Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community Health and Care NHS Foundation Trust

Notice of Meeting

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

Meeting	WUTH and WCHC Board of Directors in Public
Date	Wednesday 5 November 2025
Time	12:00 – 14:00
Location	Hybrid

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

Committee Chairs Reports			
16.	WUTH People Committee	Lesley Davies	
17.	WUTH Finance Business Performance Committee	Sue Lorimer	
18.	WCHC People and Culture Committee	Meredydd David	
19.	WCHC Audit Committee	Steve Igoe	
20.	WCHC Finance and Performance Committee	Steve Igoe	
Regulatory Reports			
21.	WUTH Monthly Maternity and Neonatal Services Report	Julie Roy	Jo Lavery
22.	WUTH Equality Diversity and Inclusion Biannual Report	Debs Smith	
23.	WUTH Freedom to Speak Up Annual Report 2024/25	Debs Smith	
24.	NHS Sexual Safety Charter	Debs Smith	
25.	WUTH Guardian of Safe Working Report – Q1 2025/26	Dr Nikki Stevenson	
26.	WUTH Emergency Preparedness, Resilience and Response Core Standards and Annual Report	Hayley Kendall	
27.	WCHC Inclusion Annual Report	Debs Smith	
Governance and Assurance			
28.	Wirral Provider Alliance MoU and Terms of Reference	Ali Hughes	
29.	Board of Directors Terms of Reference	Ali Hughes	
Closing Business			
30.	Questions from Governors and Public	Steve Igoe	
31.	Meeting Review	Steve Igoe	
32.	Any other Business	Steve Igoe	
Date and Time of Next Meeting			
Wednesday 3 December 2025, 09:00 – 12:30			

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	WUTH Board of Directors in Public
Date	Wednesday 1 October 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
SR	Dr Steve Ryan	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
NS	Dr Nikki Stevenson	Medical Director
RM	Dr Ranj Mehra	Interim Joint Medical Director
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
SW	Sam Westwell	Chief Nurse
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer & Interim Deputy CEO

In attendance:

CW	Claire Wedge	WCHC Deputy Chief Nurse
RC	Robbie Chapman	WCHC Interim Chief Finance Officer
JC	Dr Joanne Chwalko	WCHC Chief Operating Officer & Interim Deputy CEO
DM	Dave Murphy	WCHC Chief Digital Information Officer
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
LC	Lynn Collins	WCHC Lead Public Governor
SH	Sheila Hillhouse	WUTH Lead Public Governor
TC	Tony Cragg	WUTH Public Governor
SV	Sunil Varghese	WUTH Public Governor

Apologies:

SI	Steve Igoe	Joint Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed members to the meeting, which was held jointly with the WCHC Board of Directors. Members of that Board are listed as attendees. Apologies are noted above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 3 September were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story highlighting the approach to flexible working at WUTH. The video story described the benefits this brought to the Trust, including reduced sickness absence and good engagement along with the positive impact it has on individuals and teams. DH queried the take up of flexible working. DS stated due to nature of roles it was higher within corporate teams, and this applied to WCHC also. DS added equality monitoring was regularly undertaken to ensure equity of access to the various flexible working opportunities. SR asked about flexible working for medical staff. DS advised for medical staff flexibility was generally discussed as part of the job planning process and not as part of a flexible working agreement. The Board **NOTED** the video story.	
6	**Joint Chair Update** DH provided an update on recent matters and highlighted that the Cheshire and Merseyside financial position remained challenged. WUTH and WCHC continued to be fully engaged with the ICB regarding the Cheshire and Merseyside ICS being put into financial turnaround by NHS England. Members discussed this, noting both Trusts were aware of the financial risks to the plan and a mitigation plan was in place which was supported by the PWC. Members agreed it was important to maintain a focus on run rate and workforce reductions, however acknowledged various improvements would be transacted within the 2026/27 financial year. DH queried the key performance concerns.	

	HK advised the most significant risk to UEC performance remains achieving a sustained reduction in patients waiting over 12 hours in the ED and the 4hr accident and emergency standard. HK added external feedback indicated the Trust had robust processes in place but noted further work was required in terms of the consistency of application of these processes to meet both these standards. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meeting in September, noting key discussions took place on a Provider Collaborative reset and the development of a provider strategy - an NHS provider Trust blueprint. JH advised members about the NHS Oversight Framework (NOF) publication, noting WCHC was in segment 1 and WUTH was in segment 4. JH also noted both WUTH and WCHC will be completing the Provider Capability self-assessment. JH highlighted the CQC undertook an inspection of the WCHC Urgent Treatment Centre and Eastham Walk-in Centre, and the Trust was awaiting the draft report. JH explained the recent national CQC inpatient survey showed WUTH had scored 9.2 out of 10, indicating one of the highest-scoring areas was kindness and compassion. JH gave an update regarding Better Together - Journey to Integration, highlighting the various activity undertaken in September including video updates and briefings to staff and a presentation to the Cheshire and Merseyside ICB Board. JH referenced the staff flu campaign would begin from 1 October and summarised how staff could be vaccinated. JH reported at WUTH in July there were no RIDDORs (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 highlighted the various WUTH and WCHC employee of the month and standout winners for August. SR commented that it was positive WUTH had fully implemented Martha's Rule and asked about the uptake of this.	

	RM stated so far there had only been two requests to refer patients for a rapid review which led to a clinical intervention. RM noted the Trust was in the process of seeking feedback from patients regarding this. HS queried what the flu vaccination target was and the potential barriers. DS stated Trusts had been given a 5% improvement target based on 2024/25 and added the barriers relates to vaccination fatigue and combating concerns through myth busting. DS said the vaccination team were making it easy as possible to receive the flu vaccine. The Board **NOTED** the report.	
8	**Integrated Performance Report** DS reported sickness absence levels continued to be above the 5% threshold and had decreased in month. Anxiety, stress and depression was now the main reason for sickness absence. Turnover was consistent with the annual trend in August driven by the rotation of resident doctors. Appraisal compliance remained below target for the past 6 months and corrective actions were being undertaken to improve this position. Members suggested the rotation of resident doctors should be excluded from the staff turnover SPC. DS agreed to take this forward. HK explained the 4-hour accident and emergency target and the number of patients waiting over 12 hours in the Emergency Department (ED) remained the most significant risk to UEC performance. HK advised there was now a stronger Executive presence within the ED to maintain oversight and corrective actions where being implemented to ensure the consistent application of procedures was in place. SL queried if there was any opportunity to utilise the nursing workforce better in the ED to improve performance. SW stated the business case for nurses in ED would be fully recruited to by the end of the year and added Advanced Nurse Practitioners (ANPs) would help improve the 4-hour target. SR noted the number of patients waiting longer than 12 hours in the ED from a decision to admit had continued to improve and suggested learning from this should be explored. HK agreed and added this also related to consistent application of processes and a good culture.	Debs Smith

	SW explained there had been 12 C Diff incidents and 2 grade 3 healthcare associated pressure ulcers. SW added there had been 25 level 2 complaints and 257 level 1 informal concerns, indicating activity returning toward year-to-date averages. DH asked about the barriers to meeting the annual C Diff threshold target. SR indicated that some of this was not within the Trust's gift as a number of C Diff incidents arise within the community, however prompt sampling, isolation and handwashing were within the Trust's controls. DH requested further detail to address 4hr and 12hr breaches and C Diff metrics. RM indicated there were no areas of concern to raise with the Medical Director portfolio this month. The Board **NOTED** performance to the end of August 2025.	Hayley Kendall/Sam Westwell
9	**Chief Finance Officer Report** MC reported at the end of August, month 5, the Trust is reporting a deficit of £9.6m which is a £7.3m adverse variance to plan driven by the withholding of Deficit Support Funding (DSF), industrial action, pay award pressures and system stretch target. MC advised that as part of the Cheshire and Merseyside finance review process the Trust has submitted a mid-case forecast which, excluding DSF, is a £13.0m adverse variance to plan. MC noted during September the Trust agreed additional actions to support delivery of the agreed plan, excluding DSF, of a £22.1m deficit. MC also reported the original 4 key risks identified within the Trust plan remained and these were: • Full CIP delivery; • Activity/case mix; • Aseptic pharmacy income; and • Run rate MC added the cash balance at the end of month 5 was £0.34m. During month 5 the Trust requested £16.5m of cash support in September, of which £10.0m was approved. The Trust has agreed a cash mitigation plan for September, but the cash position will continue as a significant issue until the Trust has returned to a sustainable financial position.	

	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 including that the Trust has reported an adverse variance to plan. • **NOTED** that the Trust's most immediate finance risk remains the cash position. • **ENDORSED** the increase in capital budget of £0.034m. • **NOTED** the risk to delivering the 25/26 plan, that this risk is not fully addressed by the approved mitigation plan and the requirement to identify additional actions.	
10	**Chief Operating Officer Report** HK advised she would focus on planned care in this report due to discussing earlier in the agenda the two risks to unscheduled care. HK highlighted that dermatology cancer performance remained a significant pressure, having deteriorated following implementation of an AI pathway. HK noted this new pathway had increased the volume of referrals and demand exceeded capacity, resulting in an impact on the Faster Diagnosis Standard. SL queried if the outsourcing of ENT patients had commenced. HK stated this commenced in September and 65 week waiters had begun to reduce in this speciality. HS asked about the assurances the Trust had received regarding the AI pathway. HK explained the AI pathway had been implemented nationally and the modelling indicated this would reduce the number of referrals and instead it had the opposite effect. RM stated the new Chief Nursing Information Officer was in the process of developing a policy to provide assurance on new AI technologies. The Board **NOTED** the report.	
11	**Board Assurance Framework (BAF)** AH provided an overview the BAF, explaining there had been no changes to each of the strategic risk scores. AH advised a new shared strategic risk with WCHC has been added in relation to failing to develop a Joint Strategy and deliver the 2 year integration plan.	

	AH noted this had been agreed and recommended to the Board by the Integration Management Board. The risk was currently scored at 9 with an open risk appetite and a target risk rating of 6. HS queried the cyber security risk and the Trust's business continuity policy. DH suggested HS speak with CM who would be able to provide answers outside of the meeting. The Board: • **NOTED** the updates provided on the current position in relation to the strategic risks; and • **APPROVED** the addition of a new risk (9) related to integration noting continued oversight by the Integration Management Board.	
12	**Lead Governor Report** SH provided a verbal update and highlighted the Cheshire and Merseyside Governor Symposium took place September and positive feedback had been received by other Governors. SH added Governors were due to take part in the Patient-Led Assessments of the Care Environment (PLACE) at Arrowe Park and Clatterbridge in October. The Board **NOTED** the update.	
13	**Committee Chairs Reports – Charitable Funds Committee** SL alerted members that the Committee approved the proposal to formally close the Tiny Stars appeal on 30 November 2025, which was in line with the expected completion date of the Neonatal Unit refurbishment. SL noted once approved by the Board the closure would be communicated in October. SL also alerted members to the funding position as at 31 July. SL summarised the various "Advise" and "Assure" matters from the Committee meeting on 27 August. The Board • **NOTED** the report; and • **APPROVED** the formal closure of the Tiny Stars appeal on 30 November 2025	
14	**Committee Chairs Reports – Audit and Risk Committee** SI alerted members that the Committee undertook a deep dive into the BAF Risk 6 related to financial sustainability.	

	The Committee discussed the challenging financial position for the Trust, and the requirement to make further efficiencies despite transacting £54m in recurrent Cost Improvement Programme (CIP). The position was also exacerbated by ongoing high risk regarding the Trust's cash balance and requirement for deficit support funding. SI summarised the various "Advise" and "Assure" matters from the Committee meeting on 1 September. The Board **NOTED** the report.	
15	**Committee Chairs Reports – Research and Innovation Committee** SR advised there were no issues to alert members and summarised the various "Advise" and "Assure" matters from the Committee meeting on 15 September. The Board **NOTED** the report.	
16	**Committee Chairs Reports – Quality Committee** SR alerted members that the Committee had received a thematic review following the recent 4 Never Events. This review provided strong assurance that the causes had been identified, and corrective action was being taken. SR also alerted members that the Committee received a moderate rating internal audit review of the Infection Prevention and Control (IPC). SR noted this primarily related to the governance of the IPC BAF and it had been agreed to triangulate this with the Trust BAF. SR summarised the various "Advise" and "Assure" matters from the Committee meeting on 17 September. The Board **NOTED** the report.	
17	**Committee Chairs Reports – Finance Business Performance Committee** SL noted the Committee met in September and held a shorter meeting to primarily discuss the month 5 position and the mitigation plan, which were both covered in this meeting and the Private Board meeting. The Board **NOTED** the report.	
18	**Monthly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted the two areas of	

	non-compliance for August, noting this related to midwifery staffing sitting below Birth Rate + Acuity and the midwifery vacancy rate. JL reported there were no Patient Safety Investigation Incidents (PSIIs) declared in March for Maternity or Neonatal Services. JL gave an update on the Maternity Incentive Scheme (MIS) Year 7 and the ten safety actions, noting current progress to date and that this was being routinely tracked through the Women and Children's Divisional Quality Assurance meeting. JL also referenced the Maternity and Neonatal Inquiry, including the background for this and the next steps. HK queried the MIS appendix and red RAG rated position. JL advised this was because the evidence had not been reviewed and the RAG rated position would change once this had been completed. The Board: • **NOTED** the report • **NOTED** the Perinatal Clinical Surveillance Assurance report. • **NOTED** the position of the Maternity and Newborn Safety Investigations (MNSI) and PSII's • **NOTED** the position with the Maternity Incentive Scheme Year 7 requirements. • **NOTED** the update on the Maternity and Neonatal Inquiry.	
19	**2024/25 Annual Submission to NHS England North West: Appraisal and Revalidation** RM presented the report and explained the requirements set out by NHS England and provided a summary of the appraisal and revalidation data for the period year April 204 – March 2025. RM noted the Trust had a well-resourced Appraisal & Revalidation Team, including 76 trained medical appraisers. RM added the Trust also had a high appraisal compliance rate and a low revalidation deferral rate. RM summarised the various actions to be undertaken next year, including ongoing engagement with the Responsible Officer Network and to review and publish the Medical Staff Remediation Policy. RM added following ratification by Board the report would be signed by JH and returned to NHS North West before the 31 October deadline. The Board **RATIFED** the report.	

20	**Antimicrobial Stewardship Annual Report** DH noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the Chair's report. DH invited any questions on the report. No questions were raised. The Board: • **NOTED** the contents of this report and the actions being taken to drive improvements in antibiotic prescribing • **NOTED** the positive outcomes from the work described; and • **ENDORSED** the AMS priorities	
21	**Accountable Officer Controlled Drugs Annual Report** DH noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the chairs report. DH invited any questions on the report. No questions were raised. The Board **NOTED** the report.	
22	**Safeguarding and Complex Care Annual Report** DH noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the chairs report. DH invited any questions on the report. No questions were raised. The Board **NOTED** the report.	
23	**Infection Prevention and Control (IPC) Annual Report (including IPC BAF)** DH noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the chairs report. DH invited any questions on the report. No questions were raised. The Board **NOTED** the report.	
24	**Biannual Establishment Review** SW explained the previous establishment review was provided to Board in March and no changes were proposed following the first audit undertaken using the updated Adult Safer Nursing Care Tool. SW added a second audit was undertaken in May and when compared to the first audit this resulted in similar findings, indicating	

	little variance and high confidence in the Adult Safer Nursing Care Tool. SW highlighted for adult inpatients a recommendation to reduce staffing on Ward 15 had been proposed and approved. SW noted a number of other areas where undergoing Divisional or operational change and referred to the rationales in the report. The Board **NOTED** the report.	
25	**Questions from Governors and Public** No questions were raised.	
26	**Meeting Review** No comments were made.	
27	**Any other Business** No other business was raised.	

(The meeting closed 12:00)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 1 October 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
LD	Lesley Davies	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
RM	Dr Ranj Mehra	Interim Joint Medical Director
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
DM	Dave Murphy	Chief Digital Information Officer
RC	Robbie Chapman	Interim Chief Finance Officer
JC	Dr Joanne Chwalko	Chief Operating Officer & Interim Deputy CEO
CW	Claire Wedge	Deputy Chief Nurse (deputising for PS)

In attendance:

HK	Hayley Kendall	WUTH Chief Operating Officer & Interim Deputy CEO
SW	Sam Westwell	WUTH Chief Nurse
MC	Mark Chidgey	WUTH Chief Finance Officer
NS	Dr Nikki Stevenson	WUTH Medical Director
SR	Dr Steve Ryan	WUTH Non-Executive Director
SL	Sue Lorimer	WUTH Non-Executive Director
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
LC	Lynn Collins	WCHC Lead Public Governor
SH	Sheila Hillhouse	WUTH Lead Public Governor
TC	Tony Cragg	WUTH Public Governor
SV	Sunil Varghese	WUTH Public Governor

Apologies:

SI	Steve Igoe	Joint Non-Executive Director
PS	Paula Simpson	Chief Nurse

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence**	

	DH welcomed members to the meeting, which was held together with the WUTH Board of Directors. Members of that Board are listed as attendees. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 3 September were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story highlighting the approach to flexible working at WUTH. The video story described the benefits this brought to the Trust, including reduced sickness absence and good engagement along with the positive impact it has on individuals and teams. DH queried the take up of flexible working. DS stated due to nature of roles it was higher within corporate teams, and this applied to WCHC also. DS added equality monitoring was regularly undertaken to ensure equity of access to the various flexible working opportunities. SR asked about flexible working for medical staff. DS advised for medical staff flexibility was generally discussed as part of the job planning process and not as part of a flexible working agreement. The Board **NOTED** the video story.	
6	**Joint Chair Update** DH provided an update on recent matters and highlighted that the Cheshire and Merseyside financial position remained challenged. WUTH and WCHC continued to be fully engaged with the ICB regarding the Cheshire and Merseyside ICS being put into financial turnaround by NHS England. Members discussed this, noting both Trusts were aware of the financial risks to the plan and a mitigation plan was in place which was supported by the PWC. Members agreed it was important to maintain a focus on run rate and workforce reductions, however	

	acknowledged various improvements would be transacted within the 2026/27 financial year. DH queried the key performance concerns. HK advised the most significant risk to UEC performance remains achieving a sustained reduction in patients waiting over 12 hours in the ED and the 4hr accident and emergency standard. HK added external feedback indicated the Trust had robust processes in place but noted further work was required in terms of the consistency of application of these processes to meet both these standards. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meeting in September, noting key discussions took place on a Provider Collaborative reset and the development of a provider strategy - an NHS provider Trust blueprint. JH advised members about the NHS Oversight Framework (NOF) publication, noting WCHC was in segment 1 and WUTH was in segment 4. JH also noted both WUTH and WCHC will be completing the Provider Capability self-assessment. JH highlighted the CQC undertook an inspection of the WCHC Urgent Treatment Centre and Eastham Walk-in Centre, and the Trust was awaiting the draft report. JH explained the recent national CQC inpatient survey showed WUTH had scored 9.2 out of 10, indicating one of the highest-scoring areas was kindness and compassion. JH gave an update regarding Better Together - Journey to Integration, highlighting the various activity undertaken in September including video updates and briefings to staff and a presentation to the Cheshire and Merseyside ICB Board. JH referenced the staff flu campaign would begin from 1 October and summarised how staff could be vaccinated. JH reported at WUTH in July there were no RIDDORs (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 highlighted the various WUTH and WCHC employee of the month and standout winners for August.	

	SR commented that it was positive WUTH had fully implemented Martha's Rule and asked about the uptake of this. RM stated so far there had only been two requests to refer patients for a rapid review which led to a clinical intervention. RM noted the Trust was in the process of seeking feedback from patients regarding this. HS queried what the flu vaccination target was and the potential barriers. DS stated Trusts had been given a 5% improvement target based on 2024/25 and added the barriers relates to vaccination fatigue and combating concerns through myth busting. DS said the vaccination team were making it easy as possible to receive the flu vaccine. The Board **NOTED** the report.	
8	**Integrated Performance Report** DS reported sickness absence levels continued to be above Trust target and remained a concern. DS set out the actions in place to address this, including the re-prioritisation of the Head of HR at WUTH to support and drive sickness absence reduction which involved a 'line by line' review of long term-sickness absence cases. DS also explained the external occupational service was currently under review and that additional support for health and wellbeing was being made available. JC highlighted there had been improvements in 4-hour performance for WIC/UTC to 96.2% and was back above the 95% target. CICC occupancy continues above 90% and length of stay remains strong at 18 days against a 21-day target. JC advised GPOOH UCAT 30 min response was above target. UCAT 15 min improved in month to 64.3% which was just below the 65% target and remedial actions plans were in place. LD queried how patient satisfaction was measured post a GP Out-of-Hours Service interaction, specifically if patients were satisfied with the outcome. JC stated this would be assessed through the Friends and Family Test and audits to determine that patients had not attended the Emergency Department. JC agreed to explore how to gather patient experience/quality outcomes post a GP Out-of-Hours Service interaction to assess the level of patient satisfaction.	Jo Chwalko

	DH queried the progress to create a one Wirral number telephony system for patients to access information by dialling only one number. Members discussed this, noting one number Wirral would provide efficiencies including improved patient experience and there was already one number for Cheshire and Merseyside, however there were challenges because of the commissioning of existing services and the location of these as well as importance of working with Wirral system partners to implement this. JC proposed raising at the Wirral Provider Alliance meeting the ambition to create a one Wirral number telephony system for patients to access information by dialling one number, including how this could be implemented as the Alliance included key Wirral system partners. Members agreed with this as a way forward. LD commented about the importance of identifying and agreeing both the integration priorities and key organisational priorities, suggesting documenting those which cannot be delivered immediately but would be good to deliver in 2-3 years' time. CW reported in month there was one Information Commissioner Office (ICO) reportable incident relating to a personal data breach due an email error. CW added the number of concerns received in month had continued to increase and analysis of the themes had been requested to identify areas for improvement. RC highlighted at the end of August the Trust is reporting a surplus of £0.5m. This is an improvement on plan for M5 but there is no change to the projected year end surplus of £0.9m. RC noted at M5 the Trust has transacted £4.98m of CIP in year, £5.051m full year effect, against its revised target of £6.6m. MD queried the underspend on staffing, including the vacancies being held and if this was a contributory factor to the high levels of sickness absence. RC advised there was no correlation between the number of vacancies being held and the sickness absence. The Board **NOTED** performance to the end of August 2025.	Jo Chwalko
9	**Board Assurance Framework (BAF)** AH provided an overview the BAF, explaining there had been no changes to each of the strategic risk scores.	

	AH advised a new shared strategic risk with WUTH has been added in relation to failing to develop a Joint Strategy and deliver the 2 year integration plan. AH noted this had been agreed and recommended to the Board by the Integration Management Board, the risk was currently scoring 9 with an open risk appetite and a target risk rating of 6. The Board: • **NOTED** the updates provided on the current position in relation to the strategic risks; and • **APPROVED** the addition of a new risk - ID11 related to integration noting continued oversight by the Integration Management Board.	
10	**Lead Governor Report** LC provided a verbal update and highlighted the September Council of Governors meeting had been rearranged to October. Governors were due to take part in the Patient-Led Assessments of the Care Environment (PLACE) at locations across the Trust in October. LC stated she attended the Cheshire and Merseyside Governor Symposium in September, and this had been beneficial to share best practice among other Governors. The Board **NOTED** the report.	
11	**Committee Chairs Reports – Quality and Safety Committee** CB alerted members that the Committee had requested clarification on the proposed changes to its place in the emerging joint governance structures, and particularly its relation to IMB. CB noted an update would be received at the next meeting discussions around this took place at the September Board Away Day. CB also alerted members that Committee had been informed about the forthcoming CQC inspections commencing 16–18 September, separately for Urgent Treatment Centre and Eastham Walk In Centre. CB summarised the various “Advise” and “Assure” matters from the meeting on 10 September. The Board **NOTED** the report.	
12	**Questions from Governors and Public** No questions were raised.	
13	**Meeting Review**	

	No comments were raised.	
14	**Any other Business** No other business was discussed.	

(The meeting closed at 12:00)

Action Log
Board of Directors in Public
5 November 2025

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1	1 October 2025	8	To remove the rotation of resident doctors from the staff turnover chart	Debs Smith	Complete. Dashboard in Chief People Officer section of the Integrated Performance Board updated.	November 2025
2	1 October 2025	8	To provide further detail regarding the mitigation to address 4hr and 12hr breaches and C Diff	Hayley Kendall/Sam Westwell	Complete. 4hr and 12hr provided to Finance Business Performance Committee. The updated improvement plan following a review with ECIST will be provided to the next meeting. C Diff will be discussed at November Quality Committee.	November 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1	1 October 2025	8	To gather patient experience/quality outcomes post a GP Out-of-Hours Service interaction	Jo Chwalko	In progress. WCHC Deputy Chief Nurse progressing a Friends and Family Test analysis being used to inform development of specific Quality	December 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
					outcome measures. Update at Board in December.	
2	1 October 2025	8	To raise at the Wirral Provider Alliance meeting the ambition to create a one Wirral number telephony system for patients to access information by dialling one number	Jo Chwalko	To close. This will be discussed at Provider Collaborative Workshop on 17 November.	November 2025

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

Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
5 November 2025

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

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

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

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

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

1	**Narrative**
1.1	**Performance** Both Trusts continue to evolve the format of their respective IPRs in line with The Insightful Board guidance, and following the publication of the National Oversight Framework in September 2025, work is underway to include further detail on performance against the NOF metrics.

	Urgent and emergency care performance at WUTH remains challenged. Improvement work has been provided by ECIST with specific focus on 4 & 12 hour standards. Work continues with the system on financial turnaround initiatives, and internally, the Trust maintains a constant focus on cost improvement, productivity & efficiency to support the required year-end position. At WCHC operational performance remains strong in 4-hour performance for Walk-in Centres/Urgent Treatment Centre and Urgent Community Response Service performance. CICC occupancy continues to be above 90%. Waiting lists continue to improve in terms of volume and access times across all services and all key metrics for the 0-19 services across the four regional teams are performing above target. WCHC is ahead of financial plan at M6 and the focus on transformation and efficiency across services remains. Across both Trusts I would like to recognise this performance and acknowledge the efforts of staff who contribute to this strong position and support those in our care.
1.2	**Local News and Developments** **Joint Chair Update** Sir David Henshaw has been appointed as interim Chair of NHS Cheshire & Merseyside by NHS England and as such, he will be stepping away from his role as Joint Chair of WUTH and WCHC. Sir David will take over from Raj Jain who has served as Chair of NHS C&M since July 2022. Steve Igoe will take up position as Acting Joint Chair of both WUTH and WCHC, agreed with the Councils of Governors of both Trusts. The Boards of Directors of WUTH and WCHC and the Councils of Governors wish Sir David the very best as he leads NHS Cheshire & Merseyside into the next important phase of transformation and offer their unanimous support to Steve as he takes up the role of Acting Joint Chair. **CQC inspection of WUTH Medical Care and Urgent & Emergency Care Services** The CQC report following the unannounced inspection of Medical Care and Urgent & Emergency Care Services at Arrowe Park Hospital in May 2025, has been published with areas of good practice recognised by inspectors. We welcome the report as it helps us continue to make improvements in what is a challenging time for all NHS services. It is reassuring that inspectors recognised aspects of our services as ‘Good’ and highlighted how effective our services are. As with other Trusts, our Urgent and Emergency Care Services have faced very high levels of attendances throughout the year. We are close to completing our brand new Urgent and Emergency Care Facility which will greatly improve patient experience when it opens next year.

Our staff continue to work extremely hard to provide quality care for our patients and we have plans in place to ensure our staff feel supported as we head into a busy winter period.

Both services were given an overall rating of 'Requires Improvement'. The full report can be accessed on-line via the following link – Arrowe Park Hospital - Care Quality Commission

Critical Incident declared due to issue in Sterile Services

The Trust declared a Critical Incident on 21 October 2025 due to an issue in the Sterile Services Department affecting surgical instruments.

Patient safety is always the Trust's top priority and therefore we had to take the decision to pause elective activity. We had robust business continuity plans in place to manage the incident which included securing support from other Trusts to reduce the impact.

Better Together - Journey to Integration

Following the update provided in October 2025, we continue to make good progress with the integration of WUTH and WCHC.

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

The Integration Management Board continues to meet monthly and governance arrangements across both Trusts are currently under review to align where appropriate whilst supporting the process to become a single organisation. Following the support of the ICB on the next steps to integration, we are now proceeding to develop the Outline Business Case for the statutory transaction to bring the two Trusts together through a 'merger by acquisition'.

As part of our integration journey to become a single organisation, engagement with our staff, patients and key stakeholders within the system is progressing well. Phase one engagement involves several strategy focus group sessions and 1:1 conversations. To date, 43 of 89 Joint Strategy conversations have been completed. As part of the Joint Strategy engagement program a series of focus groups have been undertaken. To date there has been engagement with over 200 members of staff across both Trusts. Positive feedback has been received from all staff who have attended the sessions and conversations. Phase one engagement will be completed November 2025. The new Joint Trust strategy remains on plan for presentation to Board April 2026.

Annual Members' Meetings 2024-25

The WUTH and WCHC Annual Members' Meetings took place on 23 October. The meetings provided a highlight of the operational and financial performance across both Trusts for 2024-25 with looking ahead setting out the 2-year programme of integration between WUTH and WCHC.

Failure to Prevent Fraud

On 1st September 2025 a new fraud offence came into force. This is a corporate offence of *'failure to prevent fraud'*, which is part of the Economic Crime and Corporate Transparency Act 2023.

We have published a statement on-line on both Trusts public websites providing assurance that both organisations take their responsibilities very seriously and we have been working with our anti-fraud provider (MIAA) to ensure everyone knows their responsibilities in this area and that robust arrangements to prevent all forms of fraud, bribery and corruption are in place.

The WUTH statement can be accessed via the following link – Chief Executive statement on new 'Failure to Prevent Fraud' offence | Wirral University Hospital NHS Foundation Trust and WCHC via the following link – https://www.wchc.nhs.uk/about/compliance-commitments/failure-to-prevent-fraud-offence-and-other-financial-crimes-against-the-nhs/

Both Trusts take a rigorous, zero tolerance approach to those who commit any fraud, bribery or corruption offences against the NHS.

Cheshire and Merseyside Provider Collaborative (CMPC) Update

The Board met in October and discussed the need and opportunities that derive from developing an evidenced-based approach to provider action that is framed by what patients need and want and not dictated or shaped by NHS structures or institutions. Discussions included the potential to partner with suppliers in this space. Consideration would be given to system resource that could support development of this approach which was considered essential but equally the need for an aligned implementation plan on how services could or should be delivered in the most efficient, productive and safe way going forward.

The second half of the meeting focussed on discussion and agreement of the priorities for CMPC:

- Planned care
- Community and Patient Flow
- Blueprint
- Clinical Pathways / Fragile Services
- Efficiency at Scale including Corporate Services
- In year delivery

With subject matter leads also being identified for cancer, mental health and CYP.

The way the Leadership Board works with, connects and uses Trust leadership capacity was also discussed with the need for CEO link officers with the following groupings agreed:

- Chief Operating Officers
- Strategy Directors and Co Secs, Comms & Engagement
- Clinical forum – MDs / DONs
- Directors of Finance
- Chief Digital Officers
- Chief People Officers

	The Board also explored the current ask of providers and coordination of actions in respect of system recovery.
1.3	**National News and Developments** **Medium Term Planning Framework – delivering change together 2026/27 to 2028/29** NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published a Medium Term Planning Framework covering the financial years 2026/27 to 2028/29. Unlike most recent planning guidance covering only one year, this planning framework covers three years, following the three-year revenue and four-year capital spending review settlements published in the summer. First submissions are due 'before Christmas' and final submissions in February. The framework commits to more ambitious targets across cancer, urgent care, waiting times, access to primary and community care, mental health, and learning disabilities and autism, with an ambition to achieve constitutional standards by 2028/29 where possible. It also highlights financial and operating model reforms and forthcoming guidance. **Resident Doctors - 10-point plan and planned industrial action** I note the announcement of the planned industrial action by resident doctors across England from 14-19 November 2025 and we will be working to ensure our services can run as smoothly as possible during this time. I also acknowledge the work underway across the Trust to deliver against the resident doctors 10-point plan, published at the end of August 2025 and which will be formally incorporated into the new NHS Oversight Framework in due course. We are working hard to put plans in place against the 10-point plan including a Board Assurance Framework to provide oversight of this work at Board in December. **New NHS online hospital to give patients more control over their care** The NHS is setting up an ‘online hospital’ – NHS Online – in a significant reform to the way healthcare is delivered in England. The 10 Year Health Plan will shift the NHS from analogue to digital and this is a bold new way of delivering care while embracing new tech, built on NHS values. The innovative new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. The first patients will be able to use the service from 2027. That means patients can be seen faster, as teams triage them quickly through the NHS App and let them book in scans at times that suit them at Community Diagnostic Centres closer to home. When a patient has an appointment with their GP, they will have the option of being referred to the online hospital for their specialist care. They will then be able to book

	directly through the NHS App and have the ability to see specialists from around the country online without leaving their home or having to wait longer for a face-to-face appointment. **Independent maternity and neonatal investigation: terms of reference** On 23 June 2025 the Secretary of State for Health and Social Care announced a rapid, national, independent investigation into NHS maternity and neonatal services. Baroness Amos was appointed as Chair of the Independent Maternity and Neonatal Investigation on 14 August 2025. The investigation will look at individual services across the country alongside reviewing the maternity and neonatal system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care. Following the conclusion of the investigation Baroness Amos will deliver one clear set of national recommendations, with interim recommendations delivered in December 2025. The terms of reference are available here.
1.4	**WUTH Health and Safety** There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in September. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There was two Patient Safety Incident Investigations (PSII) opened in September under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance.
1.5	**Published Reports of Interest** The following are some reports recently published and of interest to members of the Board, staff and public. • **CQC warns lack of investment in community services threatens shift towards care outside hospital – and risks 'erosion' of care quality.** The health and social care system remains fragmented and under severe strain as it prepares for a major shift from hospital to community care, the Care Quality Commission (CQC) has warned in its annual State of Care report. • **Department of Health and Social Care – Health trends and variation in England, 2025.** This annual report provides an overview of the health of England's population, including trends over time and geographical variation. It looks at life expectancy and population change, mortality and morbidity, maternal and child health, risk factors and wider determinants, and screening and vaccination. https://www.gov.uk/government/publications/health-trends-and-variation-in-england-2025-a-chief-medical-officer-report • **Care Quality Commission – 2024 adult inpatient survey: statistical release.** The results of the latest annual survey of hospital inpatients reveal that patient

	satisfaction levels have improved slightly in the past year with a greater number of respondents rating their overall experience as nine or ten out of ten. However, the results still indicate that many aspects of inpatient care are worse than pre pandemic and show that waiting times and access to treatment are a continued frustration. Adult inpatient survey 2024 - Care Quality Commission • **UK Covid-19 Inquiry – Children and young people's voices: final report.** The UK Covid-19 Inquiry commissioned Verian to undertake this project to provide an insight of children and young people's experiences, and how they perceived the impact of the pandemic on them. This report recounts how children and young people experienced lockdown restrictions. While some found moments of closeness with family and friends, others faced new and difficult circumstances such as heightened tensions at home, disrupted education, and challenges with their physical and mental health**.** Children and Young People's Voices Research Project - UK Covid-19 Inquiry • **NHS Confederation – Delivering a neighbourhood health service: what the 10 Year Health Plan means for local integration.** The government's 10 Health Year Plan has put the establishment of a neighbourhood health service front and centre. This aims to deliver a model of care that is preventative and better supports those most in need, including those with long-term conditions who regularly come into contact with different health and care services. This long read examines the vision for a neighbourhood health service and examines what is needed to make neighbourhood working a success, looking at their features, merits and drawbacks. https://www.nhsconfed.org/long-reads/delivering-neighbourhood-health-service
1.6	**Communications and Engagement** **New MRI scanner brings more patient benefits** The new mobile MRI scanner, now located next to D Block at the rear of Arrowe Park Hospital, is bringing major improvements in patient access and service delivery. Relocated to the grass verge with a new corridor approach and lower floor level, the scanner now benefits from a shorter, wider access ramp. This design allows patients on trolleys to be scanned safely and comfortably, greatly improving access for all patients, regardless of their mobility. The enhanced layout also supports service continuity. Inpatient scans can continue even during planned or unplanned downtime of the static MRI scanner, avoiding the need to transfer patients to Clatterbridge. The new unit includes built-in washing facilities, strengthening infection prevention and control standards. As an added benefit, relocating the scanner has also released car parking spaces previously occupied by the old mobile unit. **Professor Brian Dolan OBE Keynote Speaker Event** Staff across WUTH and WCHC were invited to a special keynote event as part of WUTH's Deconditioning Improvement Programme, featuring Professor Brian Dolan OBE — international nursing leader, author, and founder of the global #EndPJParalysis movement.

Taking place on 17 October, the session titled “The TODAY Programme” explored the impact of deconditioning and the power of taking action today to improve patient outcomes. Professor Dolan shared insights from his renowned initiatives including #EndPJParalysis and #Last1000Days, which have transformed approaches to patient activity and recovery around the world.

Staff learnt how to:

- Tackle workplace culture and the ripple effects of inactivity
- Reflect on how personal actions influence patient care and safety; and
- Empower teams to drive sustainable improvement

Celebrating Allied Health Professionals Day 2025

On 14 October, staff across WUTH and WCHC celebrated Allied Health Professions (AHPs) Day, a national campaign recognising the invaluable contribution of the NHS’s third largest workforce.

Our Allied Health Professionals play a vital role in delivering high-quality care, supporting patients, service users and their families every day. Working alongside colleagues across the Trusts, AHPs help ensure people receive holistic care throughout every stage of life.

This year’s celebration is about recognising the diversity, expertise and value of AHPs, and appreciating the impact they make across all areas of care. The campaign will launched with a joint message from Sam Westwell, Chief Nurse at WUTH, and Paula Simpson, Chief Nurse at WCHC.

Red Card to Racism on Wear Red Day

On 17 October staff were asked to take a strong stand against racism by supporting Wear Red Day. With a zero tolerance approach to racism, staff marked their support for the campaign by giving racism the red card and wearing an item of red clothing.

Committed to ensuring the elimination of all forms of racism WUTH is signed up to the NHS North West Anti-Racism Framework and has achieved bronze status in the framework in recognition of its support. Staff are encouraged to speak up, identify, discuss and challenge racism.

WUTH have a Multicultural Staff Network and aim to celebrate the different cultures of staff across WUTH.

Speak Up Week and Wear Green Wednesday

Speak Up Week took place between 13-17 October and is a national campaign organised by the National Guardians Office which shines a spotlight on the importance of Freedom to Speak Up.

This year’s theme was ‘Follow Up in Action’, a reminder that speaking up is just the start. What truly matters is how we listen, respond, and take meaningful action. When colleagues see that their voices lead to real change, it builds trust and helps create a culture where everyone feels safe, valued, and supported.

	Joint Chief People Officer, Debs Smith, recorded a short video message to mark the week. In it, Debs talks about why following up is so important, and how listening, acting, and showing that feedback makes a difference are all key to building trust. As part of Speak Up Week staff were asked to take part in Wear Green Wednesday tomorrow Wednesday 15 October. **WCHC September Standout Winner** Nicola Volan, Wirral 0-19 Admin Lead was the September Standout winner. Nicola is an exceptional asset to the 0-19 service, consistently going above and beyond her role. She has independently created and maintains a complex staff rota, supports colleagues with systems like Mail Central, and manages the Wirral 0-19 admin team with professionalism and care. Nicola embodies trust values through her thoughtful, can-do attitude, always putting others first. Her dedication, positivity, and ability to create a welcoming team environment make her truly invaluable to the service. **WUTH Employee of the Month Winners** Kathy Bird, Catering Assistant was the September Support Services winner. Kathy has been recognised as an experienced, passionate and knowledgeable member of the catering team who cares deeply about her role and its impact on patient care. Amy Richardson, Speech and Language Therapist was the September Patient Care winner. Amy has been recognised for consistently going above and beyond to deliver exceptional care to her patients. Feedback from a patient's family described her as an example of outstanding clinical practice, demonstrating compassion, empathy and professionalism in every interaction.

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item 8**

05 November 2025

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

Executive Summary and Report Recommendations

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

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

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

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

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

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

NHS Oversight Framework (NOF)

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

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

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

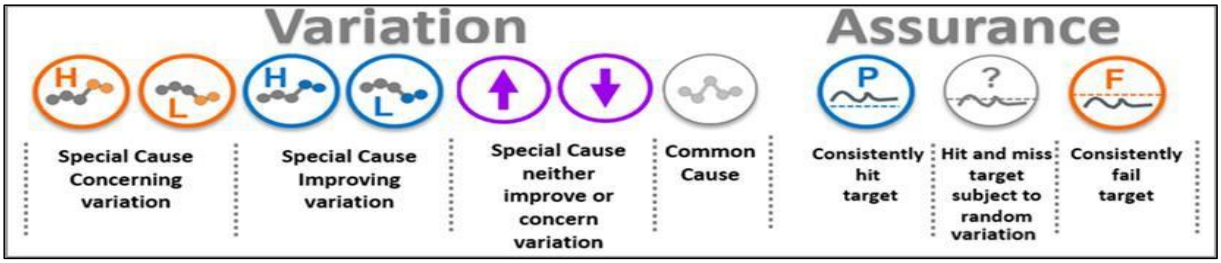
Key Risks
Strategic (Board Assurance Framework- BAF) and operational Risk and opportunities: The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the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

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

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

1	Narrative
1.1	Performance metrics for Workforce, Operations, Quality & Governance and Finance are grouped under the responsible Executive Director in the following report.

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

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

NHS

Wirral Community Health and Care

NHS Foundation Trust

Integrated Performance Report - September 2025

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

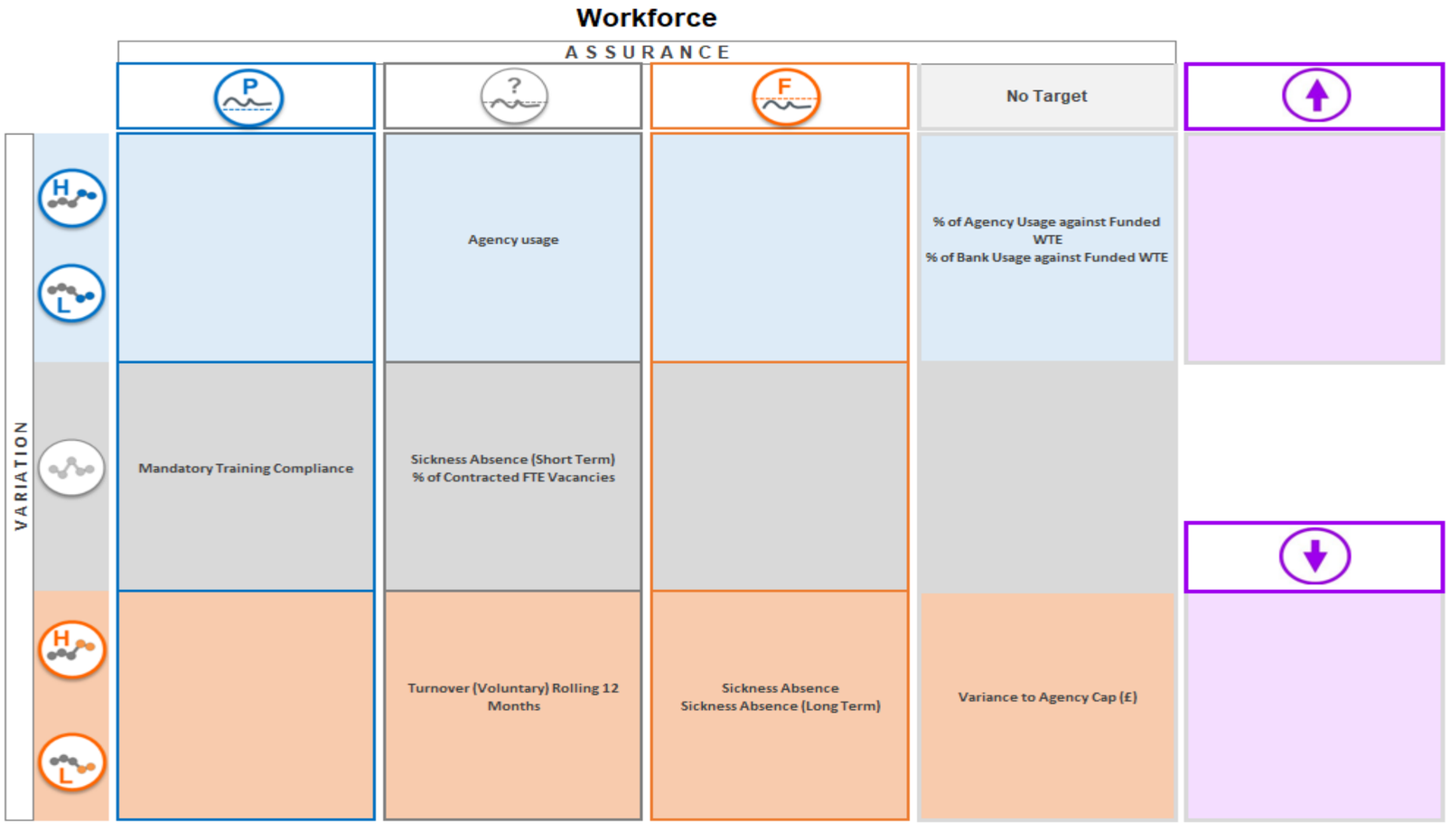
Voluntary Turnover remained steady at 9.7% (12-month average). September 24 was 9.3%. A continued gradual increase in turnover is likely in line with workforce plans to manage headcount reductions, vacancy scrutiny processes and the Trust's Mutually Agreed Resignation Scheme.

Mandatory training demonstrated a slight improvement in Sept to 94.7%. The trend is consistent and stable, and all localities are reporting over 90% target.

Agency expenditure has remained low in Sept at 0.1%. This is significantly below the regional 3.2% target. Greatest expenditure remains in Ophthalmology, GP Out of Hours, CICC, and Speech and Language.

Sickness absence levels continue to be above the Trust 5% tolerance. Sickness absence has been an area of concern for several months and latest performance is 7.4%. The Trust threshold of ≤5% was last achieved in August 2023. The absence challenges are driven mainly by long term sickness (5.7%). Short term sickness has risen to 1.7% and long-term sickness has decreased to 5.7%. Short term is within tolerance at 1.7% (0.1% increase), however long-term sickness remains the area of focus at 5.7%.

Workforce Domain Matrix



Workforce Summary

Highlights

Mandatory Training

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

Turnover

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

Agency Use

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

Bank Use

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

Areas of Concern

Sickness absence remains a cause for concern as it is above the target level at 7.4%.

The top 3 reasons remain:

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

Recorded RTW interview have improved slightly to 79% in Sept 25.

Localities with the highest sickness absence were Community Response (8.7%), Nursing (8.3%) and Specialist Medical (8.3%).

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

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

Forward Look (Actions)

Proactively supporting heath & wellbeing:

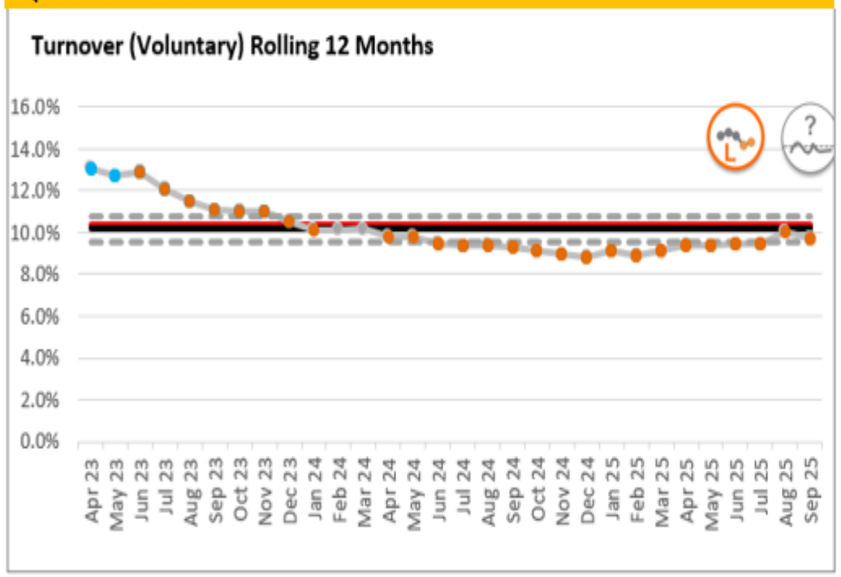
- New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - ‘Every Day Counts’.
- Delivery of the annual flu campaign to prevent increase in respiratory related absences.
- New Resilience through Change sessions led by WUTH’s psychotherapist.
- Mental Health First Aid Training– 2 new cohorts in September, 2 cohorts in October and 1 final cohort in November.
- Enhanced training for managers (preventing sickness absence through wellbeing conversations).
- New Road Map for Wellbeing showcasing all the support available to staff in one place.
- EAP uptake has increased from 8.8% to 10.4%.
- Active management of the PAM contract to deliver VfM and reduce wastage.

Managing Absence:

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

Turnover (Voluntary) – Rolling 12 Months

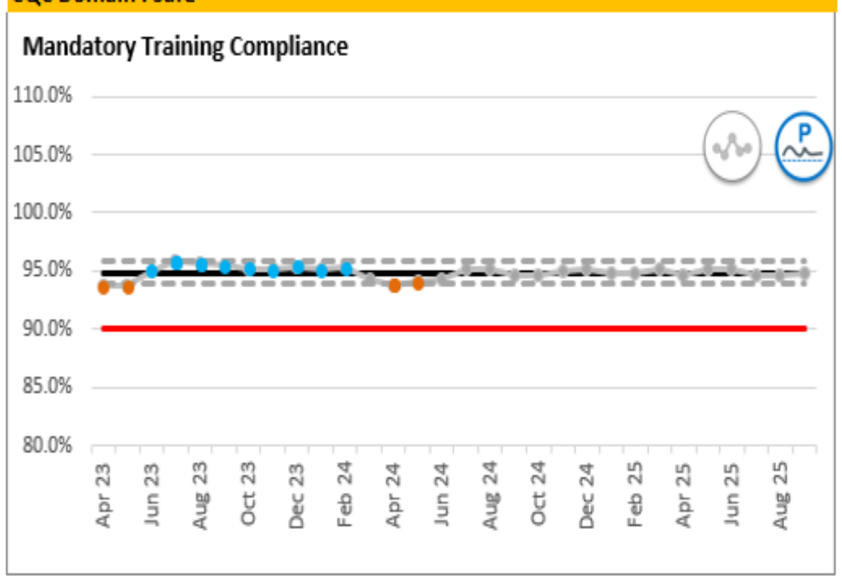
CQC Domain : Safe



Sep-25
9.7%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

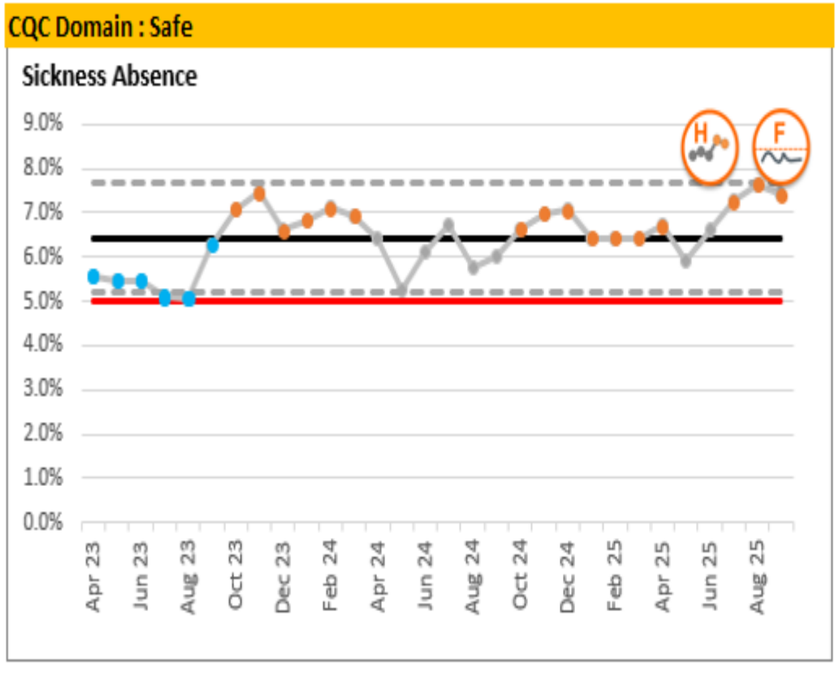
CQC Domain : Safe



Sep-25
94.7%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

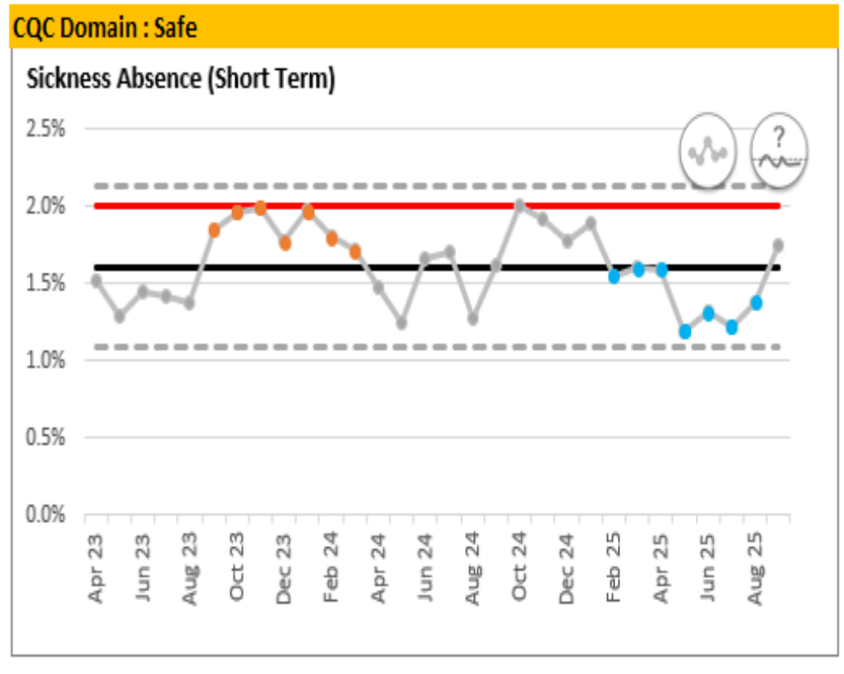
CQC Domain : Safe



Sep-25
7.4%
Variance Type
Special cause variation - Concerning
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

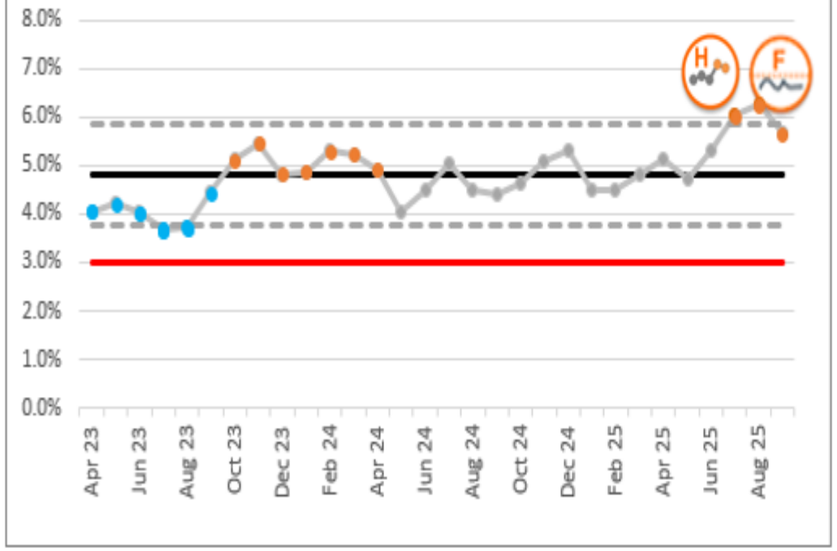
CQC Domain : Safe



Sep-25
1.7%
Variance Type
Common cause variation
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Sickness Absence (Long Term)

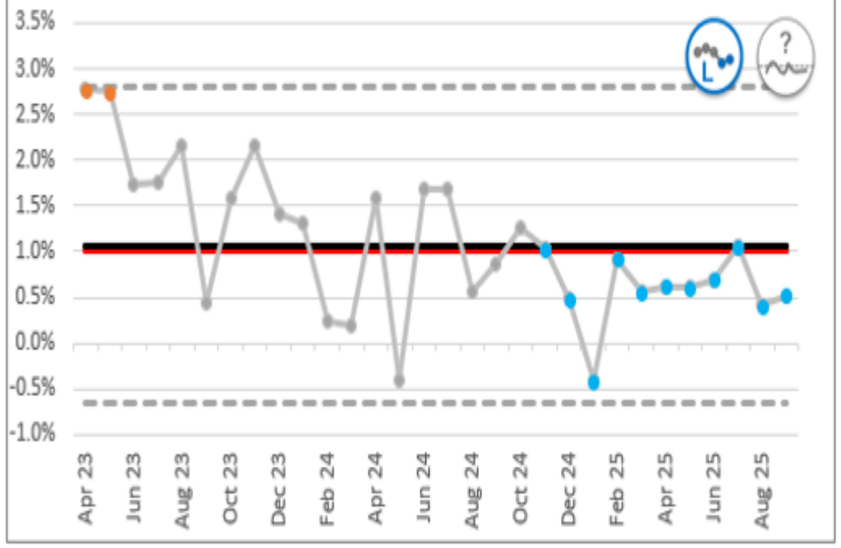
CQC Domain : Safe



Sep-25
5.7%
Variance Type
Special cause variation - Concerning
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

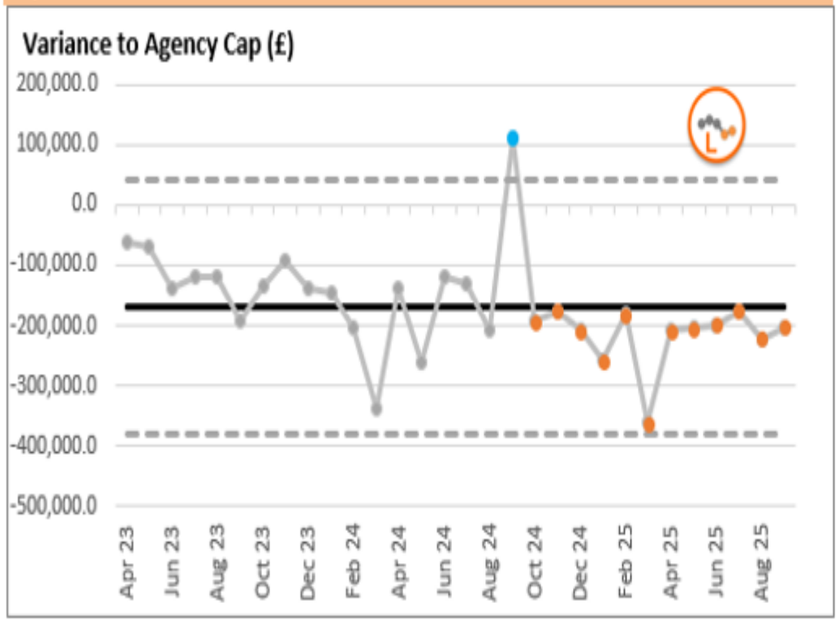
CQC Domain : Well-led



Sep-25
0.5%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

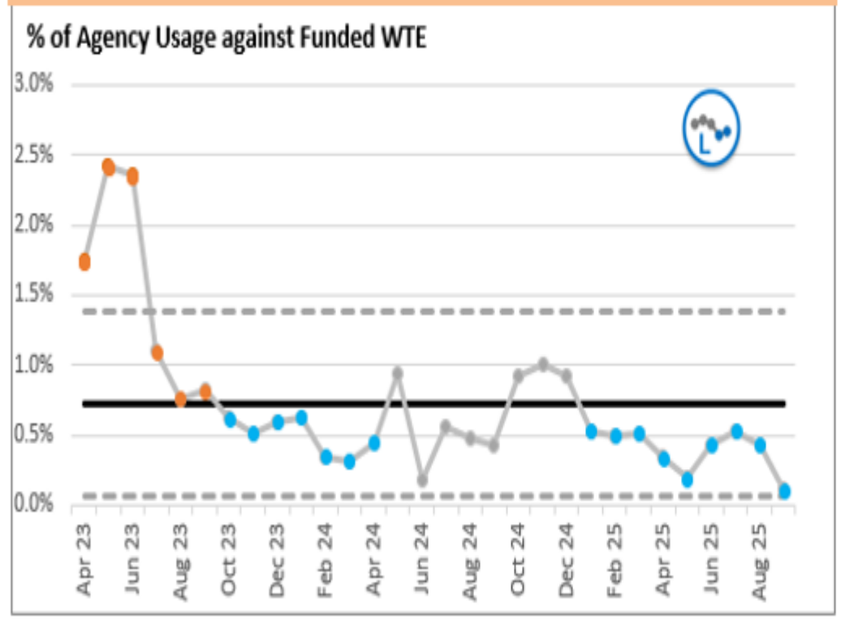
CQC Domain : Well-led



Sep-25
-£202,223.71
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

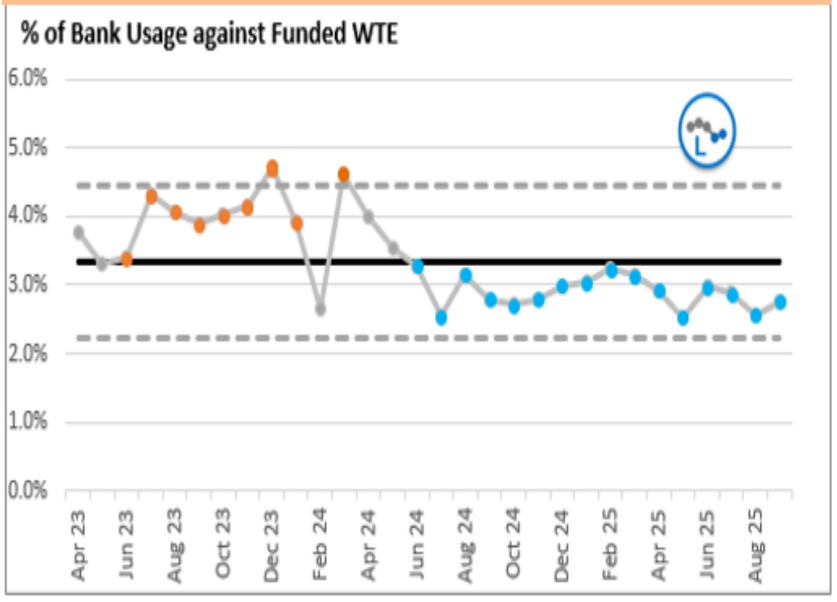
CQC Domain : Well-led



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

% of Bank Usage against Funded WTE

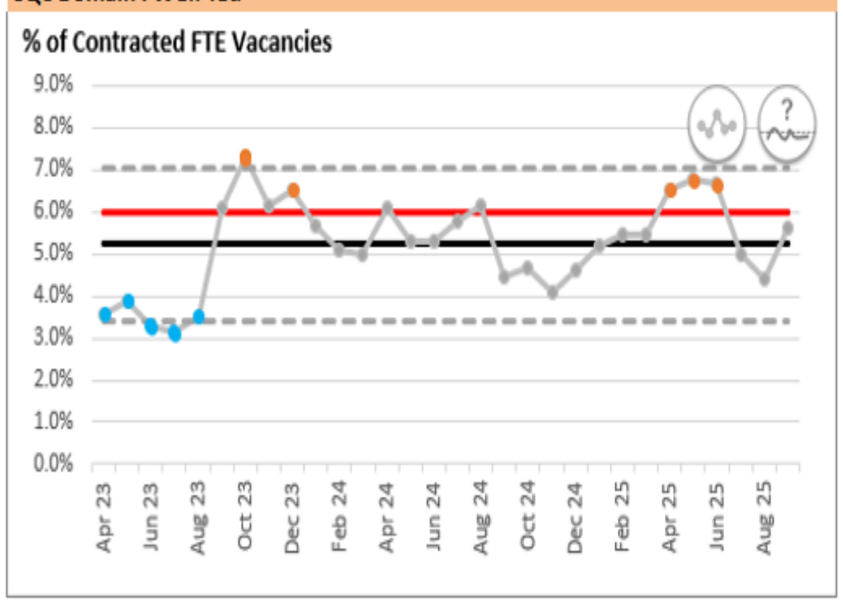
CQC Domain : Well-led



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

% of Contracted FTE Vacancies

CQC Domain : Well-led



Sep-25
5.6%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Dashboard	Operations
Lead	Chief Operating Officer

Chief Operating Officer Update

Operational performance remains strong. There are 91 operational KPIs reportable to commissioners and the position for M6 25-26 is:

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

Highlights:

- 0-19/25 services – all key metrics across the four regional teams performing above target
- UCR performance 88.6% against a 70% target and high volume of activity
- Intermediate care - CICC occupancy continues above 90% and length of stay remains at 16 days against a 21-day target
- GPOOH 30 min, 20 min, and 2 hr have improved performance in month.
- Waiting lists – RTT and DM01 100% and majority of non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times.

Areas for improvement:

- GPOOH metrics have improved. However, performance remains below expectations. Remedial action plans remain in place to support sustained performance improvements.

- Further workforce challenges impacting ability to sustain improvements in urgent care, Risk 3214. Plans include reviewing and improving the operational model through integration opportunities, recruitment into vacancies, reductions in sickness absence, daily huddles to support staff and identify learning opportunities.

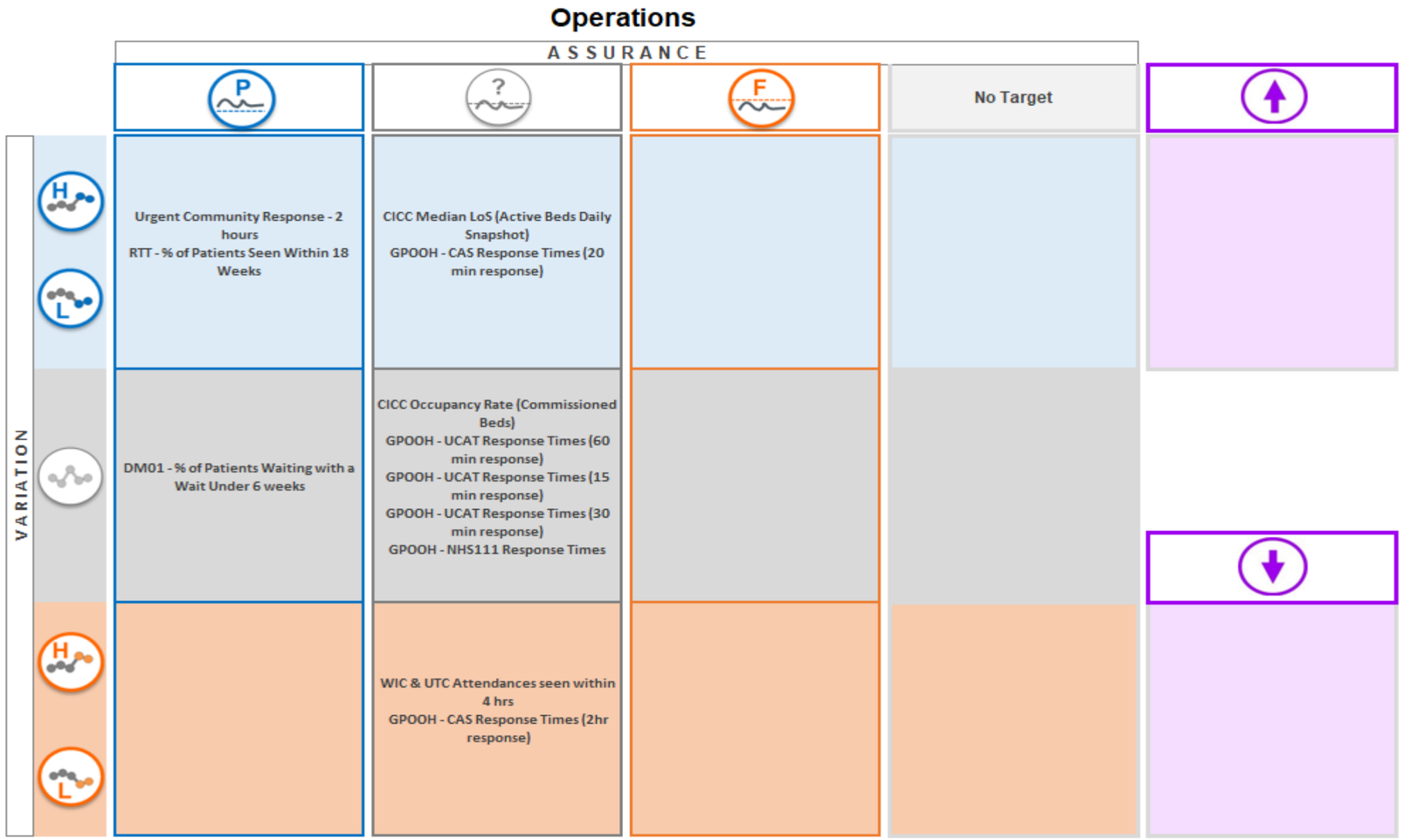
- Waiting lists: remedial action plans in place for Dental and Cardiology services.

  Dental waits are related to volume of patients awaiting paediatric exodontia (Risk 2769). There have been improvements in reducing the backlog and wait times since commencing the action plan in January 2025 with slight improvement in-month. However, achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH. Progress will be impacted by the current theatre challenges faced by WUTH. Internal and external meetings in place to monitor.

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

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

Operations Domain Matrix



Operations Summary

Highlights

- 0-19/25 services – all key metrics across the four regional teams performing above target
- 4-hour performance for WIC/UTC above 95% target in month, however further workforce challenges impacting ability to sustain improvements
- UCR performance 88.6% against a 70% target and high volume of activity
- Intermediate care - CICC occupancy continues above 90% and length of stay remains strong at 16 days against a 21-day target
- GPOOH 30 min, 20 min, and 2 hr have improved performance in month

Areas of Concern

- GPOOH performance
- Waiting lists: Dental, Cardiology
- UTC / WIC workforce

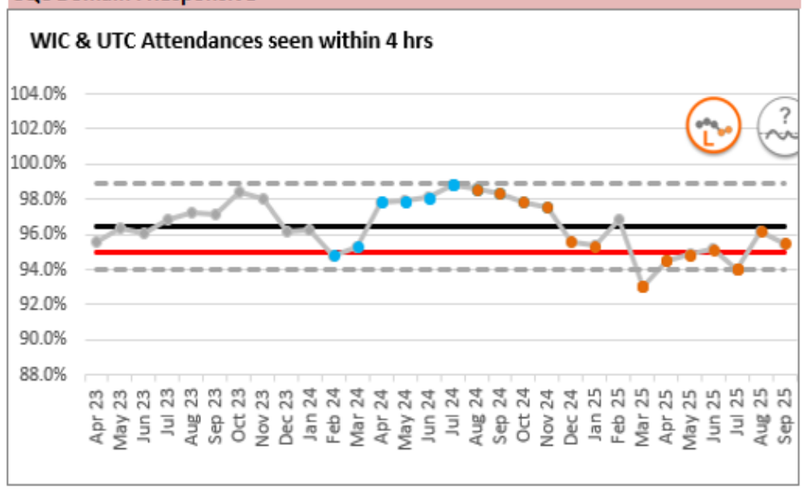
Forward Look (Actions)

- Remedial action plans are in place to support performance improvements for GPOOH and UTC
- Waiting lists: remedial action plans currently in place for Dental, Cardiology (detailed below).

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

WIC & UTC Attendances seen within 4 hrs

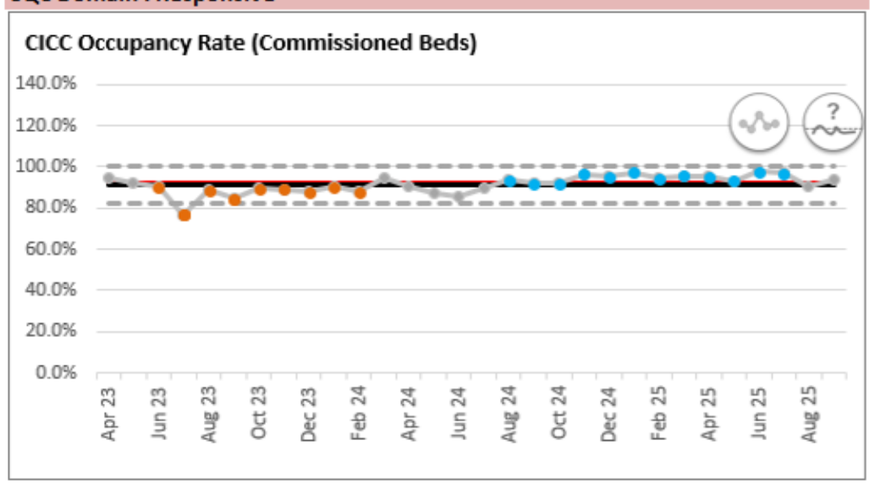
CQC Domain : Responsive



Sep-25
95.5%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CICC Occupancy Rate (Commissioned Beds)

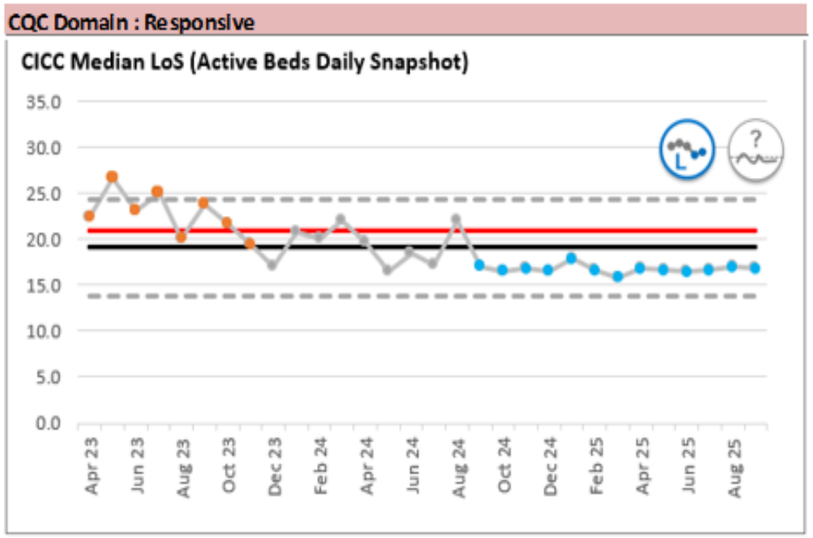
CQC Domain : Responsive



Sep-25
93.8%
Variance Type
Common cause variation
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

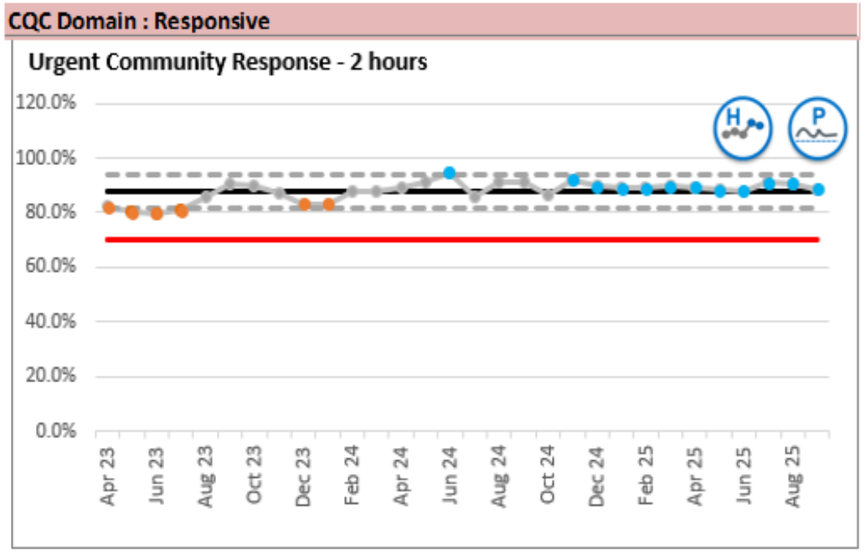
CQC Domain : Responsive



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

Urgent Community Response - 2 hours

CQC Domain : Responsive



Sep-25
88.6%
Variance Type
Special cause variation - Improving
Threshold
≥70%
Assurance
Consistanly hit target

Commentary

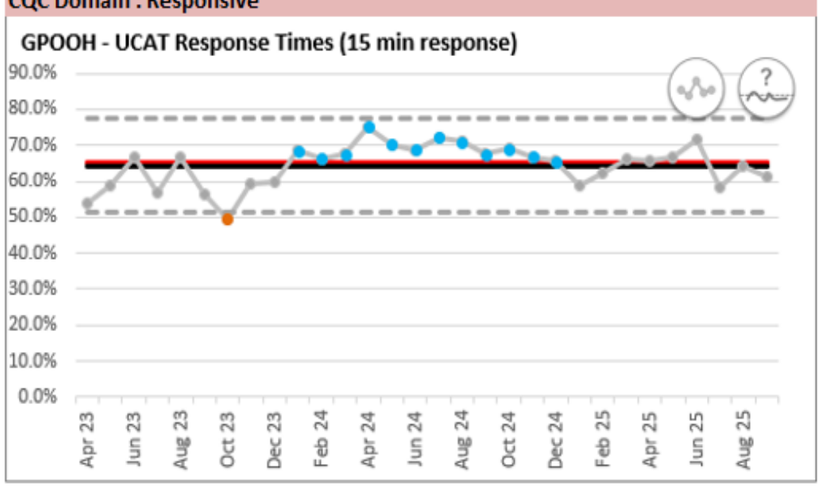
4-hour above the 95% target, however, continue with remedial action plans to sustain performance improvements. Significant workforce challenges (Risk ID: 3214, rated 16). Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration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

CICC achieving performance against targets, no concerns

UCR achieving performance against targets, no concerns

GPOOH - UCAT Response Times (15 min response)

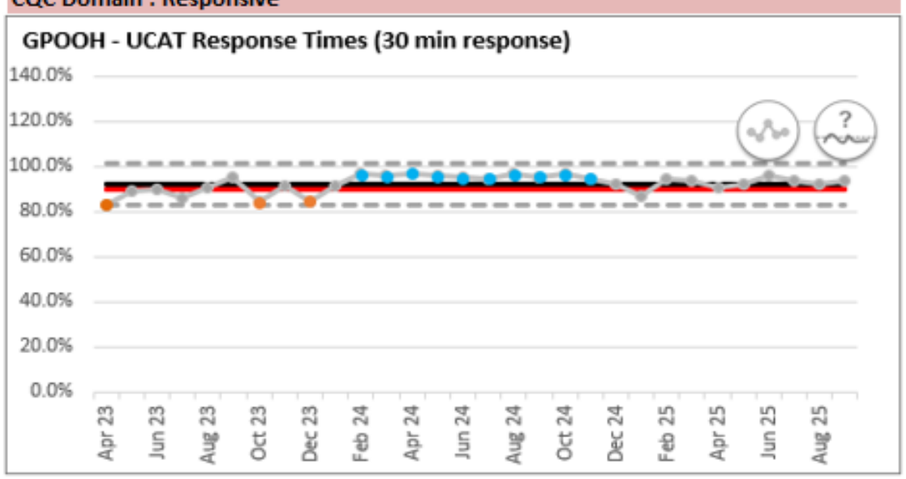
CQC Domain : Responsive



Sep-25
61.4%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

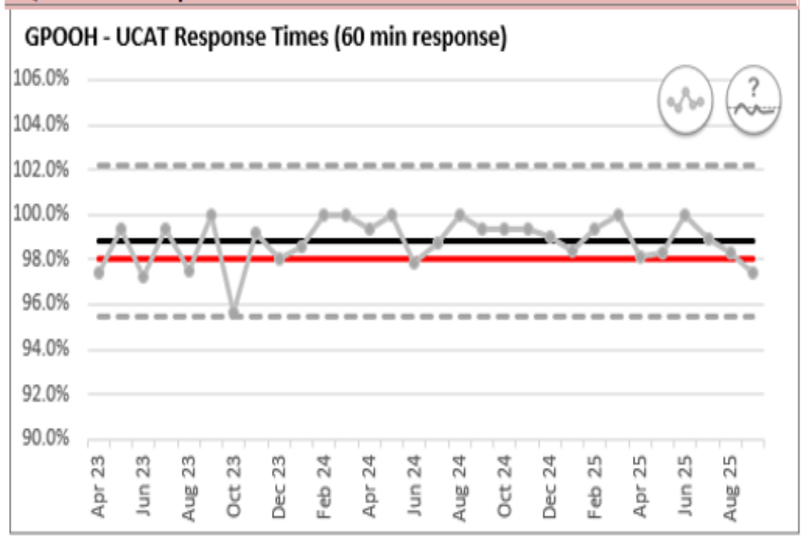
CQC Domain : Responsive



Sep-25
94.1%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

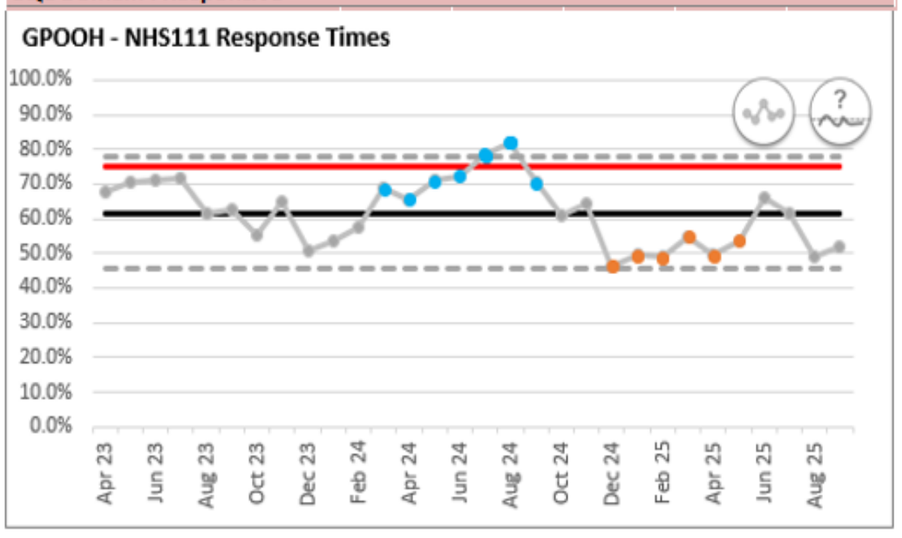
CQC Domain : Responsive



Sep-25
97.4%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive



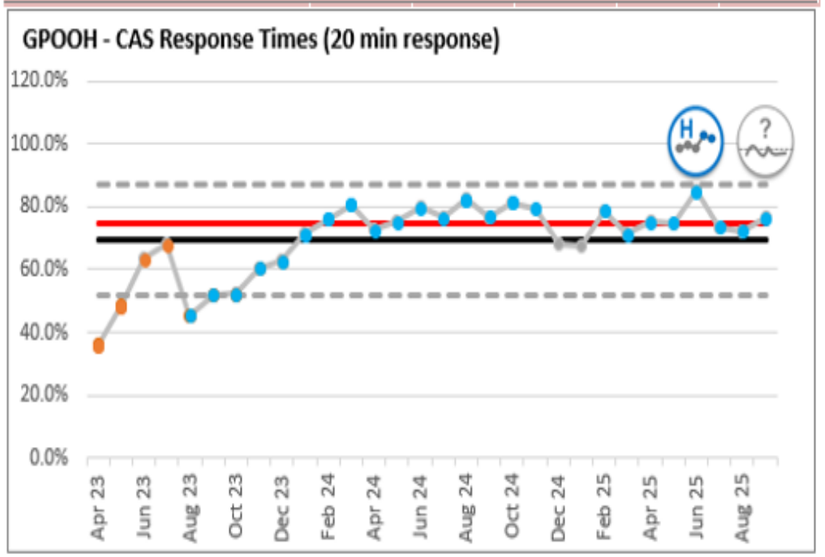
Sep-25
51.7%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

GPOOH CAS and 111 response times. UCAT 30- and 60-minute standards continue to be achieved. Performance against CAS 20 minutes, CAS 2 hours and NHS 111 have witnessed improvements in month but remain below target. Performance impacted by workforce challenges across urgent care and increased demand in some areas such as CAS 2-hour referrals. The risk is reflected on the operational risk register (ID 3227), with mitigation and action plans actively in place and progress monitored through daily oversight and monthly reporting.

GPOOH - CAS Response Times (20 min response)

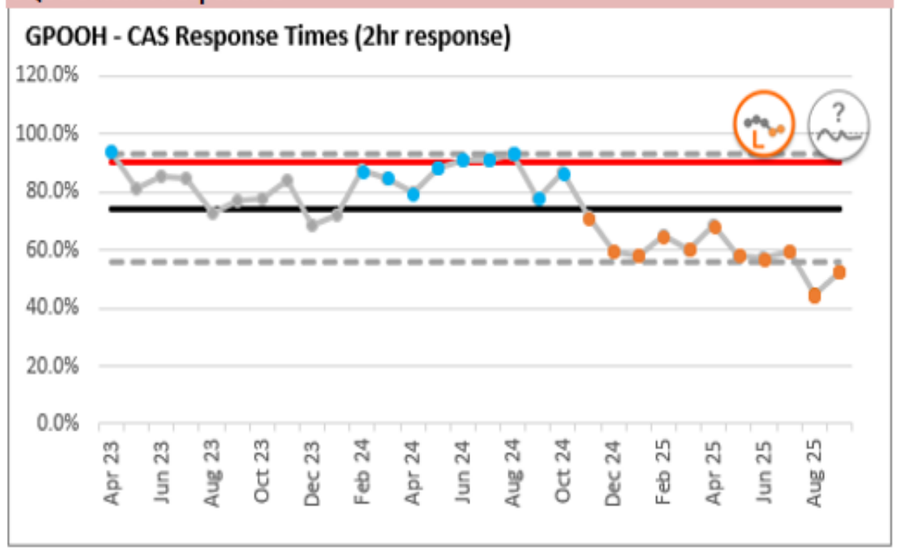
CQC Domain : Responsive



Sep-25
76.6%
Variance Type
Special Cause variation - Improving
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

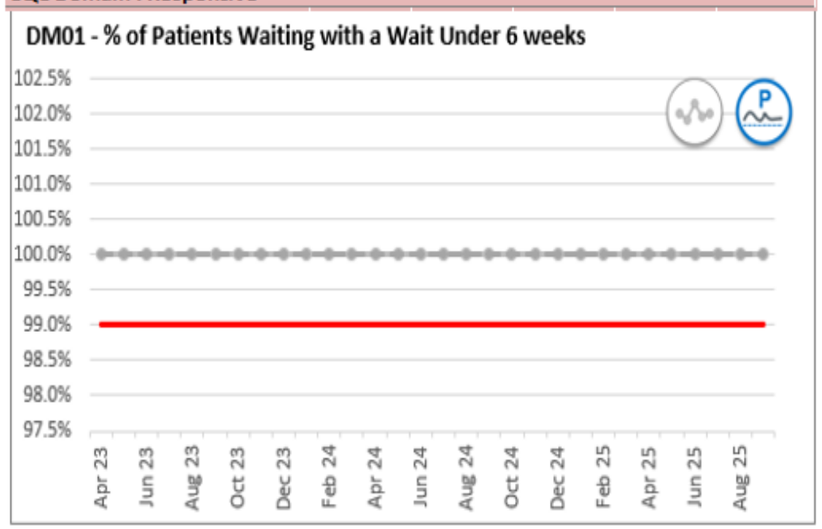
CQC Domain : Responsive



Sep-25
52.5%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

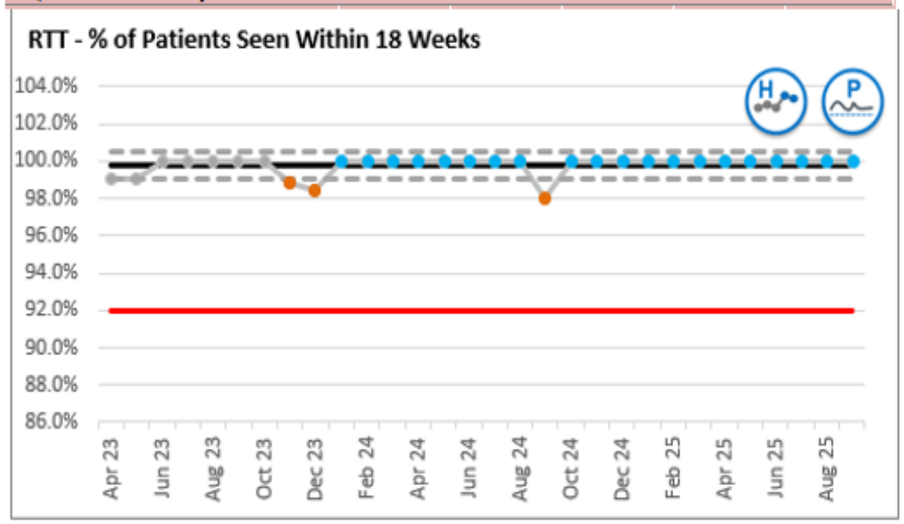
CQC Domain : Responsive



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

RTT- % of Patients seen within 18 Weeks

CQC Domain : Responsive



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

Commentary

DM01/RTT - 100% no concerns

Waiting Lists

Waiting list movement in Month - September 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	83% (9%)	97% (-2%)	100% (0%)	438 (-7)
Specialist Medical	94% (2%)	99% (0%)	100% (0%)	1338 (-391)
Specialist Medical - Dental	32% (6%)	54% (-4%)	73% (-6%)	166 (-19)
Therapies	56% (0%)	79% (-1%)	90% (2%)	4382 (-307)

0-19/25 Performance

0-19/25 Services - September 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	86.8%	88.7%	85.8%	87.5%	92.9%	93.5%	93.1%	94.6%
12 month reviews	91.1%	89.9%	89.0%	89.2%	95.4%	96.7%	94.7%	91.6%
2.5 year reviews	87.6%	88.3%	87.8%	88.7%	96.8%	94.7%	86.8%	90.1%
Breastfeeding 6-8 weeks	59.0%	57.0%	38.0%	38.0%	39.8%	39.7%	40.0%	44.8%

Commentary

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

Improvements have been made across all directorates with regards to volume of patients waiting.

Remedial action plans remain in place for Dental and Cardiology services. Dental waits are related to volume of patients awaiting paediatric exodontia (Risk 2769). Improvements in reducing the backlog and wait times since commencing the action plan in January 2025 with slight further improvement in-month. The recovery plan remains in place , with improvements continuing to be delivered through the action plan. Work is ongoing with WUTH to secure the additional theatre capacity required to ensure recovery milestones are achieved, however achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH. Progress will be impacted by the challenges WUTH face with current theatre access.

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

0-19/25 services. All key metrics across the four regional teams performing above target.

Dashboard	Quality and Governance
Lead	Chief Nurse

Chief Nurse Update

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

During the M6 reporting period, there have been no reported never events or StEIS reportable incidents.

Incident reporting is an effective measure of safety culture across an organisation. The M6 data demonstrates a reduction in incident reporting reaching a point of concerning special cause variation. A reduction in patient safety incident reporting is also evident, however, this remains within common cause variation and has progressed to further review through the Trust's governance framework. This is to identify learning opportunities which recognises the importance of developing a proactive and positive culture of safety. This is aligned to the principles of the Patient Safety Incident Response Framework.

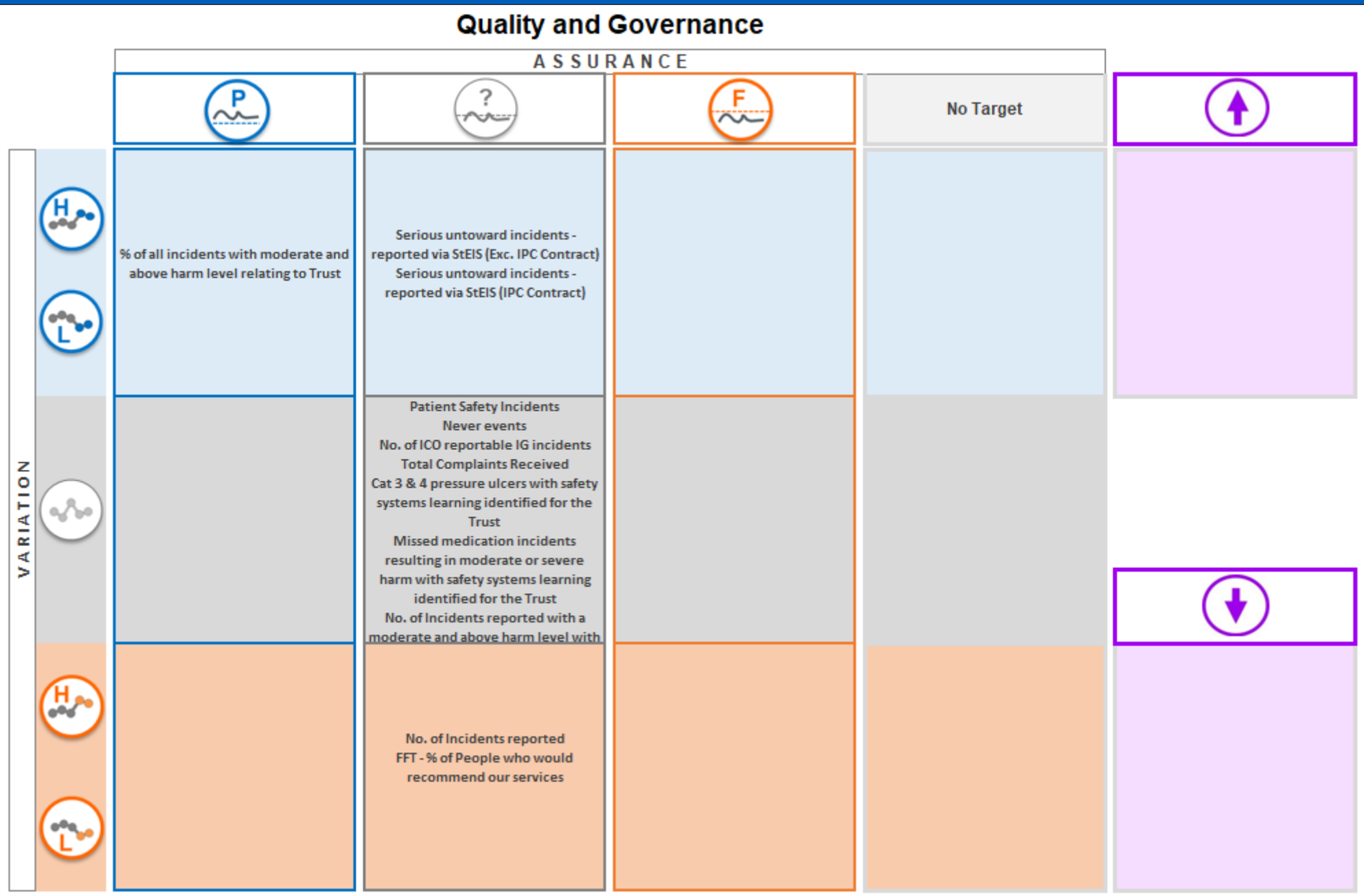
In accordance with the Patient Safety Incident Response Framework (PSIRF) the Trust monitors all patient safety incidents, including those resulting in no or low harm. During M6, 95.4% of patient safety incidents reported were no or low harm incidents.

During the M6 reporting period, there have been zero falls at CICC resulting in moderate harm, zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning for the Trust. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained. These clinical quality metrics continue to be prioritised and have been incorporated into the refresh of the Trust's 2025/26 Patient safety incident response plan.

There has been a reduction in the Friends and Family Test (FFT) score during M6 evidencing special cause variation, with 86.1% of people recommending Trust services, based on 2,025 positive responses. A reduction in FFT score had been identified during the previous reporting month, with performance being -2 standard deviations from the mean. Further analysis has highlighted that there has been an increase in the number of FFT responses utilising the 'don't know' option, this is supporting targeted quality improvement. Individual service feedback has been escalated to locality SAFE/OPG meetings to conduct a further deep dive to identify areas of improvement based on learning from experiences of care.

One complaint has been received by the Trust in M6 and the number of concerns received has reduced to 12, which is within normal variation and reporting a green RAG rated position. A robust governance framework remains embedded across Trust services to evidence the effective management of all complaints and concerns, supporting the identification of learning to continuously improve the quality of care delivered. Complaints are tracked via the Clinical Risk Management Group, reporting to the SAFE Operational Group, and reporting by exception to the Integrated Performance Board and Quality and Safety Committee.

Quality and Governance Domain Matrix

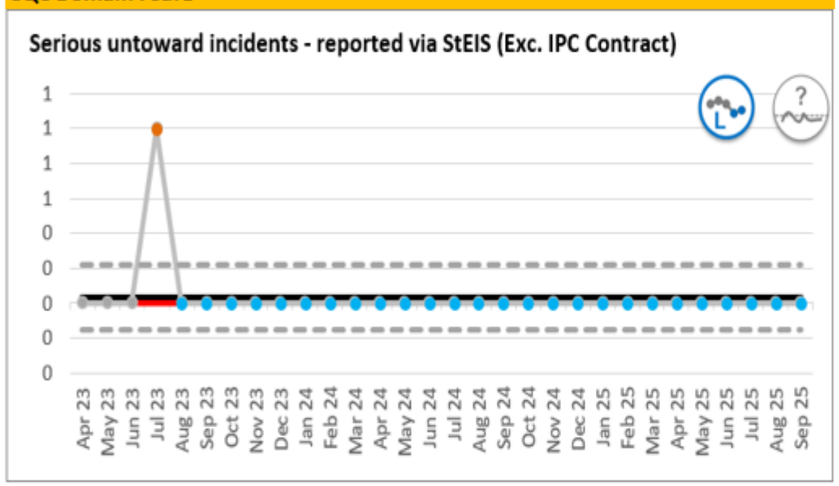


Quality and Governance Summary

The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust governance framework.	M6 data demonstrates a reduction in incident reporting reaching a point of concerning special cause variation; further review through the Trust's governance framework is in progress. There has also been a reduction in the Friends and Family Test (FFT) score during M6 evidencing special cause variation, with 86.1% of people recommending Trust services, based on 2,025 positive responses. Individual service feedback has been escalated to locality SAFE/OPG meetings to conduct a further deep dive to identify areas of improvement based on learning from experiences of care.	Clinical Risk Management Group continue to track improvement plans relating to falls prevention on inpatient units, safe administration of medications, wound care management and end of life improvements. A new plan was added during 2025/26 for monitoring indwelling urinary catheter devices. All plans have demonstrated improvements in Trust wide safety systems and their consistent application.

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

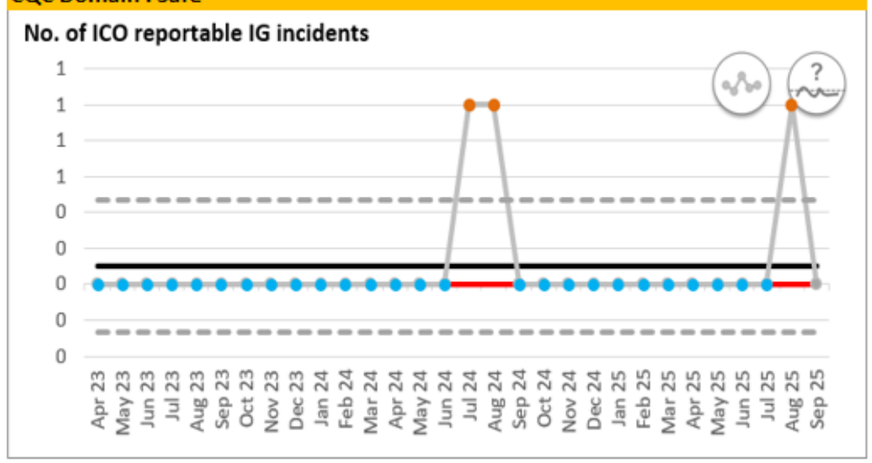
CQC Domain : Safe



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

No. of ICO reportable IG incidents

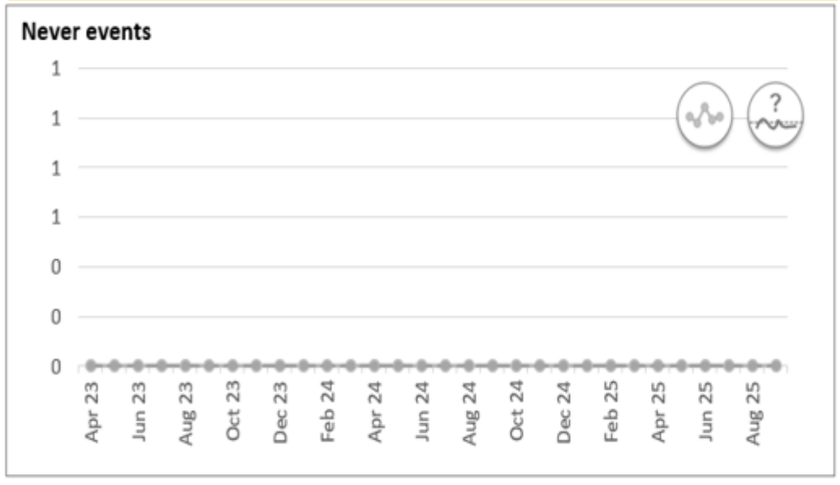
CQC Domain : Safe



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

Never events

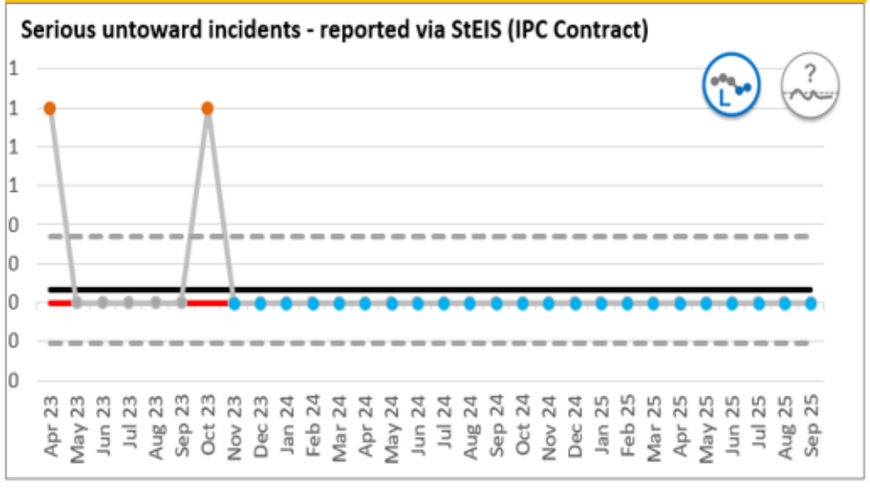
CQC Domain : Safe



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

Serious untoward incidents – reported via StEIS (IPC Contract)

CQC Domain : Safe



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

Commentary

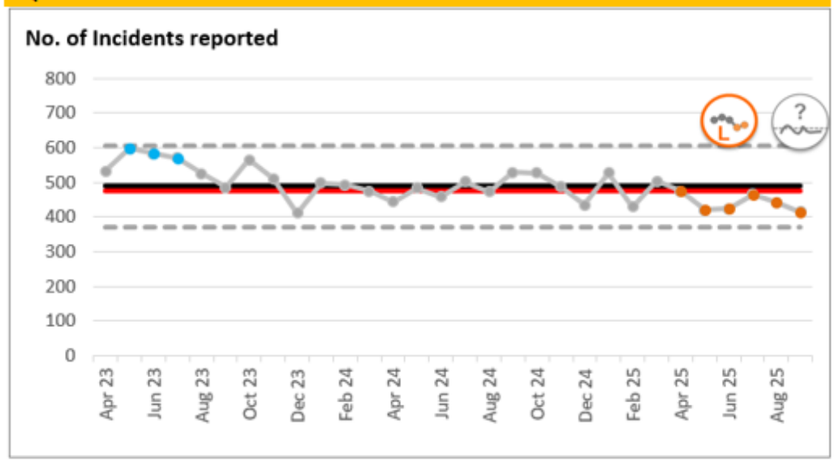
The above indicators all have tolerances of zero.

During the M6 reporting period, there have been no reported incidents relating to any of these indicators.

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

Number of Incidents reported

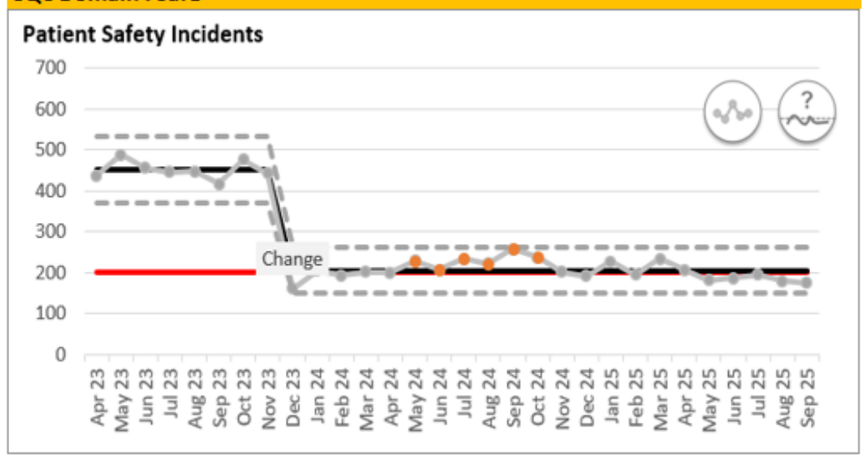
CQC Domain : Safe



Sep-25
415
Variance Type
Special cause variation - Concerning
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

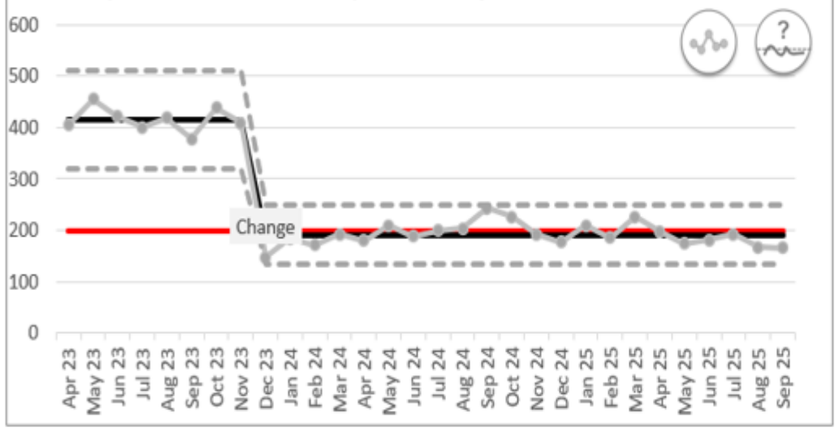
CQC Domain : Safe



Sep-25
174
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

No. of reported no and low harm patient safety incidents

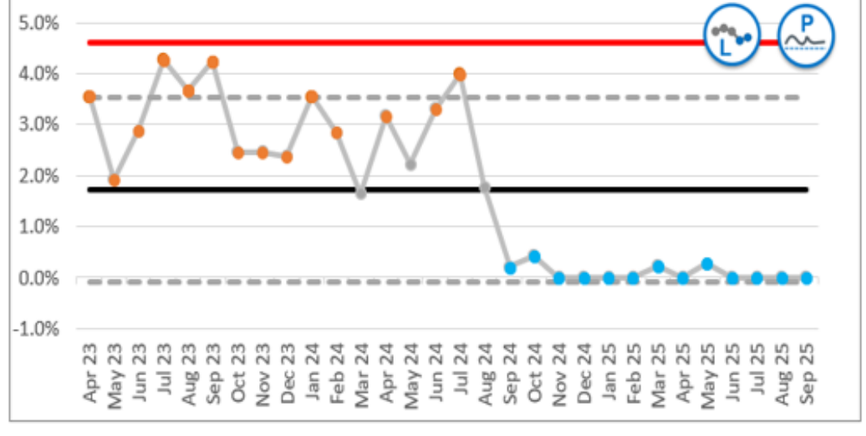
CQC Domain : Safe



Sep-25
166
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Responsive



Sep-25
0.0%
Variance Type
Special cause variation - Improving
Threshold
2.2%
Assurance
Consistently hit target

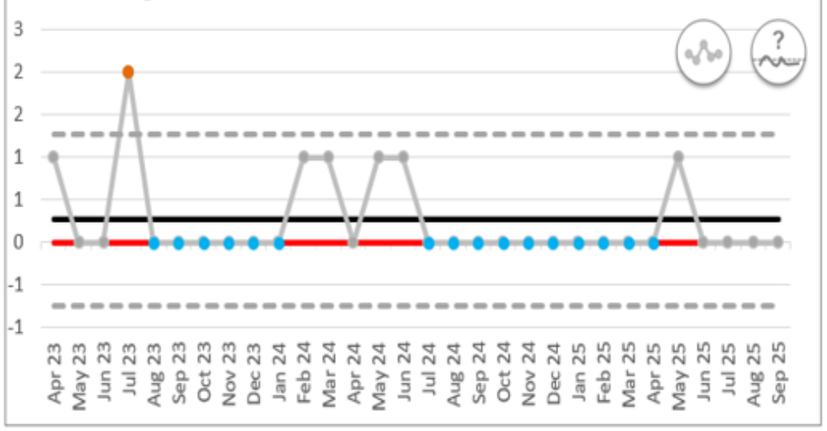
Commentary

Incident reporting is an effective measure of safety culture across an organisation. The M6 data demonstrates an in-month reduction in incident reporting reaching a point of concerning special cause variation. A reduction in patient safety incident reporting is also evident, however this remains within common cause variation. Despite the identified reduction in reporting, both quality indicators remain green RAG rated, and are subject to further review through the Trust's governance framework. This is to identify learning opportunities which recognises the importance of developing a proactive and positive culture of safety. This is aligned to the principles of the Patient Safety Incident Response Framework.

The number of low and no harm incidents remains within common cause variation and represents 95.4% of patient safety incidents reported during M6.

Falls resulting in moderate or above harm

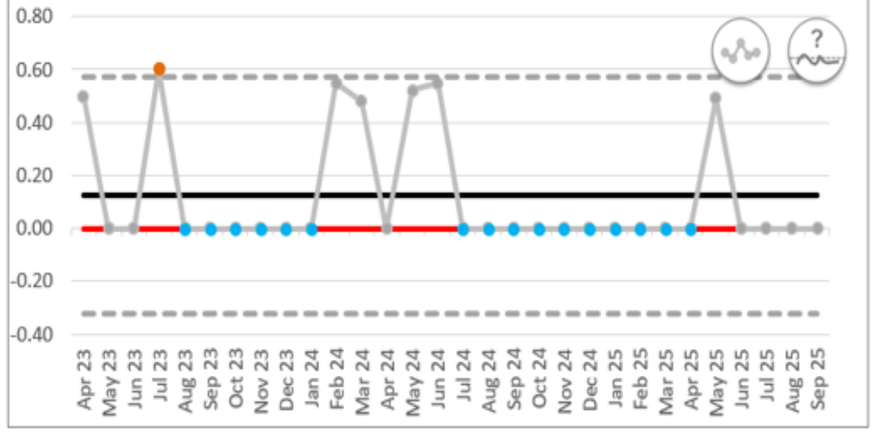
CQC Domain : Safe



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

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

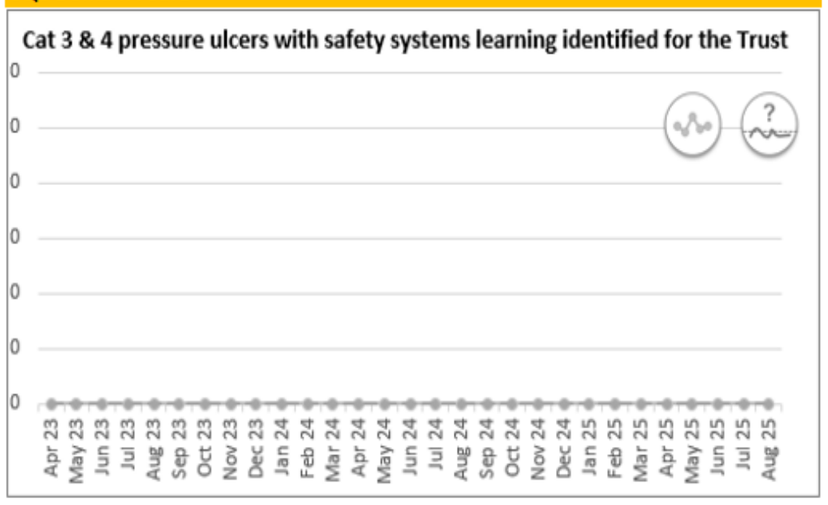
CQC Domain : Safe



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

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

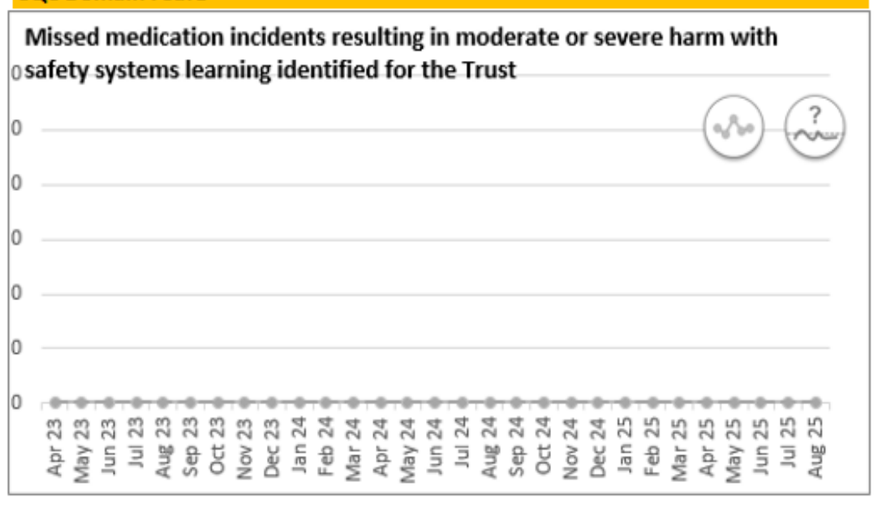
CQC Domain : Safe



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

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

CQC Domain : Safe



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

Commentary

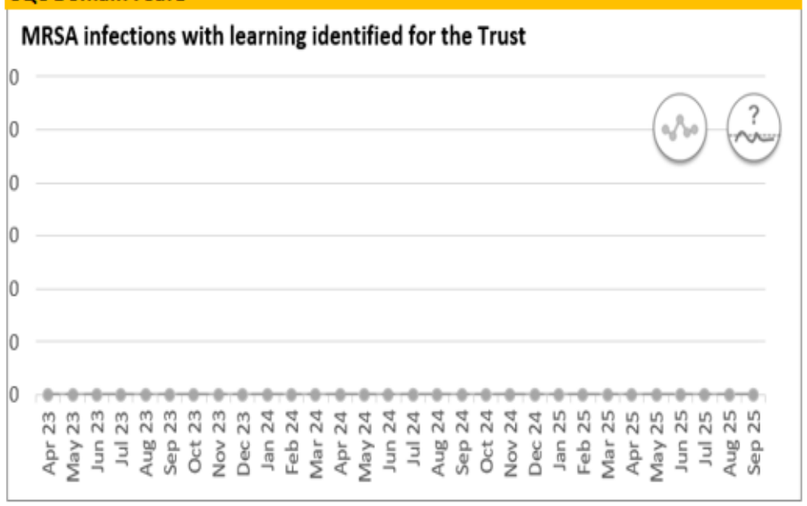
In accordance with the Patient Safety Incident Response Framework the Trust has embedded a robust governance structure to identify safety systems learning for all moderate and above harm incidents.

During the M6 reporting period, there have been zero falls at CICC resulting in moderate harm; the year to-date position is one moderate harm fall. There have been zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning identified for the Trust during the reporting period. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained.

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

MRSA infections with learning identified for the Trust

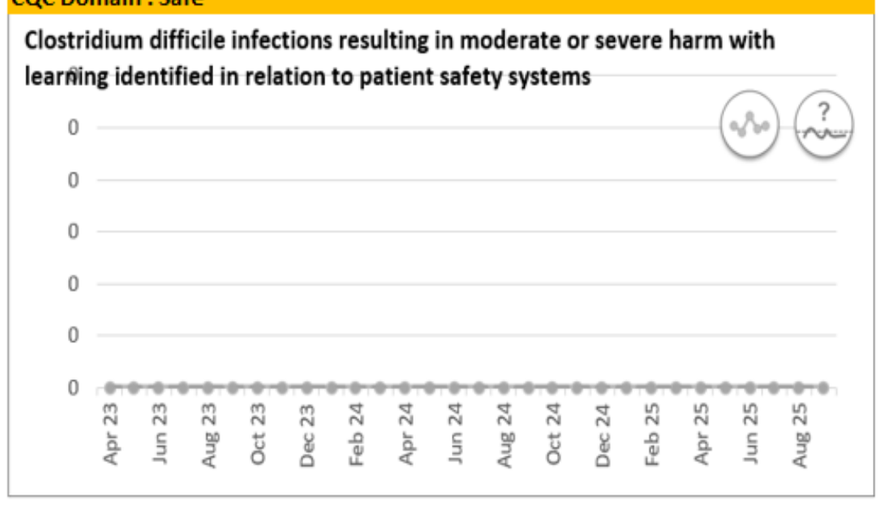
CQC Domain : Safe



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

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

CQC Domain : Safe



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

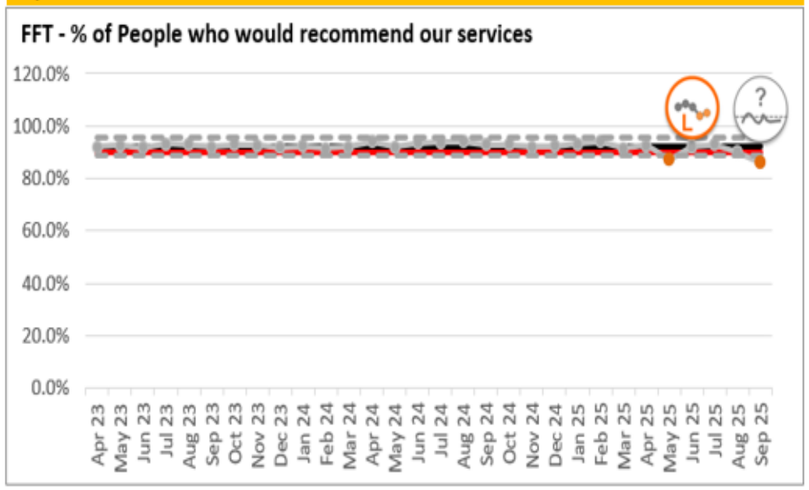
Commentary

During M6, there have been no incidents of MRSA or CDiff resulting in moderate or severe harm with learning identified in relation to patient safety systems.

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

FFT - % of People who would recommend our services

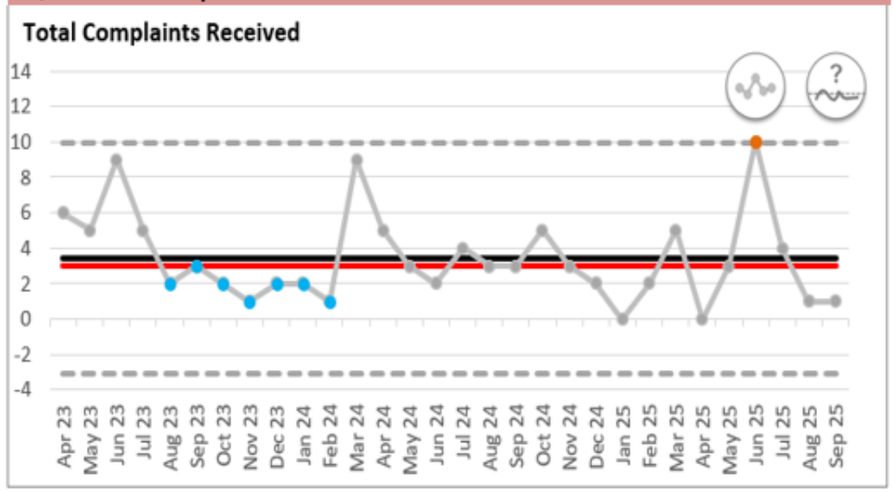
CQC Domain : Safe



Sep-25
86.1%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Total Complaints Received

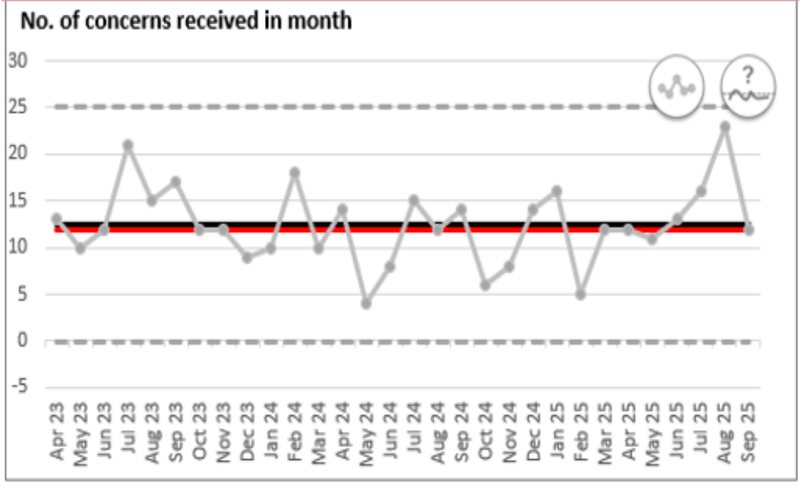
CQC Domain : Responsive



Sep-25
1
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month

CQC Domain : Responsive



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

Commentary

There has been a reduction in the Friends and Family Test (FFT) score during M6 evidencing special cause variation, with 86.1% of people recommending Trust services, based on 2,025 positive responses. A reduction in FFT score had been identified during the previous reporting month, with performance being -2 standard deviations from the mean. Further analysis has highlighted that there has been an increase in the number of FFT responses utilising the ‘don’t know’ option, this is supporting targeted quality improvement. Individual service feedback has been escalated to locality SAFE/OPG meetings to conduct a further deep dive to identify areas of improvement based on learning from experiences of care.

One complaint has been received by the Trust in M6 and the number of concerns received has reduced to 12, which is within normal variation and reporting a green RAG rated position. A robust governance framework remains embedded across Trust services to evidence the effective management of all complaints and concerns, supporting the identification of learning to continuously improve the quality of care delivered. Complaints are robustly tracked via the Clinical Risk Management Group, reporting to the SAFE Operational Group, and reporting by exception to the Integrated Performance Board and Quality and Safety Committee.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of September, the Trust is reporting a surplus of £0.7m. This is an improvement on plan for M5 but there is no change to the projected year end surplus of £0.9m.
At M6 the Trust has transacted £5.06m of CIP in year, all full year effect, against its revised target of £6.6m.

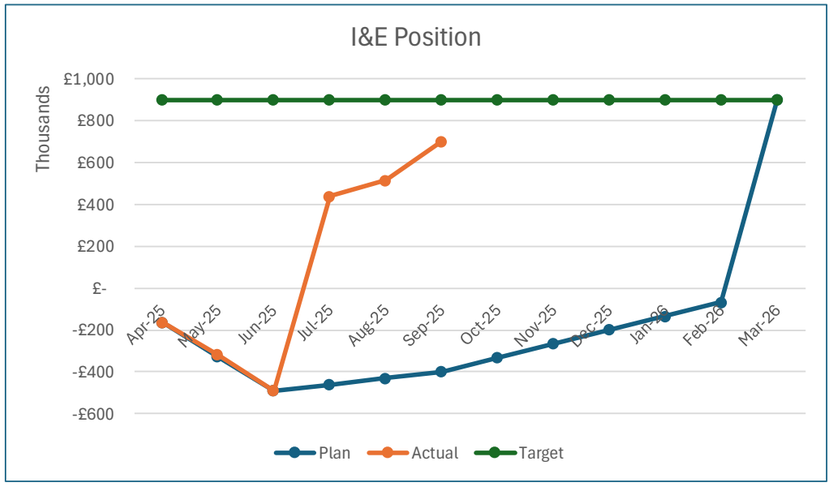
Finance Domain Matrix

Statutory Financial Targets	RAG (M6)	RAG (Forecast)
Financial stability	🟢	🟢
Agency spend	🟢	🟢
Financial sustainability	🟢	🟢
Financial Efficiency	🟡	🟢
Capital	🟡	🟢
Cash	🟡	🟢

Finance Summary

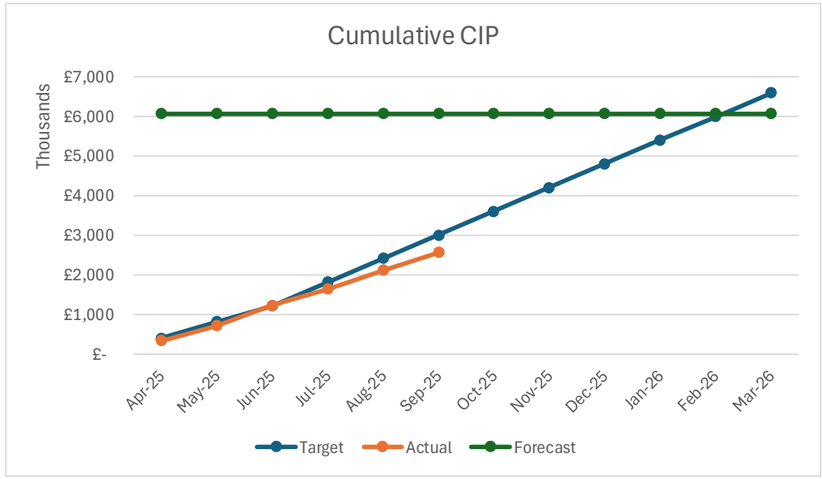
Highlights	Areas of Concern	Forward Look (Actions)
The Trust is ahead of plan at M6. Overspends in non-pay are fully mitigated by underspends on staff costs.	The key risks facing the Trust remain the negotiations around the 0-19 service and the CIP stretch target.	The Trust continues to look at identify additional CIP schemes.

I&E Position



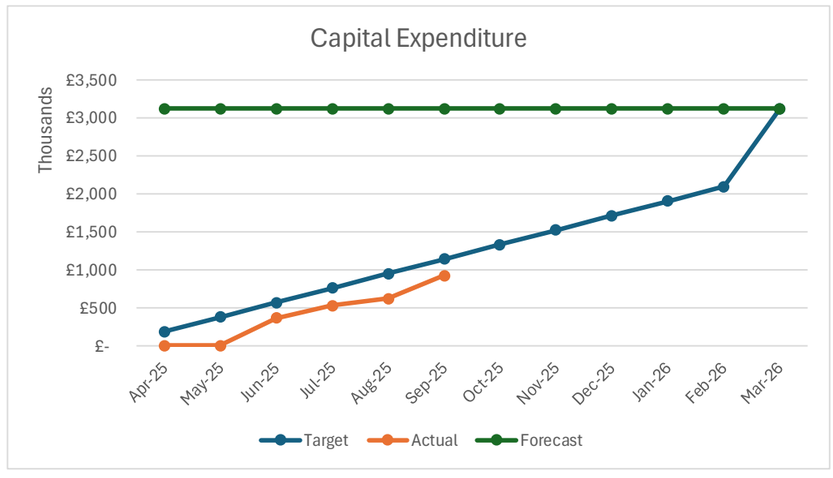
Sep-25
£703k
Variance
Position better plan
Target
£900k

Cumulative CIP



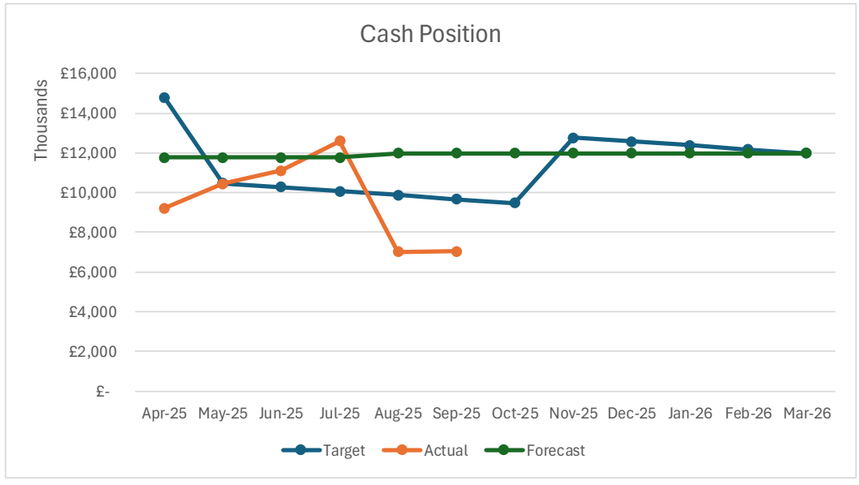
Sep-25
£2,567k
Variance
Position worse than plan
Target
£3,011k

Capital Expenditure



01/09/2025
£924k
Variance
Position worse than plan
Target
£1,142k

Cash Position



Sep-25
£7,011k
Variance
Position worse than plan
Target
£9,671k

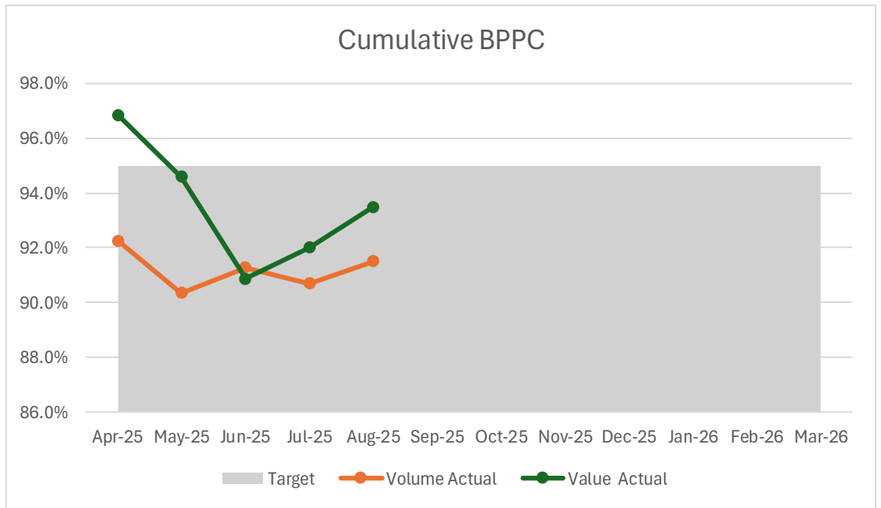
Commentary

The Trust is ahead of plan at M6. Non-pay costs are overspent due to pressures in respect of premises costs and purchase of healthcare. However, this is fully mitigated by underspends on pay driven by vacancies across the Trust.

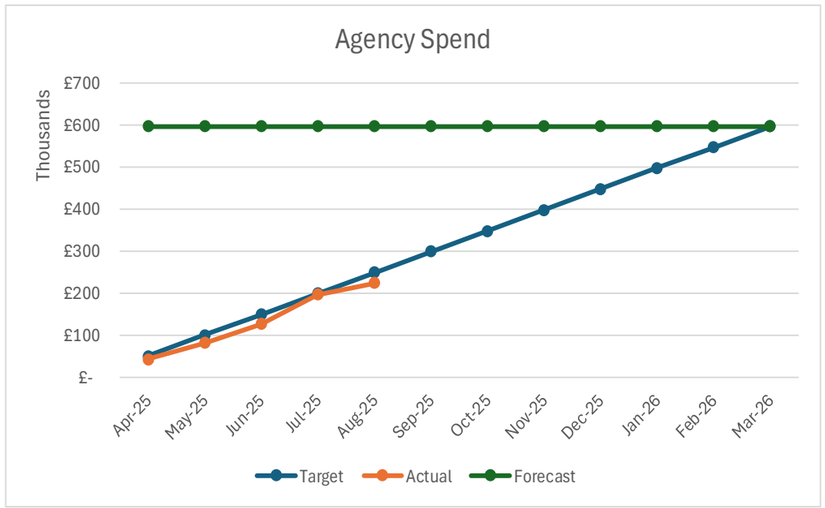
CIP transacted at M6 is £2.567m which is £0.445m behind plan.

The cash balance is lower than plan at M6 due to a contractual payment being made to Wirral University Teaching Hospital NHS FT. This will be repaid in October, and the cash balance should return to normal levels. The underlying increase in cash is linked to staff vacancies and the increase in creditors and corresponding underperformance on BPPC to date.

Cumulative BPPC



Agency Spend



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

Commentary

At Month 6 the Trust is 3.5% (volume) and 1.5% (value) behind target. The number of invoices on hold continues to create a problem and this underperformance is reflected in the increase in the creditor position.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

05 November 2025

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

Executive Summary and Report Recommendations

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

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

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

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

Domain	Achieving	Not Achieving	No Target	Total
Workforce	**2**	**2**	**-**	**4**
Operations	**2**	**15**	**1**	**18**
Quality and Safety	**8**	**12**	**4**	**24**

All Metrics For latest available data, where agreed targets have been defined, 16 metrics were achieving the agreed target and 34 were not achieving target.
N.B. There are 7 metrics without target at present.

It is recommended that the Board:

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

Key Risks

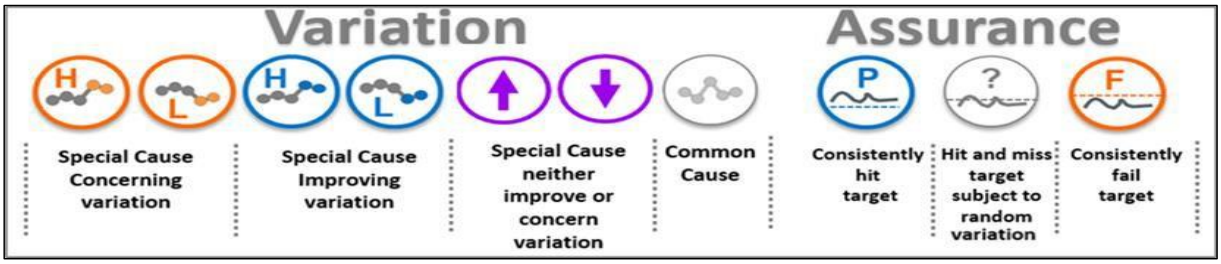
This report relates to the key risks of:

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

Sustainable use of NHS resources	Yes

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

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

3	**General guidance and Statistical Process Charts (SPC)**
3.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance. • Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend. **Blue dots signify a statistical improvement. A data point will highlight blue if it:** • Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance. • Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

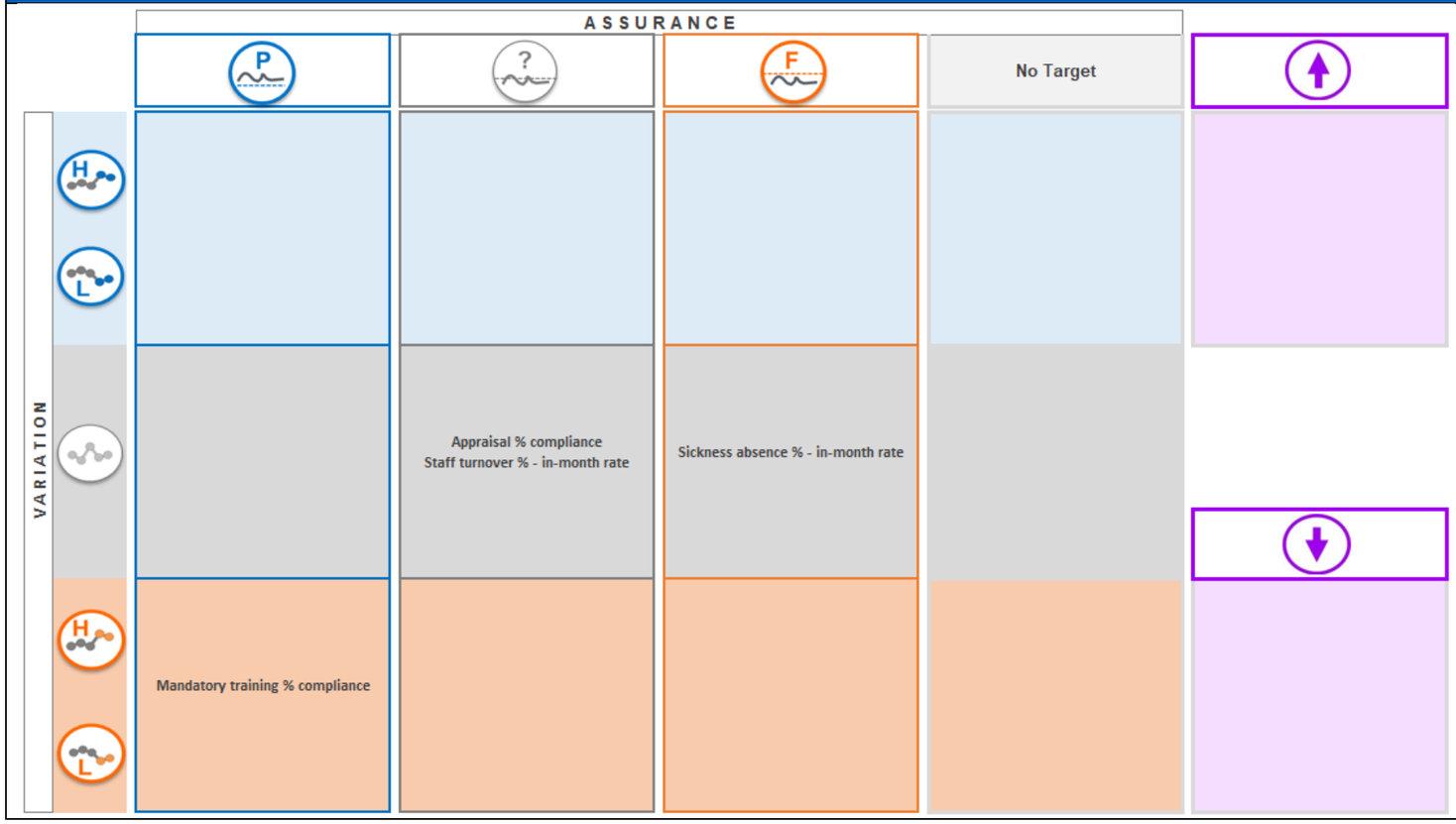
	Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Dashboard	All Indicators
Lead	All Execs

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Sep 25	5.87%	≤5%			5.96%
Staff turnover % - in-month rate	Sep 25	0.92%	≤1%			87.81%
Mandatory training % compliance	Sep 25	92.01%	≥90%			92.63%
Appraisal % compliance	Sep 25	86.70%	≥88%			0.93%
4-hour Accident and Emergency Target (including APH UTC)	Sep 25	57.13%	≥95%			61.3%
Number of inpatients not meeting the Criteria to Reside	Sep 25	134	-			160
Patients waiting longer than 12 hours in ED from a decision to admit	Sep 25	696	≤0			611
Proportion of patients more than 12 hours in ED from time of arrival	Sep 25	21.98%	≤0%			17.9%
Ambulance Handovers: % < 30 mins	Sep 25	72.32%	≥95%			53.1%
Ambulance Handovers: % < 45 mins	Sep 25	87.00%	≥100%			71.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Sep 25	61.70%	≥92%			58.6%
Referral to Treatment - total open pathway waiting list	Sep 25	48195	≤48429			44970
Referral to Treatment - cases exceeding 52 weeks	Sep 25	1138	≤866			1544
Referral to Treatment - cases waiting 78+ wks	Sep 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Aug 25	130	≤77			135
Cancer - Faster Diagnosis Standard	Aug 25	67.14%	≥77%			73.7%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Aug 25	90.09%	≥96%			91.5%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Jun 25	91.83%	≥96%			92.8%
Cancer Waits - 62 days to treatment (monthly)	Aug 25	75.07%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Jun 25	76.82%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Sep 25	87.35%	≥95%			92.8%
Long length of stay - number of patients in hospital for 21 or more days	Sep 25	143	≤79			166
Clostridioides difficile (healthcare associated)	Sep 25	16	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Sep 25	3	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Sep 25	0	≤0			0
Patient Safety Incidents	Sep 25	1312	-			1184
FFT Overall experience of very good & good: ED	Sep 25	69.1%	≥95%			76.2%
FFT Overall experience of very good & good: Inpatients	Sep 25	94.2%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Sep 25	97.5%	≥95%			95.4%
FFT Overall experience of very good & good: Maternity	Sep 25	100.0%	≥95%			95.9%
Patient Experience: concerns received in month - Level 1 (informal)	Sep 25	276	≤173			222
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Sep 25	4	≤3			3
Falls – Moderate to Severe Harm	Sep 25	0.09	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Sep 25	88.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Sep 25	90.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Sep 25	88.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Sep 25	98.0%	≥90%			99.7%
MRSA Cases	Sep 25	0	≤0			0
MSSA Cases	Sep 25	3	≤0			2
% of adult patients VTE risk-assessed on admission	Sep 25	96.2%	≥95%			97.4%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Sep 25	89.9%	≥90%			89.3%
Mortality (SHMI)	May 25	1.024	0.95-1.05			1.021
Number of studies open	Sep 25	45				
% of current studies meeting recruitment target	Sep 25	31.1%				
% of open studies with a commercial sponsor	Sep 25	4.4%				

Dashboard	Workforce
Lead	Chief People Officer

Workforce Domain Matrix



Workforce Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Sep 25	5.87%	≤5%		F	5.96%
Staff turnover % - in-month rate	Sep 25	0.92%	≤1%		?	87.81%
Mandatory training % compliance	Sep 25	92.01%	≥90%		P	92.63%
Appraisal % compliance	Sep 25	86.70%	≥88%		?	0.93%

Areas of Concern

Sickness

Sickness absence levels continue to be above the Trust's 5% target. Latest performance is 5.87% which is a further reduction since August (5.97%) and an improved position compared to both Sept' 24 (6.32%) and Sept'23 (6.15%).

The top 3 reasons are mental health, gastro and cold/flu.

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

Estates, Facilities and Capital have the highest monthly rate at 10.28%. Surgery (6.84%), Medicine (5.80%) and W&C (5.35%) have the highest Divisional sickness.

ED (4.83%), DCS (4.29%) and Corporate (3.30%) were all below tolerance.

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

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

The Trust has a robust Attendance Management Policy which is working well however, we recognise that some staff groups (Estates and Ancillary, Additional Clinical Services (CSWs) and Nursing and Midwifery) are more affected that others. The Trust continues to implement a wide range of supportive interventions as well as robust application of the policy. It is about to pilot a new approach to reducing sickness absence, targeted at staff that are struggling to return to the work place; '**Well WUTH Back to Work'** programme will launch its pilot in November 25. If successful it will be rollout across WUTH and Wirral Community Trust as a mechanism to support faster returns to work and also as a supportive measure for staff to prevent absence / maintain a return to work.

Forward Look (Actions)

Sickness

Proactively supporting physical health and wellbeing:

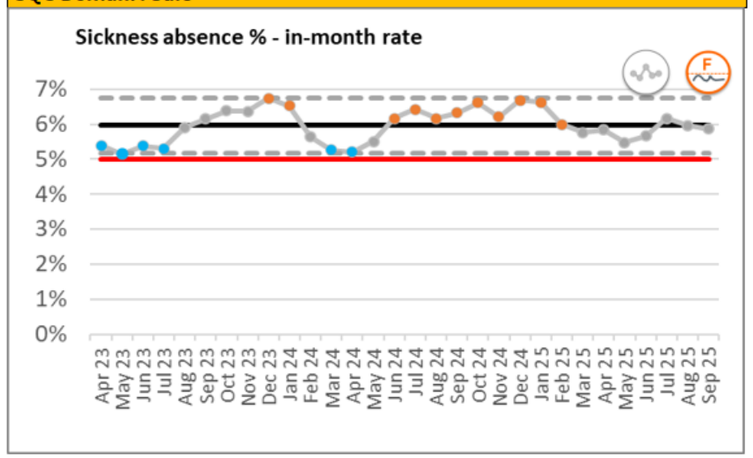
- New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - 'Every Day Counts'.
- Delivery of the annual flu campaign to prevent increase in flu related absence.
- New Resilience through Change sessions led by Trust's psychotherapist.
- Mental Health First Aid Training– 2 new cohorts in September, 2 cohorts in October and 1 final cohort in November.
- Enhanced training for managers (preventing sickness absence through wellbeing conversations).
- Wirral CiC continue to offer health checks in W&C which is the last Division, and they will produce a report of findings to inform future action / initiatives.
- New Road Map for Wellbeing showcasing all the support available to staff in one place.

Managing Absence:

- Operationalising **Well WUTH.** HR are working closely with line managers to identify suitable colleagues currently absent due to long term sickness, focusing primarily on the targeted staff groups. The pilot will launch in November 2025, aiming to return staff to work in December 2025 to support with winter pressures.
- New focus on Resident Doctors' sickness, which is creating operational challenges
- New mini manager essentials training has launched focusing on Long Term Sickness and Absence Triggers.
- High impact action plans for each Division focused on hot spots.
- Addressing policy breaches such as staff working NHSP shifts prior to having a RTW.
- Proactive targeted letters due for issue to individuals with trend for sickness during December / Christmas leave period.
- HR drop-in sessions provide managers with access to dedicated HR resource to support with case management.
- The Attendance Management Policy continues to be embedded, and numbers of final stage hearings continue to increase.
- Local Sickness Audits remain on going and are reported into WSB.

Sickness absence % in month rate

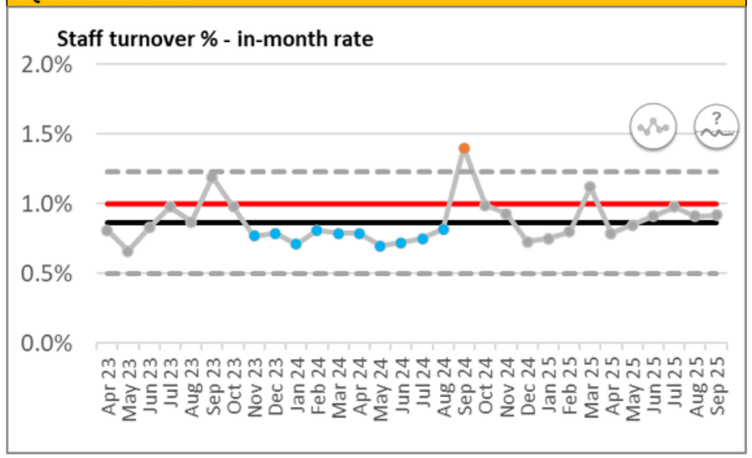
CQC Domain : Safe



Sep-25
5.9%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Consistently fail target

Staff turnover % in month rate

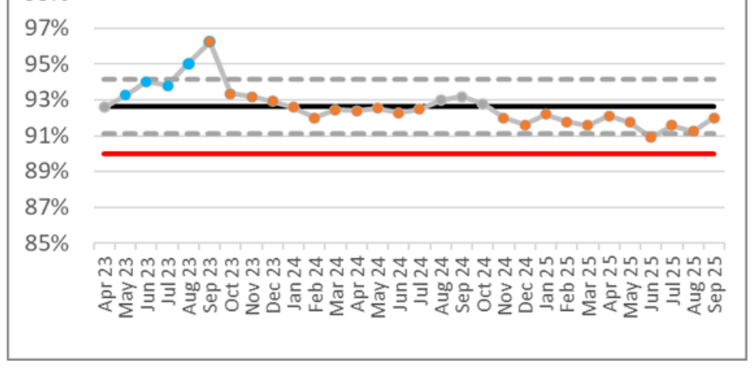
CQC Domain : Safe



Sep-25
0.9%
Variance Type
Common cause variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance

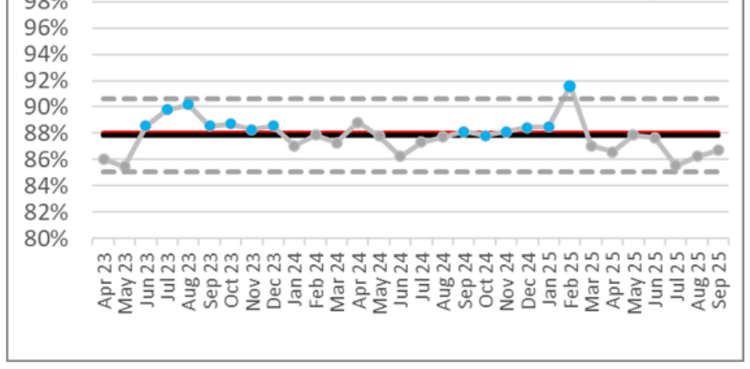
CQC Domain : Safe



Sep-25
92.0%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Consistently hit target

Appraisal % compliance

CQC Domain : Well-led



Sep-25
86.7%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

Appraisal % compliance

Appraisal compliance has so far, not met the 88% KPI during 2025/26. Data from September demonstrates a minimal increase in Trust compliance in comparison to August data, with improved compliance in Clinical Diagnostic Services, Corporate Support, Emergency, Medicine and Women & Children's divisions. Of these the following divisions met the 88% KPI in September:

- Clinical Support – 90.04%
- Medicine – 91.89%
- Women & Children's – 88.85%

To further explore the challenges around appraisal compliance, a deep dive has been conducted, this has highlighted a range of themes that will be discussed with Divisional leads at October Workforce Steering Board. Themes include:

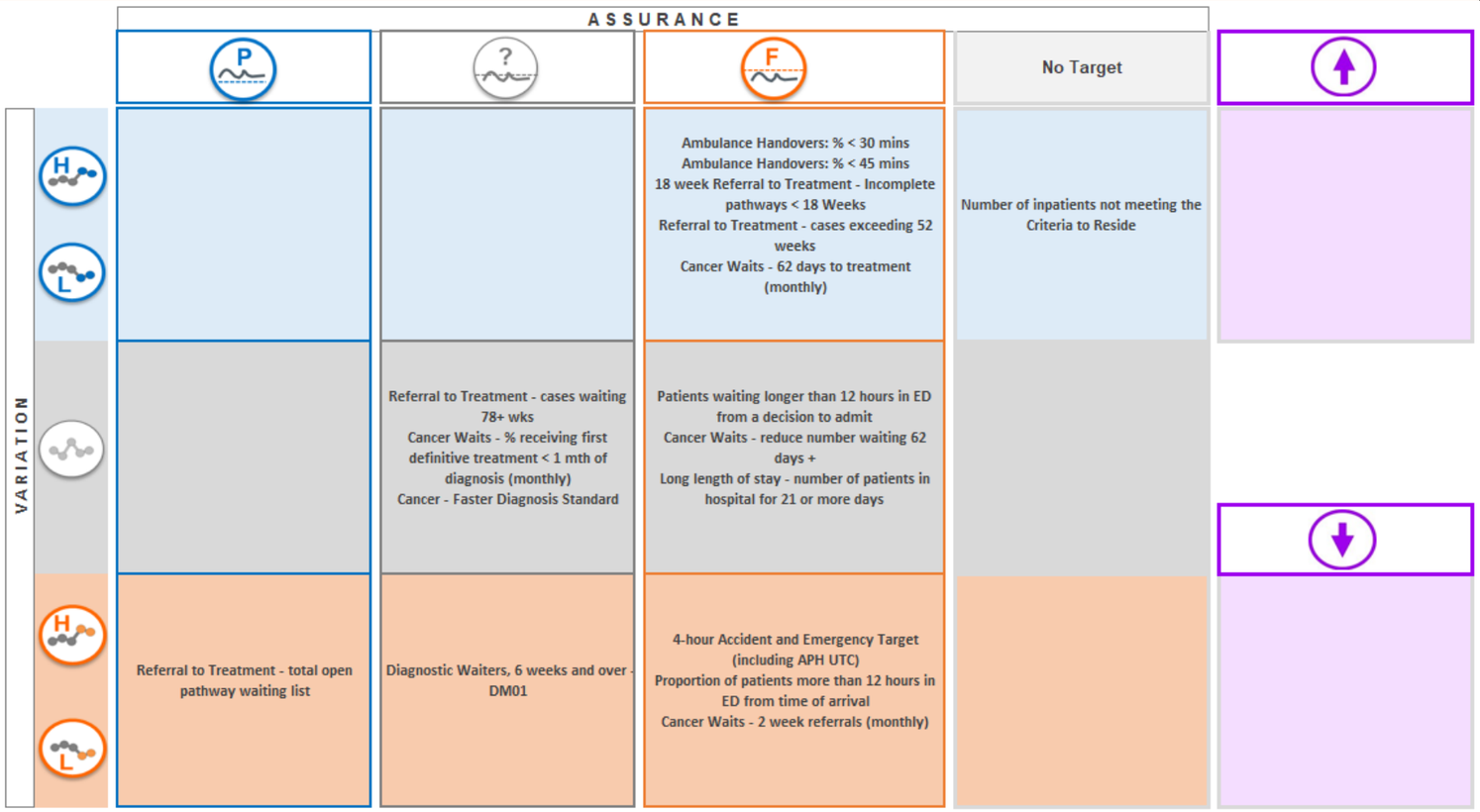
- Highlighting areas of good compliance and areas where compliance falls below 50%
- Highlighting areas where recording is poor – further work to improve knowledge and usage of ESR will be targeted.
- Identified areas where training needs to be targeted and ensuring that training capacity (currently only 33.4% of available spaces) is utilized.
- Ensuring that all managers responsible for appraisal have access to reports as the deep dive highlighted that managers weren't accessing / could not access the monthly compliance report.
- Effective use of workforce policies to further drive appraisal compliance.

Look Forward Actions to include:

- The deep dive will be presented at Workforce Steering Board on 30th October and actions agreed with divisions to address findings of the deep dive.
- Review of training materials as this was highlighted in the deep dive – increased focus on reviewing reports and effective recording of appraisals.
- Ensuring that all reviewers have access to monthly reports
- Plans to implement appraisal audit to commence from December 2025 to drive quality and compliance
- Ongoing proactive targeting of appraisal compliance for outstanding and ‘due’ appraisals
- HRBP’s working with their respective divisional leadership teams to drive compliance improvement.

Dashboard	Operations
Lead	Chief Operating Officer

Operations Domain Matrix



Operations Summary

Highlights

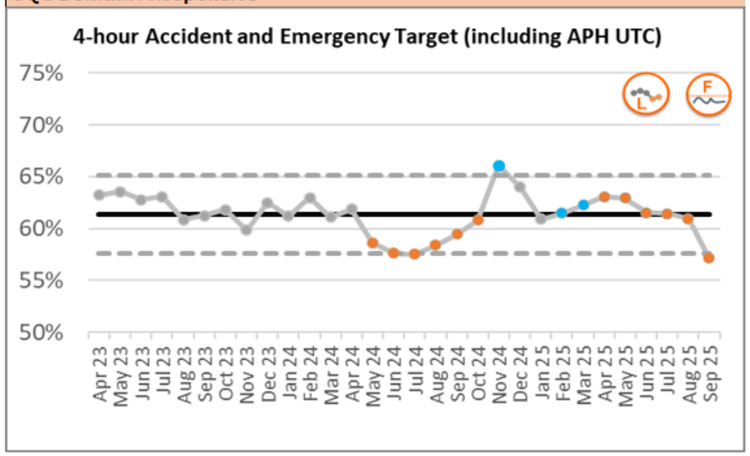
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Sep 25	57.13%	≥95%			61.3%
Number of inpatients not meeting the Criteria to Reside	Sep 25	134	-			160
Patients waiting longer than 12 hours in ED from a decision to admit	Sep 25	696	≤0			611
Proportion of patients more than 12 hours in ED from time of arrival	Sep 25	21.98%	≤0%			17.9%
Ambulance Handovers: % < 30 mins	Sep 25	72.32%	≥95%			53.1%
Ambulance Handovers: % < 45 mins	Sep 25	87.00%	≥100%			71.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Sep 25	61.70%	≥92%			58.6%
Referral to Treatment - total open pathway waiting list	Sep 25	48195	≤48429			44970
Referral to Treatment - cases exceeding 52 weeks	Sep 25	1138	≤866			1544
Referral to Treatment - cases waiting 78+ wks	Sep 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Aug 25	130	≤77			135
Cancer - Faster Diagnosis Standard	Aug 25	67.14%	≥77%			73.7%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Aug 25	90.09%	≥96%			91.5%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Jun 25	91.83%	≥96%			92.8%
Cancer Waits - 62 days to treatment (monthly)	Aug 25	75.07%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Jun 25	76.82%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Sep 25	87.35%	≥95%			92.8%
Long length of stay - number of patients in hospital for 21 or more days	Sep 25	143	≤79			166

Areas of Concern

Forward Look (Actions)

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

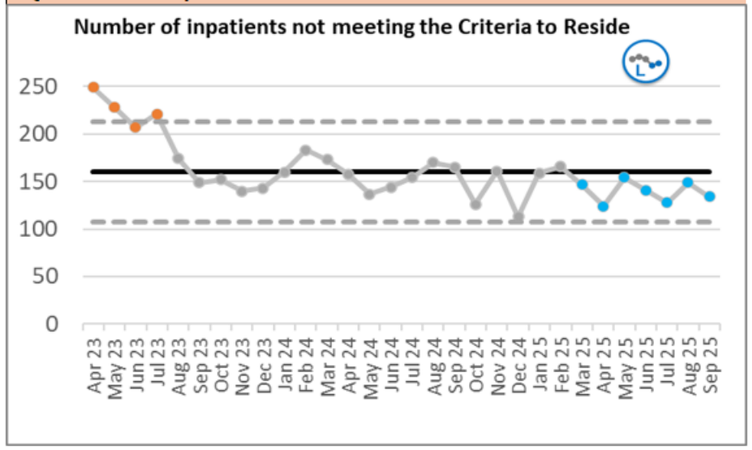
CQC Domain : Responsive



Sep-25
57.1%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

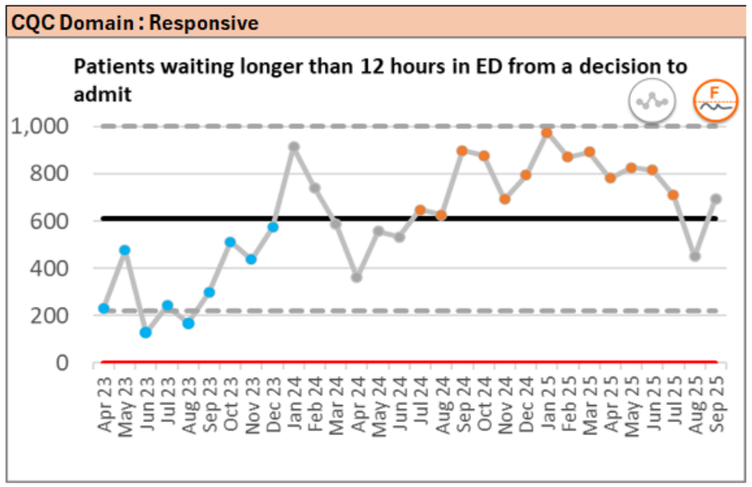
CQC Domain : Responsive



Sep-25
134
Variance Type
Special cause improving variation
Threshold
-
Assurance
Not applicable

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

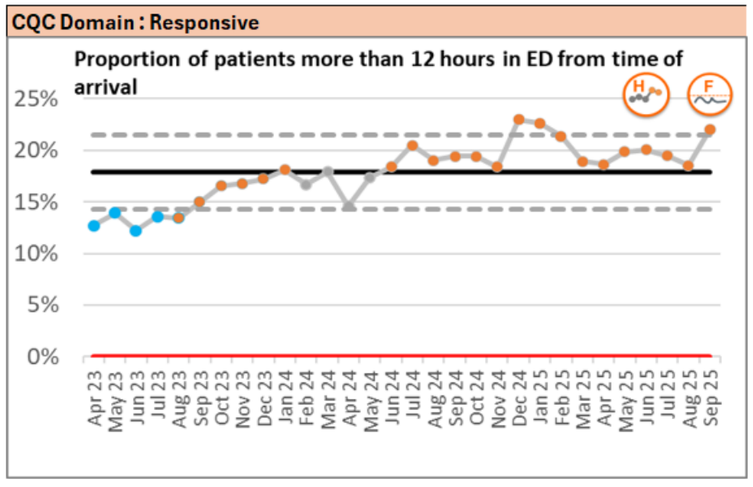
CQC Domain : Responsive



Sep-25
696
Variance Type
Common cause variation
Threshold
≤0
Assurance
Consistently fail target

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

CQC Domain : Responsive



Sep-25
22.0%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

Commentary

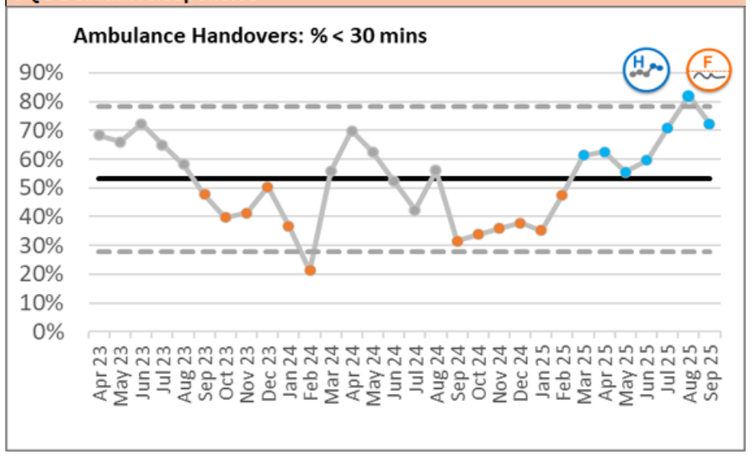
4-hours – In September, performance against the 4-hour Accident and Emergency standard (including APH UTC) was 57.%, a deterioration from 61.4% in previous month. This remains significantly below the national target of 95%. Performance has been stable in recent months but continues to fall short of the required standard, reflecting the ongoing pressures in the department which included a significant increase in average daily attendances in month for both walk-in and conveyances.

NCTR - The number of inpatients not meeting the Criteria to Reside was 134, a reduction from previous month. The position remains in the strongest in Cheshire and Merseyside, frequently running at less than 12% of patients with a NCTR status in the Trust. The Wirral system is continuing to work to a reduction in the NCTR to deliver 10% by the end of the financial year.

12 hours LoS and DTA - In September, 22% of patients remained in ED for more than 12 hours from time of arrival. This remains significantly above the national standard and within the lowest performing Trusts nationally. Reducing 12-hour breaches continues to be the greatest risk to UEC performance, driven mainly due to flow to inpatient beds from ED. The Trust is focused on improvement, with rapid progress expected through strengthened escalation processes, increased use of SDEC pathways, and improved discharge planning and ongoing improvement work with ECIST.

Ambulance handover % < 30 minutes

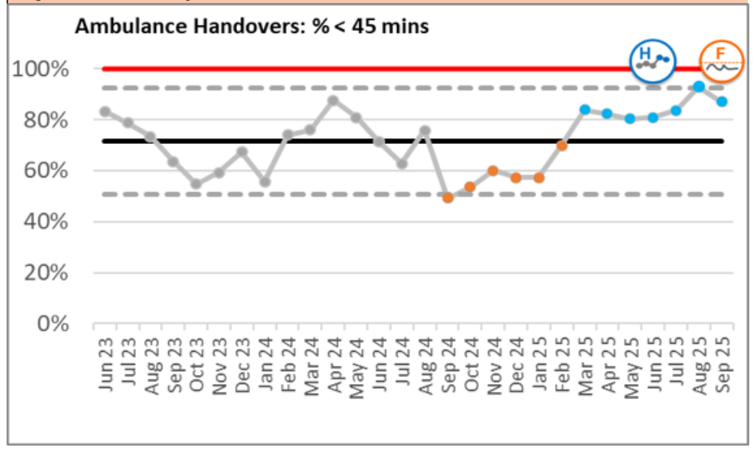
CQC Domain : Responsive



Sep-25
72.3%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

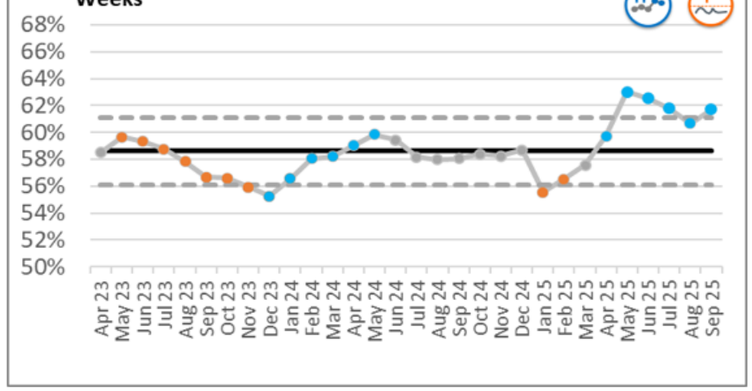
CQC Domain : Responsive



Sep-25
87.0%
Variance Type
Special cause improving variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

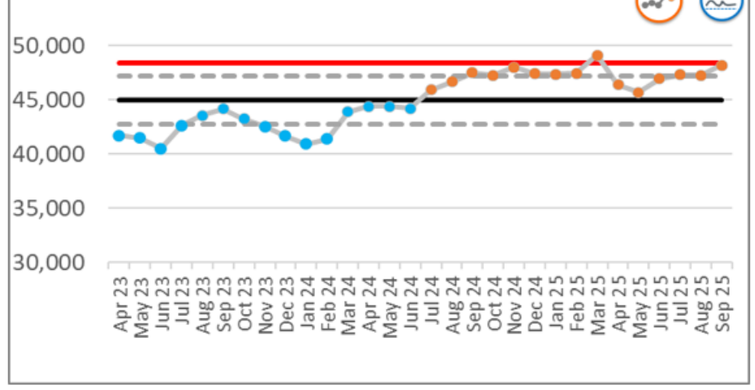
CQC Domain : Responsive



Sep-25
61.7%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



Sep-25
48195
Variance Type
Special cause concerning variation
Threshold
≤48429
Assurance
Consistently hit target

Commentary

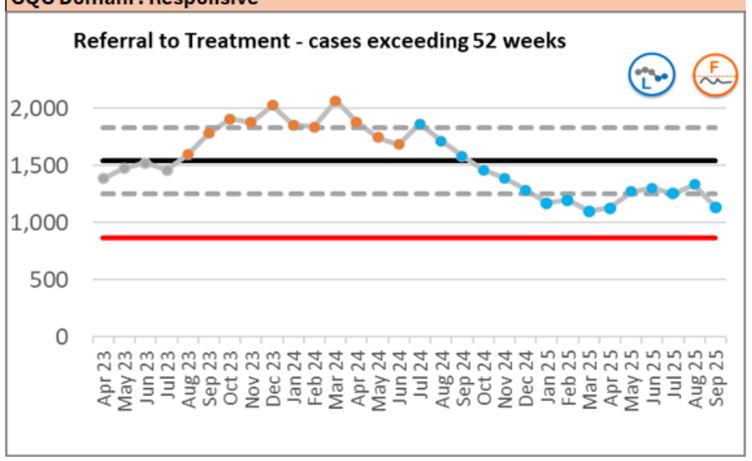
Ambulance Handover – Although a small reduction in performance in month, performance remained compliant. This is against a backdrop of the increasing level of activity with ambulance conveyances, with record attendances for one day in month.

RTT - The Trust achieved trajectory for RTT caseload and percentage of patient waiting 18 weeks or under.

The overall RTT waiting list increased in size in September 2025 but remains below trajectory. Increases in caseload are attributed to Physiotherapy, with plan for recovery of caseload by December, and a sharp increase in the number of referrals in Dermatology as a result of regional pathway changes (see section 2.3 Cancer Performance). Outsourcing within ENT which commenced in October, which along with a third national validation sprint from 3rd November, will see a reduction in caseload.

Referral to Treatment – cases exceeding 52 weeks

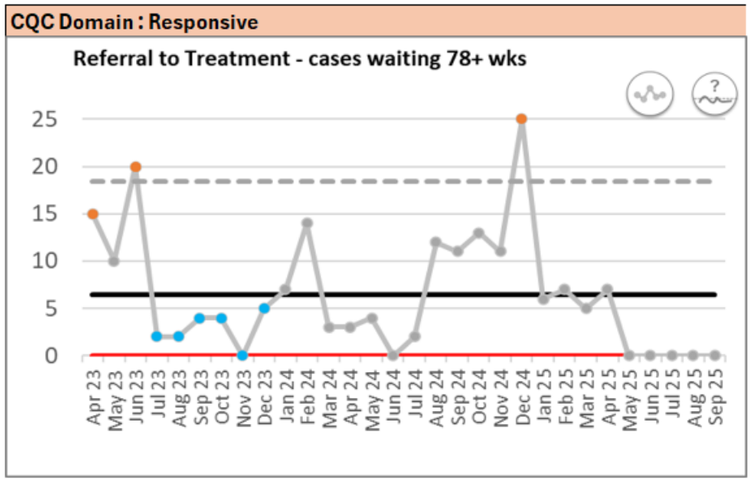
CQC Domain : Responsive



Sep-25
1138
Variance Type
Special cause improving variation
Threshold
≤866
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

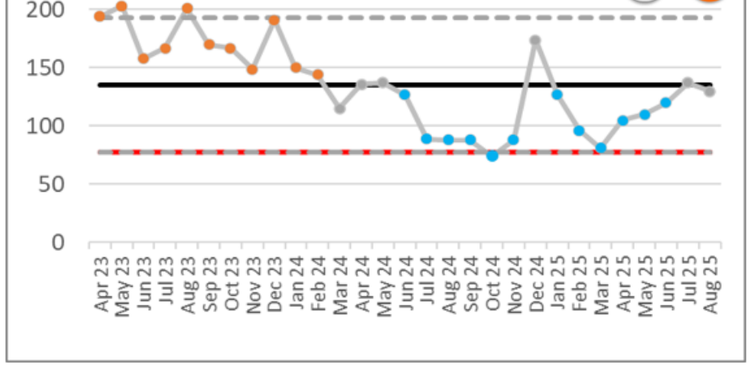
CQC Domain : Responsive



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

Cancer Waits – reduce number waiting 62 days +

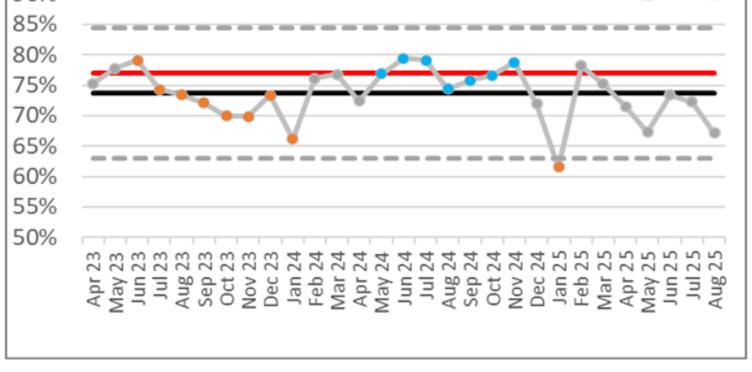
CQC Domain : Responsive



Aug-25
130
Variance Type
Common cause variation
Threshold
≤77
Assurance
Consistently fail target

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



Aug-25
67.1%
Variance Type
Common cause variation
Threshold
≥77%
Assurance
Consistently fail target

Commentary

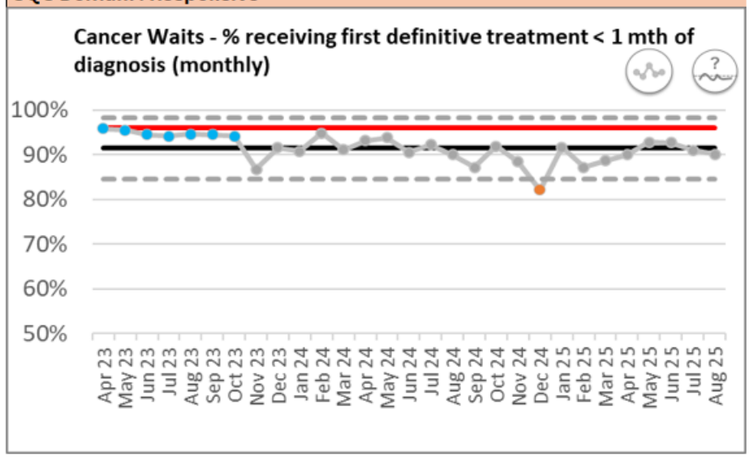
RTT - The Trust achieved 0 x 78-week waiters in September. The number of 65-week waiters has reduced to 4 in September – 3 x ENT patients and 1 x graft. Divisional teams are developing recovery plans for 52-week waiters, having focused on reduction of 65 weeks. ENT and Dermatology represent the largest variances from trajectory. As noted above, outsourcing has commenced in ENT to create additional capacity and is reducing waiting times for first appointment.

Cancer – The Trust has failed to meet the local trajectory for the Faster Diagnosis Standard, with August performance at 67.14% versus trajectory of 78.49%. Performance has improved in Gynaecology, Urology, Lower GI and more recently in Breast following change in pathway, improvements in tracking and improved cross-Divisional working. Skin cancer performance has deteriorated following regional ceasing of funding for tele-dermatology, alongside regional implementation of an AI pathway.

Skin performance is having a significant negative impact on overall Trust performance. A deterioration in Skin Faster Diagnosis Performance and is seen in a number of Trusts across the region. The Cancer Alliance has agreed funding to support dealing with part of the backlog. Plans are being developed to implement an alternative advice and guidance service and look to mobilise insourcing to support additional capacity (based on Cancer Alliance funding. The Trust has also received additional regional funding from the Cancer Alliance to support an improvement in Breast performance in order to provide additional capacity.

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

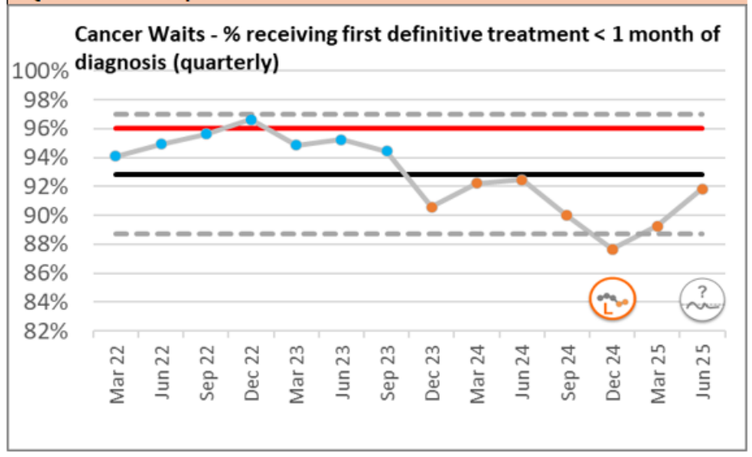
CQC Domain : Responsive



Aug-25
90.1%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

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

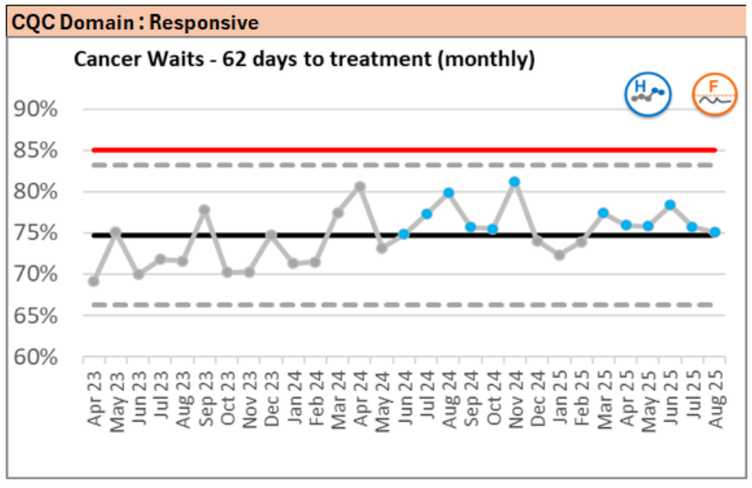
CQC Domain : Responsive



Jun-25
91.8%
Variance Type
Special cause concerning variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

Cancer waits - 62 days to treatment (monthly)

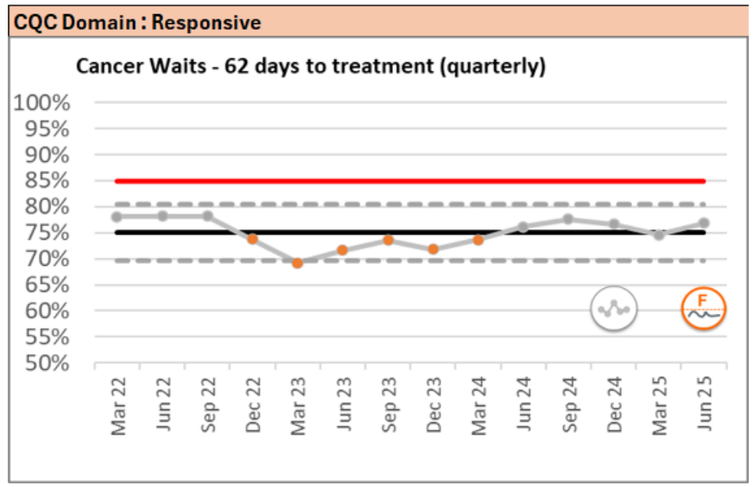
CQC Domain : Responsive



Aug-25
75.1%
Variance Type
Special cause improving variation
Threshold
≥85%
Assurance
Consistently fail target

Cancer waits - 62 days to treatment (quarterly)

CQC Domain : Responsive



Jun-25
76.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

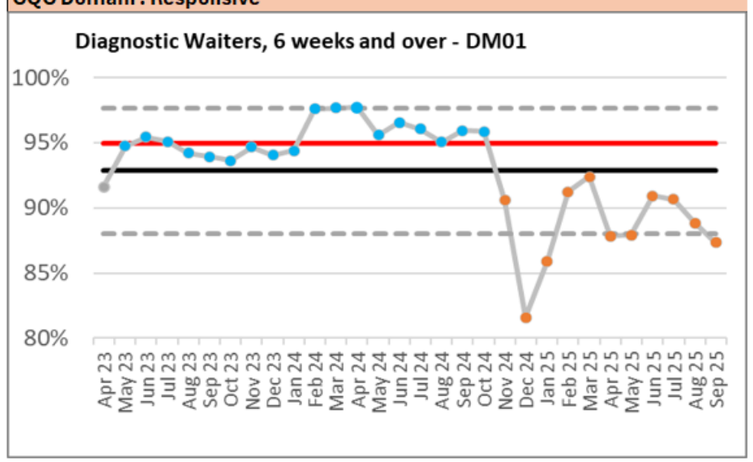
Commentary

31 Day Treatment Standard - The Trust failed to achieve local trajectory in August 2025 at 90.09% versus trajectory of 92.20%. Skin performance was seen to deteriorate, impacting the Trust overall position.

62 Day Treatment Standard - The Trust failed to achieve local trajectory in August 2025 at 75.07% versus trajectory of 76.55%. 62-day performance is noted as impacted by reduction in 28-day performance in earlier months. Improvements in Gynaecology 28-day performance (tracked weekly through October) will have a positive impact on 62 day performance from November, whilst Skin remains a challenge.

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



Sep-25
87.4%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

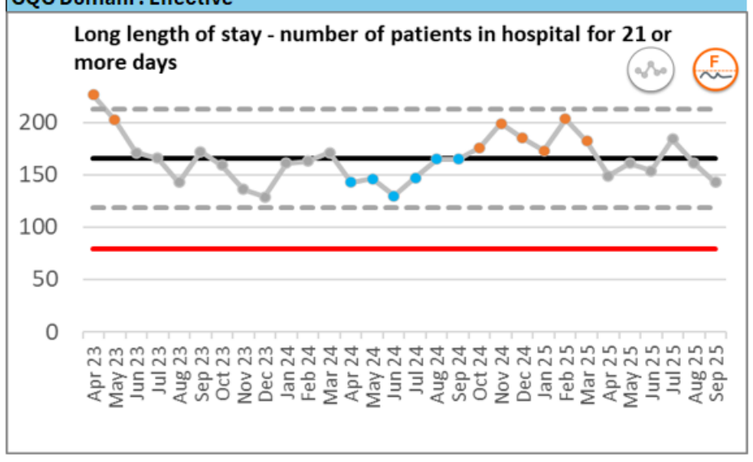
The Trust did not achieve 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 87.4% for September.

Performance is forecast to recover above trajectory by end of October.

Non-obstetric ultrasound remained the area of greatest pressure in September. The loss of an agency worker who was supporting recovery delayed forecast achievement of plan from September to October. Additional insourcing has been confirmed, and recovery is on track for October.

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

CQC Domain : Effective

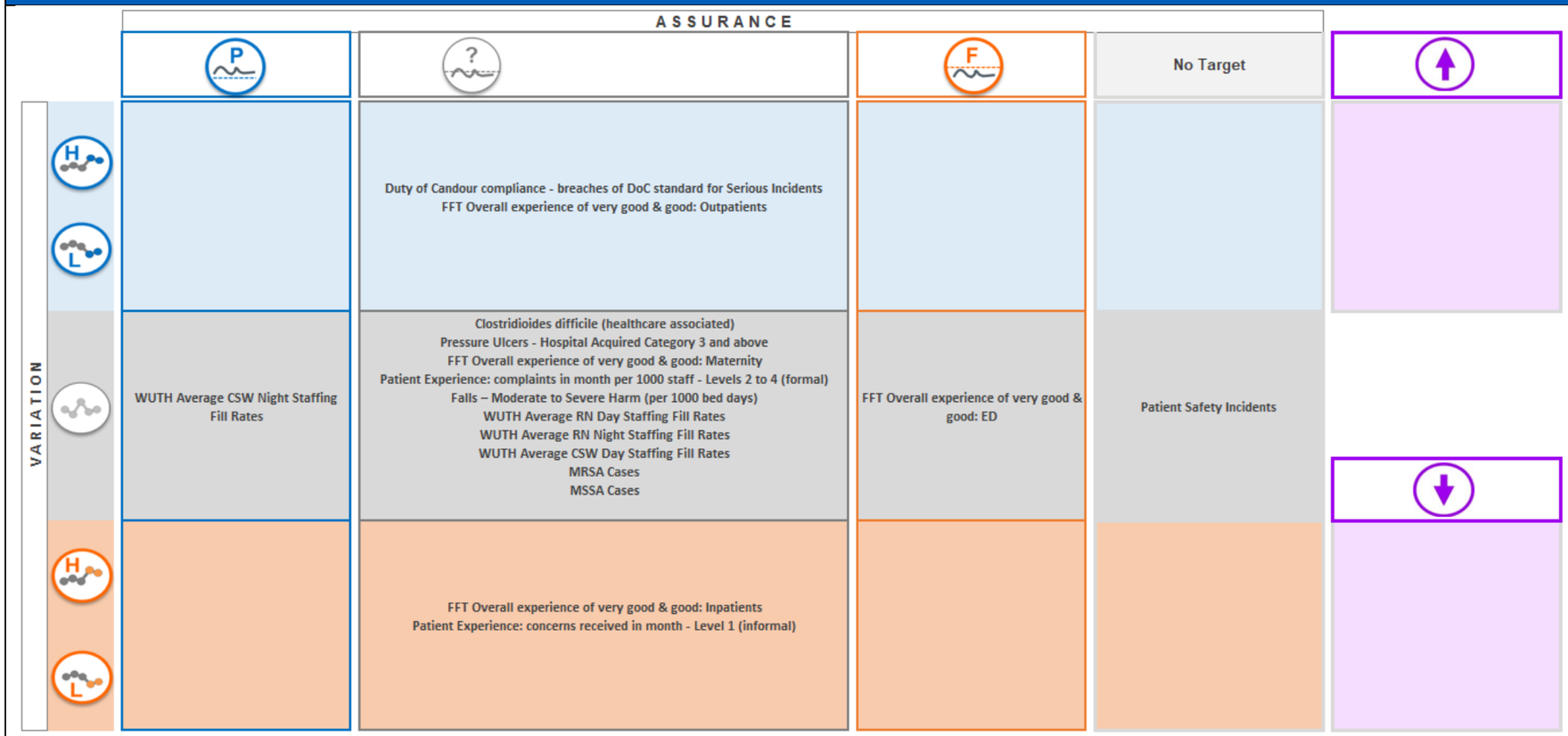


Sep-25
143
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

Commentary

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix



Quality and Safety Care Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Sep 25	16	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Sep 25	3	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Sep 25	0	≤0			0
Patient Safety Incidents	Sep 25	1312	-			1184
FFT Overall experience of very good & good: ED	Sep 25	69.1%	≥95%			76.2%
FFT Overall experience of very good & good: Inpatients	Sep 25	94.2%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Sep 25	97.5%	≥95%			95.4%
FFT Overall experience of very good & good: Maternity	Sep 25	100.0%	≥95%			95.9%
Patient Experience: concerns received in month - Level 1 (informal)	Sep 25	276	≤173			222
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Sep 25	4	≤3			3
Falls – Moderate to Severe Harm	Sep 25	0.09	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Sep 25	88.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Sep 25	90.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Sep 25	88.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Sep 25	98.0%	≥90%			99.7%
MRSA Cases	Sep 25	0	≤0			0
MSSA Cases	Sep 25	3	≤0			2

Areas of Concern

Further reduction in FFT score for ED

FFT 0.8% below target for Inpatients

Healthcare associated pressure ulcers, grade 3 and Above

Patients diagnosed with CDT toxin: 6 HOHA, 10 COHA (linked to outbreak on ward 33)

Forward Look (Actions)

CQC Improvement plan in place.
5 ED specific volunteers inducted to team ECIST supporting Trust

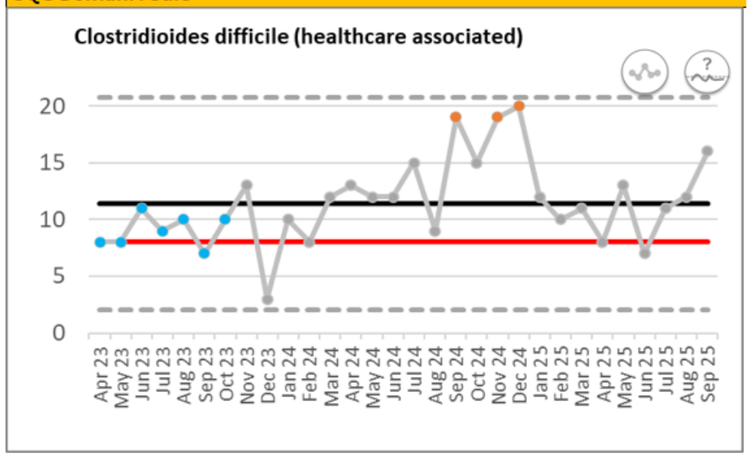
Responding to feedback action plans to be developed, areas that are below target to be prioritised

Tissue Viability Team leadership review- integration opportunities

New IPC team model and leadership with refresh of improvement plans.

Clostridioides difficile (healthcare associated)

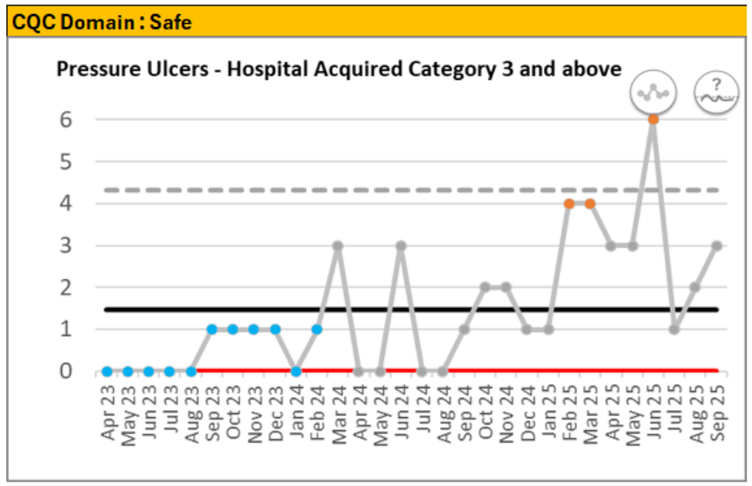
CQC Domain : Safe



Sep-25
16
Variance Type
Common cause variation
Threshold
≤8
Assurance
Hit and miss target subject to random variation

Pressure Ulcers – Hospital Acquired Category 3 and above

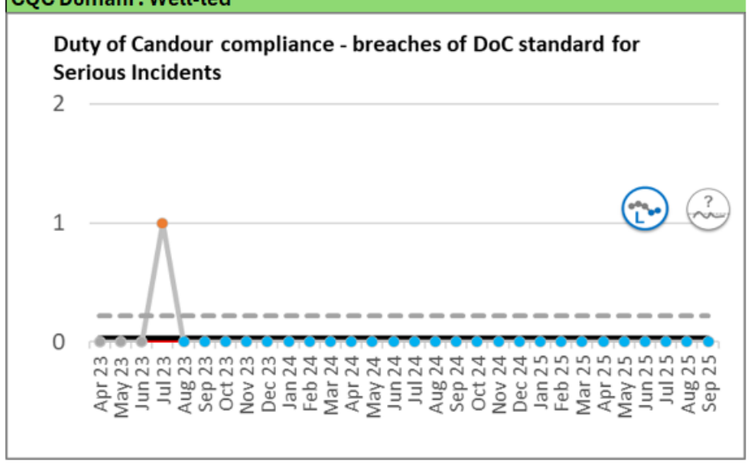
CQC Domain : Safe



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

Duty of Candour Compliance

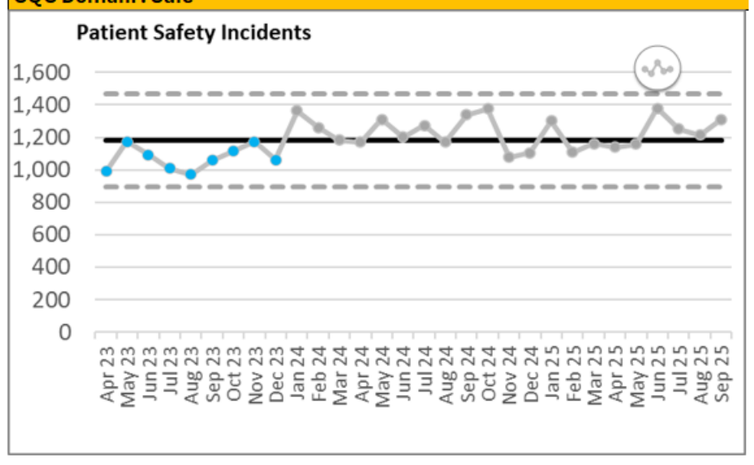
CQC Domain : Well-led



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

Patient Safety Incidents

CQC Domain : Safe



Sep-25
1312
Variance Type
Common cause variation
Threshold
-
Assurance
Not applicable

Commentary

CDT:-

10 of the 16 patients identified were COHA's which is more than is usually seen, many are related to a recent Outbreak of CDT on ward 33 and these patients were contacts of other patients with CDT who had not been isolated.

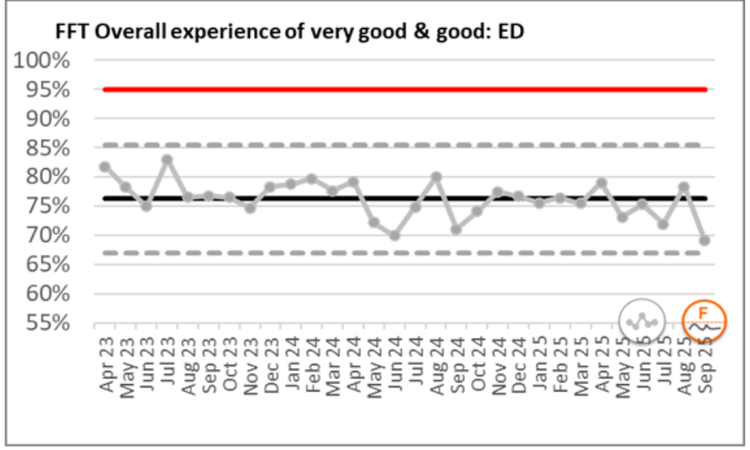
Pressure Ulcers:-

There were 2 Cat3's and 1 Cat 4 in September, all were on the sacral areas and all 3 were deteriorations within our care becoming hospital acquired, full investigations undertaken. They were all on medical division wards – divisional improvement plans reviewed through Fundamentals of Care meeting.

Improvement actions: New mattress contract in place , TV ward walk abouts. Upskilling of band 3 CSWs programme.

FFT Overall experience of very good & good – ED

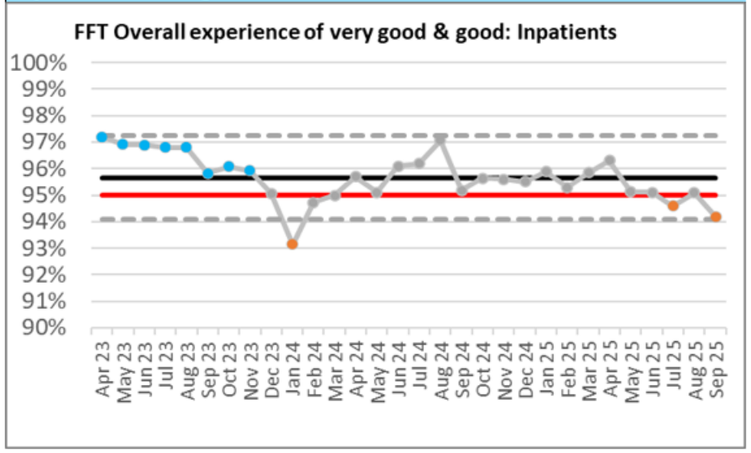
CQC Domain : Caring



Sep-25
69.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

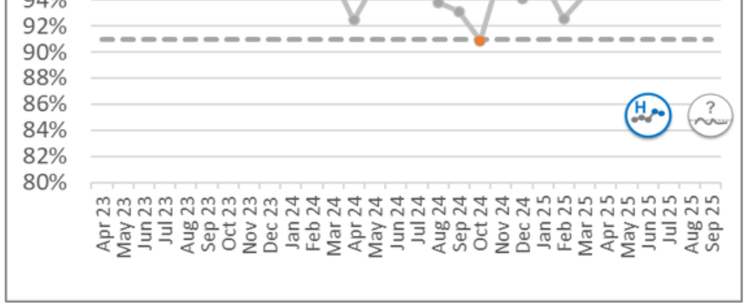
CQC Domain : Caring



Sep-25
94.2%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

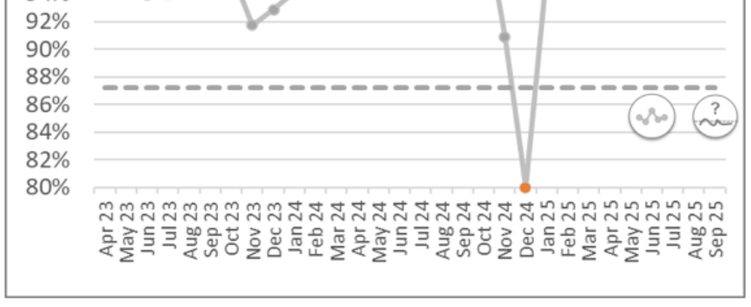
CQC Domain : Caring



Sep-25
97.5%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring



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

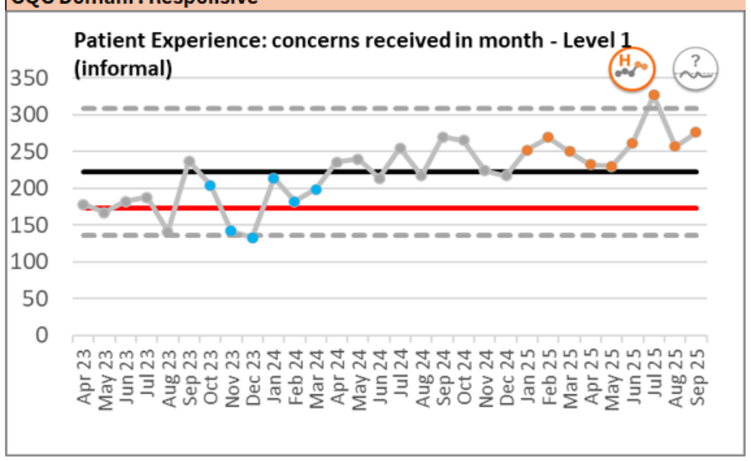
Commentary

Further reduction in FFT score for ED

FFT 0.8% below target for Inpatients – feedback action plans for areas below target in development

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

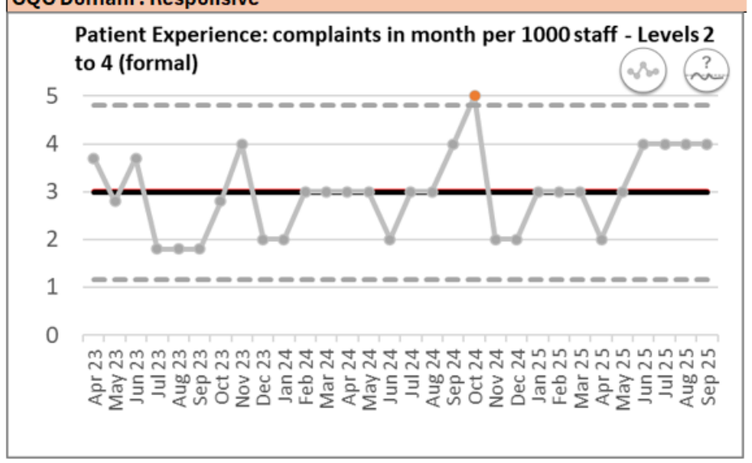
CQC Domain : Responsive



Sep-25
276
Variance Type
Special cause concerning variation
Threshold
≤173
Assurance
Hit and miss target subject to random variation

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

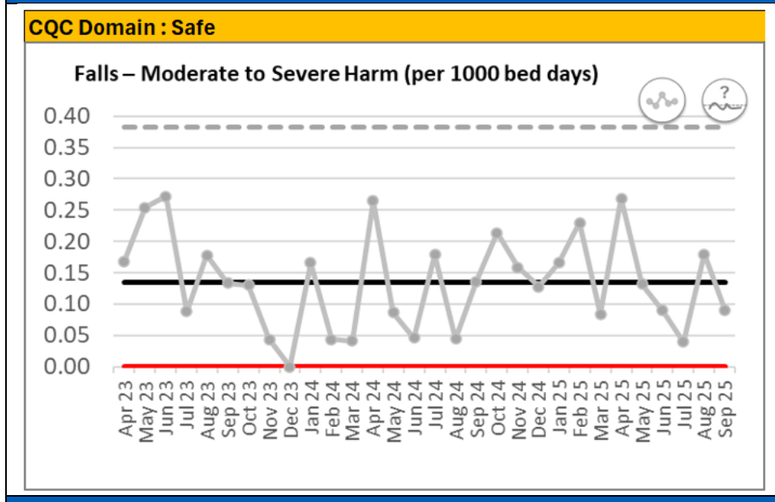
CQC Domain : Responsive



Sep-25
4
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit and miss target subject to random variation

Falls – Moderate to Severe Harm

CQC Domain : Safe



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

Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

Commentary

Concerns / Complaints
In September, the Trust received **24 formal (Level 2) complaints** and **276 informal (Level 1) concerns**, with activity above the 2024/25 monthly averages and slightly above the 2025/26 year-to-date averages.
Informal concerns were highest in **Surgery**, **Medicine**, **Women & Children's**, and **Diagnostics & Clinical Support**, with no new departmental hotspots identified. Formal complaints remained concentrated in **Medicine**, **Surgery**, **Emergency Care**, and **Diagnostics & Clinical Support**.

Key themes continued to focus on **clinical care, communication,** and **access**. Informal concerns were dominated by **appointments, access,** and **process-related issues**, and formal complaints emphasised **communication, treatment** and **procedure**.

Response timeliness showed modest changes, with **50% of complaints responded to within 40 working days** and an **average response time of 46 days**. At the end of September, **65 complaints were open**, including **24 breaches**, reflecting a slightly reduced but continuing backlog.

Ongoing oversight, weekly divisional meetings, and staff training remain in place, supporting structured management and quality improvement, although operational pressures and variability in investigation quality continue to present risks to performance.
A complaints response recovery plan is being drafted by governance lead.

Falls – moderate to severe harm

1 fall with short-term harm – patient sustained a wrist fracture

The roll-out of yellow wristbands has been well received by ward staff and this is being implemented at the front door in ED, changes also made to Cerner to incorporate this into documentation.
Ongoing training continues on the corporate nursing patient safety updates and IMPACT training

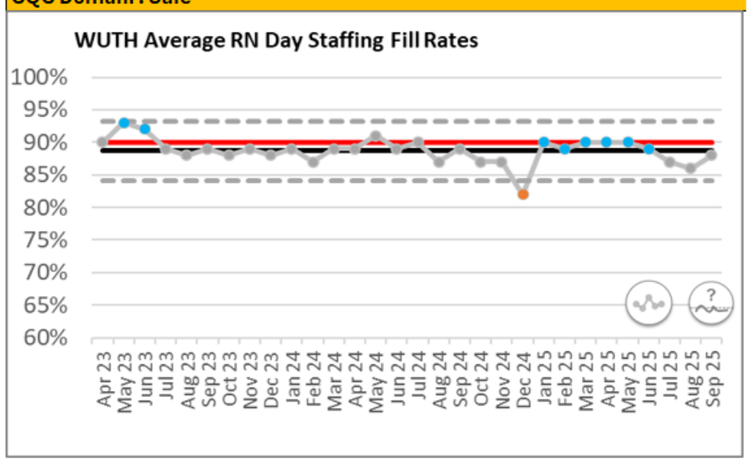
Ongoing work with falls leads from each division on falls plan, also collaborating with the community regarding the Falls policy.

New Rambleguard BOND system has been installed into ED escalation bays and training has been given to staff and superusers identified.

The prevalence of falls is higher especially at night with 85% of falls recorded as found on floor, only 36% of patient falls had assistive technology in place- ongoing education to teams.

Average Registered Nurse Day Staffing Fill Rates

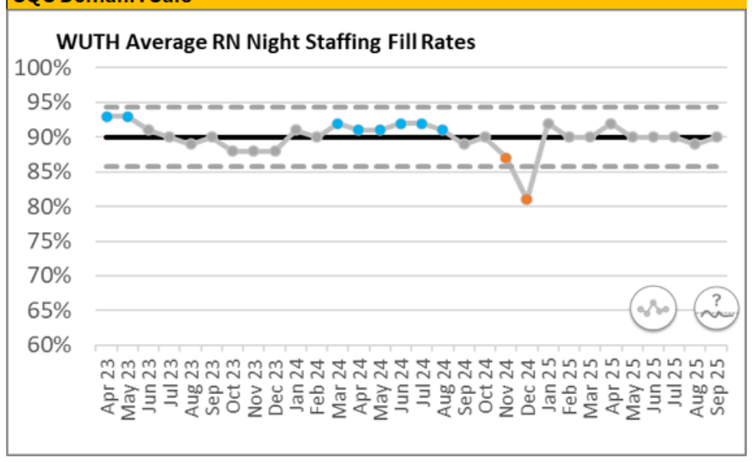
CQC Domain : Safe



Sep-25
88.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse

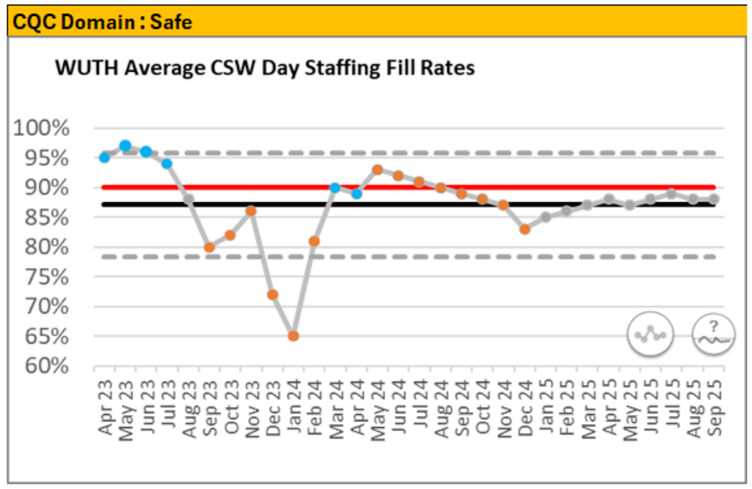
CQC Domain : Safe



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

Average Clinical Support Worker Day Staffing Fill Rates

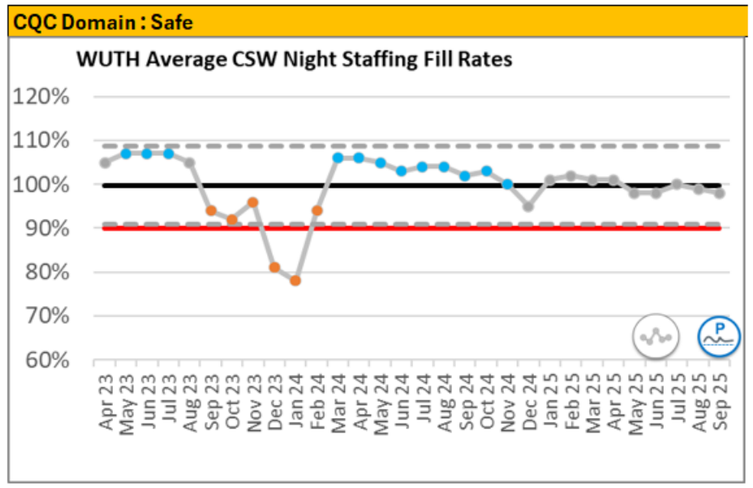
CQC Domain : Safe



Sep-25
88.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Night Staffing Fill Rates

CQC Domain : Safe



Sep-25
98.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Commentary

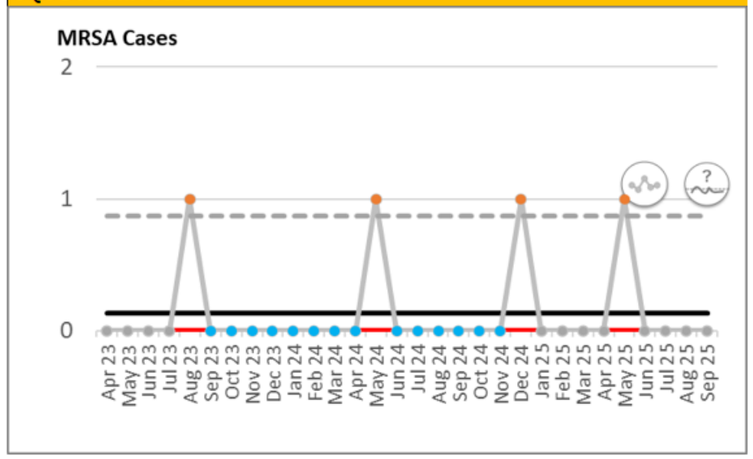
Recruitment meeting with DDNs & Deputy Chief Nurse planned for 31/10/25.

Trust wide CSW/ HCA recruitment event planned for November to address high CSW vacancy rate as new establishments following organizational change are enacted.

Improved RN fill rates in September with a number of newly qualified RNs commencing as planned.

MRSA Cases

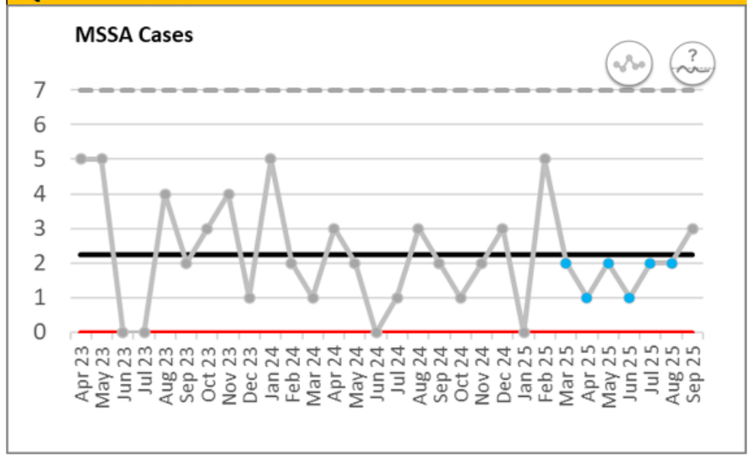
CQC Domain : Safe



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

MSSA Cases

CQC Domain : Safe



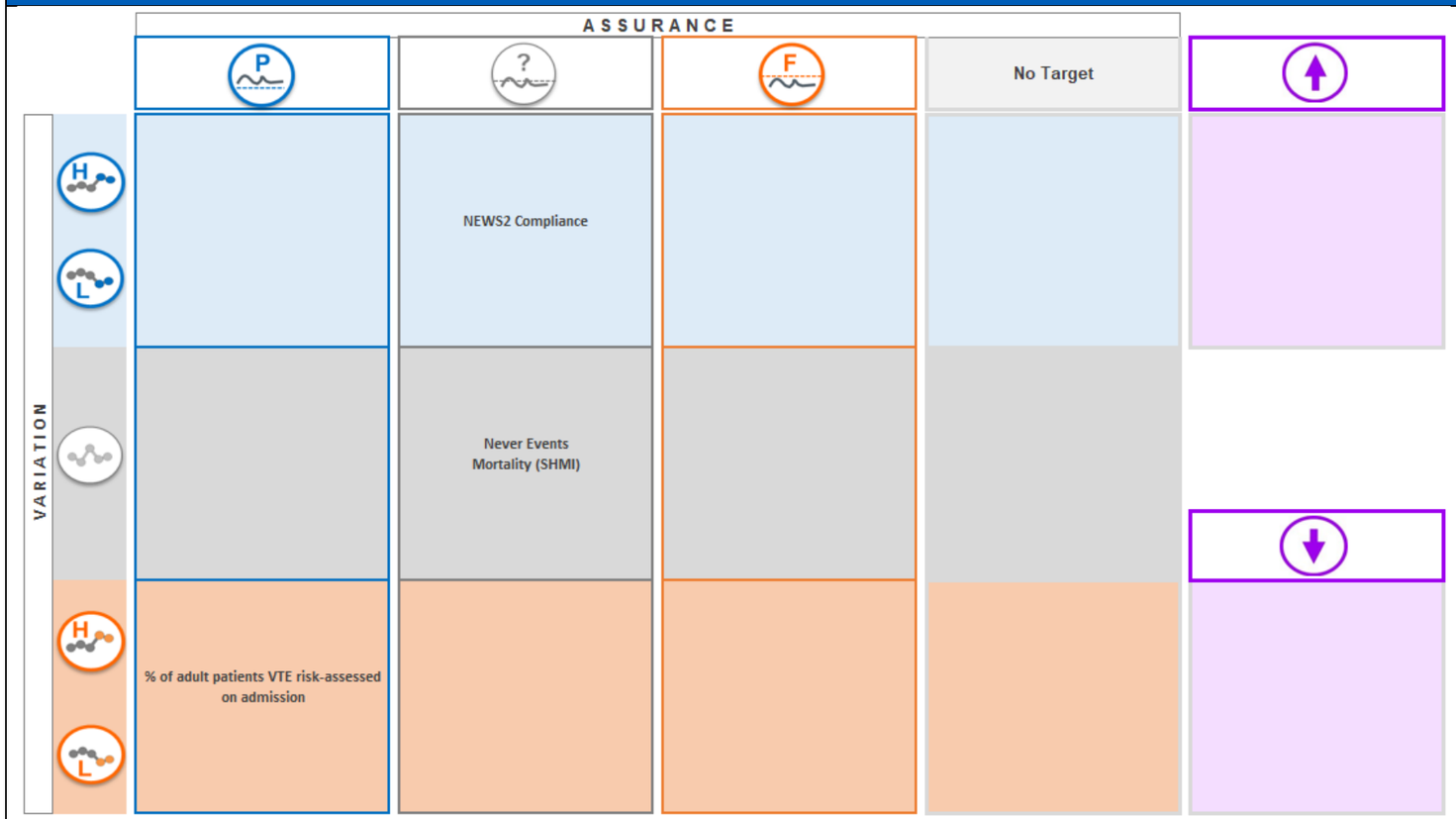
Sep-25
3
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Commentary

MSSA patients were all COHA’s (sample was taken within 48 hrs of admission and the patient had been in the Trust in the last 28 days) 1 was ?related to a PICC line and the other a potential wound source

Dashboard	Quality and Safety
Lead	Medical Director

Quality and Safety Domain Matrix



Quality and Safety Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Sep 25	96.2%	≥95%			97.4%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Sep 25	89.9%	≥90%			89.3%
Mortality (SHMI)	May 25	1.024	0.95-1.05			1.021
Number of studies open	Sep 25	45				
% of current studies meeting recruitment target	Sep 25	31.1%				
% of open studies with a commercial sponsor	Sep 25	4.4%				

Areas of Concern

4 Never Events for this financial year

News 2 compliance below target of 90%

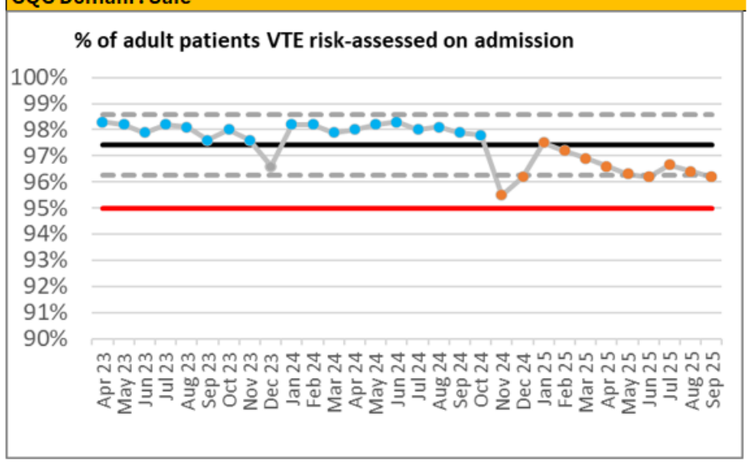
Forward Look (Actions)

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

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

% of adult patients VTE risk assessed on admission

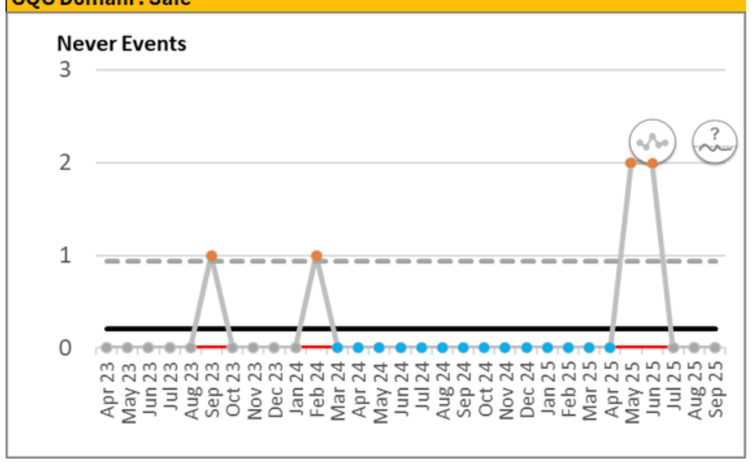
CQC Domain : Safe



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

Never Events

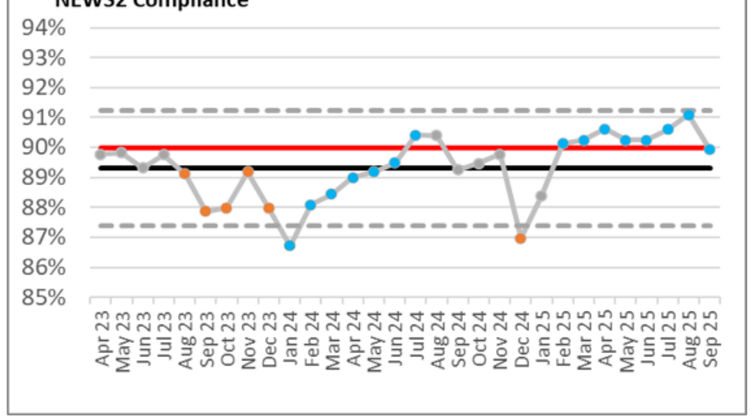
CQC Domain : Safe



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

NEWS 2 Compliance

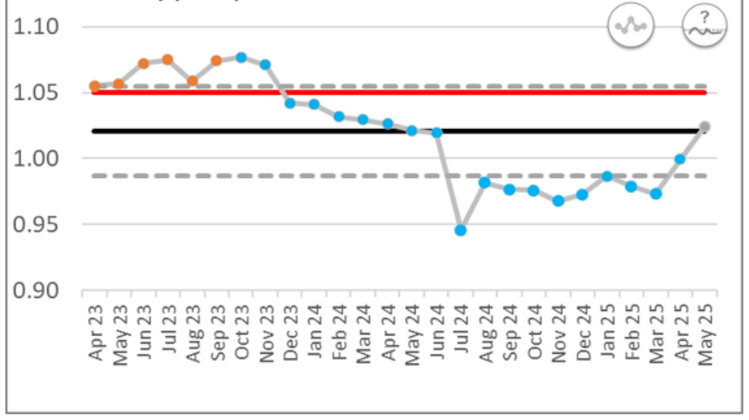
CQC Domain : Well-led



Sep-25
89.9%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



May-25
1.0242
Variance Type
Common cause variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

Commentary

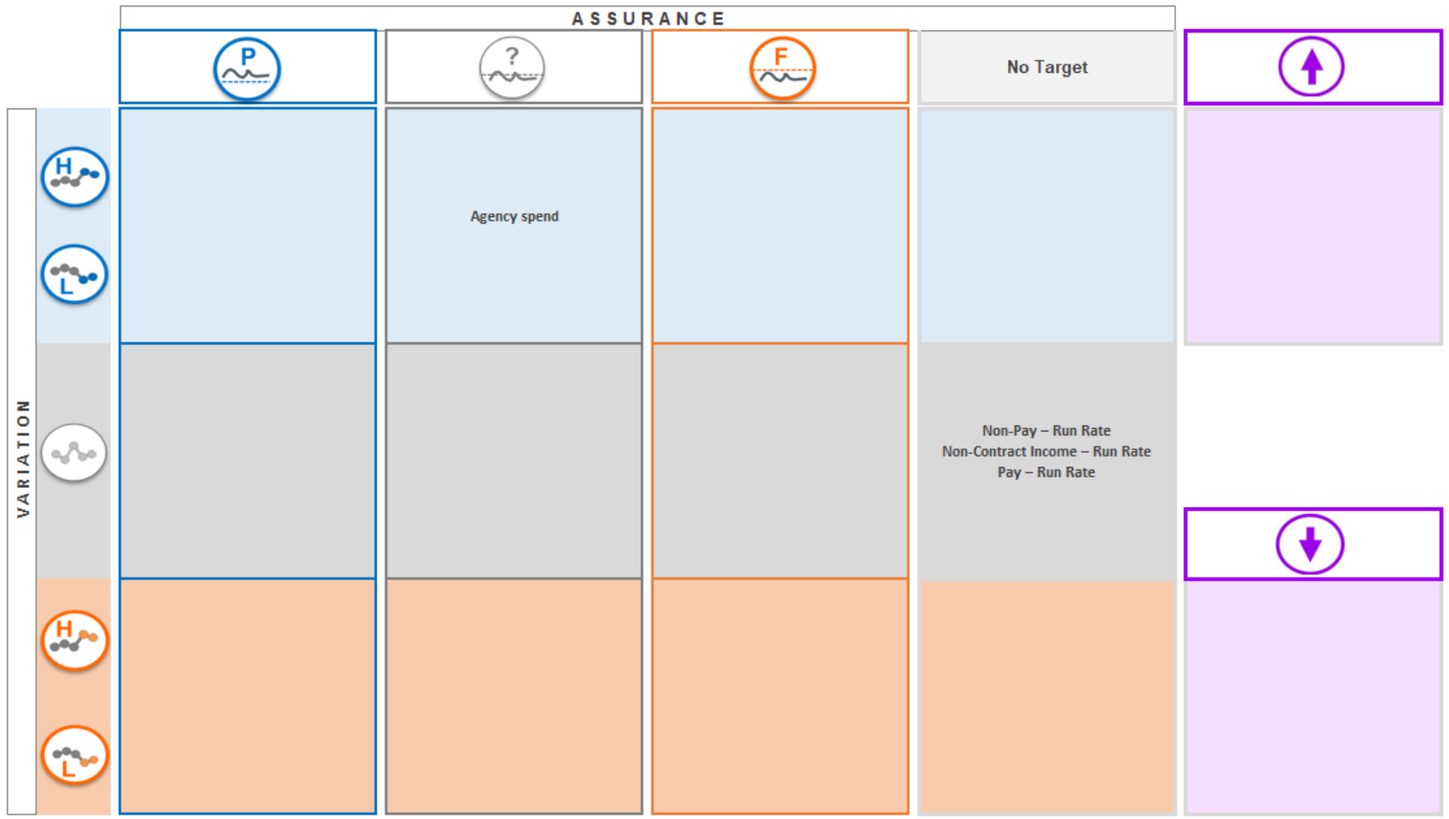
Number of studies open – Snapshot position	% of current studies meeting recruitment target – Snapshot position
45	31.1%

% of open studies with a commercial sponsor – Snapshot position	
4.4%	

Commentary

Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix



Finance Summary

Highlights

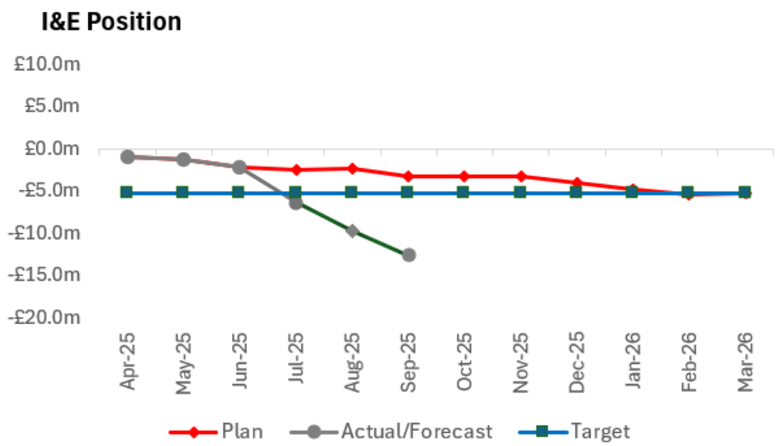
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Sep 25	1.4%	≤3%			2.7%
I&E Position	Sep 25	-£12.6m	-£5.2m			
Cumulative CIP	Sep 25	£16.0m	£16.0m			
Capital Expenditure	Sep 25	£8.9m	£13.1m			
Cash Position	Sep 25	£0.4m	£1.6m			

Areas of Concern

Forward Look (Actions)

I&E Position

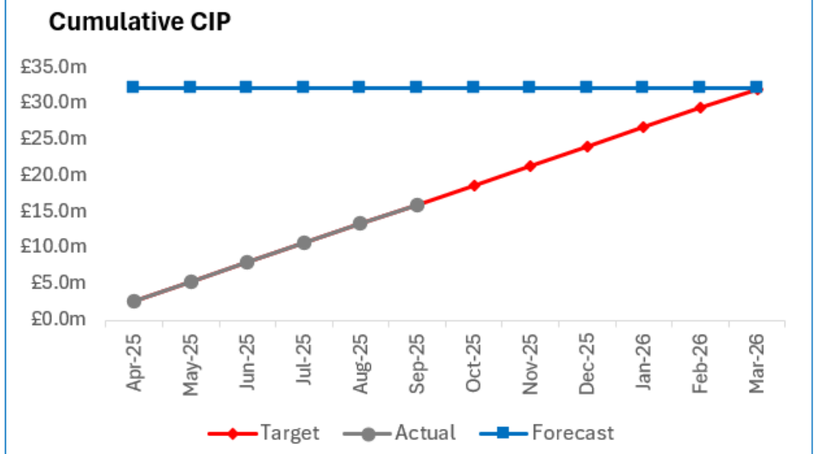
CQC Domain : Use of Resources



Sep-25
-£12.6m
Variance Type
Position doesn't meet the plan
Target
-£5.2m

Cumulative CIP

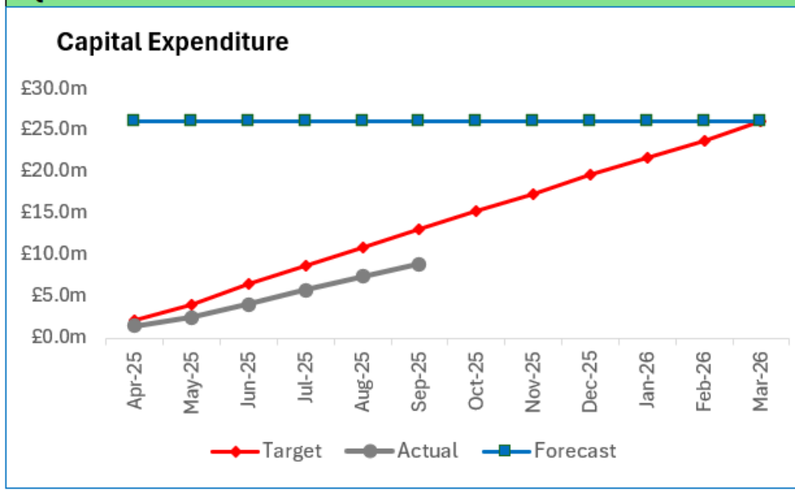
CQC Domain : Use of Resources



Sep-25
£16.0m
Variance Type
Position meets the plan
Target
£16.0m

Capital Position

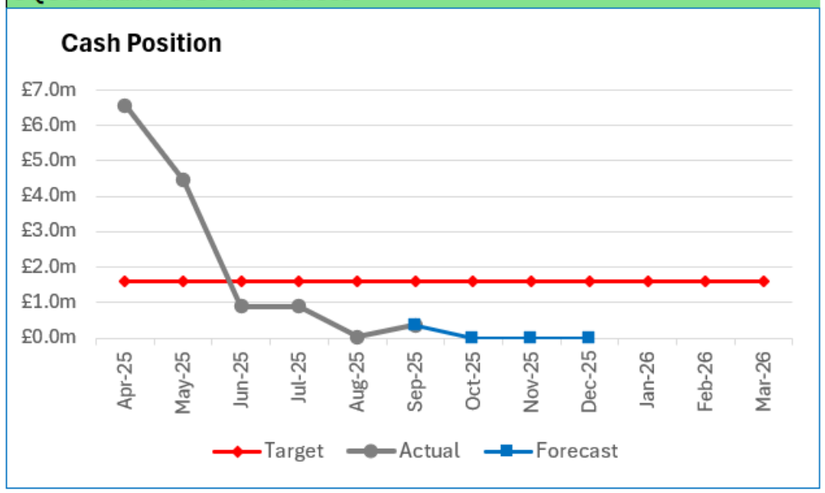
CQC Domain : Use of Resources



Sep-25
£8.9m
Variance Type
Position meets the plan
Target
£13.1m

Cash position

CQC Domain : Use of Resources

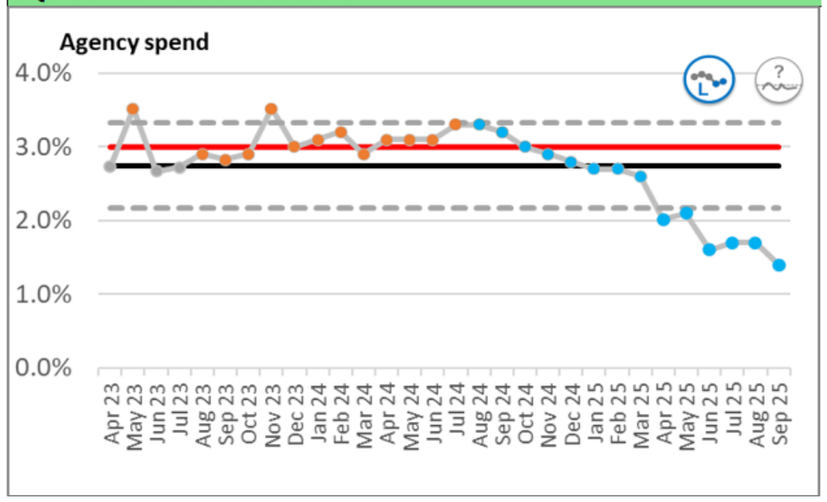


Sep-25
£0.4m
Variance
Position doesn't meet the plan
Target
£1.6m

Commentary

Agency spend %

CQC Domain : Use of Resources



Sep-25
1.4%
Variance Type
Special cause improving variation
Threshold
≤3%
Assurance
Consistently hit target

Commentary

Chief Finance Officer

Executive Summary

At the end of September 2025 (M6) the Trust is reporting a deficit of £12.6m which is £9.4m adverse to plan driven by; withheld Deficit Support Funding (DSF), industrial action, pay award pressures and system stretch target not achieved. To date, £7.0m of non-recurrent mitigations have been utilised to support delivery against plan and offset the key risks outlined below.

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

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

- Full CIP delivery – This is the primary risk to achieving the 2025–26 financial position. The risk adjusted annual forecast is below the required target. This risk includes the delivery of the ICS schemes (£14.1m).
- Activity / Casemix – Adjusting for the impact of IA, elective income remains below plan at M6.
- Aseptic Pharmacy – This risk is materialising with a significant reduction in income resulting from production compliance changes.
- Run-rate – 80% of targeted run-rate reductions have been identified and actioned.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M6 was £0.36m. The Trust implemented a cash mitigation plan in September but until a sustainable financial position is achieved this significant issue will continue. Further revenue support applications have been made for October (approved) and November (in progress).

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

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

Statutory Financial Targets	RAG (M6)	RAG (Forecast)	Section within this report / associated chart
Financial Stability	🔴	🔴	I&E Position
Agency Spend	🟢	🟢	I&E Position
Financial Sustainability	🔴	🔴	N/A (quarterly update)
Financial Efficiency	🔴	🔴	Cumulative CIP
Capital	🟢	🟢	Capital Expenditure
Cash	🟡	🔴	Cash Position

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

The Board is asked to:

- Note the report including that the Trust has reported an adverse variance to plan.
- Note that the Trust's most immediate finance risk remains the cash position and approve that the CFO submits additional applications based on confirmed need.
- Note the risk to delivering the 25/26 plan, that this risk is not fully addressed by the approved mitigation plan and the requirement to identify additional actions.
- Approve the increase in the capital budget for cyber resilience.

I&E Position

Narrative:

The table below summarises the M6 position:

	In Month			Year to Date			Forecast		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£40.4m	£38.9m	-£1.5m	£242.5m	£236.1m	-£6.4m	£485.0m	£479.4m	-£5.5m
Other Operating Income	£2.9m	£2.7m	-£0.2m	£17.6m	£16.6m	-£1.0m	£34.9m	£32.4m	-£2.6m
Total Income	**£43.3m**	**£41.6m**	**-£1.7m**	**£260.1m**	**£252.7m**	**-£7.4m**	**£519.9m**	**£511.8m**	**-£8.1m**
Employee Expenses	-£32.1m	-£31.6m	£0.5m	-£191.2m	-£192.9m	-£1.7m	-£380.1m	-£386.2m	-£6.1m
Operating Expenses	-£12.8m	-£12.7m	£0.1m	-£77.1m	-£76.9m	£0.2m	-£153.8m	-£156.6m	-£2.9m
Non Operating Expenses	-£0.4m	-£0.4m	£0.0m	-£2.5m	-£2.5m	-£0.1m	-£4.9m	-£5.0m	-£0.1m
Recurrent CIP	£1.1m	£0.0m	-£1.1m	£7.3m	£0.0m	-£7.3m	£13.7m	£2.1m	-£11.6m
Non Recurrent Mitigations	£0.0m	£0.0m	£0.0m	£0.0m	£7.0m	£7.0m	£0.0m	£7.0m	£7.0m
Total Expenditure	**-£44.2m**	**-£44.6m**	**-£0.4m**	**-£263.4m**	**-£265.3m**	**-£2.0m**	**-£525.1m**	**-£538.8m**	**-£13.6m**
PFR Reported Position Month 6	**-£0.9m**	**-£3.0m**	**-£2.1m**	**-£3.2m**	**-£12.6m**	**-£9.4m**	**-£5.2m**	**-£27.0m**	**-£21.8m**
Adjust for DSF	**-£1.4m**	**£0.0m**	**£1.4m**	**-£8.5m**	**-£4.2m**	**£4.3m**	**-£16.9m**	**-£12.7m**	**£4.2m**
Position excluding DSF	**-£2.3m**	**-£3.0m**	**-£0.7m**	**-£11.7m**	**-£16.8m**	**-£5.1m**	**-£16.9m**	**-£39.7m**	**-£17.6m**
Mitigations								**£4.6m**	**£4.6m**
Trust Mid-case Scenario							**-£16.9m**	**-£35.1m**	**-£13.0m**

Key variances within the YTD position are:

Clinical Income – £6.4m adverse variance relates to elective underperformance including industrial action and loss of DSF.
Employee Expenses - £1.7m adverse variance relates to use of bank, agency, industrial action and undelivered vacancy factors.
Operating expenses – £0.2m positive variance relates clinical supplies and depreciation.
Cost Improvement Programme – £7.3m underdelivered at month 6 which is offset by non-recurrent mitigations.

The Trust's agency costs were 1.7% of total pay bill for the month, which is significantly below the NHSE threshold of 3.2% of total staff costs.

Cumulative CIP

Narrative:
The Trust has transacted CIP with a part year effect of £28.3m at M6 of which, £7.0m has been delivered non-recurrently. The Trust has identified recurrent CIP with a full year effect of £31.3m, however, this figure reduces to £25.5m once risk adjusted reflecting a risk adjusted shortfall of £6.5m.

Review of the CIP position is ongoing through weekly CIP Assurance, chaired by the COO and monthly Productivity Improvement Board, chaired by the CEO. The Trust also meets frequently with colleagues from the ICB and across the ICS to identify and deliver the collectively agreed additional savings target (WUTH share £14.5m).

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £54.4m at Month 6 (M6), reflecting an adverse variance of £2.2m. Elective underperformance is primarily driven by the Surgical Division, specifically Trauma & Orthopaedics (T&O). Daycase underperformance is driven by the Medicine division, specifically Dermatology and Cardiology.

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

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2025/26 at M6:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M5	Revision to budget M6	Revised Budget
CDEL					
Internally Generated	£9.765m	£0.000m	£0.000m	£0.000m	£9.765m
ICB/PDC/WCHC	£14.550m	£0.516m	£0.034m	£0.058m	£15.158m
Charity	£1.100m	£0.000m	£0.000m	£0.000m	£1.100m
Confirmed CDEL	£25.415m	£0.516m	£0.034m	£0.058m	£26.023m
Total Funding for Capital	£25.415m	£0.516m	£0.034m	£0.058m	£26.023m
Capital Programme					
Estates, facilities and EBME	£3.100m	£0.516m	£0.034m	£0.000m	£3.650m
Operational delivery	£8.440m	£0.000m	£0.000m	£0.000m	£8.440m
Medical Education	£0.080m	£0.000m	£0.000m	£0.000m	£0.080m
Transformation	£0.250m	£0.000m	£0.000m	£0.000m	£0.250m
Digital	£0.750m	£0.000m	£0.000m	£0.058m	£0.808m
UECUP	£7.800m	£0.000m	£0.000m	£0.000m	£7.800m
PDC commitments	£0.304m	£0.000m	£0.000m	£0.000m	£0.304m
ICB hosted	£3.591m	£0.000m	£0.000m	£0.000m	£3.591m
Charity	£1.100m	£0.000m	£0.000m	£0.000m	£1.100m
Approved Capital Expenditure Budget	£25.415m	£0.516m	£0.034m	£0.058m	£26.023m
Total Anticipated Expenditure on Capital	£25.415m	£0.516m	£0.034m	£0.058m	£26.023m
Under/(Over) Commitment	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m

In M6 the Trust has received an additional £0.058m for Cyber Resilience which is now included within the Capital Plan.

Spend at M6 totals £8.916m which is £4.176m behind plan.

Cash Position

Narrative:

The cash balance at the end of M6 was £0.36m. This includes the impact of a £4.2m reduction in planned Deficit Support Funding; the impact of which will continue at least until Month 6 (September). As previously reported, the Trust applied in August 2025 for £16.5m of cash support, of which £10.03m

has been approved, allowing the Trust to maintain a positive cash position in September. It has also been confirmed that the Trust's application for an additional £5.5m of revenue support in October has been approved. A further application for November is in progress.

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

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

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11**
5 November 2025

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

Report Purpose and Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times and a continued challenge in the delivery of the 28 day faster diagnostic standard.

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 within the department.

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.

Although the report focusses on performance in September the Board should note the impact on elective performance for future months given the critical incident in relation to sterile services.

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
	WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway as an output of the widescale cancellation of activity during Covid. Since April 2025 many cancer services have seen unexpected levels of referrals that are much higher than the capacity available, leading to challenges in the delivery of the 28 day faster diagnostic standard. Overall routine elective waiting times are performing well with only ENT as a risk to reducing long waiting times. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. There is regional and national focus on the Trust's 4 and 12 hour performance. A daily executive performance huddle has been introduced with the Emergency Department to drive improvements in performance.

2	Planned Care
2.1	**Elective Activity** In September 2025, the Trust attained an overall performance of 96% against plan for outpatients (94% for new outpatient attendances), and an overall performance 92% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for September	Actual for September	Performance
Out pt New	12,456	11,654	93.6%
Out pt Follow up	26,827	26,070	97.2%
Out pt procedures	4,002	3,889	97.2%
Total Out pts	43,285	41,613	96.1%
Day case	4,766	4,277	89.7%
Inpatients	586	628	107.1%
Total - Elective and Daycase	5,352	4,905	91.6%

The Trust underachieved plan for outpatients and elective/daycase.

	Underachievement for elective / daycase activity was seen in Medicine and Surgery. Surgery underachievement was seen largely in T&O due to a reduction in ambulatory trauma and Oral Surgery due to ongoing consultant absence.
2.2	**Referral to Treatment (RTT)** The Trust's performance at end of September 2025 against RTT metrics was as follows *(RAG rated versus monthly trajectories from Trust planning submission)*: 		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
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Total RTT Caseload	46,400	45,691	46,939	47,312	47,271	48,195
% RTT	59.74%	63.01%	62.54%	61.80%	60.68%	61.70%
52 weeks	1,128	1,272	1,302	1,255	1,335	1,138
52 weeks % of caseload	2.43%	2.78%	2.77%	2.65%	2.82%	2.36% | |						
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104+ Week Wait Performance	0	0	0	0	0	0
78+ Week Wait Performance	7	0	0	0	0	0
65+ Week Wait Performance	24	22	13	16	7	4	 The Trust achieved trajectory for RTT caseload, percentage of patient waiting 18 weeks or under, but was over trajectory for number and percentage of 52-week waiters in September 2025. The overall RTT waiting list increased in size in September 2025 but remains below trajectory. Increases in caseload are attributed to Physiotherapy, with plan for recovery of caseload by December, and a sharp increase in the number of referrals in Dermatology as a result of regional pathway changes (see section 2.3 Cancer Performance). Outsourcing within ENT commenced in October, which along with a third national validation sprint from 3rd November, will see a reduction in caseload. There were 0 x patients waiting 78+ weeks at the end of September 2025, this position has been maintained since May 2025. The number of patients waiting 65+ weeks has reduced to 4. Of the 4 patients waiting, 1 x was a graft, 3 were due to capacity in ENT. Gynaecology as a previously challenged area in relation to numbers of long waiting patients, maintained 0 x 65 week waiters. Divisional teams are developing recovery plans for 52-week waiters, having focused on reduction of 65 weeks. ENT and Dermatology represent the largest variances from trajectory. As noted above, outsourcing has commenced in ENT to create additional capacity and reduce waiting times.
2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2:

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

National Standards:

Standard	Indicator	Threshold	July-25	August-25	September-25	Quarter 2
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	77.00%	72.24%	67.14%	N/A	69.73%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.07%	90.09%	N/A	90.63%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.78%	75.07%	N/A	75.43%

Sub Standards:

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

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for August 2025. Areas of pressure include Dermatology as a result of impact of regional ceasing of A&G / introduction of AI, Breast, Gynaecology and Urology.
- *62-day treatment* - The Trust did not achieve local trajectory in August 2025 with performance 75.07% versus trajectory of 76.55%. The impact of pressures on 28-day performance is seen to impact 62-day treatment delivery.
- *62-day waiters* – the number of waiters decreased in September but remains high as a result of pressure on 28-day performance.

	07/04	14/04	21/04	28/04	05/05	12/05	19/05	26/05	02/06	09/06	16/06	23/06	30/06	07/07	14/07	21/07	28/07	04/08	11/08	18/08	25/08	01/09	08/09	15/09	22/09	29/09
Actual 25/26	81	64	106	98	105	102	94	99	110	126	124	128	112	120	119	121	124	137	161	167	140	171	156	138	139	128
Trajectory 25/26	105	105	105	105	98	98	98	98	91	91	91	91	91	84	84	84	84	77	77	77	77	69	69	69	69	69
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104-day long waiters* – the number of waiters has decreased in September.

	07/04	14/04	21/04	28/04	05/05	12/05	19/05	26/05	02/06	09/06	16/06	23/06	30/06	07/07	14/07	21/07	28/07	04/08	11/08	18/08	25/08	01/09	08/09	15/09	22/09	29/09
Actual 25/26	26	23	22	19	21	23	22	22	26	26	23	26	24	28	26	31	28	32	41	41	45	45	40	32	29	23
Trajectory 25/26	22	22	22	22	21	21	21	21	19	19	19	19	19	17	17	17	17	15	15	15	15	13	13	13	13	13
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

Performance in Urology, Gynaecology, Breast and Dermatology tumour sites were seen to have an impact on overall 28-day FDS performance at Trust level. Dermatology cancer performance remains the most significant pressure with improvements across other tumours sites.

Dermatology performance deteriorated following implementation of pathways changes; introduction of AI pathway (WUTH go-live 14 April 2025) and regional ceasing tele-dermatology (region-wide from end of 31 May 2025), with sharpest decrease coinciding with tele-dermatology switch off. This deterioration is also reflected across the region. Demand now significantly exceeds capacity impacting FDS performance which has dropped below 50%, with a corresponding impact expected to be seen against the 62-day referral to treatment standard from August. Changes in the pathway have also led to an increase in the proportion of patients being listed, meaning that whilst the main bottleneck in the pathway is currently the initial appointment, if additional resource is identified to clear this backlog, further resource will also be needed to accommodate the increase in demand for excision and biopsy.

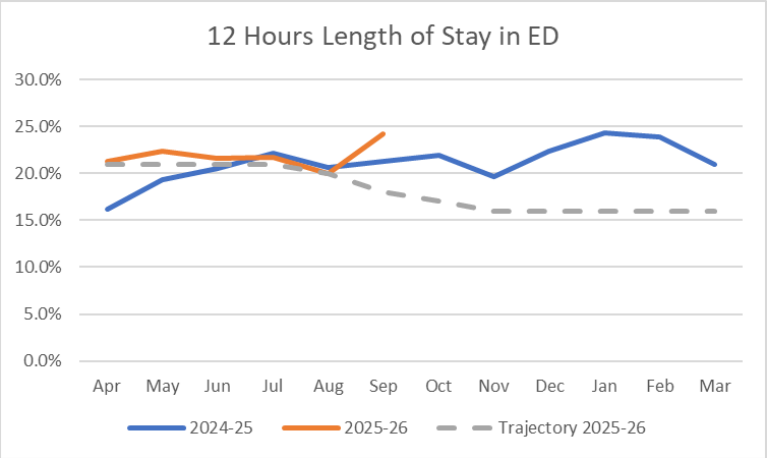
Opportunities to create additional resource are currently being explored however, the current backlog and timescales for additional resource are such that it is unlikely performance against cancer standards within skin will improve before January 2026 at the earliest. The Cheshire and Merseyside Cancer Alliance has agreed partial funding of the recovery required in Dermatology, this will be implemented during November.

Following implementation of Gynaecology pathway changes in September, performance is improving as planned, with performance forecast to meet tumour site trajectory in

	October. The Breast Service is proceeding with plans to provide additional capacity, and is forecast to improve FDS performance in October and meet tumour site trajectory in November. Urology continue to focus on optimising the cancer pathway with additional triage capacity and improved escalation for diagnostics and tracking. Improvement can be seen in more recently weekly data as result of the focused work from the Division.
2.4	**DM01 Performance – 90% Standard** The Trust did not achieve 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 87.4% for September. Non-obstetric ultrasound remains the area of greatest pressure despite increased capacity and ongoing use of mutual aid. Loss of an agency worker who was supporting recovery has delayed forecast achievement of plan from September to October. Additional insourcing has been confirmed and recovery is on track for October and the overall delivery of 90%.
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. Cancer improvement plans have been developed by divisions, including tumour site level trajectories, as well as plans to address more immediate performance issues. The new monthly cancer performance meeting is supporting focus on longer term improvement actions. The Trust has been supported with regional recovery funding in Gynaecology, Breast and Dermatology. Improvements have been seen across tumour sites for 28 day cancer performance, with the exception of Dermatology which remains the most significant risk to Trust performance.

3.0	**Unscheduled Care**
3.1	**Performance** In September, Type 1 performance was reported at 42.71%, with a combined performance across all Wirral sites reaching 70.37%. This falls well below the required standards. Type 1 ED attendances: • 7,822 in August (avg. 252/day) • 8,030 in September (avg. 268/day) • 2.7% increase from previous month Type 3 ED attendances: • 3,075 in August (avg. 99/day) • 2926 in September (avg. 97/day) • 4.8% decrease from previous month There is a system trajectory to achieve 78% 4 hour performance by the end of March 2026. In September, urgent and Emergency Care demand increased, with a rise in Type 1 attendances and a more noticeable decrease in Type 3 (UTC) attendances. While performance against the Type 1 4-hour standard was marginally below trajectory, a national focus remains on delivering over and above plans submitted at the start of the financial year. There is an internal focus to ensure that over 50% of patients are seen and treated within 4 hours as the first milestone of the improvement journey.

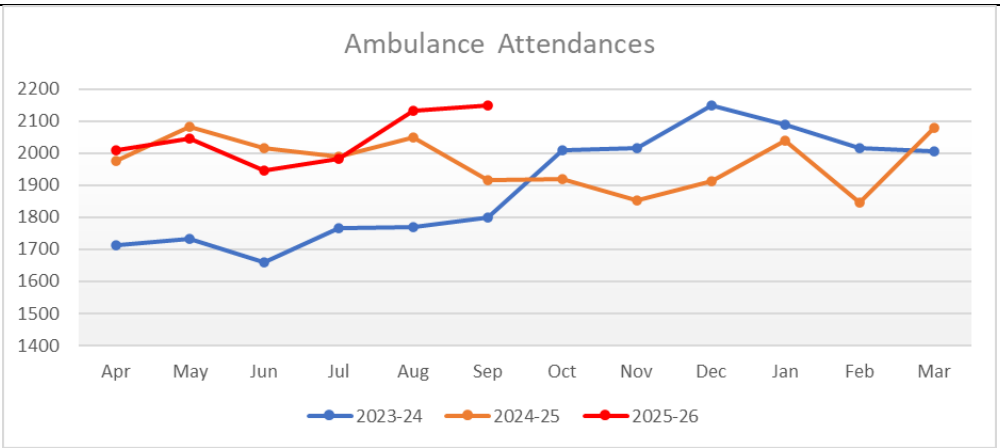
The challenged metric in UEC performance continues with 12 hour waits in the emergency department. Performance deteriorated in month however the increase in demand from both walk-ins and ambulance conveyances put significant pressure on the recovery actions to work on reducing the long waits. The Trust and the wider Cheshire and Merseyside system continue to report as national outliers, with an average of 21% of patients experiencing a stay beyond 12 hours. The system-wide focus led by NHSE and the ICB, remains in place with active collaboration across all acute providers and the two mental health providers for the region. The Trust along with others in Cheshire and Merseyside has also been put in Tier 1 for UEC performance, so further scrutiny is in place on the need to improve performance and utilise the support provided by ECIST, of which we have worked with previously. The main challenge in delivering improvements is medical patients awaiting a bed or those referred to medicine out of hours, this is the main area of focus in delivering improvements in this metric.



The programme of work with ECIST has started in September and will focus on prolonged waits in ED, wait to be seen, workforce and ward processes.

The Trust has progressed working with mental health colleagues by implementing the national mental health action cards which provides assurance and governance with long waits in ED being escalated to the mental health provider executive teams. This will be monitored into October and learning shared at system level and to NHSE and the ICB. There continued to be significantly long waits for mental health beds in ED with some patients over 100 hours.

Ambulance handover performance remains consistent, although some days have been challenged due to demand and staffing numbers able to respond, overall month position remains complaint to 45 minutes. The demand on ambulance conveyances continues to increase, with a record number of attendances in a single day of over 100, against a previous average of 65 per day. This volume impacts on the ability for the Trust to recover at pace and results in long delays in the department.



The ED department remains in a significantly reduced estate until summer next year so the capacity to manage high demand of ambulance conveyances continues to result in corridor care. Alternative areas have been explored to offset the loss of 19 ED spaces during this time.

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

In September, the position has remained stable, showing only minor variation from previous months. The reduction has been sustained year to date, providing assurance that the oversight and management of improvements continues to see a benefit to reducing length of stay for this cohort of patients.

The Trust performance for NCTR remained in a strong position in comparison to other Trusts in Cheshire & Merseyside. The most recent position in September shows a performance of 12.2%.

Provider	Current
Countess	16.2%
East Cheshire	35.1%
LUHFT	20.7%
Mid Cheshire	17.8%
MWL	20.7%
W&H	23.0%
WUTH	12.2%
Total	**19.8%**

As part of the Trusts winter planning, a multi agency discharge event (MaDE) is scheduled prior to and post-Christmas period with system partners, focusing on discharges and maintaining low NCTR numbers.

3.3 **Mental Health**

The focus on reducing 12-hour waits continues to equally focus on mental health patients. The metal health provider, continues to work with the Trust and NHSE to prioritise improvements in this area, which includes the implementation of the 12-hour escalation performance and increased visibility of performance.

	Mental health acuity remained high in month with days of demand exceeding capacity within the emergency department of which did result in some longer waits in the department, of which all had been escalated to Chief Operating Officer of the mental health provider. The Trust continues to wait on the outcome of a capital funding bid to support the development of a dedicated Mental Health Crisis Hub for the Wirral. If approved, this investment would expand local capacity and provide an alternative to the Emergency Department for s136 patients without acute medical needs, thereby helping to relieve pressure on the department and improve patient outcomes.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to implement new steps in line with best practice to make improvements against 4 and 12 hour performance. Performance is being closely monitored through the Urgent and Emergency Care (UEC) Improvement Group, with oversight of sentinel metrics provided by Place leads and the System Control Centre (SCC). Despite this progress, several risks remain. Increased patient acuity, sustained demand for beds, and high conversion rates continue to place significant pressure on patient flow and the delivery of planned improvements.

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 Trust team continue to focus on new action and steps to improve 4 and 12 hour performance that includes daily executive huddles.

	Elective recovery remains a strong point and improvements continue, but the recent critical incident in sterile services will pose a risk to the continued improvement in reducing waiting times.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 12**

05 November 2025

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

Executive Summary and Report Recommendations

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

Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the Committee. This update provides the position following review during October 2025 and three strategic risk scores have increased.

It is recommended that the Board:

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

Key Risks

This report relates to these key risks:

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

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
October 2025	People Committee	Board Assurance Framework	The Committee reviewed the position in relation to strategic risks and supported onwards reporting to the Board of Directors.
October 2025	Finance Business Performance Committee	Board Assurance Framework	The Committee reviewed the position in relation to strategic risks and supported onwards reporting to the Board of Directors.

1	**Narrative**
1.1	**Current position** The dashboard at appendix 1 confirms the current position of strategic risks as reviewed during October 2025. Risk ID02 - *Failure to meet targets and standards in relation to Planned/Scheduled care, resulting in an adverse impact on patient experience and quality of care.* Following discussion at the Finance Business Performance Committee on 20 October it is proposed to increase to RR16 (4 x 4), due to the impact on elective recovery/ scheduled care as a result of the critical incident declared in October. Risk ID04 - *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.* At the People Committee on 3 October it was proposed that the risk be increased to RR16 (4 x 4), due to the upcoming period with sickness absence, the impact of financial constraints, and the impact of integration which could have a knock on effect on sickness and recruitment. Risk ID08 - *Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.* Also following discussion at the Finance Business Performance Committee on 20 October, it is proposed to increase to RR12 (3 x 4), recognising current capacity, challenges with regional and national programmes and pressure on the hospital.

2	**Implications**
2.1	**Patients**

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

12 Month – Dashboard and Current and Quarterly Trend

Impact x Likelihood

Risk No	Strategic Priority	Risk Appetite	Owner	Risk Description	Initial Score (I x L)	Target	Sept 24	Dec 24	Mar 25	June 25	Direction	Oct 25
1	Outstanding Care **R, O, C, F**	Minimal	COO	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)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	↔	20 (4 x 5)
2	Outstanding Care **R, O, C, F**	Minimal	COO	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)	↑	16 (4 x 4)
3	Outstanding Care **R, O, C, F**	Minimal	CN/MD	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)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	↔	16 (4 x 4)
4	Compassionate Workforce **O, C, F**	Open	CPO	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	12 (3 x 4)	12 (3 x 4)	↑	16 (4 x 4)
5	Compassionate Workforce **R, O, C, F**	Open	CPO	Failure of the Trust to have the right culture, staff experience, safety and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
6	Continuous Improvement **R, O, F**	Minimal	CFO	Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision.	16 (4 x 4)	8 (4 x 2)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	↔	20 (4 x 5)
7	Digital Future and Infrastructure **R, O, F**	Seek	CFO	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
8	Continuous Improvement **R, F**	Open	COO	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↑	12 (3 x 4)
9	Our Partners **R, S, F**	Seek	CEO/CSO	Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce and financial) not being realised.	9 (3 x 3)	6 (3 x 2)					↔	9 (3 x 3)
10	Digital Future and Infrastructure **R, S, F**	Seek	CSO	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Digital Future and Infrastructure **R, O, C, F**	Seek	COO/CFO	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	15 (5x3)	15 (5 x 3)	15 (5 x 3)	15 (5 x 3)	↔	15 (5 x 3)
12	Outstanding Care **R, O, C**	Minimal	CEO	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)	12 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)

Risk Categorisation

All BAF Risk are further identified by the following risk categories:

- Reputational risk. **R** Operational risk. **O** Strategic risk. **S** Financial risk. F

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

		Initial Score	Last Quarter	Current	Target
Strategic Priority	Outstanding Care				
Risk Appetite	Minimal				
Review Date	Q3 2025/26				
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
• NOF segmentation (Q1 25-26) - 4 (0.03 below segment 3) • NOF domain score - Access to Services - 2.57 • NOF metric score - UEC 4 hours - 2.7 • NOF metric score - UEC 12 hours - 3.95 • The Trust continues to be challenged delivering the national 4-hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.

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

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

Strategic Priority	Outstanding Care				
Risk Appetite	Minimal				
Review Date	Q3 2025/26	Initial Score (I x L)	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)

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

Gaps in Control or Assurance

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

Action	Responsible	Deadline
Review data submission for NOF metrics - *Access to Services*	Chief Operating Officer / Chief Finance Officer	October 2025
Continue with delivery of mitigation plans for scheduled care,	COO	March 2026
Utilisation of premium time capacity to bridge gaps in capacity and demand	COO	March 2026

BAF RISK 3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.

		Initial Score	Last Quarter	Current	Target
Strategic Priority	**Outstanding Care**				
Risk Appetite	**Minimal**				
Review Date	**Q3 2025/26**				
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, Quality and Research and Innovation Strategies • Quality Governance Structure (including patient safety) established trust-wide • **Quality Governance Accountability Framework includes monitoring and review of quality and patient safety indicators at monthly Divisional Performance Reviews** • **PSIRF plan and policy** • **Patient Safety Partners in post** • **WISE accreditation programme** • **Infection Prevention and Control (IPC) Board Assurance Framework (with oversight at the Quality Committee) - *compliant in 46 areas; partial compliance in 8 areas with action plans in place*** • **All actions from CQC 2018 action plan formally closed** • **CQC action plan (following 2025 inspection) developed for tracking through quality governance structures** • CQC engagement meetings • Safety huddles • Nursing and Maternity Champions • **PSQB divisional reporting** • **Senior leads for statutory roles in place - DIPC, Safeguarding, CDAO, Medicines Safety Officer** • **Incident reporting culture and processes trust-wide - open reporting culture *(as evidenced in CD Annual Report - high number, low harm)* with digital dashboard**	• Executive Patient Safety and Quality Board (PQSB) oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Committee • **PSQB AAA Chair's Report to Quality Committee** • **Patient Safety Incident Response Panel (reporting to PSQB) - *identified opportunity for learning across WUTH and WCHC*** • **Safeguarding Assurance Group & Safeguarding Annual Report *(11 areas of improvement)*** • **Never-events Thematic Review *(reporting to Quality Committee)*** • **Achievements against Antimicrobial Stewardship (AMS) priorities for 24-25 *(reporting to Board)*** • Mortality Review Group oversight • Regular board review of Quality Performance via Integrated Performance Report • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Serious Incidents and Never Events action plans. • **Annual Internal Audit Plan (MiAA) and Annual Clinical Audit Programme (e.g. IPC, CD) reporting through governance structure including to Audit & Risk Committee** • Maternity self-assessment • JAG, AXA, ACCA accreditation and national SNAPP audits • C and M Surgical Centre • LLP Assurance • GIRFT including NCIP data. • Monthly Maternity Report • CEO Complaints sign-off

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 *- see action below.*** • **Lack of BI capacity impacting on patient outcome data** • **Delays in incident investigation** • **Inconsistent learning from complaints and incidents** • **MiAA IPC Review - completion of action plan to mitigate identified risks**

Action	Responsible	Deadline
Launch PSIRF plan and policy	**Chief Nurse**	**Q3, 25-26**
Involvement of Patient Safety Partners (beyond PSIIs)	**Chief Nurse**	**Q4, 25-26**
Complete implementation, monitoring and delivery of the patient safety and quality strategies.	**Chief Nurse**	**Q3, 25-26**
Strengthening of LoCSSIPs across the Trustto manage identified variation (e.g. audit programme, training)	**Medical Director**	**Q3, 25-26**
Monitoring of CQC action plan to implementation of all actions	**Chief Nurse**	**December 2025**
Complete delivery of the Maternity Safety action plan	**Chief Nurse**	**November 2025**
On-going review of IPC arrangements – SIT Review.	**Chief Nurse**	**October 2025**
CQC preparedness programme and mock inspections.	**Chief Nurse**	**Q2, 25-26**
Delivery of Mental Health key priorities.	**Chief Nurse**	**Q4, 25-26**
Wirral system strategy for CDiff.	**Chief Nurse**	**Q3, 25-26**

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

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

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group. • Staff drop in sessions. • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this. • **New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - 'Every Day Counts'.** • **Delivery of the annual flu campaign to prevent increase in flu related absence.**	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • **Monthly Workforce monitoring as Workforce Steering Committee**

• **New Resilience through Change sessions led by Trust's psychotherapist with 2 further sessions planned before the TUPE transfer in December'25.** • **Increased number of mental health first aiders across the Trust with deliver of additional cohorts of Mental Health First Aiders MHFA) Training and refresher training for existing MHFA.** • **Enhanced training for managers (preventing sickness absence through wellbeing conversations) made available.** • **Wirral CiC providing health checks across the Trust; resulting in a report of findings to inform future wellbeing action / initiatives.** • **New Road Map for Wellbeing showcasing all the support available to staff in one place launched.** • **HR drop-in sessions provide managers with access to dedicated HR resource to support with case management.** • **Local sickness audits conducted monthly to review manager capability and offer support to improve management of absence.**	

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

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

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

Strategic Priority	**Compassionate Workforce**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**	**Initial Score**	**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** • **Impact of financial pressures** • Impact of large scale organisational change (integration)

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

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

Strategic Priority	Continuous Improvement
Risk Appetite	Minimal
Review Date	Q3 2025/26
Lead	Chief Finance Officer

Initial Score	Last Quarter	Current	Target
16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	8 (4 x 2)

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

Gaps in Control or Assurance
• NOF segmentation (Q1 25-26) - 4 (0.03 below segment 3) • NOF domain score - Finance and Productivity - 2.36 • NOF combined finance metric score - 3.00 • Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • Mitigated forecast of 7m variance to plan. • Unmitigated forecast of 29m variance to plan. • Significant variance for 25/26 to approved control total. • Full mitigation plan for approval

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

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

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

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

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

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

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

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

Controls	Assurance

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

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

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

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

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

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

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

Action	Responsible	Deadline
• Presentation of the case for change to ICB	Chief Strategy Officer	September 2025
• Agreement of costs to support the necessary resources associated with the statutory transaction	Chief Strategy Officer	Q3, 25-26

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

Strategic Priority	**Infrastructure**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**	**Initial Score**	**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
• Implementation of 3 year capital programme • Delivery of 2021-2026 Estates Strategy. • Business Continuity Plans. • Procurement and contract management. • Assigned 3 year capital budgets, with Executive Director accountability • Assessment of current backlog maintenance risk and future potential risk	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks and completion of business continuity plans for critical infrastructure • Independent review of risks carried out. • Appointment of authorised engineers. • NHS England Premises Assurance Model

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

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

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

Strategic Priority	**Infrastructure**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**	**Initial Score**	**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	Responsible	Deadline
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
Risk Appetite	Seek
Review Date	Q3 2025/26
Lead	All Executive Directors

Initial Score	Last Quarter	Current	Target
16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Wirral Review Terms of Reference and recommendations from the review incorporated into 2-year integration plan. • Partnership Agreement in place between WUTH and WCHC with the exercising of joint functions. • Joint Chair and CEO in place across WCHC and WUTH. • Joint NEDs appointed and single Executive Team in progress. • Council of Governor joint development sessions with WCHC. • Integration Management Board (IMB) established; meeting monthly. • 2-year integration plan developed and in delivery, with oversight at Integration Management Group and IMB.	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Wirral Place Partnership Committees and fora. • Integration Management Board established and operational • Wirral Provider Alliance established with multi-sector membership including primary care, Local Authority and VCSFE. • Development of Joint Strategy for WCHC and WUTH, for completion in 2026

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

Action	Responsible	Deadline
Full stakeholder engagement in Joint Strategy Development and Clinical Service Strategy Development	Chief Strategy Officer	Q4, 25-26
Establishment of the Wirral Provider Alliance	Director of Corporate Affairs	October 2025
Refreshment of Wirral Place Governance.	Director of Corporate Affairs	October 2025

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 (October 2025)

536	Med	Clinical, Quality, Safety and Access risks associated with poor patient flow.	(4 x 5) 20	⇔
2151	D&CS	Limitations of OP Speech and Language Therapy workforce to deliver the out-patient service.	(5 x 4) 20	↑
2007	Surg	Replacement of portable anesthetic ventilators that are no longer supported by the manufacturer.	(4 x 5) 20	↑
2086	EF&C	Potential failure of APH medical/surgical air assets (compressors, receivers and controls) serving operating theatres, Critical Care and Neonatal Unit.	(5 x 4) 20	↑
1547	Corp	Cash management	(5 x 5) 25	↑
1578	Surg	Financial risk to the Division if the CIP target is not met in full	(4 x 5) 20	↑
1756	Corp	Clostridioides difficile	(4 x 5) 20	⇔

Appendix – Monitoring Schedule

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

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

Public Board of Directors **Item 13**

05 November 2025

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

Executive Summary and Report Recommendations

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

This update provides the position following review during October 2025.

It is noted that due to the change of date for the Board of Directors meeting, the meeting of the Quality & Safety Committee has not taken place. The committee will meet in November 2025 where each of the relevant strategic risks will be discussed, and an update provided to the Board in December 2025. It is noted that the update provided to the Board in October 2025 included recent updates in relation to quality and safety strategic risks.

The People & Culture Committee met on 8 October and agreed a recommendation to increase risk ID07 reflecting the continued increase in sickness absence across the Trust.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks
- Approves the proposed increased in risk rating of ID07 to RR16 as recommended by the People & Culture Committee

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**
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.

04/06/25	Board of Directors	BAF	The Board of Directors received the update provided on the current position in relation to the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress. It was noted in particular that the meeting of the Finance & Performance Committee and the People & Culture Committee would take place (the following week) to review relevant risks.
03/09/25	Board of Directors	BAF	The Board received the updates provided on the current position in relation to the strategic risks and approved the proposed change to the risk appetite for ID06 from Cautious to Moderate as recommended by the Finance & Performance Committee. The Board also noted inclusion of the new risk (ID05) associated with cyber security and EPRR monitored by the Finance & Performance Committee.
01/10/25	Board of Directors	BAF	The Board **NOTED** the updates provided on the current position in relation to the strategic risks; and **APPROVED** the addition of a new risk - ID11 related to integration noting continued oversight by the Integration Management Board.

1	Narrative
1.1	The Board has in place a full Board Assurance Framework which is reviewed annually to reflect the strategic priorities of the Trust. Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the committee.
1.2	At the meeting of the Board of Directors in October 2025 an update was provided on each of the strategic risks.
1.3	The summary table at **appendix 1** confirms the current position of strategic risks as reviewed during October 2025. This includes a proposed increase in risk rating of ID07 to RR16 following discussion at the People & Culture Committee on 8 October 2025 recognising the increase in sickness absence, beyond the Trust target and the impact on staff experience and their health and wellbeing.
1.4	The BAF includes 9 strategic risks, and ID07 is currently scoring at a high-level. No risk has achieved its target risk rating.
1.5	It is anticipated that as the development of the Joint Strategy progresses, shared strategic risks and Board Assurance Frameworks between WCHC and WUTH will emerge.

1.6	**Wirral Place Delivery Assurance Framework** The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF was last presented to the Place Based Partnership Board in 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

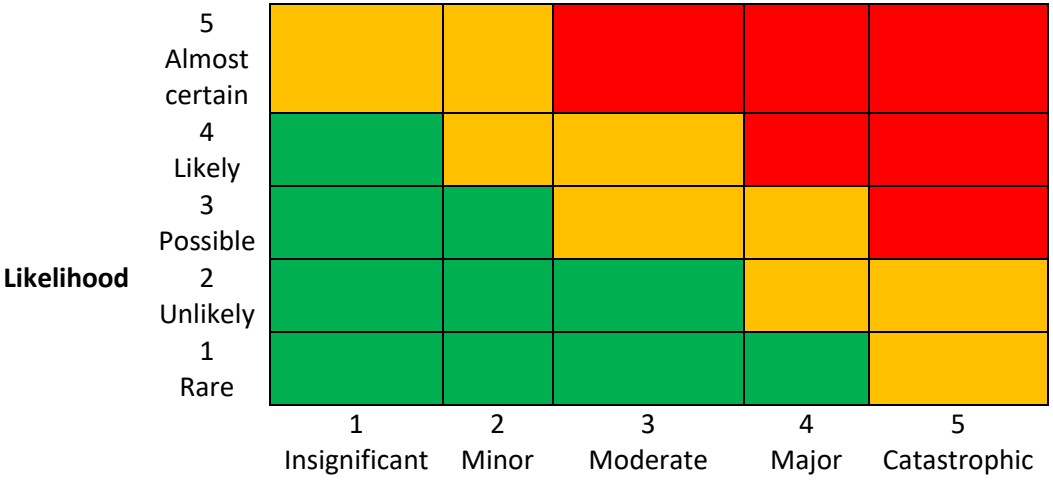
2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF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

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



Consequence

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

Board Assurance Framework 2025-26

Strategic risks with oversight at Quality & Safety Committee

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

Corporate Governance

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

Quality Governance

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

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

PSIRF

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

FTSU

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

Safeguarding governance

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

Infection prevention and control governance

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

Medicines governance

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

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

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

System Governance

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

Monitoring quality performance

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

QEIA process

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

<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

Organisational risk - ID3137 (RR16 - 4 x 4) - CICC call bells, ID3201 (RR16 - 4 x 4)</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>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td 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.
- NOF segment 1
Headline measures in-month (M04)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 0 fall (moderate & above harm) (YTD = 1) - QUAL17
- 92.9% FFT (YTD 92.3%) - QUAL22
- 4 complaints received (YTD = 17) - QUAL08</td><td>- Supervision Training Strategy - Head of L&OD
- PSIRF learning cafes roll-out Q4 - delayed to 25-26 (included in Delivery Plan - wider roll out to teams will commence during 2025/26 and have an emphasis on system learning with WUTH and beyond) - Head of Quality & Patient Experience
- QI programme to address waiting lists in specialist speech</td><td>- NOF rating / segmentation
- Sustained performance against quality metrics
- FFT response rate and satisfaction rate
- Low number of complaints
- Mandatory training sustained compliance maintained at 90%
- Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee</td><td colspan="2">- Supervision Training Strategy approved - TBC
- Reporting on expected outcomes from 4 joint high priority clinical risk areas (based on PSIRF analysis) - October 2025
- Delivery of 4 joint QI programmes based on high priority clinical risks - March 2026</td></tr>
</table>

- 466 incidents reported - QUAL02 *(0.4% moderate and above harm - QUAL18)*
- 193 patient safety incidents - QUAL03
- Mandatory training compliance trust-wide achieved target - 94.7% (vs 90% target)
- Indicators within the Quality Dashboard have been refreshed to reflect the Patient Safety Incident Response Framework and systems-learning
- The following indicators have been added;
  - QUAL25: Number of reported no and low harm patient safety incidents
  - QUAL26: Number of After-Action Reviews (AAR) requested
  - QUAL27: Number of patient safety incident investigations (PSII) requested
  - QUAL28: Number of patient safety incident investigations (PSII) completed in 3 months
- Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC
- 4 agreed clinical safety improvement priorities for 2025-26 agreed with WUTH aligned to shared priorities (Quality Goal 1)
- LFPSE (Learning from Patient Safety Events) launched including quarterly reporting to the committee (Q1 report - September 2025.
- Enhanced PSIRF training delivered (over 425 staff trained exceeding target of 250) (Quality Goal 2)
	and language and ND assessments *(aligned to Ofsted/CQC Wirral SEND inspection report established) (Quality Goal 4)* - **Deputy Chief Nurse**	~~- Role essential training compliance achieved and maintained at 90%~~
		~~- 12% of staff to be trained in Tier 2 Oliver McGowan mandatory training~~
		~~- QI summary reports with measured impacts from 4 x QI programmes and with actions for improvement~~
		~~- 20 members of staff trained in QSIR-P (5-day course now concluded with positive evaluation)~~
		~~- 80 members of staff trained in QSIR-F *(2 session for Quality Champions in Q4)*~~
		~~- Quarterly patient safety champions meetings with attendance monitored to ensure continued appropriate staff engagement across services~~
		~~- PSIRF learning cafes~~
			- Quarterly patient safety champion meetings - **December 2025**
			- Delivery of two patient safety champion training sessions - **March 2026**
			- Implement 'What matters to you' campaign in 2 more WCHC services **- December 2025**
			- 'What matters to you' campaign day - **March 2026**
			~~- 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **June 2025**~~
			- 65% of eligible staff trained in QI - ~~July 2025~~ **March 2026**
			~~- PSIRF actions to further embed in the process and culture *(quality goal 2)* - **Q1, 2025-26**~~

- PSIRF champions identified and communicated on Staff Zone (Quality Goal 2) - 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) - Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4) - Internal governance structure to support collaborative working *(aligned to Ofsted/CQC Wirral SEND inspection report established)* (Quality Goal 4) - 25-26 plan for QI curriculum training with focus on foundation training including flexible options to support compliance (Quality Goal 5) - District nursing development work underway, including engagement with frontline rearms to take forward improvement ideas - currently PAUSED awaiting consultation to commence. - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year end position of 8.6% of eligible staff trained against a target of 12%. 1 session planned for June 2025 and if all staff attend, this will take position to 10.1%. - Professional Nurse Advocate (PNA) programme in place - Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated			

Actions to ensure safe mobilisation of new services. - Business decision making process aligned to strategic objectives. - Establishment of mobilisation project at the commencement of new contracts - Mobilisation projects monitored at POG. - SRO and Project Lead identified. - New tender evaluation process agreed at private Board (July 2025) including the establishment of new BDIG with WUTH - Business Development & Investment Group **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles.** - Health Inequalities & Inclusion Strategy developed and approved. - Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC – see mitigations above related to each quality goal. - Mechanism in place to ensure involvement of people always included within PSII's (agreed at CRMG) - Participation in C&M Prevention Pledge programme agreed with identified. - Chief Nurse = Prevention Pledge Executive Lead - Inclusion dashboard developed. - Partnership forum established.	- 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.	- Sustained performance against inclusion metrics - Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data	

- 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. **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="6">ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Safe care and support every time</td></tr>
<tr><td colspan="7">Consequence;
• Inequity of access and experience and outcomes for all groups in our community
• Poor outcomes due to failure to listen to people accessing services
• Reputation impact leading to poor health and care outcomes</td></tr>
<tr><td colspan="6">Current risk rating (LxC)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>Apr 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
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(i.e., proof points that the risk has been mitigated)

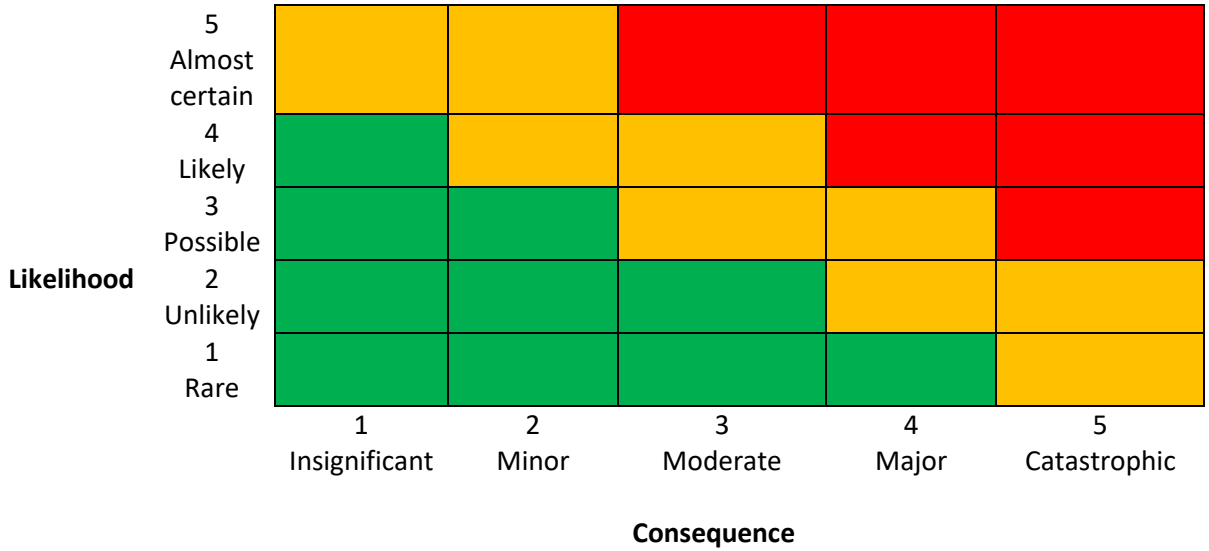
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Actions to ensure collaboration and co-design with community partners.
- EDI training compliance - 96.8%
- Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC
- ‘What matters to you’ campaign launched at Commitment to Carers conference (Quality Goal 3)
- Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4)</td><td colspan="2">- Lack of staff confidence in accessing and interpreting health inequalities data - Head of Inclusion
- Digital version of AIS and Health Inequalities Waiting List Tool questionnaire in multiple languages - Head of Inclusion
- Embed use of paper forms of questionnaire for those impacted by digital</td><td>- Sustained performance against inclusion metrics
- Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee
- Measures of equity of access demonstrated through patient/service user data and experience.
- Staff confident in delivering culturally sensitive care.</td><td>- Implement ‘What matters to you’ campaign in 2 more WCHC services - December 2025
- ‘What matters to you’ campaign day - March 2026
- 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - June 2025
- 65% of eligible staff trained in QI - ~~July 2025~~ March 2026</td></tr>
</table>

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

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

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

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 Finance & Performance Committee

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

Financial Governance

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

System Governance

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

Monitoring performance

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

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

<table>
<tr><td colspan="6">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.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Poor financial performance in the Wirral health and care system leads to a negative impact and increased monitoring and regulation

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full and ID3186 (RR12 - 3 x 4) - A significant underlying deficit financial position at both North West and C&M ICB has been reported. The ask of each system is to deliver financial balance within 3 years. C&M currently has a deficit plan of £178m. The Trust has submitted a £0.9m surplus plan for 25-26 which includes at £5.7m CIP that will be challenging making the delivery of the 25-26 financial plan a risk.</td></tr>
<tr><td colspan="7">Consequence;
Financial sustainability impact
Negative reputational impact for the Trust and system
Enhanced financial control from ICB and NHSE</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>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Cautious</td><td rowspan="2">2 x 4 (8)</td></tr>
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(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="3">NOF segment 1
Board approval of financial plan 2025-26 and subsequent revised forecast (18.7.25) linked back to current run rate and extrapolates current financial position to year-end</td><td colspan="2">Impact of ICB turnaround process is not clear - expectation to improve forecast to mitigate the risk associated with WUTH forecast.
NHSE approval of C&M financial plan</td><td>Delivery of recurrent CIP to achieve the target for 2025-26
Delivery of revised financial forecast 2025-26</td><td>CIP stretch target delivered - March 2026
Financial plan delivered or mitigated position with ICB - March 2026</td></tr>
</table>

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

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

<table>
<tr><td colspan="6">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.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Wirral system partners are unable to deliver the priority programmes within the Wirral Health and Care Plan which will result in poorer outcomes and greater inequalities for our population (RR8).

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC’s efficiency target for 25-26 and potential for identified projects not delivered in full</td></tr>
<tr><td colspan="7">Consequence;
Poor service user access, experience and outcomes
Poor contract performance - financial implications (Trust and system)
Negative reputational impact</td></tr>
<tr><td colspan="6">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>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Moderate</td><td colspan="2" rowspan="2">2 x 4 (8)</td></tr>
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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="6">NOF segment 1
Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board
CIP workstreams established with SRO Leads at Executive level</td><td>CIP delivery to support delivery of improved position - Interim Chief Finance Officer
Community Nursing Development Programme to</td><td>Delivery of the benefits of integration as described for each service
Staff experience and staff morale</td><td>Implementation of new Community Nursing model - Q4 2025-26
Key deliverables for Y1 of 2-year integration plan achieved - March 2026</td></tr>
</table>

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

<table>
<tr><td colspan="5">NEW ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber attack impacting on the quality of patient care</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - (Populations) Safe care and support every time, (Place) Make most efficient use of resources to ensure value for money</td></tr>
<tr><td colspan="6">Consequence;
• Delivery of patient care and patient experience
• Staff morale
• Financial impact
• Negative reputational impact for the Trust and system</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
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(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="3">• EPRR arrangements in place including business continuity plans for all services
• EPRR lead reporting to COO
• Annual EPRR report presented to Board with regular monitoring at FPC
• Major Incident Plan approved by Board
• EPRR work plan agreed and endorsed by Board</td><td>• Achievement of substantial compliance against the EPRR core standards self-assessment - Chief Operating Officer
• Alignment of EPRR functions with WUTH - Chief Operating Officer
• Implementation of recommendations from DSPT/CAF</td><td>• EPRR core standards self-assessment - substantial compliance</td><td>• EPRR core standards self-assessment - substantial compliance - March 2026
• Implementation of all recommendations from DSPT/CAF audit review - Q1, 26-27</td></tr>
</table>

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

Board Assurance Framework 2025-26

Strategic risks with oversight at People & Culture Committee

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

Corporate Governance

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

Workforce Governance

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

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

System Governance

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

Monitoring workforce performance

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

<table>
<tr><td colspan="6">ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="7">Consequence;
• Low staff morale - increase in sickness absence levels and reduced staff engagement
• Poor staff survey results
• Poor staff retention
• Reputation impact leading to poor health and care outcomes
• Increase in staff turnover and recruitment challenges</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by committee by month)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Moderate</td><td colspan="2" rowspan="2">1 x 4 (4)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>4 x 4 (16)</td><td></td><td></td></tr>
<tr><td colspan="6">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="6">• NOF segment 1
– NHS staff survey engagement theme sub-score 2.8 in NOF
• People Strategy Delivery Plan Year 4 developed and includes;
– Actions deferred from Year 3
– Alignment to existing national priorities
– Key themes of the People Promise</td><td>• Impact of AFC review of nursing role profiles to be reviewed (plan in place aligned to WUTH) - Chief People Officer
• Sickness absence rates increasing - flagged in IPR at Board of Directors and monthly Get Together. Sickness rates impacting on</td><td>• Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v's 2024 results 7.02
• NSS uptake Year 4 target ≥ 55% v's 2024 result 51%
• Q25c in NSS "I would recommend my organisation as a place to work" Year 4 target ≥ 63% v's 2024 result 63.21%</td><td colspan="2">See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
- Completion of actions in Year 4 PSDP 'Looking after our people' - March 2026
- Roll-out of OD programme to support integration of services between WCHC and WUTH - on-</td></tr>
</table>

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

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

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

<table>
<tr><td colspan="6">ID08 Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="7">Consequence;
Poor outcomes for the people working in the Trust
Reduced staff engagement
Failure to meet the requirements of the Equality Act 2010
Increase in staff turnover and recruitment challenges</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by committee by month)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Moderate</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td></tr>
<tr><td colspan="8">Measures remain under review and in development following committee discussions in August 2024.</td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">NOF segment 1
NHS staff survey engagement theme sub-score 2.8 in NOF
Inclusion Annual Report
People Strategy Delivery Plan Year 4 developed and includes;
Actions deferred from Year 3</td><td colspan="2">Roll out cultural competence training - Head of Inclusion
EDI dashboard to PCC - Head of Inclusion
Implement regular cultural assessment at Trust and divisional level - Deputy CPO</td><td colspan="2">Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v's 2024 results 7.02
NSS uptake Year 4 target ≥ 55% v's 2024 result 51%
Q25c in NSS "I would recommend my organisation as a place to</td><td colspan="2">See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
Completion of actions in Year 4 PSDP 'Culture and Belonging' - March 2026</td></tr>
</table>

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

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

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

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

Consequence;

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

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

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

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

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

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

Board Assurance Framework 2025-26

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

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

<table>
<tr><td colspan="6">Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce, financial and patient experience/outcomes) not being realised</td><td>Integration Management Board</td></tr>
<tr><td colspan="7">Link to WCHC and WUTH strategies – WCHC – Delivering sustainable health and care services, WUTH – Provide seamless care working with our partners</td></tr>
<tr><td colspan="7">Risk category – Reputational, Operational, Strategic, Compliance, Financial</td></tr>
<tr><td colspan="7">Consequence;
Failure to realise the benefits of integration
Poor staff and patient experience
Poor reputation</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by month of committee)</td><td>Risk appetite</td><td>Target risk rating (LxC)
(by end of 25-26)</td></tr>
<tr><td>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td rowspan="2">Open
Prepared to consider all delivery options even when there are elevated levels of associated risk</td><td rowspan="2">2 x 3 (6)</td></tr>
<tr><td>-</td><td>-</td><td>3 x 3 RR9</td><td>3 x 3 RR9</td><td></td><td></td></tr>
<tr><td colspan="6">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="6">Partnership Agreement (PA) agreed and approved by both statutory boards
Joint functions and delegated functions described in the PA</td><td>Agreement of costs to support the necessary resources associated with the statutory</td><td>Delivery of key milestones in the 2-year project plan for integration</td><td>Case for change to be presented to the ICB Board on 25.09.25 - September 2025 - COMPLETE AND ACCEPTED</td></tr>
</table>

• Integration Management Board (IMB) established as a special purpose Joint Committee with Terms of Reference • IMB reporting to both statutory boards via Chair's AAA report • Integration Management Group (IMG) established reporting to the IMB • 2-year project plan developed for integration with oversight at IMG (and bi-monthly reporting to IMB) • Transaction type approved by IMB following consideration of multiple options and risk/benefit analysis • Active engagement with the ICB and NHSE on the transaction timeline and process • Internal communications and staff engagement plans developed • TUPE transfer of Corporate Services from WCHC to WUTH agreed and project group established and reporting to IMG • Councils of Governors of both Trusts engaged with regular briefings • Development of Joint Strategy commenced with workshops and focus groups with staff across both Trusts • ICB approval of the case for change	transaction - **Chief Strategy Officer** • ~~ICB approval of the case for change - **Chief Strategy Officer**~~	• Transfer of Corporate Services from WCHC to WUTH • Completion of the statutory transaction as per agreed timeline for 25-26 • Staff experience and feedback • Delivery of financial plans in both Trusts including CIP targets for the integration of services • Patient experience	• Transfer of Corporate Services from WCHC to WUTH to be completed - **December 2025** • Completion of all agreed steps for 25-26 in the statutory transaction timeline - **March 2026**

Wirral Community Health and Care NHS Foundation Trust

Lead Governor Report

Over recent months the governors have been involved in varied and engaging discussions with the Trust supporting the programme of integration between WCHC and WUTH.

I have highlighted below some key areas of note in relation to the governor duties and activity including the most recent meeting of the CoG on 17 October 2025.

Sir David Henshaw

All members of the CoG offer their best wishes and thanks to Sir David as he takes up the position of Interim Chair for Cheshire & Merseyside Integrated Care Board.

Following his appointment as Joint Chair in November 2024, we have all appreciated Sir David's support and engagement.

Steve Igoe - Acting Joint Chair

Following the resignation of Sir David Henshaw as Joint Chair, we offer our support to Steve Igoe as Acting Joint Chair and look forward to working with him.

All members of the CoG have welcomed the insight and advice Steve has brought to the Board of WCHC since his appointment as a Joint NED earlier in the year.

We will now work with Steve to confirm a process to appoint substantively to the Joint Chair.

Joint Non-Executive Directors

Dr Steve Ryan

We recently considered and approved the appointment of Dr Steve Ryan as a Joint Non-Executive. Dr Ryan has been a NED on the WUTH Board of Directors since January 2021 and was reappointed for a second term in January 2024.

Dr Ryan's background as a senior leader in the NHS, and his extensive clinical expertise particularly in paediatrics has made him a valuable member of the Board.

The members of the CoG supported the appointment of Dr Ryan to the WCHC Board to align with his current tenure on the WUTH Board, ending January 2027.

We warmly welcome Dr Ryan to WCHC and look forward to working with him.

Governor elections 2025

The nomination window opened in early October for public and staff governor elections with 6 seats available.

The voting will begin on 12 November 2025 and the declaration of results on 3 December 2025. All public and staff members will have the opportunity to vote for nominated candidates. We look forward to a successful election and meeting our new governors in due course.

Wirral Community Health and Care NHS Foundation Trust

Council of Governors meeting - 17 October 2025

The CoG met formally on 17 October 2025 to consider important business including, the appointment of Dr Steve Ryan as a Joint NED, receiving the Auditors Annual Report 24-25, and an update on the process to appoint new external auditors.

We also received interesting briefings on the NHS 10-year plan, the new NHS Oversight Framework (and the position of the Trust), and the 2-year integration programme between WUTH and WCHC.

It was also interesting to receive the Trust's Integrated Performance Report, as recently presented at the Board of Directors on 1 October 2025.

We appreciated the attendance of Non-Executive Director colleagues who also provided reports from recent meetings of committees of the Board.

Annual Members Meeting - 23 October 2025

I was pleased to attend the AMM and provide a report summarising the work of the governors during the financial year, presented on my behalf by the Director of Corporate Affairs.

WCHC and WUTH Councils of Governor Development - 12 November 2025

We are looking forward to our next development session together with colleagues from WUTH CoG, which will focus on the development of the Joint Strategy between both Trusts. We understand there has been considerable engagement from staff across the Trusts in this important programme of work, and we are looking forward to bringing the thoughts and perspectives of governors to the strategy development.

There was support from governor colleagues together with some helpful reflections and insight from staff governors, in particular, on the importance of communication and engagement with all staff groups as the programme of integration continues.

It was also helpful that the 10-Year Health Plan has been published with governors having the opportunity to discuss and share views on the key messages, particularly in relation to the role of governors moving forwards.

All members of the CoG appreciate these development sessions and having a shared forum with WUTH governors is very helpful.

Your Voice

The members of the Your Voice group came together in September 2025 with a varied and engaging agenda. The members of the group received an update on the World Patient Safety Day by the Quality & Patient Safety Improvement Practitioner. An update on Student Placements was provided by the Practice Education Coordinator and the Head Of Quality and Experience provided and update on 'What Matters to You Campaign'.

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

Wirral Community Health and Care NHS Foundation Trust

The Your Voice group will meet again on 25 November 2025 at 10.30am.

Lynn Collins
Lead Governor (public governor, Wirral West)

24 October 2025

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 16**
5 November 2025

Report Title	Committee Chairs Report – People Committee
Date of Meeting	3rd October 2025
Author	Lesley Davies, Chair of People Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ There have been 144 applications for the Mutually Agreed Resignation Scheme (MARS). Of these, 8 applications have been approved and a further 12 are being considered. The process is being closely managed both centrally and through line managers and unsuccessful applicants are being supported through the process. ○ The Health & Safety Executive (HSE) has published new Violence and Aggression Reduction Standards which the Trust has mapped against its own gap analysis. Priorities have been identified and work in underway to strengthen the membership of the steering group overseeing this area of work. To support staff the Trust has recruited a dementia lead, seconded a mental health matron to support the Emergency Department and appointed a substance misuse nurse. The Committee noted the progress made to date and endorsed the continued implementation of the Violence Prevention and Reduction Strategy. This will continue to be a priority for the Trust and a focus of the People Committee in 2025/26 ○ The Committee agreed, based on the review of Risk 4 by the Workforce Steering Board, to propose that this risk be increased from a risk score of 12 to 16. This reflects the Trust's ongoing high level of sickness absence and the potential impact of the integration programme which might also impact on recruitment and sickness absence
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Guardian of Safe Working (GoSW) updated the Committee on the national delay to the roll-out of the new process for exceptional reporting which was originally intended to commence on the 12th September and is now delayed until the 4th February 2026. This has caused some confusion in the resident doctor group but has given the Trust more time to stress test the new system and ensure a smooth transition. The new fines tariff has yet to be confirmed but given the expected increase in penalties, it is important that the Trust's exceptional reporting procedures are understood and are effective. ○ The Committee discussed the Freedom to Speak Up Annual Report 2024/25. It was noted that the number of cases relating to attitudes and behaviours, particularly around bullying and

	harassment had increased. However, no patterns or systemic areas of concern have been identified. In terms of patient safety, any relevant cases were escalated to the nursing teams. It was also noted that no additional safety concerns had arisen from FTSU disclosures. A new monitoring system has been implemented which will enhance visibility and responsiveness across the Trust. ○ The bi-monthly Nurse & Midwifery Safe Staffing Report was presented. The report has been redesigned to be more data-rich and impactful. The report was welcomed, and the Committee commended the report, noting its relevance and clarity ○ Surgery features in several reports presented to the People Committee. The Committee noted that this had been picked up via Workforce Steering Board and therefore asked that a specific update is provided in the next Workforce Steering Board chair's report.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Given the significant workload of the Workforce department during this period of change, the Committee sought assurance that the Trust's Workforce Directorate capacity was sufficient to continue to deliver both the Trust's People Strategy and deliver the integration plan. Although there are challenges and some fragile services, the Committee was assured that the Trust's Workforce Directorate capacity is sufficient to deliver the TUPE of corporate services and subsequent reorganisation and continue with the key priorities in the Trust's People Strategy ○ The Equality, Diversity and Inclusion Bi-annual Report was discussed and noted. An EDI dashboard was presented, and the Committee noted the improvements made across several of the metrics and was assured of the continued focus on this area and the identification and focus on improvement in two key priority areas: ▪ addressing inequalities affecting staff with disabilities ▪ the recruitment outcomes for BAME applicants. ○ The Committee ratified the Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES) narrative reports. ○ The Trust's signed the NHS Sexual Safety Charter in May 2024 with the Trust's new policy commencing on the 6th June. The Committee thanked staff for their work and reflected on the significant progress that has been made in embedding the Trust's zero tolerance stance across the organisation. The Committee noted the report and a further update will be provided to the Board in November 2025.
Review of Risks	• The Committee reviewed Risk 4 in detail, and Risk 5. The recommendation of the Committee is detailed above

Other comments from the Chair	• The Committee thanked staff for the detailed reports and the open discussions which are a regular feature of the meetings. • My thanks to Shiela Hillhouse, Lead Public Governor for her attendance and contribution to the discussions

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
5 November 2025

Item No 17

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	20 October 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 6 with a deficit of £12.6m which represents a negative variance of £9.4m. This is driven largely by underachievement of the stretch savings target agreed with the ICB (£5.3m) and loss of deficit support funding for quarter 2 (£4.3m). The Committee noted that the in-month deficit or "run rate" has reduced by £0.4m from month 5 and that this is a positive sign. However, close monitoring of the run rate is essential to ensure the mitigation actions are effective in moving the Trust to its mid-range forecast of £35.1m deficit. The Committee noted that workforce numbers continue to reduce with a 10.5wte reduction from m5. However, total workforce remains at 95.8 WTE above plan. The mid case forecast remains at a variance of £13m and mitigation plans are now in place although there is uncertainty about the elective recovery plan. ○ Income performance is £7.4m behind plan. Of this sum £4.3m relates to the deficit support funding mentioned above and £2.2m relates to underachievement of the elective plan. A recovery plan for elective income was due to be presented to the Committee but unfortunately a critical incident relating to sterile services (covered elsewhere on the agenda) means that a further loss of activity has been incurred and the plan now needs to be redrafted. ○ The current year's CIP target is £46.1m comprising an internal target of £32m and a further stretch target of £14.1m. The Committee noted the magnitude of the target at circa 9% of expenditure. To date £21.3m has been achieved recurrently and £7m non-recurrently. A further £3.1m has been achieved against the stretch target. In total, despite an achievement of savings of some 6% of expenditure there remains a shortfall of £15m and this is the major issue placing pressure on achievement of the financial plan in the current year. The risk adjusted full year effect of CIP plus ICB stretch is £25.5m against a target of £46.1m.

	○ The Committee were informed that the Trust must make its own financial provision for winter pressures in order to be able to provide assurance on its winter plan. This could be a further financial pressure of £1m. ○ The Committee were informed that although cash is still extremely tight and requires careful management, there have been some approvals for cash support and for public dividend capital. The CFO continues to pursue all avenues available. ○ Urgent and Emergency Care performance remains extremely challenged and the Committee were informed that ECIST were currently supporting the Trust in making improvements.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee received a presentation from the CFO on planning principles for 2026/27. He explained that this would be the first year of the new medium term approach to planning. The outline plan provided for achievement of a break even position by 2028/29 but this would require recurrent savings over 4 years, including 2025/26 of some £125m – the value to be delivered across 26/27 to 28/29 is £90m. The savings target over the 3 years was broken down into specific areas, each with an executive director lead. The Committee welcomed the early thinking and accepted that the areas would be firmed up over the forthcoming weeks. The Committee was interested in the assumptions behind savings from addressing fragile services and requested that the initial calculations be brought back to the next Committee. There was discussion on how relative productivity levels might play in to the demands placed on Trusts and the Committee considered that despite being off plan in the current year the deficit plan itself was lower than many comparative Trusts and the Trust's productivity metrics were some of the best in the region. Therefore, in relative terms the Trust had a reasonable starting point for the 3 year plan. ○ The Committee received the National Cost Collection return for the Trust and received information on where Trust costs showed scope for review. The Committee discussed the shortage of coders and the impact on both costing information and on quality and mortality metrics. The CIO said that options for AI and managed service contracts to support employed staff were being

	explored. It was agreed that the Coding Manager would attend the Mortality Review Group. ○ The Committee received an ED attendance audit of 165 patients of which 62% had sought advice or treatment from other NHS bodies prior to attending ED. This represented a significant increase on a similar audit performed in 2024. 51 patients had spoken to a GP before attending and 24 patients had attended a Walk-In Centre or Minor Injuries unit. The Committee noted the report. ○ The Committee received an update on the LLP contract and activity. It was noted that as a result of working to reduce premium spend the budget had reduced by 50%. The main areas covered by the LLP had been the reduction of 65 and 52 week waiters in ENT and Gynaecology. The contract is currently out to tender and is at the evaluation stage. The Committee were pleased to note the reduction in spend and awaited the outcome of the tender process. ○ The CIO presented his report which showed pressure on information services largely due to the vacancy freeze in Corporate Services. It is anticipated that the TUPE transfer of staff from WCHC would present an opportunity to review the structures in Digital Healthcare. Meanwhile opportunities were also being pursued to improve performance on response to Subject Access Requests and Freedom of Information requests.
Assure	The Committee wish to assure members of the Board of Directors that: • Project Initiation Documents were received for all of the actions in the Financial Mitigation Plan. Not all plans were fully complete but nevertheless provided significant assurance of the actions required with timescales. These are being monitored by the Executive Team.
Review of Risks	• There is a significant risk to the achievement of the financial plan. Ability to achieve the plan or at a minimum the revised forecast of £35m deficit is a key priority for the ICB and the Trust's position within that. • The Committee reviewed the risks allocated to it within the BAF and agreed that - Risk 2 relating to failure to meet standards in elective care be increased to 16 due to the critical

	incident in Sterile Services and its impact on elective activity. - Risk 8 relating to failure to deliver sustainable efficiency gains be increased to 12 to recognize challenges with capacity, regional and national programmes and pressures on the hospitals.
Other comments from the Chair	• The Committee noted the considerable pressure on the Trust to deliver improved service performance and unprecedented levels of savings and thanked the team for their ongoing commitment.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 18**
5 November 2025

Report Title	WCHC People & Culture Committee Chair's Report
Date of Meeting	8 October 2025
Author	Meredydd David, Chair

Alert	• The Committee wishes to alert members of the Board of Directors that: ○ Raised sickness absence rates at the Trust with these particularly related to long term sickness at 7.7% with stress and anxiety accounting for 60% of these. Four key themes identified to address: Manager responsibility; HR Support; Absence Management; Reporting and Recording. An action plan is in place across all four areas. ○ TUPE consultation has started for the Corporate Services teams. Community Trust Corporate Services would TUPE to the acute trust on December 1st and then the process of restructure to create a joint corporate services function would commence which aims to improve quality, build resilience and create financial efficiencies
Advise	• The Committee wishes to advise members of the Board of Directors that: ○ There were nine employee relation cases during the period which is an appropriate number for a Trust of this size. ○ Rolling 12-month voluntary turnover had increased slightly to 10.1% compared with 9.13% for the same month in 2024. No concerns regarding this were raised. ○ Good progress is being made in delivering the aligned People Strategy. It was agreed to defer delivery and completion of four actions. All requests for deferrals related to external factors outside of the Trusts control. ○ Workforce sharing agreements were now well established with over 50 agreements in place across both organisations and no issues had been raised so far, with positive feedback received. There was a need to look at some practical workplace matters in relation to working across two trusts. ○ The Mutually Agreed Resignation Scheme had attracted 79 applications with 11 approved to date. ○ The Staff Survey was launched jointly on Monday 29 September 2025 and would run until Friday 28 November 2025. There would be a joint campaign with localised messages. There would also be a joint communications campaign with the slogan Your Voice Matters. The four key headings focussed on from last year's data were morale, working flexibility, feeling safe at work, career development and access to learning. ○ Annual Inclusion Report was received and approved with good performance noted and the priorities for 2025/26 identified.

	○ The Sexual Safety Update Report was presented. New legislation came out in October 2024 which included a new duty for Trusts to prevent sexual harassment and for all organisations to take reasonable steps to prevent it happening. Current training compliance was 91.8%. The next steps would be to continue the communications campaign, roll out training for all staff, embedding training for supervisors, work through the assurance framework and producing a joint action plan, complete an ongoing review of risk score, do an analysis of Staff Survey results and report to Board in November.
Assure	• The Committee wishes to assure members of the Board of Directors that: ○ Appraisal compliance is at 97% with the window closing at the end of October. ○ Good communication and engagement had happened across the organisations regarding to the merger and Corporate Services integration and frequently asked questions (FAQs) had been published. ○ There would be additional promotion around wellbeing for staff during change through occupational health and Employee Assistance Programmes (EAP) services and there were elements of wellbeing available at the acute trust through workforce sharing agreements for a clinical psychologist. ○ The committee was assured of sufficient capacity, and expertise exists within the HR teams of both Trusts however the HR team would also be going through the TUPE process and subsequent restructuring. ○ Mandatory training remained positive at 94.6% with role essential training compliance at 94.1% Compliance rate for clinical and professional supervision was 85% with management supervision at 80%. Vacancy rate of 4% did not raise concerns. ○ The MIAA audit of the Fit and Proper Person test received substantial assurance with two medium and two low level recommendations
Review of Risks	• There was one high level risk - ID 3214 (RR16) - which related to sickness rates in unplanned care services. The risk continued to be tracked actively and remained at this score. • Through the Risk Registers there are 76 organisational risks being tracked; each were reviewed monthly. There had been a reduction in corporate services risk health score noted. A request for an analysis of which risks are causing the reduction had been made as concerns were raised. The committee agreed that Audit Committee should review the decrease in corporate services risk health score and an update to be provided to the committee at next meeting. • A previously reported high level risk ID3201 relating to staffing in CICC had been archived and a new risk added ID3229 (RR9) had been opened this related to HCA staffing as that staff group had significant turnover and gaps and they had been a reliance on agency use. The recruitment position was significantly improved

	through support from the acute trust and getting bank staff from NHS Professionals. • BAF risk ID07 related to employee experience was considered in detail. The Committee determined to increase the risk rating from 12 to 16 owing to the increase in sickness absence rates.
Other comments from the Chair	• The committee approved policy extensions for 6 people policies that had recently expired with a further 6 requiring a 6-month extensions when they expire at the end of October 2025. The committee was assured all policies are current and fit for purpose. Extensions were required to allow integration work to progress across both organisations and for policies to be aligned. • The Committee discussed the workload and stretch on the People team due to the increased workload related to integration. This needs to be monitored closely.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 19**
5 November 2025

Report Title	WCHC Audit Committee Chair's Report
Date of Meeting	8 October 2025
Author	Meredydd David, Chair

Alert	• The Committee wishes to alert members of the Board of Directors that: ○ There had been a reduction in the risk health score for corporate risks to 71%. More details had been requested on which services the risks were in and which elements of the health score had not been completed, and this would be circulated to the Audit Committee members when received for further scrutiny. Further details would be provided at Finance & Performance Committee on 15 October. ○ As of 3 October 2025, there were 116 trust-wide policies and ○ 104 were approved and published. 12 had expired and were in the process of being updated and a further 18 policies were due to expire in the next six months. ○ The committee approved necessary extensions and was assured all of these policies due to be reviewed were fit for purpose and current. The above two issues may be an early indication of work pressures and stretch and will be monitored closely. ○ Four new fraud referrals had been received - one in relation to a patient who was claiming Community Healthcare funding (this may sit with the ICB), one in relation to recruitment fraud and one relating to an individual who was working whilst on sick leave. The fourth had been deemed not to be NHS Fraud. The Audit Committee was advised that that this number of cases was in line with the average for the size of organisation. ○ The process for securing external auditors for both WCHC and WUTH had been delayed due to issues out of the Trusts control and had not yet been finalised. Four bids had been received and a clarification session with all bidders was planned for the 13th October.
Advise	• The Committee wishes to advise members of the Board of Directors that: ○ The following Internal Audit reviews are in progress: ○ Data Quality – Community Cardiology (fieldwork stage) ○ Clinical and Professional Supervision (fieldwork stage) ○ IT Service Continuity / Disaster Recovery (planning stage - Terms of Reference agreed) ○ Partnership and Governance Arrangements (joint review with WUTH) (planning stage - in the process of being scoped)

	○ Transitional Arrangements - New Payroll Provider (planning stage - in the process of being scoped) ○ The Trust had requested the following changes to the Internal Audit Plan: ○ Moving the Key Financial Systems Audit from Quarter 3 to Quarter 4 due to the Trust changing financial systems mid-year. ○ The Partnership and Governance Arrangements to be an advisory piece of work (without an assigned assurance level), to support the Trust in the development of the formal joint governance arrangements. ○ Three new tender waiver applications had been approved since the last committee and were reported. These were noted and the committee was assured that processes in place were followed and waivers were compliant with the Trust's Standing Financial Instructions.
Assure	• The Committee wishes to assure members of the Board of Directors that: ○ There were no issues to escalate from the pre-meeting held with internal audit which was a very positive meeting ○ The Audit Committee noted the position in relation to the strategic risks managed through the BAF and was assured by the thorough ongoing oversight of all strategic risks through the committees of the Board ○ Internal Audit report on Data Security and Protection provided a moderate overall assurance rating with a high confidence score for the veracity of our self-assessment and commentated that WCHC is well placed compared to its peers and MIAA had a high level of confidence in our self-assessment. Supply chain mitigations was the one moderate risk identified. ○ Internal Audit of Contract management provided moderate assurance with some areas of good practice and some recommendations for improvement all of which had been accepted. ○ Fit and Proper Persons process audit provided a substantial assurance judgement. ○ An update on the Anti-Fraud progress report was received and it was confirmed that the Trust's Counter Fraud return had been submitted in May
Review of Risks	• The BAF now included nine strategic risks and none of these was scoring at a high level, but no risk had achieved its target risk rating. • It was noted that at the People and Culture Committee the likelihood rating of ID07 - *Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised* - had been increased, giving an overall risk rating of 16. • There were two new risks for 2025-26 as follows:

	○ ID05 - *Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber-attack impacting on the quality of patient care.* This risk was monitored via the Finance & Performance Committee. ○ ID11 - *Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce, financial and patient experience/outcomes) not being realised.* This risk was being monitored via the Integration Management Board. • There were currently three high-level operational risks, all of which have been escalated to the relevant committees of the Board for oversight and further management if required.
Other comments from the Chair	• Audit Committee was assured by the progress with the Internal Audit Plan 2025-26 and approved the two changes to the Audit Plan requested above. The Audit Committee was also assured by the progress made in the completion of internal audit recommendations.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 20**
5 November 2025

Report Title	Committee Chairs Report – Finance and Performance Committee
Date of Meeting	15th October 2025
Author	Steve Igoe, Chair of Finance and Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The M06 position had been finalised on 15th October. ○ WCHC was progressing to a new ledger from 1 November as a number of issues had been experienced with the current ledger. ○ The high-level risk relating to the Neurodivergent pathway was again referenced. Mitigations are in place however resolution remains challenging in the absence of ICB funding.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee discussed a recently issued checklist prepared by MIAA related to AI. It was felt that both the Acute and Community Trust Audit Committee's would benefit from completion of the checklist by the respective CIO's and subsequent discussion at the Audit Committees. ○ The Committee discussed the update on DSPT issues raised recently noting that assurance was still required around the supply chain standard which the Committee recognised was challenging.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The M06 position had been finalised on 15th October and the Trust was reporting a YTD surplus of £0.7m which was £1.1m ahead of plan. ○ The review of 0-19 contracts had yielded extra income of £0.8m. Pay had delivered a £1.5m positive variance whilst non pay was £1.5 negative. These equating to the £1.1m positive noted above. ○ The Trust was forecasting delivery of £6.7m in CIP with £5.06 implemented. ○ Operational performance remained strong with 70 of the 91 KPI's rated as green and 5 as Amber. Plans were in place to mitigate the challenges with the 7 KPI's noted as red.
Review of Risks	• There are no risks for escalation.
Other comments from the Chair	• Audit Committees at each trust to consider the AI checklist prepared by and recently issued by MIAA.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 21**

05 November 2025

Title	Monthly Extended 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	Approval

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2025 and an extended monthly report in October 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).

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

This paper provides a specific update on the Maternity Incentive Scheme (MIS) Year 7, Safety Action 5 of the MIS scheme, presentation of the Maternity Balanced Claims Scorecard and the current position of the Maternity and Neonatal Voices Partnership collaboration (MNVP).

It is recommended: -

- Note the report
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of the Maternity and Newborn Safety Investigations (MNSI) and PSII's.
- Note the position with the Maternity Incentive Scheme Year 7 requirements and progress against Safety Action 5.
- Present and discuss the content of the Maternity Claims Balanced Scorecard for Wirral University Teaching Hospital.
- Note the position of the Maternity and Neonatal Voices Partnership (MNVP).

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**
November 2025	Divisional Quality Board	Quarterly Maternity and Neonatal Services Report	For information
November 2025	Maternity and Neonatal Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
November 2025	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Perinatal Quality Oversight Model (PQOM) Assurance Report
	The Perinatal Quality Oversight Model (PQOM) dashboard is included in **Appendix 1** and provides an overview of the latest (September 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.

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). PSII's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in September 2025 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there is one active case and one new referral.

	There have been no Patient Safety Investigation Incidents (PSII's) declared in September 2025 for Neonatal services.

3	Maternity Incentive Scheme (MIS) Year 7
	Now in its seventh year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the quarterly maternity paper in December 2025 report utilising the audit tool.

4	Safety Action 5, Maternity Incentive Scheme (MIS) Year 7
	Following the Board of Directors decision to approve the Statement of Case and Workforce Plan for Maternity services, the agreed implementation timeline is actively being followed. Recruitment processes are underway in line with the approved plan, the key posts advertised and selection activity in progress. Regular monitoring via the Maternity and Neonatal Assurance Board is in place to ensure milestones are met, and updates will continue to be provided to the Board to maintain assurance on delivery against the approved plan.

5	Maternity Claims Balanced Score Card
	The maternity claims balanced score card is attached at **Appendix 3** and the Board of Directors are requested to discuss and note the report.

6	Maternity and Neonatal Voices Partnership
	The Trust continues to work closely with the Maternity and Neonatal Voices Partnership (MNVP) to ensure that the voices and experiences of women, birthing people and families are central to the ongoing improvement of maternity and neonatal services. The MNVP remains a key partner in delivering out commitment to personalised, safe, and equitable care in line with the national Maternity Transformation Programme and the Three-Year Delivery Plan for Maternity and Neonatal Services. The relationship with MNVP includes regular engagement meetings, joint participation in service development forums and co-production of improvement initiatives. The MNVP lead is an established Safety Champion and attends as a member several of the

	Maternity and Neonatal Governance Committees, ensuring the service user perspective directly informs strategic and operational decision making. Feedback from the MNVP has been instrumental in identifying priorities for improvement, including postnatal care experience, communication with families who are harder to reach, joint work has progress with a focus on inequalities and support for families with babies admitted to the neonatal unit Over the reporting period for the Maternity Incentive Scheme the Trust has strengthened in line with the guidance to comply with Safety Action 7, the MNVP lead has undertaken the appropriate training to operate and effectively be involved in Perinatal Mortality Reviews Tool (PMRT). Challenges are Areas for Development: - Despite strong partnerships, there remain challenges in ensuring sustainable funding and consistent participation across the MNVP footprint. Further work is required with the ICB/LMNS to clarify the commissioning and specification of the MNVP lead in line with the NHSE MNVP Guidance and development of an action plan to ensure any revised published standards to meet Safety Action 7 in future schemes are met. The attached **Appendix 4** provides supporting information for the Board's awareness and assurance.

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

8	**Implications**
8.1	**Patients** • The report and appendices outline the standards we adhere to deliver a safe service, with excellent patient care. • The increase in maternity workforce establishment to ensure patient safety and quality as a core requirement of national policy, professional standards and the Maternity Incentive Scheme.
8.2	**People** • Maternity services at Wirral University Teaching Hospital (WUTH) continue to deliver high quality patient care to the women and birthing people we care for. • Collaboration and co-production with the Maternity and Neonatal Voices Partnership (MNVP) Lead has promoted the voices and experiences of women, birthing people and families to the ongoing improvement of maternity and neonatal services.
8.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) investment into the maternity workforce is required to

	support safe staffing maternity levels, funding is being identified through budget setting processes.
8.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors **Item 22**

5 November 2025

Title	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including: Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)
Area Lead	Debs Smith, Chief People Officer
Author	Sharon Landrum, Head of People Experience
Report for	Ratification

Executive Summary and Report Recommendations

The Trust is required to fulfil a number of obligations that are outlined within the Equality Act (2010) and within the Public Sector Equality Duty (PSED), along with requirements built into the standard NHS contract monitored by commissioners and forms part of the Care Quality Commission's well led inspection.

This report seeks to provide assurance that WUTH is fulfilling the requirements of the Public Sector Equality Duty (PSED) and in addition, sets out how WUTH is advancing the EDI agenda and principles and objectives of the Trust's People Strategy and underpinning EDI Strategic Commitment (2022 – 2026):

"To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated".

This report is the first bi-annual report for 2025/26 reporting cycle and includes the following:

- Workforce demographic data in line with PSED requirements.
- New EDI Dashboard
- WRES full narrative report* (Appendix 2)
- WDES full narrative report* (Appendix 3)
- Summary of activities that demonstrate how we are advancing the EDI agenda at WUTH in line with the Trust's People Strategy and EDI Strategic commitment (summary overview Appendix 4).

Key Highlights:

1. Compliance and Reporting

- All statutory EDI reporting requirements are either completed or on track.
- New EDI Dashboard developed to monitor key metrics including NHS England EDI Improvement Plan indicators.

2. Workforce Demographics

- **Gender:** 78.2% female, 21.8% male – consistent with NHS trends.
- **Sexual Orientation:** 2.8% identify as LGB; declaration rates improving.
- **Disability:** 3.8% of staff self-declared as disabled; slight increase from 2024.
- **Ethnicity:** 14.7% BAME staff – a 1% increase from 2024; disparity remains between clinical (19.9%) and non-clinical (3.3%) roles.
- **Religion:** Workforce more religiously diverse than local community.
- **Age:** Broadly stable; slight increase in staff aged 56–65.

3. WRES & WDES Key Findings

- **WRES:** Improvements in 5 of 9 indicators, including BAME representation and disciplinary processes. Concerns remain around career progression and recruitment disparities.
- **WDES:** Improvements in 10 of 13 indicators. Concerns include staff engagement and reasonable adjustments for disabled staff.

4. Advancing the EDI Agenda

- EDI embedded in People Strategy and leadership programmes.
- Six active staff networks; engagement remains a challenge.
- Equality analysis policy updated; training provided.
- Calendar of events and awareness campaigns ongoing.

5. Priorities for 2025/26

- Improve satisfaction among disabled staff regarding workplace adjustments.
- Address disparities in Black, Asian and Minority Ethnic applicant recruitment outcomes.
- Deliver NHS England's 2025 EDI High Impact Actions.
- Implement regular cultural assessments at Trust and Divisional level
- Work with BAME staff to support speaking up on bullying, harassment and experiences of physical violence.

It is recommended that the Board:

- Note the updates and progress outlined.
- Note the EDI Dashboard and metrics.
- Ratify the WRES and WDES narrative reports and key findings.

Key Risks

This report relates to these key risks:

- 397 – Increased Sickness Absence
- BAF Risk – Failure of the Trust to have the right organisational culture, staff experience and organisational conditions to deliver our priorities for our patients and service users

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
27 May 2025	Executive Management Team	Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Reporting Data	Ratification of information prior to national upload
26 June 2025	Workforce Steering Board	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including: Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)	Approval
10 July 2025	EDI Steering Group	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including: Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)	Review
October 2025	People Committee	As above	As above

1	Background and Introduction to EDI Requirements
	Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations: • To eliminate unlawful harassment and victimisation. • To foster good relations between people who share a protected characteristic and those who do not. • To advance equality of opportunity between people who share a protected characteristic and those who do not. In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED. The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate. This report is one of two EDI specific bi-annual report. We report as follows: **Biannual report one** – Submission in Q1 and will include updates on: • Trust led EDI projects and progress towards EDI strategic commitment and activities to underpin our PSED commitment. • Annual WRES data and summary for noting. • Annual WDES data and summary for noting. • Workforce demographics **Biannual report two** – Submission in Q3 and will include updates on:

- Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment.
- Gender Pay Gap reporting.
- Equality Delivery System (EDS).

Reports seek to provide updates on regulatory and statutory requirements and work undertaken to advance the EDI agenda.

2 Statutory / Regulatory Reporting Requirements Update

To follow are legislative and contractual workforce EDI reporting requirements:

Reporting Element	Required by	Progress Update	Comments
Workforce Race Equality Standards (WRES) – Part 1	National data upload required by 31 May	Completed	
Workforce Race Equality Standards (WRES) – Part 2	Narrative report required by 31 October	On track	Reports contained within this paper and approved at WSB.
Workforce Disability Equality Standards (WDES) – Part 1	National data upload required by 31 May	Completed	
Workforce Disability Equality Standards (WDES) – Part 2	Narrative report required by 31 October	On track	Reports contained within this paper and approved at WSB
Public Sector Equality Duty (PSED)	Included within biannual reports	Completed and ongoing	Activities detailed within both EDI biannual reports highlight the work WUTH is doing to uphold the principles of the Public Sector Equality Duty. This includes publication of Trust workforce demographics.
Gender Pay Gap Reporting (GPG)	30 March 2024 (for March 2024 data) and 30 March 2025 (for March 2025 data)	Completed for 2024 and on track for 2025	Currently compliant with reporting, next report scheduled for inclusion within biannual report 2
Equality Delivery System (EDS)	28 Feb each year	Completed for 2024/5 and on track for 2025	Currently compliant with reporting, next report scheduled for inclusion within biannual report 2
NHS EDI Improvement Plan	Q2 and Q4	Completed for Q2	Included within new EDI dashboard of this report.
Updates to be provided on equality analysis process and progress of equality objectives	Q4	Completed for 2024/5 and on track for 25/26	Feedback integrated within EDI report and scheduled for inclusion within biannual report 2.

All regulatory and statutory reporting requirements are therefore complete or online to meet the requirements listed above.

3	Workforce Demographics
3.1	In line with specific duties under the Equality Act 2010, the Trust is required to publish information relating to employees who share protected characteristics. **Sex / Gender** 78.2 of the WUTH workforce is female and 21.8% is male. The number of male staff have increased slightly 21.7% in 2024. The numbers continue to reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts. The chart below highlights the breakdown of staff compared with community and demographics.

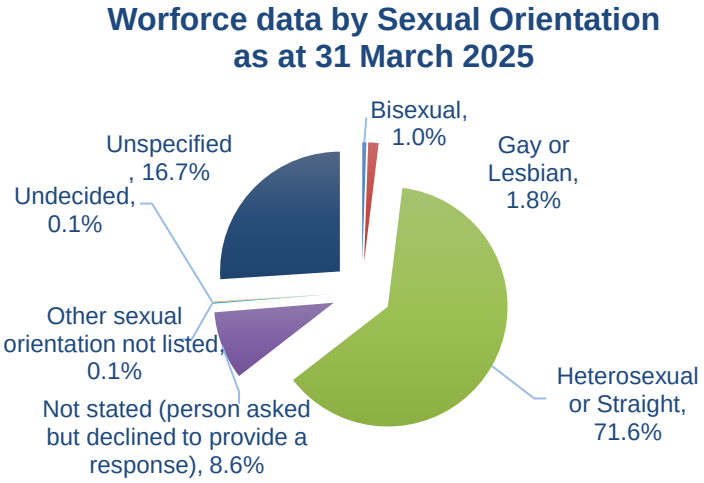
	Workforce	LA: Wirral	Region: North West
Male	21.8%	48.11%	49.13%
Female	78.2%	51.89%	50.87%

3.2

Sexual Orientation

Charts below highlight the workforce sexual orientation data on 31 March 2025, along with comparative data for community members within the North West. Data this year has seen an increase in the % of LGB staff at WUTH with a year on year increase in the number of staff specifying their sexual orientation on ESR (from 18% last year to 16.7% in 2025). Th number of bisexual staff has increased by 0.3% this year, which is deemed significant due to the small numbers employed. The number of LGB staff is also higher than those declared within the Northwest region.

Sexual Orientation	% of Workforce
Bisexual	1.0%
Gay or Lesbian	1.8%
Heterosexual or straight	71.6%
Not stated (person asked but declined to provide a response)	8.6%
Other sexual orientation not listed	0.1%
Undecided	0.1%
Unspecified	16.7%
Grand Total	**100.00%**



	Sexual Orientation Data Comparison with Community Demographics

	Workforce	Region: North West
Gay / Lesbian / Bisexual	2.8%	1.66%
Heterosexual / straight	71.6%	94.89%
Unknown	25.4%	3.45%

3.3 **Gender Reassignment / Identity**

ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed.

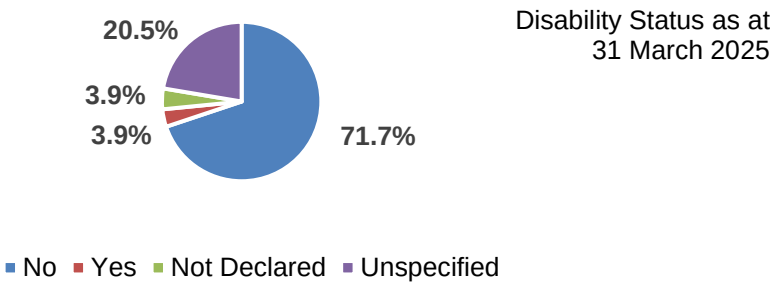
A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area.

The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

The Trust is however aware of and has supported staff in their transition journey this year and continues to support staff whose gender isn't the same as assigned at birth. 5 staff completed the 2024 staff survey, identifying that their gender was different to the one assigned at birth.

3.4 **Disability**

As of 31st March 2025, the self-reporting rate for those staff with a disability within WUTH is 3.8%, 263 people (as entered on staff ESR records). This has continued to improve, albeit only marginally from last year, whereby 3.6% of staff (244 people) had declared. Whilst it is positive to see continued improvements in declaration rates, rates continue to still be low, with 20.5% of staff ESR records still remining unspecified (22% in 2024). Work will therefore continue to support improvements in declaration rates.



Data shows slight improvements in representation of disabled staff across both clinical and non-clinical roles, with the biggest improvement seen however within non-clinical roles, improving from 4.2% (94 staff) in 2023/4 to 4.9% (104 staff) this year. Clinical staff representation has increased from 3.2% (150 staff) to 3.4% (159 staff) this year.

Breakdown of disability declaration categories by clinical and non-clinical as of 31 March 2025.

	Total Clinical Staff	% of clinical	Total non-clinical	% of non-clinical	Combined 2025	% overall 2025	% overall 2024
Disabled	159	3.4%	104	4.9%	263	3.8%	3.6%
Non-disabled	3512	73.9%	1406	65.8%	4918	71.7%	69.9%
Not declared	184	3.6%	87	4.1%	267	3.9%	4.3%
Unspecified	862	17.7%	541	25.3%	1403	20.5%	22.3%
Total	4717	100.0%	2138	100.0%	6855	100.0%	100.0%

3.5 **Religion or Belief**

The chart below highlights the religious beliefs of our workforce compared with the community demographics as of 31 March 2025. The categories are grouped together so as to aid ease of comparison; however it is important to recognise some of the heading below subgroup heading e.g. Christianity include Catholicism, Anglican etc

	Workforce	***LA: Wirral***	***Region: North West***
Atheism / Not religious	13.3%	21.33%	19.82%
Buddhism	0.6%	0.28%	0.29%
Christianity	44.5%	70.41%	67.25%
Hinduism	1.7%	0.23%	0.54%
Islam	1.7%	0.57%	5.05%
Judaism	0.0%	0.08%	0.43%
Other	8.0%	0.26%	0.27%
Sikhism	0.2%	0.07%	0.13%
Jainism	0.0%	Unknown	unknown
Unknown	30.1%*	6.77%	6.20%

**Includes 13.4% of staff who do not wish to disclose*

There are differences in this area when compared to the local community, with more Hindu and Muslim staff and staff who have other religions or beliefs.

3.6 **Ethnicity**

83.6% of WUTH staff are white, 14.7% of staff are Black, Asian, or other Ethnic Group and 1.7% of staff have not stated their ethnic group on ESR. The following chart shows the breakdown of the workforce by ethnicity and compared to community demographics as of 31 March 2025.

Ethnicity Group	Headcount	% in Trust 2025	% in Trust 2024
BAME	1008	14.7%	13.7%
Not Stated	116	1.7%	1.8%
White	5731	83.6%	84.6%
Grand Total	**6855**	100.0%	100.0%

It is pleasing to see a year on year increase in the representation of Black, Asian and Minority Ethnic staff at WUTH, with a 1% increase seen this year. That said, there continues to be a significant disparity between the levels of BAME staff within clinical and non-clinical roles, however increases can be seen in both areas.

Representation however continues to be significantly different across clinical (19.9%) and non-clinical roles (3.3%). Increases can however be seen in both areas.

Breakdown of Non-Clinical Staff by Pay Band

Count of Employee Ethnicity Gr					% BAME in
Payband WRES W	White	BAME	Not Stated	Total	band 2025
Band 1	95		2	97	0.0%
Band 2	935	38	14	987	3.9%
Band 3	361	13	1	375	3.5%
Band 4	273	4	3	280	1.4%
Band 5	113	6	3	122	4.9%
Band 6	75	3	4	82	3.7%
Band 7	64	5		69	7.2%
Band 8A	45	2		47	4.3%
Band 8B	40			40	0.0%
Band 8C	16			16	0.0%
Band 8D	13			13	0.0%
Band 9	2			2	0.0%
Other Incl VSM	8			8	0.0%
Total	**2040**	**71**	**27**	**2138**	**3.3%**

Breakdown of Clinical Staff by Pay Band

Count of Employee Nu	Ethnicity Gro				% BAME in
Payband WRES WD	White	BAME	Not Stated	Total	band 2025
Band 2	614	139	9	762	18.2%
Band 3	358	25	1	384	6.5%
Band 4	153	5	2	160	3.1%
Band 5	828	385	33	1246	30.9%
Band 6	741	87	9	837	10.4%
Band 7	428	27	9	464	5.8%
Band 8A	164	15	1	180	8.3%
Band 8B	52	3	1	56	5.4%
Band 8C	16	2		18	11.1%
Band 8D	3			3	0.0%
Band 9	2			2	0.0%
M&D - Career Grade	31	32	2	65	49.2%
M&D - Consultant	180	108	10	298	36.2%
M&D - Trainee	106	105	10	221	47.5%
Other Incl VSM	1			1	0.0%
Senior Medical Manag	14	4	2	20	20.0%
Total	**3691**	**937**	**89**	**4717**	**19.9%**

To follow is a full breakdown of staff compared with community demographics.

	Workforce	LA: Wirral	Region: North West
White - British (inc English, Scottish & Cornish)	**81.08%**	94.97%	87.08%
White - Irish	**0.77%**	0.83%	0.92%
White Traveller / Gypsy / Irish Traveller	**0.00%**	0.02%	0.06%
White - other	**1.74%**	1.17%	2.15%

Mixed - White & Black Caribbean	**0.19%**	0.30%	0.56%
Mixed - White & Black African	**0.19%**	0.17%	0.26%
Mixed - White & Asian	**0.34%**	0.30%	0.43%
Mixed - Any other mixed background	**0.22%**	0.25%	0.32%
Asian or Asian British - Indian	**7.41%**	0.42%	1.52%
Asian or Asian British - Pakistani	**0.66%**	0.07%	2.69%
Asian or Asian British - Bangladeshi	**0.32%**	0.27%	0.65%
Asian / Asian British: Chinese	**0.41%**	0.52%	0.68%
Asian or Asian British - Any other Asian background	**1.09%**	0.33%	0.66%
Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean	**1.95%**	0.18%	1.17%
Any other Black African / Caribbean	**0.18%**	0.04%	0.22%
Arab	**0.00%**	0.07%	0.35%
Any Other	**1.36%**	0.10%	0.28%

3.7 **Age**

The following chart highlights the age profile within WUTH as of 31 March 2025.

Age Band	% in Trust 2025
<=20 Years	1.6%
21-25	6.2%
26-30	10.8%
31-35	12.1%
36-40	12.9%
41-45	11.9%
46-50	10.7%
51-55	11.4%
56-60	10.6%
61-65	8.9%
66-70	2.1%
>=71 Years	0.8%
Grand Total	100.0%

Age demographics have remained similar to last year, with the biggest changes seen between ages 56 and 65, with both age brackets increasing by 0.3%.

3.8 **Key Findings**

The Trust has seen improvements in workforce demographics in a number of areas that have been a priority. This includes increased representation of Black, Asian and Minority Ethnic staff, disabled staff and LGB staff. It is pleasing to see more staff are specifying their demographic data and thus allowing more accurate monitoring information. Workforce demographics are broadly aligned to those of the local community.

4 EDI Dashboard

In order to more effectively monitor and review performance and progress with the EDI agenda, a key objective of the 2025/26 People Strategy key deliverables was to develop an EDI dashboard that would identify key metrics and provide Trust progress against these.

	Appendix 1 provides a proposed dashboard, with metrics that seek to provide a greater understanding of EDI related aspects in the employee life cycle (in line with a request from People Committee) along with monitoring data to support NHS England EDI Improvement Plan reporting requirements (see section 2). National staff survey findings, as required by NHS England, however once approved, the dashboard can be widened to incorporate additional elements as deemed necessary. The dashboard highlights key areas of strength and concern, with main areas for review including: 1) Staff satisfaction with opportunities for career progression have declined and/or are lower than the national average for all groups; 2) Decline in likelihood of Black, Asian and Minority Ethnic applicants being appointed from shortlisting; 3) Staff engagement scores – which are low for all staff, previously highlighted and recognised as part of People experience and staff survey update reports. As the report focuses on equality, diversity and inclusion – points 1 and 3, whilst have declined, are equal for all staff groups. This is however different for point 2, which highlights a particular area of potential inequality.

5	**Workforce Race Equality Standards (WRES)**
	Summary findings The aim of the WRES is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS. The full narrative report is attached at appendix 2 and outlines the national indicators that the Trust is required to submit data and monitor progress against, with a helpful summary overview contained within the appendices of the report. Data shows improvements in 5 of the 9 WRES indicators with further improvements seen in: • BAME representation for all groups e.g. clinical; non-clinical and VSM • Relative likelihood that staff will enter the formal disciplinary process • Staff survey related question linked with bullying, harassment, abuse and discrimination. It is however disappointing to see a decline in: • Staff believing the Trust provides equal opportunities for career progression and promotion (50.19% last year to 49.46% this year); • Relative likelihood that BAME applicants will be appointed from shortlisting when compared with white applicants (from 2.02 last year to 2.23 this year). Whilst there may be potential impacting factors on recruitment linked with national changes to visas and a recent immigration white paper published on 12 May 2025; data will be reviewed in full along with findings from a recent recruitment audit and included within the subsequent full narrative report. The difference between representation of Board membership has also increased due to the increased representation at Trust level overall (from 7.0% to 7.56%).

	The report outlines measures that have been taken to support improvements this year, along with key objectives for 2025/26 as part of the People Strategy key deliverables, that seek to ensure further improvements.

6	**Workforce Disability Equality Standards (WDES)**
	WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment. The full narrative report is attached at appendix 3 and outlines the national indicators that the Trust is required to submit data and monitor progress against, with a helpful summary overview contained within the appendices of the report. Data shows improvements in 10 of the 13 relevant WDES indicators this year, which is really pleasing to see. Board membership has remained the same and two areas have unfortunately declined: 1) Staff engagement score, which unfortunately declined for all staff this year; 2) % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. Despite seeing improvements for all staff in this area this year, results have unfortunately reduced for disabled staff. Where comparative data is shown, results identify the same trends for disabled and non-disabled staff e.g. reduced staff engagement score for disabled and non-disabled staff and improvements in experiences of all staff, with the exception of indicator 7. Disabled staff are more satisfied with the extent to which the organisation values their work when compared with non-disabled staff who feel less valued this year. Whilst it is pleasing to see an improvement in the overall % of disabled staff, numbers of self -declarations continue to remain low at 3.8%. It is also pleasing to see continued improvements in recruitment data, with results showing an equal likelihood that disabled staff will be appointed from shortlisting when compared with non-disabled applicants. The report outlines measures that have been taken to support improvements this year, along with key objectives for 2025/26 as part of the People Strategy key deliverables, that seek to ensure further improvements.

6	**Advancing the EDI Agenda**
6.1	**People Strategy and EDI Strategic Commitment** Since the launch of the new People Strategy and underpinning EDI Strategic Commitment, the Trust is striving to ensure EDI is embedded within all of our people processes and practices. This has resulted in a shift of areas and individuals seeking support to understand how they can advance EDI within their sphere of influence and progressing actions to commence improvements. The annual objectives set out in the People Strategy delivery plan have also been mapped to the EDI Strategic Commitment to ensure EDI is reflected in all strategic people projects. This is reported to WSB and People Committee as part of People

	Strategy Updates. It is therefore hoped that this will have a positive impact on staff experiences moving forwards. In addition to the content provided in the other sections of this report, appendix 4 seeks to summarise a range of key actions undertaken to support advancement of the EDI agenda and fulfil the Trust's commitment to the Public Sector equality Duty: advancing equality of opportunity and fostering good relations between people who share protected characteristics and people who don't and eliminating unlawful discrimination harassment and victimization.
6.2	**Staff Network Update** WUTH now has six staff networks, with the most recent addition being a volunteer network. All other networks have co-chairs in place, however with the exception of the rainbow alliance that is still without leadership. Discussions are underway with WCHC colleagues with invitations extended to colleagues from both Trusts to forthcoming events and activities and steps being taken to merge networks in the near future. Network meetings continue to be offered to members on a regular basis, with joint "one network" events also offered on a quarterly basis to ensure an intersectional approach. Attendance is however poor across all networks currently and as such, has been logged as a risk for WUTH (risk 1944). Whilst network co-chairs continue to be offered two days per month per network, to support network activities, time is also a challenge for co-chairs too. Bev Shaw, co-chair of the Armed Forces network has recently stepped down due to challenges meeting demands on her time and a special thanks goes to Bev for her support of the network during her time. Network updates continue to form part of the EDI Steering group agenda, with regular updates provided to WSB members. A calendar of events is planned for 2025/26 in conjunction with staff network co-chairs and has been shared as part of a previous WSB report. Whilst Executive Partners are in place for networks, Executive partners rotate every twelve months in WCHC and as such, this approach is being adopted at WUTH, with a plan in development to rotate executive partners. Further details will follow in due course. The rainbow alliance, armed forces, multicultural and volunteer networks have now all been part of sharing information as part of leaders in touch. The remaining networks will be scheduled as soon as possible. Network co-chairs have also been invited to join Workforce Steering Board to ensure they are able to represent their network members and share key views as part of discussions held.
6.3	**Equality Analysis** The Trust's equality analysis policy has now had a major review, with feedback from a number of key stakeholders.

	The NHSE Health Equalities Assessment Tool has been included, along with consideration of NHSE recommended health inclusion groups and a more robust approach to reviewing the areas required. Members are reminded that when planning service or organisational changes; cost improvement programmes; changes in or development of new policies and particularly where changes will affect staff, patients or the wider community, then an equality impact assessment must be completed at the earliest opportunity. Training sessions have been held to support staff with the process and are available on request.

7	**Next Steps and Key Areas of Focus**
	The report identifies a number of areas of progress and also decline and in conjunction with Workforce Steering Board members, two areas of priority have been identified for focus within 2025/26. These are: 1) Improvement in staff with disabilities and long term conditions; feeling satisfied that the Trust has made reasonable adjustments to enable them to carry out their work. 2) Relative likelihood of BAME staff being appointed from shortlisting. For priority 1 – engagement will be undertaken with two key areas of low satisfaction from the last staff survey and support provided to management teams accordingly. For priority 2 – completion of a recent recruitment audit will be completed and findings reviewed to understand potential reasons for the results and actions identified to support improvements where possible. In addition to the above, as part of the Trust's People Strategy key deliverables for the EDI agenda in 2025/26, as stated in appendix C of the WRES report: 1) Deliver the 2025 elements of the NHS England EDI High Impact Actions 2) Implement regular Cultural assessment at Trust and divisional level 3) Work with BAME Staff to support speaking up on bullying, harassment and experiences of physical violence.

8	**Implications**
8.1	**Patients** The work undertaken to advance the EDI agenda aims to improve awareness of a range of aspects and celebrate diversity for all. Whilst this should be a positive experience for all, there is also recognition of the diverse nature of our workforce and community and promotion and celebration of some areas, may not be in line with individual values, beliefs and behaviours. Whilst we strive to ensure appropriate values and behaviours are upheld for our workforce, this can be more challenging for our patients.
8.2	**People** As also detailed in section 2.1.

8.3	**Finance** Whilst a small budget has been ringfenced for network activities, the Trust financial position is acknowledged and network co-chairs remain committed to avoiding costs where possible and thinking creatively about alternative options.
8.4	**Compliance** This report seeks to provide assurance that WUTH is currently in line with EDI reporting requirements for 2024/5.

EDI Monitoring Dashboard - June 2025

Key:
- ≥ last year and ≥ the national average
- ≥ last year < national average **or** < last year ≥ national average
- < last year and < national average

Element	Area of measurement	KPI	Demographic	2020/21	2021/22	2022/23	2023/24	2024/25	Compliance	Trend	Summary
Recruitment & Progression	RP1 - Relative likelihood of appointment from shortlisting	Ratio between 0.8 and 1.2:1	BAME	3.28	0.96	1.28	2.02	2.23			* Monitoring now in place * Applicants across all PC's listed have an equal likelihood of appointment from shortlisting, with the exception of BAME applicants. This has declined and is a cause for concern. A recruitment audit has been developed and piloted, with findings under review.
			Disabled	1.20	1.80	1.30	1.19	1.00			
			Female					0.87			
			LGB+					0.95			
			Christian					0.90			
			Atheist					1.08			
	RP2 -Staff satisfaction with opportunities for career progression (Q24b from NSS)	≥ national average Improvement from last year	**Org. Ave**		**47.8%**	**49.8%**	**48.2%**	**46.3%**			* A decline in experience can be seen for all staff. Findings for BAME staff still remain above the national average, however have declined in line with all staff groups.
			Nat. Ave		**52.2%**	**53.5%**	**55.2%**	**54.3%**			
			BAME		62.0%	61.5%	56.6%	54.6%			
			White		46.2%	48.6%	48.3%	45.6%			
			Disabled		38.7%	41.9%	41.0%	36.0%			
			Non-disabled		50.2%	52.4%	52.1%	50.5%			
			Female		47.7%	50.1%	48.7%	46.0%			
			Male		48.2%	51.9%	54.7%	50.3%			
			LGB+		45.0%	53.5%	48.9%	45.0%			
			Straight		47.8%	50.5%	49.9%	47.4%			
			Christian		46.5%	49.9%	48.9%	46.7%			
			Other Religions		58.0%	57.0%	54.0%	51.8%			
	RP3: Staff feeling the organisation acts fairly with regards to career progression (Q15 from NSS)	≥ national average Improvement from last year	**Org. Ave**	**54.1%**	**54.3%**	**56.8%**	**55.5%**	**56.2%**			* A mixture of results can be seen in this area with organisational and national averages increasing along with white, non-disabled, female and straight staff groups. * Particular areas of focus are BAME staff and those whose religion is other than Christian as experiences in these areas have declined this year and fall below the national average.
			Nat. Ave	**56.5%**	**55.9%**	**55.8%**	**55.9%**	**56.0%**			
			BAME	43.5%	49.3%	49.6%	50.2%	49.5%			
			White	55.4%	54.6%	57.9%	56.9%	57.9%			
			Disabled	46.3%	45.8%	52.5%	51.1%	51.1%			
			Non-disabled	56.6%	56.6%	58.1%	57.7%	58.6%			
			Female	55.5%	55.1%	57.8%	56.7%	57.3%			
			Male	52.2%	52.9%	56.5%	58.2%	56.8%			
			LGB+		55.5%	62.4%	52.7%	55.5%			
			Straight	55.1%	54.8%	57.7%	57.4%	57.8%			
			Christian	55.2%	56.3%	57.3%	57.9%	56.6%			
			Other Religions	52.0%	54.0%	58.0%	55.0%	54.0%			
Staff Satisfaction - What's it like to work at WUTH	S1: Staff engagement score	≥ national average Improvement from last year	**Org. Ave**	**6.87**	**6.67**	**6.69**	**6.67**	**6.56**			*Staff engagement scores have declined at an organisational and national level this year. This can also be seen in the majority of staff groups, with the exception of LGB+ who are the only staff group to be more engaged this year
			Nat. Ave	**7.03**	**6.84**	**6.80**	**6.91**	**6.84**			
			BAME	7.15	7.22	7.30	7.17	7.08			
			White	6.84	6.63	6.62	6.62	6.51			
			Disabled	6.45	6.28	6.26	6.19	6.07			
			Non-disabled	6.94	6.80	6.82	6.86	6.75			
			Female	6.93	6.70	6.71	6.73	6.61			
			Male	6.68	6.67	6.71	6.74	6.61			
			Straight	6.91	6.72	6.77	6.77	6.64			
			LGB+			6.08	6.02	6.26			
			Christian	7.02	6.79	6.86	6.86	6.72			
			Other Religions	6.91	6.96	7.13	7.19	6.85			
	S2: Equality and Diversity sub-score (NSS)	≥ national average Improvement from last year	**Org. Ave**		**8.20**	**8.26**	**8.18**	**8.18**			* The majority of staff groups have seen an increase in experiences relating to equality and diversity this year and are above the national average. * However, experiences of disabled, LGB+ staff and those with other religions have declined and fall below the national average.
			Nat. Ave		**8.13**	**8.10**	**8.12**	**8.08**			
			BAME		7.66	7.66	7.25	7.27			
			White		8.25	8.35	8.35	8.37			
			Disabled		7.73	7.96	7.90	7.89			
			Non-disabled		8.35	8.36	8.34	8.34			
			Female		8.23	8.30	8.27	8.27			
			Male		8.20	8.26	8.25	8.26			
			LGB+			8.00	8.05	7.90			
			Straight		8.25	8.32	8.28	8.30			
			Christian		8.29	8.25	8.25	8.22			
			Other Religions		8.02	8.30	8.19	7.91			
	S3: Inclusion sub-score (NSS)	≥ national average Improvement from last year	**Org. Ave**		**6.84**	**6.92**	**6.83**	**6.81**			*LGB+ staff have seen the biggest improvement in this area this year, however disabled and BAME staff have declined and fall below the national average.
			Nat. Ave		**6.78**	**6.84**	**6.86**	**6.81**			
			BAME		6.78	7.08	6.70	6.67			
			White		6.80	6.89	6.85	6.85			
			Disabled		6.50	6.60	6.49	6.39			
			Non-disabled		6.90	6.99	6.95	6.98			
			Female		6.80	6.92	6.85	6.85			
			Male		6.83	7.00	6.95	6.92			
			LGB+			6.40	6.31	6.57			
			Straight		6.82	6.96	6.91	6.89			
			Christian		6.84	6.98	6.91	6.86			
			Other Religions		6.83	6.89	7.11	6.92			
Retention	R1: Turnover	≥ org average Improvement from last year	BAME			2.0%	1.6%	2.4%			* Turnover data is deemed to be healthy, with no additional concerns presented
			White			12.2%	10.2%	9.2%			
			Disabled			0.3%	0.5%	0.7%			
			Non-disabled			13.9%	11.6%	10.9%			
			Female			10.6%	9.0%	8.4%			
			Male			3.5%	2.9%	3.1%			
			LGB+			1.7%	1.5%	1.0%			
			Straight			12.4%	10.4%	11.1%			
			Christian			6.0%	4.9%	4.8%			
			Other Religions			8.2%	7.0%	6.8%			
	R2: Thinking of leaving (NSS score)	≥ national average Improvement from last year	**Org. Ave**	**6.23**	**5.99**	**5.91**	**5.82**	**5.79**			* Only two staff groups have seen improvements in this area, with less male staff and those with religions other than Christian, thinking of leaving. * Trend analysis shows a reducing picture over the last few years, however with a slowed reduction more latterly.
			Nat. Ave	**6.31**	**5.97**	**5.86**	**6.06**	**6.04**			
			BAME	6.73	6.55	6.41	6.13	6.11			
			White	6.28	6.00	5.86	5.86	5.84			
			Disabled	5.78	5.53	5.39	5.38	5.34			
			Non-disabled	6.43	6.21	6.08	6.07	6.04			
			Female	6.38	6.05	5.97	5.95	5.90			
			Male	6.15	6.15	5.90	5.87	5.93			
			LGB+			5.51	5.12	4.99			
			Straight	6.37	6.09	5.98	5.97	5.97			
			Christian	6.46	6.16	6.06	6.08	6.02			
			Other Religions	6.49	6.37	6.10	6.39	6.49			

NHS EDI Improvement Plan

				2020/21	2021/22	2022/23	2023/24	2024/25		Progress Rating	Summary
	HIA 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	**Success Metric 1** - Annual chair and chief executive appraisals on EDI objectives								Limited progress	* Board members all now have EDI objectives, with appraisals scheduled to review progress.
		HIA 1: Progress overall								**Good progress**	
		Success Metric 1 Relative likelihood of staff being appointed from shortlisting across all posts	BAME	3.28	0.96	1.28	2.02	2.23			* Monitoring now in place * Applicants across all PC's listed have an equal likelihood of appointment from shortlisting, with the exception of BAME applicants. This has declined and is a cause for concern. A recruitment audit has been developed and piloted, with findings under review.
			Disabled	1.20	1.80	1.30	1.19	1.00			
			Female					0.87			
			LGB+					0.95			

			Christian				0.90			
			Atheist				1.08			
			Success Metric Overall						**Very Good Progress**	
		Success Metric 2 Access to career progression, training and development opportunities.	**Org. Ave**		**47.8%**	**49.8%**	**48.2%**	**46.3%**		* A decline in experience can be seen for all staff. Findings for BAME staff still remain above the national average, however have declined in line with all staff groups.
			Nat. Ave		**52.2%**	**53.5%**	**55.2%**	**54.3%**		
			BAME		62.0%	61.5%	56.6%	54.6%		
			White		46.2%	48.6%	48.3%	45.6%		
			Disabled		38.7%	41.9%	41.0%	36.0%		
			Non-disabled		50.2%	52.4%	52.1%	50.5%		
			Female		47.7%	50.1%	48.7%	46.0%		
			Male		48.2%	51.9%	54.7%	50.3%		
			LGB+		45.0%	53.5%	48.9%	45.0%		
			Straight		47.8%	50.5%	49.9%	47.4%		
			Christian		46.5%	49.9%	48.9%	46.7%		
			Other Religions		58.0%	57.0%	54.0%	51.8%		
			Success Metric Overall						**Limited progress**	
		Success Metric 3 -Improvement in race and disability representation leading to parity over the life of the plan.	Disability		2.0%	2.8%	3.6%	3.8%		* Year on year improvement in representation of both disabled and BAME staff. * Self declaration rates still remain low however for disabled staff, with 20% of staff still remaining undefined * Whilst BAME representation is increasing, this is not equal across all areas, with significantly higher levels of BAME clinical staff compared to non-clinical.
			Race		10.4%	12.3%	13.7%	14.7%		
			Success Metric Overall						**Very Good Progress**	
		Success Metric 4 - Improvement in representation of senior leadership (Band 8C and above) over the life of the plan.	Disability				0.98%	1.07%		* Whilst bands 8c and above have increased representation, diversity at Board level for BAME and disability is low.
			Race				3.45%	8.00%		
			Success Metric Overall						**Good Progress**	
		Success Metric 5 - HEE National Education and Training Survey (NETS) Score metric on quality of training.				69.24%	70.48%	71.54%	Excellent progress	* Year on year improvement in NETS results
		Success Metric 6 - Diversity in shortlisted candidates.	Data to be included moving forwards						No progress	* Data reviewed as part of wider WRES and WDES metrics, however to be included as separate reporting item moving forwards
		HIA 2: Progress overall							**Good progress**	Progress is varied across the metrics, with focus to be placed on areas of improvement for 2025/26
	HIA 3: Develop an improvement plan to eliminate pay gaps.	**Success metric 1** - Improvement in the gender, race and disability pay gaps (Mean average used)	Gender		21.1%	21.2%	19.4%	20.1%		* Whilst reporting commenced in 2023 as a pilot, full reporting has been completed this year and published as part of Gender pay gap reporting. * Whilst gender pay gap has increased slightly this year, the median pay gap has improved, along with bonus gaps and the gap has reduced over a number of years.
			Ethnicity				-11.7%	-14.9%		
			Disability				10.2%	10.2%		
			Sexual Orientation				7.8%	6.1%		
		HIA 3: Progress overall							**Very Good Progress**	
	HIA 4: Develop an improvement plan to address health inequalities within their workforce.	**Success Metric 1** - Organisation action on staff health and wellbeing (NSS Q 11a)			50.01%	52.94%	49.18%	46.51%	Limited progress	* WUTH staff experiences have been reducing for Q11a, the Trust has launched a health inequalities plan and has seen improvements in experiences from immediate managers regarding action on health and wellbeing.
		Success Metric 2 - HEE National Education & Training Survey (NETS) Separate Indicator Score metric on quality of training.				69.24%	70.48%	71.54%	Excellent progress	
		HIA 4: Progress overall							**Limited progress**	
	HIA 5: Develop a comprehensive induction, onboarding and development programme for internationally recruited staff.	**Success Metric 1 -** Sense of belonging for internationally recruited staff (Inclusion sub score used from NSS)			7.05	6.82	6.55	6.5	Limited progress	* There is no specific question regarding "sense of belonging" in the staff survey. The people promise "Inclusion" score has therefore been used as an alternative and feedback provided as part of reporting processes * Despite an increase last year, an improvement in experiences can be seen over the last four years. * WUTH has been awarded a pastoral certificate for its onboarding and development programme for IR staff. * Listening events held with staff; staff network support in place and surveys sent to staff to understand experiences with a range of Trust activities to support improvements
		Success Metric 2 - Reduction in instances of bullying and harassment from team/line manager experienced by (internationally recruited staff).	By colleagues		26.00%	21.69%	26.95%	22.67%	Very good progress	
			By line manager		16.00%	8.48%	12.69%	13.91%	Limited progress	
		HIA 5: Progress overall							**Limited progress**	
	HIA 6: Create an environment which eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occurs	**Success Metric 1** - Improvement in staff survey results of bullying and harassment from line managers or teams	% of staff experiencing bullying, harassment or abuse from managers in the last 12 months (NSS Q14b)	14.28%	13.91%	11.56%	11.34%	10.33%	Excellent progress	* Excellent progress made following a series of actions to understand staff experiences and support improvements
			% of staff experiencing bullying, harassment or abuse from colleagues in the last 12 months (NSS Q14c)	18.48%	20.23%	16.79%	19.16%	16.99%	Excellent progress	
		Success Metric 2 - Improvement in National Education and Training Survey (NETS) bullying and harassment score metric				92.40%	83.73%	86.46%	Good progress	
		Success Metric 3 - Improvement in staff survey results of discrimination from line managers or teams (All staff NSS results)	No. of staff experiencing discrimination at work from colleagues/managers/team leaders (NSS Q16b)	5.87%	6.80%	6.70%	7.34%	7.18%	Excellent progress	
		HIA 6: Progress overall							**Excellent progress**	

NHS EDI Improvement Plan

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Race Equality Standards (WRES) Report

June 2025

Sharon Landrum, Head of People Experience

together we will

wuth.nhs.uk

Contents

Background

All the available evidence shows that Black, Asian and Ethnic Minority (BAME) staff have a significantly inferior experience of the NHS as employees when compared to white staff. This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

The aim of the WRES is to improve the experience of Black, Asian and Ethnic Minority (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

In the context of the WRES, "white staff" comprises of white British, white Irish and white other, whereas "BAME staff" comprise all other categories with the exception of "not stated".

The report shows annual comparisons to assess whether any improvements have been achieved.

Executive Summary

Appendix A provides a summary overview of the Trust's performance against the required indicators, compared to national and regional averages.

Data shows improvements in 5 of the 9 WRES indicators with further improvements seen in:

- BAME representation for all groups e.g. clinical; non-clinical and Very Senior Manager (VSM)
- Relative likelihood that staff will enter the formal disciplinary process
- Staff survey related question linked with bullying, harassment, abuse and discrimination.

It is however disappointing to see a decline in:

- Staff believing the Trust provides equal opportunities for career progression and promotion (50.19% last year to 49.46% this year);
- Relative likelihood that BAME applicants will be appointed from shortlisting when compared with white applicants (from 2.02 last year to 2.23 this year).

Whilst there may be potential impacting factors on recruitment linked with national changes to visas and a recent immigration white paper published on 12 May 2025; data will be reviewed in full along with findings from a recent recruitment audit and included within the subsequent full narrative report.

The difference between representation of Board membership has also increased due to the increased representation at Trust level overall (from 7.0% to 7.56%).

Work has continued to further support our BAME staff and understand their experiences, capture ideas for improvement and ultimately to offer additional support.

Led by the Chief People Officer, listening events have been held with BAME staff to understand experiences and identify high impact actions to ensure improvements. Regular discussion and promotion of staff experiences and actions needed were promoted throughout the year to affirm our commitment to being an anti-racist organisation and WUTH was one of only four Trusts in the North West region to achieve new anti-racist framework bronze status.

The Trust continues to support and promote its multicultural staff network with three network co-chairs in place for the majority of the year and following the completion of a three- year tenure, two chairs are currently leading the network for 2025/26. It is hoped that a further co-chair will be recruited this year. An Executive Partner is in place for the staff network and efforts continue to be made to improve Trust wide communications and in celebrating diversity at WUTH.

Leadership and management development programmes continue to run, with equality, diversity and inclusion embedded as a golden thread throughout all programmes and with stand-alone sessions also in place focused on Inclusive leadership and inclusive recruitment. Interview preparation and development sessions have also been offered to BAME staff, following feedback received from listening eve

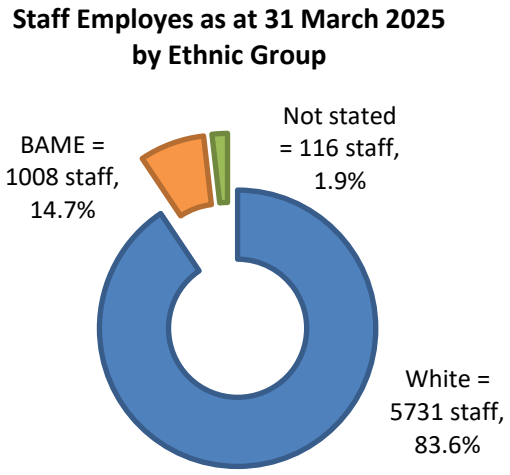
Leaders are encouraged to consider their own sphere of influence and actions they can take to ensure a compassionate and inclusive culture, with a number of examples launched by individuals to share culture, learning and celebration of difference.

Appendix B provides an update on actions identified for 2024/5 and appendix C highlights key objectives for 2025/6 as part of this years' People Strategy key deliverables.

Total Staff by Ethnicity 31 March 2025

As at 31 March 2025, a total of 6855 staff were employed by WUTH. Of these, 1008 (14.7%) were BAME and 5731 (83.6%) were white. 116 staff however, (1.7%) were unstated for their ethnicity.

The results highlight therefore that there continues to be a significant increase in the number of BAME staff within the Trust, with numbers remaining higher than that within the local population (95.2% of residents identified as "white" in the 2021 census). That said, there is a significant disparity between the levels of BAME staff within clinical and non-clinical roles, however increases can be seen in both areas.



The definitions of "Black, Asian and Minority Ethnic" and "White" used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. "White" staff includes White British, Irish and Any Other White. The "Black, Asian and Minority Ethnic" staff category includes all other staff except "unknown" and "not stated."

Section One

The WRES Standard Indicators

Table 1. The Workforce Race Equality Standard Indicators	
Workforce Indicators For each of these four workforce indicators, compare the data for White and BAME staff.	

1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (*including executive Board members*) compared with the percentage of staff in the overall workforce disaggregated by:
	• Non-clinical staff
	• Clinical staff – of which
	  • Non-medical staff
	  • Medical and Dental staff

2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* **Note:** *this indicator will be based on data at 31 March.*
4	Relative likelihood of BAME staff accessing non-mandatory training and CPD.
National NHS Staff Survey findings (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff.	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	Percentage believing that trust provides equal opportunities for career progression or promotion.
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) manager/team leader or other colleagues
Boards representation indicator For this indicator, compare the difference for White and BAME staff	
9	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WUTH as a whole workforce for 2024/5.

Staff breakdown for 2024/5 (clinical and non-clinical combined)

Payband	White	BAME	Not Stated	Grand Total	% in Band 2025	% in band 2024
Band 1	95		2	97	0.00%	0%
Band 2	1549	177	23	1749	10.12%	8.28%
Band 3	719	38	2	759	5.01%	4.36%
Band 4	426	9	5	440	2.05%	2.32%
Band 5	941	391	36	1368	28.58%	28.36%
Band 6	816	90	13	919	9.79%	8.85%
Band 7	492	32	9	533	6.00%	5.48%
Band 8A	209	17	1	227	7.49%	8.37%
Band 8B	92	3	1	96	3.13%	5.15%
Band 8C	32	2		34	5.88%	6.45%
Band 8D	16			16	0.00%	0.00%
Band 9	4			4	0.00%	0%
M&D - Career Grade	31	32	2	65	49.23%	47.62%
M&D - Consultant	180	108	10	298	36.24%	33.87%
M&D - Trainee	106	105	10	221	47.51%	44.02%
Other Incl VSM	9			9	0.00%	0.00%
Senior Medical Manager	14	4	2	20	20.00%	13.66%
Grand Total	**5731**	**1008**	**116**	**6855**	**14.70%**	**13.66%**

Staff breakdown for 2024/5 (by Clinical and non-Clinical staff group)

Count of Employee Nu		Ethnicity Gr				% BAME in group	% BAME in group
Clinical/Non-Clinica	Staff Group	White	BAME	Not Stated	Grand Total	2025	2024
Clinical	Add Prof Scientific and Technic	201	13	1	215	**6.05%**	8.25%
	Additional Clinical Services	1134	175	12	1321	**13.25%**	10.83%
	Allied Health Professionals	424	56	6	486	**11.52%**	9.87%
	Healthcare Scientists	132	16	2	150	**10.67%**	9.27%
	Nursing and Midwifery Registered	1469	428	44	1941	**22.05%**	22.10%
Clinical - Medical	Medical and Dental	331	249	24	604	**41.23%**	38.97%
Non-Clinical	Administrative and Clerical	1089	41	12	1142	**3.59%**	3.56%
	Estates and Ancillary	957	30	15	1002	**2.99%**	2.42%
Grand Total		**5737**	**1008**	**116**	**6861**	**14.69%**	**13.66%**

Clinical staff breakdown for 2024/5 (by pay band)

Count of Employee Nu	Ethnicity Grou				% BAME in
Payband WRES WD	White	BAME	Not Stated	Total	band 2025
Band 2	614	139	9	762	18.2%
Band 3	358	25	1	384	6.5%
Band 4	153	5	2	160	3.1%
Band 5	828	385	33	1246	30.9%
Band 6	741	87	9	837	10.4%
Band 7	428	27	9	464	5.8%
Band 8A	164	15	1	180	8.3%
Band 8B	52	3	1	56	5.4%
Band 8C	16	2		18	11.1%
Band 8D	3			3	0.0%
Band 9	2			2	0.0%
M&D - Career Grade	31	32	2	65	49.2%
M&D - Consultant	180	108	10	298	36.2%
M&D - Trainee	106	105	10	221	47.5%
Other Incl VSM	1			1	0.0%
Senior Medical Manag	14	4	2	20	20.0%
Total	**3691**	**937**	**89**	**4717**	**19.9%**

Non-clinical staff breakdown for 2024/5 (by pay band)

Count of Employee Ethnicity Gr					% BAME in
Payband WRES W	White	BAME	Not Stated	Total	band 2025
Band 1	95		2	97	0.0%
Band 2	935	38	14	987	3.9%
Band 3	361	13	1	375	3.5%
Band 4	273	4	3	280	1.4%
Band 5	113	6	3	122	4.9%
Band 6	75	3	4	82	3.7%
Band 7	64	5		69	7.2%
Band 8A	45	2		47	4.3%
Band 8B	40			40	0.0%
Band 8C	16			16	0.0%
Band 8D	13			13	0.0%
Band 9	2			2	0.0%
Other Incl VSM	8			8	0.0%
Total	**2040**	**71**	**27**	**2138**	**3.3%**

Key Findings:-

- The percentage of BAME staff employed at WUTH has increased from 13.66% last year to 14.7% this year with increases seen across clinical, non-clinical and very senior managers (for clinical staff)
- For non-clinical staff, representation is broadly in line with the overall Trust representation, with the exception of bands 8b and above and band 4, with particularly positive representation in band 7. Clinical staff have a mixture of levels of representation across bandings, with particularly high levels of BAME staff within medical and dental roles and band 5, which may largely be due to a significant international nurse recruitment campaign over the last few years.

- The percentage of BAME staff employed at WUTH (14.7%) continues to be greater than the population of Wirral as a whole, although the percentage is significantly higher in some areas.

Indicator 2

This indicator relates to the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

Key Findings
Results this year unfortunately show a further decline, with data highlighting that BAME applicants are less likely to appointed from shortlisting than white applicants this year, with a likelihood of 2.23 (2.02 last year).

A recruitment audit has been developed and piloted, with results awaited, which seeks to understand potential reasons for this.

Indicator 3

This indicator relates to the relative likelihood of BAME staff entering the formal disciplinary process, compared with that of non-BAME staff.

Key Findings:
Within 2024/5, 104 people entered the disciplinary process. 14 staff were BAME (1.4% of workforce numbers), 84 were white (including any “white ethnic group”) (1.5% of workforce numbers) and 8 people have an undisclosed ethnicity.

This data highlights that BAME staff are as likely to enter the disciplinary process than white staff, with a relative likelihood of 0.87.

Indicator 4

Relative likelihood of BAME staff accessing non-mandatory training and CPD.

Key Findings

Data highlights that BAME staff have an equal likelihood of accessing non-mandatory training and CPD as with white colleagues.

National NHS Staff Survey Findings

The next 4 indicators are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

Indicator 5

The chart below highlights the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
BAME Staff	32.00%	30.10%	22.30%	27.80%	25.60%	30.03%	28.15%		28.27%
Non BAME colleagues	25.20%	25.40%	21.40%	23.40%	22.80%	21.25%	21.32%		23.21%

Indicator 6

The chart below highlights the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
BAME Staff	36.00%	25.50%	29.70%	26.20%	21.57%	28.93%	22.01%		24.78%
Non BAME colleagues	29.60%	29.40%	23.90%	24.80%	21.48%	22.35%	19.98%		21.53%

Indicator 7

The chart below shows the percentage believing that the Trust provides equal opportunities for career progression or promotion.

Data prior to 2019 is not included as a national error was identified lasty year and available data updated to 2019 only.

	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
BAME Staff	47.18%	43.54%	49.30%	49.56%	50.19%	49.46%		49.70%
Non BAME colleagues	56.16%	55.35%	54.59%	57.92%	56.86%	57.86%		58.82%

Indicator 8

In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
BAME Staff	13.90%	10.00%	13.40%	15.60%	13.60%	17.36%	16.89%		15.72%
Non BAME colleagues	6.00%	5.00%	5.30%	6.00%	5.60%	5.86%	5.12%		6.69%

Indicator 9

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

Key Finding:
The Trust has 14 Board members, 12 of whom are voting members and 13 identify as white (which includes all white categories as defined within ESR).

This gives a percentage difference for both the Trust boards voting and executive membership and its overall workforce of – 7.6%.

Conclusion

Data shows improvements in 5 of the 9 WRES indicators:

- BAME representation for all groups e.g. clinical; non-clinical and Very Senior Manager (VSM)
- Relative likelihood that staff will enter the formal disciplinary process
- Staff survey related question linked with bullying, harassment, abuse and discrimination.

Despite a number of improvements this year, particular areas of decline for attention are:

- Staff believing the Trust provides equal opportunities for career progression and promotion (50.19% last year to 49.46% this year);
- Relative likelihood that BAME applicants will be appointed from shortlisting when compared with white applicants (from 2.02 last year to 2.23 this year).

Appendix C highlights Trust objectives as part of the overarching People Strategy key deliverables for 2025/26 that seek to support further improvements for our Black, Asian and Minority Ethnic Staff at WUTH.

Appendix A

WRES Indicator Summary table for NHS trusts in England compared to WUTH

WRES Indicator			National Average 2024	WUTH 2021-22	WUTH 2022-23	WUTH 2023-24	WUTH 2024-25
1	% of BAME staff	Overall		10.40%	12.30%	13.66%	14.70%
		VSM		0%	5.30%	0%	13.80%
		Clinical		14.60%	17.00%	18.75%	19.86%
		Non-Clinical		1.70%	2.50%	3.01%	3.31%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants			0.96	1.28	2.02	2.23
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff			0.48	0.22	0.6	0.87
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff			1.1	1	1	1
5	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BAME**	**28.27%**	**27.78%**	**25.58%**	**30.03%**	**28.15%**
		White	23.21%	23.41%	22.80%	21.25%	21.32%
6	% of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BAME**	**24.78%**	**26.17%**	**21.57%**	**28.93%**	**22.01%**
		White	21.53%	24.75%	21.48%	22.35%	19.98%
7	% of staff believing that the Trust provides equal opportunities for career progression or promotion	**BAME**	**49.70%**	**49.30%**	**49.56%**	**50.19%**	**49.46%**
		White	58.82%	54.59%	57.92%	56.86%	57.86%
8	% of staff personally experiencing discrimination at work from a manager, team leader or other colleagues	**BAME**	**15.72%**	**15.57%**	**13.62%**	**17.36%**	**16.89%**
		White	6.69%	6.03%	5.60%	5.86%	5.12%
9	Board membership			-10.40%	-6.40%	-7.00%	**-7.56%**

Key:

	≥ last year and ≥ the national average
	≥ last year < national average **or** < last year ≥ national average
	< last year and < national average

Workforce Race Equality Standard (WRES) Action Plan 2024/5

Elements		Action	Responsibility	Deadline	Progress	Comments
Seek to Understand	1	Develop process of regular recruitment audits of processes for under-represented areas / roles to understand challenges / barriers or areas of potential bias	Recruitment Services	30/09/2024	Amber	Process developed and piloted, however due to capacity within the service, this has been unable to be embedded as yet.
	2	Working with the Trust's multicultural staff network to undertake a series of listening events to understand experiences of working at WUTH and identify potential reasons for areas of deterioration and actions needed for improvement	CPO	31/08/24	Green	Listening events held and high impact actions identified and progressed. Improvements seen in 2024 staff survey results, with ongoing feedback and further listening events to be held.
	3	Develop a process to identify and triangulate data relating to incidents/concerns and employee relations case linked to protected characteristics	People Experience	31/12/24	Green	Completed and included within ER reports and individual subject areas as required e.g. sexual safety and bullying and harassment
Support	1	Build capacity and capability of Trust staff networks, with appointment of new co-chairs and re-establishment of regular meetings.	Co-chairs / Exec Partners	31/03/2025	Green	New co-chairs appointed and offering regular opportunities to meet staff. Uptake is however low, however opportunities are available. Whats app groups in place and active. First Multicultural large event held
	2	Increase the number of non-white FTSU Champions to promote and encourage staff to speak up.	FTSU Lead	31/12/24	Green	New multicultural link staff identified.
	3	Continue to encourage staff to enter/update personal information via ESR self-service, with guidance documents and support offered to complete.	Comms / Workforce Information / SL	31/03/25	Green	Work continues to support staff via ESR drop ins and regular promotion is communicated.
Educate and Develop	1	Visible Respect at Work campaign to promote zero tolerance to bullying, harassment or abuse within the workplace	HR / H&S	Ongoing	Amber	Zero tolerance posters and communications have been issued; however a new approach is being taken to staff safety and managing challenging behaviours. Stakeholder review sessions have been held, with a new strategy in development
	2	Application submitted for NHS Northwest Ant-Racist Framework Bronze status with outcome	SL / DG	30/06/24	Green	Submitted and Trust one of 4 in the region to receive accreditation. Action plan in place to achieve silver status

Workforce Race Equality Standard (WRES) Action Plan 2024/5

		reviewed and further areas of priority to be identified				
	3	EDI training to support leaders in understanding how to ensure WUTH is an anti-racist organisation and upholds the principles of the sexual safety charter.	CPO	31/03/25	Green	As with the above section. Key messages are also shared as part of induction programmes for all staff and both through internal and external articles. Letters have also been sent to staff to promote sexual safety in the workplace and offer support for staff, along with the launch of eLearning for managers on sexual safety.
Celebrate and Promote	1	Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support	People Experience	Ongoing	Green	In place and ongoing
	2	Promoting WUTH as an inclusive employer that celebrates diversity and harnesses individuality	People Experience / Comms / Recruitment	Ongoing	Green	Regular Trust wide promotions are undertaken, with particular campaigns shared for Race equality Week and Red Card to Racism Day. WUTH was reaccredited with the Navajo chartermark that seeks to recognise inclusive employers.
	3	Develop a series of staff stories to share experiences of non-white staff	OH / Comms / People Experience	31/08/24	Green	Project undertaken within NNU and stories captured and shared. Experiences shared as part of Race Equality Week. Further work to be undertaken to ensure regular stories are shared.

People Strategy Objectives for 2025/26

Objective	Deliverable / Output
Deliver the 2025 elements of the NHS England EDI High Impact Actions	1) Development of an EDI Dashboard that incorporates NHSE High Impact Actions 2) Robust reporting of High Impact Actions through workforce governance 3) Recruitment audit undertaken on a quarterly basis 4) Relative likelihood of staff being appointed from shortlisting, monitored for all protected characteristics 5) Undertake a review to identify the experience of career progression for staff who hold protected characteristics 6) Development and implementation of an inclusive recruitment toolkit 7) Undertake a health assessment for the workforce to identify health inequalities and identify key actions to address.
Implement regular Cultural assessment at Trust and divisional level.	1) Agree a methodology for assessing and monitoring culture 2) Monitoring tool / dashboard developed 3) Divisions are engaged and understand framework for assessing and monitoring culture 4) Data triangulation undertaken, with key findings and analysis embedded within Trust reporting processes.
Work with BAME Staff to support speaking upon bullying and harassment	1) Increase in BAME staff attendance at Multi Cultural network 2) Increase in number of BAME FTSU Champions with particular targeting wards / services with higher number of internationally recruited staff 3) Facilitate a number of BAME staff to become "role models" sharing key messages to encourage colleagues to speak up - One role model per division 4) BAME staff representation at Trust violence and aggression working group to ensure lived experience is represented 5) Series of listening events for BAME staff with Chief People Officer to continue to identify opportunities to address bullying and harassment

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Disability Equality Standards (WDES) Report

June 2025

Sharon Landrum, Head of People Experience

Contents

Background

Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that have been reviewed as part of a consultation process with NHS staff across the country and seek to enable Trust to compare the experiences of disabled and non-disabled staff.

Full details of the metrics are attached at Appendix i.

The WDES has been mandated by the NHS Standard Contract since 1 April 2019 and all Trusts must ensure data is uploaded to a government portal by no later than 31 May each year. Detailed reports including action plans to address areas of further work needed must also be developed and made public by no later than 31 October.

WUTH has declared its commitment to supporting staff to feel they belong in our organisation as outlined in our People Strategy 2022 – 2026 and to address areas of inequality. This is delivered through our equality, diversity and inclusion strategic commitment:

“To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated”.

WUTH is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- To eliminate unlawful harassment and victimisation.
- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

WRES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

Executive Summary

WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.

Appendix i outlines the national indicators that the Trust is required to submit data for and monitor progress against.

Appendix ii provides a summary overview of the Trust's performance against the required indicators, compared to national averages.

Data shows improvements in 10 of the 13 relevant WDES indicators this year, which is really pleasing to see. Board membership has remained the same and two areas have unfortunately declined:

1) Staff engagement score, which unfortunately declined for all staff this year;
2) % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. Despite seeing improvements for all staff in this area this year, results have unfortunately reduced for disabled staff.

Where comparative data is shown, results identify the same trends for disabled and non-disabled staff e.g. reduced staff engagement score for disabled and non-disabled staff and improvements in experiences of all staff, with the exception of indicator 7. Disabled staff are more satisfied with the extent to which the organisation values their work when compared with non-disabled staff who feel less valued this year.

Whilst it is pleasing to see an improvement in the overall % of disabled staff, numbers of self - declarations continue to remain low at 3.8%.

It is also pleasing to see continued improvements in recruitment data, with results showing an equal likelihood that disabled staff will be appointed from shortlisting when compared with non-disabled applicants.

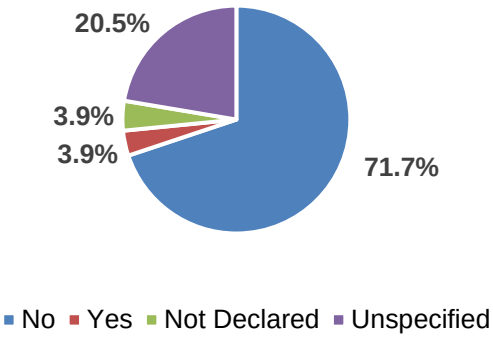
Appendix iii provides an update on progress against the actions identified for 2024/45 along with appendix iv that highlights key objectives identified as part of the Trust's overarching People Strategy, that seeks to ensure enhanced monitoring and improvement of staff experience in 2025/26.

Metric 1

Staff breakdown for 2024/25 (all staff)

As of 31st March 2025, the self-reporting rate for those staff with a disability within WUTH is 3.8%, 263 people (as entered on staff ESR records). Whilst only marginal, this is a further improvement from last year, when only 3.6% of staff (244 people) had declared. Whilst it is positive to see continued improvements in declaration rates, rates continue however to still be low, with 20.5% of staff ESR records still remining unspecified. Work will therefore continue to support improvements.

Chart 1 – Disability Status as of 31 March 2025



Data shows slight improvements in representation of disabled staff across both clinical and non-clinical roles, with the biggest improvement seen however within non-clinical roles, improving from 4.2% (94 staff) in 2023/4 to 4.9% (104 staff) this year. Clinical staff representation has increased from 3.2% (150 staff) to 3.4% (159 staff) this year.

Breakdown of workforce data by disability status as of 31 March 2025 and compared to 2023/4 data.

Chart 2 - Breakdown of disability declaration categories by clinical and non-clinical as of 31 March 2025.

	Total Clinical Staff	% of clinical	Total non-clinical	% of non-clinical	Combined 2025	% overall 2025	% overall 2024
Disabled	159	3.4%	104	4.9%	263	3.8%	3.6%
Non-disabled	3512	73.9%	1406	65.8%	4918	71.7%	69.9%
Not declared	184	3.6%	87	4.1%	267	3.9%	4.3%
Unspecified	862	17.7%	541	25.3%	1403	20.5%	22.3%
Total	4717	100.0%	2138	100.0%	6855	100.0%	100.0%

Further work is still required to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

Percentage of staff in A4C paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce as of 31 March 2025.

Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

Clinical/Non-Clinical	Values											
		Clinical				Non-Clinical				Total Headcount	Total WTE	Total % of Column Total
Cluster	Disability	Headcount	WTE	% of Row Total	% of Column Total	Headcount	WTE	% of Row Total	% of Column Total			
Cluster 1	No	976	810.27	50.07%	19.79%	1122	808.11	49.93%	49.23%	2098	1618.39	28.21%
	Not Declared	40	29.57	35.88%	0.72%	76	52.85	64.12%	3.22%	116	82.41	1.44%
Bands 1-4	Prefer Not To Answer	1	1.00	100.00%	0.02%			0.00%	0.00%	1	1.00	0.02%
	Unspecified	239	193.84	36.33%	4.73%	464	339.76	63.67%	20.70%	703	533.60	9.30%
	Yes	50	43.99	44.08%	1.07%	77	55.81	55.92%	3.40%	127	99.81	1.74%
Cluster 1 Total		**1306**	**1078.67**	**46.19%**	**26.34%**	**1739**	**1256.54**	**53.81%**	**76.56%**	**3045**	**2335.21**	**40.71%**
Cluster 2	No	1860	1654.03	90.32%	40.39%	183	177.25	9.68%	10.80%	2043	1831.28	31.93%
	Not Declared	111	90.35	90.07%	2.21%	10	9.96	9.93%	0.61%	121	100.31	1.75%
Bands 5-7	Unspecified	486	405.03	87.55%	9.89%	63	57.60	12.45%	3.51%	549	462.63	8.07%
	Yes	90	79.84	83.18%	1.95%	17	16.15	16.82%	0.98%	107	95.99	1.67%
Cluster 2 Total		**2547**	**2229.25**	**89.52%**	**54.44%**	**273**	**260.96**	**10.48%**	**15.90%**	**2820**	**2490.21**	**43.41%**
Cluster 3	No	159	147.18	68.51%	3.59%	69	67.65	31.49%	4.12%	228	214.84	3.75%
	Not Declared	6	5.37	84.30%	0.13%	1	1.00	15.70%	0.06%	7	6.37	0.11%
Bands 8a&8b	Unspecified	67	60.90	85.17%	1.49%	11	10.60	14.83%	0.65%	78	71.50	1.25%
	Yes	4	3.78	39.46%	0.09%	6	5.80	60.54%	0.35%	10	9.58	0.17%
Cluster 3 Total		**236**	**217.24**	**71.86%**	**5.31%**	**87**	**85.05**	**28.14%**	**5.18%**	**323**	**302.29**	**5.27%**
Cluster 4	No	21	19.83	38.40%	0.48%	32	31.80	61.60%	1.94%	53	51.63	0.90%
Bands 8c – 9&VSM	Unspecified	3	2.87	48.86%	0.07%	3	3.00	51.14%	0.18%	6	5.87	0.10%
	Yes			0.00%	0.00%	4	4.00	100.00%	0.24%	4	4.00	0.07%
Cluster 4 Total		**24**	**22.69**	**36.90%**	**0.55%**	**39**	**38.80**	**63.10%**	**2.36%**	**63**	**61.49**	**1.07%**
Cluster 5	No	246	232.45	100.00%	5.68%			0.00%	0.00%	246	232.45	4.05%
	Not Declared	14	12.46	100.00%	0.30%			0.00%	0.00%	14	12.46	0.22%
Consultants	Unspecified	55	51.34	100.00%	1.25%			0.00%	0.00%	55	51.34	0.90%
	Yes	3	3.00	100.00%	0.07%			0.00%	0.00%	3	3.00	0.05%
Cluster 5 Total		**318**	**299.25**	**100.00%**	**7.31%**			**0.00%**	**0.00%**	**318**	**299.25**	**5.22%**
Cluster 6	No	49	34.53	100.00%	0.84%			0.00%	0.00%	49	34.53	0.60%
	Not Declared	4	2.64	100.00%	0.06%			0.00%	0.00%	4	2.64	0.05%
Career Grades	Unspecified	11	8.87	100.00%	0.22%			0.00%	0.00%	11	8.87	0.15%
	Yes	1	0.22	100.00%	0.01%			0.00%	0.00%	1	0.22	0.00%
Cluster 6 Total		**65**	**46.26**	**100.00%**	**1.13%**			**0.00%**	**0.00%**	**65**	**46.26**	**0.81%**
Cluster 7	No	201	184.81	100.00%	4.51%			0.00%	0.00%	201	184.81	3.22%
	Not Declared	5	3.89	100.00%	0.10%			0.00%	0.00%	5	3.89	0.07%
Trainee Grades	Prefer Not To Answer	3	3.00	100.00%	0.07%			0.00%	0.00%	3	3.00	0.05%
	Unspecified	1	1.00	100.00%	0.02%			0.00%	0.00%	1	1.00	0.02%
	Yes	11	8.69	100.00%	0.21%			0.00%	0.00%	11	8.69	0.15%
Cluster 7 Total		**221**	**201.39**	**100.00%**	**4.92%**			**0.00%**	**0.00%**	**221**	**201.39**	**3.51%**
Grand Total		**4717**	**4094.75**	**71.39%**	**100.00%**	**2138**	**1641.35**	**28.61%**	**100.00%**	**6855**	**5736.10**	**100.00%**

Appendix i

Metric 2

This refers to the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Data for this indicator continues to remain positive this year, with disabled applicants as likely to be appointed as non-disabled applicants. A relative likelihood of 1:1.

Metric 3

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year.

23 staff entered the formal capability process over the last two years (April 2023 to March 2024 and April 2024 to March 2025), and none were identified as disabled. Whilst the relative likelihood of occurrence is therefore "0", the disability status of 14 was unknown and therefore further work will be undertaken this year to improve declaration rates in this area where possible.

National NHS Staff Survey Findings

Metrics 4 - 8 are taken directly from the staff survey results and relate to staff experiences of bullying and harassment, career progression opportunities and personally experienced discrimination. A summary overview can also be found at appendix iii.

Metric 4

Results of this metric are based on Q14 of the National Staff survey.

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months (chart 1)
   ii) Managers (chart 2)
   iii) Other colleagues (chart 3)

Chart 1 (4a.1) - Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**34.40%**	**31.86%**	**24.85%**	**27.54%**	**28.63%**	**28.83%**	**28.68%**		**29.37%**
Non-disabled staff	**23.90%**	23.95%	20.60%	22.64%	21.68%	20.17%	19.79%		22.71%

Chart 2 (4a.2) - % of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**26.30%**	**23.65%**	**18.09%**	**18.64%**	**15.88%**	**14.98%**	**14.72%**		**15.10%**
Non-disabled staff	15.50%	14.59%	12.26%	11.64%	9.89%	9.32%	8.00%		8.08%

Chart 3 (4a.3) - Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**34.90%**	**28.74%**	**25.40%**	**25.19%**	**21.87%**	**24.72%**	**24.09%**		**25.24%**
Non-disabled staff	19.50%	19.35%	15.61%	17.49%	14.92%	16.25%	13.56%		16.22%

Chart 4 (4b) - % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**55.30%**	**46.57%**	**49.21%**	**51.29%**	**53.05%**	**53.07%**	**58.77%**		**51.82%**
Non-disabled staff	**43.80%**	45.39%	43.06%	46.30%	47.34%	49.32%	54.27%		51.71%

Metric 5

This metric is also taken from the national staff survey results and is the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Q15).

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**51.50%**	**51.51%**	**46.25%**	**45.81%**	**52.51%**	**51.12%**	**51.13%**		**51.30%**
Non-disabled staff	**56.50%**	56.52%	56.56%	56.57%	58.07%	57.72%	58.60%		57.57%

Metric 6

This metric is again taken from the national staff survey results (Q11e) and looks at the percentage of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties.

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**39.90%**	**35.13%**	**30.00%**	**32.15%**	**30.67%**	**27.84%**	**25.57%**		**26.85%**
Non-disabled staff	**26.80%**	23.44%	27.56%	25.74%	25.29%	21.62%	19.03%		18.71%

Metric 7

This metric looks at the percentage of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work (Q4b).

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	**29.10%**	**32.48%**	**30.12%**	**28.85%**	**32.42%**	**30.43%**	**31.53%**		**34.73%**
Non-disabled staff	**40.80%**	44.13%	44.30%	40.20%	41.23%	42.93%	41.44%		46.98%

Metric 8

This metric is also taken from the national staff survey results and seeks to identify the number of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b)

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	66.50%	72.90%	75.40%	70.20%	71.10%	70.80%	70.40%		73.98%

Metric 9

This metric is also taken from the national staff survey results and comprises of two elements:

a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall staff engagement score for the organisation.

b) Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?

Part a - Staff Engagement Scores

	2018	2019	2020	2021	2022	2023	2024	Trend	National Average 2024
Disabled staff	6.3	6.39	6.45	6.28	6.26	6.19	6.07		6.40
Non-disabled staff	6.8	6.93	6.94	6.8	6.82	6.86	6.75		7.00

Part b

A number of actions have taken place to facilitate the voices of disabled staff.

The Trust has a WUTH Sunflowers staff network for staff with disabilities and long-term conditions. The network has two staff network co-chairs and an Executive Partner. Network co-chairs were new in post this year and have been working hard to reach staff; offering bi-monthly drop-in sessions across both main hospital sites and supporting Trust led combined “one network” meetings and workshops to ensure an intersectional approach. WUTH has however added a risk to the risk register regarding staffs ability to attend and support network activities. Current pressures within the organisation are resulting in staff struggling to support network activities, with challenges faced across all networks. Work to promote and support staff does however continue.

WUTH supports network co-chairs with two days per month per network, although work pressures can impact on time to support network activities. A network toolkit has been developed, along with a development plan for co-chairs. A small budget has been allocated for network activities, however due to current financial restrictions, networks are asked to think creatively about network activities, to unfortunately limit financial spending where possible.

An action on disability co-creation task and finish group was established in 2023/24 which involved a number of key stakeholders and WUTH Sunflower staff network members. Key priorities were identified and actions undertaken to ensure achievement. Engagement events were held with staff to understand experiences and key actions needed and these were the focus for 2023/24. The group concluded in June 2024 and actions completed were included within a revised version of the Trust’s Disability and long-term health condition policy and promoted through Trust communications, network activities and EDI Steering group.

A hidden disabilities group was also established under the Trusts Patient Experience strategy and saw a number of staff involved in sharing experiences and contributing to improvements for both staff and patients.

Staff stories continue to be shared across the Trust, with a number of staff network members sharing video and written narratives, also linked to national and international awareness days e.g. Deaf Awareness Week.

WUTH continues to roll out the Hidden Disabilities sunflower initiative and give badges or lanyards out to staff with hidden / invisible disabilities if they want one. Promotion of this commences at recruitment and induction and is integrated within our management and leadership development programmes.

Regular communications are produced to raise awareness of key national and international awareness days and links made to areas for consideration, action needed and support services available for both staff and patients.

The Trust's equality, diversity and inclusion (EDI) strategic commitment underpins the Trust's People Strategy and seeks to ensure that EDI is a golden thread throughout all of our people practices and processes.

Equality, diversity and inclusion (EDI) has been embedded within our new leadership for all and management development programmes and individuals encouraged to seek support for themselves and offer support and compassionate and inclusive leadership to others.

Dedicated EDI sessions are also held as part of Manager Essential and Leading Teams programmes, with themes of Inclusive Leadership and Inclusive Recruitment delivered.

A new engagement plan was developed and launched in 2023/24 to support wider recognition and engagement for all staff. As part of this plan, a new approach was taken to promote and support uptake of this years' staff survey and as such, an increased response rate was achieved (9%) including disabled staff. 26.45% of staff identified in the staff survey as having a physical or mental health condition or illness lasting or expected to last for 12 months or more. This was 2% higher than the national average of 24.25% and 0.2% higher than last year.

Metric 10

Percentage difference between the organisations Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

The Trust has 14 Board member, 12 of whom are voting members, and none identify as disabled.

Conclusion

Data shows improvements in 10 of the 13 relevant WDES indicators this year, which is really pleasing to see. Board membership has remained the same and two areas have unfortunately declined:

1) Staff engagement score, which unfortunately declined for all staff this year;

2) % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. Despite seeing improvements for all staff in this area this year, results have unfortunately reduced for disabled staff.

Where comparative data is shown, results identify the same trends for disabled and non-disabled staff e.g. reduced staff engagement score for disabled and non-disabled staff and improvements in experiences of all staff, with the exception of indicator 7. Disabled staff are more satisfied with the extent to which the organisation values their work when compared with non-disabled staff who feel less valued this year.

Whilst it is pleasing to see an improvement in the overall % of disabled staff, numbers of self - declarations continue to remain low at 3.8%.

It is also pleasing to see continued improvements in recruitment data, with results showing an equal likelihood that disabled staff will be appointed from shortlisting when compared with non-disabled applicants.

Appendix iii provides an update on progress against the actions identified for 2024/45 along with appendix iv that highlights key objectives identified as part of the Trust's overarching People Strategy, that seeks to ensure enhanced monitoring and improvement of staff experience in 2025/26.

WDES Metrics

Workforce Metrics For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	**Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.** Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric is voluntary in year one.
National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

Appendix i

WDES Metrics

Metric 5 Staff Survey Q14	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
Metric 6 Staff Survey Q11	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**
Metric 7 Staff Survey Q5	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
The following NHS Staff Survey Metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q28b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score For part b) add evidence to the Trust's WDES Annual Report	
Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.** **b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no,** please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.
Board representation Metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

Appendix ii

2024/5 WDES Indicator Summary of Indicators Compared to Regional and National Comparators

WDES Indicator			National Average 2024 where available / Aim	WUTH 2021-22	WUTH 2022-23	WUTH 2023-24	WUTH 2024-25
1	% of disabled staff			2.0%	2.8%	3.6%	3.8%
2	Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts			1.8	1.3	1.19	1
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year			0	0	0	0
4a.1	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled**	**29.37%**	**27.54%**	**28.63%**	**28.83%**	**28.68%**
		Non-Disabled	22.71%	22.64%	21.68%	20.17%	19.79%
4a.2	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled**	**15.10%**	**18.64%**	**15.88%**	**14.98%**	**14.72%**
		Non-Disabled	8.08%	11.64%	9.89%	9.32%	8.00%
4a.3	% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	**Disabled**	**25.24%**	**25.19%**	**21.87%**	**24.72%**	**24.09%**
		Non-Disabled	16.22%	17.49%	14.92%	16.25%	13.56%
4b	% of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it	**Disabled**	**51.82%**	**51.29%**	**53.05%**	**53.07%**	**58.77%**
		Non-Disabled	51.71%	46.30%	47.34%	49.32%	54.27%
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion	**Disabled**	**51.30%**	**45.81%**	**52.51%**	**51.12%**	**51.13%**
		Non-Disabled	57.57%	56.57%	58.07%	57.72%	58.60%
6	% of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties	**Disabled**	**26.85%**	**32.15%**	**30.67%**	**27.84%**	**25.57%**
		Non-Disabled	18.71%	25.74%	25.29%	21.62%	19.03%
7	% of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	**Disabled**	**34.73%**	**28.85%**	**32.42%**	**30.43%**	**31.53%**
		Non-Disabled	46.98%	40.20%	41.23%	42.93%	41.44%
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	**73.98%**	**70.20%**	**71.12%**	**70.79%**	**70.40%**
9a	Staff engagement score	**Disabled**	**6.40%**	**6.28**	**6.26**	**6.19**	**6.07**
		Non-Disabled	7.00%	6.80	6.82	6.86	6.75
9b	Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?		N/A	Yes	Yes	Yes	Yes
10	Board membership			3.60%	-2.80%	-4%	-4%

Key:

	≥ last year and ≥ the national average
	≥ last year < national average **or** < last year ≥ national average
	< last year and < national average

Appendix iii

WDES Update on Action Plan for 2024-25

Elements		Action	Responsibility	Deadline	Progress	Comments
Seek to Understand	1	Develop process of regular recruitment audits of processes for under-represented areas / roles to understand challenges / barriers or areas of potential bias	Recruitment Services	30/09/2024	Amber	Process developed and piloted, however due to capacity within the service, this has been unable to be embedded as yet.
	2	Enhanced review of 2024 staff survey results to understand potential impact of action on disability co-creation group and associated actions.	People Experience	31/03/25	Green	Actions reviewed and presented to EDI steering, with involvement of staff network members. For further review with network members as part of WDES findings.
	3	Develop a process to identify and triangulate data relating to incidents/concerns and employee relations case linked to protected characteristics	People Experience	31/12/24	Green	Completed and included within ER reports and individual subject areas as required e.g. sexual safety and bullying and harassment
Support	1	Build capacity and capability of Trust staff networks, with appointment of new co-chairs and re-establishment of regular meetings.	Co-chairs / Exec Partners	31/03/2025	Amber	New co-chairs appointed and offering bi-monthly drop-ins, with quarterly dates scheduled.
	2	Enhanced promotion of support available, including staff network, access to work and examples of reasonable adjustments and health passport for staff	DG / SL / Sunflowers	31/03/25	Green	Whilst promotion has taken place, the disability policy has been updated with new documentation and promotion undertaken, more work continues to be needed to promote.
	3	Continue to encourage staff to enter/update personal information via ESR self-service, with guidance documents and support offered to complete.	Comms / Workforce Information / SL	31/03/25	Green	The number of unspecified staff continues to drop as staff are updating their disability status, with support from ESR drop-in sessions and various promotional opportunities. More is still needed to ensure further increases in declarations.
Educate and Develop	1	Visible Respect at Work campaign to promote zero tolerance to bullying, harassment or abuse within the workplace	HR / H&S	Ongoing	Amber	Zero tolerance posters and communications have been issued; however a new approach is being taken to staff safety and managing challenging behaviours. Stakeholder review sessions have been held, with a new strategy in development
	2	Deliver education and training sessions to promote key priorities e.g. Deaf awareness, neurodiversity awareness and general advice and support for manager	SL / DG	31/03/25	Green	A variety of sessions have been held including monthly deaf awareness session neurodiversity and autism awareness sessions and mini manager essentials sessions. Session held with solicitors and priorities reviewed with WCHC colleagues and further education to be launched. EDI training included as part of leadership and management development programmes,

						with specific examples relating to disability used.
	3	EDI training to support leaders in understanding how to ensure WUTH is an anti-racist organisation and upholds the principles of the sexual safety charter.	CPO	31/03/25	Green	As with the above section. Key messages are also shared as part of induction programmes for all staff and both through internal and external articles. Letters have also been sent to staff to promote sexual safety in the workplace and offer support for staff, along with the launch of eLearning for managers on sexual safety.
Celebrate and Promote	1	Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support	People Experience	Ongoing	Green	In place and ongoing
	2	Promoting WUTH as an inclusive employer that celebrates diversity and harnesses individuality	People Experience / Comms / Recruitment	Ongoing	Green	Regular Trust wide promotions are undertaken. WUTH was reaccredited as a Disability Confident Employer WUTH was reaccredited with the Navajo chartermark that seeks to recognise inclusive employers.
	3	Launch and promote actions completed by the Action on Disability Co-Creation group	OH / Comms / People Experience	31/08/24	Green	Actions were integrated within a revised Disability and Long-term conditions policy and promoted, with Trust wide communications. More work is needed to ensure promotion to all staff with actions identified as part of a recent lessons learnt session.

Appendix iv

People Strategy Objectives for 2025/26

Objective	Deliverable / Output
Deliver the 2025 elements of the NHS England EDI High Impact Actions	1) Development of an EDI Dashboard that incorporates NHSE High Impact Actions 2) Robust reporting of High Impact Actions through workforce governance 3) Recruitment audit undertaken on a quarterly basis 4) Relative likelihood of staff being appointed from shortlisting, monitored for all protected characteristics 5) Undertake a review to identify the experience of career progression for staff who hold protected characteristics 6) Development and implementation of an inclusive recruitment toolkit 7) Undertake a health assessment for the workforce to identify health inequalities and identify key actions to address.
Implement regular Cultural assessment at Trust and divisional level.	1) Agree a methodology for assessing and monitoring culture 2) Monitoring tool / dashboard developed 3) Divisions are engaged and understand framework for assessing and monitoring culture 4) Data triangulation undertaken, with key findings and analysis embedded within Trust reporting processes.

Appendix 4 - Workforce Equality, Diversity and Inclusion (EDI) Update Summary – June 2025

Setting Direction

- EDI Strategic Commitment (including objectives) launched for 2022-2026 and underpins WUTH's People Strategy with annual key deliverables
- Staff networks maintained with regular opportunities created to understand experiences and involve staff in decision making processes and shaping direction
- EDI Objectives set for all Exec and Non-Exec Directors
- KLOE included within Divisional performance reviews
- Working with WCHC to understand areas of good practice and opportunities to collaborate.
- Action plans in place to support re-accreditation processes and drive improvements in specialist areas
- Engagement Framework launched with focus on recognition and improving staff voice -significant increase in NSS response rates as a result.
- EDI Dashboard developed and under review
- New approach to reviewing staff survey data with a workshops held to understand data and set priorities

What's next…

- Further listening events for non-white staff
- Approval of EDI dashboard and key metrics

Development, Education and Awareness

- 94.7% compliance with EDI mandatory training (May)
- EDI embedded within induction, leadership for all and manager essential programmes
- Dedicated EDI Board session on health inequalities
- Mini manager sessions on: supporting staff with disabilities; equality analysis and impact assessments and LGBT+ awareness
- Monthly deaf awareness programme in place
- Neurodiversity sessions delivered by the Brain Charity
- Autism session delivered by Autism Together
- Staff and patient stories shared at key meetings and as part of a range of internal and external comms
- Range of national e-learning programmes promoted
- "Drop Everything and Read" sessions held on a variety of EDI topics
- Interview and development support sessions held for non-white staff

What's next…

- Further training for managers on how to support staff with disabilities and the support / resources available.

Monitoring and Assurance

- Workforce Race and Disability (WRES and WDES) and gender pay gap reporting completed
- New reporting cycle implemented with EDI Bi-Annual reporting commenced
- Trust maintained "achieving" EDS status
- Enhanced review and monitoring of staff survey data
- Increased demographic monitoring and triangulation of experiences, to further understand ER cases, flexible working applications, Bullying and harassment and sexual safety and volunteer resource.
- Significant increase in staff survey response rate due to revised approach.
- EDI related question now included within Divisional Performance Reviews

What's next…

- Approval of EDI dashboard and key metrics
- Delivery of 2025/26 people strategy key deliverables

Communications

- Regular Trust communications to promote key events an information, with a heightened focus on individual stories and experiences
- EDI webpages updated with key reports
- Reachdeck software in place to support web accessibility
- Enhanced communications to promote messages of anti-racism and offer of support to staff.

What's next…

- Exploration of assistive technology to support communications

Events

- Flag raising for PRIDE month
- Neurodiversity and autism awareness sessions held
- Intersectional "one network" events, for staff networks to meet together and share feedback and ideas
- Menopause Q&A sessions held with experts in areas
- Calendar of events in place for 2025/26 to support various national and international awareness days/weeks and months e.g. International Women and Mens day
- Departmental events e.g. Culture Days
- Volunteer week
- Chinese New Year menu in canteen

What's next…

- Further listening events for non-white staff
- #splash of colour day to show PRIDE in your team
- Raising the flag and celebrating our armed forces community, with staff sharing their experiences

Staff Support

- New volunteer staff network in place and work underway to link WCHC and WUTH networks
- EDI team & networks meet new staff at induction
- Network members "buddying" with colleagues
- Staff sharing experiences to help others
- Networks hosting themed meetings & guest speaker sessions held
- Staff menopause clinic continues with dedicated menopause website, including guidance and support
- Wellbeing Week focused on supporting staff with disabilities
- Provision of Iftar boxes for staff during Ramadan
- Disability engagement events
- Launch of sexual safety charter and a range of actions to support staff

What's next…

- Further promotion of support and resources available for disabled staff
- Listening events

Accreditations

- Veteran Aware Accreditation
- Merseyside In Touch Navajo LGBTIQA+
- Defence Employer Recognition Scheme (DERS)Silver Level Achieved
- Disability Confident Employer
- Anti-Racist Framework Bronze status

What's next…

- Re-accreditation of Veteran Aware

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 23**
5 November 2025

Title	Freedom to Speak Up Annual Report 2024/25
Area Lead	Deb Smith – Chief People Officer / Executive Lead for FTSU
Author	Tracey Nolan – FTSU Guardian/People Experience Lead
Report for	Information

Report Purpose and Recommendations

National Guardians Office (NGO) guidance ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should be on a bi-annual basis.

The purpose of this report is ensure Trust Board are sighted on the FTSU themes and to provide assurance that concerns raised via the FTSU Guardian are listened to and resolved via the correct channels. Where themes/trends are identified this report outlines action taken to escalate themes for further review/action. The report includes data for 2024/25 reporting periods.

It is recommended that the Board:

- Note the report

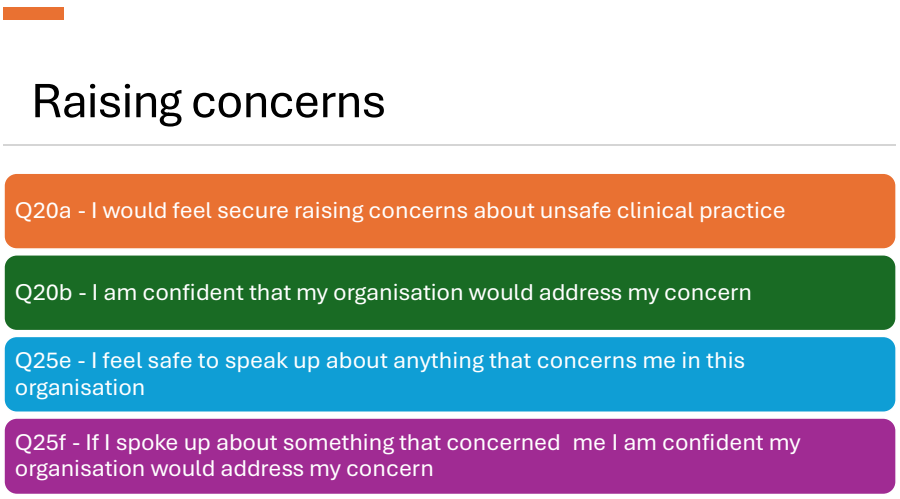
Key Risks

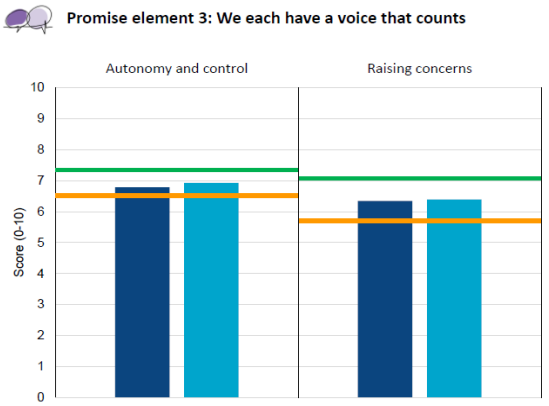
This report relates to key Board Assurance Framework (BAF) Risks: BAF 5: Failure to have the right culture, staff experience, and organisational conditions to delivery our priorities for our patients and service users.

NOTE: Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary.

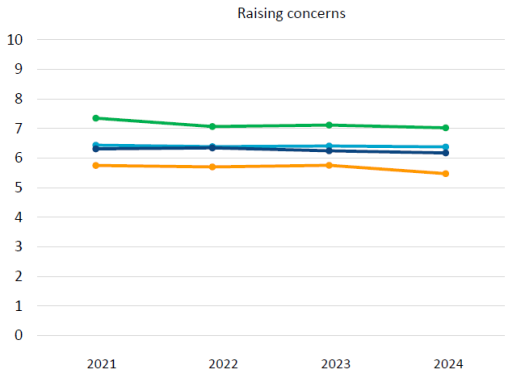
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
September 2025	People Committee	As above	As above

1	Narrative
1.1	Revised NGO guidance for 2022 (“Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services” 2022) highlights that reporting activity should now be on a bi-annual basis and therefore this report seeks to meet those requirements and outline FTSU activity for 2024/25. This report provides an overview of activity data for 12 months 2024/25 and work undertaken to progress the agenda in line with national policy and best practice guidance. Data is presented in a way that maintains the confidentiality of individuals who speak up. **Staff Survey and FTSU** The NHS Staff Survey provides crucial insight into whether staff feel confident that their voices will be heard. WUTH adopted a new approach to the staff survey campaign this year which saw greater involvement and ownership by Divisions, with connectors identified to support promotion and uptake within their areas. A 9% increase in response rates was seen overall, with 47% of staff sharing their views this year. This is particularly pleasing to see and whilst still below the national average of 49%, a Cyber Attack impacted on the final week of fieldwork and unfortunately halted uptake. Since 2020 the staff survey has included a question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year’s survey along with the follow-up question: ‘If I spoke up about something that concerned me, and I am confident my organisation would address my concern.’ (see question details below).  Results for the “Raising Concerns” People Promise sub-score are highlighted below:

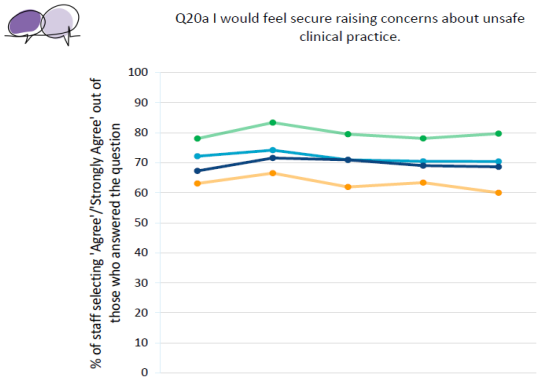


	Autonomy and control	Raising concerns
Your org	6.8	6.3
Best	7.3	7.1
Average	6.9	6.4
Worst	6.5	5.7
Responses	3123	3099

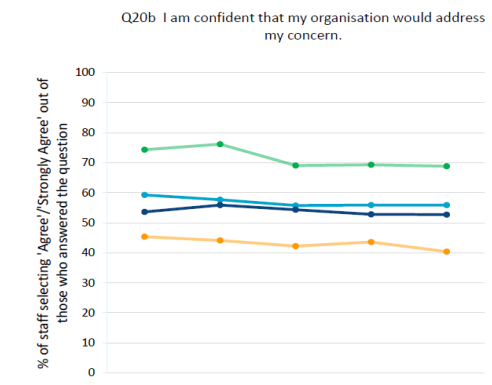


	2021	2022	2023	2024
Your org	6.31	6.35	6.25	6.17
Best result	7.35	7.07	7.12	7.02
Average result	6.44	6.39	6.41	6.38
Worst result	5.75	5.70	5.76	5.48
Responses	2863	3099	2432	3093

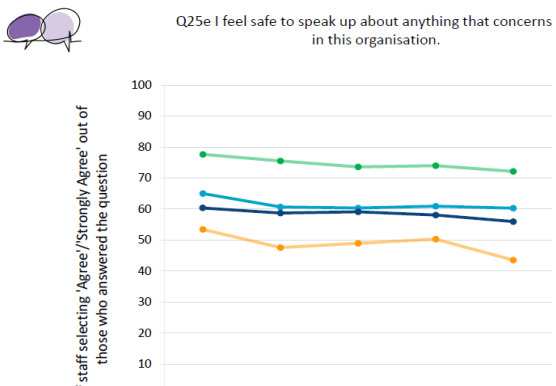
Results for the individual questions are detailed below:



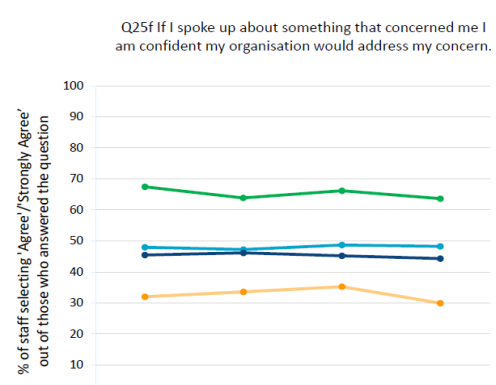
	2020	2021	2022	2023	2024
Your org	67.30%	71.59%	70.97%	69.04%	68.63%
Best result	78.06%	83.39%	79.51%	78.11%	79.71%
Average result	72.16%	74.20%	70.96%	70.47%	70.44%
Worst result	63.08%	66.55%	61.96%	63.38%	60.03%
Responses	2443	2878	3115	2433	3108



	2020	2021	2022	2023	2024
Your org	53.63%	55.92%	54.39%	52.81%	52.75%
Best result	74.37%	76.20%	69.10%	69.35%	68.85%
Average result	59.29%	57.68%	55.79%	55.93%	55.91%
Worst result	45.38%	44.13%	42.28%	43.61%	40.42%
Responses	2444	2870	3115	2440	3100



	2020	2021	2022	2023	2024
Your org	60.35%	58.74%	59.10%	58.06%	55.98%
Best result	77.65%	75.50%	73.58%	74.00%	72.15%
Average result	65.01%	60.68%	60.37%	60.93%	60.29%
Worst result	53.44%	47.61%	48.97%	50.33%	43.56%
Responses	2462	2872	3105	2438	3101



	2021	2022	2023	2024
Your org	45.43%	46.15%	45.20%	44.30%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	2863	3103	2435	3095

Findings
Results unfortunately show a decline in staff experience in this area and fall below the national average for comparator Trusts.

Trust results are comparable to national findings, identified by the National Guardians office as indicating “a plateau in confidence”. In view of this, the National Guardians office is calling for the role of the Freedom to Speak Up Guardian to be strengthened and standardised with greater accountability for leaders and organisations, and the embedding of a culture of listening and action across the entire NHS.

A new approach was adopted in reviewing the staff survey results, with FTSU Champions involved in a workshop event held to review results and support identification of priority areas for 2025/26.

As a result of the feedback from staff, WUTH has identified “Responding to concerns: Improving staff confidence” as an area of focus for 2025/26, with actions included in the FTSU action plan for 2025/26.

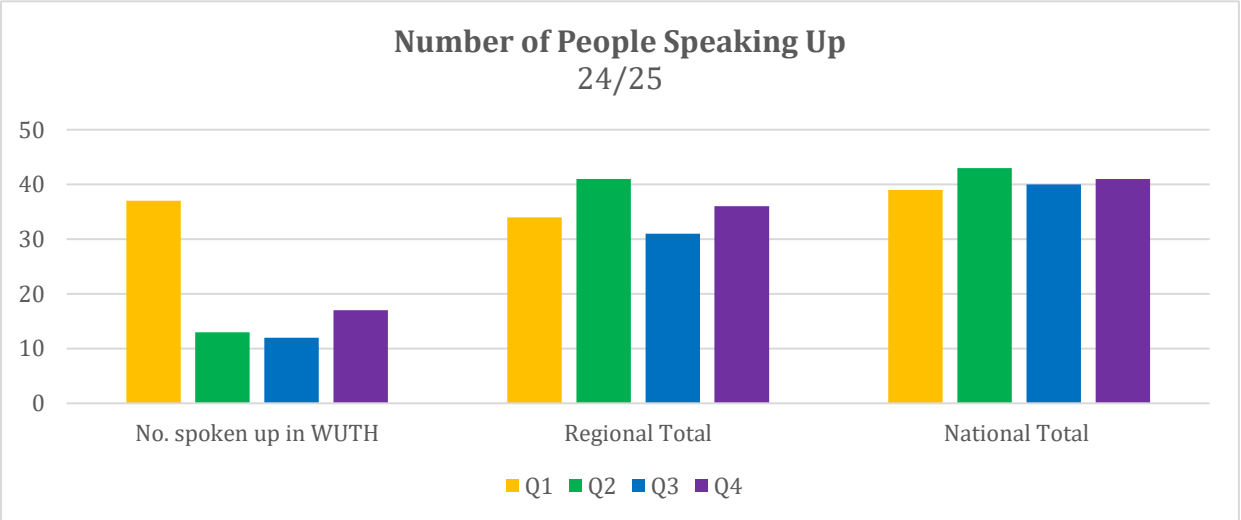
The divisions with the lowest confidence will also form part of the action plan this year to target in terms of building trust with staff.

2 FTSU Activity

2.1 - Number of People Speaking Up

Data is submitted to the National Guardians Office (NGO) on a quarterly basis and the chart below demonstrates comparison between the overall number of people speaking up against regional and national Trusts of similar size.

The number of people speaking up to FTSU Guardians has decreased over the past year with 79 people speaking out in 24/25 compared to 104 staff speaking up in 23/24. The chart below demonstrates that WUTH staff raise fewer concerns than the regional and national average hospitals similar in size.



Increased visibility around the hospital and promoting the service within induction as well as all managers training events may see a rise in concerns raised in the coming year, however feedback from staff to FTSU Guardians suggests staff feel more able to raise concerns with their line manager themselves this year. The 2024 staff survey highlights a 1.2% increase in staff feeling their immediate manager cares about their concerns, however the question is broad. staff experience data will continue to be monitored

Staff survey data at WUTH mirrors national results whereby the National Guardians office annual report 2024/25 states that "workers are less encouraged to raise concerns" and are "expressing declining confidence that their organisation will act on them". The report states that staff speaking up are "losing faith" in the process due to "lengthy human resource processes" and "delays in investigations" and that these were "barriers to achieving meaningful outcomes".

The National Guardians Office have identified a growing disconnect between FTSU Guardian reported activity and staff sentiment which highlights the need for targeted cultural and leadership interventions to rebuild trust and foster a more supportive speaking up environment.

A key action this year is to therefore build staff confidence in the speaking up process. Our action plan this year includes targeting the lower scoring areas (identified above) from the staff survey as well as establishing a "following up" process to ensure that managers appreciate the importance of following up in a timely manner.

2.2 - Concerns Raised by Theme

The table below sets out the concerns raised during 24/25 by theme. This 12 month period has witnessed a surge in concerns raised about Attitudes and Behaviours, accounting for over 43% of all concerns raised during the year. When comparing this to last year the figure was 22% suggesting a significant increase.

Bullying and harrasment has increased from last year with concerns accounting for an overall percentage of 28%. Last year bullying and harrasment accounted for 20% of concerns raised, again an increase is apparent. It is important to note that concerns can often span numerous themes.

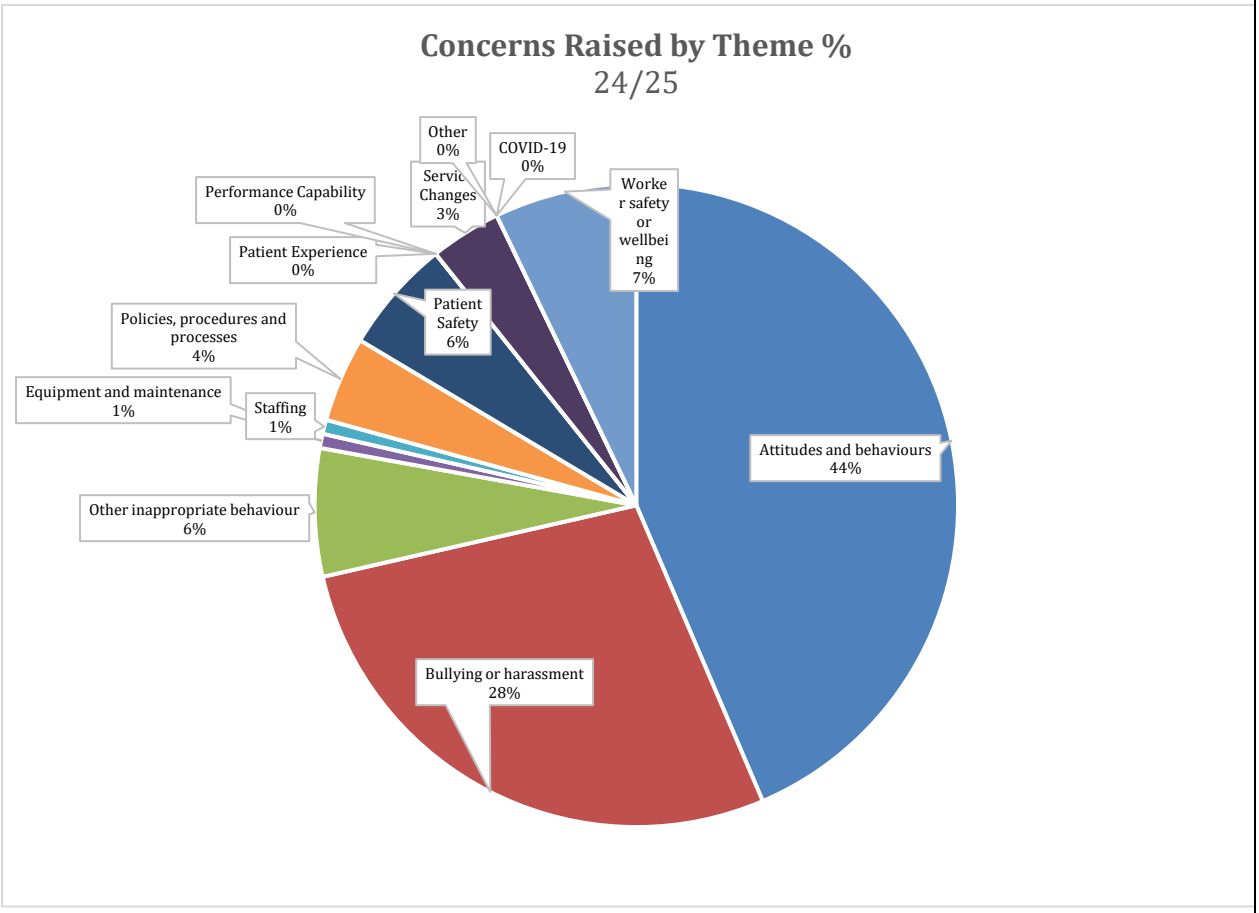
During the financial year there was a total of 79 FTSU cases (individuals), these 79 staff members between them raised 140 concerns. These concerns were then grouped into the national guidance reporting themes (13 themes). Of the 140 concerns raised, 39 related to bullying and harassment – this accounts for 28% of all 140 concerns raised. Regionally 18% of cases were around bullying and harassment and nationally this accounted for 16% of concerns.

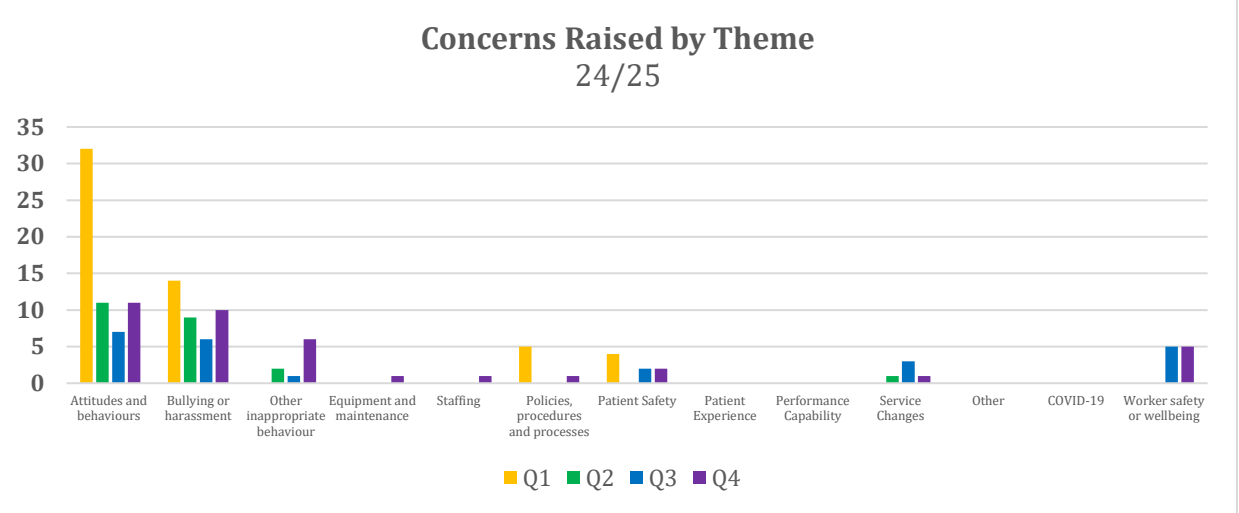
As the Trust data suggested WUTH was an 'outlier' for Bullying and Harrassment with a significant proportion of cases reported having a theme of bullying and harrassment, FTSU guardian and Head of HR undertook a triangulation exercise to determine if concerns raised had been processed approriately in line with Trust policy and to determine if HR processes was implemented following fact find. NOTE: anonymity of individuals raising concerns was maintained throughout the exercise.

Although bullying and harrassment was mentioned 39 times (28%), coded triangulation suggests there were 10 formal HR cases, 4 of these cases (12.66%) progressed by the reporters to HR via the Trust's Fairness to Work process. Within the 10 cases (60%) concerns were raised by both parties to either FTSU or HR or both.

However, only in 10 cases did the individual concern progress formally with HR (12.66 %). In 6 of the cases the reporter to FTSU was also the same person that concerns were raised about. 4 FTSU cases progressed to formal grievance (5.06%). Rather than direct or indirect bullying and harassment, data suggested poor communication and incivility was the primary driver causing upset to either or both parties.

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





Staff raised concerns around incivility and rudeness and were saddened on occasion at the manner in which they had been spoken to – staff collectively reported that "the outcome would have been the same" however, the way that managers' had spoken to staff had caused significant upset with some staff reporting rude, aggressive management styles when instructions or requests were being given. This explains that it is the way staff are spoken to, and not what they are spoken to about, that is causing their concerns.

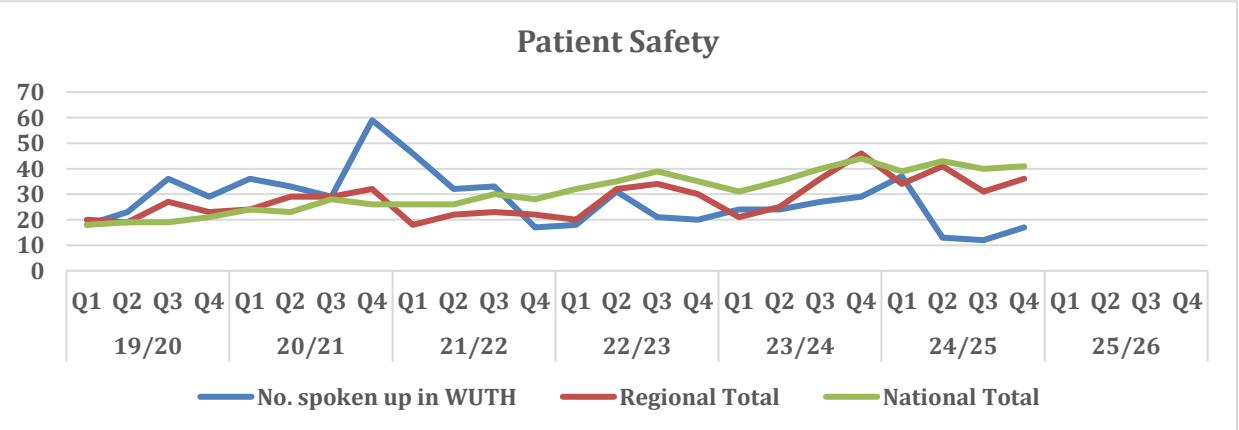
2.3 - FTSU Patient Safety Data

Patient safety concerns have risen this year compared to last with an increase across the year of 8 concerns compared to only 1 last year.

Regionally and Nationally WUTH are very similar in the number of patient safety concerns raised.

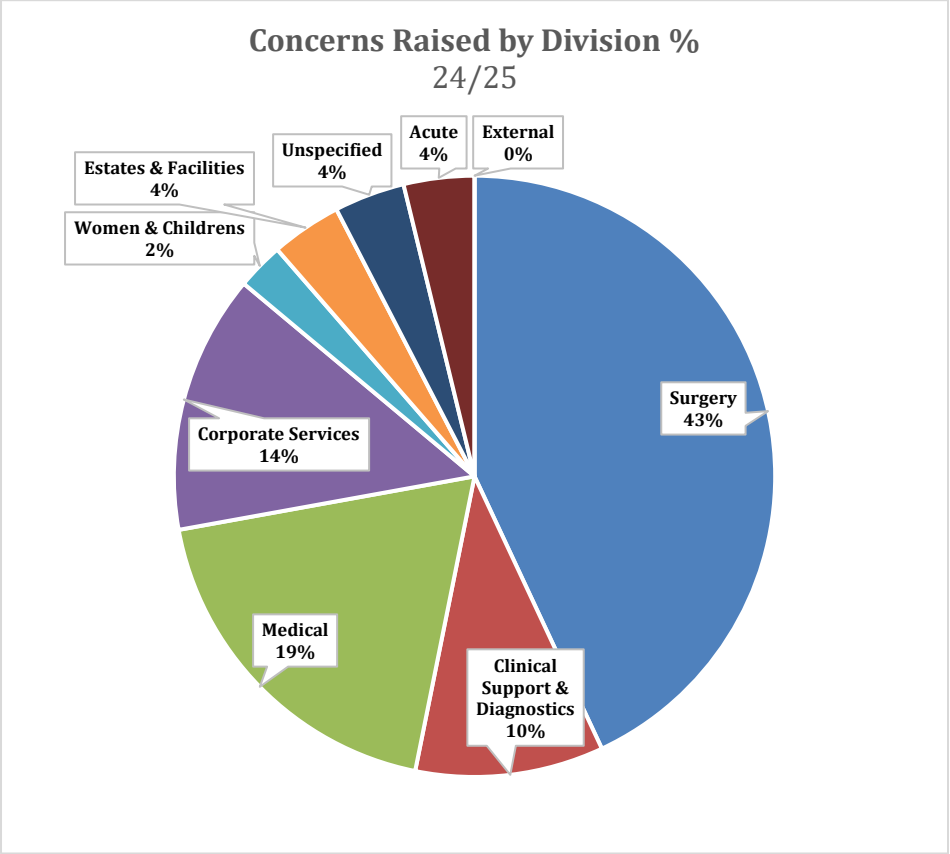
The graph below highlights the % of cases concerning patient safety for the 12-month period compared to the regional and national average. 9% of all Freedom to speak up concerns at WUTH were around patient safety, slightly higher than both the regional and national average.

To provide a comparator if we compare the annual figures the regional average for patient safety concerns being raised is 7.9% and the national average is 7% and WUTH is 5%.



2.4 - Concerns Raised by Division

The chart below shows the concerns raised by division.



Divisional info

Surgery Division staff have raised the most concerns this year – accounting for 43% of the total concerns raised. Significant work has previously focused on the Surgery Division which may have accounted for staff feeling able to speak up as they have done over the last 12 months.

Following a never event and previous staff survey scores, a bespoke electronic survey was created and shared with staff, to understand areas of concern and areas for improvement. The survey highlighted that staff felt unable to speak up and as such, supporting staff to speak up was incorporated within local improvement plans. Managers took action to encourage staff to speak up. Various listening events were held across both sites, along with feedback and engagement sessions. Sessions included senior Divisional leaders, FTSU Guardian and the Trust's Engagement and Inclusion Lead. It is felt that these have encouraged staff to speak up and raise themes however staff are still reluctant to be identified when raising concerns.

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

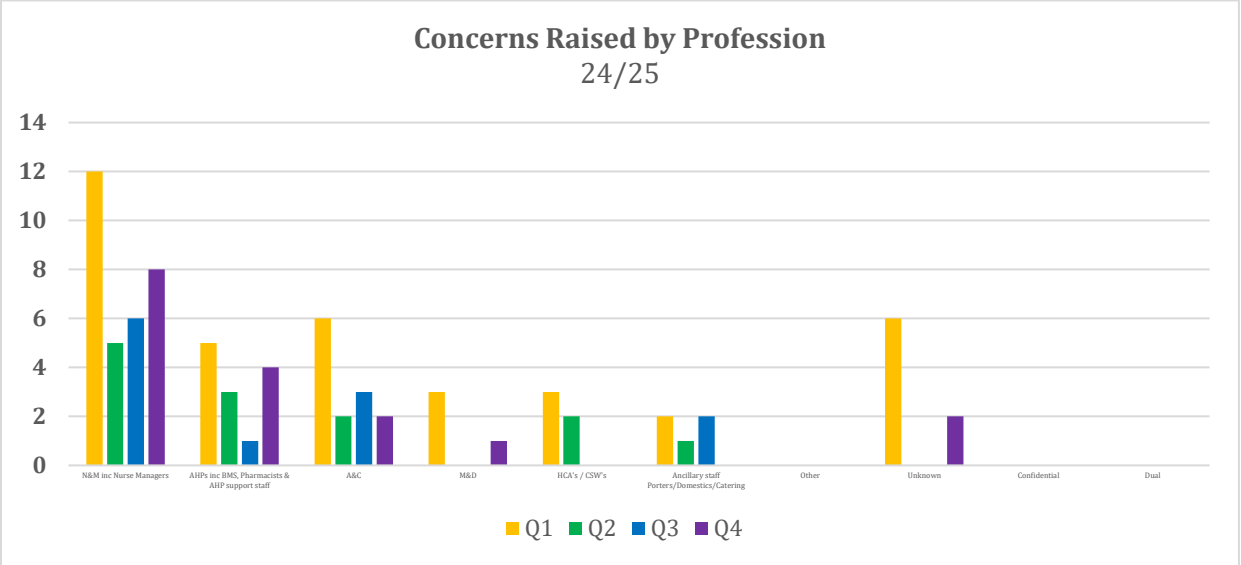
A positive point was that surgery were the only division to demonstrate an increase in staff experience for all 4 speaking up questions in this years' staff survey indicating a positive improvement in speak up culture for the division.

WUTH is keen to increase the number of FTSU champions in certain divisions and will be focussing on this throughout the year. Medicine and Surgery Divisions have the

highest number of champions to date. Estates and facilities have the lowest number of champions and is therefore an area of priority for Champion recruitment.

2.5 - Concerns Raised by Professional Group

The following table highlights the concerns raised by professional group.



The highest staff group raising concerns across the 12-month period are from Registered Nurses/Midwives accounting for 34% of all concerns raised. Clerical roles account for 32% of concerns raised (29 staff) across the year.

According to the Staff Survey the staff group who appear to have the lowest confidence in speaking up are Healthcare scientists, this suggests that Freedom to Speak up needs to target the lab areas this year to ensure that they know who to speak up to and build confidence in the process – audit days will be used to target FTSU awareness across sites.

2.6 - Anonymous Concerns

3 anonymous concerns were received throughout the year, 2 were about bullying and 1 was about equipment. Anonymous reporting continues to remain low which is pleasing to see. Staff are encouraged in the first instance to discuss their concerns with their line manager where possible if they haven't already tried this prior to raising a concern via FTSU.

2.7 - Demographics

79 staff raised concerns.

8% of staff were BAME staff – 1 concern considered that there was underlying racism in the department.

9% of staff were neurodiverse and every concern raised was around lack of understanding and appreciation of neurodiversity in the workplace.

1% of staff considered themself disabled and raised concerns around reasonable adjustments.

	2.8 - Disadvantageous or Demeaning Treatment as Result of Speaking Up None were reported across the 12-month period. **2.9 Time Taken to Close Cases** The average time taken to close cases across the year was 8 days – most cases are quickly resolved resulting in staff feeling happy with an outcome and managers being receptive to the concern being raised. This figure has decreased from 2 weeks from the previous year.

3	Lessons Learned
	Whilst the 2024 staff survey highlights a 1.2% increase in staff feeling their immediate managers cares about their concerns, less staff feel safe to speak up about anything that concerns them in the organisation and are less confident that the organisation would address their concerns. It is vital that the Trust through its leaders continue to promote a positive speak up culture to build staff confidence in knowing that when they do speak up that they will be listened to, and action will be taken. Work continues to further improve the timeliness of responses from managers once a concern has been raised, with FTSU Guardians setting expectations of managers when concerns are raised. A new monitoring and escalation process has also been implemented with Executive, Non-Executive and Senior Trust leaders to review themes and trends and ensure timely progress and actions are taken. Themes throughout the year have demonstrated that the way we talk to each other is important and the way that we ask people for help or to change can impact people significantly, both positively and negatively. Kindness can make a huge difference to people and can have a significant impact on individuals and divisions. Kindness can create a more positive and supportive environment. **Triangulation of Data** New methodology has been developed this year to support greater understanding of staff experiences. FTSU data has been included as part of a number of triangulation exercises including understanding numbers of staff experiencing incidents of a sexual nature and cases of bullying and harassment. Anonymity of individuals and specific cases is maintained throughout all triangulation exercises; these exercises support trend analysis to better understand staff experience and culture at WUTH. WUTH is also working with WCHC to understand areas of best practice, with plans in place to mirror triangulation meetings here at WUTH later in the year.

4	Progressing the FTSU Agenda
	Significant development of the FTSU agenda continues to be led nationally with the recent guidance around "Strengthening our foundations". The guidance has made recommendations for NHS Provider Trusts to consider within the next 12 months. Guidance sets out a number of recommendations.

A gap analysis is underway to review recommendations against the Trust's current provision and not only ensure the Trust remains aligned to national FTSU requirements but also continues to improve and provide a quality FTSU service at WUTH as well as consider the "Well Led" domain within CQC guidance.

NHS England has revised its Freedom to Speak Up guidance for workers and information governance leads, to understand the confidentiality and record keeping requirements of Freedom to Speak Up guardians. New guidance is available, and the National Guardians Office have recommended that this is shared with our Information governance department – this has been shared.

There have been some highlights throughout the year:

We are working with The University of Chester to educate student nurses about Freedom to Speak Up and the importance of speaking up if students see anything of concern before they go into their practice placements. 100 student nurses have been trained in anticipation of commencing on placement at WUTH. All students completed their Freedom to Speak Up e learning level 1 and 2 prior to their practice placement.

The following objectives have been identified as part of an annual action plan.

1. **Review Governance and reporting structures for FTSU Guardians** – Through this objective reporting and oversight arrangements have been strengthened to ensure robust Board assurance. In addition, a process for triangulating FTSU cases with employee relations cases and patient safety incidents has been reestablished

2. **Ensure the Trust is up to date with national and local guidance, policy and best practice** – The new National Guardian framework has been published with recommendations made for NHS Trusts.

3. **Increase FTSU capacity** – Increase champion network to ensure that all divisions have champions within them – we will continue to engage new champions, currently WUTH have 39 trained champions throughout the divisions – champions are able to promote FTSU and signpost staff.

4. **Staff survey** – we will continue to use the annual Staff Survey to identify areas of strength and areas for development.

5. **Awareness & Training -** As of July 2025 86.45 %, staff have completed their level 1 speak up training This is below Trust target of 90% compliance, with the lowest areas for completion being Estates, Facilities and Capital Planning division. There is a plan in place to increase training uptake along with increasing the number of FTSU Champions in this division.

   Level 2 is now also unfortunately below the Trust compliance level, with 88.98% of staff completing. The area with the lowest compliance is Clinical Support and Diagnostics at 80.99% and Estates, Facilities and Capital Planning are also below target at 85.71%.

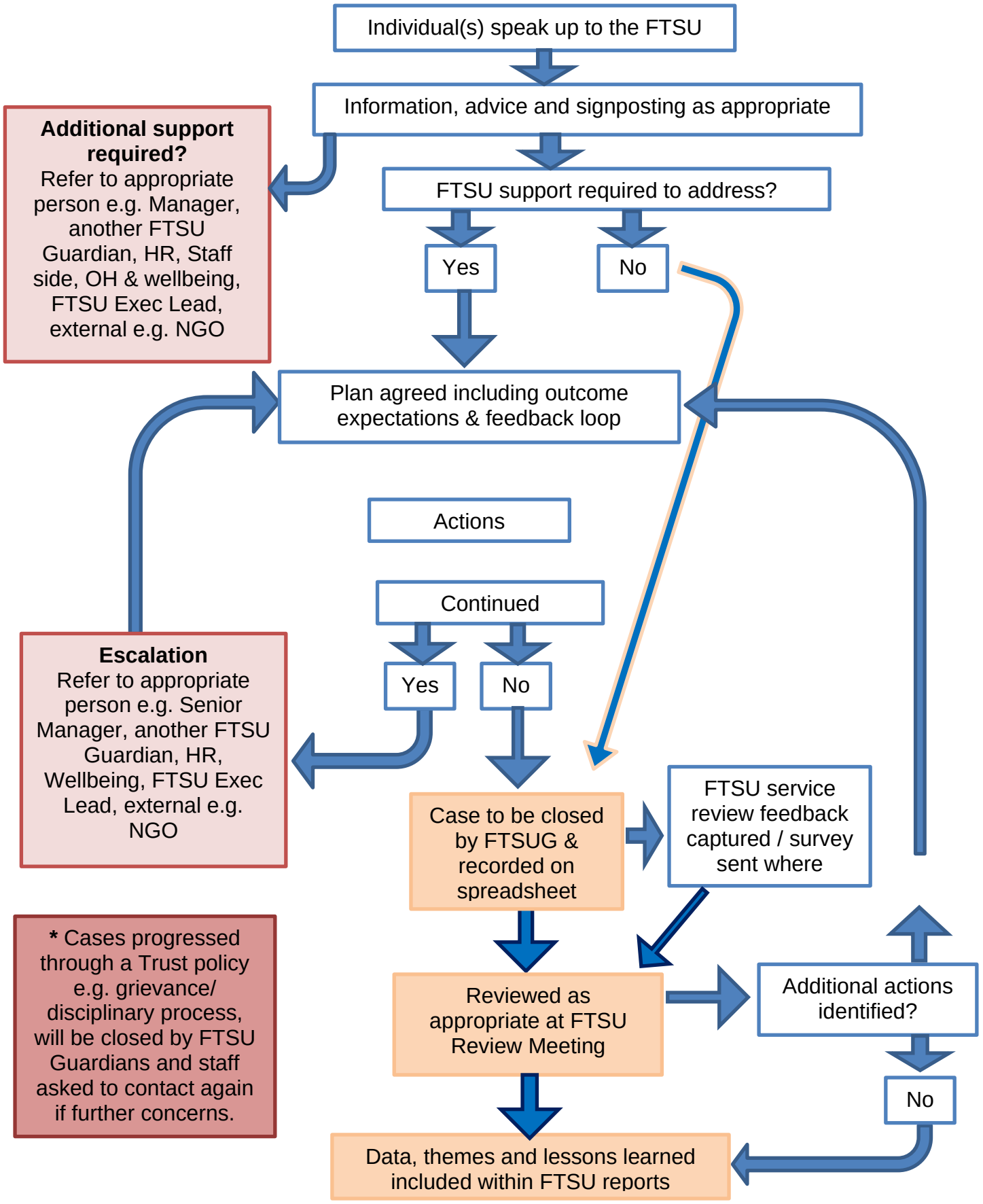
   WUTHs training compliance continues to be high when compared with regional Trusts and seeks to promote awareness and support to all staff.

	Level 3 training for members of the Board was launched last year and is currently 100% There are plans to roll this training out to Trust senior leaders (i.e. Corporate Deputies, Divisional Triumvirates) in the 2025/26 action plan. 6. **Identify groups potentially facing barriers to speaking up and work towards addressing those barriers** – This objective seeks to engage staff from minority groups who are potentially less likely to speak up. Within the last 12 months FTSU champions are present within all the staff networks. The work of the FTSU champions is particularly important to promote and champion the FTSU agenda amongst staff with protected characteristics, particularly following feedback from listening events held with non-white staff this year. Focused work will therefore be undertaken to increase FTSU Champions in this area. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. Demographic data is collected when individuals speak up. 7. **Review effectiveness of FTSU process** – Continuous improvement is paramount to developing a FTSU culture. A new survey tool has been developed to provide a feedback loop following the closure of FTSU cases The data identified by this feedback survey will also be incorporated into future reporting.

5	**Conclusion**
5.1	The number of people speaking up to FTSU Guardians has decreased over the 12-month period. Whilst this could be attributed to staffs feeding back in the 2024 staff survey that they feel less confident in the FTSU process, it could also be attributed to an improved confidence that line managers care about their concerns, also reported in the survey. Considerable work has been undertaken during the year to implement national FTSU policy and guidance including a gap analysis, development of an annual action plan and establishment of new policy and processes that triangulate FTSU cases with employee relations and patient incidents to determine themes and opportunities for learning. Work continues to enhance reporting and provide board assurance of the FTSU agenda. The FTSU Guardian / Staff Experience Lead continues to build and develop the role, promoting the service, regular walkabouts to ensure visibility and membership within key groups such as close links with governance and FTSU agenda continues to be heard, and the promotion of this significant role continues to be raised.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Freedom to Speak Up Guardian Governance Arrangements
October 2022



Board of Directors in Public **Item 24**
5 November 2025

Title	NHS Sexual Safety Charter Update
Area Lead	Debs Smith, Chief People Officer
Author	Amy Park, Head of HR
Report for	Information

Executive Summary and Report Recommendations

This report provides the Board with an update and overview of both Trusts approach to the implementation of the NHS England Sexual Safety Charter and assurance of the progress made to date and next steps.

Sexual Safety at work is a key priority and will continue to be a focus going forward. There is a national focus across the NHS and other public sector organisations on improving the way that we respond to concerns relating to sexual safety.

The report is for information; more detailed updates regarding the NHS Sexual Safety Charter are provided to both People Committee and People and Culture Committee, and the last update was provided to People Committee in September 2025 (held in October 2025) and People and Culture Committee in October 2025.

It is recommended that the Board:

- Note the updates provided
- The significant progress made to date
- The escalation process from People Committee and People and Culture Committee to Board
- The work that is currently being undertaken in line with the newly revised NHS England self-assessment framework.

Key Risks

This report relates to these key risks:

- WUTH 2056: There is a risk that staff within the working environment may experience / encounter behaviour of an inappropriate sexual nature and/or sexual harassment in the course of their employment and the Trust has a preventative duty to be positive and proactive in taking reasonable steps to prevent sexual harassment.
- National evidence (drawing upon 2023 national staff survey data and the 2023 National Education Training Survey) suggests that staff are experiencing sexual harassment and violence whilst at work. Therefore, there is a risk to staff wellbeing and safety from sexual harassment and sexual violence in the workplace. The current WUTH risk assessment score is Likelihood 2 ‘Unlikely’ and Severity 3 ‘Moderate’ creating and overall risk rating of 6.

- WCHC – BAF ID07, ID08 and ID10 and Operational Risk ID3140.
- National evidence (drawing upon 2023 national staff survey data and the 2023 National Education Training Survey) suggests that staff are experiencing sexual harassment and violence whilst at work. Therefore, there is a risk to staff wellbeing and safety from sexual harassment and sexual violence in the workplace (which includes visiting patients in their homes etc.). The current WCHC risk assessment score is Likelihood 3 'Possible' and Consequence 3 'Moderate' creating and overall risk rating of 9 (medium). The current WCHC risk score is slightly higher based on the community-based element of lone working in patient homes.

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

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

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	Yes
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	No
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**
September 2025 *(held 3 October 2025)*	People Committee	NHS Sexual Safety Charter	Information, assurance and

			awareness of the escalation.
October 2025	People and Culture Committee	NHS Sexual Safety Charter Update	Information, assurance and awareness of the escalation.
October 2025	People and Culture Oversight Group (PCOG)	Presentation: Sexual Safety of NHS staff and patients	Information and discussion
August 2025	Workforce Steering Board (WSB)	NHS England Sexual Safety Charter Update	Information and discussion

1	Narrative
1.1	**Background and context** As the Board is aware, the WUTH signed the NHS England Sexual Safety Charter in May 2024 and WCHC in June 2024, and both Trusts confirmed their alignment with the ten charter core principles, and are now listed as signatories to the charter as detailed on the website (NHS England » Sexual safety in healthcare – organisational charter). The NHS is committed to supporting the working lives of all its staff and ensuring their safety. Unfortunately, some staff continue to report experiencing unwanted behaviour in the workplace and the national profile regarding sexual harassment and assault within the NHS is growing. As signatories to this charter both Trusts commits to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, along with ten core principles and associated actions to help achieve these. The ten core charter principles are: 1. We will actively work to eradicate sexual harassment and abuse in the workplace. 2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours. 3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate. 4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours. 5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour. 6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators. 7. We will ensure appropriate, specific, and clear training is in place. 8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours. 9. We will take all reports seriously and appropriate and timely action will be taken in all cases. 10. We will capture and share data on prevalence and staff experience transparently.

	Both Trusts encourage a culture of respect and support for all staff and the initial action plans aligned with the above principles has been achieved by both Trusts.
1.2	**Lessons from research – informing our actions** We know that: • Sexual harassment rarely happens in isolation • To prevent/reduce instances there must be a culture of respect • Everyone must understand what sexual harassment is • Complaints must be taken seriously • A clear message from the top that it will not be tolerated • Proactively create a culture where people are comfortable in speaking up These are just some of the principles that have underpinned the letters and priority work that has been undertaken, and a detailed update that was provided to WSB in August 2025 and PCOG in October 2025.
1.3	**Clear standards of behaviour** **Leading from the Top** All leaders have been encouraged to: • Foster a zero-tolerance working environment • Not to ignore or overlook incident(s) of sexual harassment which they witness / have reported to them / come to their attention • Take responsibility / ownership for making sure sexual harassment is dealt with appropriately • Ensuring appropriate steps are taken to stop sexual harassment from happening again • Ensure that they and their staff adhere to the new policy • Co-operate fully and promptly in any investigation **Staff** • Act in accordance with the new Sexual Safety in the Workplace policy • Not engage in sexual harassment (duty extending beyond the workplace) • Disclose any instance of sexual harassment of which they become aware either towards themselves or others) to managers / FTSU / HR etc. • Co-operate fully and promptly in any investigation Both Trusts have also signed up to become a member of the EIDA Employer Initiative on Domestic Abuse www.eida.org.uk – which provides free online quality resources, network and help. NHSE recommended that all NHS organisations, GP practices, pharmacies and other partners become members.
1.4	**The new duty to prevent sexual harassment** On 26 October 2024, the Worker Protection (Amendment of Equality Act 2010) Act 2023 came into force. The Act: • places a new duty on employers to "take reasonable steps" to prevent sexual harassment of their employees.

	• does not give employees a standalone claim, but gives employment tribunals the power to uplift compensation by up to 25% where an employee is successful in a sexual harassment claim and the employer is found to have breached the new duty; • gives the Equality and Human Rights Commission (EHRC) power to take enforcement action where employers breach the new duty. Compliance with the new duty – referred to as the "preventative duty" – requires employers to take a variety of possible measures such as: • have an effective anti-harassment policy; • engage with staff; • assess and take steps to reduce risk; • reporting; • training; • complaint handling; • deal with and prevent third party harassment; and • monitor and evaluate effectiveness of actions. A few key highlights (the new policy, risk assessment, staff / survey pulse survey, training and communication campaign) abridged updates have been provided below to update the Board on what has been updated in detail through WSB and PCOG to build assurance.
1.5	**Current Position** Significant work has been undertaken to implement the required approach including a new WCHC 'Preventing Sexual Misconduct' Policy which was published in May 2025 and the WUTH 'Sexual Safety in the Workplace' Policy which was published in June 2025, a risk assessment which identified some additional measures which were incorporated into the respective Trust's enhanced action plans that have been discharged, a process of data triangulation including National Staff Survey results and incidents reported via Ulysess / Datix and the launch of a training package 'Understanding Sexual Misconduct in the Workplace' course which was assigned as role essential training to all staff with supervisory or management responsibilities. Detailed updates have been provided to both WSB and PCOG.
1.6	**Policy – clear standards of behaviour and enforcement** Both Trusts have sought to adopt the new NHS national sexual misconduct policy framework which has been developed with input from the national Workforce Issues Group of the NHS Social Partnership Forum. The new WCHC policy 'Preventing Sexual Misconduct Policy' was agreed with JUSS/Staff Side colleagues and published in May 2025. The new WUTH policy 'Sexual Safety in the Workplace' was approved at Partnership Steering Group and Workforce Steering Board in March 2025 and was published on the intranet on 6 June 2025. Both policies incorporated extensive stakeholder feedback and whilst the respective Trusts had previously been effectively dealing and responding under their existing Trust

	policies it was felt that having the new dedicated policy and procedure in place to prevent and respond to sexual harassment at work was very important, especially for any employee who experiences sexual harassment / misconduct to help raise their awareness of how to raise this and feel confident to do so and ensuring that managers know how to deal with an incident of sexual harassment, and harassers know that there are consequences for their inappropriate behaviour. At each Trust everyone's voice counts, and the policy was an important step in recognising the seriousness of disclosures about sexual safety and setting out the Trusts responses. Both policies are further complemented by the nation training.
1.7	**Risk Assessment** The Equality and Human Rights Commission (EHRC) published some updated technical guidance on sexual harassment and harassment at work with the aim of helping employers to navigate and comply with this new duty. The technical guidance states that employers are unlikely to be able to meet the requirement of the preventative duty to take reasonable steps to prevent sexual harassment of their workers, if they do not carry out a risk assessment. The risk assessment process includes the following steps: • Identify the potential hazards/risks. • Identify who might be harmed and how i.e. power imbalances, job security, lone working, presence of alcohol, workforce demographics etc. • Evaluate the risk (which may include consideration of the likelihood of the particular type of harassment occurring and the severity of the potential harm it would involve), and assess the effectiveness of any risk control measures that are already in place. • Identify what, if any, other risk control measures could potentially be put in place. Decide whether it is reasonable to put those measures in place, taking into account the circumstances of the Trust, including the cost and potential disruption of implementing the measure balanced against its likely effectiveness/the benefit it could achieve. These steps broadly reflect the Health and Safety Executive (HSE) approach to risk assessments and therefore is a sound methodology. Accordingly, a risk assessment was undertaken by each Trust and used to incorporate additional actions / controls into their enhanced action plans. An organisational risk has been added to each risk register and is regularly reviewed as per the risk review process.
1.8	**Triangulation of data** Data is available from a number of sources in relation to sexual safety in the workplace and this was triangulated and presented to WSB in both February and August 2025 and PCOG in February and October 2025. It included data from the National Staff Survey in

	relations to incidents of sexual harassment from other members of staff. The staff survey data identified a marginal reduction in experiences this year at WUTH and an increase in the % of staff stating they had been abused by patients at WCHC. WUTH also made an active decision to look beyond the 'known data sources' and included a bespoke question within the National Quarterly Pulse Survey for July 2025. **Key Findings for WUTH:** • Divisional areas of focus are Estates, Facilities and Capital Planning and Acute. • Staff group areas of focus are Estates and Ancillary staff and Medical and Dental. • Additional areas of focus are LGB+, Muslim, disabled, male and staff aged under 30. The findings were shared via WSB with Divisions and the Staff Inclusion and Engagement Lead shared the findings with the Staff Networks to align with staff experience to shape targeted communications and support for staff. Additional triangulation was also undertaken by both Trusts to review Incidents, ER Cases, Safeguarding and FTSU cases and this was used to review the respective risks; and the risk scores were maintained supported by this additional intelligence.
1.9	**Training** We know that managers are key to success – beyond policy implementation through to proactive prevention. Therefore, it was very important that we adopted the national training to ensure managers are aware of their responsibilities, and that we equip them with the skills they need. Role Essential Training - The 'Understanding sexual misconduct in the workplace' course was launched within ESR in January 2025 and initially assigned as role essential training to all colleagues who have supervisory or management responsibility. Compliance targets have been set at 90%, in line with all Mandatory and Role Essential training at WUTH, with a trajectory to meet this target compliance by end Q2. This implementation approach has been shared with WSB and PCOG members for cascade within their areas of responsibility. September reporting shows compliance aligned with this trajectory at 93.67% for WUTH and 93.3% for WCHC. It is anticipated that the Sexual Misconduct in the Workplace module will be assigned to all employees across both Trusts in Q3 and compliance to achieve the 90% Training KPI by end March 2026.
1.10	**Communications Campaign for all staff** A global email containing a second (updated) letter was issued to all WUTH staff on 1st September 2025 and a letter to WCHC staff on 24th September 2025 from the Executive Team reaffirming our commitment to ensuring all staff feel safe at work and shared understanding that sexual misconduct will not be tolerated by either Trust. The WUTH

	letter provided an update on progress following on from the letter sent to all staff in June 2024 and for WCHC staff this was the first letter to all staff. The **key messages** included; • A zero-tolerance policy towards unwanted, inappropriate, and harmful sexual behaviour in the workplace. • Responsibilities for all staff to help eradicate sexual misconduct and create a safe work environment. • Support for those who experience or witness incidents, with multiple ways to report concerns confidentially. • Promoted the new Sexual Safety in the Workplace Policy / Preventing Sexual Misconduct that was launched in June 2025 / May 2025 and • Encouraged managers to ensure that they have completed the role essential training, if not already done so. • Signposting for further support and local resources available on the intranet / Staff Zone.
1.11	**NHS England Letter** On 20 August 2025 NHS England wrote asking all Trusts and ICBs to take further action to identify and act against potential perpetrators of sexual misconduct in the NHS (see Appendix A: Letter). This includes a self-assessment against the new NHS refreshed sexual safety assurance framework (see Appendix B, encouraging staff to complete the e-learning on sexual misconduct, and consider specialist training, review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations, ensure that ESR (where an organisation uses this to record employee relations issues) is up to date with ongoing and complete investigations into staff etc NHS England have confirmed that an audit will take place in the Autumn to review progress on the implementation of the Charter, as well as the actions outlined their letter (Appendix A).
1.12	**Risk Management** As detailed in the key risk section above; the current risk assessment score for WUTH is 6 and was discussed and reviewed and maintained at WSB in August 2025, and also as part of the WSB risk report in September 2025. For WCHC the risk score assessment is 9 and was maintained following PCOG in October 2025. **Escalation Process** In line with the sexual safety charter assurance framework the escalation process for sexual misconduct, including defined risk thresholds for escalation to Executive and Board levels will be from WSB and/or PCOG. There is a WSB Chair's Report which highlights exceptions into People Committee and accordingly the People Committee Chair's Report by exception into WUTH and WCHC Board of Directors in Public. Also, respectively from PCOG to People and Culture Committee and from People and Culture Committee by exceptions into WUTH and WCHC Board of Directors in Public.

1.13	**Priority and next steps** • Continuation of the sexual safety communications campaign • Launch of the training for all staff in Q3 • Embedding the training for supervisors • Working through the new updated NHS England self-assessment assurance framework and production of a joint action plan for WUTH and WCHC to address the gaps • Ongoing review of the current risk score
1.14	**Recommendations** It is therefore recommended that the Board note the significant progress made against the sexual safety charter action plan, the substantial current work being undertaken to comply with the new duty, the NHS England self-assessment gap analysis work and the devising of a new joint (WUTH & WCHC) action plan based on the output of the self-assessment framework and planned next steps to further advance sexual safety in both Trusts.

2	**Implications**
2.1	**Patients** • The sexual safety charter recognises the important of sexual safety in the workplace and the Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties. • We are working to eradicate sexual harassment and abuse in the workplace. • There is a clear link between staff experience, quality of care and outcomes for patients
2.2	**People** • The policy and core training are important as they build knowledge, skills and overall competence. Staff are clear about the standards of behaviour required in each Trust and their knowledge and awareness of issues relating to sexual misconduct increases. • Staff feel empowered to take action should they witness or experience unwanted and/or harmful sexual behaviour. • Staff are clear on roles and responsibilities. • Through training managers are clear on their responsibilities to escalate potential sexual misconduct and the process for doing so. Staff who feel competent and invested in, not only feel more confident in undertaking their role but evidence correlates with increased motivation and staff feeling valued and supported. • There will be an increased confidence in the Trusts tackling sexual misconduct and improving safety for all staff. • We use data from NHS staff surveys, cut by EDI metrics, to understand staff experiences and inform actions. • Information and resources are available on the intranet / Staff Zone and staff are signposted to them.
2.3	**Finance** • The core training is delivered via online training.

	• There will be a cost implication of approx. £2k for specialist training for those who need it.
2.4	**Compliance** • The sexual safety charter recognises the important of sexual safety in the workplace and the Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties. • The Trusts promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.

To:
- NHS trusts and foundation trusts:
  - chief executive officers
  - chief people officers
- Integrated care boards:
  - chief executive officers
  - chief people officers

cc.
- NHS England regions:
  - regional directors
  - regional medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 August 2025

Dear colleagues,

Actions to tackle sexual misconduct in the NHS

In September 2023, the Sexual Safety Charter was published by NHS England with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace.

Every NHS trust and integrated care board (ICB) has since signed up to this Sexual Safety Charter and we are grateful for your efforts in making the NHS a safer place to work.

Today we are writing to you to ask you to take further actions to identify and act against potential perpetrators of sexual misconduct in the NHS.

NHS England is committed to supporting and challenging the system to ensure a sexually safe environment for our staff and patients.

We are asking all trusts and ICBs to:

- begin self-assessment against the assurance framework
- encourage staff to complete the e-learning on sexual misconduct, and consider specialist training
- review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations

    - this should include investigation findings, relevant DBS information, and reflect cumulative patterns of behaviour
    - sexual misconduct should be considered through a patient safety lens as well as through HR processes
- ensure that ESR (where an organisation uses this to record employee relations issues) is up to date with ongoing and complete investigations into staff
    - inter-authority transfers (IATs) may reveal where there are ongoing investigations, and should be built into onboarding processes
- review chaperoning policies to ensure they empower chaperones and lead to the creation of auditable records
- engage with your EPR suppliers (including prospective providers) to monitor unusual access to patient records and ensure safeguarding oversight

We are also asking any trusts who haven't completed the sexual misconduct policy audit (sent to chief people officers in the spring) to do so **by Monday 1 September**.

We will write to primary care providers with guidance on how sexual safety frameworks such as the Charter and sexual misconduct policy framework may be adapted for their structures.

Ahead of that we ask that:

- as commissioners of primary care services, ICBs ensure primary care providers receive the support needed to focus on the sexual safety of their staff and patients
- primary care providers notify their commissioner of any allegations of sexual misconduct made against a member of their team
    - if the subject of the allegation is on the Performers List (medical, dental and ophthalmic), this should be via the Regional Medical Director Systems Improvement and Professional Standards (MDSIPS)

Further details on these asks are set out below.

Assuring progress on sexual safety

NHS England issued a sexual misconduct policy framework and tools for trusts and ICBs to update their policies in October 2024. We need to complete our audit of implementation of the policy framework.

As a matter of urgency, we ask that trusts who have not completed this do so by Monday 1 September.

Today, we are publishing a refreshed sexual safety assurance framework, enabling boards to assess progress against the Sexual Safety Charter.

An audit will take place in the autumn to review progress on the implementation of the Charter, as well as the actions outlined in this letter.

Additional work in support of local action

We recognise the need for greater clarity on how regional and national identification of instances of sexual misconduct at an organisational level should feed into system-wide learning and actions to prevent them occurring.

We will work with all organisations to ensure that this happens.

Of particular concern is the movement of professionals between NHS organisations without appropriate information being shared, even where behavioural concerns exist.

For clarity, data protection should not be a barrier to sharing information that could protect patients or staff. We will publish new guidance by the end of the year clarifying responsibilities on information sharing.

In the meantime, NHS organisations should remind themselves of the NHS Employers guidance on disclosure, which is clear that an enhanced DBS check may not reveal all relevant concerns, and a lack of information should not be taken as reassurance.

Organisational policies and safeguards

Care must be taken to ensure that investigations do not take just a clinical or educational lens on issues where there is any possibility of sexual misconduct or a potential sexual motive.

The sexual misconduct policy framework includes guidance on how to ensure robust investigations are undertaken, including appointing expert advisers and investigators who are specifically trained in dealing with sexual misconduct.

Chaperoning policies

NHS chaperoning policies must also be reviewed. Chaperones are not always equipped and empowered to know whether a procedure is appropriate and how to speak up if they are concerned.

Policies should ensure chaperones understand the purpose of procedures; that the purpose is documented; and that they are empowered to act on or report concerns when necessary.

In due course, we will produce good practice guidance on chaperoning policies to support local review.

Electronic patient records

Finally, while electronic patient records could be misused to target vulnerable individuals, they also offer opportunities to detect inappropriate access.

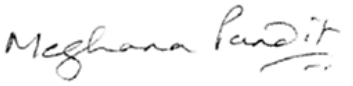
Trusts should work with suppliers to audit and monitor access patterns, and – where they are in implementation or pre-implementation – ensure this capability is built into new systems from the outset.

People put their trust in the NHS every day and it is our duty to do everything we can to make sure that that this trust is deserved. We know that you will join us in our commitment to safeguard our patients and our staff against sexual misconduct in the NHS.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Dr Claire Fuller
National Medical Director
NHS England



Professor Meghana Pandit
National Medical Director
NHS England

NHS England

Sexual safety charter assurance framework

Publication reference: PRN02126

About this framework

In September 2023, NHS England published the sexual safety in healthcare organisational charter in collaboration with healthcare partners. The Charter was developed by NHS England, lived experience organisations, professional bodies, employers and partners across healthcare. All NHS Trusts and integrated care boards (ICBs) have signed the Charter.

This framework sets out the outcomes from each principle in the Charter and lists actions that would assure their delivery. The actions are recommended best practice.

The Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties. Using this framework will support boards and their leaders to assure themselves against this legal duty.

This document was updated on 20/08/2025 to reflect the latest letter to the system on new actions to safeguard patients and staff against sexual misconduct. We ask Trusts and ICBs to review these new actions and assess themselves against them.

NHS England

Charter principles 1 to 10: implementation assurance

Principle	Actions	Outcome
1. We will actively work to eradicate sexual harassment and abuse in the workplace.	• have clear plans to focus the organisation on prevention and culture change • set clear standards of behaviour in policies and enforce them • core training for all staff and specialist training for those who need it • communications campaign shared with all staff • establish a structured risk management and escalation process for sexual misconduct, including defined risk thresholds for escalation to executive and board levels	• sexual misconduct, its prevalence, impact and how to eradicate it, is discussed openly and appropriately within the organisation • the executive board has agreed a suitable governance process to understand prevalence rates, staff experience and the outcomes of cases in their organisation • data about prevalence, actions taken and learning from cases is shared across the organisation • reduction in cases (recognising likely to be an initial increase due to increased confidence in reporting)
2. We will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.		

Publication reference: PRN02126

	• board-level ownership and accountability for cultural issues, prevention strategies, and oversight • embed tackling sexual misconduct and protecting the sexual safety of our workforce into all relevant business as usual areas – for example, training, contracts, induction and equality, diversity and inclusion (EDI) improvement plans • clear signposting to policies and support services, which are easily accessible to all staff • visible, senior leadership • appoint domestic abuse and sexual violence lead	• reduction in staff saying in annual staff survey they have experienced sexual misconduct in the workplace • The Board proactively governs and escalates emerging sexual misconduct risks, ensuring accountability, oversight, and early intervention across the organisation • increased confidence in the organisation at tackling sexual misconduct and improving safety for all staff
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual	• complete equality impact assessment of sexual safety and misconduct work (including policies) • engage through staff networks, EDI officials and experts by experience to	• a clear understanding of the prevalence of sexual misconduct within different workforce groups

harassment and abuse at a disproportionate rate.[1]	ensure all cohorts of our staff are represented appropriately and robustly as part of this work • use data from NHS staff surveys, cut by EDI metrics, to understand staff experience and inform iterative development of key products • tailor responses to ensure they are appropriate for groups that experience sexual misconduct at a disproportionate rate	• support is tailored, appropriate and effective in tackling intersectional experience of sexual misconduct
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.	• Confidential information and resources are available on the intranet and staff are signposted to them regularly • staff support structures, like the Employee Assistance Programme, have guidance on sexual misconduct processes and pathways to specialist support	• staff have knowledge of and access to a range of support tools and mechanisms that are iteratively reviewed and based on a growing evidence base • specific and specialist support for those who experience sexual misconduct is embedded into organisational staff support structures

[1] For example, women, black, ethnic minority, disabled and LGBTQ+ groups

	• the support offer is monitored to inform continuous improvement and ensure appropriateness. Offsite support can be offered • relevant policies are evidence based and informed by data and subject matter expertise	
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.	• sexual misconduct policy is clear on standards of behaviour, the role of those who witness inappropriate behaviour, and any interactions with other relevant policies • roll out communications campaign to all staff • sexual safety and misconduct are comprehensively addressed in induction and all staff training	• staff are clear about the standards of behaviour required in the organisation • the organisation adheres to policies and applies them consistently • staff feel empowered to take action should they witness or experience unwanted and/or harmful sexual behaviour

6. We will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators.	• publish a policy on sexual misconduct in line with the NHS national policy framework • sexual misconduct policy is supported by flowchart and easy-read version and is easily accessible to all staff • conduct/competence policies should take account of complexities in cases where it may initially be unclear whether behaviours and actions should be considered as conduct or capability • policies set out roles and responsibilities of people in the organisation, for example, HR and people professionals, safeguarding teams, freedom to speak up guardians, mental health first aiders, leadership, line managers • provide tools and support for line managers to understand their responsibilities and how to follow escalation processes consistently	• action is always taken against perpetrators, and in line with policies • clear, evidence-based and trauma-informed processes are documented in policies • all staff are clear on roles and responsibilities • line managers are clear on their responsibility to escalate potential sexual misconduct issues and the processes for doing so • HR and people professionals are clear on the necessary steps required to take timely action against alleged perpetrators and this is part of their induction and ongoing training • HR and people professionals are clear about when information needs to be shared with future employers relating to sexual misconduct complaints and investigations • Chaperones should clearly establish the purpose for any sensitive examination and record this in an auditable way

	• policies are clear about action that needs to be taken against perpetrators, by whom, when and how • policies are clear about investigation processes and standards • policies are clear about the circumstances in which complaints and investigations about staff should be shared with future employers and police • chaperoning policies are clear about the role of chaperones in relation to sensitive examinations	
7. We will ensure appropriate, specific, clear training is in place	• training is available for all staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses) • specialist training is available for those who need it to ensure effective support, reporting and investigations (for case	• training on sexual misconduct and sexual safety is accessible to all staff • specialist training is accessible to those who need it • staff knowledge and awareness of issues relating to sexual misconduct increases

	managers, investigators and responsible officers) • training is developed for managers to support culture change • all staff have undertaken national e-learning on sexual misconduct	
8. We will ensure appropriate reporting mechanisms are in place.	• policy outlines sexual misconduct reporting mechanisms, including anonymous reporting • reporting mechanisms are widely communicated to ensure awareness • Freedom to Speak Up infrastructure and training for guardians updated to include sexual misconduct • there is a clear safeguarding process for identifying unusual patterns of patient record access (where an electronic patient record is in place)	• staff can report an instance of alleged sexual misconduct through multiple routes, including anonymously • staff have confidence their disclosure will be treated confidentially (and understand where it might need to be shared for safeguarding reasons) and escalated appropriately • disproportionate and inappropriate access of patient records is picked up earlier

9. We will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases.	• clear actions and action-owners set out in the sexual misconduct policy • timeframes for action set out in sexual misconduct policy • ensure access to external investigators • ensure access to external subject matter experts • executive / board reporting, including on relevant data and learning from surveys, reports and investigations of sexual misconduct, FTSU, complaints • establish a governance and risk oversight process for serious and complex sexual misconduct cases, with defined escalation thresholds for executive and Board review • there are timely routes to share with HR concerns raised through professional and clinical avenues that could have a sexual component plus data from FTSU and	• sexual misconduct is identified in a timely way, all reports are actioned following organisational policies, and incidents are escalated appropriately • staff have increased confidence to report concerns • patterns of behaviour are spotted sooner by triangulating all available information • complex cases have Board and executive scrutiny, aiding the identification of systemic and organisation-wide issues • concerns that are initially identified as relating to clinical capability are effectively recognised and dealt with as potential sexual misconduct

	sexual misconduct reporting is triangulated to support • there is a process for investigations to move from competence to conduct	
10. We will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct	• staff survey results are published and shared, with actions taken/to be taken to address issues and risks raised in the results • executive / board reporting on cases, including relevant data and learning	• executive board understands prevalence rates, staff experience and the outcomes of cases in their organisation, including impacts and any differences between different groups of staff and required actions • staff have access to data on sexual misconduct prevalence in their organisation

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 25**

05 November 2025

Title	Guardian of Safe Working Report Q1 2025/26
Area Lead	Dr Ranj Mehra, Executive Medical Director
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

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

This report covers the period 1st April to 30th June 2025 (Q1 2025) and outlines the following:

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

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

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
October 2025	People Committee	As above	As above

1	Narrative

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

High level data for Wirral University Teaching Hospital NHS Foundation Trust

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

Exception reports (regarding working hours)

Exception reports by Department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident and Emergency	0	2	2	0
Paediatrics	0	2	2	0
General Medicine	0	22	20	2
Obstetrics and Gynaecology	0	1	1	0
General Surgery	0	4	4	0
Traumatic and Orthopaedic	0	2	2	0
Total	0	33	31	2

Exception reports by Grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	21	19	2
F2	0	0	0	0
CT1-2 / ST1-2	0	10	10	0
ST3-8	0	2	2	0
Total	0	33	31	2

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E 20 per cent Fellow Work Sched 6m plus	0	1	1	0
A and E ST3	0	1	1	0
General Paediatrics T1 LTFT 0.8 Flexi	0	2	2	0
Ger Med GPST LTFT 0.8 MTWT	0	3	3	0
Medicine Extra F1	0	5	4	1
Medicine F1	0	11	10	1
Medicine SHO	0	1	1	0
Medicine SpR	0	1	1	0
O and G F1	0	1	1	0
Stroke T1	0	1	1	0
Surgical F1	0	4	4	0
T&O SHO	0	2	2	0
Total	0	33	31	2

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	5	5	6	2	1	2
F2	0	0	0	0	0	0
SHO	1	2	5	2	0	0
SpR	0	1	1	1	0	0
Total	6	8	12	5	1	2

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E 20 per cent Fellow Work Sched 6m plus	0	1	1	0
A and E ST3	0	1	1	0
General Paediatrics T1 LTFT 0.8 Flexi	0	2	2	0
Ger Med GPST LTFT 0.8 MTWT	0	3	3	0
Medicine F1	0	16	14	2
Medicine SHO	0	1	1	0

Exception Reports

The Exception Reports in this quarter again are, in the majority, from Foundation Year 1 doctors with Medicine being the majority specialty. Although 2 were still open at the end of the reporting period these have since been closed. There was one Exception Report submitted in error by an SAS doctor. Exception Reports are in relation to the 2016 Doctors in Training contract and this report has been returned to be managed in line with the appropriate process.

Work schedule reviews

There were work schedule reviews for the LTFT maternity rotas which have been reviewed and the work schedules amended in line with the FTE rotas in this quarter.

Vacancies

There remain a number of vacancies on the rotas. These are being covered where possible by locums or trust employed doctors. There are several wards where there are minimum staffing levels which are resulting in a larger number of Exception Reports and these are under review by Medical Staffing and the medical education leadership team.

Fines

There are still very few fines issued and the balance in the GOSW Fines pot remains very low. No fine monies were dispersed during this quarter.

Progress towards updated Exception Reporting processes

The new implementation date for the updated Exception Reporting Framework is working towards an implementation date of 4th February 2026. A working group including the GOSW team, Medical Staffing, HR and Medical Education are working towards this being delivered on time, in line with the Improving Working Lives 10 point plan and will continue to update the board on progress.

A GAP analysis has been completed and systems are being put in place to facilitate HR processing of reports in the first instance with escalation to the GOSW as detailed in

	the framework. The access and test reporting processes were stress tested at the August 2025 changeover and adaptations made to make the system more functional. Full functionality will rely on the availability and use of updated software which is not yet available on the market but has been nationally agreed to be necessary.

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 26**

05 November 2025

Title	WUTH Emergency Preparedness, Resilience and Response Core Standards and Annual Report
Area Lead	Hayley Kendall, Accountable Emergency Officer
Author	Steve Povey, Head of EPRR
Report for	Approval

Executive Summary and Report Recommendations

The Department of Health & Social Care and NHS England require all Trusts to undertake an annual self-assessment of their Core Standards for Emergency Preparedness, Resilience & Response as defined in the NHS Emergency Preparedness, Resilience & response Framework, July 2022.

For any standard that is not fully compliant the required actions to improve its position are added to the action plan contained within the Core Standards spreadsheet.

Trusts were required to complete their Core Standards Assessment and submit to a central repository on Resilience Direct by the 3rd October 2025 following which the ICB reviewed 5 standards per trust on a random basis. Feedback on the standards is then received with an opportunity for both parties to seek any clarification on the responses.

It is recommended that the Board notes the content of the report.

Key Risks

This report relates to these key risks:

- BAF Risk 11- 'Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the ability to deliver services to patients'

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

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

1	Narrative
1.1	**Core Standards Board Report** The core standards report is a high level report which is reviewed by the Board of Directors before being disseminated to any other committee. As part of the core standards declaration the standards are required to be signed off by the Trust Accountable Emergency Officer and Chief Operating Officer, Hayley Kendall, then presented to a Public Board meeting, the date of which needs to be documented on the Trust declaration. EPRR core standards consist of 66 standards, of which 62 are applicable to WUTH, the standards are spreadsheet based with columns for standard detail, Supporting information examples and organisational evidence along with RAG status and actions to be taken. The Trust uploaded 177 supporting documents to the standard with some documents being referenced in multiple standards. For 2024/25 the Trust declared full compliance with 52 of the 62 standards for an overall rating of 84% - 'Partially Compliant'. For 2025/26 the Trust has declared full compliance with 59 of the 62 standards for a 95% rating which rates at 'Substantially Compliant'. As in the previous year Standard 16 – evacuation and shelter has been recorded partially compliant as the working group for the subject has been paused with no guidance to Trusts available at this time. This is expected to be the same position for all Trusts across Cheshire and Merseyside. On Wednesday 10th September, Cheshire & Merseyside's Acting Head of EPRR undertook a site visit to discuss the core standards submission. No concerns were raised and the Trust asked for confirmation on the position with standard 16 to be discussed at regional level. Standards 1, 18, 20, 31 & 53 were reviewed from the WUTH submission with the following description: • Standard 1 covers the EPRR senior leadership and identification of the Accountable Emergency Officer (AEO) within EPRR policies and documentation along with a clear indication of who the AEO is. Information provided showed the Trust is compliant with the standard.

	• Standard 18 is the duty to maintain plans. This description covers 'protected individuals' including VIP's and high profile patients and visitors. Trust policy was mid consultation at submission and further information has been sent having been requested to confirm completion of consultation and the date the policy will be adopted. • Standard 20 covers oncall and the use of command and control. The Trust has submitted additional information supporting the use of command and control within the Trust Major Incident Plan. At present the Trust is mid way through a complete refresh of oncall documentation, policies and training for individuals on the oncall rotas. Assurance has been provided that oncall staff have the correct information during this transition period. • Core Standard 31 covers ED staff access to clinical guidelines for major incident and mass casualty events. Additional screen shots of the locations of the documentation have been provided following request. • Core Standard 53 relates to business continuity and assurance from commissioned providers and suppliers. Documentation provided included Trust procurement information resulted in no concerns on this. The action plan for any standards to be improved will be worked through by the Head of EPRR who will identify any additional resources required to ensure that the Trust continue to evolve and improve its position for emergency preparedness. These will be reported to the Trust Executive Assurance and Risk Committee as part of the EPRR quarterly report.
1.2	In addition to the main Core Standards, normally a Deep Dive Investigation into a specialist area takes place. This year however, due to the position with ICB's and NHSE there was no deep dive subject.

2	**Implications**
2.1	**Patients** • Failure to prepare for an emergency would impact patient quality and experience adversely.
2.2	**People** • In the event of a major emergency staff will be pivotal to the response. There are specific action cards in place to follow that show how roles may vary and evolve during a response. • External stakeholders are integral to the Trust preparedness and response and are included in the regional planning for incidents
2.3	**Finance** • No impact financially.
2.4	**Compliance** • Achieving compliance with the EPRR core standards will ensure the Trust meets the requirements of its NHS contract and also the requirements of the NHSE Framework for EPRR, thereby leading to meeting its obligations under the Civil Contingencies Act.

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

Wirral University Teaching Hospital has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Wirral University Teaching Hospital will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the 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.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

02/10/2025

Date signed

05/11/2025
Date of Board/governing body meeting

05/11/2025
Date presented at Public Board

Date published in organisations Annual Report

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance										
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Section 3 of the Trust EPRR Policy (WUTH001) identifies the Chief Operating Officer as the Accountable Emergency Officer for EPRR and outlines their duties and responsibilities as role holder.	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Document WUTH001 is the Trust EPRR Policy and is subject to an approval and consultation process with ratified, published and review dates along with version control. Section 1 includes WUTH's commitment as a Category 1 responder to assess risks, develop and maintain plans, share information and co-operate on civil contingency response matters. Section 4 of document WUTH001 identifies the EPRR arrangements including resourcing commitments and access to funding. Sections 1, 2, 3 & 4 outline the coommittment to EPRR and section 6 for training and exercising. The trust commitment to Business Continuity is within document WUTH002 - Business Continuity Policy.	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	The trust EPRR function produces a quarterly report to Executive Assurance and Risk Committee (EARC) which are then sent to trust Board (document WUTH003) . In addition an annual report is produced (WUTH004) which went to EARC in August 2025, . The trust annual assurance core standards are taken as a seperate item to EARC and trust board and will be on the agenda for the EARC meeting in October 2025.	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The EPRR Annual Plan is published within the quaterly report (WUTH003)	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The trust EPRR Policy (WUTH001) identifies the resources required within section 4 'EPRR arrangements' to respond to an incident along with the roles of EPRR and wider staff in the event of a major incident within section 3. Document WUTH005 is the job descrition and person specification for the Head of EPRR role. Structure for EPRR reporting is contained within document WUTH006	Fully compliant				
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Section 6.4 of the EPRR Policy (WUTH001) contains the trust position for 'Learning from Exercises and Incidents'. In addition sections 3.10 & 3.11 of the Major Incident Plan (WUTH007) has details of Major Incident Stand Down and debrief & Purpose of the debrief respectively. Document WUTH008 - Exercise Calliope internal trust debrief is a completed example of the trust approach. WUTH136 debrief for the trust cyber incident in November/December 2024 is also included as evidence	Fully compliant				
Domain 2 - Duty to risk assess										
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Document WUTH010 shows a series of screenshots showing EPRR risks on the trust risk register, these are subject to periodic review as per the trust Risk Management Policy (WUTH009) which is supported by the trust Incident Reporting Management Policy (WUTH152).. As part of the trust LHRP attendace the regional risk register is referenced and aligned to trust risks and local risks relevant to the trust. The trust Executive Assurance & Risk Committee meets monthly to look at the trusts current	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The trust has a dedicated Risk Management Policy (WUTH009) and within the EPRR Policy sections 1 & 4 (WUTH001), in particular section 4.3. the trust risk matrix is within WUTH091. Information Risk is covered in policy WUTH144.The trust Executive Assurance & Risk Committee meets monthly to look at the trusts current risks and on a monthly basis includes the EPRR quarterly report, page 34 onwards of WUTH 148. the trust Incident Reporting Management Policy is within WUTH152.	Fully compliant				
Domain 3 - Duty to maintain Plans										
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The WUTH approach to sharing information with partners is via Resilinece Direct (Screenshot on document WUTH133). All WUTH plans are consulted upon following committee approval (WUTH011) as identified within the 'Policies & proedures (trust-wide) - Development & Management Policy (WUTH012). The trust works with partners in other speciaities where patients may attend rtthat have specialst needs, training has been provided by CWP re Mental Health patients (WUTH099 (attendance in WUTH124)) and the Prometheus Service spec is within WUTH100. The Cheshire & Mersey system mutual aid agreement v2.0 is in document WUTH111. The trust shares details with other local organisations which are collated in the MRF contacts directory (WUTH112).	Fully compliant				

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10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Major Incident Response is documented within policy WUTH007 - Major Incident Plan, this follows current guidance in line with the NHSE EPRR Framework and is in line with risk assessments documented within the trust risk management system (summary WUTH010). Activation of the policy is tested with in and out of hours communications tests (WUTH013, 013A & 014) , along with activations for genuine events. Training is covered by section 4 of the plan with training for switchboard (WUTH015) and both internal and external training for on call managers and directors (WUTH016 & WUTH017). Equipment required as part of a major incident response is identified within the policy and the trust major incident room has a pre-populated cupboard containing key resources which are managed by the trust Head of EPRR. The trust has a patient safety incident response plan and policy (WUTH100 & WUTH101). The trust cyber security incident response is contained within WUTH115, 115A. the Trust Fire Safety Policy is within document WUTH129 and the medical gas cylinders policy in WUTH130 and the risk assessment for oxygen cylinder management in WUTH137.	Fully compliant				
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The trust has an Adverse Weather Plan (WUTH018) based upon the UKHSA Adverse Weather and Health Plan 2025/26 Edition (WUTH019). The policy considers the risks from adverse weather and climate change within the trust risk management system (WUTH009). Trust EPRR are registered with the Met Office and receive Heath Health & Cold Weather Planning advise directly whilst also being a registered user of Met Office Hazard Manager.. Major weather alerts are passed directly to teams that may be affacted (email to departments re a weather warning example within WUTH020). A link to the Met Office weather warnings page is included within the weekend plan for on call managers and directors to use, example slide within WUTH021. The policy is circulated across the trust and is held on the EPRR intranet pages along with being in the managers and directors on call teams groups. A C&M update on climate adaption is included in WUTH109.	Fully compliant				
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	We currently have: •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023) •Regular clinical advisory group meetings with senior leaders to discuss new and emerging threats and sign of local plans Close liaison with Occupational health should vaccinations be required following local alerts i.e Pertussis, RSV, Measles. The trust PPE Policy is available in WUTH075 and contains details of the wearing of masks and respirators. the trust pandemic flu plan is within document WUTH104. The trust policy for the management of suspected or confirmed MPox cases is in document WUTH122. The trust norovirus outbreak policy is document WUTH128. The trust safe management of healthcare waste policy is in WUTH142 with WUTH143 being a SOP with regard to MPox contaminated materials for Estates action.	Fully compliant				
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	We currently have an Infection Control Policy (WUTH028) along with an •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023) Regular clinical advisory group meetings with senior leades to discuss new and emerging threats and sign off local plans. The trust PPE Policy is available in WUTH075 and contains details of the wearing of masks and respirators. PRPS buddy training details are in WUTH105. Daily trustwide safety huddle where any new or emerging threats can and will be raised. Rabies post exposure management is in WUTH138, MRSA IPC Policy in WUTH139 and MPox guidance in WUTH140 & 141.	Fully compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	We currently have •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023)- Regular clinical advisory group meetings with senior leades to discuss new and emerging threats and sign of local plans •Annual vaccination plans for COVID & Influenza led by the Occupational Health dept •Monthly meetings with the community IPC team Countermeasures led by the Pharmacy team will utlisie the NHSE Countermeasures guidance (WUTH131) Pharmacy resources and stock requests are in documents WUTH125 & WUTH126	Fully compliant				
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Royal Liverpool Hospital is the Mass Fatalities centre for the region. All casualties would be sent directly to the mortuary at Liverpool who would co-ordinate the DVI. WUTH may be asked to supply mortuary staffing to assist and this would be co-ordinated the the Merseyside LRF (MRF) MRF Policies (WUTH024 & WUTH025) contain the details. The regional mass casualty distribution plavs are in WUTH092. Document WUTH113 is the NHSE Concept of operations for managing mass casualties which is used in planning at C&M level. The trust PREVENT policy is contained in document WUTH116. The trust has a major trauma SOP which is contained in document WUTH127 & 127a	Fully compliant				

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16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	There has been no comunication from the local authority (Wirral MBC) with regard to evacuation and shelter. The trust are unable to update their own plans until meaningful plans are in place when the vacant position at WMBC is filled	Partially compliant	EPRR to follow up with ICB and Wirral Council on plans for evacuation and shelter	SP	Mar-26	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Lockdown Policy (WUTH026) contains the required elements. Additionally WUTH153 covers the policy and procedures for body worn cameras and security notebooks to assist with the management and investigation/debrief of any incident.	Fully compliant				
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has A VIP, celebrity & media representative policy (WUTH027) the current and out for consultation v3 are included, in addition the Major Incident Plan (WUTH007 & 027a) section 2.6 is a section relating to visits by VIP's and the need for co-ordination with an executive director. The trust also has policies in place: Chaperone Policy (WUTH029), for during downtime periods: Safeguarding Adults (WUTH030), Safeguarding Children (WUTH031), safeguarding maternity (WUTH032) also a Safeguarding referral SOP(WUTH042)and a Social Media Policy (WUTH033).	Fully compliant				
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WUTH mortuary manager is part of the MRF group which forms the multi agency response for the regions excess deaths policy. This group monitors capacity to prompt contingency measures such as increased cremations and additional storage. Excess deaths mnagement has been tested during the covid pandemic without any areas of concern in the North West,. See also Core Standard 15.	Fully compliant				
Domain 4 - Command and control										
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has a two tier on call system. 1st on call (manager) and 2nd on call (Director). Command and Control and On Call Arrangemnts along with the on call rota and contact details are in section5 of the EPRR policy (WUTH001). To support the on call function a Manager/Director On Call Handbook is published (WUTH034) (currently under review). All documents are available on the trust intranet (screenshot WUTH035) and also in the On Call Teams Groups (WUTH036). The trust on call rota is published quarterly with version control in place for any changes/swaps etc. (WUTH037 & WUTH038). Major Incident switcboard policies are in WUTH106 and WUTH108. Document WUTH 149 shows the latest report for the regional call out exercise, Exercise Mayday which WUTH take part in. Documents WUTH 150 & 151 detail the C&M outbreak plan and appandices for all trusts to follow and these have been embedded within the trust IPC response.	Fully compliant				
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The EPRR training process is included in section 6.1 of the trust EPRR policy (WUTH001) with reference to compliance with NOS standards, the trust EPRR Training Needs Analysis (WUTH039) details the sessions required by role within an emergency with timescales. the training slides for On Call Managers and Directors is in WUTH044 and is also currently under review. All on call staff are trained in the Principles of Health Command (also see Core Standard 20 &22). the POHC Learner Handbook is in WUTH045. Specific AEO training ins included in WUTH046	Fully compliant				
Domain 5 - Training and exercising										
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.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The use of the training needs analysis is within section 6.1 of the EPRR Policy (WUTH001). Training is recorded within individual folders within Microsoft Teams, a screen shot of the traning repository is within WUTH040 and WUTH041 and the Training Needs Analysis is available in WUTH039. The same repository is where invidual portfolios are held, secreenshots are within WUTH040 and WUTH041 and the completed portfolios for Steve Povey (WUTH043) and supporting certificates WUTH043A x6 is included. Training for a major incident which is available to divisions is in document WUTH103.	Fully compliant				
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)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The trust holds six monthly communication tests for both in hours and out of hours, latest tests are available in WUTH013/014. The need for a live exercise and command post exercise was met with Covid reponse with further exercises sheduled for 2025/6. The exercise and training schedule is within WUTH047. EComms Exercises are in WUTH008.. Discussion at Peer review about the inclusion of Covid as part of response. ICB indicated real response can be included as a test and official stand down of covid response was May 2023.	Fully compliant				
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	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training for responders is within their individual evidence files, screenshots in WUTH040 and WUTH041 and evidence for Steve Povey include within WUTH043 & 043A. Training is ongoing over a three year cycle.	Fully compliant				

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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.	As part of mandatory training Exercise and Training attendance records reported to Board	Staff awareness of their roles in an incident is within the training for on call staff and within departmental training for other areas including the Emergency Department, Switchboard, Digital, Estates & Security as examples. Training is referenced within the EPRR quarterly report. On Call staff are required to attend Principles of Health Command Training and maintain a training portfolio which is located on Teams (screenshot on WUTH040 and WUTH041. The trust EPRR Policy (WUTH001), section 3 contains details of roles within an emergency. Slides on Induction referring to EPRR are in document WUTH114.	Partially compliant	New awareness training to be agreed			
Domain 6 - Response										
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The location of the trust ICC's is within section 2.2 of the trust Major Incident Plan (WUTH007), this identifies a primary location and two back up locations. The ICC does not have any equipmnt that needs to be physically tested, all equipment to be used is provided by responders who bring their own equipment. Training is identified in the Training Needs Analysis within WUTH039. Action Cards are maintained for all areas, a screen shot of cards are available in WUTH048 & WUTH 049. An example of a completed action card is in WUTH050. The primary ICC is within a secure room and is able to be locked down. In the event of loss of voip telecommunications the room has two pstn lines with identical numbers for incoming and outgoing calls and plug in handsets in the Major Incident store cupboard. The store also contains paper forms for essential information, patient transfer forms, site plans and aerial photograpghs, a stationarty store with paper/pens/markers/flipchart/camera/incident commander and hi viz tabards/log books/policies/laminated action cards. Also included is a sealed box for NWAS response and a box file with Communications response and lanyards with press ID. The room has 4 large screens that can be connected to the trust network, have an external source connected independant of the network and a connection to live tv & radio. There are no windows to the room. Major Incidet Switchboard policies and call priorities are contained within WUTH106 & WUTH108. The trust attends the Wirral Events Safety Advisory Group, the latest agenda for this is in WUTH107 as the host at Wirral Council has been a acant position since the last meeting.. For major incident nootification the trusts uses the JESIP M/ETHANE form contained within WUTH121	Fully compliant				
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	All trust EPRR policies are on the intranet (screenshot of landing page WUTH051), within the Director & Manager On Call S drive folder and on the On Call Teams groups for Managers & Directors (WUTH036). This is also replicated within the trust on call page in resilience Direct	Fully compliant				
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business continuity response plans have an intranet page within the EPRR pages (screenshot WUTH035) and contain phased response and escalation arrangements. The trust has a BCP policy (WUTH002) which has been converted to an approved policy rather than a trust plan for document control purposes and covers all areas of the trust.. The plan uses Plan, Do, Check, Act as the cycle for continuoous improvement.. Examples on Trust BCP's are in WUTH052/053/054/055/056/057/058.	Fully compliant	Update FCP and update			
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The trust has trained loggists that may be called upon to assist in an incdient response, WUTH059, and WUTH060 give examples of the Loggists available and a sample couse certificate. Section 3.3.1 of the major incident plan (WUTH007) refernces the Loggist Action Card (WUTH061), Log books, call out procedure and information on the use of Loggists.	Fully compliant				
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Within the trust major incident plan (WUTH007), section 3.14 references the procedures for SitReps and section 3.14.1 details the approval process, Appendix 13 of the policy has the SitRep template. In addition to this SitReps may also be distributed and collected via the Strategic Data Collection Service (SDCS). SitReps through SDCS are submitted via a specific teemplate which is MS Excel based and submitted by the BI department or additional named individuals given access to SDCS. An example of an SDCS SitRep ready for upload is within WUTH090. The trust has a new Incident Response Plan which is currently being assessed prior to going to trustwide consultation and this will further enhance the trust processes abd response.	Fully compliant				
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Copies of this are available electronically along with hard copies in the Emergency Department. The document is also stored in the CBRN folder of the On Call Manager and On Call Director MS Teams group and on the on call pages within Resilience Direct.	Fully compliant				
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Copies of this are available electronically along with hard copies in the Emergency Department. The document is also stored in the CBRN folder of the On Call Manager and On Call Director MS Teams group.	Fully compliant				
Domain 7 - Warning and informing										
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The trust Major Incident Plan (WUTH007) contains a dedicated section, 5, that is dedicated to Communications and the media and was co-written with the Communications Department to ensure compatability with communiations expectations. Sub sections includes: 5.1 overview, 5.2 internal Communications, 5.3 Key Internal Audiences, 5.4 Key communications channels, 5.5 briefings to staff, 5.6 guidance for staff, 5.7 working with the media, 5.8 external communications including sub sections fpr key audiences, key communication channels, vulnerable groups, interpreting services, out of hours cover & access to secured/preferred routes. 5.9 communications in an emergency including overview, NHS Incident levels, communications during a major incdent, local and national media, VIP visits, local and national media during a major incident, key methods for communication messages, helpline, further information, Major Incident Communications Plan. the plan also includes appendix 4 - message recording sheet & appendix 6 - communication cascade. Document WUTH062 contains contact details for out of hours media support via a slide within the weekend plan. This has been briefed seperately to all 1st and 2nd on call staff. the trust Weekend Plan (WUTH132) also contains a slide for out of hours communications. the trust are looking at adefined approch to out of hours communications at the present time.	Fully compliant	Add weekend plan slide to evidence			

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34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Incident Communications Plan is within section 5 of the trust major incident plan (WUTH007), in addition an action card is available on the trust intranet pages (WUTH048). The plan includes updating NHSE & Cheshire & Mersey ICB (section 5.8.1). Sign off for communications is detailed within the different sections according to the incident level and agencies involved (the trust response may be to refer to NHSE, C&M ICB, Police etc.) as per section 5.9.1. The trust shares its information with others in the MRF contacts directory (WUTH112) via the trust Resilience Direct response pages for C&M partner organisations, non C&M organisations are able to request access from the trust administrator.	Fully compliant				
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Section 5.9 of the trust Major Incident Plan (WUTH007) includes all communications routes, key methodology is demonstrated in section 5.9.7. Individual divisions have within their BCP's the procedure for contacting patients regarding the status of any of their appointments. Contact details for partner organisations are held within the Merseyside Resilience Forum Contacts Directory, copies of which are held within the On Call Directors Teams group and a hard copy in the trust major incident room. Elected officials and union contact details are held by the HR department. Patient relatives contact details are within section 5.2. External communications to get messages out to a wider audience is within section 5.8.	Fully compliant				
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Sections 5.9.3 & 5.9.4 of the trust major incident plan (WUTH007) considers communications during a major incident and local and national media respectively alonmg with 5.9.6 local and national media during a multi agency incident and 5.9.7 Key methods for communication messages which is a table of who does what in and out of hours. Section 5.9.10 includes the role of Trust Spokesperson. The trust has a specific policy for Social Media use (WUTH033).	Fully compliant				
Domain 8 - Cooperation										
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	LHRP strategic and tactical meetings have been attended at the required level . WUTH063/064	Fully compliant				
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The trust is represented at LRF (Mersey Resilience Forum) by NHS Cheshire & Mersey with an agenda item at LHRP Strategic and Tactical meetings to cascade subject matter. Please see Strategic and Tactical minutes/agenda on WUTH065 & WUTH066 to see LRF as discussed items. The Cheshire Resilience Forum Concept of Operations which confrim this is in WUTH088.	Fully compliant				
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	WUTH has a mutual aid agreement in place with the Spire Murrayfield. Across the LHRP a Memorandum of Understanding was signed across all trusts, version 2.0 in June 2025 and is referenced in WUTH067, this is available to on call teams via their respective Teams groups. Additionally WUTH works with system partners at Super MADE events, SCC co-ordination meetings, Mental Health co-ordination. the process for making MACA requests is in section 3.13 of the Major Incident Policy (WUTH007)	Fully compliant				
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Information is available to on call staff in the on call teams groups for Information Sharing in an Emergency (WUTH068/069/070). The trust has also signed the C&M memorandum of understanding between trusts (WUTH067)The trust has in place a structure in relation to Freedom of Inforomation requests (WUTH071 & 072). WUTH - How we use your information is availble via this link https://www.wuth.nhs.uk/about-us/how-we-use-your-information/ Trust senior roles in data protection is available on https://www.wuth.nhs.uk/your-wuth/trust-guidance-and-documentation/information-governance/data-protection/senior-roles-in-data-protection/ IG information is on: https://www.wuth.nhs.uk/your-wuth/trust-guidance-and-documentation/information-governance/	Fully compliant				
Domain 9 - Business Continuity										
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The trust has a Business Continuity Policy (WUTH002) which is adaopted from the NHSE Business Continuity Toolkit, this identifies the strategic direction within section 1 and its approach within section 6. The plan is approved by the trust Executive Assurance & Risk Committee to demonstrate the trust commitment. Section 4 of the policy is based upon Risk Assessment and how divisions will identify BC risks through the risk process.	Fully compliant				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The trust Business Continuity Policy (WUTH002), adopted from the NHSE toolkit includes section 9 on external suppliers and contractors and identifies roles, responsibilities and resources within section 3. the associated templates to the plan identify key areas to consider with regard to business continuity to allow divisions to consider all parts of their function and ensure arrangements are in place and are scaleable. the trust Risk Management policy (WUTH009) states the roles and responsibilities in relation to risk. Section 2 of the Major Incident Plan (WUTH007) references responsibilities.	Fully compliant				

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46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The trust Business Continuity Plan (WUTH002) adopted from the NHSE toolkit contains section 5 on Business Impact Analysis, this includes consideration of the Maximum Tolerable Period of Disruption (MTPD) and Recovery Time Objectives (RTO). Roll ot across all departments of the NHSE toolkit methods ensures consistency in the approach to BIA's.this is underway and on target	Fully compliant				
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	All divisions within WUTH are required to have in place appropriate business continuity plans, this is facilitated by using the NHSE toolkit which has been transferred into the WUTH Business Continuity Policy (WUTH002). All divisions and departments have updated their BCP's across 2024/25, exampleas of which are in WUTH052-058.Training for divisions is evidenced in document WUTH087. The trust escalation policy is document WUTH118 and the maternity version in WUTH119. The response to bombs and suspect packages is within WUTH120.	Fully compliant				
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Within the trust business continuity policy (WUTH002) are arrangements for exercise planning, implementaion and learning, including debriefing. TThe trust has continues to undertake exercises with reports available in WUTH008, WUTH136 & WUTH145.	Fully compliant				
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The trust has met the requiremnst of the Data Protection and Security Toolkit, the report is available within WUTH073. The trust information governance policy in support of this is within WUTH146 and the Infotrmation security policy is within WUTH 154.	Fully compliant				
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The trust business continuity policy includes quarterly reporting via the EPRR assurance report and continuous monitoring through the Plan, Do, Check, Act (PDCA) cycle. The trust has table top exercise for the BCP testing scheduled for Monday 6th October. The trust is currently having an external audit undertaken by MIAA, the terms of reference for this are in WUTH134 with the final report being available upon completion. Polices WUTH155/156/157 relate to safeguarding and the protection of	Fully compliant				
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The annual report for EPRR contain a section on Business Continuity preparedness and the rolling schedule of testing and exercising. MIAA are unertaking an audit of the trust BCP process with the terms of reference available in WUTH134. the final report will be available upon completion.	Fully compliant				
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The trust Business Continuity Policy (WUTH002) based upon the NHS England Business Continuity Toolkit. This includes continuous review of the policy and of business continuity plans in divisions. This is an ongoing process using the Plan, Do, Check, Act process. All of the required elements are included in the dedicated Business Continuity Policy (WUTH002)and continuous improvement included. All Divisions and departments refreshed their BCP's during 2025 and a table top exercise is scheduled for 6th October to test the updated plans. The post exercise report will be available following this.	Fully compliant				

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53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The trust Business Continuity Policy (WUTH002) section 9 specifically includes external suppliers and contractors to consider their own resilience and arrangements to ensure continued supply to the trust. Centrally procured suppliers/items are monitored by NHS Supply Chain with locally procured goods subject to checks through divisions and trust procurement. This is in progress as the policy is within its first year and on target. Procurement state that the process for procurement checks is based on the contract value: *The process does depend on the value as per the Trust's SFI's. Ad hoc purchases below £5k would not be subject to these checks, official quotations (£5,001 to £30k) that were conducted by Procurement would have certain checks dependent on the requirement. Tenders (£30,001 to PCR Threshold) and PCR Tenders would require cyber essentials as minimum and also request business continuity plans. This is quite a broad statement as it does always depend on the requirement.* The current contract management SOP is within WUTH135.	Partially compliant	Action to discuss contract management further with procurement including a tiered approach for suppliers based on contract value and including croteria for Gold level contracts under the WUTH SOP (WUTH135).	S Povey	Mar-26	
Domain 10 - CBRN										
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	The trust CBRNe plan (WUTH074) identifies the specific actions1.7, training & 1.8 maintenance, The Trust EPRR Policy (WUTH001) section 2, identifies the Accountable Emergency Officer for the succesful implementation of Emergency Preparedness, Resilience & Response and the assessment of EPRR risks.	Fully compliant				
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Document WUTH010 shows the EPRR risks on the trust risk register. The process uses the trust Risk Mangement Process as identified in policy WUTH009. The trust CBRNe plan (WUTH074) details the procedure for hazardous waste. The trust has a COSHH policy for hazardous substance management which is document WUTH117. The trust radiation safety policy is document WUTH123	Fully compliant				
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	The ED accesses advice and information on a Hazmat/CBRN advice line and had has access to the National Poisins Information Service, Toxbase and UKHSA the following links are availbale for staff to advice: https://www.wuth.nhs.uk/media/9062/cbrn-handbook-2018.pdf ,https://www.wuth.nhs.uk/media/9709/nhse-managing-mass-casualties.pdf and the trust CBRNe plan (WUTH074) The ED department uses and has displayed the IOR remove guidance shown in WUTH094/095/096/097/098.Specialist advice for nerve agents is in document WUTH110. the COMAH emergency action plan from Merseyside Fire & Rescue Service in suport of the trust plans and detailing their initial response to incidents is within WUTH147.	Fully compliant				
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Command & Control structures are identified within section 5.2 of the trust EPRR policy (WUTH001). Collaboration with NWAS is met through sharing of the relevant trust policies and a site audit visit is also scheduled for November 2025 to further discuss this and the trust MoU under section 4.3.3 of the CBRNe Plan (WUTH074). The CBRNe plan (WUTH074 relates to the following sections: Details of alerting other stakeholders (via the ROCC) is within section 4.3 of the CBRNe plan. Declaration and activation are in sections 3 and 4 of the CBRNe plan. The location of the decontamination units is within Appendix 6 of the CBRNe plan which has space for two aire shelters and one aire shower which are aligned to ensure a flow from the 'dirty' end to the 'clean' end and beyond for treatment. the designated area is away from the ambulance arrival zone and inbetween the ED entrance and the mainentrance/outpatients entrance which could be used as a receiving area once dencontamination has been completed. the are has fitted running (hot/warm) water and a fixed electrical supply to supply power to equipment. the policy includes decontamoination probedures within section 5.4 tor 5.4.1 dry dentamination and 5.4.2 wet decontamination. Sectoin 5.2 details cordons for patients awaiting decontamination and access through the cordons. Sections 5.5 Mass decontamination, 5.6 waste management, 5.7 removal and disposal of contaminated waste, 5.8 decontamination run off, 5.9 external triage, 5.10 people requiring treatment, 5.11 decontaminating live patients, 5.12 decontaminating deceased, 5.13 deceased decontaminated patients, 5.14 living contaminated patients, 5.15 people not requiring treatment, 5.16 trust holding area - all day walk in centre and 5.17 recovery add to the information held within the policy. Sections 4 and 5.15 relate to activation of plans and recovery.Business continuity arrangements and considerations are contained within section 3.7.1 of the trust major incident plan (WUTH007). The trust PPE policy (WUTH 116) considers the training for donning & doffing protective equipment including Fit Testing and process for rearing or replacing equipment, as appropriate. In addition section 1.8 of the CBRNe plan (WUTH074) covers the	Fully compliant				
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	All ED staff have been trained in the use of PRPS suits with an ongoing schedule for new staff or those requiring refresher training, training details are availalbe in WUTH076 & WUTH077). the training includes reception staff who may be required to take patient details during the decontamination process. The docontamination equipment includes a control board on which the designated roles v person fulfilling are documented, this also includes spaces to document times within PRPS suits for staff.. the trust has MoU's in place with MFRS and NWAS. EPRR risk assessments identify local hazards (WUTH010). An audit of equipment initiated by NWAS is availalbe in WUTH078. The inventory of PRPS suits and their service status is within WUTH079. Staff training statistics for PRPS suit training is contained in document WUTH158.	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	The trust has an inventory of all CBRNe equioment held by it along with risk assessments along with planning for the replacement of equipment within the trust CBRNe plan (WUTH074). PRPS suits are maintained under a service contract and kept in secure storage. The Emergency Department has Risk Assessments in place for the department. An audit of equipment initiated by NWAS is available in WUTH078. The inventory of PRPS suits and their service status is within WUTH079. In June 2025 all equipment was transferred from the exterrnal contained into a dedicated storage room as part of the new ED development. this provides a secure and controlled environment for the storage of equipment.	Fully compliant				
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	The trust has a routine plan to check equipmet and identify any issues or shortfalls within the CBRNe policy (WUTH074). Equipment is managed by the ED Stores keeper with the Head of EPRR also making periodic checks. PRPS suits are maintained on a service contract from the suit manufacturers to ensure competency. An audit of equipment initiated by NWAS is available in WUTH078 with the 2025 audit scheduled for November 2025. The trust has the designated required amount (24 sets) and arrangements to ensure continuity in the event of any damage. The inventory of PRPS suits and their service status is within WUTH079. The latest audit of equipment including tents and shelters is within WUTH082.	Fully compliant				
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	The trust SOP for removal of contaminated waste is in document WUTH080 Contaminated waste is held in the Waste compound in estates pending removal under the contract with Veolia (WUTH081) which is managed by NWAS and audited by them. Any contaminated waste is stored in the designated area in the estates waste compound pending collection.	Fully compliant				
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	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	The trust has 8 trainers to deliver hazmat training, as per section 1.7 of the CBRNe plan (WUTH074). Details of training are within WUTH083/084/085. The trust has a sufficient number of training and/or decommissioned suits for training and have hosted two courses for NWAS using the trust resource. The training delivered is within WUTH077 and the lesson plan to accompany in WUTH076.	Fully compliant				
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	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	The training delivered to staff used the training material within WUTH076 & WUTH077. For Staff traiing **ALL** ED staff were re-trained during 2024 with an ongoing progtramme in place for refesher and new starter training . NHS England guidance (WUTH086) on the initial guidance for self presenters is followed should any self presenters arrive outside of a main incident scene who have missed decon at scene. ED Reception staff are included within the decontamination training of staff.	Fully compliant				
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	All ED staff have been trainied in the use of PRPS suits and all staff are required to be trained in the use of two different FFP3 masks. This is an ongoing process and has been reinformed in preparations recent potential Mpox and measles outbreaks. The trust currently has a programme of ensuring all required staff have the training in the use of two FFP3 models and that they rotate usage. To facilitate this the trust has 7 portacount machines to assist with staff training. In addition for bearded staff the trust has powered hoods for staff with beards that mean a face fit seal is not possible for masks.	Fully compliant				
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Hazmat exercising and re-training of all staff took place between April and July 2024, ongoing new starter and refresher training is scheduled for all staff to maintain competences. Training records are included in WUTH136.	Fully compliant				

Wirral University Teaching Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response (EPRR)

Annual Report

2024/25

Report date:
August 2025

Author: Steve Povey, Head of EPRR/EPO

Sponsor: Hayley Kendall, Chief Operating Officer, and Accountable Emergency Officer

Contents

Executive Summary

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

The Trust has the required Accountable Emergency Officer (AEO), supported by the Emergency Preparedness Officer (EPO) along with the appropriate emergency planning meeting structure.

All of the mandated emergency plans to respond to a major incident are in place and published on the Trust emergency planning intranet page.

Introduction

The NHS needs to be able to plan for, and respond to, a wide range of incidents that could impact on health or patient care. These could be anything from extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A significant incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority.

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with such incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of its services in the event of a disruption.

Purpose

The purpose of the annual report is to:

- Provide an overview of the emergency preparedness arrangements within Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
- Describe the Trust's responses to incidents that have occurred during 2024-25
- Outline the work that has been undertaken in this area during the past 12 months
- Summarise the planned work streams and priorities for the year ahead

Emergency Preparedness Structure

Lead Officers

Accountable Emergency Officer (AEO)

The NHS Act 2006 (as amended) places a duty on providers to appoint an individual to be responsible for discharging their duties. This individual is known as the AEO. For the period covered in this report, the AEO was:

Hayley Kendall Chief Operating Officer	**01/04/24 – 31/03/25**

Emergency Planning Officer

The AEO is supported in this role with the role of Emergency Planning Officer (EPO). For the period covered in this report, the Head of EPRR acting as the EPO was:

Steve Povey	**01/04/24 – 31/03/25**

Meeting Structure

In order to discharge the Trust's responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the Trust's operational structure.

Trust wide ad-hoc planning meetings are initiated for any required emergency planning such as large scale community events, planned IT downtime planning, bank holiday planning, service/ward change or other operational pressure where services may be affected. Section 9 details the events that have been formally planned for during this period.

EPRR meeting structure:

- The Local Health Resilience Partnership (LHRP) meetings provide a forum to ensure that planning is not be conducted in isolation by a single organisation, but is undertaken in partnership with other local responders and commissioners. There are 2 levels of LHRP meetings; Strategic and Practitioner.
- The AEO, or their representative, attends the Strategic LHRP meetings for Cheshire & Mersey. These meetings are held three times a year at Strategic Level.
- A Deputy Executive Director, Deputy Chief Operating Officer or the EPO attends the Cheshire & Mersey LHRP Strategic LHRP meetings on behalf of the AEO should they be unavailable.
- The EPO attends the Cheshire & Mersey LHRP Tactical level meeting.
- During the course of the report both the Strategic and Tactical Level LHRPs meetings were regularly attended by a WUTH representative.
- Attendance of at least 75% of these meetings is required to comply with NHS Core Standards for EPRR. The trust has met this requirement during the reporting period.

Out of Hours Arrangements

On-call rota

The Trust operates an on-call rota which is on a 24/7/365 basis and ensures that 1st On Call Managers and 2nd On Call Directors are contactable at all times and are able to respond quickly to business continuity, critical or majo incident at any given time. This structure is supported by specific clinical and departmental on-call rotas which are designed to respond to local service-related operational issues. There is central coordination of these rotas.

On-call booklet

The Hospital Manager/Executive On-call booklet is regularly reviewed and updated to ensure that current information is to hand for any operational issue and risk assessment forms for major incidents.

On-call training

Induction meetings are in place for members of the on-call director and manager rota, this includes major incident training. The on-call managers hold quarterly on-call forums where on-call issues, new guidance, updates and major incident refresher training is held.

NHS England and the Cheshire and Mersey ICB host Principles of Health Command Training throughout the year. Attendance on this course is mandatory for all oncall managers and directors with compliance measurable and part of the NHS England Cores Standards for EPRR response.

Risk Register (LHRP)

The Cheshire & Merseyside LHRP maintains a register of risks which are likely to present a threat to the wider community. These risks are updated at the LHRP quarterly meetings and provide the basis for setting the planning agenda and establishing emergency preparedness work plans for the Cheshire & Merseyside region.

Exercises and Training

The Civil Contingencies Act (2004) outlines the organisational responsibility to exercise plans. Under the Act, all NHS organisations are required to undertake:

- Live exercises (or incident) every three years
- Table top exercises annually
- Communications exercises every 6 months

Given the Trust and the NHS has been operating in an emergency state for the last two years through the COVID-19 pandemic, in line with national guidance, all EPRR exercises and training were stood down.

In May 2023, the response to Covid-19 was stepped down to allow the re-commencement of normal training and exercising. It should be noted that as the Trust was under a command structure for the entirety of the pandemic the Trust's EPRR was thoroughly tested.

Exercises, incidents and projects with EPRR support

During the year the Trust experienced a number of incidents which involved an EPRR Response, these included live responses aswell as full EPRR Command & Control be stood up to deal with trust responses to known events.

Incident	Overview	Declared Date	Stepped Down Date
NHSBT Low Red Cell Amber Alert	Command & Control meetings in place to manage usage of trust resources	19/07/2024	Final meeting 29/07/24
IT Incident	Issues affecting Roster staffing	19/07/24	19/07/24

Southport Attacks	Standby to support local trusts	08/08/24	08/08/24
Cyber Incident	Cyber attack on trust systems	25/11/24	04/12/24
CareAware Cloud Migration	Upgrade to Millennium to migrate some services to the cloud	16/11/24	17/11/24
UECUP ND2 Cable Jointing	Power upgrade project requiring power off and generator support for selected areas in rotation	30/11/24	
UECUP ND7 Cable Jointing	Power upgrade project requiring power off and generator support for selected areas in rotation	25/11/24	
UECUP Phase 4 Service Connection	Power upgrade projects requiring power off and generator support for selected areas in rotation	January to March 2025	
W&C Lift 1 Replacement	Project to replace lift 1 in W&C building	March 2025	May 2025

Communications

The major incident contact list for in and out of hours was successfully tested during 2024/25 as outlined in the table below:

OUT OF HOURS
12/12/2024
IN HOURS
22/04/2024

In addition the regional ICB also conducted communications exercises into trusts which WUTH were part of, these were:

Exercise Hermes
13/04/2024
Exercise Calliope
29/08/2024

External Review

NHS England Assurance for EPRR

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust self-assessed against these standards between July and September 2024. Following assessment, the organisation self-assessed as demonstrating **partial compliance** level.

Core Standards Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

A copy of this assessment along with the declaration of the level of compliance achieved was taken to the Public Board of Directors in September 2024.

Reports to Committee and Public Board

EPRR Reports to Board/Committee were presented on the following dates:

Item	RMC/EARC	Public Board of Directors
EPRR Annual Report 2024/25	September 2024	
EPRR Core Standards 2024/25 Compliance Report	September 2024	
Quarterly EPRR Report to Risk Management Committee	May 2024	
Quarterly EPRR Report to Risk Management Committee	August 2024	
Quarterly EPRR Report to EARC	January 2025	
Quarterly EPRR Report to EARC	April 2025	

Event Planning

During 2024-25 planning meetings supported by EPRR have taken place to ensure that safe robust plans were in place for the following events:

Event	Summary
Half Term/Bank Holiday Planning **Easter, early and late May, August, October Half-term, Christmas/New Year period, February Half-term**	Trust wide plans are developed to outline the arrangements that are put in place in the Trust and within key partner organisations in preparation for the Bank Holiday and selected Half Term periods. They provide assurance to the Wirral system and describe initiatives that have been put in place to maintain safe patient flow during a period of known increased demand. They provide robust plans for internal oncall teams to follow through the oncall structure. The planning also ensures that the process for bank holiday reporting to NHSE/I (NHSE daily operational pressures and NHSI SITREP) is in place during the bank holiday weekend period.
Trust wide Wirral Millennium planned upgrades/downtime:	Planned Wirral Millennium 'downtime' and system upgrades requires trust wide planning to ensure that issues/risk and actions have been identified and that staff in all areas are aware of the formal downtime process to follow to maintain patient safety. The EPO coordinates all such responses with leads from the specialty area. The EPO agrees all potential disruption plans with the AEO.
Multiple estates planning events: **Projects supported during this period included the Trust UECUP programme surveys, planned power outages at APH and CBH.**	Planned Estates projects that affect the Trust operationally require careful planning with key stakeholders to ensure that risk is identified and mitigation put in place to ensure patient and staff safety. The EPO is involved in the planning of all such events and approves the progression of such events with the AEO.

Work undertaken in 2024-25

The following work-streams were completed during the year under review:

- Provided assurance for NHS England Core Standards for EPRR
- Facilitated internal communication exercises, plus the end of the declared pandemic, that tested alerting procedures as part of incident response procedures
- Delivered major incident training to new on-call managers and directors
- Developed Trust wide plans for planned events such as IT planned downtime, Bank Holiday/Half Term periods and multiple estate projects

Progress with work programme for 2024-25

All actions are complete as detailed in appendix 2, these were the improvement actions from the 2023/24 plan.

Work programme for 2025-26

Work streams have been developed using recommendations from the Local Health Resilience Partnership. They will be undertaken during the 2023/24 financial year. Please refer to the plan in appendix 3.

Appendix One

EPRR Statement of Compliance

Wirral University Teaching Hospital, NHS Foundation Trust has a duty to protect the health of our community. This duty extends to times of emergency.

The purpose of this Major Incident Plan is to outline how we will respond in the event of an emergency, meet our responsibilities as a Category 1 Responder and comply with relevant guidance and legislation.

The Major Incident Plan is built on the principles of risk assessment, co-operation with partners, emergency planning, communication and information sharing. It is essential that we are prepared to look beyond a major incident, and put in place business continuity management arrangements, to secure the day to day running of the organisation.

The Management Team within Wirral University Teaching Hospital NHS Foundation Trust has an important role in ensuring we respond professionally to an emergency whilst maintaining vital services. It is essential that you are familiar with how the Trust will operate during such an event, what role you may play and the role of the other organisations we will be working with.

A Major Incident can take place at any time day or night and it may be necessary for staff to work in unfamiliar environments for flexible / extended periods. The plan will be subject to an annual test.

This Plan includes the provision of action cards for the different roles that may be involved.

Janelle Holmes

Chief Executive
Wirral University Teaching Hospital

Appendix 2

Progress with 2024/2025 Improvement Plan

Recommendation /Issue (in line with EPPR Framework)	By end of Quarter 2023-24	Progress
Produce an annual report on Emergency Preparedness 2023/24 to Risk Management Committee September 2024	Q2	Complete
Undertake the self-assessment for the 2023/24 EPRR assurance process	Q3	Complete
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Q3	Complete
Ensure RMC and the Public Board of Directors (BoD) has sight on the level of compliance against the 2024/25 revised process for the revised EPRR assurance	Q3	Complete
Carry out a Communication Exercise at a 6-month interval	Q3 & Q4	Complete
Carry out the 3-yearly review of all relevant emergency plans and note at BoD	Q4	N/A
Develop and deliver strategic refresher Major Incident Training to on-call Hospital Managers, Hospital Clinical Coordinators and Executives	Q4	Complete
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire & Merseyside LHRP – *N/a for this period*	Q4	N/a
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Q4	Complete

Lead: Steve Povey, Head of EPRR

Recommendation /Issue (in line with EPPR Framework)	By end of 2024/25
Undertake a table top exercise – Proposed July 2024	Complete
Produce an annual report on Emergency Preparedness 2023/24 to Risk Management Committee (RMC) May or September 2024 and ensure noted at the Public Board Meeting	Complete
Undertake the self-assessment for the 2024/5 EPRR assurance process	Complete
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Complete
Carry out a communication exercise at a 6-month interval	Complete
Ensure the Board of Directors (BoD) has sight on the level of compliance achieved, the results of the 2024/25 self-assessment and the improvement plan for the forthcoming period	Complete
Carry out the 3-yearly review of all relevant emergency plans and note at BoD, where required	Complete
Update and deliver strategic refresher major incident training to on-call hospital managers, hospital clinical coordinators and executives, review On Call Training and re-publish On Call handbook.	Under Review
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire and Merseyside LHRP	Complete
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Complete

Appendix 3

2025/26 Work Plan

Activity	Review Date due	Progress
EPRR Annual Report to RMC	September 2025	Complete
NHSE Core Standards to RMC/BoD	September 2025	To Board meeting October 2025
Update report to EARC	March 2025	Complete
Plans		
Severe Weather Plan	March 2026	Brought forward for Core Standards
Pan Flu Plan	March 2026	Brought forward for Core Standards
Evacuation Plan	March 2026	Brought forward for Core Standards
Major Incident Plan & Action Cards	March 2026	Brought forward for Core Standards
CBRN Plan	March 2026	Brought forward for Core Standards
Power Failure Action Cards	September 2026	
Business Continuity Plans	September 2026	
Fuel Plan	December 2026	
Comms Tests (requirement 6-monthly)		

Out of Hours Comms Test	September 2025	Complete
	February 2026	
In Hours Comms Test	January 2026	
	March 2026	
Training & Exercising		
On-Call Training 1:1	At induction	Refer to on-call spreadsheet
Via On-call Forum – ad-hoc	June/Sep/Dec/Mar	Managed via Paul McNulty
On Call Competencies Portfolios	Ongoing 3 yearly cycle	
Tabletop Exercise – Lockdown	October 2025	
Exercise Pegasus	October & November 2025	Regional Teams only, Trust involvement downgraded
Meetings		
LHRP Strategic	Mar, July, Nov	Reported in Annual Report
LHRP Practitioner	May/Jul/Sep/Nov/Jan/Mar	
CBRN training		
CBRN Train the trainer	2026	NWAS Course dates released
PRPS Training for ED Staff	Course programme via ED	Ongoing
Miscellaneous training		
On-call staff update to Switchboard	January 2025	Complete

Loggists	Dates to be set	Sessions to be programmed

Board of Directors in Public **Item 27**

05 November 2025

Title	Inclusion Annual Report 2024/25
Lead Director	Deb Smith, Joint Chief People Officer
Author	Neil Perris, Head of EDI (patient) and Workforce Wellbeing Lead & Emma Ashley, Staff Inclusion and Engagement Lead
Report for	Approval

Executive Summary and Report Recommendations

The Inclusion Annual report summarises our continued organisational compliance with the Equality Act 2010 and provides assurance of contractual compliance.

The report summarises the Trust's progress around the EDI agenda during 2024/25 and presents key patient and workforce related equality data and analysis. It includes the Trust's Key Inclusion priorities for 2025/26.

It is recommended that the Board

- Approve the report for publication

Key Risks

This report relates to the following key risks:

This report provides evidence and monitoring in relation to Strategic Risk ID08, within the Trust's Board Assurance Framework: 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 - 3 x 4 (12) – Risk Appetite: Moderate. There are no new BAF escalations identified, based on the content of this report

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

Contribution to WCHC strategic objectives	
Populations	Yes
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	No
People	Yes
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	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	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
15/09/2025	PCOG	Inclusion Annual Report	Approved
08/10/2025	People and Culture Committee	Inclusion Annual Report	Approved

1	Narrative
1.1	This annual report has been approved at People and Culture Committee in October 2025 and will go to the next scheduled Quality and Safety Committee. This report is presented to Board for approval: • The report summarises the Trusts progress around the EDI agenda during 2024/25 and presents key patient and workforce related equality data and analysis. • It includes the Trusts Key Inclusion priorities for 2025/26 • To ensure alignment with inclusion schedule of report cycle which is to align with WUTH

2	Implications
2.1	**Quality/Inclusion** The report summarises our Inclusion activity and outcomes (patients & workforce) for 2024/25 and outlines our Inclusion priorities for 2025/26.
2.2	**Finance** None
2.3	**Compliance** Supports our compliance with the Public Sector Equality Duty under the Equality Act Regulations.

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 ☐

Inclusion
Getting it right for everyone

NHS
Wirral Community Health and Care
NHS Foundation Trust

Inclusion Annual Report | 2024/25

Contents

Section 1

Inclusion and Health Inequalities Strategy 2022-2027

Inclusion
Getting it right for everyone

Wirral Community Health and Care NHS Foundation Trust has a 5-year organisational strategy which outlines our vision to be a population-health focused organisation specialising in supporting people to live independent and healthy lives. We are now into the fourth year of delivery of this strategy.

There are a range of supporting strategies that underpin the Organisational strategy including Quality, Digital, People and Inclusion and Health Inequalities strategies. The Inclusion and Health Inequalities Strategy contains our equality objectives for this period. Detailed delivery plans are developed each year for our Quality and People strategies which include specific actions to support our Inclusion and Inequalities ambitions. Progress on the delivery plans for these two strategies is included in this report.

To support Inclusive leadership throughout the organisation being led from the top, each of the board members have Equality, Diversity and Inclusion objectives to meet.

Our Strategies can be accessed here

Section 2

Overview of population focussed inclusion activity

Inclusion
Getting it right for everyone

To help us understand the people we care for we collect information about you and your preferences and characteristics such as age, gender, religion, ethnicity, sexual orientation and any disabilities or impairments you may have.

We use this information to make sure we communicate well with you; we make adjustments in how we deliver our services to you to take account of your needs.

We also use this data to monitor which groups of people are accessing our services and who is less able to, and we use this to inform how and where we deliver our services, targeting those at most disadvantage. You may be asked some of these questions when you attend for your appointment, or in advance of this via text message or via the telephone and you can of course choose not to answer any or all of these, but it helps us if you do choose to answer.

All this information is all held confidentially within the organisation. This information supports us in our compliance with our Public Sector Equality Duties and the Accessible Information Standard (AIS) ensuring we treat people fairly and equitably and we communicate in a way that supports people with disabilities or impairments.

We have been making ongoing improvements to how and when we collect this information and ensuring that we only ask you when we first see you and then periodically to make sure nothing has changed. The chart below shows as a percentage of all patient records, how many have the patients' details recorded under a range of characteristics. The chart shows an improvement for the 2024/25 period compared to the 2023/24 period for Religion and Sexual Orientation, but a small decline in recording performance for Ethnicity and a sharper decline for marital status

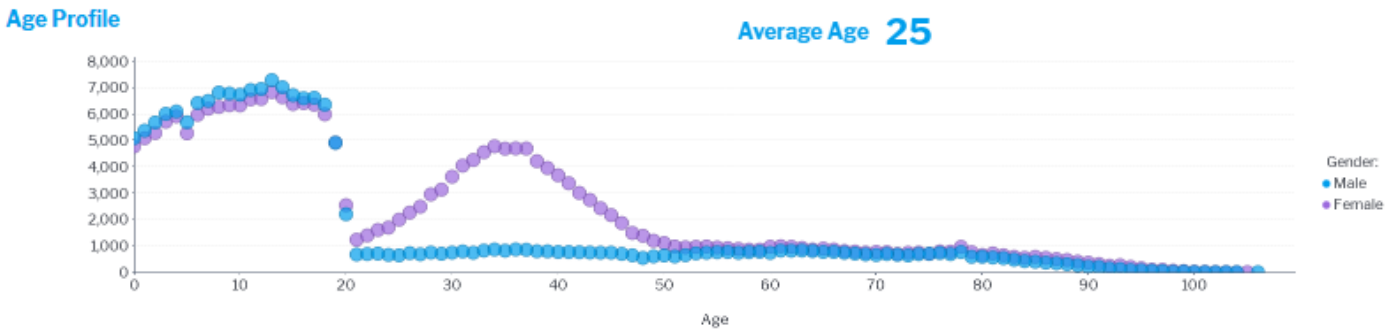
Protected Characteristics Recording

Year	Ethnicity	Marital Status	Religion	Sexual Orientation
2022/23	53.2%	21.2%	3.0%	1.3%
2023/24	69.6%	21.7%	21.8%	7.8%
2024/25	64.0%	3.1%	25.0%	10.1%

Information about the people we serve – age range of our patients

The following section shows information about the people who are using our services. We split this information into groups of characteristics that are protected under law by the Equality Act 2010, commonly called the “Protected Characteristics”.

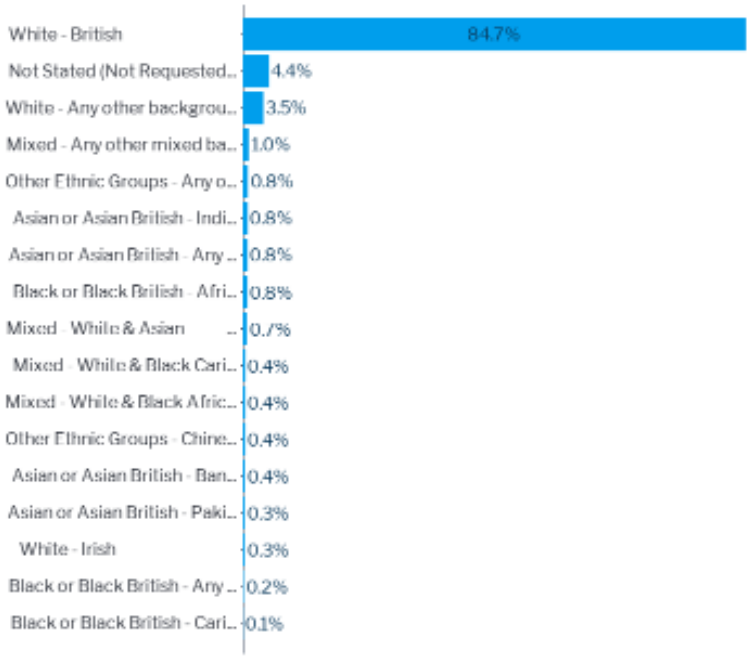
This shows the number of patients in each age banding that we saw in 2024/25 (split by gender).



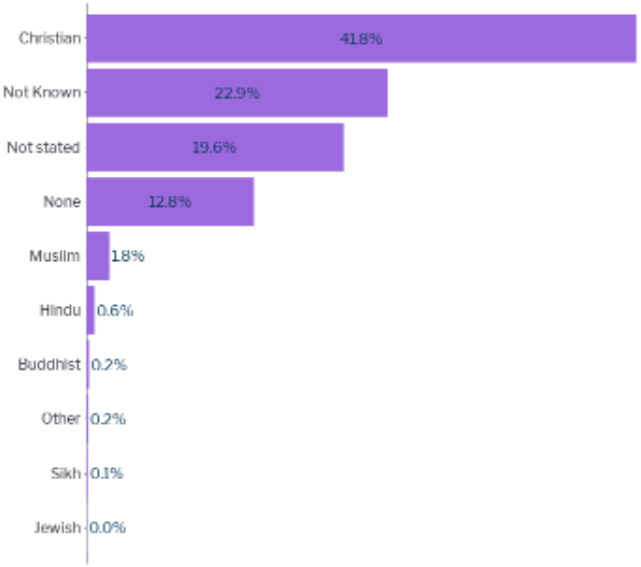
Information about the people we serve – other protected characteristics

This shows the % of patients we saw in 2023/24 by a range of protected characteristics.

Ethnicity *(excludes not recorded)*



Religion *(excludes not recorded)*



Accessibility and Inclusion Template

In 2022/23 we undertook a Quality Improvement project to improve the collection of protected characteristics data and to clarify and improve how we record and act upon the communication needs of patients and carers that result from disability and impairment.

To do this we developed a single form which appears on every patient's electronic health record. We have asked staff to complete this for every patient we see either face to face or via telephone or video.

During 2023/24 & 2024/25 we continued to monitor completion rates across our services, setting an ambition to have the template completed for 85% of all new patient contacts. Whilst we have continued to make progress toward this ambition in 2024/25 and two of our 5 directorates are now performing over target, there is further work for us to do to achieve this level of performance and to use digital innovation to support this.

Health Inequalities Waiting List Tool

During 2024/25 we have continued to evolve the tool we piloted in the previous year to support our services in managing our waiting lists in a way that helps us to reduce potential health inequalities and allows us to better prioritise those who are most in need whilst waiting for a service.

Patients receive a pre-appointment questionnaire whilst on the waiting list for these services. This is texted out to the patient who can complete it on their smartphone, tablet or computer, or call us to assist with completing it over the telephone.

This data is used alongside patients own clinical coding and other data sets including the Indices of Multiple Deprivation to identify those people who may be a risk of experiencing health inequalities.

The tool is aligned to the National Core 20 Plus 5 model and Patient Safety Incident Response Framework (PSIRF) and is then used to flag anyone at increased risk of inequalities and allow us to prioritise them or adjust their care accordingly alongside standard clinical triage. Work in 2024/25 focused on digital innovation and making the questionnaire for the tool available for patients to complete digitally at their convenience prior to their appointment. Work is ongoing to develop the tool to embed it as part of usual business for our services, supporting us to reduce known health inequalities.

Armed forces community Inclusion

The Trust signed the Armed Forces Covenant in June 2022, confirming our commitment to support the armed forces recognising the value serving personnel, both regular and reservists, and military families contribute to the Trust and our country.

To support this work, we established the Armed Forces Community Working Group to include those with lived experience, led by an Executive, Management and Clinical leads.

The work of the group has included ongoing partnership development work and engagement with other related local networks and partners Including Poppy Factory, Cheshire and Wirral Partnership NHS Foundation Trust, Primary care colleagues and more.

During 2024/25 the Working Group focussed on working towards the annual review of VCHA Veterans Aware Status.

The group has also established an Armed Forces Community Staff Network to support those members of our workforce who are a part of this community.

ARMED FORCES COVENANT

EMPLOYER RECOGNITION SCHEME

SILVER AWARD 2023

Proudly supporting those who serve.

VETERAN AWARE

Inclusion Events and Campaigns

A number of Events and Campaigns throughout the 2024/25 period have been hosted by the Trust, aimed at encouraging both staff and members of the public to celebrate diversity with us, and to embed inclusive practices to ensure that we are getting it right for everyone.

Menopause network - in October 2024 to celebrate Menopause Day a number of awareness raising events were held including an online "cuppa and a chat" to open the network up to new members. The network continues to meet regularly and has an active membership.

LGBTQ+ Pride - the Trust formally supported New Brighton Pride in August 2024 for the third successive year . Supported from our LGBTQ+ staff network, our Sexual Health Wirral service and our colleagues in Sahir (a local HIV support organisation) ensured that we celebrated the diversity in our communities and our workforce showing positive allyship to our LGBTQ+ colleagues, friends, families and to LGBTQ+ communities where we provide services.

LGBT+ History Month (Feb 24). We produced an infographic to support staff with understanding the issues faced by the LGBTQ+ community and to understand some of the language and terminology currently in use around this community.

Staff Network Celebration event and understanding allyship - in December 2024 all of our staff networks came together for a half day celebration event to celebrate our individual and collective successes over the last 12 months and to reflect on and celebrate our intersectionality. We were joined by the Trust board who were able to share in our celebrations and to contribute to our work on defining how 'allyship' should look and feel within our organisation.

Carers Awareness week - during carers week (June 2024) the Working Carers staff network and the HR team supported an Information Stand in St Catherine's Health Centre. The stall was supporting unpaid carers within the organisation or people who use our services, to identify themselves as a carer. We shared a wealth of information about the support available to carers across Wirral and to carers who are also a part of our workforce. This information included the carer's passport, useful apps, and information about our policies and procedures that support staff with caring responsibilities. The Trust also had a marketplace staff at Wirral Carers Alliance 'Commitment to carers event in New Brighton, and took part in Healthwatch's Carers event at Arrowe Park Hospital in the summer working closely in partnership with Hospital Trust Colleagues and a wide range of organisations offering services to carers.

Ability Network - the group has welcomed new members during the year and widened to include neurodivergent staff. This has highlighted the need to increase awareness and promote access to shared resources and learning. The group has contributed to the review of the following policies: managing attendance, reasonable adjustments, navigating access to work processes and flexible working.

Cheshire and Merseyside NHS Prevention Pledge

Wirral Community Health and Care NHS Foundation Trusts has continued to support and actively strive to put 'prevention first' in line with the commitments we have made under the Cheshire and Merseyside NHS Prevention Pledge

The NHS Prevention Pledge is underpinned by 14 'core commitments' (below) that have been developed through extensive consultation with representatives from provider Trusts, NHS England, local authority public health teams, Office for Health Improvement and Disparities (OHID), and third sector organisations across the region.

Wirral Community Health and Care NHS Foundation Trust signed up to the pledge in 2022/23 and has worked on delivering 14 commitments during 2024/25.

The pledge links strongly to the ambitions in our strategies and is reflected in our delivery plans. As a result, the pledge contributes to key priorities for the Trust including; Population Health, Health Inequalities; Workforce Health and Wellbeing, Social Value and supporting our role as an Anchor Institution.

CHESHIRE & MERSEYSIDE NHS PREVENTION PLEDGE

1 Prioritise long-term focus on prevention, early intervention, embedd it in governance. Appoint Exec Sponser, MECC (make every contact count) prevention is everybodys business

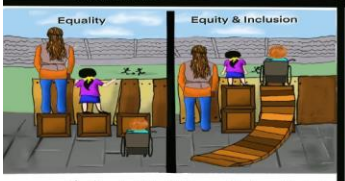
11 Review food & drink provision make it healthier, convenient & affordable. limit access to high fat/sugar/salt content. Increase access to fresh water & encourage reusable bottle refills.

2 Create conditions to support service managers & staff to take a Quality improvement approach to review & transform services to embedd prevention.

5 Increase social value by establishing anchor practices, that positively impact on the wider determinants of health AND climate health. Use Social responsibility in procurement and purchasing supplies.

8 Support workforce development, train staff in brief advice & referral in supporting people to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental well-being.

12 Support the sub-regional physical activity strategy: promote & create opportunities for people to be physically active, on & off site and in line with active travel & sustainable management plans.



3 Use Marmot principles; develop approaches to prevention, work with partners at place to address inequalities, deliver local priorities and prevention plans (as per NHS Plan & COVID rec

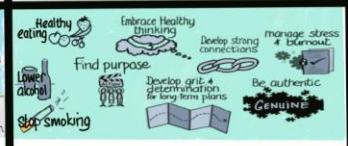
6 Adopt & embedd a MECC approach, increase the number of brief or very brief interventions, supporting people to eat well, be physically active, reduce harm from alcohol & tobacco, promote mental well-being

9 Ensure a smoke free environment, linked to support to stop smoking for patients and staff who need it

13 Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embedd the Prevention Concordat across health & care policies and practices.

4 Work in partnership of common prevention pathways across Trusts work on prevention that reduces the impact of disease through lifestyle advice and cardiac or stroke rehabilitation programmes.

7 Work with primary care, LA, Voluntary sector to refer to non clinical support via social prescribing, build community capacity to reduce GP, A&E, hospitalisation, medication use and social care



10 Workplace health programmes, foster org culture that promote workplace resilience, creates opportunities for staff to eat well, be active, reduce harm from alcohol, tobacco & promote MH well-being

14 Monitor the progress of the pledge against all commitments And to publishing the results of our progress at regular intervals.

Section 3

Overview of workforce focussed inclusion activity

Inclusion
Getting it right for everyone

Workforce Accreditations

The Trust has continued its work to achieve a range of standards and accreditations focussed on ensuring that we are an inclusive organisation for our workforce and the following accreditations have been achieved or maintained during 2024/25

- Disability Confident Employer
- Mindful Employer
- Menopause Pledge
- Rainbow Pin Badge
- Veteran Aware (VCHA)
- Silver Defence Employer Recognition Scheme

Inclusion Learning and Development

Ensuring our people have the relevant knowledge, skills and competencies to deliver our Inclusion and Health Inequality ambitions is a key deliverable in our strategies. In 2024/25 we have achieved the following outcomes.

- Maintained compliance with Mandatory Equality Diversity and Inclusion Learning at over 90% across the whole year
- The trust continues to work with local organisations who support people with Learning Disabilities (LD) and Autism to implement the Oliver McGowan Mandatory Training for LD and Autism. The training is delivered in two parts, the first is eLearning and the second is a workshop delivered by people who have lived experience of LD and Autism. The Trust has maintained well over 90% target compliance with the eLearning element of this training in 2024/and has commenced delivery of the second part of the Teir 2 training to relevant staff via our partnership with Autism Together, and we remain in line with our three year delivery plan target.
- We have an inclusion champions network in the organisation, and they have continued to meet regularly to share best practice around Equality, Diversity and Inclusion and to share with their teams information and experiences to support our understanding of vulnerable or excluded people and communities.
- During 2024 the Behavioural Standards Framework continued to be implemented which had been shared with all staff network groups for their involvement into the content.
- As part of our Festival of Leadership, during October-November 2024, sessions were delivered on Microaggressions and Allyship to the Senior Leadership Forum within the organisation.

- At the Senior Leadership Forum in November 2024 all delegates attended a session on Health Inequalities to raise awareness of the impact we have as health professionals on the outcomes and experience of marginalised or vulnerable groups

- The 5 staff networks and representatives from the Inclusion and Human Resources teams celebrated the achievements of the networks at a celebration event in December 2024. This event also continued our work on defining what 'Allyship' was for us all and helped us to define the behaviours we would like to see amongst our colleagues, ensuring that respect and kindness is fostered for everyone. The event shared with Trust Board members the work of the networks over the year and to discuss the role that the Board have in leading the organisation by sharing and discussing the emerging vision for active allyship within the organisation.

Engagement Forums

The Trust also has two Engagement forums, Involve and Your Voice who support the organisation in our quality improvement work by ensuring we consult with and involve both under 18's (Involve) and adults (Your Voice) in the co-design of our services.

Both groups have been meeting on a regular basis throughout 2024/25 and we have continued focus on recruitment to the groups from a diverse range of individuals to better reflect the diversity in the communities we serve.

Both forums have been involved in a range of initiatives and reviews of public facing information resources and provide invaluable feedback supporting the services to ensure their quality improvements are effective and meaningful to the patient. For example, the Your Voice group were engaged with the development of a 'Patient Information Leaflet' detailing the choice of continence products available as the service introduced washable continence products, ensuring the content, including the language used and tone of the leaflet was understood and well received by patients. The group were also consulted on a range of quality improvements implemented our urgent care services helping to support the public in understanding what our Walk-in Centre and Urgent Treatment Centre is able to treat.

Celebration and Sharing Events

As a showcase opportunity for our services who have undertaken Quality Improvement Projects and as an opportunity to celebrate and share these innovations and improvements with others, we run Celebration and Sharing events twice a year. During 2024/25 we had two successful events in the main atrium area of St Catherine's Health Centre. These events are a great opportunity for services to show how they are improving for better patient outcomes. These improvements often include a focus on access to services for all, ensuring that the patient

experience is also positive and that we are able to deliver better outcomes for everyone. We were also joined by a range of key stakeholder organisations at our Celebration and Sharing events including organisations such as DA Languages, Signalise Cooperative, Age UK, Healthwatch, and others who we work with to ensure we make our services accessible and appropriate for the diverse individuals who may need them.

Staff Networks update

The trust has 5 staff network groups and is currently supporting the formation of a sixth Armed Forces Community Staff Network.

Our staff networks provide important peer support and a sense of belonging for staff who share a particular protected characteristic or other vulnerability. Alongside the important function of support for members, the network also provides important steer and challenge to the organisation around its strategic direction, with a wide range of policies and procedures going to some or all of the staff networks for consultation and feedback. This helps to ensure that the Trust remains an inclusive and supportive organisation for everyone to work in but also ensures that the policies that impact on patients and service users are also inclusive and put prevention first, ensuring we do all that is possible to tackle health inequalities.

Our staff networks are:

- Ability Staff Network (including long term conditions, disabilities and neurodiversity)
- Black Asian and Minority Ethnic (BAME) Staff Network
- PRIDE Staff Network (LGBTQ+)
- Menopause Staff Network
- Working Carers Staff Network
- Armed Forces Group (under development)

Each of our staff networks benefit from an executive sponsor. The sponsors are committed to gaining a deeper understanding of the groups' lived experience and representing their network at the board level providing escalation of any identified issues to their exec and non-exec colleagues.

Section 4

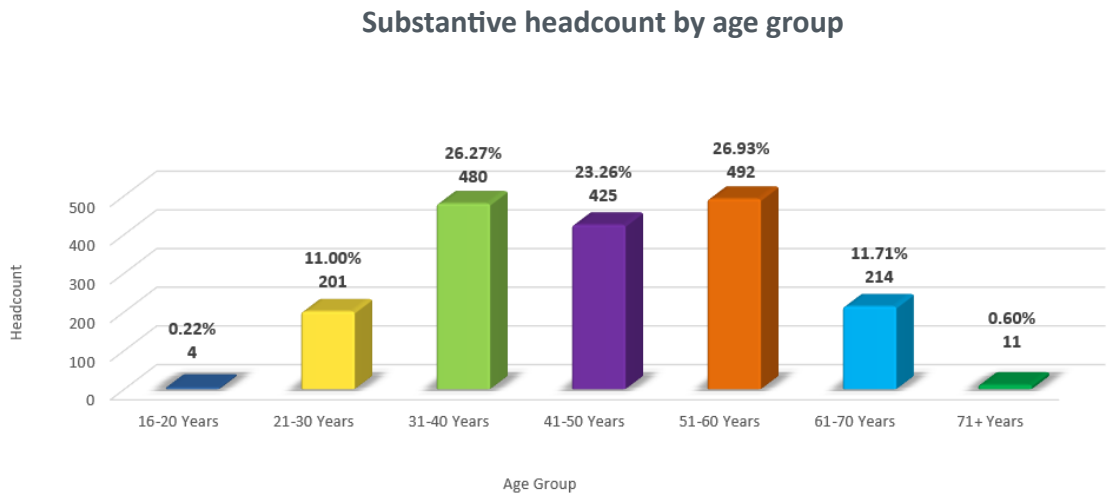
Workforce Inclusion Data

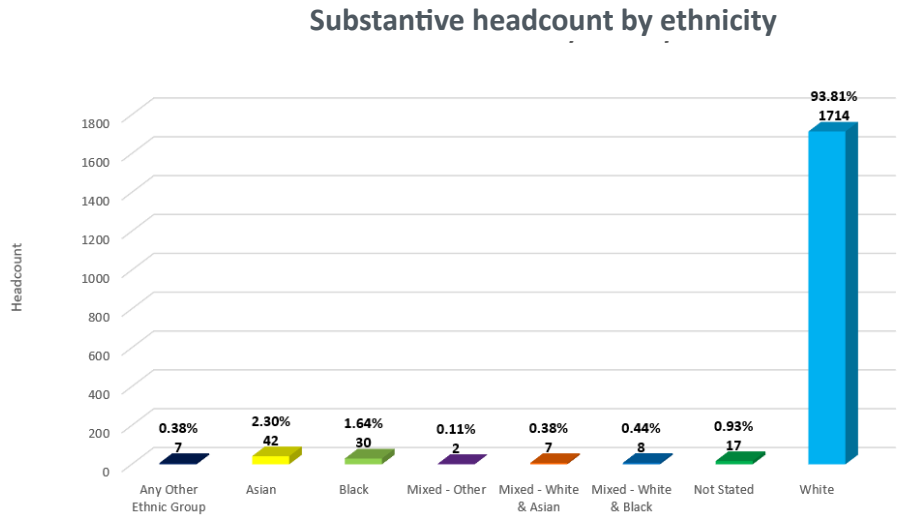
Inclusion
Getting it right for everyone

Reporting is a requirement of the public sector equality duty. The next few pages tells you a bit more about the make-up and profile of the workforce. Where possible we have compared to 2021 census data available here.

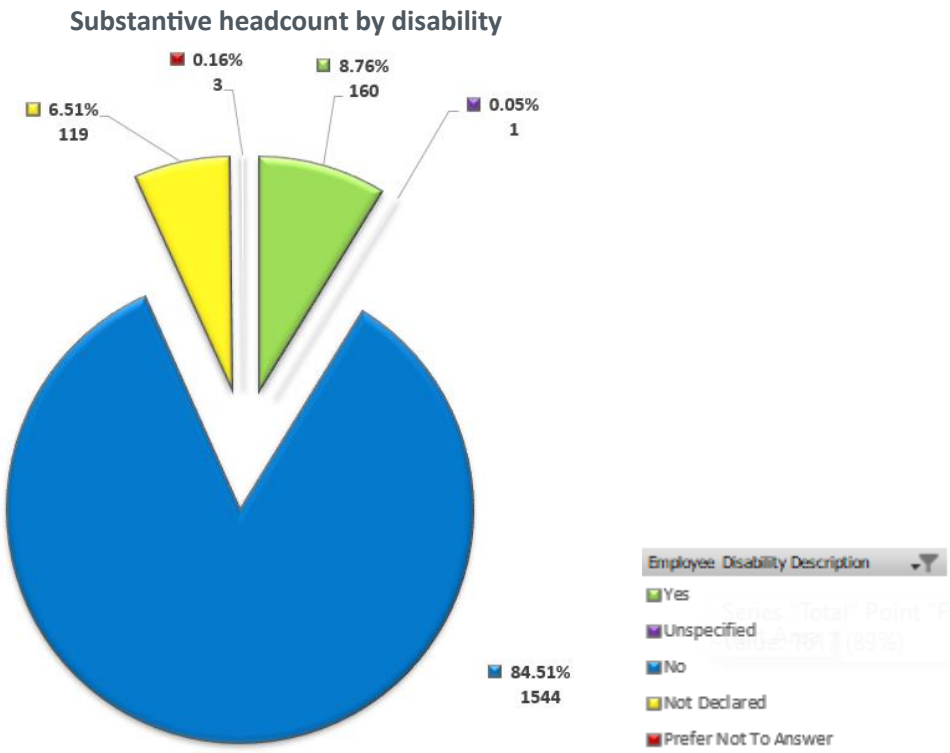
Workforce diversity

This information has been generated from our Electronic Staff Record (ESR) system and shows data as of 31 March 2025.

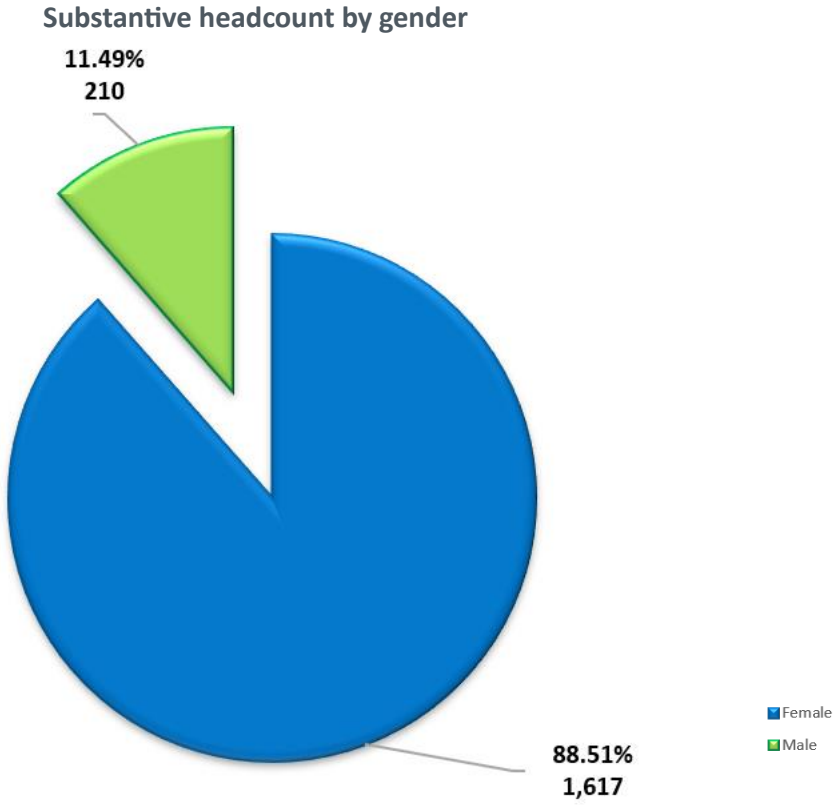




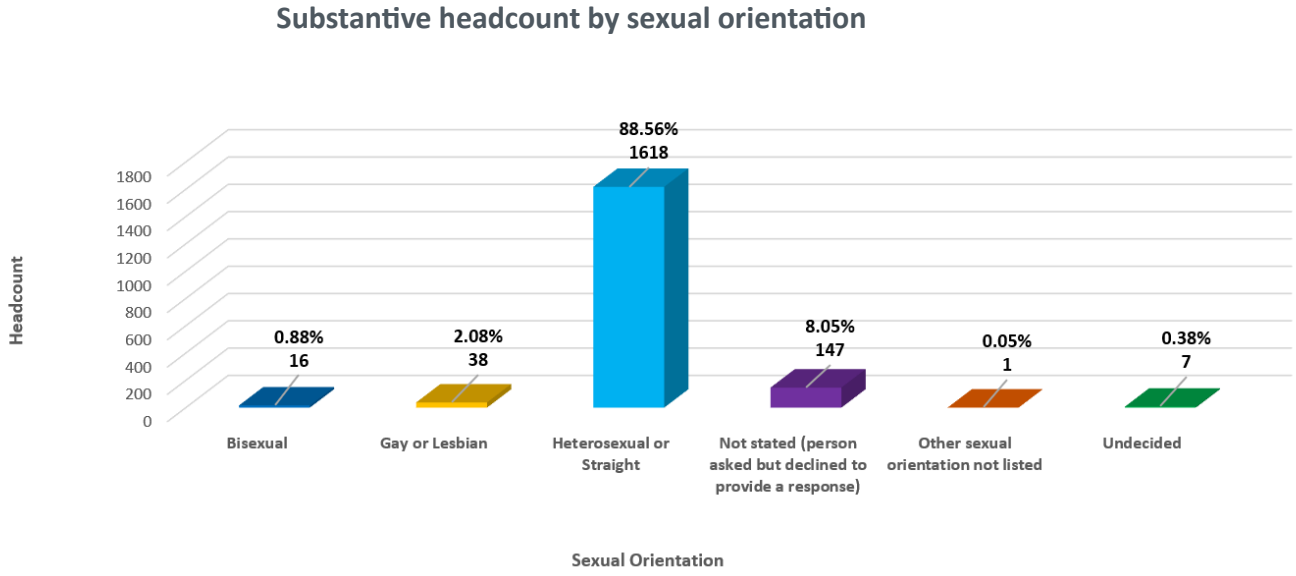
BAME staff increased from 4.4% March 2024 to 5.26% in March 2025.



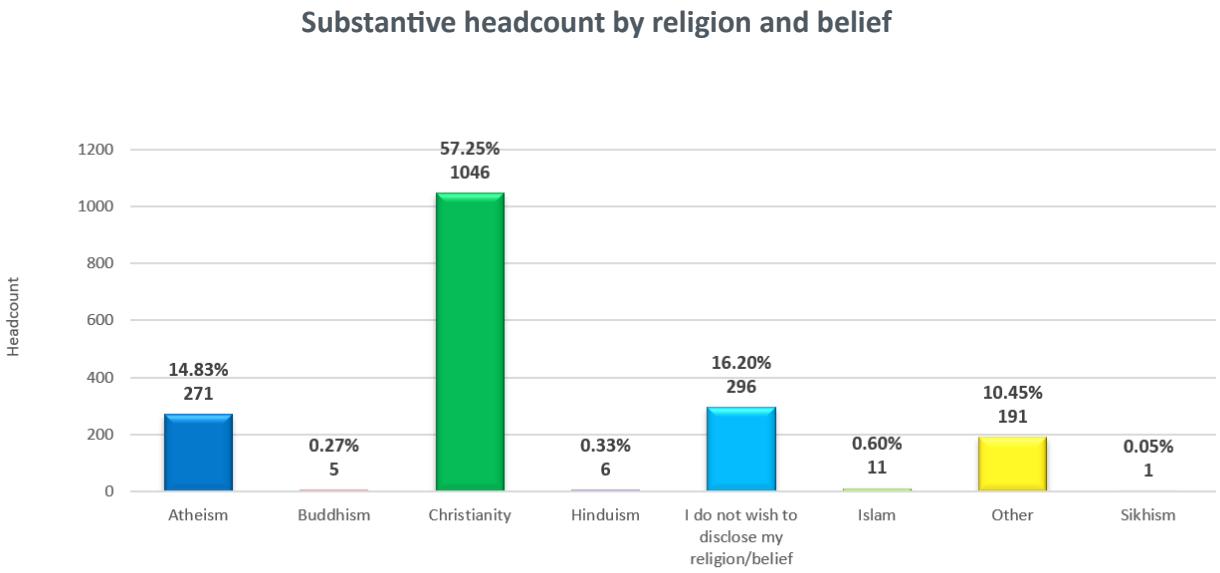
Declaration rates have improved from 7.26% in March 2023 to 8.76% in March 2024.
This compares to a Wirral figure for Disabled (under Equality Act) of 22.2%.



This has not changed from March 2023 to March 2024. This compares to Wirral 51.6% Female. Trans/non-binary status is not recordable in ESR.



This has not significantly changed since March 2024 and this compares to Wirral 90.65% straight/heterosexual.



The measure for Christianity for the Trust has not significantly changed from March 2024 and is at 57.25% which compares to a Wirral Population figure of 55.0%. Staff with the religion and belief of Islam / Muslim is 0.33% compared to the Wirral 1.00% and has gone up by 0.05% from 2024.

Disciplinary cases

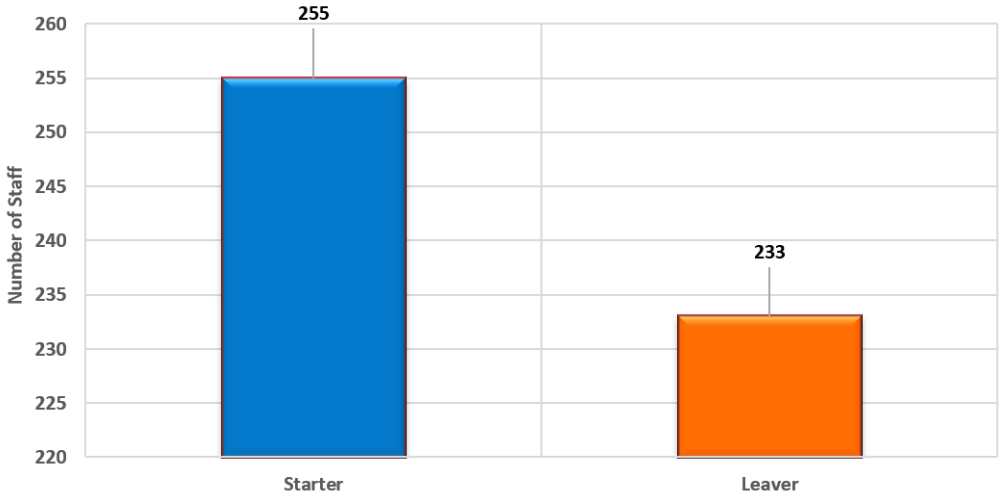
Closed Cases 2024/25	Ethnicity	Sex	Disability
17 in total	16 white British	14 female	4 disabled
	1 BAME	3 male	11 not disabled

			2 not stated
Patient related: 5 out of 17 cases patient related incidents			

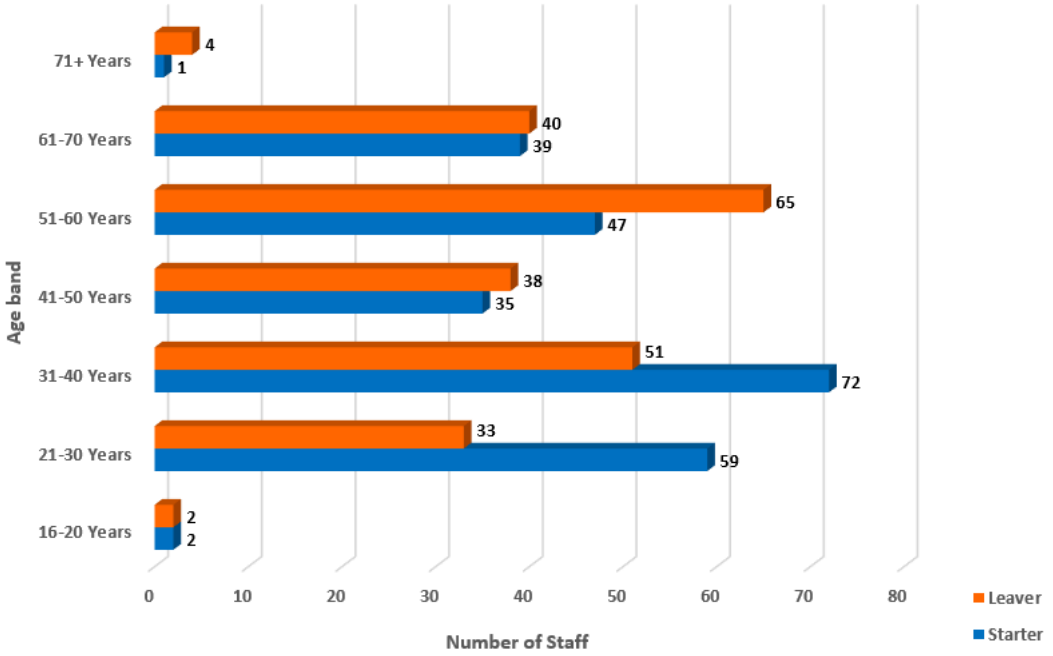
Starters and leavers

The following graphs tells you a bit more about the make-up and profile of new starters in the organisation and those that have left the organisation, by protected characteristic.

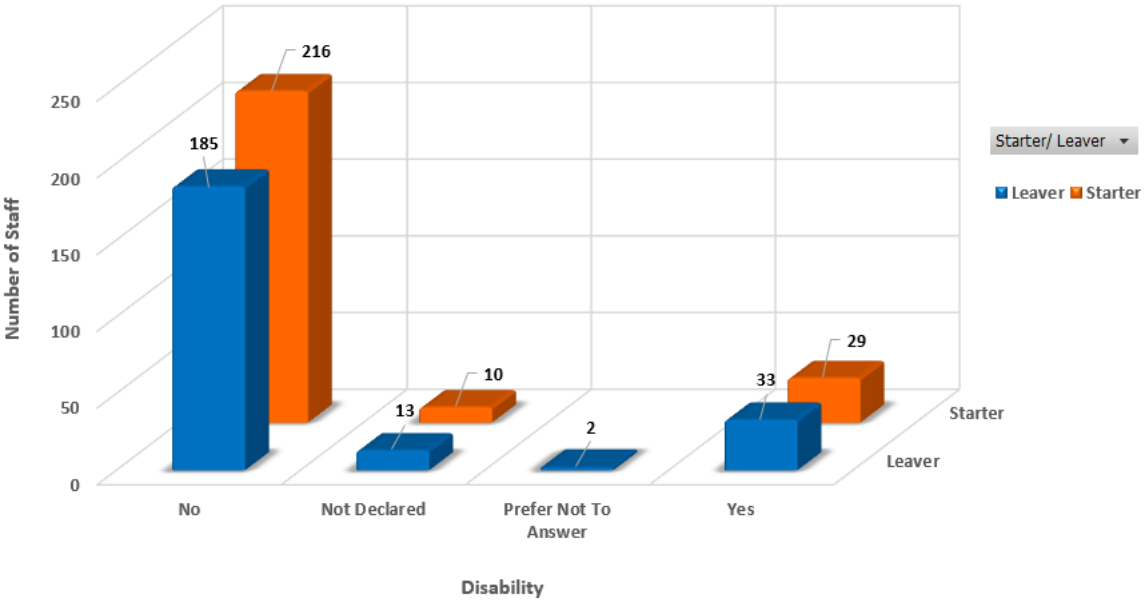
Substantive total of starters and leavers



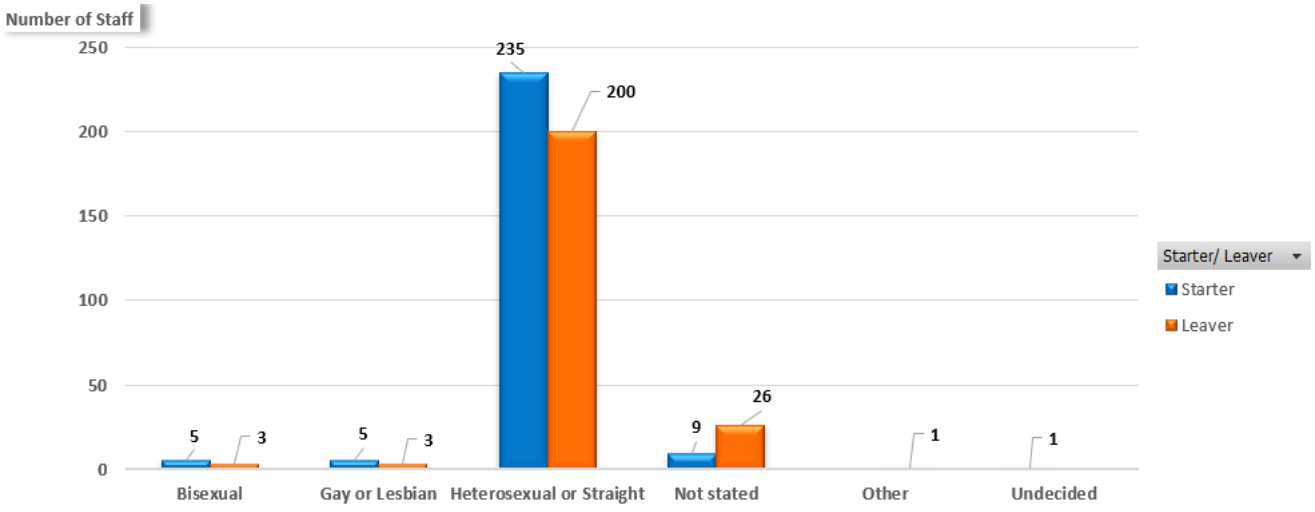
Substantive total of leavers and starters by age

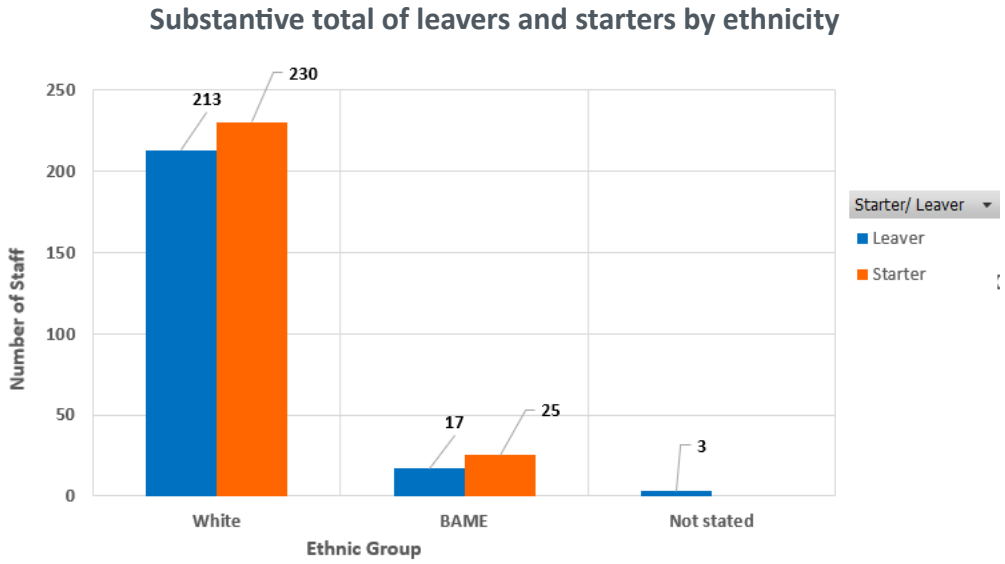


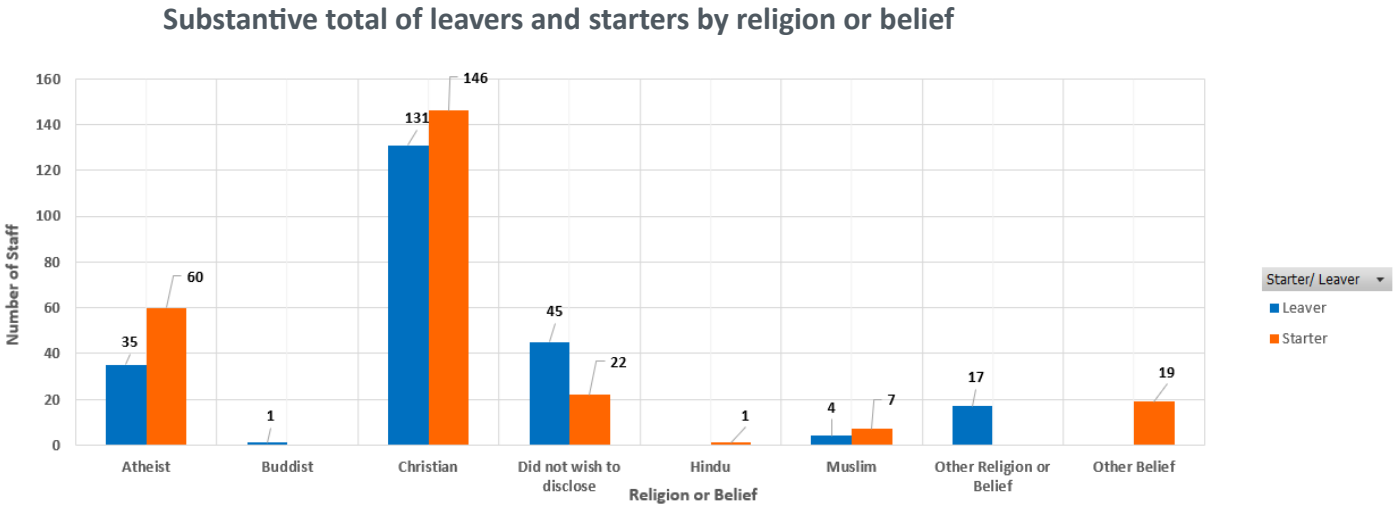
Substantive total of starters and starters by disability

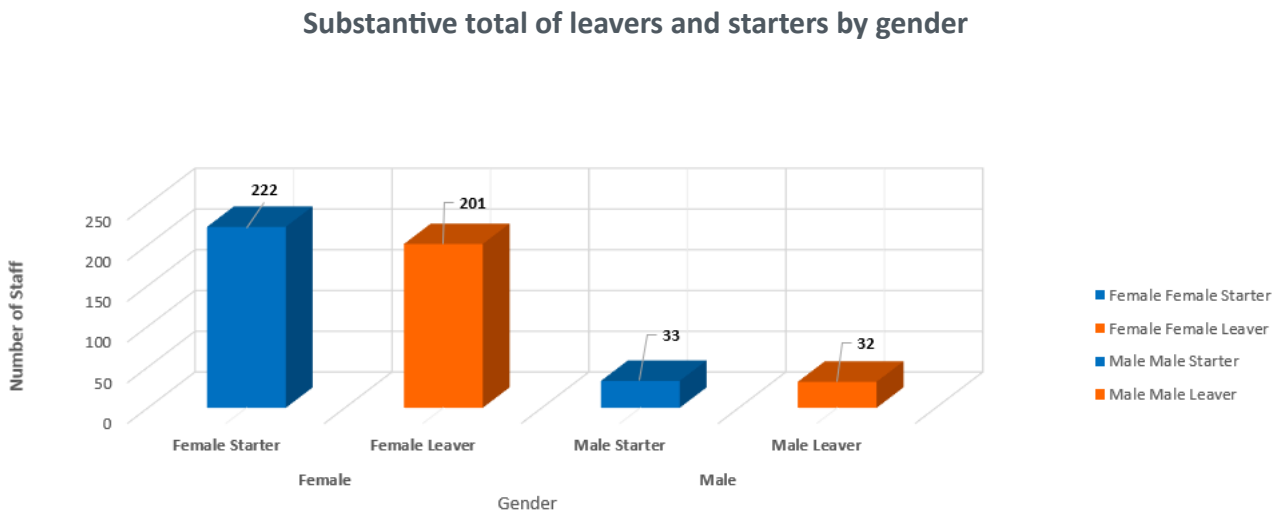


Substantive total of leavers and starters by sexual orientation


Number of Staff
250
200
150
100
50
0
235
200
5
3
5
3
9
26
1
1
Bisexual
Gay or Lesbian
Heterosexual or Straight
Not stated
Other
Undecided
Starter/ Leaver
Starter
Leaver


Substantive total of leavers and starters by ethnicity
250
200
150
100
50
0
Number of Staff
213
230
17
25
3
White
BAME
Not stated
Ethnic Group
Starter/ Leaver
Leaver
Starter


Substantive total of leavers and starters by religion or belief
160
140
120
100
80
60
40
20
0
Number of Staff
35
60
1
131
146
45
22
1
4
7
17
19
Atheist
Buddist
Christian
Did not wish to disclose
Hindu
Muslim
Other Religion or Belief
Other Belief
Religion or Belief
Starter/ Leaver
Leaver
Starter



Recruitment - positive action

During 2024/25 the Trust continued to support positive action in relation to increasing diversity through its inclusive recruitment programmes.

For disabled applicants we continue to maintain our accreditation with the Disability Confident Scheme at Employer level status.

For those applicants who state they meet the Armed Forces status when applying for roles will have guaranteed interview scheme implemented if they meet the essential criteria for roles and this resulted in 16 applicants being offered interviews.

We continued to use positive action to increase the number of BME staff within the Trust and for senior roles which are Band 8a and above applicants have the guaranteed interview scheme implemented if they meet the essential criteria for roles and this resulted in 13 applicants being offered interviews.

Section 5

Assurance and compliance against Statutory duties

Inclusion
Getting it right for everyone

Equality Delivery System

The Equality Delivery System (EDS2022) is designed to support local and regional NHS organisations to help them fully develop inclusive services in response to the NHS Long Term Plan.

In 2024/25 we implemented the third version (EDS2022) of the EDS and did this jointly with Wirral University Teaching Hospitals NHS Foundation Trust focussing on the experience of Learning Disability patients for Domain 1.

The EDS process was undertaken alongside local and place-based partnerships of NHS and local authority commissioners, providers and others; and ultimately Integrated Care Systems (ICSs).

EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

The EDS assists organisations in looking at the physical impact of discrimination, stress and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes across three Domains:

1. Commissioned or provided services.
2. Workforce health and wellbeing.
3. Inclusive leadership.

Services examined this year for Domain 1 were:

- Community Dental services

The Trust was rated **'Achieving'** across all three domains. The framework can be seen in full at NHS England/Equality Delivery System 2023.

Improvement actions identified are incorporated into Trust-wide delivery plans and service improvement plans for 2025/26.

The full report and the accessible summary report are available here.

Workforce Race Equality Standard (WRES)

The annual report and action plan were completed with involvement from the BAME Staff Network.

The data was submitted to the national team in May 2025 and, in line with requirements, will be published on the external website in October 2025.

9 indicators - based on data from the annual national NHS Staff Survey and % BME staff in the Trust using ESR, disciplinaries, applications and appointed staff and board membership.

Based on WRES data for 2024/25 key actions were identified as:

- improve the awareness of issues faced by BME staff
- to support the BAME staff network and new co-chairs

- Deliver education and training sessions on disability and neurodiversity
- Celebrate and promote inclusion events to enhance understanding and support for staff

Workforce Disability Equality Standard (WDES)

The annual report and action plan were completed with involvement from the Ability Staff Network.

The data was submitted to the national team in May 2025 and, in line with requirements, will be published on the external website in October 2025.

10 indicators - based on data from the annual national NHS Staff Survey and % disabled staff in the Trust using ESR, capability, applications and appointed staff and board membership.

Based on WDES data for 2024/25 key actions were identified as:

- To seek to understand the issues faced by disabled and neurodiverse staff
- Support the promotion the awareness and utilisation of reasonable adjustments

- Deliver education and training sessions on disability and neurodiversity
- Celebrate and promote inclusion events to enhance understanding and support for staff

Gender Pay Gap

Gender Pay Gap is a measure of the average difference between how much men and women are paid in an organisation.

We must find and compare:

- the average difference between men and women's hourly and bonus pay
- the percentage of men and women in the highest, middle and lowest pay groups in the organisation

All companies, including NHS organisations, with more than 250 employees have to declare their gender pay gap data which needs to be published within 1 year of the data.

The results for 2024/25 (31st March 2024) for the mean average hourly rate demonstrate a pay gap of 8.59%. The second measure is the median difference with a 0.56% gap, a slight increase compared to 2023.

Download the full Gender Pay Gap Report in our Publications.

Race Pay Gap

Race Pay Gap is a measure of the average difference between how much staff from different ethnic backgrounds are paid in an organisation.

We must find and compare:

- the average difference between staff from a BME background and white staff hourly and bonus pay
- the percentage of BME and white staff in the highest, middle and lowest pay groups in the organisation

This is now a requirement as part of the NHS England Equality, Diversity and Inclusion Improvement Plan and this is the second year the Trust has undertaken a Race Pay Gap analysis. The report is not yet available but will be published on the Trust website.

Section 6

Inclusion Priorities 2024/25

Inclusion
Getting it right for everyone

Our priorities

The following priorities have been identified for 2024/25 from our People Strategy, our Quality Strategy and our Inclusion and Health Inequalities Strategy and their delivery plans.

- Continue our work around Carers and work with Wirral Carer Alliance to pilot their Carers Standards Framework within a Community Nursing Team
- Continue our roll out of the Oliver McGowan Mandatory Training on Learning Disability and Autism level 2 training, prioritising our service who see most people with Learning Disability or Autism with an aim to achieve our 90% target of Eligible staff by the 31/03/2027
- Continue to develop better ways to collect and manage data about protected characteristics, disabilities or impairments and reasonable adjustments, ensuring compliance with the Accessible Information Standard (AIS) and sharing practices with the hospital trust
- We will further develop and evaluate our approach to waiting list management and prioritising those at risk of experiencing health inequalities across all of our services as business as usual
- We will continue to work with our providers and other key stakeholders including the hospital trusts and members of the communities we are supporting, to improve our Interpretation and Translation service helping to remove barriers for those who don't have English as a first language or have sensory impairments.

- Continue our work with those from Black, Asian and minority ethnic communities via Wirral Multicultural Organsiation and Wirral Change alongside our partners at the hospital trust to better understand and improve their access, experience and outcomes of our services
- Develop and launch cultural awareness training for managers and staff, utilising the behavioural standards framework and including reference to the importance of allyship and the identification of different examples of discrimination
- We will demonstrate our commitment to becoming and Anti-racist organisation by developing and launching our Anti-racism statement and implementing the North West BAME Assembly Anti-racism framework and achieve the bronze status by 31.12.25

Inclusion
Getting it right for everyone

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item 30**

05 November 2025

Title	Wirral Provider Alliance MoU and Terms of Reference
Area Leads	Ali Hughes, Joint Interim Director of Corporate Affairs
Author	Ali Hughes, Joint Interim Director of Corporate Affairs
Report for	Approval

Executive Summary and Report Recommendations

The attached Memorandum of Understanding and Terms of Reference for the Wirral Provider Alliance has been developed and is shared for members review, comment and approval.

A Memorandum of Understanding is a common arrangement in early-stage collaboratives.

All parties will remain separate legal entities with their own accountabilities and responsibilities.

The WPA will facilitate work against each of the identified priority programmes of work, as described in the Terms of Reference.

It is recommended that the WUTH Board:

- Receives and approves the attached Memorandum of Understanding for the Wirral Provider Alliance, noting that it will be reviewed annually and amended when required with mutual consent.
- Notes the draft Terms of Reference for the Wirral Provider Alliance which are subject to further review by the WPA.

It is recommended that the WCHC Board:

- Receives and approves the attached Memorandum of Understanding for the Wirral Provider Alliance, noting that it will be reviewed annually and amended when required with mutual consent.
- Notes the draft Terms of Reference for the Wirral Provider Alliance which are subject to further review by the WPA

Key Risks

This report relates to the key risks of:

- 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.

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

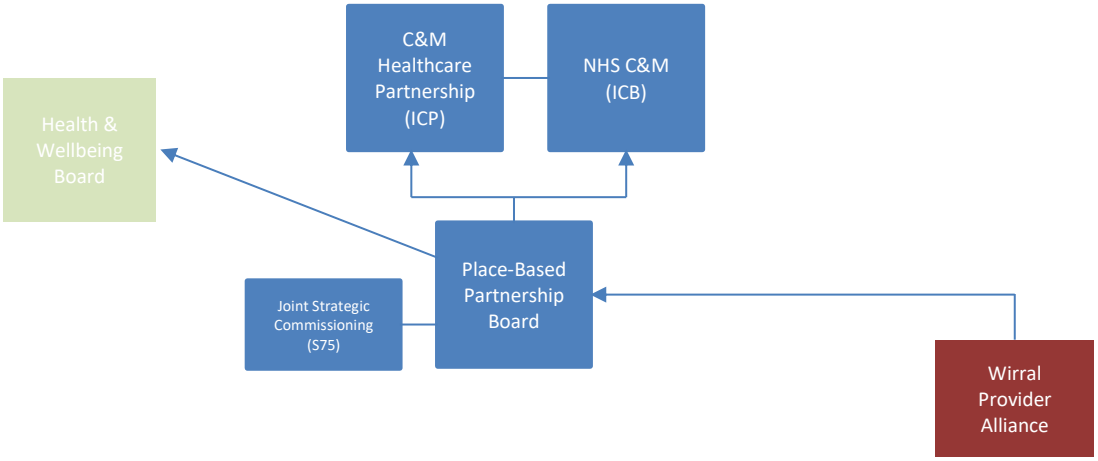
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives	
Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	Yes
People	Choose an item.
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Yes
Make most efficient use of resources to ensure value for money	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	**Background** • In March 2024, the Cheshire and Merseyside Integrated Care Board (C&M ICB) commissioned an independent review to explore collaboration and integration opportunities across NHS provider services in Wirral, focusing on Wirral University Teaching Hospital (WUTH), Wirral Community Health and Care NHS Foundation Trust (WCHC), and system partners. This review, carried out by Value Circle, aimed to deliver recommendations for enhancing clinical, operational, and financial integration while aligning with strategic priorities for the Wirral system. • Some of the key findings included: Opportunities for Integration: While the system recognises opportunities for improving service delivery and productivity, proactive action has been limited, particularly beyond aspects of urgent care. • Inconsistent Relationships: Relationships between primary care, WCHC, WUTH, and Wirral Council are inconsistent, with challenges in balancing organisational sovereignty and broader collaboration. • Role of ICB and Place Teams: The ICB and Place Teams are essential for driving collaboration and addressing governance challenges across the system.

	• One of the recommendations of the review was regarding Place-Based Governance to review and refine governance arrangements to prevent duplication, ensure appropriate delegations, and align with place-based care priorities. • Following this review, system leads have recognised the need to establish a Wirral Provider Alliance which incorporates a collective of health and care providers, that convert the Place-based Partnership strategic intent into coordinated delivery. • Provider collaboratives are a key component of system working, being one way in which providers work together to plan, deliver and transform services • By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities • Significant scope to deliver these benefits exists within current legislation and new options for trusts to make joint decisions as amended in the Health & Care Act 2022.
1.2	**Governance documents - Memorandum of Understanding** • The DRAFT MoU aims to set out the vision, the principles that will guide how all partners across Wirral will work together. • The purpose of the MoU is to establish a good-faith foundation between the Parties for future collaborative efforts that are mutually beneficial and provide benefit and impact to the population of Wirral. • The MOU does not obligate the Parties to provide funds or payment, nor does it bind Parties to any legal obligations but rather sets out the principles to be adopted to support the statutory organisations working more collaboratively where there is joint benefit in doing so.
1.3	**Governance documents - Terms of Reference** • The Terms of Reference relate to the Programme Board which it is proposed is established as part of the Wirral Provider Alliance. • Any further groups established (e.g., to lead specific programmes of work) will have Terms of Reference and will report into the Programme Board

1.4	**Place Governance** • Work has previously been carried out between partners to consider the most effective manner to govern Place arrangements for the Wirral. Particular focus has been given to the need to avoid unnecessary duplication of decision making and to ensure that the most appropriate delegations are in place and agreed by partners to ensure the best outcomes for patients and the communities we serve. • Following the outcome of the Wirral Review further work has been carried out to consider refreshed governance structures to complement the outcomes of that review • In light of these requirements the new proposed structure is outlined below  • An update was provided to the Place-Based Partnership Board in July 2025 with a further update agreed following the inaugural meeting of the WPA and agreement of the Programme Board ToRs.
1.5	**Inaugural Meeting of the Wirral Provider Alliance** • At the inaugural meeting of the WPA on 6 October 2025 in principle no objections were raised to the MoU. It was agreed that members would take the document through their organisations' governance processes for discussion and approval and return a signed copy by 17 November 2025. • The WPA approved the Terms of Reference subject to revision of the membership table in relation to voting. • The Wirral Provider Alliance supported a rotation of the Chair and Deputy Chair at 6 months and as agreed, Expressions of Interest from all eligible parties have been invited.

2	**Implications**
2.1	**Patients** A key principle of the WPA will be to place patients and communities' interests first.
2.2	**People**

	No immediate implications.
2.3	**Finance** No immediate implications.
2.4	**Compliance** • One of the key recommendations of the Wirral System Review was regarding Place-Based Governance to review and refine governance arrangements to prevent duplication, ensure appropriate delegations, and align with place-based care priorities.

Wirral Provider Alliance (WPA) Programme Board

DRAFT Terms of Reference v2.0

Purpose

To promote effective partnership working at Place across NHS bodies and other statutory and non-statutory provider organisations to ensure the strategic intent determined by the Health & Wellbeing Board, and agreed by the Place Based Partnership Board is implemented effectively and efficiently with due regard for population health to ensure the equitable provision of services to the community, financial stewardship and safety, whilst also supporting transformation and innovation to drive appropriate change at Place.

The WPA will integrate existing programmes delivered at Place. These programmes ensure continuity, enhance system-wide collaboration and improve service efficiency and are structured into three key categories;

- Guiding programmes - providing strategic direction and ensuring services align with local population needs
- Delivery programmes - focus on core provider service areas, driving improvements in efficiency and quality of care
- Enabling programmes - offer essential infrastructure, workforce and operational support to sustain service delivery

Status and Authority

The WPA is established by the Wirral Place Based Partnership Board (PBPB) and led (or delivered) by the provider organisations at Place, each of which remains a sovereign organisation, to provide a governance framework for the further development of joint working in line with the core principles agreed with system providers that align to the Wirral Plan, and in order to support the development and delivery of integrated care for the Wirral (see below).

The WPA is not a separate legal entity, and as such is unable to take decisions separately from the provider organisations or bind any one of them; nor can one provider organisation 'overrule' the other on any matter. As a result, the WPA will operate as a place for discussion of issues with the aim of reaching consensus between the Parties in line with the principles.

The WPA will function through engagement and discussion between its members so that each Party makes a decision in respect of, and expresses its views about, each matter considered by the WPA. The decisions of the WPA will, therefore, be the decisions of the individual Party, the mechanism for which shall be authority delegated by the individual Parties to their representatives on the WPA Programme Board.

The Parties will delegate to their representative(s) on the WPA Programme Board such authority as is agreed to be necessary in order for it to function effectively in

discharging its responsibilities in these Terms of Reference. The Parties will ensure that each of their representatives has equivalent delegated authority, which is in writing, agreed between the Parties and recognised to the extent necessary in their respective Schemes of Delegation (or similar) or through the approval or their respective Boards of Directors (where applicable).

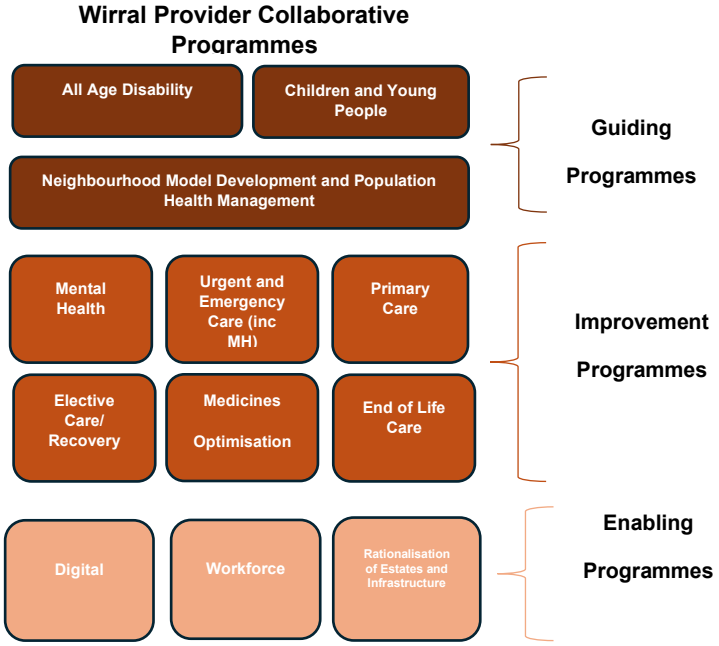
The Parties will ensure that their members understand the status of the WPA and the limits of the authority delegated to them.

Accountability

The WPA Programme Board will focus on the following strategic priorities to ensure effective integration and system-wide improvements:

- Promoting integration of health and care services through alignment of partner strategies and funding priorities.
- Ensuring robust governance and quality of care processes are embedded in delivery, aligning with CQC 'Well Led' and system oversight regulation.
- Formal reporting to the Place-Based Partnership Board on progress against agreed metrics.
- Establishing robust systems and processes for the negotiation and management of contract and financial performance.
- Making recommendations to partner Boards regarding risk and gain share, as well as reinvestment decisions.
- Formal reporting to partner Boards on progress against agreed metrics.

The figure below provides a structure to each of the programmes.



Responsibility

The WPA Programme Board is responsible for leading the Parties' joint working in accordance with the Scope, Purpose and Objectives and in line with the terms of an agreed Memorandum of Understanding.

The WPA Programme Board members will make decisions together at meetings in respect of the Scope and Purpose of the partnership, including in relation to recommendations from the PBPB.

When making decisions together at Programme Board meetings, the members will act in line with the principles and their respective obligations under the MoU.

Membership

	Nominated Representative (Role/Title)	Organisation
1	Joint CEO	Wirral University Teaching Hospital and Wirral Community Health and Care
1	CEO	Cheshire and Wirral Partnership NHS Foundation Trust
1	CEO*	Wirral Borough Council
2	Chair GP-Lead	Wirral Primary Care Collaborative Ltd
1	Chair	Wirral Primary Care Council
1	TBC *via nomination process*	Wirral CVS
1	CEO	Wirral Hospice St John's
1	CEO	Clatterbridge Cancer Centre
	• The Place Director, NHS Cheshire & Merseyside will be invited to attend meetings • Key programme leads (e.g. Programme Delivery Unit) will be in attendance as required	

**CEO to nominate a representative from Wirral Borough Council (e.g. Director of Adult Social Services or Director of Public Health)*

In the absence of a member, a nominated deputy may attend with the agreement of the Chair and will be formally nominated with the same rights, privileges and accountabilities.

Administrative support will be provided to the meetings of the WPA Programme Board to ensure accurate recording of any decisions and actions.

In Attendance

The following non-voting members will attend WPA meetings:

- a Director of Corporate Affairs from one of the provider organisations.
- a minute-taker from one of the provider organisations.

- The WPA may invite others to attend meetings as observers. Such observers will not participate in decisions.

Quorum

The Programme Board will be quorate if at least half of the members (or nominated deputies) are present one of whom shall be the Chair or the Deputy Chair. A member shall be deemed present if they are physically at the meeting or joining the meeting by telephone or video conference

Chair and Deputy Chair

The Chair and Deputy Chair shall be selected on a rotational basis (annually) from all Parties.

The Chair and Deputy Chair may choose to change roles at the mid-year point to allowing leadership and succession from across the membership.

Decision Making

The WPA will aim to achieve consensus wherever possible.

Each member of the Programme Board will be representing their organisation and presently will only make decisions at the Programme Board in respect of their own organisation in accordance with any delegated authority.

Reporting Groups

The Programme Board will establish sub-groups as required to deliver agreed programmes of work, which will report progress to the programme board.

Conduct of Business

The Programme Board will meet monthly, with a minimum of 10 meetings annually.

Any member may call extraordinary meetings of the WPA at their discretion subject to providing at least five working days' notice to the WPA members (via the Chair).

Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting.

In the event members wish to add an item to the agenda they must notify the Director of Corporate Affairs who will confirm this with the Chair and other members accordingly.

The Programme Board will have administrative support agreed between Parties to:

- take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and
- maintain a register of interests of Programme Board members.

The minutes of Programme Board meetings will be sent to members within 14 days of each meeting. It will be the members' responsibility to disseminate minutes and notes inside their respective organisations according to agreed governance arrangements.

Conflicts of interest

The members of the WPA must refrain from actions that are likely to create any actual or perceived conflicts of interests.

WPA members must declare all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

If there is any conflict between these terms of reference and the MoU, the latter will prevail.

Administrative Arrangements

The Director of Corporate Affairs will allocate appropriate administrative support to ensure:

- The WPA receives sufficient resources to undertake its duties.
- Timely and accurate minutes of meetings are taken and once agreed by the Chair are distributed to the members for internal reporting purposes.
- A summary of the meetings is reported to the next meeting of the Place Based Partnership Board.
- An action list is produced following each meeting and any outstanding action is carried forward on the action list until complete.
- Conflicts of interest are recorded along with the arrangements for managing those conflicts.
- Appropriate support to the Chair and WPA members to enable them to fulfil their role.
- Advice is provided to the WPA on pertinent areas of governance and meeting etiquette.
- The agenda is agreed with the Chair prior to sending papers to members no later than five working days before the meeting (taking into account any annual cycle of business).
- The papers of the WPA are filed in accordance with appropriate policies and procedures.

Review

These terms of reference will be reviewed on an annual basis, in line with the review of the MoU.

Memorandum of Understanding

For Wirral Provider Alliance

This Memorandum of Understanding (MoU) is made and entered into on this [date] by and among the following organisations (hereafter referred to collectively as the 'Parties')

(1) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

(2) WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST

(3) CHESHIRE & WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

(4) CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

(5) WIRRAL PRIMARY CARE COLLABORATIVE LTD

(6) WIRRAL LOCAL REPRESENTATIVE COMMITTEE (LRC)

(7) WIRRAL BOROUGH COUNCIL

(8) WIRRAL CVS

(9) WIRRAL HOSPICE ST JOHN'S

1 INTRODUCTION AND BACKGROUND

1.1 In March 2024, the Cheshire and Merseyside Integrated Care Board (**C&M ICB**) commissioned an independent review to explore collaboration and integration opportunities across NHS provider services in Wirral, focusing on Wirral University Teaching Hospital NHS Foundation Trust (**WUTH**), Wirral Community Health and Care NHS Foundation Trust (**WCHC**), and system partners. This review, carried out by The Value Circle, aimed to deliver recommendations for enhancing clinical, operational, and financial integration while aligning with strategic priorities for the Wirral system.

1.2 Some of the key findings include:

- Opportunities for Integration: While the system recognises opportunities for improving service delivery and productivity, proactive action has been limited, particularly beyond aspects of urgent care.
- Inconsistent Relationships: Relationships between primary care, WCHC, WUTH, and Wirral Council are inconsistent, with challenges in balancing organisational sovereignty and broader collaboration
- Role of C&M ICB and Place Teams: The C&M ICB and Place Teams are essential for driving collaboration and addressing governance challenges across the system.

1.3 One of the recommendations of the review was regarding Place-Based Governance to review and refine governance arrangements to prevent duplication, ensure appropriate delegations, and align with place-based care priorities.

1.4 Following this review, system leads have recognised the need to establish a **Wirral Provider Alliance (WPA)**, which includes a collective of health and care providers, that convert the Place-Based Partnership strategic intent into coordinated delivery through the delivery of several guiding, delivery and enabling programmes.

2 PURPOSE

2.1 The purpose of this MoU is to establish a framework for cooperation between the Parties to form the WPA.

2.2 The WPA will promote effective partnership working at Place across NHS bodies and other statutory and non-statutory organisations whilst maintaining each Party's autonomy and statutory responsibilities.

2.3 This MoU is not legally binding, but the Parties enter into this MoU with the approval of their boards and intending to honour all their obligations to each other.

3 OBJECTIVES

3.1 The Parties agree to work together to achieve the following objectives:

3.1.1 Deliver integrated and person-centred services;

3.1.2 Share best practice and innovation;

3.1.3 Reduce duplication and improve the use of resources at Place;

3.1.4 Promote equity and reduce inequalities in access and outcomes; and

3.1.5 Meet national and regional healthcare priorities and mandates.

4 STRATEGIC PRIORITIES

4.1 The WPA Programme Board will focus on the following strategic priorities to ensure effective integration and system-wide improvements;

- Promoting integration of health and care services through alignment of partner strategies and funding priorities.
- Ensuring robust governance and quality of care processes are embedded in delivery, aligning with CQC 'Well Led' and system oversight regulation.
- Formal reporting to the Place-Based Partnership Board on progress against agreed metrics.
- Establishing robust systems and processes for the negotiation and management of contract and financial performance.
- Making recommendations to partner Boards regarding risk and gain share, as well as reinvestment decisions.
- Formal reporting to partner Boards on progress against agreed metrics.

5 PRINCIPLES OF COLLABORATION / RULES OF WORKING

5.1 The Parties agree to:

5.1.1 Work together in the spirit of trust, openness and mutual respect;

5.1.2 Put patients and communities' interests first;

5.1.3 Have regard to staff and consider workforce in all that we do;

5.1.4 Support each other to deliver shared and system objectives;

5.1.5 Air challenges to collective approach / direction within the collaborative openly and proactively seek solutions

5.1.6 Recognise and respect the collective view and keep to any agreements made between the Parties

5.1.7 Respect the statutory duties, governance and accountability structures of each Party;

5.1.8 Maintain the WPA collective position on shared decisions in all relevant communications;

5.1.9 Consider the wider system impact and perspective and discuss proposals before any unilateral action which may impact other Parties

5.1.10 Be accountable – take on, manage and account to each other on respective roles and responsibilities

5.1.11 Share relevant data and information responsibly; and

5.1.12 Appropriately engage with the ICB, NHSE and others.

6 GOVERNANCE AND STRUCTURE

6.1 The WPA is established by the Wirral Place Based Partnership Board (PBPB) and led (or delivered) by the provider organisations at Place

6.2 The WPA Programme Board will be established in accordance with the Terms of Reference set out in Appendix 1.

6.3 The WPA Programme Board Terms of Reference set out its purpose, authority, accountability and responsibility and its membership.

6.4 Subject to complying with all applicable law and the Parties unanimous agreement, other parties may become parties to this MoU on such terms as the Parties shall unanimously agree.

6.5 The WPA Programme Board will meet monthly and be responsible for;

6.5.1 Monitoring delivery against the identified programmes at Place; and

6.5.2 Risk management (in relation to the above).

6.6 The Parties have identified that a preferred model for collaboration is to establish governance arrangements that, so far as possible within the legislation, enables 'group' and common decision-making structures.

As set out in the Terms of Reference, decision-making will be based on consensus.

7 ROLES AND RESPONSIBILITIES

7.1 Each member will;

7.1.1 Contribute to shared objectives and programmes of work;

7.1.2 Allocate appropriate operational resources to deliver agreed objectives

7.1.3 Participate in programme measurement and evaluation;

7.1.4 Act only in accordance with any authority delegated to them by each Party; and

7.1.5 Declare any conflicts of interest relevant to the programme of work to be delivered by the WPA.

8 DATA SHARING AND CONFIDENTIALITY

8.1 This MoU is not legally binding and therefore currently unenforceable. If confidential information and personal data is to be shared between the parties a separate legally binding agreement will be agreed to cover such sharing.

9 DURATION AND REVIEW

9.1 This MoU shall remain in effect for two (2) years, commencing from the date of the last signature below (**date**).

9.2 This MoU may be reviewed annually and amended with mutual consent.

10 VARIATION

10.1 This MoU may only be varied by the written agreement of the Parties.

11 CONFLICTS OF INTEREST

11.1 Each Party shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made will be taken and seen to be taken without being unduly influenced by external or private interest and do not affect the integrity of the WPA Programme Boards' decision-making processes.

11.2 In respect of conflicts of interest, if there is any conflict between this MoU and the Terms of Reference, the MoU will take precedence.

12 NON-BINDING AGREEMENT

12.1 This MoU is not legally binding and does not create any legal obligations or liabilities. It reflects the good faith intentions of the Parties.

13. TERMINATION

13.1 The Parties acknowledge and confirm that none of them shall be entitled to terminate this MoU during the first twelve (12) months from the Commencement Date.

13.2 Following the first anniversary of the Commencement Date, a Party may only terminate this MoU by giving written notice of at least three (3) months, that expires on the 31 March.

13.3 The Parties may agree in writing to abridge or otherwise vary the notice period under Clause 12.2 in accordance with the variation process set out in Clause 9.

SIGNATORIES

Signed on behalf of;

Wirral Community Health & Care NHS Foundation Trust

Name

Title

Signature

Date

Wirral University Teaching Hospital NHS Foundation Trust

Name

Title

Signature

Date

Cheshire & Wirral Partnership NHS Foundation Trust

Name

Title

Signature

Date

Clatterbridge Cancer Centre NHS Foundation Trust

Name

Title

Signature

Date

Wirral Primary Care Collaborative Ltd

Name

Title

Signature

Date

Local Representative Committee

Name

Title

Signature

Date

Wirral Borough Council

Name

Title

Signature

Date

Wirral CVS

Name

Title

Signature

Date

Wirral Hospice St John's

Name

Title

Signature

Date

APPENDIX 1 - WIRRAL PROVIDER COLLABORATIVE PROGRAMME BOARD TERMS OF REFERENCE

[To be included following approval]

APPENDIX 2 - SCHEDULE OF DEFINED TERMS

Provider Collaborative	the body established by each of the Trusts to work alongside the committees established by all partners shall be interpreted accordingly
Place Teams	The Wirral ICB Team
Place-Based Governance	The governance arrangements supporting the Wirral Place
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the Member nominated (from time to time) in accordance with the Terms of Reference, to preside over and run the meeting
Member	a person nominated as a member of the provide Collaborative in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Partners	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CHESHIRE & WIRRAL PARTNERSHIP NHS FOUNDATION TRUST CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST WIRRAL PRIMARY CARE COLLABORATIVE LTD LOCAL REPRESENTATIVE COMMITTEE (LRC) WIRRAL BOROUGH COUNCIL WIRRAL CVS ST JOHN'S HOSPICE

Board of Directors in Public **Item 31**
5 November 2025

Title	Board of Directors Terms of Reference
Area Lead	Ali Hughes, Interim Joint Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

This report presents amended Terms of Reference documents for both WUTH and WCHC Board, with specific provision for concurrent meetings in line with current arrangements.

It is recommended that the Boards:

- Approve their respective revised Terms of Reference.

Key Risks

This report relates to these key risks:

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

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

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	No
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
n/a

1	**Narrative**
1.1	The Boards of WUTH and WCHC began meeting at the same time in June 2025. The meetings share an agenda, but decisions and minutes are recorded separately to reflect the nature of the two statutory entities. The Boards have continued to meet concurrently, and will continue to do so for the immediate future. The Terms of Reference documents for both boards have therefore been amended to make specific provision for this, though it should be noted that further reviews of the Terms of Reference documents will be required as the integration continues. Both Boards' Terms of Reference are appended to this report.

2	**Implications**
2.1	**Patients** • No direct implications on patients.
2.2	**People** • No direct implications on workforce.
2.3	**Finance** • No financial implications arise from this report.
2.4	**Compliance** • The amended documents support both Trusts' compliance with their key governance documents.

Terms of Reference - Board of Directors

What is the aim of the Board?

To set the strategic direction for the Foundation Trust and to be responsible for shaping the culture, setting the values and ensuring the behaviour of the Board is consistent with those values whilst maintaining high standards of corporate governance
To drive the implementation of the Trust strategy ensuring the equitable allocation of resources whenever possible to address health inequalities and improve the health of our population
To operate in a manner which accords with agreed Board behaviours and the Nolan principles of public life
To lead on the promotion of observance by the Trust of the principles of Duty of Candour for healthcare providers
To promote commitment to equality diversity and human rights within an inclusive environment for both staff and service users

What is the purpose of the Board?

- Take corporate responsibility for all the Trust's activity
- Establish the organisation's strategic aims, taking into consideration annually the view of the Council of Governors
- Monitor progress in the achievement of strategic aims as set out in the board approved strategy for the Trust
- Monitor and review management performance to ensure objectives are met
- Ensure national policy and legislative requirements are effectively addressed and implemented (at place and system level)
- Provide leadership within a framework of prudent and effective controls, enabling risk to be assessed and managed
- Take responsibility for adding value to the organisation by promoting its success through the direction and supervision of its affairs
- Ensure an effective system of integrated governance, risk management and internal control across all clinical and corporate activities
- Ensure an effective communication channel between the Trust, Council of Governors, members, staff and the local community.

What is the operating framework for the Board?

Membership

Chair - *Chairman
Executive Lead - *Chief Executive

Voting Members:
Chair
4 x Non-Executive Directors
*Chief Executive
* Chief Finance Officer
* Medical Director
Chief Nurse

Non-Voting Members:
* Chief Operating Officer
Chief People Officer
Director of Corporate Affairs
Chief Strategy Officer
Chief Digital Information Officer

Other senior employees may be invited to attend according to specific agenda items. The Lead Governor will attend to present a regular report on the work of the Council of Governors.

NOTE: votes are always taken at Board. If a dispute arises at a committee, the decision is escalated to the board.

** To the extent filled by interim placements, the post holder assumes this position*

Quorate

One-third of the whole number of voting directors (including Chair or Deputy Chair) to be present including at least 1 Executive Director and 1 Non-Executive.

In the absence of the Chair, the Deputy Chair will take on the Chair's duties.
Members should attend at least three quarters of scheduled meetings annually.

Governance

- Ensure compliance with FT licence, the Trust constitution and all relevant legislative and regulatory requirements
- Receive reports from the sub-committees of the Board via regularly Chairs reports
- Receive updates on the work of the Executive Leadership Team, Staff Voice Forum, Professional Forum and the Council of Governors
- Support the work of the Council of Governors
- The Board of Directors is authorised by its Terms of Reference and at the discretion of the Chairman to conduct business via a process of 'e-governance'.

Standing agenda

- Journey of Care
- Staff Story
- Reports from Chair, Lead Governor and CEO.
- Reports from Board sub committees
- Integrated Performance Report
- Board Assurance Framework
- Invitation for public comments (by the Chair)
- Place/system updates from Place Based Partnership Board

NOTE: A schedule is in place for quarterly assurance reports and annual reports for approval

NOTE: Annually the Board will self-assess its performance and review its Terms of Reference.

Frequency

- ~~Bi-monthly~~
- ~~February, April, June, August, October, December.~~
- Meetings will be held in public, at the same time and in the same place as Wirral University Teaching Hospital. Minutes and decisions will be recorded separately.
- A private meeting will be held for any commercially sensitive matters.

Members and attendees shall abide by the following etiquette;

- **Presence** - colleagues are required to attend and contribute
- **Prepared** - colleagues must have read the papers and materials
- **Punctual** - attend in good time for the meeting to begin; and
- **Participate** - colleagues are required to engage in the discussion or debate and be prepared to challenge and be challenged, accepting differing perspectives and observing the Trust values of **Trust, Open and Compassion**

Compassion | Open | Trust

Reviewed October 2023
Reviewed October 2024
Reviewed October 2025

Appendix 1 - E-governance process

What is the purpose of the e-governance approval process?

In order to facilitate the Board of Directors undertaking the business required of it, there will on occasion be a need for this to be conducted outside of its scheduled meetings in circumstances where it would not be practical to convene a meeting 'in person'.

In such circumstances the Board of Directors is authorised by its Terms of Reference to conduct business via a process of 'e-governance'.

What are the rules to be observed?

- The business to be conducted must be set out in formal papers accompanied by the usual cover sheets which clearly set out the nature of the business to be conducted and the proposal which members are being asked to consider.
- The papers will be forwarded by the Director of Corporate Affairs or their nominated deputy via e-mail to all members of the Board of Directors who, subject to their availability, are expected to respond by e-mail to the same distribution list with their views within three working days of receipt of the papers.
- For the conclusion of the Board to be valid, responses must be received from a quorum (at least one third of the whole number of voting directors) of Board membership and in instances where the approval of the Board of Directors is sought; all such responses should support the proposal.
- In the event that there is not a unanimous agreement of all responding members, the proposal shall be considered not to be approved.
- The Director of Corporate Affairs or their nominated deputy will summarise the conclusions reached for the agreement of the Chair and this summary will be presented to the next scheduled meeting of the Board following which it will be appended to the minutes of that meeting.

Emergency powers and urgent decisions

The powers which the Board of Directors has reserved to itself within the Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. This is referred to as a Chair's Action

What are the rules to be observed?

The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for formal ratification.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Constitution** **Standing Orders** **Scheme of Reservations and Delegations**

Review Date: November 2025
Issue Date: September 2023
Version: 1.0
Authorisation Date: September 2024

1. Constitution

The Board of Directors is established to set the strategic direction of the Trust, to set and guide the delivery of the Trust's values, mission, and culture, and is responsible for the overall performance of the Trust. It is derived from NHS Act 2006 and as amended by the Health and Social Care Acts 2012 and 2022. This document should be read in conjunction with the Acts and the Trust Constitution.

2. Authority

The Board of Directors' authority is set out in the Trust Constitution and is derived from the legislation noted above.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Board within the scope of its authority.

The Board is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Board will establish Committees with delegated authority to carry out specific functions and may request that any item be considered first or further by a Committee.

3. Objectives and Duties

The general duty of the Board of Directors and of each Director individually is to act with a view to promoting the success of the Trust, so as to maximise the benefits for the members of the Trust and as a whole for the public.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy

- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation

The main duties of the Board of Directors, underpinning these three roles, are as follows:

- To set the strategic direction of the Trust within the overall policies both regionally and nationally, to define its annual and longer-term objectives, and to agree sufficiently resourced plans to achieve these
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy, and taking approvals in line with the Scheme of Reservation and Delegation.
- To ensure that high standards of corporate governance are implemented and maintained, to support compliance with its statutory and regulatory requirements, and to support high standards of transparency, probity, and integrity in the conduct of the business of the whole Trust
- To ensure that high standards of clinical governance are implemented and maintained, to ensure clinical services are effective and safe, and take into account patient experience
- To appoint, appraise and remunerate senior Executives
- To ensure that there is effective dialogue and partnership working between the Trust and the local community on its plans and performance and that these are responsive to the community's needs

The Board of Directors delegates duties and responsibilities to Board Committees and to the Trust Executive Team in accordance with the Trust's Standing Orders, Schemes of Reservations and Delegations and Standing Financial Instructions.

4. Equality and Diversity

The Board of Directors will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches. The Board will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Constitution requires that the Board of Directors shall consist of:

- a Non-Executive Chair; and
- not more than seven other Non-Executive Directors; and
- not more than seven Executive Directors,

At least half of the Board of Directors, excluding the Non-Executive Chair, shall at all times comprise Non-executive Directors.

One of the Executive Directors shall be the Chief Executive. The Chief Executive shall be the Accounting Officer.

One of the Executive Directors shall be the Director of Finance.

One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

One of the Executive directors is to be a registered nurse or a registered midwife.

The Trust chooses to interpret these four constitutional roles to mean the Chief Executive, Medical Director, Chief Finance Officer, and Chief Nurse.

Attendance at meetings will be monitored and shall be reported in the Annual Report.

6. Attendance

Meetings of the Board of Directors may be attended by:

- Director of Corporate Affairs
- Board Secretary
- Other officers of the Trust as requested by the Board of Directors.

Meetings of the Board of Directors shall be held in public may be attended by any member of the Trust, the public, or staff who have notified the Board Secretary in advance.

Meetings of the Board of Directors in private, held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, may be attended by a non-Board member, only at the request of the Board.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, due consideration of interests will be regularly monitored.

Both Executive and Non-Executive Directors may not take part in any discussions or decisions which pertain to their own employment, performance, or remuneration.

It will be for the Chair of the Board to determine whether or not it is appropriate for Directors to be in attendance to advise on these matters. In such circumstances where that person is in attendance, they will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be six Directors, including at least three executive Directors (one of whom must be the Chief Executive, or another executive Director nominated by the Chief Executive) and at least three non-executive Directors (one of whom must be the Chair or the Deputy Chair).

An Officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

Meetings of the Board of Directors shall be held at least three times in each financial year at such times and places that the Board of Directors may determine.

Meetings shall be open to the public unless the Board of Directors in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial confidentiality or on other proper grounds. Private sessions of the Board will be held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960.

9. Reporting

The Board of Directors will develop a Cycle of Business where scheduled items throughout the year will be presented.

The minutes of all meetings shall be formally recorded and presented to the next meeting for approval.

The agenda prior to any meeting of the Board of Directors will be provided to the Council of Governors, and a copy of the approved minutes as soon as is practicable afterwards.

The agenda and supporting papers of each meeting shall be displayed on the Trust website.

The Board has established a number of assurance Committees and will receive regular Chair's updates from those Committees.

The Trust reports activity externally through Trust's annual report and accounts. This shall be laid before Parliament annually and published in line with national guidance.

10. Conduct of Meetings

The Board of Directors for Wirral University Teaching Hospital will meet at the same time and in the same place as the Board of Directors for Wirral Community Health and Care. Minutes and decisions will be recorded separately.

The agenda and supporting papers will be sent out at least four working days prior to the Board of Directors, unless there are exceptional circumstances authorised by the Chair.

Authors of papers must use the standard template.

Presenters of papers can expect all Members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Members may question the presenter.

11. Other Committees

The Board of Directors acting as corporate Trustee has established the Charitable Funds Committee.

12. Effectiveness Review

As part of the annual performance review process outlined in the Board Effectiveness and Evaluation Policy, the Board of Directors shall review its collective effectiveness annually.

13. Review

The Board of Directors shall review its Terms of Reference as required and at least annually.