directors meeting, the meetings of the Finance & Performance Committee and the People & Culture Committee have not taken place. Both committees will meet on 11 June 2015 where each of the relevant strategic risks will be discussed and updated to reflect the Q1 position.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress.

Key Risks

This report relates to the following key risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):

Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
19/06/24	Board of Directors	BAF	The Board of Directors approved the recommendations in the report and was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board.
17/07/24	Informal Board	BAF	The Board of Directors had a discussion on new and emerging risks to be included in the BAF - see ID11.
21/08/24	Board of Directors	BAF	The Board of Directors approved the position reported and approved the introduction of new risk ID11 for tracking and oversight by the Board.
16/10/24	Board of Directors	BAF	The Board of Directors was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board and noted the current risk ratings and ID04 as the highest scoring risk.

11/12/24	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the recommendation from the Finance & Performance Committee that ID06 had achieved its target risk rating and would be kept under review for the remainder of the financial year.
19/02/25	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the MIAA Assurance Framework Report 2024/25.
19/03/25	Informal Board	BAF	The members of the Board supported an informal discussion to review current and emerging risks for 2025-26 and to inform the position presented to the committees and the Board in April and May 2025.
23/04/25	Board of Directors	BAF	The Board of Directors approved the recommendation for new risks for 2025-26.

1	Narrative
1.1	The Board has in place a full Board Assurance Framework which is reviewed annually to reflect the strategic priorities of the Trust. Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the committee.
1.2	At the meeting of the Board of Directors in April 2025 the strategic risks for monitoring through the BAF during 2025-26 were discussed and approved. The Board of Directors also welcomed updates provided on further emerging risks and the alignment where relevant with WUTH strategic risks during 2025-26.
1.3	The summary table at **appendix 1** confirms the current position of strategic risks but the Board is asked to note that the scoring of the new financial risks and review of

	mitigations, gaps and outcomes will be completed at the Finance & Performance Committee on 11 June 2025.
1.4	A revised risk description for ID11 is being developed to reflect the Partnership Agreement established between both WCHC and WUTH and the risk of failing to develop a Joint Strategy and deliver the 2-year plan to realise the benefits of integration. This will be considered by both Boards in a board seminar session in July 2025.
1.5	The Quality & Safety Committee met on 7 May 2025 and reviewed strategic risks ID01 and ID02 noting the mitigations, gaps, outcomes and trajectories for each. The committee reviewed the risk ratings against the updates, noting that neither risk was scoring higher than RR12 and no changes were proposed. The committee noted that a previous risk tracked during 2024-25, ID06 related to operational performance had achieved its target risk rating in-year and had been archived. It was therefore recommended to the committee that the mitigation relating to QEIA processes was strengthened to further support ID01; this was supported and is reflected in the relevant risks.
1.6	Through each of the committees of the Board it has also been acknowledged that a cross-reference between WCHC strategic risks and WUTH strategic risks will be important during 2025-26 to include appropriate mitigations based on partnership working for key strategic risks. For example, the highest scoring risk on the WUTH BAF relates to Unscheduled Care - *Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience (RR20 4 x 5).* There are key mitigations that the Trust supports in relation to this risk, and it is therefore proposed that until such a time that the two BAFs combine, the committees will receive updates associated with relevant WUTH strategic risks and where the Trust can provide additional mitigation. It is anticipated that as the development of the Joint Strategy progresses, shared strategic risks and Board Assurance Frameworks between WCHC and WUTH will emerge.
1.7	**Wirral Place Delivery Assurance Framework** The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF was last presented to the Place Based Partnership Board in March 2025, and can be accessed via the following link - Agenda for Wirral Place Based Partnership Board on Thursday, 27th March 2025, 10.00 a.m. | Wirral Council

2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.

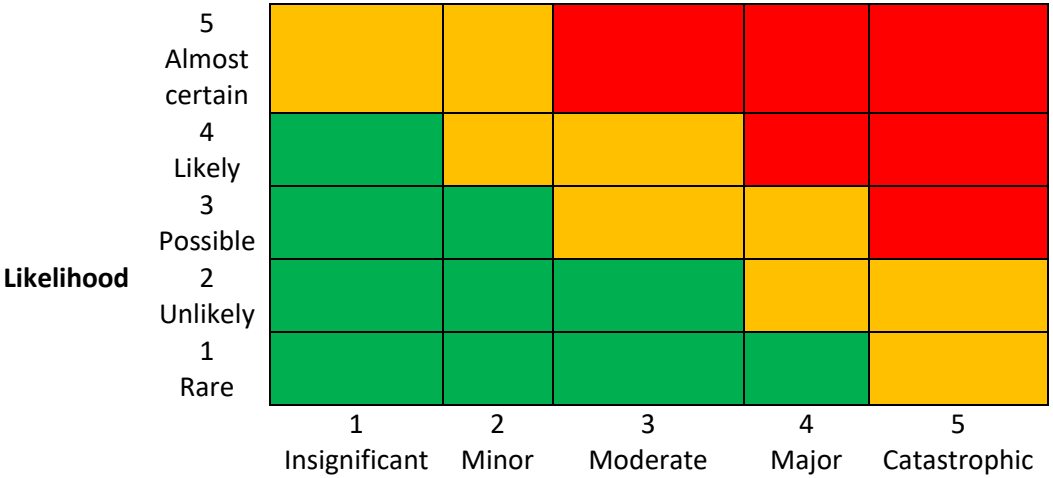
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF is key to effective governance and is subject to an annual Assurance Framework Review as per internal audit standards in order to inform the Head of Internal Audit Opinion (HOIA) each year. The strategic risks tracked through the BAF are reported annually through the Annual Governance Statement.

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

Strategic risk summary 2025-26

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC) (April 2025)	Current risk rating (LxC) (May 2025)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	3 x 4 (12) ⟷	2 x 4 (8)	Averse
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change.	Quality & Safety Committee	Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	3 x 4 (12)	3 x 4 (12) ⟷	2 x 4 (8)	Averse
Previous ID03 archived at end of 2023-24.						
NEW ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	*Subject to Finance & Performance Committee meeting on 11 June 2025*			
Previous ID05 closed for 2024-25.						
NEW ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	*Subject to Finance & Performance Committee meeting on 11 June 2025*			
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8) ⟷	1 x 4 (4)	Moderate
ID08 - Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12) ⟷	1 x 4 (4)	Moderate

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC) (April 2025)	Current risk rating (LxC) (May 2025)	Target risk rating (LxC)	Risk Appetite
Previous ID09 archived during 2023-24 and included in ID01.						
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee	Grow, develop and realise employee potential. Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8) ⟷	1 x 4 (4)	Open
~~ID11 - Failure to achieve the Trust's 5-year strategy due to the absence of effective partnership working resulting in damaged external relations, failure to deliver the financial plan 24-25 and the recommendations from the Wirral Review, with poorer outcomes for patients and a threat to service sustainability.~~	Board of Directors	Make most efficient use of resources and ensure value for money	New risk to be developed between WCHC and WUTH.			



Consequence

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

Board Assurance Framework 2025-26

Strategic risks with oversight at Quality & Safety Committee

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

Corporate Governance

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

Quality Governance

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

- The Trust has implemented a health inequalities stratification waiting list tool - Joint AIS and Health Inequalities Waiting List Tool questionnaire now live in System one with all fields mandated
- Just and Learning culture supported by FTSU framework allowing staff to openly raise concerns.
- QEIA processes established with SOP in place trust-wide to ensure the benefits and risks of change are determined

PSIRF

- Patient Safety Lead in post and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation reported to the committee
- PSIRF policies and procedures developed and implemented to promote sustainability.
- PSIRF stakeholder group established.
- Robust gantt chart aligned to the national PSIRF implementation timeframes, reporting to POG monthly by exception.
- High-level of compliance with patient safety training.

FTSU

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

Safeguarding governance

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

Infection prevention and control governance

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

Medicines governance

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

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

- Safe staffing model on CICC supports professional judgement by maximising use of available staffing resource, implementing a holistic multidisciplinary team model including the use of therapies staff.

- Enhanced reporting through the governance agreed via PCC and QSC.
- Metrics and measures developed to monitor, analyse and review and report against e-rostering system use and performance *(MiAA recommendation completed)*
- Reporting timetable developed to ensure regular, timely updating to PCOG and SOG including any trends or areas for improvement *(MiAA recommendation completed)*
- Trust engaged in national pilot of Community Nursing Safer Staffing Tool (CNSST) - the first cohort of community trusts to collect safe staffing data

System Governance

- Wirral Place Quality Performance Group established with CNO as member
- Partnership working with Local Authorities and other stakeholder organisations via Place (e.g., Quality & Performance Group, Safeguarding Children Partnerships, Safeguarding Adults Partnership Board) and regional (e.g., C&M Chief Nurse Network, MHLDC Provider Collaborative) meetings

Monitoring quality performance

- The committee receives a quality report from TIG providing a YTD summary (via SPC charts) of all quality performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway to monitor quality performance and to access the Audit Tracker Tool to monitor progress.
- The committee contributes to and receives the annual quality improvement audit programme and tracks implementation.
- The committee receives updates live from the system on regulatory compliance including local audits and procedural documents.

<table>
<tr><td colspan="6">ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Safe care and support every time</td></tr>
<tr><td colspan="7">Consequence;
• Poor experience of care resulting in deterioration and poor health and care outcomes
• Non-compliance with regulatory standards and conditions
• Widening of health inequalities</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>Apr 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Averse</td><td colspan="2" rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Actions to ensure safe care and support every time to prevent variation of standards across localities and teams.
Headline measures in-month (M12)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 0 falls (moderate & above harm) - QUAL17
- 93.0% FFT - QUAL22 YTD
- 5 complaints received (36 YTD) - QUAL08
- 503 incidents reported - QUAL02 (2.2% moderate and above harm - QUAL18)
- 232 patient safety incidents (M9) - QUAL03</td><td colspan="2">- Clinical and professional supervision compliance sustained at 90% - Team Leaders (trust-wide trajectory on TIG and set trajectory for Q2, Q3 and Q4 aiming for above 90%)
- Supervision Training Strategy - Head of L&OD
- Further embed PSIRF principles through process and culture - Deputy Chief Nurse
- PSIRF learning cafes roll-out Q4 - delayed to Q1 25-26</td><td>- CQC rating GOOD with Outstanding elements.
- FFT response rate and satisfaction rate
- Low number of complaints
- Publication of Quality Account 2023-24 published with key achievements and progress to deliver quality goals highlighted.
- Mandatory training sustained compliance maintained at 90%</td><td colspan="2">- 60% of eligible staff trained in QI curriculum - March 2025 (quality goal 7) - at risk due to operational pressures. There are 2 QSIR-F sessions for quality champions being held in Q4 and this is being widely promoted across all teams to increase uptake. The Trust have exceeded the target in relation to quality experts and QSIR-P delivery</td></tr>
</table>

- Indicators within the Quality Dashboard have been refreshed to reflect the Patient Safety Incident Response Framework and systems-learning
- The following indicators have been added;
  - QUAL25: Number of reported no and low harm patient safety incidents
  - QUAL26: Number of After-Action Reviews (AAR) requested
  - QUAL27: Number of patient safety incident investigations (PSII) requested
  - QUAL28: Number of patient safety incident investigations (PSII) completed in 3 months
- CQC actions (from 2023 inspection) completed and reported to QSC and PCC
- Vacancy control measures implemented to respond to ICB FICC process provide oversight of quality & safety - assurance on process provided to the committee in September 2024
- SAFE mechanism for recording clinical and professional supervision captures method of delivery to include peer, group and 1:1 delivery
- Quality of supervision audit completed, and feedback used to improve processes.
- Clinical protocol for Clinical Supervision (CP95)
- Safeguarding Supervision Policy (SG04)
- Management Supervision procedure (HRP07)
	- An increase in Incident Reporting identified during January 2025 which is above the mean but within normal variation - **Deputy Chief Nurse** (to be closely monitored to support trend analysis)	- Role essential training compliance achieved and maintained at 90%
		- Clinical and professional supervision sustained compliance at 90% *(quality goal 3).*
		- 12% of staff to be trained in Tier 2 Oliver McGowan mandatory training *(quality goal 4)*
		- QI summary reports with measured impacts from 4 x QI programmes and with actions for improvement
		- Audits on the quality of supervision (end of Q2 and Q4)
		- 20 members of staff trained in QSIR-P (5-day course now concluded with positive evaluation)
		- 80 members of staff trained in QSIR-F *(2 session for Quality Champions in Q4)*
		- Quarterly patient safety champions meetings with attendance monitored to ensure continued appropriate staff engagement across services
		- PSIRF learning cafes
			- Supervision Training Strategy approved - **November 2023 -** (Extension for action approved by QSC)
			- 90% of clinical staff receiving supervision - **31 June 2024** (*quality goal 3 reset for 24/25* - targeted approach to set trajectories for improvement if below 85%)
			- ~~20%~~ 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **31 March 2025** *(quality goal 4)* 8 training sessions (20 staff per session) planned before 31/3/25 - *at risk due to operational pressures. 4 of 8 sessions have been delivered (8%) and a further 2 scheduled before 31 March 2025.*
			- 4 x QI programmes delivered - **March 2025** with measured impact *(quality goal 1)*
			- PSIRF actions to further embed in the process and culture *(quality goal 2)* - ~~**March 2025**~~ **Q1, 2025-26**

- Mandatory training compliance trust-wide achieved target - M12 95.2% (vs 90% target) - Role essential training compliance - M12 92.3% (vs 90% target) - 2024-25 clinical audit programme agreed. - Patient Safety Incident Response Plan (GP60) approved. - LFPSE (Learning from Patient Safety Events) launched. - Professional Nurse Advocate (PNA) programme in place - Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated - 20% baseline of staff trained in Quality Improvement curriculum. - Baseline completed to determine a clear denominator and criteria for eligible staff for the national patient safety curriculum. - Training compliance visible on TIG for L1 & L2 of the national patient safety curriculum. - Current compliance L1 & L2 - 95.1% L1 for board and senior management - 95.3%, L1 for other staff (agreed cohort) - 97.5%. - 4 x QI programmes identified - *wound care, medicines, falls, end of life care and deteriorating patient* - and stakeholder analysis completed for all. - QI training compliance tracked monthly through locality governance meetings. - District nursing development work underway, including engagement with			

frontline rearms to take forward improvement ideas. - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year end position of 8.6% of eligible staff trained against a target of 12%. A further session is due to be delivered in May 2025. **Actions to ensure safe mobilisation of new services.** - Business decision making process aligned to strategic objectives. - Establishment of mobilisation project at the commencement of new contracts - Mobilisation projects monitored at POG. - SRO and Project Lead identified. **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles.** - Health Inequalities & Inclusion Strategy developed and approved. - QEIA SOP in place to determine any impact on quality and equality from change - Inclusion Annual Report 2023-24 presented to PCC and Board - Mechanism in place to ensure involvement of people always included within RCA's (agreed at CRMG) - Participation in C&M Prevention Pledge programme agreed with identified. - Chief Nurse = Prevention Pledge Executive Lead - Inclusion dashboard developed.	- Review of the NHS Providers guide on reducing health inequalities will be undertaken, resulting in a clear plan for delivery of health inequalities data analysis and intelligence reporting to Board.	- Regular reporting to the Trust Board on health inequalities data through the Integrated Performance Report. - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data - Tracking of health inequalities data in TIG across the identified 4 co-designed care pathways	- Summary report from 4 co-designed care pathways - **March 2025** *(quality goal 6)* – *ON TRACK* - 'What matters to you?' question embedded into 1 service as part of routine care planning and personalised care - **March 2025** *(quality goal 5)* - **COMPLETE and embedded in 4 services**

- Partnership forum established. - 4 x care pathways to be co-designed with people and community partners identified (aimed at reducing health inequalities) - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Silver award in the Armed Forces Covenant Employer Recognition Scheme - Veteran Aware accreditation achieved for the Trust. - EDS2 assessment criteria agreed and completed for 2022-23 - achieving across all areas including Domain 1 commissioned services (community cardiology and bladder and bowel) - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. Included as an action from EDS domain 1. - MiAA report on health inequalities completed with 5 core recommendations agreed. - 4 x QI programmes identified - *wound care, medicines, falls and deteriorating patient* - and stakeholder analysis completed for all. - Locality governance reflects trust-wide governance across different geographies with any variation related to specific service specification (i.e., different 0-19 services) - *What matters to you?* campaign developed with other actions *(e.g. campaign days, embedding question as part of routine care*		aimed at reducing health inequalities *(quality goal 6)* - Successful launch of 'what matters to you?' campaign *(quality goal 5)*	

planning now in 4 services - cardio rehab, CICC, Long Covid and ICCT) **Actions to ensure safe demobilisation of services.** - Demobilisation plan in progress for Lancashire 0-19+ contract. - Long-COVID services demobilisation in progress - School aged immunisation service demobilisation			

<table>
<tr><td colspan="5">ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - Safe care and support every time</td></tr>
<tr><td colspan="6">Consequence;
• Inequity of access and experience and outcomes for all groups in our community
• Poor outcomes due to failure to listen to people accessing services
• Reputation impact leading to poor health and care outcomes</td></tr>
<tr><td colspan="3">Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>Apr 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
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(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">Actions to ensure collaboration and co-design with community partners.
- EDI training compliance - 96.8% (date: 01/05/25)
- Quality Strategy ambition “People and communities guiding care”.
- Inclusion Principle 1 - Positive action for inclusive access
- 6000 public members sharing their experience and inspiring improvement.
- Level 1 Always Events accreditation focussing on what good looks like and replicating it every time.</td><td colspan="2">- ~~Completion of all actions agreed following MIAA review to address variation in practice and incomplete data.~~
- Lack of staff confidence in accessing and interpreting health inequalities data - Head of Inclusion
- Further embed health inequalities waiting list tool evidencing outcomes and ensuring equitable</td><td>- Measures of equity of access demonstrated through patient/service user data and experience.
- Staff confident in delivering culturally sensitive care.
- All reasonable adjustments are made to facilitate most effective care delivery.
- ~~20%~~ 12% of staff to be trained in Tier 2 Oliver McGowan mandatory training (quality goal 4)</td><td>- 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - 31 March 2025 (quality goal 4) 8 training sessions (20 staff per session) planned before 31/3/25 - at risk due to operational pressures. 4 of 8 (8%) sessions have been delivered and a further 2 scheduled before 31 March 2025.</td></tr>
</table>

- Complaint's process putting people at the heart of learning.
- QIA and EIA SOP refreshed and approved
- Recruitment of Population Health Fellow role
- Quality Improvement sharing and celebration events.
- Experience dashboard built on TIG.
- Partner Safety Partners recruited.
- Re-balancing of resources in community nursing to support caseload in PCNs underway.
- 5 community partners recruited.
- Completion of all actions agreed following MIAA review to address variation in practice and incomplete data.
~~- Lancashire mobilisation governance includes Service Delivery workstream.~~
 	
Actions to address health inequalities by hearing from those with poorer health outcomes, learning and understanding the context of people's lives and what the barriers to better health might be
- On-going work with system partners (system health inequalities group) to improve identification of minority and vulnerable groups within the population, ensuring that we reach into these communities and make it as easy as possible for people to access appropriate care when required.
- Quality Strategy - *quality goal 6* - 5 co-designed care pathways identified - *NPOP and referral pathway to memory clinic, translation and interpretation, Long Covid and rehabilitation, Rehab @ Home and home hazards checklist,*
	access *(inclusion principle 1)* - **Deputy Chief Operating Officer / Deputy Chief Nurse / Head of Inclusion**
	- Tier 2 Oliver McGowan training to be rolled out to eligible staff - **OMMT lead trainer -** see revised quality goal (12%) and mitigation with Autism Together *(and link to ID01).*
		- 60% of eligible staff trained in QI curriculum *(quality goal 7)*
		- Staff will report increased skill, knowledge and confidence in quality improvement methodology.
		- Completion of 4 co-designed care pathways aimed at reducing health inequalities with stakeholder engagement *(quality goal 6)*
		- Successful launch of 'what matters to you?' campaign *(quality goal 5)*
		- Further embed health inequalities waiting list tool
		- Regular reporting to the Trust Board on health inequalities data through the Integrated Performance Report.
		- Expected outcomes from 4 identified high priority clinical risk areas
		  - Reduction in pressure ulcers (all categories)
		  - Reduction in falls at CICC
		  - Reduction in medication incidents
		  - Improved quality of care for patients who are end of life
			- Achievement of 90% completion rate of AIS and inclusion template across all services - **March 2025** *(Inclusion principle 1)* - locality completion rates range from 47% - 80%; monitoring at SOG.
			- Summary report from 4 co-designed care pathways - **March 2025** *(quality goal 6) – ON TRACK*
			- Completion of all agreed actions to address MIAA recommendations - ~~**September 2024**~~ **December 2024**
			- 60% of eligible staff trained in QI curriculum - **March 2025** *(quality goal 7) - at risk due to operational pressures. There are 2 QSIR-F sessions for quality champions being held in Q4 and this is being widely promoted across all teams to increase uptake. The Trust have exceeded the target in relation to quality experts and QSIR-P delivery*

FNP-Improving accessibility of information for first time parents. **Actions to ensure that all voices, including under-represented groups can be heard and encouraged to influence change.** - MiAA report on health inequalities completed with 5 core recommendations agreed. - Active engagement through the Partnership Forum with multiple groups/agencies across Wirral (e.g., Wirral Change, Mencap, LGBT, veterans) supporting close links with our communities and positively influencing participation and involvement. - Veteran Aware accreditation (Bronze and Silver) achieved for the Trust. - EDS 2022-23 published on public website with actions identified. - 98.5% of staff completed comprehensive learning disability and autism e-learning (Oliver McGowan Level 1) - 2 x QI programmes identified with specific focus on children and young people – Translation and Interpretation and Family Nurse Partnership - 'What matters to you' campaign and first 'What matters to you' day trust-wide scheduled for 25/9/24. 'What matters to you' dashboard available on TIG. - Services identified to embed 'what matters to you' question as part of care planning and personalised care.			

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

Public Board of Directors **Item 29**

04 June 2025

Title	Charitable Funds Annual Report
Lead Director	Robbie Chapman, Interim Chief Financial Officer
Author	Shameem Kalandar, Chief Financial Accountant
Report for	Information

Executive Summary and Report Recommendations

The purpose of this paper is to provide the Board with assurance on the reporting and governance arrangements regarding Wirral Community Health and Care NHS Foundation Trust's charitable funds.

The Board is asked to note the latest published financial statements for the Trust's charitable funds (for the financial year ending 31 March 2024), which are included within the funds of the Cheshire and Wirral Partnership (CWP) Charity.

The Board is also asked to note updates to the charitable funds during 2024/25 and beyond and the plans to promote and encourage donations and funding applications throughout the Trust.

It is recommended that the Board:

- To be assured on the financial reporting arrangements for the WCHC's charitable funds.

Key Risks

This report relates to the following key risks:

The purpose of the report is to provide assurance on the reporting and governance arrangements for the Trust's charitable funds and the balances available for suitable applications

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Not applicable			

1	Narrative
1.1	**Financial statements of the Charity 2023/24** Attached is the latest set of signed accounts for the Charity covering the period 1 April 2023 to 31 March 2024 which were approved by CWP and subject to an independent examination. These accounts are also available to view on the Charity Commission website: CWP Charitable Funds Annual Report and Accounts 2023/24 (Registered Charity
1.2	The accounts cover the total funds held by the Charity, but split out the income, expenditure and opening and closing fund balances relating to the Trust's charitable funds. This is shown most clearly in note 12 of the accounts (sum of unrestricted and restricted funds - page 18) and is summarised in the table below:

	2022/23	2023/24
	£	£
Opening WCT fund balance at 1 April	**121,835**	**121,429**
Income for the year	8,715	15,591
Expenditure for the year	(5,214)	(39,150)
Investment gains/(losses)	(6,282)	2,859
Closing WCT fund balance at 31 March	**119,054**	**100,729**
Closing available funds*	121,429	98,342

**Unrealised gains/(losses) and other adjustments on investments are included within the fund value but are not available to spend.*

The investments are being monitored by CWP and the investment manager on a daily basis.

1.3 For the CWP Charity, the funds belonging to the Trust are mainly disclosed in the financial statements as a single, ear-marked fund. There is also a single restricted fund. However, in agreement between the Charity and the Trust, the funds are further broken down into local ear-marked or restricted funds.

1.4 **Financial activities of the Charity 2024/25 and beyond**

The funds, and activity for 2024/25, are reflected in the table below:

	April 2024 to March 2025 (£)							
Fund	Cash Balance April 2024	Income	Expenditure	Investment Apportionment	Adjustment in-year	Cash Balance March 2025	Commitments	Available Cash May 2025
F22 General Fund	27,773	1,067	(1,204)	1,287	0	28,924	(17,794)	11,129
F33 Wirral Heart Support	5,247	202	(227)	243	0	5,464	(1,863)	3,601
F35 Palliative Care	27,555	1,059	(1,194)	1,277	0	28,696	(2,139)	26,558
F36 Community Nursing	6,921	266	(300)	321	0	7,208	(2,584)	4,624
F37 League of Friends of Wallasey Hospitals (restricted)	30,695	1,180	(1,330)	1,422	0	31,967	(2,752)	29,214
Total	**98,191**	**3,774**	**(4,256)**	**4,550**	**0**	**102,259**	**(27,132)**	**75,127**

**Expenditure includes fees, charges and administration costs. Commitments include a prior year balance totalling £4,823.*

The figures in the table above are subject to audit.

The expenditure incurred included the following highlights:

- £2,723 – CWP Admin Charges
- £1,175 – Professional fees

1.5 StaffZone is updated regularly to make the charitable funds more accessible and the Charitable Funds policy has been updated and published during 2025/26. Further work will continue with the Comms team to encourage fundraising and donations along with larger and more ambitious applications.

1.6 A service level agreement (SLA) between CWP and the Trust has been produced. The CWP Charity currently invoices the Trust for services provided based on a percentage of funds held – the fee for 2024/25 was £5,000.

2	Implications
2.1	**Quality/Inclusion** This report notes the latest published financial statements for the Trust's charitable funds and further financial activity to March 2024 and beyond. Therefore, no Quality and Equality Impact Assessment was completed.
2.2	**Finance** The report highlights the balances and financial activity of the Trust's charitable funds over the period April 2023 to date. It lists the money currently available for applications which meet the Charity and Fund objectives.
2.3	**Compliance** The accounts are subject to independent review and are available to view on the Charity Commission website.

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: **Community engagement and support** ☒ **Purchasing and investing locally for social benefit** ☒ **Representative workforce and access to quality work** ☒ **Increasing wellbeing and health equity** ☒

Public Board of Directors **Item 30**

04 June 2025

Title	Annual Emergency Preparedness, Resilience and Response (EPRR) Report for 2024/25
Lead Director	Jo Chwalko – Chief Operating Officer / Director of Integration
Author	Mick Blease LSMS/EPRR Lead
Report for	Approval

Executive Summary and Report Recommendations

The report summarises the Trust's Emergency Preparedness, Resilience and Response (EPRR) activity for 2024/25.

The report is sectioned as follows:
1. Planning
2. Training and Exercising
3. Response
4. Partnership Working
5. Assurance
6. Priorities for 2025/26

Key achievements include the review of the Major Incident Plan, a Business Continuity audit across services, and delivery of targeted training for On Call Managers (including cyber, hazmat, legal, and media preparedness). The Trust also responded effectively to several significant incidents, including flooding, service disruption, and a cyber event.

The 2024 Core Standards Self-Assessment confirmed 86% compliance ("Partially Compliant"), with a plan in place to achieve "Substantial Compliance" in 2025/26.

An MIAA audit provided a "Substantial" assurance rating, with a recommendation that the Trust complete 2 'low risk' actions to strengthen EPRR delivery.

The Trust is working with Wirral University Teaching Hospital NHS Foundation Trust to explore alignment of EPRR functions as part of wider collaborative planning.

It is recommended that the Board/Committee:

- Notes the report and the assurance provided through incident response, internal audit, and training activity
- Approves the revised **Major Incident Plan (Appendix A)** as part of the annual EPRR submission
- Approves the 2024 **Core Standards Self-Assessment** outcome (86% – Partially Compliant)
- Notes the findings of the 2025 **MIAA audit** (Substantial assurance, with two low-risk actions)
- Endorses the **2025/26 EPRR Work Plan** (Appendix G)
- Supports ongoing collaborative working with Wirral University Teaching Hospital to coordinate EPRR resources and, where possible, strengthen shared arrangements

Key Risks
This report relates to the following key risks: ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.ID06 - Trust operational performance declines resulting in poorer outcomes and greater inequalities for our population.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7 May 2025	Quality & Safety Committee	EPRR Report 2024/25	Approved for onward reporting to Board.

1	Planning
1.1	**Accountable Emergency Officer /Emergency Preparedness Officer** Under the EPRR framework, the Trust is required to be represented at the Local Health Resilience Partnership (LHRP) for Cheshire and Merseyside by the Accountable Emergency Officer (AEO). From 1st April 2025, the role of AEO is held by Dr Joanne Chwalko, Chief Operating Officer. Mick Blease is the Trust's Emergency Preparedness Officer and represents the Trust at the regional LHRP practitioner meetings. The Trust has maintained attendance at both the Strategic and Practitioner meetings throughout 2024/25.
1.2	**Major Incident Plan** In line with the requirements of the Civil Contingencies Act 2004, the EPRR Framework (July 2022), and the Standard NHS Contract, the Trust — as a Category 1 Responder — must have emergency plans that make explicit how the organisation will respond in the event of an emergency or major incident. The Major Incident Plan has been subject to a regular annual review. Changes made during this year's review include contact details for the EPRR teams at NHS England and the ICB. The other change relates to the new requirement for providers to complete an SBAR template and submit to the ICB within a given time frame whenever a Business Continuity, Critical, or Major Incident has been declared. The major incident plan is attached as **Appendix A** for approval of part of this annual EPRR submission. All changes to the previous MIP have been highlighted in red.
1.3	**Business Continuity Planning** WCHC has a legal and contractual duty to develop robust business continuity arrangements which set out how the Trust will maintain critical functions if there is a major emergency or disruption. Business Continuity Plans (BCPs) are in place at service level to provide a consistent methodology and format across the Trust. A Business Continuity Policy, aligned to ISO22301 (International Standard for Business Continuity Management), has been developed.

	The Operational Restructure programme that took place in Q3 2024/25 was an ideal opportunity to reset the Trust's business continuity (BC) requirements. All services required to complete a BCP were aligned to a service director, with a BC lead identified within each service. The Core Standard Self-Assessment process for 2024 identified an action to complete a Business Continuity Plan Audit to ensure compliance with Standard 51. This audit took place during December 2024 with the assistance of the Trust audit team. Twelve services were included in the audit, and seven questions were posed. Four services were assessed as green for all seven questions. The remaining eight were assessed as green in six out of the seven questions but were assessed as red in the following question • Are new staff made aware of the Trust's business continuity management arrangements on joining their teams as part of their local team induction process? The audit procedure identified one action: • The EPRR lead to liaise with HR to review the induction toolkit, with a view to referencing Business Continuity Plans. This action has been completed. Business Continuity Plans have been utilised on several occasions during 2024/25, most notably following the cyber issues that affected WUTH in November 2023, which had an adverse effect on WCHC.
1.4	**Health Safety Security Resilience Group (HSSR)** The HSSR Group has met on a quarterly basis throughout 2024/25. It is chaired by the EPRR Lead. The group includes representation from services across the organisation and Staff Side representatives. EPRR plans are reviewed by this group prior to implementation. The group is also consulted on new and reviewed EPRR-related policies. Please see Section 1.7 on current plan and policy status. The Terms of Reference for this group were reviewed following feedback from the Cheshire and Merseyside ICB EPRR team, responding to the Trust Core Standard Self-Assessment in October 2024. The Terms of Reference have also been included in an audit conducted by MIAA addressing the Trust's EPRR (please see Section 1.9). That review produced an action relating to the HSSR Terms of Reference, specifically to reference the reports that the group would receive and review. The HSSR reports into the Quality and Safety Committee.
1.5	**On Call Manager Process**

	WCHC operates a two-tier On Call rota system. The Trust utilises a Tactical level as its first level of On Call. This level consists of service directors and deputy directors, with ten named individuals currently performing this role. The Tactical level consists of managers performing the role on a daily basis. This system requires the transfer of the On Call phone to the individual's phone and is managed by the Centralised Booking Service, which operates seven days a week. The Strategic level, referred to locally as the escalation level. This level is made up of Chief Officers and Directors. The rota has seven named individuals. The escalation level also operates on a day-about basis. Rotas are managed by the EPRR Lead and are produced two months in advance, taking into account dates when managers have indicated they will be unavailable to perform the role. The rota is available on StaffZone and issued to the WUTH switchboard as a back-up. It is also included within the "On Call" pack available to all On Call managers. The process is continually subject to review by the EPRR Lead and members of the rota. On Call incident logs are completed on Datix, allowing for more effective management of incidents. Reporting and analysis of On Call incidents take place at the HSSR and within On Call Manager training.
1.6	**Counter Terrorism** There are five levels of threat from terrorism: • **Low** – an attack is highly unlikely • **Moderate** – an attack is possible but not likely • **Substantial** – an attack is likely • **Severe** – an attack is highly likely • **Critical** – an attack is highly likely in the near future The level is set by the Joint Terrorism Analysis Centre and the Security Service (MI5). The current threat level in relation to international terrorism in the UK is **"Substantial"** – an attack is likely – and was last changed on 9th February 2022. The previous rating of "Severe" had been in place since November 2021, following the attack outside Liverpool Women's Hospital. Nationally, there were 248 arrests for terrorism-related activity in the year ending 31st December 2024, an increase of 29 on the previous 12-month period (an increase of 13%), which also represents the highest arrest rate since 2019. The EPRR Lead continues to maintain close links with counter terrorism policing and attends regional training and exercise events. The Trust is also signed up to the periodical counter terrorism circulation UK Protect. Key messages to staff concerning preparedness and security are communicated via Staff Bulletin, StaffZone, and training

	sessions. The Trust is also able to access the Action Counters Terrorism e-learning training package. The Trust is represented at the monthly Wirral Channel Panel, which collectively assesses the risk to an individual and decides whether an intervention is necessary. If a Channel intervention is required, the panel works with local partners to develop an appropriate, tailored support package.
1.7	**Policy/Plan Development** The table in **Appendix B** provides an up-to-date position regarding EPRR related policies and plans that support the EPRR programme. The EPRR Policy (GP52) has been reviewed Mar 2025 and takes account of the comments made by the Cheshire and Merseyside ICB EPRR following their review of our 2024 Core Standards Self-Assessment submission.
1.8	**EPRR Resourcing reword this section** The Trust continues to assess the resources in place to fully discharge its EPRR duties. No additional resourcing requirements have been identified during 24/25. Following the findings of the recent Wirral review and plans to progress formal integration with the acute provider, Wirral University Teaching Hospital, work plans for the coming year will focus on identifying opportunities to strengthen EPRR resources across both organisations. The Trust employs an EPRR Lead / Local Security Management Specialist on a full-time basis. Fifty percent (50%) of this role is dedicated to EPRR. The EPRR Lead utilises the services of the Estates Senior Administrator on an ad hoc basis to assist with EPRR-related matters, including supporting the Health, Safety, Security and Resilience Group meetings. Other financial support is provided from central budgets to support the EPRR programme. This includes an annual payment to the Integrated Care Board that supports additional EPRR training and other EPRR-related activities. Individual services utilise their own budgets to support the EPRR programme. Services purchase their required PPE, including masks, gowns, and gloves. The two Walk-in Centres also purchase the required CBRN(e) response equipment from their own budgets. The EPRR programme is funded both centrally and locally — the central team handles broad training and coordination (including payments to the ICB), while individual services fund the supplies and equipment they specifically need. On 9 September 2024**,** all NHS provider Trusts within the Cheshire and Mersey area signed a Method of Understanding with the following key principle: NHS Cheshire and Merseyside is authorised to access and deploy relevant resources from any or all of the eighteen signatory organisations within the Local Resilience

	Forum areas of Cheshire and Merseyside, in response to a Business Continuity, Critical, or Major Incident.
1.9	**MIAA Review of Trust EPRR arrangements.** During Q4 24/25, Mersey Internal Audit Agency (MIAA) was commissioned to review and evaluate the Trust's arrangements in place in relation to emergency preparedness, resilience, and response, considering local and national guidance and compliance with the NHS EPRR Core Standards. The review took place during the months of February and March 2025**.** The review produced an overall rating of "**Substantial**," with six of the seven objectives rated **GREEN**, and the objective relating to the training programme rated AMBER. The executive summary of the MIAA report can be seen at **Appendix C** of this report.
2.0	**Training and Exercising**
2.1	**On Call Manager training** The On Call Manager (Strategic and Tactical) training programme has been developed and delivered to individuals who have been recruited onto the respective on call rotas. The training has been delivered by EPRR Lead and is scenario-based. Numerous real events are utilised to provide individuals with sufficient knowledge to perform the role of an On Call Manager. The on-call mechanisms are fully described, as are the systems available to support individuals performing the role. The EPRR Lead maintains a close working relationship with all On Call Managers and holds regular debriefs to continue to understand the issues being raised and the resolutions utilised to resolve them. This information is used to refresh the On Call training packages. On Call Managers are also required to complete the Principles of Health Command training, developed and delivered by the NHS England EPRR team. Separate packages are delivered to members of the Strategic and Tactical on call rotas. At the time of producing this report, all On Call Managers on both the Tactical and Strategic rotas have completed the required training.
2.2	**Media Training** Core Standard 36 outlines the requirement for the Trust to have arrangements in place to enable rapid and structured communication via the media and social media. The Core Standards process of 2023 identified the requirement to have a pool of directors to respond to media requests and to be suitably trained in this area. On 3 October 2024**,** four members of the Executive Team attended media training provided by a recognised provider, which focused on several likely scenarios that could affect the Trust. Feedback from those attending the training was extremely positive.
2.3	**Hazmat Training** Several Core Standards, including 55, 63, and 64**,** relate to the provision of training in the area of Chemical, Biological, Radiological and Nuclear (CBRN) and Hazardous

	Material events. In order to evidence compliance in this area, the EPRR Lead attended a decontamination training package delivered by the North West Ambulance Service (NWAS). Upon completion of this training, the EPRR Lead developed and delivered a new training package to 40 members of staff employed in our Urgent Treatment and Walk-In Centres throughout August and September 2024.
2.4	**Legal Awareness training** Recognising the inherent risks and complexities within the EPRR portfolio, Trust leaders must have a clear understanding of the challenges it presents. To support this, the ICB identified an accredited trainer in this area to deliver a training programme to Strategic Commanders and EPRR Leads across the system. Six members of the Trust, including five directors and the EPRR Lead, attended training sessions in August and September 2024**,** which ensure compliance in this area. Again, the feedback from those attending the training was that it was extremely useful and enlightening.
2.5	**Loggist Training** To enhance the response of the Trust in the area of trained Loggists to assist Incident Commanders during an EPRR incident, training was provided to a total of 10 new staff**.** An additional refresher for these staff will be delivered during Q2 of 2025/26**.** In addition to this training, a section will be included in future On Call Manager exercises that will reference “Working with Your Loggist.”
2.6	**Tests and Exercises** The trust is required to ensure response plans have been appropriately tested, conducting: • A live exercise/Incident every 3 years • A tabletop exercise annually • Communications test every 6 months • The table in **Appendix D** advises on the exercises and training that have taken place involving the Trust during the past three years.
2.7	**Training and Exercise programme** The Trust is required to complete a live exercise within a three-year period that can test elements of the emergency planning measures in place. The occurrence of an incident that has tested the effectiveness of elements of the plans in that period may also demonstrate compliance in this area. The table in **Appendix E** lists the incidents and exercises that have occurred during the past three years and evidence of compliance with this standard.
2.8	**Incident Coordination Centre (ICC)** The Trust is required to maintain appropriate Incident Control Centre (ICC) facilities to control and co-ordinate the response to an emergency. Incident Control Centres are established at St Catherine’s Health Centre, with a backup facility at the Albert Lodge training wing, located at VCHC. ICC equipment and connectivity are checked and tested on a monthly basis.
3.0	**Response**

3.1	**Incident – Major Water Leak Marine Lake** On 6 December 2024, staff arriving for work at 0600 hours at Marine Lake Health Centre discovered that the premises had been subjected to substantial flooding on the ground floor. This resulted in the immediate closure of the premises and contact with the On Call Estates Engineer. Upon arrival, the engineer identified the cause of the leak and isolated the supply. All services being delivered from the premises were suspended, and BCPs were invoked. A plan was put in place to reinstate those services without delay, and the Estates Team began a major clean-up exercise, which involved the utilisation of industrial pumps and drying devices. All services were fully restored, and the premises were reopened at 14:00 hours on the day of the leak.
3.2	**Cyber Incident – WUTH** On 25 November 2024, WUTH declared a Major Incident in relation to a potential cyber threat. The threat resulted in the organisation shutting down some essential servers in order to protect its systems. The loss of those servers had an adverse effect on a number of services being delivered across the Trust. WUTH established a Digital Incident Response Team (DIRT), and our own Chief Digital Information Officer formed part of the regional response. WCHC established its own team to respond to any disruption experienced and to mitigate any risk to the Trust. A number of services reported disruption, including Cardiology services, Urgent Treatment Centre services (due to lack of access to patient records), and IPC services (specifically regarding laboratory test results). In the early stages of the incident, the Trust Incident Response Team met twice daily, supporting services in mitigating disruption, providing additional assistance where necessary, and issuing communication updates across the Trust. IT services worked tirelessly to ensure all Trust IT systems were protected.
3.3	**Disorder following Southport attacks.** In response to the attack that took place in Southport and the subsequent riots across the county, a communications response was developed. This response was led by the Interim Chief Executive, Mark Greatrex. A communications statement was shared with staff, acknowledging the incident, showing compassion for those affected, providing support and reassurance to staff, and clearly stating the Trust's position on racism and discrimination. A further two CEO messages to all staff were issued. In partnership with the BAME Network, a number of actions were agreed, including: – Communications to staff to provide reassurance and signposting – 'We will not tolerate' posters for clinics – Statement on the public website: Racism and discrimination – our commitment to patients, service users and staff

3.4	**Lessons Identified and learning from Incidents and Exercises.** • Following a review of the cause of the flood at Marine Lake Health Centre**,** the leak was identified as the result of "poor workmanship" during the build stage of the health centre. As a result of this finding, those responsible for the build were tasked with reviewing all similar pipe fittings and correcting them where necessary**.** • In the early stages of the WUTH cyber-attack**,** there were a number of complaints regarding the lack of a clearly communicated "cause" of the incident being shared with other organisations, which affected their ability to respond. By having a representative on the regional response team, we were able to cascade that the lack of information was intentional and aligned with guidance provided by the Cyber Security Operations Group**.** • This incident also provided validation that WCHC's response plans to a cyber incident were effective. • Early engagement with the Trust's BAME Network by the Executive Team and Communications was key to ensuring that the right messages were shared with staff and the public in a timely way. Actively listening to the experiences of BAME staff directly influenced the actions the Trust put in place to support staff.
4.0	**Partnership Working**
4.1	The Trust actively participates in the following multi-agency groups to ensure a proactive and coordinated approach to informing and sharing best practice: • **Local Health Resilience Partnership (LHRP – Strategic):** Attended by the Accountable Emergency Officer and led by ICB EPRR • **LHRP Practitioners Group:** A working group for both Merseyside and Cheshire, attended by the Emergency Planning Lead and led by ICB EPRR • **Wirral Emergency Planning Group:** A multi-agency working group attended by industry, Category 1 and 2 responders, to review resilience arrangements and public events across Wirral • **WUTH Emergency Planning Team Meeting** • **CWP Emergency Planning Team** • **Local Resilience Forum (Merseyside):** Via ICB representation • **Cheshire & Merseyside (C&M) Community and Mental Health Core Standards Working Group** • **Cheshire & Merseyside ICB Core Standards Task and Finish Group**
5.0	**Assurance**
5.1	Under the Civil Contingencies Act (CCA) 2004, the Trust has legal responsibilities in six specific areas: • **Co-operating** with other responder organisations • **Risk assessment** • **Emergency planning** • **Communicating** with the public

	• **Sharing information** with local responder organisations • **Business continuity plans** to ensure that services can continue to deliver their functions in the event of an emergency, so far as is reasonably practicable Compliance against the EPRR requirements of the CCA 2004 is monitored via an annual self-assessment exercise, the results of which are required to be submitted to the Trust Board for approval before submission to NHS England. Organisations are expected to state an overall assurance rating as to whether they are fully, substantially, partially, or non-compliant with the NHS EPRR Core Standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

5.2	**Core Standards Self-assessment and action plan** In September 2024, the Trust completed its annual Core Standards Self-Assessment submission. The self-assessment process for 2024 was completed by the EPRR Lead. The initial self-assessment was subject to a check-and-challenge process conducted by the Cheshire and Merseyside ICB EPRR Team. As a result of the self-assessment submitted and the associated evidence provided, the ICB agreed that WCHC had an overall assessment of "**Partially Compliant"**, with a compliance percentage of **86%.**
5.3	**Action Plan** In response to the Core Standards Self-Assessment, the EPRR Lead has produced an action plan that addresses the standards that were not fully compliant. That action plan is included at **Appendix F** of the EPRR report. The Trust has set an overall target assessment of "Substantial Compliance" for the 2025/26 submission

6.0	Priorities
6.1	**Work Plan for 2025/26** A full EPRR work plan has been developed for the year 2025/26. This work plan can be found at **Appendix G** of the EPRR report.

7	Implications
7.1	**Quality/Inclusion** The proposals will enhance service resilience and ensure continuity of safe, high-quality care during emergencies. Improvements to training, communication, and incident learning will support equitable responses for staff and service users. No negative impact on quality or equality is anticipated
7.2	**Finance** There are no additional financial or capital pressures identified. For further resource clarification please refer to section 1.8
7.3	**Compliance** The Trust has been assessed as Partially Complaint with regards to the EPRR requirements of the Civil Contingencies Act 2004.

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

Appendix A

Wirral Community Health and Care NHS Foundation Trust

MAJOR INCIDENT PLAN

Document Title	Wirral Community NHS Foundation Trust Major Incident Plan
Authorising Manager	Jo Chwalko
Job Title	Chief Operating Officer
Plan Author	Mick Blease
Issue Date (this version)	April 2025
Revision Status	Version 15
Review Date	April 2026
Approval Committee & Date	Quality and Safety Committee
Intended Audience	• Wirral Community Health and Care NHS Foundation Trust Board • Senior Management Team/Service Directors • Multi Agency Partners within Cheshire and Merseyside Areas.

Version Control:

Version History:		
V1	Development of Major Incident Plan to reflect organisational change	April 2011
V2	Amendments to update information	April 2012
V3	Amendments to include update in line with NHS commission Board Structures and Emergency Preparedness, Resilience and Response (EPRR) arrangements	April 2013
V4	Amendments to update information	October 2014
V5	Review of information and addition of escalation pathways	October 2015

V6	Update of ICC details Update of phone contact details	September 2016
V7	Amendments to Authorising Manager and Plan Author Rest Centre process	September 2017
V8	Amendments made to the trust On Call arrangements section 4.3	August 2018
V9	Amendments made in relation to the Trust name. Executive pack included which provides summary of the MIP for On Call managers.	August 2019
V10	Amendments to Action cards to include requirement to Tenants of WCHC controlled buildings, Amendments to Authorising Manager	September 2020
V11	Reference to Integrated Care systems and updates relating to communication links	September 2021
V12	Change of reference from CCG to ICB including relevant contact details. Change reference of Divisional Managers to Service Directors.	S 2022
V13	Removal of reference to Rest Centre Management.	August 2023
V14	Removal of out-of-date terminology. Include reference to the NHS Emergency Preparedness Resilience Response Framework July 2022. Cognisance taken from NHSE Core Standards feedback 2023. Inclusion of Countermeasures (CBRN)	August 2024
V15	Changes to ICB and NHSE EPRR Contact details. New NHSE/ICB Incident Reporting process included at 4.8	April 2025.

Further information about this document:

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Published by	Wirral Community Health and Care NHS Foundation Trust St Catherines Health centre Derby Road Birkenhead CH43 0LQ
This document can be made available in a range of alternative formats including various languages, large print, Braille and audiocassette	
Copies of this document are available from	Emergency Planning Lead

Distribution

The plan will be made available to all staff via the StaffZone

Hard copies are also available in both ICC rooms

The plan is included in the On Call Managers pack

Contents

Major Incident Plan Overview

SECTION 1: Introduction

1.1 Background

The NHS needs to plan for, respond to and recover from a wide range of incidents, emergencies or disruptive challenges that could impact on health or patient care. These range from extreme weather conditions to an outbreak of an infectious disease, or a major transport incident. The Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 and the Health and Care Act 2022 require NHS England and NHS-funded organisations to demonstrate that they can deal with such incidents while maintaining services to patients. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR).

During times of pressure and in response to incidents, NHS-funded organisations require a structured approach to support effective decision-making. This structure provides a clear leadership pathway with accountable decision-making in response to information about the incident. This approach to leadership is commonly known as ‘command and control’.

In compiling this plan reference is made to the NHS Emergency Preparedness Resilience Response Framework July 2022.

The Framework describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (EPRR), to help all NHS funded Organisations in England meet the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

This Framework reflects the changes introduced from the Health and Care Act 2022 and the formation of Integrated Care Boards (ICBs).

1.2 Purpose

The Major Incident Plan (MIP) plan acts as a reference and signposting document to provide appropriate guidance in planning and response and recognises that the NHS follows the principles of subsidiarity in that an incident should be managed at the level closest to the people affected so far as is reasonably practicable.

NHS-funded organisations are required to fulfil the requirements as Category 1 or Category 2 responders, as appropriate, under the CCA 2004, the NHS Act 2006 and the Health and Care Act 2022, as well as the NHS EPRR Framework, and to apply the principles of integrated emergency management (IEM) in their preparation for and response to incidents and emergencies.

This MIP outlines how the Wirral Community Health and Care NHS Foundation Trust (WCHC) will Respond in the event of a major emergency and is structured around the recognised phases of a response.

- Alerting
- Activation
- Operation
- Escalation and de-escalation
- Stand down

The Major Incident Plan is a generic plan and can be applied to all major incidents and significant internal incidents.

1.3 Who is the Plan for?

All staff within the organisation should be aware of the existence and purpose of the MIP and their individual contributions to the success of the Plan.

All such staff should know and understand their specific role in the overall plan. Service Directors, Heads and Service Leads have a duty to ensure their Business Continuity Plans are in place to support the MIP.

Staff likely to be involved in a major incident response should ensure they have the appropriate training, equipment and knowledge to be able to respond safely and effectively to an emergency. In the event of a major incident, it is likely that several organisations will respond.

1.4 Consultation and Distribution of the Major Incident Plan

This plan will be reviewed annually by the EPRR lead. The Health Safety Security Resilience Group (HSSR) will be consulted on the reviewed plan prior to submission to the Quality and Safety Committee for approval prior to distribution.

The plan is made available as follows:

- Electronically on StaffZone
- A hard copy in the major Incident rooms.
- External partner agencies will receive a copy electronically

When a revised plan is issued recipients will be expected to destroy previous versions.

1.5 Incident Types

1.5.1 Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels. This would require special arrangements to be put in place until services can

return to an acceptable level. This could be a surge in demand requiring resources to be temporarily redeployed within the organisation.

1.5.2 Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to services.

1.5.3 Major Incident

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally.

The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

Each will impact on service delivery within the NHS, and this may undermine public confidence and require contingency plans to be implemented. When making the decision to declare an incident the person making the decision should be clear on what the declaration of an incident will achieve. NHS organisations and NHS-funded organisations should be confident in judging the severity of an incident and determining if declaration is warranted.

1.5.4 Classification of types of Major Incidents

The following list provides commonly used classifications for types of Major Incidents. This list is not exhaustive and other classifications may be used as appropriate to describe the nature of the incident.

• **Rapid onset** – develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g. a serious transport accident, explosion or series of smaller incidents.

• **Rising tide** – a developing infectious disease epidemic or a capacity/staffing crisis or industrial action.

• **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action.

• **Headline news** - public or media alarm about an impending situation, significant reputation management issues, e.g. an unpopular patient treatment plan which gathers significant publicity.

• **Chemical, biological, radiological, nuclear and explosives** – CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.

• **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials.

• **Cyber security incident** – a breach of a system's security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.

• **Mass casualty** – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage

1.5.6 Levels of Incidents

As an incident evolves it may be described, in terms of its level, as identified in the table below.

NHS England Incident Levels	
1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans.
2	An incident that requires the response of a number of NHS-funded organisations within an integrated care system (ICS) and NHS co-ordination by the integrated care board (ICB) in liaison with the relevant NHS England region.

3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to co-ordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to co-ordinate the NHS response at the strategic level. NHS England (Region) to co-ordinate the NHS response, in collaboration with the ICB, at the tactical level.

1.6 Review and Audit

The MIP will be reviewed and updated (where necessary) at least annually and, where required, following exercises or after an incident has occurred.

Audit

The MIP will be subject to annual review and as a minimum tested through an annual desktop exercise. Lessons learnt will be captured, incorporated into the MIP where relevant and shared with the wider NHS.

The Foundation Trust's approach to emergency preparedness will be assessed every twelve months either by means of external audit or via self-assessment and assurance provided to the Local Health Resilience partnerships

1.6.1 Training Schedule

Regular training will be provided for Wirral Community Health and Care NHS Foundation Trust (WCHC) staff to ensure they fully understand their role in the event of a major incident. In addition, the Foundation Trust will undertake the following:

- A communications cascade test every six months
- A table top exercise every year
- A live exercise every three years
- Refresher and awareness training for individuals undertaking information handling roles
- Familiarisation of Incident Coordination Centre (ICC) awareness sessions

1.6.2 Other Related Plans

The following plans have been developed to response to specific hazard and threats

- Business Continuity Plans
- Chemical, biological, radiological and nuclear (CBRN) Plan
- Pandemic Plan
- Community Outbreak Plan
- Fuel Plan

- Escalation and Surge Plan
- Adverse Weather Health Plan
- Industrial Action Plan

1.6.3 Underpinning Principles for the NHS EPRR

These underpinning principles apply to all commissioners and NHS-funded organisations.

a) **Preparedness and anticipation** – the NHS needs to anticipate and manage the consequences of incidents and emergencies by identifying risks and understanding direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared. This includes having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules thatdeliver against this principle.

b) Continuity – the response to incidents should be grounded within organisations' existing functions and their familiar ways of working. Actions will need to be faster, on a larger scale and in more testing circumstances during a response to an incident.

c) Subsidiarity – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building blocks of response for an incident of any scale.

d) Communication – good two-way communication is critical to any effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) Cooperation and integration – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. This includes active mutual aid across organisations, within the UK and across international boundaries as appropriate (see Section 8.7).

f) Direction - clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident

1.6.4 Mutual Aid Arrangements.

The successful response to incidents has demonstrated that joint working can resolve very difficult problems which fall across organisational boundaries. Mutual aid arrangements should exist between NHS-funded organisations, and between NHS-funded organisations and partner organisations. These should be regularly reviewed and updated.

In the event of NHS Cheshire and Merseyside requiring mutual aid to support the incident response or recovery arrangements, these can be requested by the NHS Cheshire and Merseyside Commander through NHS England or the relevant TCG / SCG. Mutual aid could include staffing, equipment, services, or supplies.

Requests for Military Aid to the Civil Authorities (MACA) can be made when the NHS capacity has been exceeded or the NHS does not have the specific capability to deliver; in these cases the military may be required to augment responses. MACA support is not guaranteed and may incur a charge for its provision unless it is in response to an immediate threat to life.

Clinical networks will retain a key role in coordinating their specialist capacity.

SECTION 2: COMMAND AND CONTROL

2.1 Command, Control and Co-ordination

For the NHS to be able to respond to a wide range of incidents and emergencies that could affect health or patient care, the appropriate alerting processes need to be in place to inform those responsible for co-ordinating the applicable response.

Under the framework, the management of the response to major incidents will normally be undertaken at one or more of three levels – Strategic, Tactical and Operational. The degree of management and co-ordination required will depend on the nature and scale of the emergency.

2.2 Multi-Agency Command

If a significant incident or emergency is large or widespread, it may be necessary to co-ordinate the response of several organisations. This may be at tactical level or at both tactical and strategic level.

2.3 Multi-Strategic Co-Ordinating Group (SCG)

Most emergencies are dealt with by local responders at a local level through SCG. A Multi-SCG Co-ordinating Group may be convened where the local response has been or may be overwhelmed and wider support is required, or where an emergency affects a number of neighbouring organisations.

2.4 Strategic Co-ordinating Group

Multi-agency strategic co-ordination is undertaken through an SCG. Any agency that feels a strategic multi-agency approach is necessary can request that an SCG is convened (e.g. pandemic influenza).

The geographical responsibility of an SCG follows that of the Local Resilience Forum (LRF) and in turn with the local Police service boundary. The NHS is usually represented at the SCG by an NHS England area team and Ambulance Service senior manager.

The SCG is a fast moving, information sharing and strategic decision making group. Its role is to allow organisations responding to the incident to share information and co-ordinate their response options.

2.5 Tactical Co-ordinating Group (TCG)

A multi-agency TCG may be called to deal with local emergencies that do not warrant the activation of an SCG. A TCG may also be established to support an SCG, dependent upon the scale/severity of the incident. In these circumstances, the NHS Tactical (Silver) Commander may deploy to the TCG if required.

2.6 Roles and Responsibilities

2.6.1 NHS Strategic Commander

Role: The role of the NHS Strategic Commander is to direct and command the response of all NHS resources.

Responsibilities: The NHS Strategic Commander attends the multi-agency SCG on behalf of NHS organisations locally and is responsible for:

- Declaring a local emergency or major incident
- Representing the NHS at SCG meetings
- Advising the Police Commander
- Co-ordinating the local NHS response to a local emergency (major incident)
- Implementing public health advise as directed by SCG
- Liaising directly with NHS England Merseyside Area Team Tactical (Silver) Commander, ICB's, UKHSA and Foundation Trusts' incident management rooms
- Mobilising primary (including ICB's) and community care resources to support acute and non-acute Foundation Trust
- Acting as the health focal point with other agencies and organisations and fulfil the requirements as a Category 1 Responder as detailed within the CCA 2004

The initial activation of the Merseyside NHS Strategic (Gold) Commander (Merseyside Area Team 2nd on call) is via the North West Ambulance Service Health Control Desk (01772 867640) who holds a copy of the on call rota.

2.6.2 NHS Tactical Commander

Role: The role of the NHS Tactical Commander is to initially assess the information received upon initial activation, co-ordinate the response of local NHS resources, or escalating to the NHS Strategic Commander whilst focusing upon the tactical management of NHS resources

Responsibilities:

- Declare a local emergency (major incident)

- Work closely with any location suffering a business continuity interruption
- Work closely with Clinical Commissioning Groups during a business interruption/local emergency
- Work closely with the NHS Staff Officer during a business interruption/local emergency out of hours
- Co-ordinate the local NHS response to a local emergency (major incident)
- Mobilise primary and community care resources to support the response
- Manage demands on resources
- Communicate regularly and systematically with the NHS Strategic Commander
- Compile situation reports for the NHS Strategic Commander
- Contact the NHS Strategic Commander when resources are required
- Represent the NHS at the multi-agency TCG
- Act as the health focal point for other agencies and organisations, e.g. Public Health
- Work closely with the North West Ambulance Service Silver Commander
- Inform the NHS North of England Director on call via the Health Control Desk (if appropriate)
- Ensure communication networks are set up
- Support the distribution of the public and media communications messages agreed by multi-agency partners; and
- Fulfil the responsibilities of a Category 1 Responder as detailed within the Civil Contingencies Act 2004.

2.6.3 WCHC Tactical On call Manager

Role: NHS Foundation Trusts or key partners responding to a multi-agency incident would become Operational command and will be required to co-operate with the NHS Tactical Commander and NHS Strategic Commander requests.

Individual organisations remain in command of their own resources and staff but each one must liaise and co-ordinate with all the other agencies.

The role of the WCHC Tactical On-call Manager/Strategic Commander is to respond to the local emergency (significant incident), either in isolation or as part of a wider NHS response.

Responsibilities:

- Implement internal command and control structures to manage and support the wider response
- Provide regular information to NHS Tactical Command/NHS Strategic Commander using recognised methods and established report formats as required within specified timescales; and
- Contribute to the debrief process and recovery phase.

2.7 Integrated Care Boards

Wirral Community Health and Care NHS Foundation Trust forms part of the Cheshire and Merseyside Integrated Care Board. Integrated Care Boards support NHS England, Merseyside Area Team in discharging its EPRR functions and duties locally.

The ICB will chair the Local Health Resilience Partnership (LHRP) forum. The ICB provides a 24/7 escalation route for providers should they fail to maintain necessary EPRR capacity and capability.

The EPRR role of the ICB is to:

- Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
- Support the NHS England in discharging its EPRR functions and duties locally
- Provide a route of escalation for the LHRP should a provider fail to maintain necessary EPRR capacity and capability
- Fulfil the responsibilities as a Category 1 Responder under the CCA including maintaining business continuity plans for their own organisation
- Chair the LHRP; and
- Seek assurance provider organisations are delivering their contractual obligation.

2.8 Local Authority

Each LA manages a civil contingency planning function. The principal concern of the LA in the immediate aftermath of an emergency is to provide support for the people in their area. Generally, they do so by co-operating with the emergency services in the overall response. The LA will also activate and co-ordinate voluntary sector support.

The health EPRR role of the Local Authority, via their Director of Public Health (DPH) is to:

- Provide leadership for the public health system within their LA
- Ensure that plans are in place to protect the health of their populations and escalate any concerns or issued to the relevant organisations or the Local Health Resilience Partnership as appropriate (LHRP).
- Provide initial leadership with UKHSA for the response to public health incidents and emergencies within their LA area. The DPH will maintain oversight of population health and ensure effective communication with local communities. UKSHA will deliver and manage the specialist health protection services.

2.9 UK Health Security Agency (UKHSA)

UKHSA combines public health and scientific knowledge, research and EPRR within one organisation and works at international, national, regional and local levels.

In terms of EPRR UKHSA will:

- Work with the NHS at all levels
- Support and advise other organisations that play a part in protecting health
- Be responsible for leading the mobilisation of UKHSA in the event of an emergency or incident
- Deliver public health services including, but not limited to, surveillance, intelligence gathering, risk assessment, scientific and technical advice and microbiology service to emergency responders, Government and the public during emergencies at all levels
- Undertake, at all levels, its responsibilities on behalf of the Secretary of State for Health as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA).

2.9.1 UKHSA – Nationally

The EPRR role of UKHSA nationally is to:

- Provide support to DH to fulfil its role in the UK central Government's National Risk Assessment (NRA) process
- Participate in national multi-agency planning processes including risk assessment, exercising and assurance
- Provide leadership and co-ordination of UKHSA and national information on behalf of the UKHSA during periods of national emergencies
- Support the response to incidents that affect two or more UKHSA regions.

2.10 Scientific and Technical Advice Cell (STAC)

The STAC will access comprehensive and authoritative advice from a wide range of sources, including NHS England and Public Health England and other key scientific and technical sources to support and advise the SCG in directing the response to an incident. The nature of the incident will determine the range of relevant specialist and needed to form a STAC and membership of the STAC will be determined by the type of incident.

SECTION3: Reception Centres

Role the WCHC in supporting Rest Centres

Reception centre is the generic name given to all forms of centres which give shelter.

There are four main types:

- Rest Centres
- Survivor/Evacuee Reception Centres
- Friends and Relatives Reception Centres
- Mass Holding Centres

The Local Authority will determine the requirement for a Rest Centre and determine a suitable location.

If requested WCHC will provide appropriate staff at rest centres to support the needs of patients in the community. Requests for such services will come via the rest centre manager to the On Call Manager, either in hours or out of hours or via tactical command.

Typically, Community Nurses will be required to attend and assess non-urgent nursing care needs of any people in the designated rest centre, and if appropriate to provide relevant care, for example, providing dressings to a patient. A record of any treatment will be recorded in the rest centre treatment log Appendix 5 and medications recorded in the prescriptions record sheet Appendix 3

If *emergency* oxygen is required liaise with local surgeries to understand who may have stocks in surgeries or the Ambulance service. Replacement Cylinders for patients for longer term can be arranged via GPs completing a Home Oxygen Order Form for the suppliers Appendix 4

Community Nurses are equipped with bags containing a range of equipment to support delivery of care and a range of dressings are available from community nurse bases. In addition, there are specific rest centre bags the contents of which are checked on a monthly basis Appendix 6. Bags are located at each base.

SECTION 4: Alert and Activation

4.1 When a Major Incident is declared by an agency or other health provider, the WCHC will:

- Assess the impact on the Trust and if required activate the major incident procedure including the setting up of the Incident Coordination Centre (ICC
- Mobilise community resources in response to the incident
- Support the Local Health economy by taking steps to relieve pressure in the system

Responding to and Managing Major Emergencies

4.2 Activation of the Plan and Declaring Incident Over

The Trust can be formally informed of a major incident from a variety of sources including

- other Category 1 and 2 Responders
- through the NHS Strategic and or Tactical Command activation process

However to prevent inappropriate activation of the Plan there will always be an assessment phase prior to activation.

The Executive Team and/or the On-call Duty Manager has the overall responsibility for activating the MIP and is required declaring a major incident. They will also be responsible for declaring the incident closed and instructing the Incident Team to 'Stand Down.'

4.3 WCHC On-Call arrangements

WCHC has a 24hrs a day/7 days per week/365 days a year on-call rota. This rota consists of two levels including Tactical and Strategic levels. The Tactical Level level consists of service directors and deputy directors. There are currently nine (10) managers rostered to perform the role of Tactical on call and will complete a day on call at a time.

There are seven (7) directors rostered to perform the role of Strategic on call manager and will complete a day on call at a time. Following the declaration of a Major Incident affecting WCHC. The Strategic On Call will form the role of Strategic Commander for the Trust.

The Trust Tactical on call manager will be the first point of contact for any calls relating to incidents, whether internal or external in hours or out of hours and relating to minor or significant incidents. The Tactical on call manager will contact the Strategic on call manager and escalate any incidents they deem necessary.

The Tactical on call manager can be contacted on the 07810 754 138. This number is widely publicised across the Trust and included in Business Continuity Plans.

The EPRR Lead is responsible for maintaining the two individual rotas and published a month in advance. Rotas are shared with all individual managers and also included in the On Call section of the Team drive that all managers have access to.

If the Trust On call manager decides to escalate to the NHS England Area Team they will need to follow the steps below and consider the following:

- Will or has the incident the potential to affect the wider health economy?
- Will or has the incident the potential to affect multi-agency partners?
- Will additional support from NHS England Team be required?

4.4 Criteria for Activation of the Major Incident Plan

The Trust will need to consider the activation of its incident response plan in a number of different circumstances See Appendix 7

- An incident which cannot be managed by normal business continuity management e.g. the closure or evacuation of one or more health care premises, serious staffing issues
- An incident causes serious disruption to one or more of the services provided and requires special arrangements to be put in place

- An incident that causes or could cause implications for partner organisations
- An incident occurs which represents a threat to public health or well-being or involves serious concern or alarm and is within the scope of the services offered
- Information received from NHS England, Cheshire and Merseyside ICB, NWAS, Multi Agency Partners , Media or the public.

In all of these circumstances the Tactical On Call manager will need to assess the information. The information received will need to be assessed utilising a risk assessment, and a decision made as to whether to activate this plan.

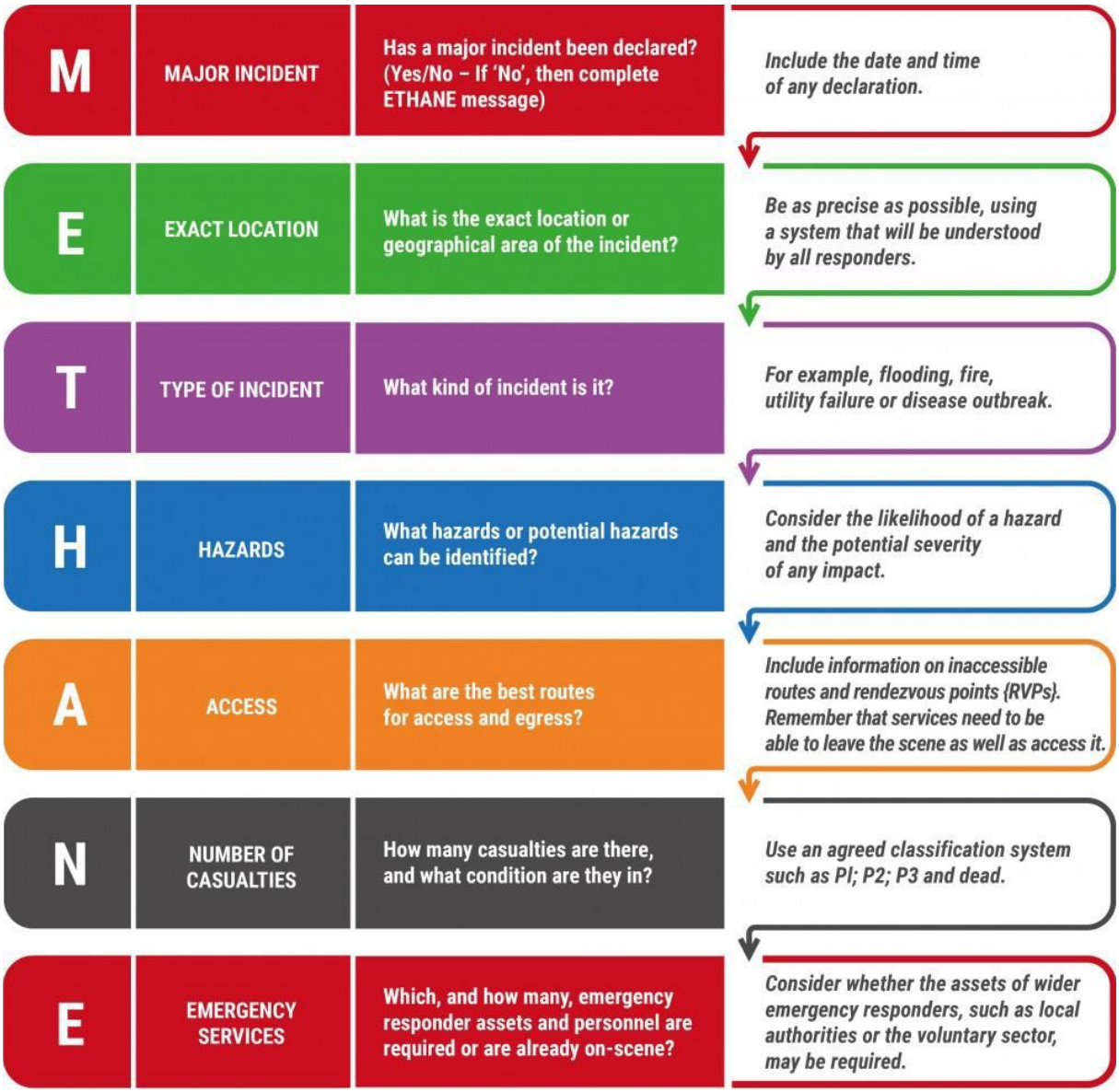
4.5 Joint Decision Model

Commanders should use the Joint Emergency Services Interoperability Principles (JESIP) Joint Decision Making (JDM) Model to help bring together the available information, reconcile objectives and make effective decisions. The JDM centres around three primary considerations; working together, saving lives, and reducing harm .

4.6 METHANE Model

Standard messaging should be utilised when relaying information to other organisations. The METHANE model is an established reporting framework from the Joint Emergency Services Interoperability Principles (JESIP), which provides a

common structure for responders and their Incident Coordination Centre's to share incident information. It is recommended that M/ETHANE is used for all incidents.



A M/ETHANE Reporting Template is available at Appendix 3

4.7. Contact Arrangements

4.7.1 ICB Contact Arrangements

Note: *In the event that the Trust declares an emergency the ICB must be contacted*

On Call ICB Contact Numbers

For **Cheshire and Merseyside ICB** the following number will be used:

- 0845 124 9802
- Incident Response 01323 690830

- Option 1 – Tactical Commander
- Option 2 – EPRR
- Option 3 – Regional Communications Team
- Option 4 – Strategic Commander

- The ICB can also be contacted via email
- General - EPRR@Cheshireandmerseyside.nhs.uk
- Incident Control Centre – ICC@Cheshireandmerseyside.nhs.uk
- System Control Centre – SCC@Cheshireandmerseyside.nhs.uk

NHSE North West Regional Operations Centre (NW ROC)

- 0345 113 0099
- NHSE Email - england.eprrnw@nhs.net

4.8 NHS England Northwest SBAR Reporting

When WCHC declares a Business Continuity or Critical Incident (including implementation of Business Continuity arrangements) it must notify the Cheshire and Merseyside ICB within 15 minutes of declaration – and **within a maximum of 1 hour** of invocation/declaration, this notification must be followed up with an SBAR by email. The document will be emailed to ICC@Cheshireandmerseyside.nhs.uk The initial notification and associated SBAR will be completed by the Tactical On Call manager. Ongoing incidents requiring daily updates will be the responsibility of the Incident Commander to ensure completion. The SBAR template is included at Appendix 10.

SECTION 5: INCIDENT COORDINATION CENTRE (ICC)

5.6.1 Staff Recall

In the event of a major incident, staff are expected to respond outside their contracted hours, subject to their personal availability. This may include the introduction of shift working and will involve duties which are different from their normal role. The numbers and type of staff required will be co-ordinated by the On-call manager. Staff may be contacted through the business continuity arrangements outside of normal working hours and will be asked to bring their staff ID card with them, if possible, particularly if they have patient facing roles.

5.6.2 Establishment of WCHC ICC

Responsibility for making the decision to establish the ICC on behalf of the Trust lies with the Trust Executive Team or on-call manager.

Following the decision to establish, the Incident Management Team will be convened at the main ICC. Details on how to access the facility out of hours are contained in Part 2 of this plan.

5.6.3 Staffing of the ICC

During working hours the ICC will require the redeployment of appropriate staff to work as required. Outside normal working hours, staff will be asked to support an incident should they be able to do so.

The Incident Management team will include all of the following roles

- Strategic Commander (On Call Strategic)
- Tactical On Call Manager
- Operational Support (Emergency Planning lead or Senior Manager)
- Loggist
- Admin support x 2
- Communications representative
- Clinical lead as appropriate to the incident

Other staff may be asked to support the incident management team by invitation, for example, HR, Estates or IT staff, and Service Directors/Service Leads The staff identified to support the incident management team will be determined by the type and size of the incident.

Roles and responsibilities of the incident management team are outlined in the action cards in section 11

5.6.4 Management of a Major Incident

When a Major Incident is declared the Incident Management Team (IMT) takes over responsibility for management of the organisation in order to optimise the effectiveness of its response, where appropriate liaising with the Executive Team. All normal management arrangements are over-ruled for the duration of the incident. To create capacity to deal with the incident, the IMT may in line with Business Continuity Plans

- Utilise resources (e.g. staff) from any area of the Trust
- Scale down any business
- Suspend any area of business

The organisation has a duty to respond to a major incident and also to maintain its normal business activities during the major incident as far as is reasonably practicable. This may involve making difficult decisions which seek to balance differing priorities. The IMT will be assisted in these decisions by emergency plans developed to deal with specific types of incidents and by the Trusts Business Continuity Plan(s).

5.6.5 Alerting and mobilising staff

It may be necessary to reduce or suspend non-essential work in accordance with internal business continuity arrangements in order to create resources needed to support the overall response.

Where it is clear that staff will need to be mobilised in our response to a significant incident, the response will be delegated from the Incident Management Team team.

Staff who work in either a senior management role or a community role are provided with a mobile telephone or blackberry, this would be the first method of contact to staff where there is an urgent need to mobilise staff resources. Alternative methods for contacting staff would be telephone, SMS, text message or email.

5.6.6 Shift Patterns

Shift patterns will need to be considered from the very beginning of the response. If there is the potential for the response and recovery to be prolonged, then appropriate replacements must be identified and stood-down from normal duties if necessary, in order to allow them to come onto shift in a condition to be effective. Shift patterns should ideally marry up with the other Responders' changeovers. All records will be stored and used within briefing meetings in the control room.

5.6.7 Battle Rhythm

The frequency of meetings and timescales for collation of requested information or 'battle rhythm' must be established at the earliest opportunity. This will drive the process to enable the timely receipt of information to be collated and considered so that the Strategic Commander can develop the response in support of the incident.

5.7 Record Keeping

As an operational responder the Trust will record all its actions utilising designated Log books and forms held within the Incident Coordination Centre (ICC)

Decision Log Books must be clear, intelligible, accurate and follow best practice, which is no 'ELBOW':

- No Erasures
- No Leaves torn out
- No Blank Spaces
- No Overwriting
- No Writing between lines

Commanders are responsible for recording all decisions, actions and rationale that they make in relation to the incident within a Decision Log Book, which are stored in the ICC's.

Record keeping is necessary to:

- Provide information to people newly arrived at the control room (e.g. when a new shift comes on duty) about what has already been done and what has not been done
- Provide evidence after the event to help us respond better to future incidents
- Provide evidence, if required, for internal or public reviews of the incident

During a major incident accurate records must be kept of every message received, action taken or instruction given. All records should be dated, timed, initialled and written in black ink. Pages should be numbered. As such the following system of logging messages and decisions has been developed.

5.7.1 Role of the Loggist

The role of the Loggist includes the following:-

- To capture decisions and rationale during an incident or emergency' following 'best practice'
- To aid with response to the incident or emergency'
- To support any future inquiries which may occur.

In order to achieve these aims the Loggist will work with the Strategic Commander. And ensure that all decisions are included in a contemporaneous log that accurately reflects the decisions made and the rationale behind them. At the conclusion of a tour of duty the Loggist and the Strategic Commander will review the log, amend if necessary and sign, time and date the entry to that point.

Individuals will receive the necessary training in order to perform the role of a Loggist.

Contact details of all Trained Loggists will be included in the telephone directory of the On Call folder.

The Loggist should refer to Action card 4

Please note: until the Loggist arrives, the Commander is responsible for maintaining their own Decision Log Book. Failure to keep a Decision Log could legally jeopardise the organisation's ability to justify its actions in response to the incident.

5.7.2 Message Records Sheets

These are used to record all incoming and outgoing information, which includes reference to all phone calls, emails and faxes. Once a message is taken, this will go to the Strategic Commander, then either delegated or given to the Message Records Handler for recording and then filing. A copy of the message records sheet can be found in Appendix 3.

5.7.3 Decision Log

These are to record significant complex decisions. These must be passed to the Strategic Commander who will decide on a decision or delegate to another decision maker within the team i.e., Operations Manager.

Decisions will be recorded by the Strategic Commander Decision Loggist. All active decision logs should be used as a basis for the situation reports and should reflect the key issues on the whiteboard. A copy of the Emergency Logbook is held centrally within the Major Incident Room.

5.7.4 Personal Logs

It is vital that all messages are logged accordingly. Occasionally members of the Major Incident Team may record their own log i.e. time arrived, breaks taken, notes. This should be recorded in their own pocket note books. All notes are to be submitted to the Strategic Commander after the incident and will form part of the Foundation Trusts incident records.

Tactical Commanders will inform Operational Command of their requests for information.

5.7.5 Summary Report of Major Incident

The Strategic Commander is responsible for compiling a report of the major incident and presenting it to the Senior Management Team

5.7.6 Specific Emergency Plans

The Foundation Trust has developed a range of specific plans (e.g. Pandemic Flu, Heatwave) to deal with certain kinds of incidents which have been assessed either locally or nationally as significant risks. The plans are available from the Foundation Trusts intranet.

5.8 Briefings

WECHC must relay the decisions and actions required in a structured way. This ensures it is understood by those who are tasked with completing actions as part of the handover to another Commander.

There are two briefing tools which can be used: SBAR and IIMARCH. SBAR which covers Situation, Background, Assessment and Recommendation is a structured method for communicating critical information that requires immediate action contributing to effective, escalated, and increased patient safety (Appendix 6).

For handovers, Commanders should utilise IIMARCH covering Information, Intent, Method, Administration, Risk Assessment, Communications and Humanitarian Issues as it is a more detailed briefing tool (Appendix 5).

When using IIMARCH, it is helpful to consider the following:

- Brevity is important - if it is not relevant, leave it out
- Communicate using unambiguous language free from jargon and in terms people will understand

- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used

5.9 Health and Safety

A major incident may involve staff working in areas they do not normally work.

The Trust is committed to providing and maintaining a healthy and safe working environment for all staff, patients, visitors and contractors.

The Trust recognises the benefits of ensuring safe systems of work, continuous improvement in Health and Safety and compliance with the relevant Health and Safety legislation.

During the response to an incident, members of staff will not be expected to compromise their personal health and safety and the Trust policies will continue to apply.

As all staff carries some degree of responsibility for health and safety, staff will undertake those same responsibilities during the response to an incident.

5.10 Vulnerable Groups

During a significant incident or emergency, the NHS has a specific requirement, in conjunction with other agencies, to ensure at risk groups are specifically catered for. The guidance relating to the CCA 2004, Emergency Preparedness sets out the responsibilities placed on category 1 responders to plan and meet the needs of those who may be vulnerable in emergency situations

Examples of vulnerable groups are:

- Those already ill, either acutely or with chronic health problems
- People dependant on medicines
- People with mental health problems
- People with learning disabilities
- Parents with babies or young children or pregnant women
- The elderly
- People with physical disabilities

In addition, there may be other groups who are vulnerable because of shared or individual equality characteristic such as people who do not read or understand English.

5.11 Countermeasures (CBRN)

Countermeasures, within the NHS scope are a group of medications developed to enable the protection and treatment of the public in Hazardous Materials (HAZMAT) or chemical, Biological, Radiological or Nuclear (CBRN) incidents.

The United Kingdom Health Security Agency (UKHSA) store the national stock of countermeasures. When requested these can be distributed between two to five hours. This will be dependant on the type of countermeasure and the holding location required. NHS England acts as the conduit between the requesting provider and UKHSA.

The providers should liaise directly with NHS England Regional First On Call via 0345 113 0099. Please see process below.

NHS Providers	NHS Regional On Call	NHS England National Duty Officer
On identification of the need for countermeasures	Regional first On Call confirms genuine request, postal address , and contact details	Confirms locations and incidents requiring countermeasures
On Call Strategic, With Medical Director approval calls NHS England First on Call	Regional on-call requests stock from either : NHS Blood and Transport (chemical) NHS National Duty Officer (BRN)	Contacts UKHSA Duty Officer and confirms countermeasures request (if BRN Stocks confirm delivery location to UKHSA)
GIVE Cause of request, Affected population Name and Quantity of countermeasure being requested. Full postal address of receiving location . Name and Contact Number of person designated to receive countermeasure.	Regional first on-call contacts National EPRR duty Officer (if request made to NHS BT) Regional First on-call informs Regional second on-call.	Contact Second on-call and brief on situation. DHSC Duty Officer

A CBRN incident requiring the deployment of countermeasures would automatically trigger a level 3 incident, resulting in the incident being led by the NHS England Regional Team.

SECTION 6: GUIDANCE FOR STAFF

6.1 Staff working away from their office base

When a major incident occurs, many staff may be away from their office base, working at a remote site, working in the community or off duty. All staff must contact their office base as soon as they are made aware of a major incident. This is so they can:

- Assure their manager of their personal safety
- Inform their manager of their location
- Receive instructions from their manager about any changes to their duties arising from the incident
- During a major incident, staff may be directed to work at locations other than their usual workplace.

It is essential that during a major incident line managers are kept informed of their staff's whereabouts at all times.

Trust Staff should not speak to the media – if they are approached, they should direct enquiries to the On Call manager.

Staff Welfare

An emergency situation can be a stressful time. Staff may be called in unexpectedly from home, asked to work in unfamiliar environments and for extended periods. When called to assist in an emergency there are a number of key actions staff should take before and during their response:

Notify your family, partner or significant other:

- Staff should not work for longer than eight hours without going off duty. Please ensure regular breaks are taken
- Staff will be reimbursed and insured for any activities carried out during a major incident, whether at their normal place of work or otherwise

6.2 Approach for Trust Staff Located at Trust Premises

Many Trust staff work on sites managed by other Trusts, e.g. Wirral University Teaching Hospital NHS Foundation Trust, or on other organisations' sites. The organisation which manages the premises is responsible for responding to a major incident occurring on those premises. The employing organisation for staff has responsibility for utilising staff resource.

6.3 Counselling Services

Anyone involved in a major incident may suffer from stress and trauma, therefore counselling and support needs to be planned for individuals, including carers, siblings, relatives and staff.

Access to psychological and counselling support will be co-ordinated by general practitioners. Patients requiring such support will be directed to the most appropriate provider(s).

SECTION 7: BUSINESS CONTINUITY

7.1 Maintaining Business Continuity

7.1.1 Overview of Business Continuity

The CCA requires category 1 responders to put in place arrangements to ensure that they continue their functions in the event of an emergency. This requires the NHS to ensure that those organisations delivering services on their behalf e.g. contracted out services, which underpin service provision e.g. information technology and telecommunications providers can deliver in the event of an emergency.

7.1.2 WCHC Business Continuity Arrangements

Business Continuity Planning complements the MIP and also addresses potentially serious disruptions in the services provided by the Foundation Trust that *may not* be of sufficiently high risk to trigger the MIP.

The central co-ordination of a planned response to such events whose impact could not be handled within routine service arrangements and could require the implementation of *special planning procedures by the Trust* to respond to it, rests with the Director of Nursing and Performance or the On Call Manager

Significant incidents likely to cause serious disruption of the continuity of the Trusts business may warrant activation of the MIP. Minor business interruptions are dealt with using routine management intervention and service level business continuity plans *or escalation plans where appropriate.*

Service Directors, and Service Leads are responsible for developing, maintaining, communicating and operating their own service level business continuity procedures to mitigate the impact of any incident affecting the normal delivery of services. Service level continuity plans are prepared within an overarching Foundation Trust continuity framework.

The Trust Business Continuity Policy (GP52) provides additional information relating to Business Continuity.

7.2 Hazard, Risk Assessment and identified Risks

7.2.1 Hazard and Risk Assessment

A vital component in the plan preparation process is the identification of potential hazards and threats and applying the risk assessment process.

The Merseyside Community Risk Register has been created for two reasons. Firstly, to reassure the people and communities of Merseyside that an assessment of

potential hazards and threats has been made or considered. Secondly, to satisfy the requirements outlined in the CCA and its statutory guidance (Emergency Preparedness), the **Community Risk Register** and is available online at Merseyside Fire and Rescue Service's website at www.merseyfire.gov.uk and click on the icon 'Merseyside Community Risk Register'

The hazards and threats which may affect the Foundation Trust fall into the following categories and form the basis of the development of this plan and the individual Service continuity plans:

The number of risks is not exhaustive but could include

Risk	Reason
Loss of workplace/ premises	Fire Flood Act of terrorism Unsafe building Extreme weather conditions
Loss of staff	Industrial action Pandemic Flu or other communicable disease Extreme weather causing transport difficulties
Loss of IT computer	Loss of server access Loss of Power Theft/crime Loss of information Cyber attack
Loss of communications	Power failure affecting phone exchange server Loss of service due to supplier issues Industrial action Severe weather
Loss of utilities	Loss of supply on site Loss of supply off site
Loss of supplies	Supplier in receivership Fuel shortage Product recall

7.5 Departmental Business Continuity Plans

Further information on dealing with a wide range of events can be found in Departmental Business Continuity Plans. These plans can be located within the on call pages on the Team drive.

7.6 Mutual Aid

Mutual Aid is an agreement to lend assistance across neighbouring boundaries and partner organisations. This may occur due to a major incident response that exceeds local resources, such as a significant disaster. It can involve offering resources to help support partners e.g. man hours, materials

SECTION 8: COMMUNICATIONS

8.1 Communications and the Media

The overall aim for communications in a major incident will be to provide effective, accurate and timely communications to the public, staff and other stakeholders.

8.2 Internal Communications

The following systems are in place for communications during a major incident

- Internal communications system for notifying all the Trusts staff of any change in major incident status
- The use of the Central Alert System will receive external health alerts for internal cascade, via Service Directors and service leads
- List of contact numbers of key staff and individuals
- Site addresses for all services

Services are responsible for maintaining a register of the current contact details for their staff for use during major incidents and other emergencies.

A central register of current contact details of all Trust staff will be maintained by Human Resources via Electronic Staff Record (ESR)

8.2.1 Situation Reports

A Situation Report (SITREP) is a form of status reporting that provides decision-makers/ Strategic Commander of a quick understanding of the current situation. It provides a clear, concise understanding of the situation.

During any major Incident the Business Operations Support team will develop a situation Report template that will be relevant to the specific incident being experienced. An example of a Situation Report is included at Appendix 4 of this plan.

The template will contain all relevant fields that will require responses from service leads in order to provide up to date information to the Incident Coordination Centre.

The specific submission times of Situation reports will be decided by the Strategic Commander at the commencement of an incident.

In addition to internal situation reports there it is likely there will be the requirement for external situation reports, regionally and nationally. Requests for these reports will be sent to the Trust Major Incident email account. The Trust EPRR Lead and the Business Intelligence team will support this process.

8.2.2 Key Internal Audiences

- Directly employed staff/staff representatives
- Trust Board members
- Cross-organisational Services

8.2.3 Key Communication Channels

- Telephone
- Global email
- Group emails
- Social Media
- Regular bulletins/briefings
- Cascade systems via Service Directors and service leads
- Dedicated information phone help lines

8.2.4 Lost Communications

In the event of not being able to establish, or a loss of communications the following alternative methods are to be considered for the passage of information:

- Mobile phones/SMS text messages/WhatsApp
- Alternative Analogue/digital phone lines in the ICC
- Email 4G connectivity
- Fax Runner

8.2.5 Briefings to Staff

Regular staff briefings will be issued according to the severity and type of incident to ensure staff are aware of what is happening, what they can do to play their part and what to advise their patients. All communications to staff will also be posted onto the staff intranet.

8.2.6 Guidance for Staff

It is essential that during a major incident line managers are kept informed of their staff's whereabouts at all times whilst at work..

WCHC staff should not speak to the media – if they are approached.

All media enquiries during normal office hours 9.00 am to 5.00 pm Monday to Friday must be directed to Communications and Marketing Team wcnt.communications@nhs.net or 0151 514 6365. Outside these hours media relations will be the responsibility of the on-call Duty Manager

- Do not disclose personal or confidential details of either patients or staff
- Do not confirm or deny that an incident has occurred
- Do not speculate on the cause of the incident
- Do not discuss the incident

- Do not criticise any organisation or individual
- Do not comment on the presence of suspects, VIPs or any other person on NHS premises

8.2.6 Working with the media

The media will be a key means of communicating with the public. The Communications lead will co-ordinate in partnership with Tactical/Strategic Communications Cell to produce timely briefings to be given to the media at regular intervals if required.

8.3 External Communications

8.3.1 Key audiences

- Trust Development Authority / Monitor
- Patients
- Wider public including vulnerable groups
- Integrated Care Systems.
- NHS England area team
- Members
- WUTH
- Neighbouring Foundation Trusts
- Wirral Council/Social Care (adults and children)
- Stakeholders
- Local Media

8.3.2 Key communication channels - external communications will be disseminated via:

- Media (Press releases, Advertorials, Radio interviews etc.) - supervised by the Communication Team
- NHS Direct (health advice where appropriate)
- Existing/newly created dedicated information phone help lines/call centre
- Public Website

8.3.3 Vulnerable Groups

Within the CCA the particular needs of vulnerable persons are recognised. The general definition of vulnerable persons is: people present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies.

Vulnerable groups include:

- Black & Minority Ethnic communities
- People with mental health problems
- People with physical or learning difficulties
- Older people
- Children and young people

Communication channels may include:

- Social Inclusion Team
- Community Health Link Works
- NHS England, Merseyside
- Integrated Care Systems
- Wirral Borough Council

NHS offer a text service for the deaf/hard of hearing – https://www.nhs.uk/services/service-directory/text-relay/N10499195

Access to interpreters can be arranged by contacting Language Line https://staff.wirralct.nhs.uk/services-support/interpretation-translation-and-accessibility/

8.4 Incident Communication Plan

A separate Incident Communication Plan is available in order to support the communications team.

8.5 Information Sharing

WCHC, as a Category 1 responder under the Civil Contingencies Act (2004) have a duty to share information with other local responders to enhance coordination**.**

SECTION 9: STAND DOWN AND RECOVERY

9.1 Incident Stand Down

In the event of a significant major incident NHS England Area Team Strategic Commander or Tactical Commander will inform all organisations when a significant incident is closed.

The on Trust Strategic Commander, following consultation with key personnel and relevant stakeholders will have the responsibility of formally making the decision for the Trust to stand down. The following matters will be taken into account in reaching this decision.

- The incident has been controlled
- The immediate needs of the affected people and the community have been met

9.2 Debrief

Immediately after a Major Incident STAND DOWN the Strategic Commander will hold a ‘hot’ debrief with staff.

All staff will be given the opportunity to give more detailed, anonymous feedback to a scheduled full de-brief process.

9.3 Post Incident Considerations

It is vital that a senior manager be appointed to assume responsibility for the debriefing and recording process

- Evaluation of a response to the incident (including nominated staff to attend a multi-agency evaluation). How was the incident handled? What problems were there? What needs to change to ensure a better response time if appropriate?
- Assessing the continued health needs of those affected by the incident including psychological needs and the identification and referral route of any support services needed for staff, patients, and relatives involved in the major incident.
- Consideration of the effect of the incident on KPIs and services
- Ensuring all relevant documents are collected and a major incident report prepared. Patient confidentiality must be respected at all times
- Careful secure storage of all records relating to the incident. This should include all papers, logs and notes made during and related to the incident response. These may be requested by the agencies or other investigative body. The records associated with an incident should be archived in line with The Corporate Records Policy

9.4 Post Incident Report

The Strategic Commander is responsible for ensuring that a full internal report and action plan specific to the incident will be prepared and submitted to the Senior Management Team within 1 month from the date of the incident.

If appropriate any lessons learnt from the incident should be shared with the appropriate NHS England Area Team, ICB's and other key stakeholder's partners. Following the debrief and preparation of the internal report and associated action plan, the MIP and any other relevant plans will be reviewed and amended as required.

9.5 Incident Recovery

After a major incident the IMT will meet to assess the disruption to functions caused by the incident, including any long-term implications. This assessment will include:

- Effects on staffing (e.g. loss of staff through injury or sickness, impact of overtime worked by staff during the incident on staffing levels)
- Support needs of staff affected by the incident (including trauma support)
- Development of recovery plan supporting Business Continuity
- Disruption caused to patient care
- Disruption caused to other functions
- Damage inflicted to buildings
- Financial losses

- Future provision of services in the short, medium, and long-term

It is important to work with partners as appropriate to facilitate the post incident recovery.

SECTION 10: MAJOR INCIDENT PACK INCLUDING ACTION CARDS

10.1 Foundation Trust Incident Control Team – Roles and Responsibilities

10.1.1 Background

This section outlines the roles and responsibilities of the Major Incident Team and should be used in a major incident.

During a major Incident any member of staff may be asked to perform a key role on behalf of the organisation. These roles may not be closely related to their usual responsibilities and Action Cards have been developed to support staff in these situations.

The Strategic Commander will allocate roles as appropriate. A copy of your Action Card must be kept with you at all times, and includes contact details for the emergency alert system, and the control room.

All on-call staff should be familiar with the contents of their Action Card and should use it from the moment they are contacted about an incident.

Actions Cards are ROLE specific and are not designed for designated individuals.

Action Cards may only be passed to another person once a full briefing and handover has been given, in writing, on the actions taken to-date and outstanding issues.

10.1.2 Responsibilities

By using the Action Cards, your role will be clearly outlined. If there are any queries, please discuss with the Strategic Commander and confirm in writing any alterations to the Action Cards.

During a handover of roles, i.e. starting a shift or finishing a shift, a full briefing must be given as to the process taken and decisions made. The Information Handling Manager will conduct the handover.

10.1.3 Action Card Summary

- Must be used by all members of the Incident Management Team
- Remove the need to consult large or complex plans during an incident
- Are role specific and provide all essential information needed to perform the specific role

- Help people focus on their role and provide guidance
- Prevent important tasks being forgotten or delayed

Action Card 1: Strategic Commander
Role Escalation On Call Manager
Responsibilities • Identify whether an Internal incident is responded to as a Major Incident, or Provide advice to, and operate under the instruction of, any command and control structures in place for an Externally identified Major Incident • Assemble and direct the Incident Response Team, with effective workload distribution • Ensure clear aims and objectives for response to the incident • Ensure effective co-ordination of resources. • Ensure robust communication links with NHS England Local Area Team and other partners including Tenants of SCHC and Trust Controlled premises. • Ensure that all records and data are captured and stored in a readily retrievable manner • Ensure all records are archived accurately post incident and stored securely briefing

Action Card 1: Strategic Commander

or outgoing/incoming shift staff

Checklist

- If a major incident has been declared inform all relevant staff including Exec Team and NHS England Local area team
- Contact, inform and assemble all incident response team members
- Brief the Incident Response Team with aims and objectives for WCHC's response to the incident
- Determine priorities – safety of staff, patients, service users –any groups particularly at risk?
- Safety and security of buildings, equipment and information
- Business continuity: services and locations – which services and buildings are required to implement BC plans
- Ability to communicate with staff and service users, partners and public; messages to be provided (who, what, when, how and how often)
- Sitrep reporting structure internally and to external partners (who, what, when, how and how often)
- Briefing structure with key staff (who, what, when, how and how often)
- Mobilise additional, appropriate staff if necessary
- Keep a record of your own tasks including telephone calls that you make
- Produce effective handover notes for incoming shift

Incident Stand Down

- Following confirmation of 'Stand Down' by NHSE or after taking the Trust decision to 'Stand Down' for an internally declared incident, ensure all relevant staff or agencies are notified of the stand down
- Ensure all records are forwarded to Emergency Planning Lead
- Ensure effective post-incident debriefing sessions

Action Card 2: Operational Support

Function specification

Emergency Planning Lead and/or Operational On Call Manager

Responsibilities

Provide additional operational management support to Strategic Commander

Depending on circumstances, this may include the tasks identified for Service Director (Action Card 3), Communications Lead (Action Card 6) and Admin Support (Action Card 9).

Checklist

- Assist the Strategic Commander in assembling the Incident Response Team
- Support the setting up of the Incident Response Team
- Set up and maintain plan and record of tasks and events (as distinct from decision log)
- Distribute action cards
- Support the Strategic Commander in coordinating the resources to support the incident
- Assess which WCHC operations will be affected by the incident and inform them of the situation. If any action is required ensure this is fed back to the Strategic Commander
- Attend meetings and teleconferences and update the Strategic Commander
- Maintain an overview of incoming emails, faxes and phone calls
- Assist with briefings and debriefings
- Keep a record of your own tasks including telephone calls that you make
- Produce handover notes for incoming shift.

Incident Stand Down

- Ensure stand down message is communicated
- Inform all agencies that the team has been dealing with that WCHC has stood down
- Ensure all records are forwarded to Emergency Planning Lead
- Contribute to post-incident debriefing sessions

Action Card 3: Service Director

Function specification

In Hours: Service Director identified deputy

Out of Hours: Operational On Call Manager

Responsibilities

At the direction of, manage all service resources to support the major incident

Checklist

- Determine service priorities – safety of staff, patients, service users –any groups particularly at risk and consider safety and security of buildings, equipment and information.
- Implement Business Continuity Plans for the division as appropriate
- Review staffing levels and rotas for current day and next 24/48 hours at affected locations
- Provide regular updates as required by the Strategic Commander
- Appropriate communication with staff and service users, partners and public; messages to be provided (who, what, when, how and how often)
- Keep a record of your own tasks including telephone calls that you make
- Produce handover notes for the incoming shift.

Incident Stand Down

- Receive incident Stand Down, communicate as appropriate
- Contribute to post-incident debriefing sessions
- Ensure all records are forwarded to Emergency Planning Lead

Action Card 4: Decision Loggist

Function specification

WCHC trained loggist

Responsibilities

Maintain a complete record of key decisions made by Strategic Commander

Checklist

- ☐ Meet with Strategic Commander to clarify role and responsibility during major incident
- ☐ Retrieve Green Emergency Log Book
- ☐ Detail key attendees and clarify their initials, name and role
- ☐ Record key decisions the Strategic Commander makes
- ☐ Ensure that all key times are included, such as the start time, when the log was started and each entry is timed

Incident Stand Down

- ☐ Contribute to post-incident debriefing sessions
- ☐ Ensure all records are forwarded to Emergency Planning Lead

Notes for loggists:

- Entries must be chronological
- Begin each entry on a new line but ensure there are no complete line gaps between entries
- Record stand down from the major incident and sign the log book
- Unused space at the end of the series of entries must be ruled through (with a ‘Z’) then signed in full, dated and timed
- All entries made must be written in black ink

- At the end of the incident ensure each entry is agreed by Strategic Commander
- Do not include any assumptions/comment/opinion
- Do not erase large portions of text so what was underneath is then illegible
- Do not tear out pages from the book
- Do not write in the margins
- Do initial any crossings out or mistakes you make
- If you make a mistake whilst compiling your note, score through the mistake with a single line, initial it and insert the correct word after the error
- If you see a mistake after an entry was made you must bring this to the attention of the person for whom you are compiling the log. The mistake should be cross-referenced (in red ink and using alphabet notation) to the corrected entry which should appear on the next available page or if there is sufficient space at the foot of the page for the entry. You and the other person must sign, date and time this.

Action Card 5: Estates and Facilities Support

Function Specification

Staff member with knowledge of estates infrastructure and utilities

Responsibilities

Provide advice and assistance in respect of estates and facilities

Checklist

- Identify impact on estates and facilities
- Identify what additional facilities are available to support the response to the incident if required
- Advise on availability of/access to additional premises as necessary and provide guidance on health and safety issues
- Where appropriate confirm availability from Landlord/Provider if not WCT site/facility
- Ensure that any problems with facilities e.g. heating, water, electricity, etc. are appropriately managed and promptly resolved
- Provide/arrange for specialist support and assistance as necessary
- Keep a record of your own tasks including telephone calls that you make

Incident Stand Down

- Produce handover notes for the incoming shift
- Contribute to post incident debriefing sessions
- Ensure all relevant documents are forwarded to the EPRR lead.

Action Card 6: Communications Lead

Function Specification

In Hours: Head of Communications and Marketing

Out of Hours: Operational On Call Manager

Responsibilities

Provision of communication co-ordination, advice and support to the Strategic Commander

Checklist

- Establish contact with local NHSE **(0345 113 0099)** and Cheshire and Merseyside ICB Communications Team **(0847 124 9802)** as appropriate.
- Manage the media response to a major incident by liaising with the Strategic Commander regarding Press arrangements
- Ensure that media and staff know that all media enquiries are directed to the Incident Communication Lead
- Respond to Press enquiries
- In conjunction with the Chief Executive, Strategic Commander and NHSE, prepare Press briefings as appropriate
- Communicate briefings and updates to all WCT staff so that they are aware of the incident and the response the WCT is providing
- Make sure that all briefings/press releases are signed off by the Strategic Commander
- Press briefings, once approved, to be placed on suitable media channels including social media
- Keep records of your own tasks together with telephone calls made
- Produce handover notes or the incoming shift

Incident Stand Down

- Ensure that all records, notes and documents associated with the incident are collated and archived
- Contribute to post-incident debriefing sessions

Useful Telephone numbers.

British Red Cross	0300 023 0700
Royal Voluntary Service	02476 681369
Salvation Army	0300 123 8028
RSPCA	0300 123 8028

Action Card 8: Rest Centre Clinical Support

Function specification

Community Nurses and/or GP Out of Hours and/or Trust Pharmacist.

Responsibilities

Assess and treat any person placed in rest centres, coordinating additional care as needed

Checklist

Incident declared

- Collect documentation (Patient Treatment Record and Prescription Record Sheet) and relevant medical equipment.
- Attend the rest centre as directed by the Strategic Commander /Service Director.
- Confirm contact details to Service Director Strategic Commander /.
- On arrival report to Rest Centre Manager and clarify if there are any clinical needs already identified and confirm resources within rest centre (space/equipment etc)
- Assess health needs of evacuated persons. Any major health needs identified should be prioritised until arrival of ambulance.
- Provide immediate first aid interventions to patients.
- Maintain health records of all people for whom care has been provided.
- Provide regular updates to the Incident Coordination Centre/Service Director and request any additional support needed.
- Confirm shift times in plenty of time to enable replacement providing relevant handover information to those replacements.

Incident Stand Down

- Gather all records and make arrangements for these records to and liaise with Service Director to ensure that these are uploaded to electronic patient records where applicable.
- Contribute to post-incident debriefing sessions.

Action Card 9: Admin Support

Functional specification

In Hours: Corporate Secretariat

Out of Hours: Operational On Call Manager

Responsibilities

To provide administrative support to the Strategic Commander including set up and running Incident Coordination Centre, responding to messages etc

Checklist

- ☐ Setting up Incident Coordination Centre according to the instructions in the Major Incident Plan including:
  - Opening Major Incident cupboards
  - Connecting phones to appropriate phone sockets

- ☐ Completing the board with details of those persons who are in attendance and their responsibilities, e.g. loggist

- ☐ Checking the Major Incident email account and informing the Strategic Commander of incoming emails

- ☐ Responding to phones within the Incident Coordination Centre and relaying information.

- ☐ Responding to emails on the instruction of the Strategic Commander

Incident Stand Down

- ☐ On being informed of incident stand down support Strategic Commander Operational Manager in recording of debrief information

- ☐ Restore room to pre-incident set up

- ☐ Contribute to post-incident debriefing sessions.

APPENDIX 1A: Contact Details of Incident Coordination Centres Rooms

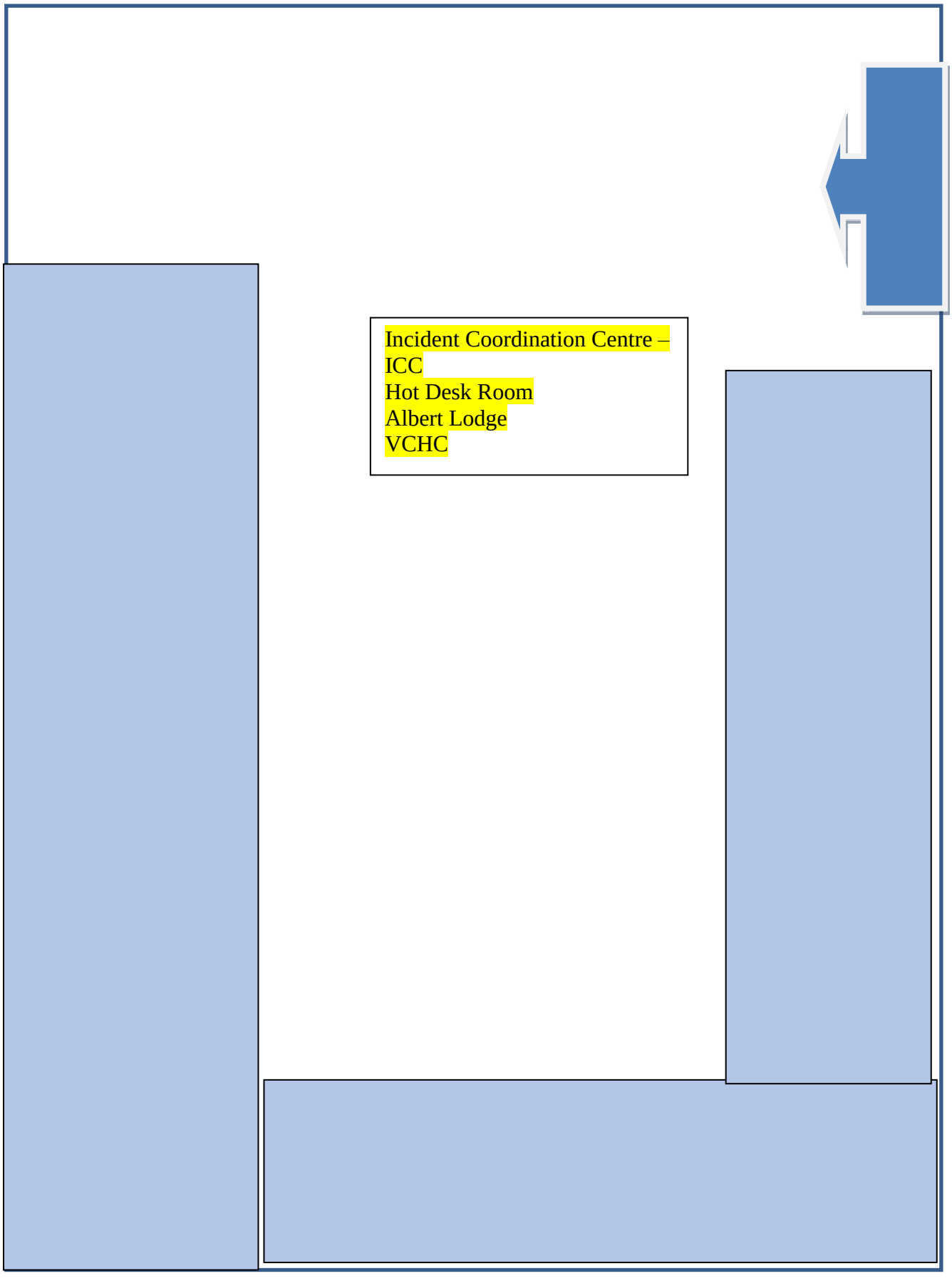
Incident Coordination Centre

Name:	St Catherine's Incident Coordination Centre
Address:	Training Room 1 & 2 St Catherine's Health Centre Derby Road Birkenhead Wirral CH43 0LQ
Normal Access:	7.00 am – 9.30 pm, 7 days per week
Out of Hours Access:	Contact Arrowe Security: 0151 609 0909
Incident Coordination Centre Numbers	0151 514 2177 Ext 592177 0151 514 2178 Ext 592178 0151 514 2179 Wxt 592179 0151 652 6468 (Analogue)
Fax Numbers:	0151 652 1569
Email Address:	WCNT.MajorIncident@nhs.net
Cabinet Padlocks:	9999

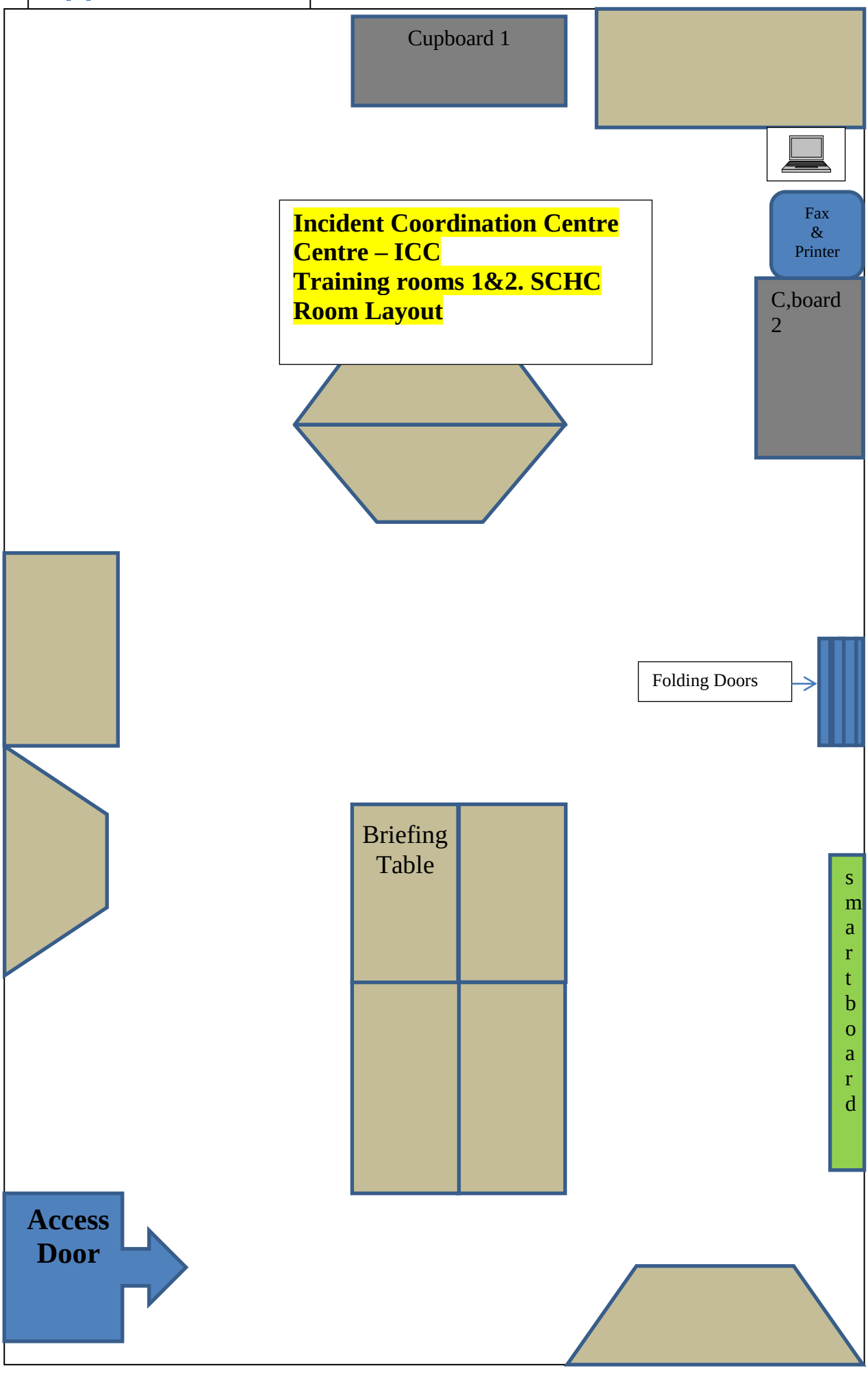
APPENDIX 1B: Backup Major Incident Coordination Room

Name:	**VCHC, Albert Lodge**
Address:	Hot Desk Room Albert Lodge Victoria Central Health Centre Mill Lane Wirral CH44 5UF
Normal Access:	8.00am – 10.00pm, 7 days per week.
Out of Hours Access:	Contact Arrowe Security: 0151 609 0909
Incident Coordination Centre Numbers	Main Telephone numbers 0151 514 2674 ext 592674 0151 514 2673 ext 592673
Fax Numbers:	No Fax Machine
Email Address:	WCNT.MajorIncident@nhs.net
Cabinet Padlocks:	9999. The ICC Storage tambour unit is located in the store area in Entrance number 1 to the building. In addition to the Hot desk room. Training rooms 1 and 2 can utilised in order to use screens to facilitate meetings etc.

Appendix 1C


Incident Coordination Centre – ICC
Hot Desk Room
Albert Lodge
VCHC

Appendix 1D


Cupboard 1
Fax
&
Printer
C,board
2
Incident Coordination Centre
Centre – ICC
Training rooms 1&2. SCHC
Room Layout
Folding Doors
Briefing
Table
smartboard
Access
Door

Appendix 2: Telephone Message Form

The Major Incident Telephone Message Form is used to record all incoming and outgoing messages relating to the major incident. These pads are located with in the Major Incident Store cupboards.

Incident: **Date:** **Location:**

Log completed by:

Time	To / From* (*Delete as appropriate)	Name of Contact	Name of Org	Contact details
Outline of message				
Decision Made/Action To Be Taken/Advice Given and Reasons			**By Who**	**By When**

S:\Pubhealth-All\PH-All-folders\PH-Emergency-Planning\Major Incident\Major Incident Rooms\INCIDENT LOG - MONITORING CALLS DECISONS v0 1.doc

Appendix 3: M/ETHANE Template

Time	Date
Organisation	
Name of Caller	Tel No

M	Major Incident	Has a Major Incident been declared? (Yes/No - *If 'No', then complete ETHANE message)*	

E	Exact Location	What is the exact location or geographical area of incident?	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/personnel are required or are already on-scene?	

Restricted once complete

Signature

Appendix 4: Situation Report Template

Please ensure all completed Situation Report Templates are sent to WCNT.majorincident@nhs.net

Organisation:		**Date:**	
Name (completed by):		**Time:**	
Telephone number:			
Email address:			
Authorised for release by (name & title):			

Type of Incident (Name)	
Organisations reporting serious operational difficulties	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	
Mitigating actions for the above impacts	

Impact of business continuity arrangements	
Media interest expected/received	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
WCHC Incident Coordination Centre contact details **Name:** **Telephone number:** **Email:**	

Appendix 5: IIMARCH Briefing Tool Template

Element	Key questions and considerations	Action
I	**Information** **What, where, when, how, how many, so what, what might?** Timeline and history (if applicable), key facts reported using M/ETHANE	
I	**Intent** **Why are we here, what are we trying to achieve?** Strategic aim and objectives, joint working strategy	
M	**Method** **How are we going to do it?** Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans.	
A	**Administration** **What is required for effective, efficient, and safe implementation?** Identification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics.	

Element	Key questions and considerations	Action
R	**Risk assessment** **What are the relevant risks, and what measures are required to mitigate them?** Risk assessments (dynamic and analytical) should be shared to establish a joint understanding of risk. Risks should be reduced to the lowest reasonably practicable level by taking preventative measures, in order of priority. Consider the hierarchy of controls. Consider Decision Controls.	
C	**Communications** **How are we going to initiate and maintain communications with all partners and interested parties?** Radio call signs, other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy	
H	**Humanitarian issues** **What humanitarian assistance and human rights issues arise or may arise from this event and the response to it?** Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights	

Appendix 6: SBAR Briefing Tool Template

SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals and organisations.

S	**Situation:** A concise statement of the problem
B	**Background:** Pertinent and brief information related to the situation
A	**Assessment:** Analysis and considerations of options
R	**Recommendation:** Action requested / recommendation
Completed By: **Date:** **Signed:**	

Appendix 7: Rest Centre – Prescription Record Sheet.

Prescriptions Record Sheet to be completed for each patient requiring medicines

Record details of prescriptions issued to patients at reception centres. This form does not replace the usual FP10 prescription

Name of Patient: .....

Date of Birth: .....

Address of Patient: .....

.....

.....

GP Name: .....

Practice: .....

Details of Medication Prescribed:

Name of Drug	Strength	Dose	Frequency	Quantity

Signature of DOCTOR: ..... **Date:**

Appendix 8: Rest Centre – Record Of Treatment.

MAJOR INCIDENT REST CENTRE
PATIENT RECORD OF TREATMENT

DATE OF INCIDENT:

<table>
<tr><td colspan="3">First Name:</td><td colspan="4">Last Name:</td></tr>
<tr><td colspan="3">DOB:</td><td colspan="4">Known Allergies:</td></tr>
<tr><td colspan="3">Address:

Postcode: Tel no:</td><td colspan="4">NOK Details:

Name:

Relationship:

Contact No:</td></tr>
<tr><td colspan="3">GP Name:</td><td colspan="4">Surgery Address:</td></tr>
<tr><td colspan="3">Medical History:</td><td colspan="4">Medications:</td></tr>
<tr><td colspan="7">Summary of Treatment/Intervention (use continuation sheet if required)</td></tr>
<tr><td colspan="7">Ongoing Treatment Referral (Specify Service)</td></tr>
<tr><td colspan="3">Consent to share information gained:
(tick as appropriate)</td><td>YES</td><td></td><td>NO</td><td></td></tr>
<tr><td colspan="2">Print Name:</td><td colspan="2">Signature:</td><td colspan="3">Destination:</td></tr>
</table>

Continuation Sheet

Date: **Time:**		**PRINT NAME:** **Signature:** **Designation:**

Appendix 9: Incident Severity Rating

The information within the table below and the descriptors contained therein are not exhaustive. Each incident should be assessed against the impact experienced.

Incident	One or more of the following apply	
Localised Disruption / incident	The incident is not serious or widespread and is unlikely to affect business operations to a significant degree No significant impact on patient or staff safety No significant impact on performance or finance The incident can be dealt with and closed by relevant managers No significant media or political interest	**Incident managed within the affected areas** Where the initial impact assessment grades the situation as a localised minor incident, the affected management team should deal with this using localised contingency arrangements. Where this incident has the potential to impact on clinical delivery the service lead must be notified. Where this incident has the potential to spill over into the evening / weekend the On call manager should be notified and informed of the contingency arrangements in place.
Minor Disruption / Incident	Limited impact on patient and staff safety Incident expected to be fully resolved and closed within 24 hours Limited but some impact on service delivery in critical	**Incident managed using local contingency arrangements** Where the initial impact assessment grades the situation as a minor disruption, the incident should be managed by the Service Director/Deputy These Service Directors will escalate where necessary and inform the relevant Managers as appropriate. Where this incident has the potential to impact on clinical delivery the service lead

	areas One or a number of local contingency plans activated Incident still expected to be managed through localised contingency arrangements Limited financial / performance impact Limited Governance issues Possible public/media/political interest	must be notified. Where this incident has the potential to spill over into the evening / weekend the On-call manager should be notified and informed of the contingency arrangements in place.
Significant Disruption / Incident	Disruption to a number of critical services likely to last for more than 1 working day Significant impact on patients and staff Access to one or more sites denied where critical services are carried out for more than 24 hours Suspension of a number of services required Access to systems denied and incident expected to last more than 1 working	**Numerous contingency plans activated thus requiring effective management by calling together of a specific multi directorate team** Where the initial impact assessment grades the situation as significant the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The on call manager should consider how nest to manage the incident and ifactivation of the Foundation Trust major Incident plan is required . It may also be necessary to inform the NHS Merseyside First on Call.

	day and therefore impacting on operational service delivery A number of critical services seeking to activate service level contingency plans thus requiring overall management Significant impacts on finances and performance Significant Governance issues Possible public/media/political interest	
Major Disruption / Incident	Incident expected to impact on critical services for more than 48 hours Wide spread disruption, loss of a major or multi-occupancy site Major impact on patient and staff safety Wide-scale incident in a geographical area affecting multiple critical services Significant disruption to business activities Local contingency	**Widespread incident requiring overall strategic management – Possible Major Incident** Where the Initial impact assessment grades the situation as major disruption the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The AEO, following Liaison with the on Call managers, Executive members and other Senior Managers agree the composition of a n Incident Management Team A decision may be made to declare a **Major Incident** in line with agreed protocols contained within the Foundation Trust Major Incident Plan. Consideration should be given to informing the ICB and other Health Economy Partners – this will be determined by the Senior Manager in charge of the Foundation Trust response. **NB: The term Major Incident should not be used lightly or confused with a Major Incident that sets out the Foundation Trusts response to an external Trauma type mass casualty incident'.** However, the

	plans inadequate to deal with incident Response requires strategic coordination and assistance from other health economy partners	Command and Control principles adopted by the Foundation Trust for both types of incident are the same.

Significant Incident/serious disruption to services – requiring command and control, but not requiring strategic co-ordination and special arrangements from other health economy partners

Major Incident/major disruption to services – an event whose impact cannot be handled within routine service arrangements and requires the implementation of special arrangements, by one or more of the emergency series, the NHS or local authorities, to respond to it.

Appendix 10 – NW Incident Notification SBAR

North West SBAR Reporting Template V1.0 (2025)

Any NHS organisation declaring a Business Continuity or Critical Incident (including implementation of Business Continuity arrangements) must notify their ICB within 15 minutes of declaration – and **within a maximum of 1 hour** of invocation/declaration, this notification must be followed up with an SBAR by email.
ICB colleagues are required to notify NHS England Regional on call within the same time periods and followed up with an SBAR by email to england.eprrnw@nhs.net with additional commentary around what supportive actions the ICB is taking to mitigate any system level or service level risks within their community.

Organisation name						
Site(s) affected						
Date of report			Time of report		Report number	
Type of incident declared						
Date declared			Time declared			
Completed by (name, role)						
Point of Contact (name and email)						
Exec Sign off by (name, role)						
Signature						
Element	Prompts	Description				
S	**Situation** Clearly and briefly describe the current situation.					
B	**Background** Provide clear, relevant background information on the incident including: • Timings • Media					

	• Exact situation	
A	**Assessment** State your assessment of the situation based on the situation and background. Include impacts to the Trust and service delivery	
R	**Recommendations** Explain the actions being taken by the organisation to standdown from the incident/situation alongside any support required of partner agencies, ICB or NHS England	

Provider only		
ICB notified at:	(Date & Time)	
	(name)	(role)
SBAR sent to ICB at:	(Date & Time)	

Stakeholders Informed	Organisation	Date & Time
Ambulance Trust		
Neighbouring Trusts		
Other		

Next update to be available/provided at:	(Date & Time)

Integrated Care Board only	
Additional system commentary e.g. Does the SBAR content reflect the operational situation and the actions being taken?	
ICB actions taken	

ICB actions required				
ICB Colleagues Briefed	Tactical Commander	(time)	Communications & Media team	
	Strategic Commander		System Coordination Centre	
Level of incident coordination	Level 1 (Provider)		Level 3 (NHSE Region)	
	Level 2 (ICB)		Level 4 (NHSE National)	
Sign off	(name)		(role)	
Signature				
NHS England notified at:	(Date & Time)			
	(name)		(role)	
SBAR sent to NHSE at:	(Date & Time)			

NHS England Region only				
Additional regional commentary e.g. Does the SBAR content reflect the operational situation and the actions being taken?				
Regional actions taken				
Regional actions required				
Regional Colleagues Briefed	Tactical On Call	(time)	Regional Communications team	
	Strategic On Call		Regional Operations Centre	
Level of incident coordination	Level 1 (provider)		Level 3 (NHSE Region)	
	Level 2 (ICB)		Level 4 (NHSE National)	

Sign off	(name)	(role)
Signature		
NHS Resilience notified at:	(Date & Time)	
	(name)	(role)
SBAR sent to NHS Resilience at:	(Date & Time)	

Appendix B

The below tables provides an up-to-date position regarding EPRR related policies and plans that support the EPRR programme.

EPRR Policies	Title	Last Updated	Review Due	Comments
1	EPRR Policy (GP52)	Apr-25	Apr-26	
2	Business Continuity Policy (GP62)	Mar-24	Mar-27	

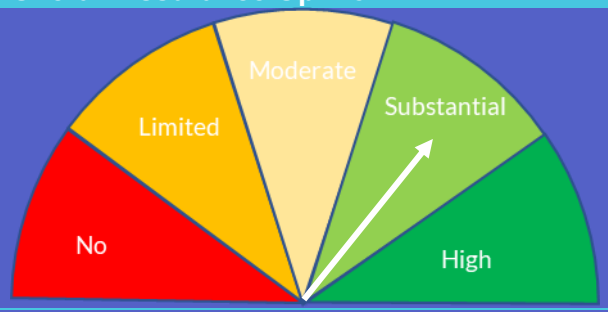
Emergency Planning Documents.				
	Title	**Last Updated**	**Review Due**	**Comments**
1	Major Incident Plan	Apr-25	Apr-26	Reviewed Annually
2	CBRN Plan	Jul-24	Jun-25	Reviewed Annually
3	Adverse Weather Health Plan	Jun-24	Jun-25	Reviewed Annually
4	Pandemic Plan	Aug 24	Aug-25	
5	Fuel Plan	Apr-24	Apr-27	
6	Industrial Action Plan	Dec-24	Dec-25	
7	Lockdown Plan	Dec-24	Dec-27	New Plan
8	ICC Development Plan	Apr-25	Apr-26	New Plan.

Emergency Preparedness, Resilience and Response Review Assignment Report 2024/25 (Final)

Wirral Community Health and Care NHS Foundation Trust

133WIRRCFT_2425_013

Overall Assurance Opinion



There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

Contents

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation and is for your sole use. If you have any queries regarding this review, please contact the Engagement Manager. To discuss any other issues then please contact the Director.

3 Executive Summary

Overall Audit Objective: To review and evaluate the arrangements in place in relation to emergency preparedness, resilience and response, considering local and national guidance, and compliance with the NHS EPRR Core Standards.

Scope Limitations: Refer to Appendix A below.

Key Findings/Conclusion

Overall, we found that there was a good system of internal control designed to meet the system objectives, and controls were generally being applied consistently.

Areas of good practice included the Emergency Preparedness Resilience and Response (EPRR) Policy, Business Continuity (BC) Policy and the Major Incident Plan. Within these documents, roles and responsibilities were clearly identified and this included national guidance in relation to EPRR.

The Trust has a self-assessment document for the NHS EPRR Core Standards. This incorporates a RAG rating for each standard, with the arrangements required to reach full compliance. This also records which exercises relate to the different standards, and how planning and completion of these exercises have assisted with compliance against the NHS Core Standards. Review of a sample of 5 Core Standards confirmed that all of the appropriate and stated evidence had been retained and documented for 4 of the Standards. The remaining standard (Staff Awareness & Training) was not fully compliant.

A medium recommendation has been made regarding the Terms of Reference (ToR) for the Health Safety, Security and Resilience (HSSR) Group which required updating. Testing of a sample of 10 training records highlighted that one record had a different date of completion on the Training Needs Analysis (TNA) compared to the certificate. Also, review of the TNA found that training records were not consistently completed (to include renewal dates), therefore a low recommendation has been made.

Objectives Reviewed	RAG Rating
Policies, Procedures and Plans	Green
Governance Arrangements	Amber
EPRR Exercises	Green
Results and Lessons Learnt	Green
Training Programme	Green
EPRR Self-Assessment	Green
Risk Management Arrangements	Green
Overall Assurance Rating	**Substantial**

Recommendations		
Risk Rating	Control Design	Operating Effectiveness
Critical	-	-
High	-	-
Medium	-	1
Low	-	1
Total	**-**	**2**

Areas of Good Practice

- The Trust had policies in place for EPRR and Business Continuity (BC) and these were available on the staff intranet. At the time of the review the EPRR policy was in draft and awaiting final approval (version 5). The BC policy had been approved at the Quality and Safety Committee (QSC) in March 2024.
- Audit review of the EPRR policy confirmed that it outlined the roles of all staff in the development of plans, as well as supporting the implementation of plans. Appendices had been included within the policy which highlighted the type of EPRR incidents and required responses.
- The HSSR Group and EPRR Lead were responsible for reviewing policies and processes and monitor the implications of new legislation and guidance, to ensure appropriate plans are in place.
- Both policies included the arrangements for On-call Managers (strategic and tactical), as well as the escalation processes if business continuity plans (BCP) required further communication outside of services.
- Audit review of the Trust's EPRR self-assessment confirmed that this incorporated RAG rating against each standard, a deep dive investigation for cyber security and an action plan for each standard.
- The EPRR governance structure had been clearly defined as part of the EPRR policy – appendix 5. Review of the minutes and agendas for the HSSR Group (Jul-24, Oct-24 and Jan-25), QSC (Jul-24, Sep-24 and Nov-24) and Board (Aug-24, Oct-24 and Dec-24) confirmed regular discussion of Business Continuity Plans and EPRR.
- The Trust had an exercise planning guide in place, which outlined the different types of exercises and key points which should be considered when planning and executing exercises.
- A copy of the Trust's Pandemic Response Plan was obtained, this was dated Aug-24 and monitoring arrangements of this had been reflected in the core standard 'New and emerging pandemics'.
- The Annual EPRR report contained all the tests and exercises that had been completed over the last 3 years. This also documented whether these were internal or external, the topics covered and attendees.
- Documents for the following exercises were reviewed – Alexander, CBRN and Niveous (adverse weather). Exercise Niveous related to the risks on the Trust risk register and all contained action plans, lessons learned and planning guides.
- Attendance records for exercises were maintained and those on the TNA were present.
- Audit review of the Annual EPRR report confirmed that examples of lessons learned from completed exercises and incidents (over the last 3 years), with after action reviews completed, had been included in the report.
- Additional training (internal and external) had also been referred to within the Annual EPRR report and confirmed that this could be added to on an ad-hoc basis if deemed relevant to any events or incidents as they occur, to prepare for or how to best capture lessons.
- All exercise plans reviewed included a timetable noting a final session to debrief, this had been based on the lessons identified and an opportunity for any further closing comments.
- The EPRR training and exercise for programme for 2024/25 outlined the Emergency Planning Officer's duties as well as providing assurance and evidence of NHS core standards. In addition, this highlighted the regularity of the required exercises along with the aim and objectives. The dates, a summary and attendees had also been documented as part of this.

- A sample of 5 of the NHS core standards were tested – Data Protection and Security Toolkit, Business Continuity Management Systems (BCMS) Scope and Objective, Staff Awareness & Training, Collaborative Planning and Continuous Improvement. Audit testing confirmed that supporting information for 4 of these standards was available and documented well by the Trust. Staff Awareness & Training was not fully compliant however mandatory training was discussed and monitored at the Board minutes reviewed.
- Review of the Trust risk register confirmed that EPRR and BC related risks had been considered. These were inherent risks - Cyber Risk, Adverse Weather Risk and Core Standard Risk, all had ID references and assigned owners.
- Review of the HSSR Group agendas and minutes confirmed the EPRR risk register was a standard item and had been discussed at the meetings reviewed (Jul-24, Oct-24 and Jan-25). This included the inherent risks mentioned above.

Key Findings – Issues Identified	
Medium	1.1 The ToR for the HSSR Group did not outline the reports that are to be reviewed/monitored. A review date for the ToR was also not present.
Low	1.2 Testing of 10 training records found that for 1 record the dates on the TNA and certificate did not reconcile. The training record (TNA) did not consistently include dates of completed courses, or renewal dates. Also, we identified areas of non-compliance for some courses.

2 Findings and Management Action

1. Terms of Reference – HSSR Group		Risk Rating: Medium
Operating Effectiveness		
Key Finding – The ToR included the aim of the HSSR, the purpose and the operating framework for the group - membership, quoracy, governance, standing agenda and frequency. However, this did not explicitly outline the reports to be reviewed. For example, reports were presented covering Health Safety and Fire, Security, HR and BCP but it was unclear on what basis this was required (Jan-25). In addition, the document did not include a next review date.	**Specific Risk** – Inconsistent monitoring of key reports that are relevant to EPRR and BCP. Also, irregular review of the ToR may result in omissions of responsibilities and not reflect current national guidance.	**Recommendation** – The ToR for the HSSR Group should clearly outline the relevant reports to be reviewed and include a review date.
Management Response - Terms of Reference to be reviewed in order to address the issue relating to which reports should be reviewed by the group. Responsible Officer – Local Security Management Specialist and EPRR Lead Implementation Date – May 2025		Evidence to confirm implementation – Updated HSSR TOR

2. Training Records		Risk Rating: Low
Operating Effectiveness		
Key Finding – Testing of a sample of 10 staff records found that 1 record on the TNA was dated 12.09.24, however the date of completion on the certificate shown 19.08.24. This was training on Legal Awareness. Review of the TNA highlighted the below level of low/no compliance for staff trained: - Tactical & Strategic - Working with your Loggist Training = 0.00% The TNA included a summary tab, as well as further details of the individuals to complete the courses. Review of the latest version found that a number of tabs had not been consistently completed to show course renewal dates.	**Specific Risk** – If training requirements and dates are not correctly updated, staff may not have received the latest training as per the NHS guidance. Similarly, if staff do not receive appropriate training, they may lack the skills to co-ordinate and manage any emergencies or major incidents that may arise.	**Recommendation** - The training records (TNA) should be regularly updated to include the correct dates of completion and renewal of courses. Also, training compliance should be regularly monitored to ensure sufficient levels are achieved.
Management Response - EPRR TNA to be reviewed in order to accurately capture the EPRR training compliance. The TNA should be included as a standing agenda item within the HSSR meeting. A training exercise to be developed to be delivered to Strategic On Call commanders focusing on Working With Your Loggist. Responsible Officer – Local Security Management Specialist and EPRR Lead Implementation Date – June 2025		Evidence to confirm implementation – HSSR Agenda TNA Exercise Planning documentation and Attendance record

Appendix A: Engagement Scope

Scope

The overall objective was to review and evaluate the arrangements in place in relation to emergency preparedness, resilience and response, considering local and national guidance, and compliance with the NHS EPRR Core Standards.

The review focused on the following sub-objectives:

Sub Objective	Risk
There are comprehensive policies, procedures and plans in place covering Emergency Planning and Business Continuity, which clearly define the arrangements in place to respond to major incidents (in line with latest NHS guidance), which have been communicated to relevant stakeholders and are subject to regular review for appropriateness.	Inadequate arrangements and procedures to protect patients, staff and assets in an emergency. Non-compliance with national guidance and obligations, for example those outlined within the Civil Contingencies Act 2004, the Health and Social Care Act (2022), the NHS standard contract, the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022), the NHS EPRR Core Standards and NHS England Business Continuity Management Toolkit (2023). The organisation may fail to engage with clinicians, partner organisations, and its own staff regarding their roles and responsibilities. Communication and actions needed in the event of an emergency situation may not be clear, leading to inappropriate responses in an emergency.
There are clear and effective resources and governance arrangements surrounding EPRR and Business Continuity.	Governance arrangements over plans and outcomes may not be effective, meaning that senior management do not receive appropriate updates and assurances.
The organisation participates in a range of EPRR exercises to ensure it has the capacity and capability to deliver against emergency and business continuity plans. The results of EPRR exercises are documented, and areas for improvement/ lessons are identified and actioned.	Unskilled or untrained staff co-ordinate and manage any emergencies or major incidents that may arise, or staffing may not be appropriate for a particular emergency. Emergency preparedness plans are not regularly reviewed to confirm that they are deliverable, efficient and effective.

Sub Objective	Risk
There is a training programme in place which meets the specific needs of different staff groups involved in EPRR, in line with national standards.	The organisation may fail to prepare itself effectively for an emergency or major incident through training and scenario planning.
Strategic risks that may trigger Emergency and Business Continuity Plans have been documented, are subject to effective ownership and monitoring and actions have been taken to mitigate the risks.	Risk management and risk prioritisation is not effective.
The EPRR Core Standards Assurance self-assessment undertaken is supported by appropriate evidence, and the results have been reported. Progress is being made on the partially compliant standards.	Self-assessment is not supported by evidence. Progress is not being made against the partially complaint standards.

Scope Limitations

The limitations to scope were as follows:

- The scope of this review focused on the objectives described above and was limited to the controls in operation at the Trust.

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system

Appendix B: Assurance Definitions and Risk Classifications

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

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significantimpact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however, implementation of the recommendation would improve overall control.

Appendix C: Report Distribution

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Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards and conforms with the International Standards for the Professional Practice of Internal Auditing.

Appendix D

The tables below advise on the exercises and training that have taken place involving the Trust during the past three years.

Date	Type	Topic	Attendees
Internal Exercises			
10/08/2022	Live Exercise	Operation Lockdown at SCHC	All staff at SCHC . Led by LSMS.
12/05/2022	Trust Tabletop	Cyber Attack Exercise	Representation from across the organisation. Delivered by IT with the support of an external facilitator.
18/11/2022	Trust Tabletop	Industrial Action Exercise	Attendance by Service leads and Service Directors. The exercise focused on the imminent Industrial Action that was likely to affect numerous services across the organisation. The exercise tested service Business Continuity Plans re IA.
29/04/2022	Live Exercise	Fire Evacuation SCHC	All duty staff at SCHC.
10/05/2023	Exercise Tabletop	Cyber Exercise delivered by external provider. Testing Cyber response plan.	IT Staff On call Managers EPRR Lead
04/09/2023	Live Exercise	CBRN Exercise at VCHC WIC to test response to a HAZMAT incident and the IOR Principles	Facilitated by EPRR Lead targeting first responders at VCHC WIC.
13-18/11/2023	Live Exercise	Communication Exercise Alexander. Testing the effectiveness of the Trust On Call mechanisms.	Facilitated by EPRR Lead. All Strategic and Tactical Commanders. Loggists.
05/12/2023	Table Top Exercise	Exercise Niveous. Testing the effectiveness of the Adverse Weather Health Plan.	Facilitated by the EPRR Lead. Service Leads and On Call Managers.

29/12/2023	Live Exercise	SCHC Lockdown Exercise. Testing the effectiveness of the Lockdown Plan.	Facilitated by the EPRR Lead. On Call Strategic. Security and Estates staff.
10-15/06/2024	Live Exercise	Communication Exercise Alexander. Testing the effectiveness of the Trust On Call mechanisms.	Facilitated by EPRR Lead. All Strategic and Tactical Commanders. Loggists.
31/07/2024	Table top exercise	Cyber Incident Response Exercise	IT Staff
18-23/11/2024	Live Exercise	Communication Exercise Alexander. Testing the effectiveness of the Trust On Call mechanisms.	Facilitated by the EPRR Lead. On Call Strategic. Security and Estates staff.
31/12/2024	Live Exercise	SCHC Lockdown Exercise. Testing the effectiveness of the Lockdown Plan.	Facilitated by the EPRR Lead. On Call Strategic. Security and Estates staff.
External Exercises/Debriefs/Briefings (previous 3 Years)			
01/11/2022	Briefing	Energy Resilience and Potential Power Outages – ICB EPRR Lead	EPRR Lead
22/11/2022	Exercise	Operation Fuego – Fire evacuation Clatterbridge Site. – Multi Agency. Led by CWP EPRR Team	EPRR Lead
29/11/2022	Exercise	Arctic Willow Exercise – Address Trust response to simultaneous multi operational incidents including Power Outage, Industrial Action and Adverse Weather	EPRR Lead, All service Directors.
04/01/2023	Debrief	Capture Lessons learnt from 1st wave of RCN Industrial Action ICB EPRR Lead.	EPRR Lead
16/02/2023	Exercise	Rest Centre Awareness. Delivered by Merseyside Resilience Forum.	EPRR Lead

24/02/2023	Briefing	Action Counters Terrorism awareness session.	EPRR Lead
28/04/2023	Exercise	Rest Centre Management	EPRR Lead
10/05/2023	Briefing	Adverse Weather. Delivered by UKHSA	EPRR Lead
11/05/23 & 5/06/23	Briefing	Summer Preparedness Webinar and Workshop delivered by UKHSA	EPRR Lead
03/11/2023	Briefing	Counter Terrorism Security Agency (CTSA) Event	EPRR/LSMS
22/02/2024	Briefing	National presentation relating to Martyns Law and security requirements following mass gatherings.	EPRR Lead
09/05/2024	Briefing	Summer Preparedness Webinar and Workshop delivered by UKHSA	EPRR Lead
10-15/06/24	Live Exercise	Exercise Alexander – In Trust Communication Exercise.	EPRR Lead – On Call Managers - On Call IT, Loggists and estates.
11/06/2024	Live Exercise	Fire Evacuation - Fender way, Health Centre	All Staff and Patients
3/07/2024	Table Top Exercise	Cyber Incident Response Exercise.	It Staff
26/07/2024	Live Exercise	Fire Evacuation – Marine Lake Health Centre	All staff and Patients
29/08/2024	Live Exercise	Exercise Calliope – ICB led communication exercise leading to the establishment of an Incident Management Team. WCHC Trust response facilitated by EPRR lead.	EPRR Lead On Call Managers. IMT members
10/102024	Workshop	Winter Preparedness Workshop facilitated by the Local resilience Forum.	EPRR Lead
03/12/2024	Table Top Exercise	Exercise Nexus - Community Outbreak Exercise based in an asylum seeker setting.	EPRRLead and IPC Staff
26/09/2024	Briefing	Cold Weather Webinar delivered by UKHSA	EPRR Lead
21/03/2025	Table Top Exercise	Fire evacuation of CICC	On Duty staff.

08/04/2025	Briefing	Martyns Law Legislation for NHS providers	EPRR Lead Estates Manager COO (AEO) Dep COO Chief Strategy Officer.
Internal Training			
Various dates	E Learning	Action Counters Terrorism input.	Accessed by relevant staff Receptions etc)
Various dates	Face to Face	On call Manager training	Delivered to new recruits of the On call Manager rotas.
27/07/2023	Face to Face	Loggist Training	Delivered to five volunteers by EPRR Lead.
18/01/2024	Face to Face	BCP Development Training	Delivered by the EPRR Lead to Service BC Reps.
12/05/2024	Face to Face	Loggist Training	On Call Loggist staff
08/08/2024 15/08/2024 17/09/2024	Teams	Hazmat/CBRN Training	WIC Staff
08/04/2025	Teams		
External Training In past 3 Years			
26/04/2023	Face to Face	Fit Test Training	Provided by Face 2 Fit . 8 members of staff.
22/02/2024	Face to Face	Fit Test Training	Provided by Face 2 Fit . 6 members of staff.
07/03/2024	Face to Face	Fit Test Training	Provided by Face 2 Fit . 6 members of staff.
Various Dates	Teams	Principles of Health Command.	Delivered by NHSE EPRR to Tactical and Strategic On Call.
Various Dates Summer 2024	Teams	Legal Awareness Training	Delivered to EPRR Lead and Strategic On Call Commanders.
22/08/2024	Face to Face	NWAS Decontamination Training	Delivered to EPRR Lead
03.10.2024	Face to Face	Media Training for Strategic Leads to support response to major incidents	Strategic Commanders.

11/02/2025	Face to Face	Structured incident Debriefing Training	EPRR Lead

Appendix E

Listed below are the Incidents and exercises that have occurred during the past three years and evidence of compliance with this standard.

Date	Exercise/ Incident	Details
18 & 19/01/2023	Incident	**Industrial Action by RCN staff:** In addition to the planning and development of an internal Industrial Action Plan, the Trust utilised its Major Incident Plan as part of the response to the strike action. The Trust ran an Incident Control Centre throughout the strike action from its ICC room located at the VCHC site. An Incident Lead was established, in addition to a Loggist. The incident was subject to a debrief and a presentation to the Executive Leadership Team, which outlined many positives from the planning and response to the incident.
12/08/2023	Incident	**Refurbishment work was being completed at the communications room located at the VCHC Walk-In Centre.** During these works, there was a failure of a BT circuit that adversely affected the ability to communicate via telephony and internet at various locations throughout the Trust. Some initial mitigation was put in place utilising the 4G network, but additional work was required in order to facilitate printing. Full normal service was achieved **within** 36 hours. Lessons learnt included the need to establish a full risk assessment with stakeholders who could be affected by such works. Full testing of network connections should include a number of checkpoints at each stage to ensure expected outcomes are met.
03/01/2024	Incidents	**A VCH IT and telephony circuit failure** affected many services throughout the organisation through the loss of IT and telephony. This occurred following a decision **by BT** to terminate an incorrect line. Full recovery took a number of days and required the assistance of other providers, including **WUTH,** who supported the Trust by affording access to their systems. This temporary measure is still in place, as **BT has not yet provided** the new line that **can be tested.** A new "failover" system has been introduced, **which is tested weekly** and provides additional mitigation. This measure is a **permanent enhancement to the Trust's resilience** in this area. Weekly contact is **maintained** with the BT account manager to ensure the matter is rectified as soon as possible. An Incident Management Team was established, **led by the Deputy Chief Operations Officer**. The team met several times each day until the situation reached a satisfactory conclusion. **The delay in the provision of the new line is also affecting** the ability of the IT service to adequately assess any lessons identified from this IT failure.
10/01/2024	Incidents	**A primary domain controller failure at SCHC caused IT issues for users.** Staff were unable to log on to computers, as the failed controller

		was responsible for verifying all log-on details. Recovery involved utilising a secondary server at VCHC to verify accounts. However, this mitigation did not restore all systems, including **Mail Central** and **Datix.** A new primary domain controller was installed, which cleared the known errors but introduced a new issue with the **Always On Virtual Private Network (AOVPN),** which was not syncing. Additional work took place to rectify this, and all systems were fully operational **72 hours after the incident commenced.** Lessons identified are still being assessed, as the Trust's IT team works closely with one of its partners to ensure that automatic updates of domain controllers are managed safely.
26/01/2024	Incident	**Infection Prevention and Control Service completed a risk assessment** and developed an action plan to ensure that WCHC was in the strongest position to deal with a local measles outbreak. An internal measles preparedness meeting group was established with relevant services and the EPRR Lead to progress actions. **The action plan and risk assessment were continually monitored by the Trust's Clinical Assurance Group,** with oversight provided by the Infection Prevention and Control Group. Walkthroughs were completed within the Urgent Treatment Centre and the VCH Walk-In Centre to support preparedness plans in relation **to measles.** This helped to identify learning to improve the patient journey, and any associated actions have been implemented by the service.
24/04/2024	Incident	**Loss of Water Supply – VCHC:** Information was received that the water supply in the area of the Health Centre had been disrupted. This occurred at the commencement of the working day and **had the potential to significantly impact** the services being delivered from the site. The EPRR Lead attended the site, reviewed the levels remaining in the tank, and established that there were only a couple of hours of supply left. Communications were sent out to all affected services, with a request that service-level Business Continuity Plans be utilised to begin planning for the delivery of services away from the VCHC site. The EPRR Lead identified that the issue was the result of a burst pipe in a nearby street. The EPRR Lead attended the scene, where emergency staff were present but awaiting instruction. The EPRR Lead liaised with the utility provider and expressed the urgency of resolving the issue. The water supply was fully restored before the reserve water stocks were depleted
19/07/2024	Incident	The computer **cyber security technology** company **CrowdStrike** introduced a faulty update to its **Falcon Sensor** security software for Microsoft. The outcome was synonymous with the phrase **"the blue**

		screen of death." Trust IT services were quickly mobilised to ensure that our networks remained relatively unaffected.
29/07/2024	Incident	Following the atrocious deaths of three young girls at a Southport dance class, the country witnessed numerous incidents of violent disorder, which were triggered by false claims circulated online that the person responsible was an asylum seeker who had arrived in the UK by boat and was Muslim. In addition to the disorder, there was an increase in reports of racist abuse. This included the targeting of NHS staff. **The Trust ?** The Trust …sentence wasn't finished ? ***responded by issuing supportive communications to staff, reaffirming its zero-tolerance stance on discrimination and working with local partners to monitor and address staff safety concerns. ????***

Appendix F

Action Plan Core Standards Self-Assessment 2024
KEY (Change status)

1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented

Action plan lead	EPRR Core Standards 2024/25– Mick Blease

	Actions required and Core Standard Targeted	Completion date	Person responsible	Change stage	Description of current position	Evidence of Completion
1	Review EPRR Policy. To include required elements of statement of intent, including:- • Description of Operation Commander Role. • Enhance the description for the arrangements of key suppliers and contractors. • Enhance the debriefing section of the policy. **CS 2**	01.04.25	MB	3	Policy under review. Operational commander role included in updated Policy together with an enhanced debrief section with in the policy. Liaison with Procurement to take place in order to finalise policy review. Update 9th April 2025. Policy has been fully reviewed. The policy has completed its journey and has been approved by the Quality and Safety Committee.	Policy has been uploaded to StaffZone and Datix.
2	Test the Evacuation and Shelter plan with regards to the CICC in the form of a tabletop exercise. **CS 16**	01.02.25	PT/MB	3	PT has liaised with Fire Safety Manager at PropCo who ae responsible for the CCC where our wards are located with a view to conduct a tale top exercise.	

	Actions required and Core Standard Targeted	Completion date	Person responsible	Change stage	Description of current position	Evidence of Completion
					Update 9th April Tabletop Exercise to capture Evacuation and Shelter arrangements for the CICC took place on the 21st March 2004. The exercise included all duty staff at the time.	Exercise review documentation. Fire Safety Officer P. TAYLOR
3	Develop a Trust EPRR awareness training package for all staff to complete on recruitment. **CS25**	01.04.25	MB/LP	2	Fellow EPRR leads have been contacted and a contact with Trust L&OD has been established. The Trust induction checklist has been updated to include reference to EPRR. Update 9th April EPRR lead at WUTH as part of integration programme to ascertain best practice.	
4	Review the communication support arrangements for On Call staff on a 24/7 basis. **CS33**	01.04.25	MB/FF	2	Update 9th April. Liaised with WCHC Comms lead with a view to ascertain what support could be enhanced if integrated with WUTH	
5	The Key Performance Indicators relating to the completion of BCP's needs to be included in the the Business Continuity Policy and the performance in this area to be included in the Annual EPRR report to board. **CS50**	01.04.25	MB	3	Compliance of BCP has been developed into an Excell Spreadsheet. Update 9th April – A section with in Annual EPRR report captures BCP Performance.	Annual EPRR Report to board.

	Actions required and Core Standard Targeted	Completion date	Person responsible	Change stage	Description of current position	Evidence of Completion
6	Complete an audit of BC plans for 24/25. **CS51**	31.12.24	MB/SP	3	Audit completed and report shared with HSSR Group 15th January,	BCP Audit Report
7	Assurance of Commissioned providers/suppliers Business Continuity Plans. Samples of a number of suppliers BC Plans to be tested to seek assurance. **CS53**	01.05.25		2	Update 9th April – EPRR lead and Procurement lead have met to develop plan to test supplier BC Plans. Basic principles agreed.	
8	A CBRN Exercise to be developed and delivered to relevant staff including walk in centre and On Call personnel. **CS66**	01.02.25		2	Exercise Coborn developed and will be delivered to relevant staff on 20th March. Update 9th April – Due to staffing levels the exercise planned for the 20th March has now been postponed until 1st May 2025	

Appendix G

EPRR Training and Exercise Programme 2025/26

Introduction

This document outlines **Wirral Community Health and Care NHS Foundation Trust's (WCHC)** training and exercise programme covering Emergency Preparedness, Resilience and Response (EPRR), both internally and externally, for **2024/25**.

The EPRR programme sets out both statutory and non-statutory training requirements, as outlined in the **Civil Contingencies Act (2004)** and the **EPRR Framework (2022)**, stating:

• A plan is required to include provision for the carrying out of exercises.
• A plan is required to include provision for the training of staff or other persons.
(**Reference: CCA 2004**)

(Reference. CCA 2004)

• *The NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically.*
All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.
(Reference. EPRR Framework 2022 Section 8.3)

National Occupational Standards (NOS)

Standards for NHS incident training are contained within the Skills for Justice National Occupational Standards (NOS) framework and should be referred to when identifying staff training needs; please see

NHS EPRR National Occupational standards

Emergency Planning Officer

The Emergency Planning Officer role is to ensure the EPRR Training and Exercise programme is maintained and reviewed on an annual basis.

Teaching Plan

Teaching and learning plan will breakdown in detail each training or exercise programme set out within the overall EPRR annual programme, outlining all the teaching and learning activities, with allocated timings, assessment activities and resources required.

All material provided is adjusted dependent on type of training and exercise carried out ensuring that individual needs are met.

Multi-Agency Training

This plan is focused on internal training for WCHC but recognises the ongoing training and exercising with multi-agency partners in meeting the statutory responsibilities set out within CCA 2004.

The ICB represents the system at the local Merseyside Local Resilience Forum and will advise the Emergency Planning Officer on any Multi-Agency training opportunities.

CPD / PDR

Currently training carried out by the Emergency Planning Officer is not accredited. Records of training delivered will be maintained by the Emergency Planning Officer with support from the Learning and Organisational Development Team.

Core Standards

WCHC EPRR Training and Exercise programme provides assurance and evidence to the following NHS Core Standards question under Domain 5.

22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.

23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.

The core standards also identifies the following training requirements under the headings of Hazardous Materials and Chemical Biological Radiological and Nuclear (CBRN) incidents.

63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments

64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented

WCHC Training Programme

Training Programme	Aim	Objectives		NOS
On Call	To analyse and construct the theory and practical processes of being an on call manager/Director for external and internal incidents including Gold/Silver command or support for MKUH.	• Summarise the legislation and guidance associated with civil protection. • Describe how this guidance applies to their organisation and the role of on-call. • 3. Explain the responsibilities of their organisation in preparing for and responding to emergencies and major incidents. • Discuss the types of 'emergencies and potential threats they may encounter. • Describe the environment where a Loggist may be utilised during an 'Emergency'. • State the importance of the legal aspects and requirements in relation to		CC AA1 CC AA2 CC AA3 CC AB1 CC AC1 CC AE2 CC AE3 CC AF1 CC AF2 CCAG1 CCAG2 CCAG3

		logs, records and documentation. • Understand MKUH ICC 'Tactical' and 'Strategic' set-up and process. • To be assessed through on-call competency programme		CCAG4 CC AH1 CC AH2
Hazmat/CBRN		• Summarise the legislation and guidance associated with CBRN /HAZMAT • Describe how this guidance applies to WCHC and identify the services that may be affected. • Explain the responsibilities of their organisation in preparing for and responding to CBRN / HAZMAT incidents. • Discuss the types CBRN / HAZMAT and potential threats they may encounter in a Community Trust setting. • Demonstrate the skills and methods as underpinned by IOR and its principles.		CC AA2 CC AA3 CC AF1 CC AA1
Loggist Training	To analyse and construct the legal, and practical processes for record keeping during an incident and how loggists play a key role	• Summarise the legislation and guidance associated with civil protection. • Describe how this guidance applies to their organisation and the role of the loggist. • Explain the responsibilities of their organisation in preparing for and responding to emergencies and major incidents. • Discuss the types of 'emergencies and potential threats they may encounter. • Describe the environment where a Loggist may be utilised during an 'Emergency'. • State the importance of the legal aspects and requirements in		CC AA1 CC AA2 CC AA3

		• relation to logs, records and documentation. • Demonstrate the skills and methods of decision logging.		
Business Continuity Exercise	The exercise aims to develop an overview of Business Continuity Management System (BCMS) as underpinned by statutory requirements, and the applications in activating BCP in response	• To outline what BCMS is and why WCHC requires business continuity. • To describe the process in how BCMS is developed. • To apply BCMS development in the Trust and role of the Business Continuity Lead • To test current BCPs in accordance with national guidance and best practice		

Annual WCHC Exercise Programme

Provider Exercise	Aim	Objectives
Communication Exercise NB: Every 6 months	To test all internal on-call cascade process.	• To test WCHC cascade system for OOH • To test on-call arrangements for the Organisation and its ability to respond to an incident.
IOR / Dry Decon NB: Annually	To test WCHC process to carry out a Dry Decontamination following self-presenters in line with IOR guidance.	• To test WCHC capabilities in carrying out a Dry Decontamination. • To test WCHC planning arrangements concerning Dry Decontamination • To test staff on the Dry Decontamination process and its application
Business Continuity NB: Annually	To test WCHC application in response to a internal 'critical incident' requiring business continuity response	• To test WCHC capabilities in carrying out a business continuity response, In and Out-of-Hours • To test WCHC planning arrangements concerning business continuity. • To test key staff on the business continuity process and its application

Table Top Exercise NB: Annually	To test and assess WCHC planning arrangements against specific incident. within a tabletop environment .	To be developed dependent on type of tabletop exercise outlined
Live Exercise NB: <3 years	To test and assess WCHC planning arrangements against specific incident within a live exercise environment.	To be developed dependent on type of tabletop exercise Outlined. **NB If the Trust has had to respond to a real time EPRR Incident then this can be utilised as evidence and comply with the requirement to have a live event every three years.**

Proposed Training for 2025/2026.

Training Exercise	Dates	Summary	Attendees
On Call Manager Training	September 2025	Capture identified Learning from recent On Call manager incidents and other scenarios.	On Call Managers
Lockdown Exercise (SCHC)	December 2025	The Exercise will test the newly developed Lockdown Plan for the Trust.	Security Personal/Estates staff On call Manager(s)
Pandemic Exercise Pegasus	September 2025 – November 2025	National Pandemic 0065ercise which will be workbook based. Full details to follow.	All Trust Staff
Cyber Tabletop Exercise	24thMay 2025	Provide knowledge to service nominated individuals who are responsible for the development of Business Continuity Plans.	IT Staff On Call Manager
Media Training	TBD Awaiting support confirmation from ICB	The training will be delivered to Strategic level On Call directors who are the nominated individuals who will address any media enquiries during a Major Incident.	Strategic Level On Call Managers
Loggist Training	July 2025	This training will enhance the Trust resilience with regards to its Major Incident Loggist ability.	Volunteer Loggists

Communication Exercise (6 Monthly)	May 2025 Nov 25	Test the ON Call response times of key EP roles including On Call managers, Loggists, Estates and IT.	On Call staff and Loggists
Hazardous Material/CBRN Exercise	May 2025	Test the response of key staff who would be required to provide a response during a self-presenter at a Trust WIC and to test the effectiveness of the Trust CBRN Plan. To Include IOR principles.	WIC staff and On Call Managers
Evacuation Exercise. CICC	March 2025	Test the effectiveness of the Trust Evacuation Plan of the CICC wards	CICC Ward Managers and other CICC staff.
AEO Training	May 2025	ICB Training Package on rolls and responsibilities of the Accountable Emergency Officer. Delivered by ICB lead.	COO (AEO) Dep COO
Exercise Kaus Astralias- Business continuity Exercise	July 2025	A business Continuity Exercise led by NHS England and will be delivered to all North West Providers.	EPRR Lead On Call Staff

External training opportunities:-

Via the Local Resilience Forums (LRF):

- Multi Agency Gold Incident Command (MAGIC) Training (dates TBC)
- LRF awareness (dates TBC)

Via NHS England:

- Principles of Health Command (NHSE dates available) Tactical and Strategic On Call Managers.

Via the ICB:

- Resilience Direct Training (ICB supplied)

Additional Training can be added on an Ad Hoc basis that is relevant to incidents or events as they occur in order to prepare for or capture lessons from.

Public Board of Directors **Item 31**

04 June 2025

Title	Communications and Marketing Strategy Assurance Report for Quarter 4 - 2024/25
Lead Director	Alison Hughes, Director of Corporate Affairs
Author	Fiona Fleming, Head of Communications and Marketing
Report for	Information

Executive Summary and Report Recommendations

Quarter 4 presented a diverse range of campaigns demonstrating how the team supports business critical objectives aligned to organisational strategy delivery. This is alongside operational support and responding to the changing needs of staff, patients, service users and stakeholders. The team continue to explore new ways of engaging with the workforce, our communities and raise the profile of the Trust.

Overall reporting is aligned to the Trust's strategic objectives (slide 2). Communications 'We will' statements under each organisational objective, guide our activity.

Reporting includes emphasis on impact and the direct support for operational services and their objectives. Project summaries are structured under three headings of objectives, what we did and impact and measures, providing oversight on each project's purpose and outcome.

Throughout 2025-26 further developments will be made to ensure that clear objectives and measures are agreed with services. A focus on evaluation and campaign performance remains a priority.

The Board of Directors is asked to be assured that the communications, marketing and engagement activity evidenced in this report for Q 4 - 2024-25 meets the aims of the Trust.

Key Risks

This report relates to the following key risks:

The report represents a positive mitigation to BAF risks ID01, ID02, ID07, ID10. There are no risks identified in this report. The risk in failing to have effective communication and engagement across the workforce and with the local population is mitigated by the numerous campaigns and priorities delivered. Greater partnership working through the Cheshire and Merseyside ICB Communications network ensures a focus on system priorities.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes

Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Quarterly report	Board of Directors	Communications & Marketing Assurance Report	For assurance.

1	**Narrative**
1.1	The attached report provides an overview of all activity across key strategic objectives and includes priorities for the new financial year.

2	**Implications**
2.1	**Quality/Inclusion** All communications, marketing and engagement activity aims to positively impact on Trust staff and those who access our services.
2.2	**Finance** There are no financial/resources implications for consideration within the report
2.3	**Compliance** The report includes detail on relevant areas of compliance including AIS and GDPR.

3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Yes.

	If Yes, please select all of the social value themes that apply: **Community engagement and support** ☒ **Purchasing and investing locally for social benefit** ☒ **Representative workforce and access to quality work** ☒ **Increasing wellbeing and health equity** ☒

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Communications & Marketing Board Report Quarter 4

Date: 4 June 2025

Name: Alison Hughes, Director of Corporate Affairs

Reporting for 2024 - 2025

- The report aims to align to activity with the Trust 5-year strategy and supporting strategies (Quality, People, Digital and Inclusion)
- Communications and marketing reporting is structured to evidence how activity supports the Trust's strategic objectives and goals:

  Populations - Support our populations to thrive by optimising wellbeing and independence.

  People - Support our people to create a place where they are proud and excited to work.

  Place - Deliver sustainable health and care services within our communities enabling the creation of healthy places
- Our communications led 'We will' statements guide our activity under the organisational objectives
- Reporting includes emphasis on impact and measures and how the team directly support operational services and their objectives
- The report provides details of the communications and marketing strategy focusing on - internal and external communications, brand management, system support and crisis management

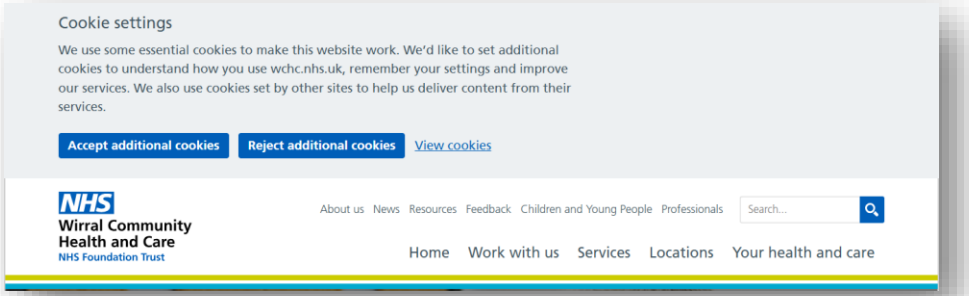
Overview of Quarter 4 (January – March 2025)

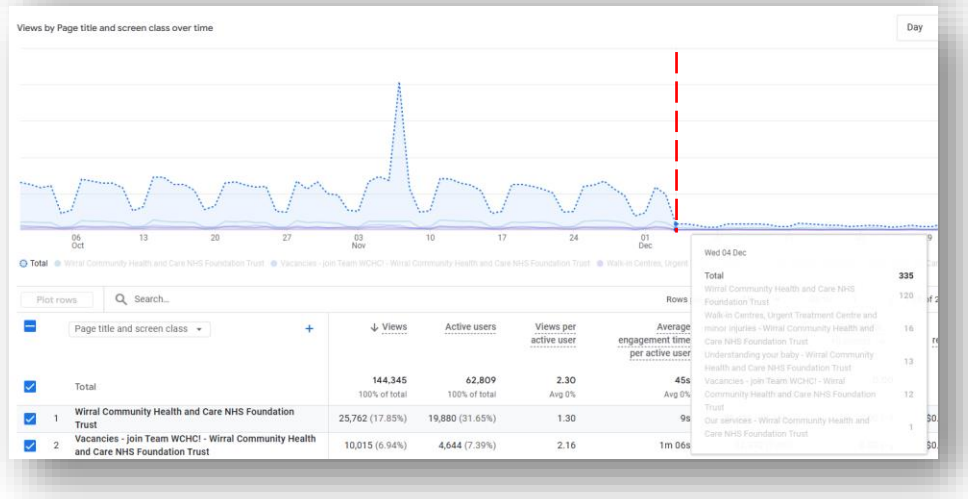
Business as usual

- 24 Editions of The Update plus 3 Special Editions: Data Protection, Green Plan & Sustainability, and Cold Weather
- 145 Shout Outs published
- 2 CEO and Executive messages to all staff
- 65 screensavers
- 1,130 email requests from services - average of 17.4 jobs per day (including design) via the comms mailbox

GDPR compliance - websites

- To maintain compliance with GDPR, the cookies banner on the public website (wchc.nhs.uk) has been enhanced and made more prominent
- Accepting cookies allows us to track visitors
- We cannot track users who reject cookies or those who do not make any choice
- Since the enhancement, we have seen an increase in users rejecting additional cookies
- This limits our ability to track users who visit our website, and we have seen a significant drop in recorded visits
- Historical data has remained consistent and therefore we are confident that this drop in numbers does not reflect actual visits
- This % drop in data is consistent with national data trends/insight





The graph shows the impact to tracking on Google Analytics since implementation in December 2024 (red line).

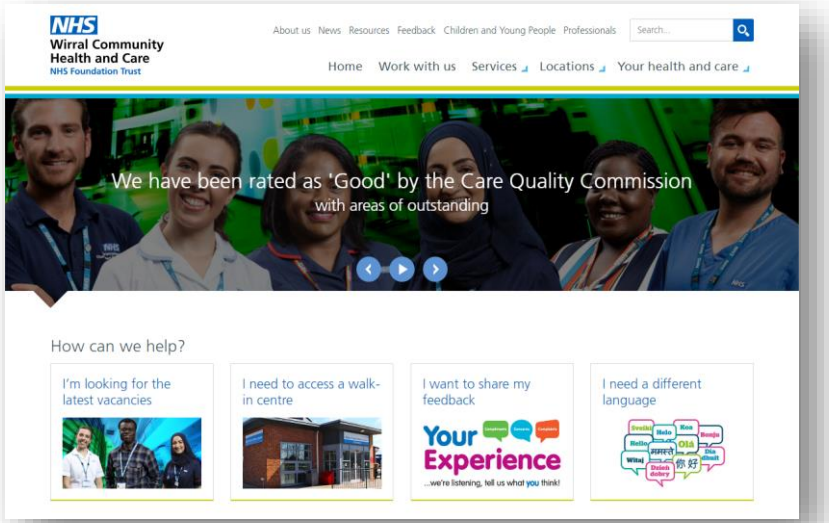
Digital Summary Q4

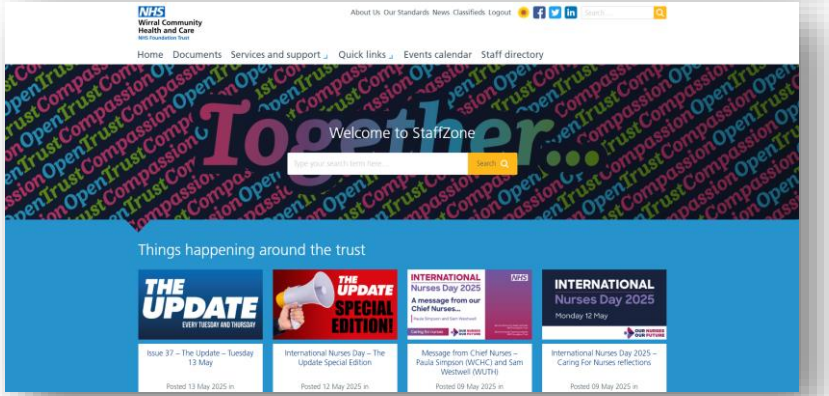
Public website figures impacted by cookie tracking for Google Analytics (see previous slide)

Public website – 39,873 page views *(Q1. 190,209 page views)*

- Vacancies – 2,035
- Walk-in centres, UTC and minor injuries - 1,939
- Understanding your baby – 1,229

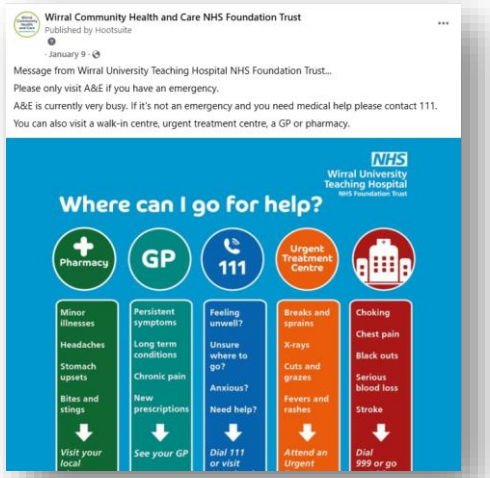
- **StaffZone** – 132,631 page views ***(unaffected by cookies)***
  - Documents – 6,419 page views
  - Services and Support – 2,753 page views
  - Current vacancies – 2,509 page views

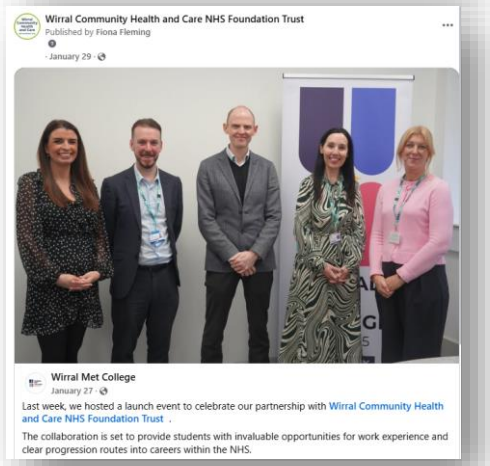




Social Media Summary

- X account @wchc_nhs - total followers = 4,368 (decrease of 12 followers)
- X impressions not available (X analytics are now behind a paywall)
- Facebook account @nhsbuzz - total followers = 2k+ (29 increase)
- Facebook impressions = 24.2k
- LinkedIn - total followers = 2.6k (increase of 110)
  LinkedIn impressions = 2.5k



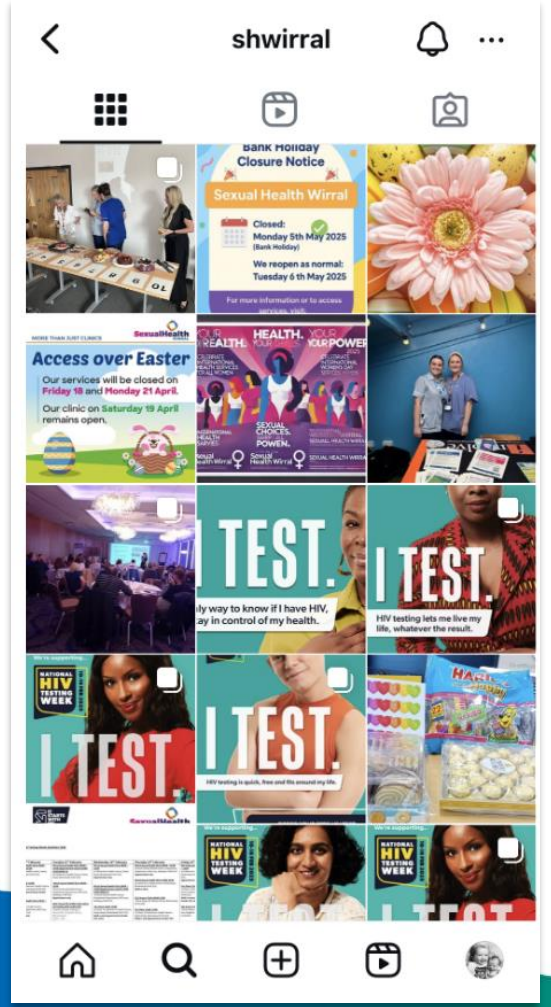


Service specific - social media summary Q4

Social media is an effective platform for a number of services to provide information and engage with their target audience. Content plans are developed in advance to ensure best use of resources and to protect Trust reputation.

Platforms (Facebook and Instagram) - Wirral Cardiovascular Rehabilitation, Sexual Health Wirral, Children's Speech and Language Therapy, Family Nurse Partnership Wirral, Health Visiting Hubs (localities), School Nursing Hubs (localities)
Content - subject matter experts providing information, education, advice, tips, updates and exercise / how to videos. Signposting across the system and sharing partner/stakeholder content.
Combined data across service specific platforms -

- Posts - 585
- Likes, reactions, comments and shares -2,616
- Views and reach (the number of times content was displayed or viewed) - 126,486
- Video content watch time - 38 hours, 7 minutes and 8 seconds



Examples of audience engagement…

"You may like to know that it's five years since I undertook your 'rehab' programme and I still do some of the exercises. I have not needed to consult my GP since."

"All really helpful. Lots of tips to try."

"My little boy has become so fussy. I will definitely be giving these tips a try."

"Finding the talks very helpful."

"I got mine (AAA screening) done a few weeks ago, doesn't take long, all clear."

CMS Training and accessibility

- During Q4, we continued to deliver our content management system (CMS) training programme with colleagues from corporate and clinical roles trained in basic website administration using our CMS WordPress
- Teams are therefore more responsive in updating their own content and only request support from communications for more complex content/digital development
- Best practice and accessibility guidelines are shared as part of the training to ensure we uphold our high standards of web content for staff and the public. We now have over 50 web administrators across the Trust

Ongoing accessibility assurance

- We maintain high accessibility standards on our website (top 10 nationally) adapting to guidance as it changes. In Q4 over 100 PDF patient leaflets were converted into accessible page content on our public website as part of our ongoing commitment.

Strategic aim - Populations

We will support our populations to thrive by optimising wellbeing and independence.

Safe care and support every time • People and communities guiding care • Groundbreaking innovation and research

We will deliver communications and marketing activity that ensures public, and patients have access to information that enables them to access the right care in the right place and at the right time. We will engage with patients and the public to support improvements to service delivery, raising awareness of the specialist and innovative practice within community services.

- During Q4 the team continued their support for clinical services including; Bladder and Bowel Service – change of products, **HIV Testing Week** , **Cervical Screening**, **Let's, Talk - co-creation of weight management toolkit**, Children's Dietetics social media platform, Let's Talk Digital Hub
- The following slides provide more detail and analysis of highlighted projects.

HIV Testing Week - public health

- **Objective(s) -** To raise awareness about HIV testing and educate communities on the importance of knowing their HIV status for early treatment. Additional campaign aims included the normalisation of HIV testing, proactive testing and addressing and reducing fear, tackling stigma and misinformation around HIV testing.

- **What we did -** We created a digital campaign which included localised messages. The campaign promoted testing opportunities and clinics, facilitated in collaboration with Sexual Health Wirral and Sahir House (locations: St Catherine's Health Centre, ourPlace, VCH, Wirral Met, Wirral Ways, Nightingale Community Cafe). A successful education event for Primary Care colleagues was also delivered, with **over 50 delegates and guest speakers** attending - ***"Fantastic teaching event", "It improved my knowledge on a number of topics."***

- **Impact and measures (10 - 16 February)** - Digital: social media posts were shared across the system via Trust, SHW and partner platforms - **11 post shared wide** by Wirral wide partners: Birkenhead Community News, Patient WUTH, SHW Nurse Practitioner - **combination of 9.6k followers and 4,759 friends. Over 3,500** website views: free postal test kit - **1,951 views**, clinic timetable - **595 views**, online booking - **494 views**, walk in and wait clinics, **491 views**, HIV - **23 views**
- **83** HIV tests ordered.
- Stakeholder feedback: ***"These afternoons pop up session was amazing, the team saw 11 of our clients!!"***

Cervical Screening Week - public health

- **Objective(s) -** To raise awareness of the importance of cervical screening amongst women, alleviate fear and dispel myths. Additional objectives included: an increase in the number of women accessing cervical screening appointments, successfully engaging with vulnerable women and improving access to cervical screening clinics.

- **What we did -** We created a suite of external and internal marketing and promotional materials including flyers, posters and digital assets - social media graphics, website banner and screensaver.

- **Impact and measures -** **16 women** were screened at **outreach clinics** during 20 - 26 January, helping to detect potential issues early and reinforcing the importance of regular screening.
- Digital impact: social media posts were shared via Trust, SHW and partner platforms - **34 post shares** by Wirral wide partners including **Vittoria Medical Centre Birkenhead, Wirral Menopause Group, Tomorrow's Women, Wirral Community Group, Pelvic Health Physio -** sharing to a potential network of **11,128 page likes, 19,562 followers and 1,488 friends**
- Website views - **36 smear page views**
- Stakeholder feedback: "*Sexual Health work alongside us here at Tomorrow's Women. They provide a smear pop up clinic numerous times throughout the year where our service users can come in and have their smears in our centre where they feel comfortable attending. As well as offering sexual health advice to women who need support.*"

To any woman thinking about doing this - I'd missed my smear for over ten years before I finally booked one at TWW.
From start to finish I was treated with kindness & respect & I can honestly say it was a doddle.
Got my (clear) result quickly, too.
Don't just think about it, my friends. Get it done Xx

Never too old to have a smear,I had one and a cervical polyp was detected,it was removed easily and was benign 😋

Let's Talk weight management toolkit - co-creation

— **Objective(s) -** To co-create a weight management resource to support local families to make healthier lifestyle choices. Gather feedback on the current DIY parents support pack and identify areas for improvement and explore how and where parents and carers prefer to access the information and support. Understand the types, formats, and sources of health and wellbeing messages that resonate with people and identify the specific areas where parents and carers need support or information to make informed choices or lifestyle changes.

- **What we did -** Co-ordination and facilitation of a co-creation session with parents and carers at Fender Way Primary School. Working in collaboration with the project team a briefing paper was produced to ensure insightful feedback was captured and the session was structured around three core areas:

1. reviewing the existing DIY parents support pack
2. health and wellbeing related messages
3. Topic areas

Let's Talk weight management toolkit - co-creation

- **Impact and measures – 18 parents / carers** attended the engagement session to **share feedback, recommendations and improvements** for the new DIY Parents' Resource Pack for families to actively use and refer to
- **Increased awareness** among attendees of local family-friendly activities and community initiatives
- **Signposting** to local support
- Delivered **nutritional and healthy eating education and tips**, equipping families with practical knowledge and advice to make small meaningful lifestyle changes at home
- **Strengthened relationship** between Let's Talk Team and Fender Way Primary School
- Next steps – developed of a parent / carer resource based on local insight to support meaningful lifestyle changes

LET'S TALK
Helping young people thrive

Strategic aim - People

People – We will support our people to create a place where they are proud and excited to work.

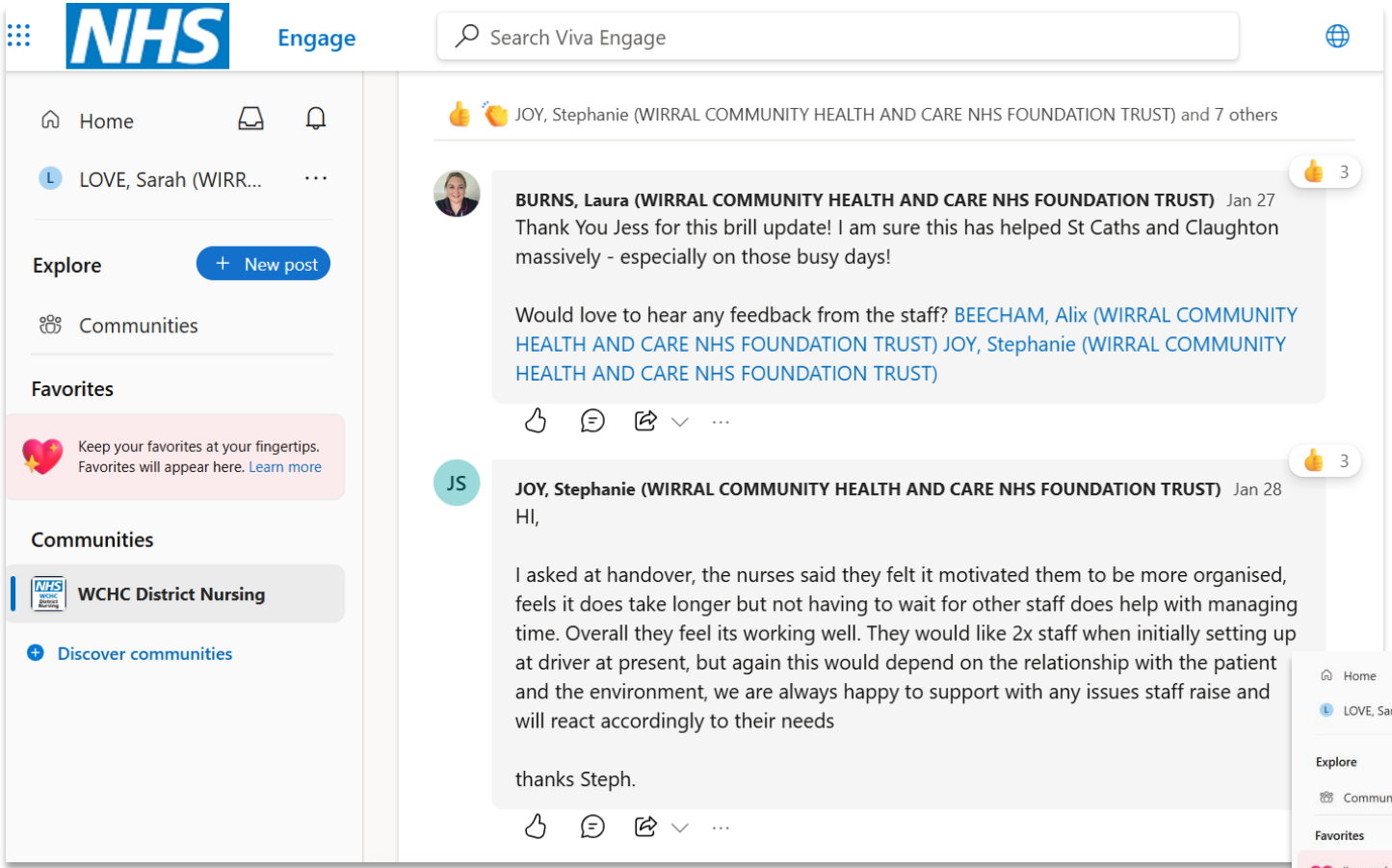
Improve the wellbeing of our employees • Better employee experience to attract and retain talent • Grow, develop and realise employee potential

We will deliver high quality internal communications activity and campaigns that ensure staff understand the vision for the organisation and have access to the information they need to carry out their roles. Communications will also support their wellbeing, celebrate achievements, help colleagues understand what is expected of them and ensure that they are able to engage and feedback.

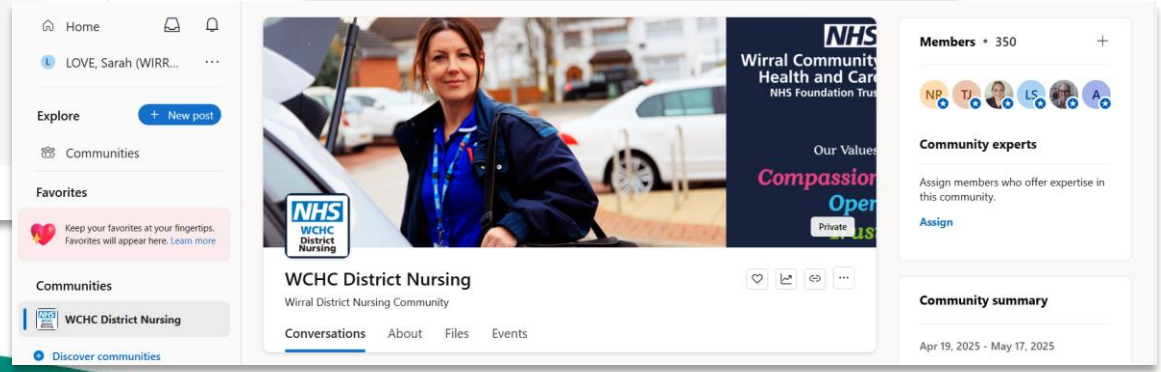
- During Q4 the team delivered a packed schedule of campaigns targeted at staff including: **Internal communications review**, **District Nurse Transformation Project**, January People Pulse, Wirral Review, Information Governance – Data Protection focus
- The following slides provide more detail and analysis of highlighted projects.

District Nurse Transformation

- **Objective(s) -**
  - Cascade of consistent and timely communications to the district nursing workforce and Joint Union Staff Side (JUSS)
  - Promote two-way engagement - opportunities for staff to ask questions, raise concerns, and feedback on developments
  - Highlight positive transformation updates and developments - reinforcing the benefits and progress of initiatives to support service delivery and transformation
  - Support for staff during service transformation
  - Supported the facilitation of staff engagement events
  - Encourage staff participation
- **What we did –** Worked closely with the project team to ensure staff and representatives from JUSS were kept informed about key project updates. Weekly project meetings ensured queries were responded to and shared via the District Nursing Hub on StaffZone and messages were relevant and timely.
- **Impact and measures -** Viva Engage (data Dec - May) - **350 members** with **messages reaching 91%, views on posts 12,294.**
- **Over 330 members of the District Nursing workforce** were kept up to date with regular messages, **5 staff queries** submitted via the online anonymous form, **245 views** of the District Nursing Hub on StaffZone.


NHS
Engage
Search Viva Engage
Home
LOVE, Sarah (WIRR...
Explore
New post
Communities
Favorites
Keep your favorites at your fingertips. Favorites will appear here. Learn more
Communities
WCHC District Nursing
Discover communities
JOY, Stephanie (WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST) and 7 others
3
BURNS, Laura (WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST) Jan 27
Thank You Jess for this brill update! I am sure this has helped St Caths and Claughton massively - especially on those busy days!
Would love to hear any feedback from the staff? BEECHAM, Alix (WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST) JOY, Stephanie (WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST)
3
JS
JOY, Stephanie (WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST) Jan 28
HI,
I asked at handover, the nurses said they felt it motivated them to be more organised, feels it does take longer but not having to wait for other staff does help with managing time. Overall they feel its working well. They would like 2x staff when initially setting up at driver at present, but again this would depend on the relationship with the patient and the environment, we are always happy to support with any issues staff raise and will react accordingly to their needs
thanks Steph.


District Nursing Development Project
NHS
Wirral Community Health and Care
NHS Foundation Trust
Key updates and information.
Issue 4
In this issue
1. Background to the District Nursing Development Project
2. Engagement session overview - Tuesday 21 January
3. Key developments - January 2025
4. Spotlight on…single registered practitioners for syringe drivers
5. Next steps - phase 2 of the project
6. Team huddles during engagement sessions
7. Enhancing the patient folder
8. Brigid app - for viewing visit and patient information
9. Helping you stay connected with project updates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Wirral Community Health and Care
NHS Foundation Trust
Our Values
Private
WCHC District Nursing
Wirral District Nursing Community
Conversations
About
Files
Events
Members • 350
Community experts
Assign members who offer expertise in this community.
Assign
Community summary
Apr 19, 2025 - May 17, 2025

Internal communications review

- **Objective(s) –** To carry out a review of internal communications across the organisation. The main objectives were to evaluate effectiveness and determine how well existing internal communication channels and strategies are working. To understand barriers, reach and impact and assess the usefulness of channels to see if they meet the needs of different groups of staff. To understand views on leadership communications, recognition (awards) and capture staff suggestions and ideas for improvement. Other areas included engagement with digital channels and social media.

- **What we did –** An online survey was created and tested with a small groups staff. The survey then launched via The Update and ran for five weeks. The survey asked questions relating to (in summary) – The Update readership, StaffZone usage, CEO messages, Get Together, Recognition, Social Media. The survey included a mix of yes/no responses and options for staff to leave comments and suggest areas for improvement. Links to the survey were shared regularly in The Update, staff Facebook group, Viva Engage. Hard copies were made available for teams eg community nursing, CICC.

- **Impact and measures –** High level summary of results - **287 responses** received. **53%** clinical role. **47%** non-clinical/corporate role. **15** staff said they wished to be involved in further eg focus groups. *Further data available on the next slide.*

- **Next steps –** The team are using quality improvement methodology to analyse the data and make recommendations for improvement. These will be developed in Q1 and Q2 2025-26.

Summary of results

Summary of findings

- 91% regularly read The Update
- 72% read the Friday Round-up
- 74% find messages from the Chief Executive useful and informative
- 41% attend The Get Together
- 70% use StaffZone throughout the week (most popular sections - Documents, Quick Links and Services and Support)
- 51% had sent in a Shout Out
- 43% had submitted a Team WCHC Award nomination
- 86% thought the staff awards were a good idea

Respondents split by directorate

- 27% Corporate
- 25% Nursing
- 12% Therapies
- 7% Community Response
- 7% Specialist Medical
- 22% 0-19+/25

Strategic aim - Place

We will deliver sustainable health and care services within our communities enabling the creation of healthy places.

Improve the health of our populations and actively contribute to tackle health inequalities • Increase our social value offer as an Anchor Institution • Make most efficient use of resources to ensure value for money

We will protect the reputation of the Trust and ensure that our communications are responsive and accessible. That staff, the public and stakeholders are engaged and informed about our contribution within Cheshire and Merseyside. We will collaborate with partners to share resources, maximise our reach and amplify our shared messages.

- During Q4, key priorities included - Wirral Review external communications, **Long Covid service decommission**, Stakeholder Communications - Knowsley and St Helens 0-19/25, SEND Inspection – Wirral.
- The following slides provide more detail and analysis of a selection of projects.

Better Together – communications (internal and external)

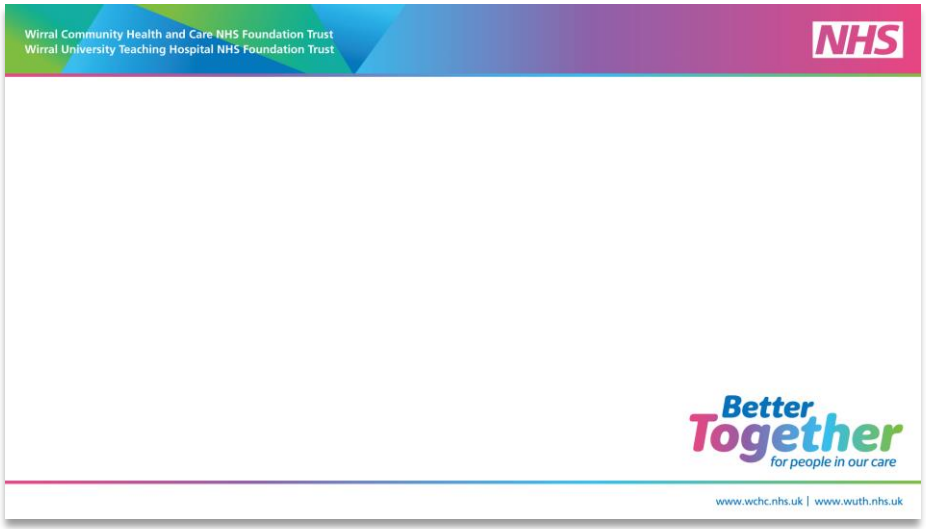
- **Objective(s) –** Working jointly with the communications and marketing team at Wirral University Teaching Hospital (WUTH) to progress the actions outlined in the internal and external communications and engagement plans, ensuring staff in both Trusts and stakeholders are updated on the progress of the Wirral Review. Ensure appropriate channels are open for different target groups and deliver messages in a consistent and timely way providing opportunities for feedback.

- **What we did –** Introduction of a senior leaders briefing and Ask ELT Q&A form. Regular updates shared through existing internal forums—*Get Together* and *Leaders in Touch*—helping to keep staff informed and engaged. Plans are in place to open both forums to colleagues across both organisations in Q1, promoting a more unified approach to communication. Consolidation of stakeholder lists to streamline communication efforts, increase reach and reduce duplication. Development of a new communications brand—**Better Together, for people in our care -** to support all Wirral Review messaging. This integrated branding reinforces shared values and reflects the collaborative direction of the programme.

- **Impact and measures –** Consistently good numbers of staff attending both Get Together and Leaders in Touch with numbers ranging from **100-200** per session. Ask ELT has generated **18** questions to date directly relating to integration. 300+ external stakeholder groups have been identified, and further work is underway to refine and segment this to ensure communications are targeted.

Communications branding for WCHC and WUTH

Better Together
for people in our care



PowerPoint template example

Awareness days/weeks in Q4

We are asked nationally, regionally and at service level to support awareness days throughout the year.

— **In quarter 4 we supported the following campaigns**.

- Veganuary
- Safer Sleep Week
- Neurodiversity Week
- Parkinson's Awareness Week
- Greener AHP Week
- Smoking cessation/No Smoking Day
- Cervical Screening Awareness Week
- HIV Testing Week
- International Women's Day
- Nutrition and Hydration Week
- Moisture Associated Skin Damage Awareness Day
- Children's Mental Health Week
- Time to Talk Day
- Kind to your Mind
- Vaccinations in pregnancy

The level of communications and marketing activity varies according to Trust priorities and service objectives. We support via - The Update, social media, StaffZone, website, Get Together and screensavers.

Priorities for Quarter 1: April – June 2025/26

International Nurses Day	World Hand Hygiene Day	Dying Matters Awareness Week
District Nursing Transformation	Better Together	The One Show – One Big Thank You
Sexual Health Wirral	April Pulse Survey	PSIRF communications
Breastfeeding Month	Performance Report	Men's Health Week
Call before Convey	Let's Talk Digital Hub	Better Together communications
School Nursing Health Assessments	Appraisals	UTC/WiC staff communications