Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	WUTH Council of Governors
Date	Thursday 14 May 2026
Time	15:30 onwards
Location	Clinical Skills Lab, St Catherine's Health Centre

Agenda Item		Lead	Action
1.	Welcome and Apologies for Absence	Steve Igoe	Note
2.	Declarations of Interest	Steve Igoe	Note
3.	Minutes of Previous Meeting	Steve Igoe	Approve
4.	Action Log	Steve Igoe	Note
5.	Joint Chair Update – **Verbal**	Steve Igoe	Note
6.	Lead Governor Feedback – **Verbal**	Sheila Hillhouse	Note
Items for Discussion and Decision			
7.	NHS Staff Survey Results	Carla Burns	Note
8.	Joint Strategy (2026-2032)	Matthew Swanborough	Note
9.	Statutory Transaction Update	Matthew Swanborough	Note
10.	Committee Updates		Note
	10.1) Audit and Risk Committee	Mark Chidgey	
	10.2) Finance and Performance Committee	Meredydd David	
	10.3) Quality Committee	Dr Nikki Stevenson	
	10.4) People Committee	Lesley Davies	
	10.5) Joint People Committee – **Verbal**	Lesley Davies	
11.	Integrated Performance Report	Executive Directors	Note
12.	Ratification of Group Governance Documents – **Verbal**	Cate Herbert	Ratify
Wallet Items for Information			
13.	Board of Directors' Minutes	Steve Igoe	Note
Closing Business			
14.	Meeting Review	Steve Igoe	
15.	Any other Business	Steve Igoe	

Date and Time of Next Meeting

Thursday 23 July, 14:00 – 16:00

Meeting	WUTH Council of Governors
Date	Thursday 26 February 2026
Location	Clinical Skills Lab, St Catherine's Health Centre

Members present:

SI	Steve Igoe	Joint Chair
SH	Sheila Hillhouse	Lead Public Governor
RT	Robert Thompson	Deputy Lead Public Governor
PP	Peter Peters	Public Governor
AL	Andy Liston	Public Governor
TC	Tony Cragg	Public Governor
KJ	Keith Johns	Public Governor
IH	Ian Huntley	Public Governor
DF	David Funston	Public Governor
AGB	Andrew Bradley-Gibbons	Staff Governor
NW	Neil Wright	Public Governor
GB	Gary Bennett	Appointed Governor

In attendance:

SR	Dr Steve Ryan	Joint Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
LG	Lisa Greenhalgh	Joint Non-Executive Director
JR	Julie Roy (until 2:45)	Deputy Chief Nurse (deputising for CD)
HR	Hayley Rigby	Deputy Chief People Officer (deputising for DS)
JC	Dr Joanne Chwalko	Joint Chief Integration and Partnerships Officer
MS	Matthew Swanborough	Joint Chief Strategy Officer
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer

Apologies:

JH	Janelle Holmes	Joint Chief Executive
NS	Dr Nikki Stevenson	Joint Chief Medical Officer
CD	Chris Douglas	Joint Chief Nurse
HK	Hayley Kendall	Joint Executive Managing Director
DS	Debs Smith	Joint Chief People Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications
MC	Mark Chidgey	Joint Chief Finance Officer
HS	Haris Sultan	Joint Non-Executive Director
MP	Manoj Purohit	Public Governor
JJ	Julie Jellicoe	Staff Governor

SV	Sunil Varghese	Staff Governor
PB	Philippa Boston	Staff Governor
AK	Anand Kamalanathan	Staff Governor
SPW	Sue Powell-Wilde	Appointed Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed everyone to meeting and apologies are noted above.	
2	**Declarations of Interest** No new interests were declared and no other interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on 30 October were **APPROVED** as an accurate record.	
4	**Action Log** The Council of Governors **NOTED** the action log.	
5	**Chair's Update** SI referenced the new monthly update emails to NEDs and Lead Governors to provide updates on key issues between meetings. SI highlighted the Trust continued to work closely with PwC and the Integrated Care Board (ICB) on the turnaround plan. The reported £13m deficit includes non-cash items and ICB Cost Improvement Programme (CIP) adjustments totalling £14m; when these are excluded, the position is close to the original financial plan. SI added the Trust's exit run rate was one of the lowest and that the financial position is subject to rigorous ongoing review. The three-year financial plan has been submitted, and the Trust has been called to a meeting on Monday with the ICB. SI explained the Trust had been successful in securing additional capital funding, noting £8m was for the Same Day Emergency Care (SDEC) development, which is expected to come online in December, with a further £5m allocated for diagnostic testing. The Council of Governors **NOTED** the update.	
6	**Lead Governor Update** SH stated she attended a national Governor online seminar which included discussions on the proposal to remove Governors as part of the NHS 10 Year Plan.	

	SH added a number of Committees had met since the last meeting and Governors had the opportunity to observe these, and Governors updated each other about the key matters in the Pre-Council of Governors meeting. SH explained a proposal would be brought to the next meeting to agree whether or not to move to a WUTH and WCHC Council of Governors meeting in Common. SH referenced the recent pressures in the Emergency Department and the increased press attention, which had caused concern for Governors. The Council of Governors **NOTED** the update.	
7	**Committee Updates** **7.1) Estates and Capital Committee** SI alerted members that reactive maintenance performance had deteriorated and that a further deterioration was anticipated due to reduced overtime available, in line with the Trust's financial mitigation plan. SI also referenced the deep dive presentation provided relating to fire safety. Committee acknowledged the significant improvements made since 2021 to improve compliance but noted some residual risks remained and requested that mitigation for these risks be provided to the next meeting. SI alerted members that the Committee discussed the Frontis Building and had agreed with the recommendation to demolish this. A longer-term proposal for the redevelopment of the site had been requested. SI summarised the various "Advise" and "Assure" matters from the meeting on 3 November. SI highlighted this was the last meeting of the Estates and Capital Committee, moving forward the Finance Business Performance Committee will have oversight and receive assurance on performance related to estates, capital and safety. RT noted violence and aggression towards staff remained the highest non-clinical incident and queried who the aggressors typically were. LD stated a standing report on this was provided to People Committee and patients with dementia and alcoholism in the Emergency Department were generally aggressive towards staff.	

	Members requested if a breakdown of the type and location of violence and aggression incidents could be provided.	Hayley Kendall
	7.2) Charitable Funds Committee LD alerted members that discussions were underway to agree the Charity's next significant campaign. LD also alerted members to the upcoming fund-raising activities planned for the rest of the year, including the winter ball, hospital carol service, an evening with Paul Burrell and book signing and an Abseiling event. LD summarised the various "Advise" and "Assure" matters from the meeting on 11 November. RT queried the £161k per annum cost for running the Charity. LD advised this was correct and related to costs associated with staffing, resources, and premises. LD added operational costs were kept low as possible and the Charity had recently agreed additional expenditure on infrastructure. **7.3) Quality Committee** SR alerted members that the Committee heard about a patient story received at Patient Safety Quality Board regarding a patient receiving corridor care. The Committee acknowledged this had been challenging for staff to hear and were assured that actions to address specific issues were being taken. SR also alerted members the ED continued to have high levels of attendance, up to 370 per day and this was leading to providing corridor care which the Trust did not wish to "normalise". SR alerted members that due to these pressures additional escalation beds had been opened to deal with the high acuity. SR also alerted members that the Trust had reached its annual threshold for cases of hospital C Diff and will pass the threshold. SR noted this will negatively impact its scoring of the NOF. SR summarised the various "Advise" and "Assure" matters from the meeting on 21 January. SH referenced the clinical coding issues and increase in the Hospital Standardised Mortality Rate (HSMR) and queried how this issue was identified. SR stated this was identified by Telstra Health who provided external benchmarking data, adding this was due to under coding	

	and an action plan was in place to address this by end of quarter 1 2026/27. SH also queried how many cots the refurbished neonatal unit had. SR stated the occupancy level varied, and number of cots had not increased but the amount of space available was greater. SR added staff and patients were happy with the refurbished unit. CB added the Committee also discussed the Cancer Services Annual Report, noting strong examples of personalised care and holistic assessments which was in line the NHS 10 Year Plan and the focus on the health inequalities. **7.4) Finance Business Performance Committee** MD noted that the Committee reviewed the month 8 financial position and the Trust's cash position which was included in the Integrated Performance Report. MD alerted members that the Committee discussed the 2026/27 plan and recognised the significant challenges associated with delivering the control total of £9.1m for next year, including a CIP target of 10%. The Trust's MTFP is clear on the drivers of deficit and the improvement programmes required to address these. MD also alerted members that the referral to treatment position for October was significantly impacted by the sterile services incident which resulted in the cancellation of 1,378 elective cases in October and November. MD summarised the various "Advise" and "Assure" matters from the meeting on 15 December. SH queried if the Trust had received any complaints regarding the non-completed Subject Access Requests outside of the time limit. MD stated there had been no complaints, but the Trust was a reputational risk for the Trust if the regulator investigated this. MS explained the Service Improvement Team had recently undertaken a review of the processes and made a number of improvements to improve efficiency. **7.5) Audit and Risk Committee** MD alerted members that this year's core standards assessment has been assessed as compliant with this area being reviewed by MIAA and assurance levels reported are moderate. MD also alerted members that there are large backlogs with responding to subject access requests (SARs), which is an area	

	impacted by vacancies and long-term sickness coupled with high demand. An improvement plan and business case to address the backlog has been developed. MD alerted members that clinical coding backlog has improioned, and recent performance has been stronger than previous months, and there are mitigation plans to try to continue this. MD also alerted members that cyber security also remained an area of focus following the cyber incident in 2024. MD summarised the various “Advise” and “Assure” matters from the meeting on 10 December. **7.6) Research and Innovation Committee** SI provided a verbal update and explained previous meeting had held on 12 December, and it has been agreed that this Committee will be stepped down. SI added moving forward a research annual report will be provided to Patient Safety Quality Board which will travel to Quality Committee. **7.7) People Committee** LD provided a verbal update, explaining the Committee had received a deep dive into the sickness absence within Estates and Facilities Division as well as the length of employee relations cases. LD added the Committee also received a number of annual reports including the Gender Pay Gap, Equality Diversity, and Inclusion as well routine reports on Freedom to Speak Up and Guardian of Safe Working. LD explained the Committee also received an update on the workforce integration and progress to date. SH queried those who were unsuccessful for Mutually Agreed Resignation Scheme (MARS) and how these were being managed. HR confirmed a few had since left the Trust and if applicable any concerns would be manged through the appropriate policy. IH queried the long term sickness absence rate. HR advised the long term sickness absence was low compared to short term and the Trust was exploring reducing the threshold classified as long term from 28 days to 21 days. The Council of Governors **NOTED** the Committee Updates.	

8	**Ratification of Electronic Resolutions** The Council of Governors **RATIFED**: • Appointment of Steve Igoe as Joint Chair • Appointment of Lisa Greenhalgh as Joint NED • Appointment of Lesley Davies as Joint Deputy Chair • Appointment of Meredydd David as Joint SID • Appointment of Azets	
9	**Integrated Performance Report** SH queried the current position for C Diff. JR advised there had been an improved position through November and December, however in January the number of cases had increased to significant pressures in the hospital. JR added the inability decant areas and the increase of norovirus had a further impact on this. SH also queried if the joint working with the WCHC infection prevention control team was helpful. JR confirmed greater joint working was taking place between the two teams and it was beneficial. SI queried if patients with C Diff were being cohorted to the same ward to avoid infecting with other patients. JR stated this was challenging due to the existing estate limitations and a greater risk of repeat infections. SR commented about the increasing trend for hospital acquired pressure ulcers and queried this. JR stated this was a challenging indicator, noting there had been a further 3 in January within the Emergency Department despite the implementation of pressure relieving mattresses. The Council of Governors **NOTED** the report.	
10	**Board of Directors' Minutes** The Council of Governors **NOTED** the Board of Directors' Minutes.	
11	**Meeting Review** Members agreed it had been a good meeting with useful discussions, and everyone had the opportunity to contribute effectively.	
12	**Any other Business**	

	CH advised that the NED appraisals would take place this year again in line with Board Effectiveness Policy, which the Council approved in 2024.	

(The meeting closed at 16:15)

Action Log
WUTH Council of Governors
May 2026

No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1	February 2026	7.1	To provide a breakdown of the type and location of violence and aggression incidents	Hayley Kendall	Complete. Between April 2025 to March 2026, the Trust recorded a total of 1,017 violence and aggression incidents. The majority of incidents involved patient-on-staff behaviours, with physical assaults (550 incidents) exceeding verbal abuse (345 incidents), highlighting a notable risk profile to frontline staff. Harm levels were predominantly low, with over 75% of incidents resulting in no or minimal harm (757 incidents), though a small number of moderate harm cases (13 incidents). Activity is concentrated in the Emergency Department reporting the highest volume (159 incidents), followed by key medical wards including Ward 36, AMU, Ward 26 and Ward 24, indicating clear hotspots aligned to patient flow and acuity.	May 2026

Council of Governors **Item 7**

14 May 2026

Title	WUTH Staff Survey Results
Area Lead	Debs Smith, Chief People Officer
Author	Sharon Landrum, Head of People Experience
Report for	Information

Executive Summary and Report Recommendations

Following the lifting of the 2025 staff survey national embargo on 12 March 2026, further analysis has taken place:

Attached is a summary presentation with key points to note:

- WCHC maintained a 51% response rate this year, however lower than the 62% national average (comparator group is however small).
- WUTH response rate declined from 47% to 42% this year and is below the national average of 47% for comparator Trusts.
- WCHC – the majority of people promise themes saw no statistically significant change, with the exception of three areas; 'Reward and Recognition'; "We are Always Learning' and 'Staff Engagement'.
- WUTH - five areas had a statistically significant decline in staff satisfaction; 'We Each Have a Voice that Counts'; 'We are Safe and Healthy'; 'We are Always Learning'; 'Staff Engagement' and 'Morale'.

Steps already taken

- Workshops with Divisional / Service Director and Corporate Service leads – to share Trust results; support understanding of local results and identification of 'hot spot' areas and key areas of focus.
- Supported a number of Divisional feedback and engagement events, with further planned
- Shared a summary of results as part of the All staff briefing (March)
- Feedback and engagement sessions held with staff side colleagues
- Further workshops planned for FTSU Champions and staff network members

Key areas of focus:

- Focus on back to basics, to include:
  - Improved feedback, communications and engagement
  - Feedback on actions taken and celebrating success – including a heightened focus on feeding back from staff survey and 'free text' comments were possible
  - Leadership visibility - Promoting and celebrating leaders across the organisation, ensuring staff know who their line manager and their roles and responsibilities
  - Enhanced support for middle managers
  - Enhanced support for 'hot spot' areas

Members to note the decline in staff satisfaction and the statistically significant different decline in a number of areas. Members to also note the key areas for improvement and focus on ensuring basics which should be applied locally and across the organisation.

It is recommended that the Council:

- Note the presentation

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	No
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives	
Populations	
Safe care and support every time	No
People and communities guiding care	No
Groundbreaking innovation and research	No
People	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	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**
March 2026	Joint People Committee	As above	As above
April 2026	Group Board	As Above	As above

1	Implications
1.1	**Patients** • Research shows that happier and more engaged staff can improve experience for our patients and improved patient outcomes. Activities detailed in this report seek to improve experiences for patients positively.
1.2	**People** • WUTH seeks to be the employer of choice and improve experiences for staff. No negative implications.
1.3	• **Finance** • Reduced staff experience can result in increased sickness absence, turnover and loss of productivity. • Lack of involvement and engagement of staff can result in ineffective resolutions and improvements and create enhanced staff dissatisfaction.
1.4	• **Compliance** • Completion of national staff survey and quarterly pulse surveys, fulfils WUTH's standard contractual responsibilities

Staff Survey 2025 Findings

Debs Smith

Chief People Officer

May 2026

Final Response Rates

WUTH			WCHC		
2024	**2025**	National Average	2024	**2025**	National Average
47%	**42%**	47%	51%	**51%**	62%
	2825 respondents			862 respondents	

WUTH Response rates

Division	Response Rate
Emergency	**20.3%**
Clinical Support & Diagnostics	**52.0%**
Corporate Support	**70.4%**
Estates, Facilities & Capital Planning	**45.9%**
Medicine	**30.8%**
Surgery	**34.5%**
Women & Children	**47.4%**

WCHC Response rates

Directorate	Response Rate
Children's	60.2%
Community Response	39.7%
Corporate Services	82.0%
Nursing	38.4%
Specialist Medical	40.3%
Therapies	55.7%
Board, Ops Management & Hosted	78.3%

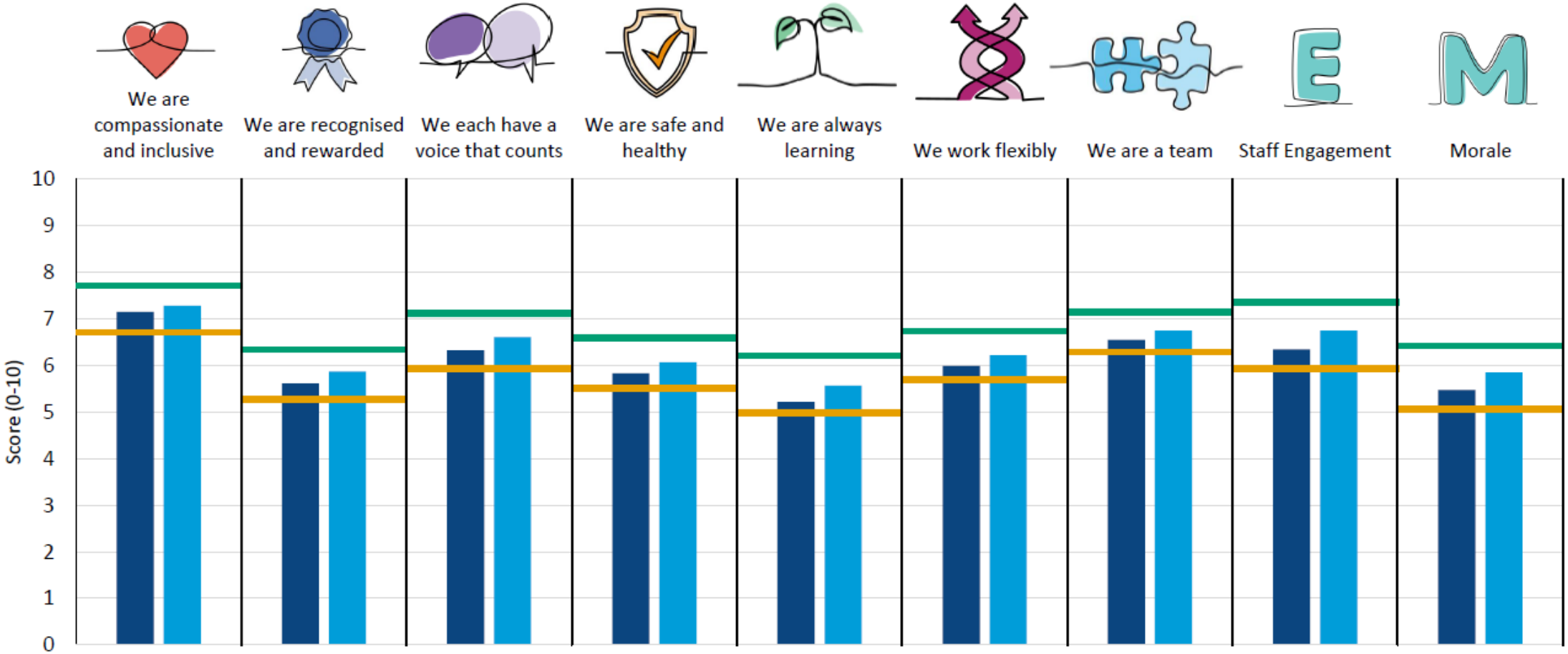
People Promise elements and themes: Overview

WUTH

Survey Coordination Centre

NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.15	5.61	6.33	5.83	5.22	5.99	6.55	6.35	5.48
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	2799	2802	2773	2767	2617	2781	2793	2801	2801

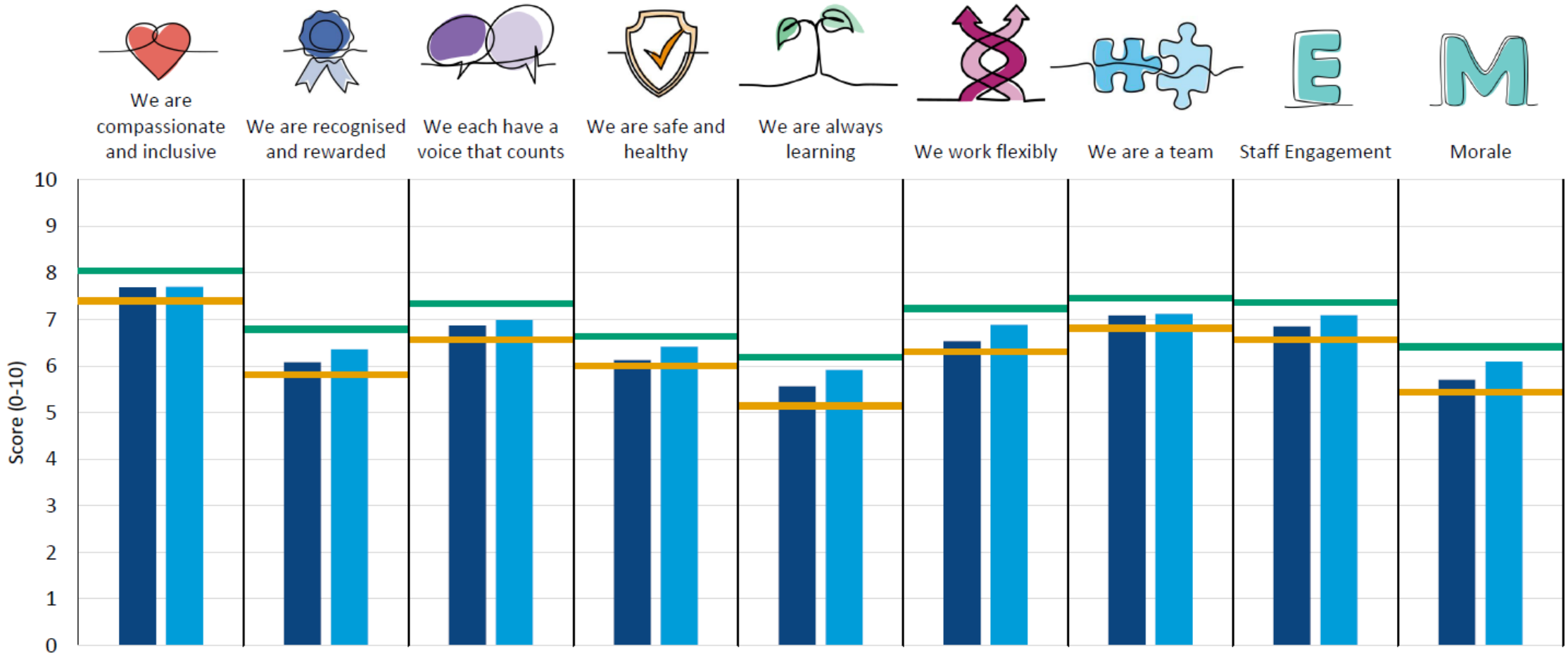
People Promise elements and themes: Overview

WCHC

Survey Coordination Centre

NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.69	6.09	6.87	6.13	5.56	6.53	7.08	6.85	5.71
Best result	8.05	6.79	7.34	6.64	6.18	7.23	7.47	7.36	6.41
Average result	7.70	6.36	6.98	6.41	5.92	6.89	7.12	7.09	6.09
Worst result	7.40	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Responses	860	861	860	861	836	859	859	862	862

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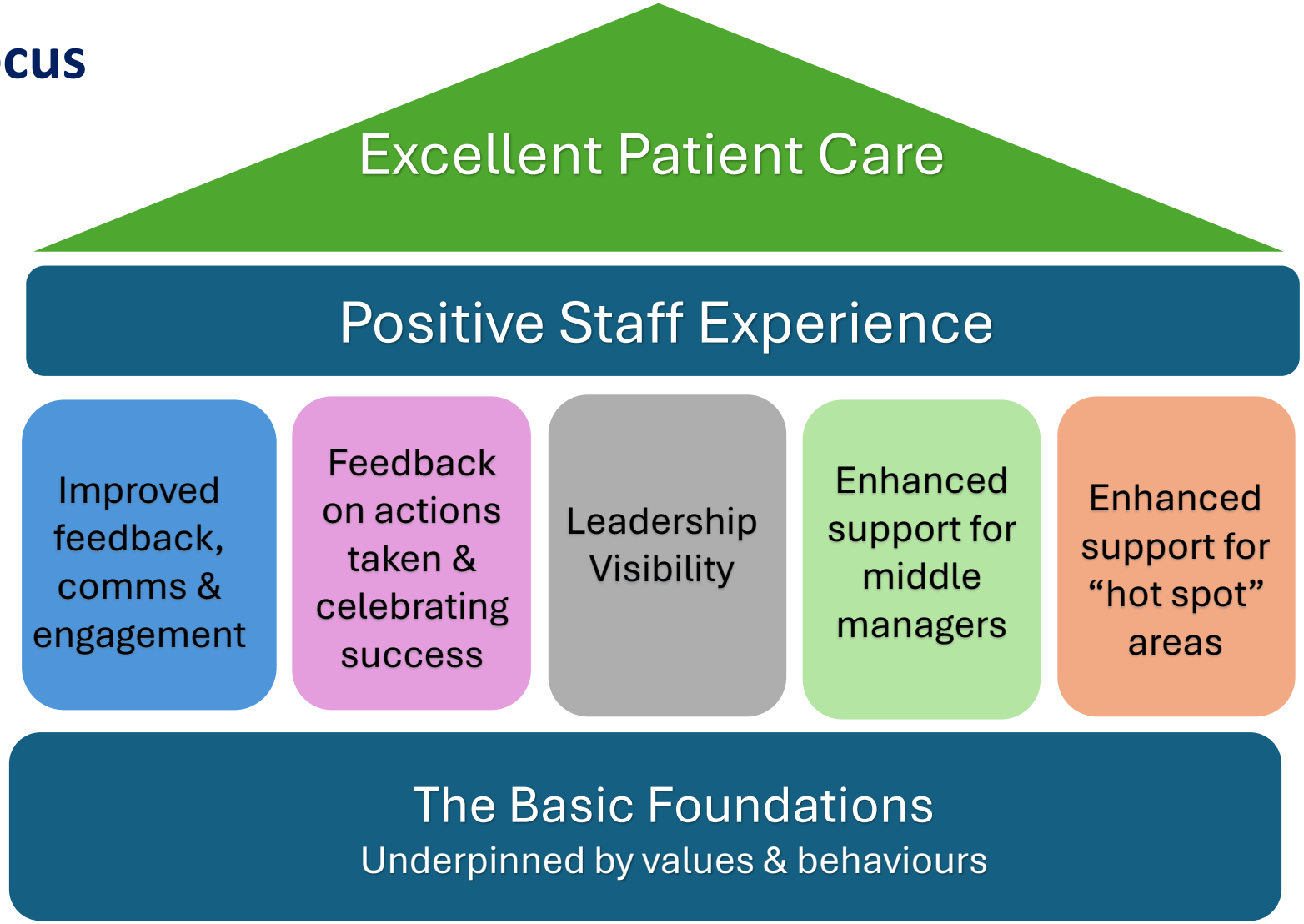
Summary of Priorities

Summary of key areas for improvement

WUTH	WCHC
Voice that counts – building staff confidence in raising concerns through robust feedback mechanisms to highlight progress made and actions taken where possible.	**Reward and recognition** - Staff feeling valued and recognised by the organisation
Safe and healthy – understanding and supporting "hot spot" areas of concern and dissatisfaction with resources and wellbeing support.	**Always learning** - opportunities to improve skills and support career development. Quality/effectiveness of appraisal process.
Always learning - improving skills, feeling supported, clinical supervision access	**Staff engagement –** improving staff motivation and involvement in making improvements. Recommending the organisation as a place to work.
Staff engagement (Advocacy) - Staff feeling that patient care is the organisations top priority, recommending as a place to work or receive treatment	
Morale – improving staff retention and work pressures	

Feedback from free text comments

Areas of Focus



Next steps

Next steps include:

- Understanding your results (attending one of our support sessions if needed)
- Identification and progression of key priorities and improvement actions
- Engagement and involvement of staff to lead and shape key actions
- Feedback and action on “free text” comments where possible
- Regular monitoring of progress made
- Regular updates and feedback shared
- Ongoing feedback via quarterly pulse surveys – next one is open 1st April

Council of Governors **Item 8**

14 May 2026

Title	Joint Strategy (2026-2032)
Area Lead	M Swanborough, Chief Strategy Officer, WUTH
Author	M Swanborough, Chief Strategy Officer, WUTH

Purpose of the Report and Recommendation	
Report For	Information

Attached is the draft Joint Strategy (2026-2032) between Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care (WCHC). This follows extensive engagement with staff, local and regional stakeholders and patients in the development of the document.

It is recommended that the Council:

- Note the Joint Strategy (2026-2032)

Key Points to Note

This document sets out the Strategic Objectives and Priorities for the Trusts across the next 6 years as well as highlighting our new vision for the organisations. The Joint Strategy also details the delivery approach and annual strategic priority cycle for the Board, Executives and Divisions, to ensure delivery of the Strategic Objectives and Priorities.

Key Risks

This report relates to these key risks:

- BAF 10 - Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes

Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
20/01/26	Integration Management Group	Joint Strategy Progress Update	Noted
04/03/26	Integration Management Board	Draft Joint Strategy	Noted
24/03/26	Executive Committee	Joint Strategy (2026-2032)	Noted
April 2026	Group Board	As above	Approve

	Narrative
1.1	**Background** • To support wider integration between WCHC and WUTH as well as the key components of the Transaction Full Business Case, it is the Trust Boards approved the development of a Joint WCHC/WUTH Strategy, Strategic Framework and joint enabling strategies as well as a single vision for the organisations.
1.2	**Engagement and Research** • Engagement activity was undertaken between September and December 2025, with strong participation across both organisations and broad representation from clinical, professional, leadership, public and partner groups. A total of 82 Joint Strategy conversations/interviews were delivered and 21 staff/stakeholder Focus Groups were also undertaken. Overall, this has totalled over 450 staff interactions. • As part of this stage, extensive research was undertaken, examining national and local context, understanding the current position of the Trusts and local and regional strategies and direction. • In addition, a number of Strategic Tools we used to support the development of the Joint Strategy, including PESTLE analyses and SWOT analyses, supporting the identification of risks and opportunities for the Trusts, at present and over the coming years.

1.3	**Development of Strategic Objectives and Priorities**
	• Through this engagement process and research, the Strategic Objectives were identified and have been further developed, each with a series of Strategic Priorities. These include:
	  • Delivering Excellence
	  • Our People
	  • Improve and Innovate
	  • Healthier Communities
	  • Collaboration and Partnerships

	• Advance Digitally • As part of this process, a joint vision for the Trusts was identified ‘Together we will create healthier lives and stronger communities’.
1.4	**Strategic Framework and moving to delivery** • As part of the Joint Strategy, we have developed a delivery approach for the Trusts, setting out the key steps and process to support delivery of the Strategy between 2026-2032, including the Annual Strategic Priority Cycle and the design of the Enabling Strategies.

Joint Strategy
2026 - 2032

Wirral University Teaching Hospital NHS Foundation Trust
Wirral Community Health and Care NHS Foundation Trust

Contents

Foreword

We are proud to present our first joint strategy as Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health and Care NHS Foundation Trust. This marks the beginning of a new chapter for health and care in Wirral - one built on collaboration, integration, and a shared ambition to improve the lives of the people we serve.

The last few years have brought extraordinary challenges. The Covid-19 pandemic tested every part of our services and our communities, but it also demonstrated the resilience, compassion, and commitment of our staff, partners, and the public. We saw how much stronger we are when we work together, and how quickly we can innovate to keep people safe and well. This strategy builds on those lessons - moving beyond recovery to create a sustainable, joined-up model of care for the future.

Our vision is simple but powerful: **together we will create healthier lives and stronger communities**. By bringing together the expertise of a major acute hospital with the strengths of community-based health and care, we are uniquely placed to deliver seamless services that meet people's needs wherever they are - at home, in local settings, or in hospital. In doing so, we are moving towards becoming an Advanced Foundation Trust and an Integrated Health Organisation - the national direction of travel for empowering NHS Trusts and creating a single system of care that breaks down traditional boundaries and puts people at the centre.

This strategy has been shaped through engagement with our patients, staff, partners, and communities. It reflects what matters most to local people: better access, more joined-up care, tackling inequalities, and ensuring our services are sustainable for future generations. Over the coming years, our priorities will be delivered through a series of clinical and enabling strategies, underpinned by our shared values and commitment to continuous improvement.

We know that a strategy is only meaningful if it leads to real change. That is why this document is not just a plan for the Boardroom - it is a call to action for every member of our workforce, every partner organisation, and every community we serve. Together, we can shape a healthier, fairer future for Wirral and beyond.

Steve Igoe
Chair

Janelle Holmes
Chief Executive

About us

We are proud to serve the people of Wirral and beyond through the combined strengths of Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC). Together, we provide services to people living in Wirral and neighbouring areas, including Ellesmere Port, Neston, Cheshire East, St Helens, Knowsley, and North Wales, representing a population of around one million people.

As Wirral's largest employer, with more than 8,500 staff, we provide a full range of acute, community, and specialist services. Our joint organisation brings together the expertise of a major teaching hospital with the reach of specialist community health and care enabling us to deliver more joined-up services at home, in the community, and in hospital.

Our main sites include:

- Arrowe Park Hospital (Upton) – the main acute hospital and home to Wirral Women and Children's Hospital.
- Clatterbridge Hospital (Clatterbridge) – planned surgery, rehabilitation, stroke, dermatology, and diagnostics.
- St Catherine's Health Centre (Birkenhead) – community health, diagnostics, and outpatient services.
- Victoria Central Health Centre (Wallasey) – community health, diagnostics, and urgent care.
- Marine Lake Health and Wellbeing Centre (West Kirby) – community health, and outpatient services.
- Community Intermediate Care Centre (Clatterbridge) – 71-bed reablement facility in readiness for hospital discharge.

We also deliver care locally through a wide range of clinics, centres and other settings, as well as in schools, care homes, GP practices and people's own homes, with children's services extending across Wirral, Cheshire East, St Helens and Knowsley.

Beyond healthcare, we are proud to play a vital role as an Anchor Institution supporting local jobs, training, and the economy, while helping to reduce health inequalities across Wirral and further afield.

Our population, services and scale

Our population

1 million
people served across Wirral, North Wales, and Cheshire and Merseyside

43%
of children and families supported across the Cheshire and Merseyside region

22%
of our population is aged 65+

97%
increase in our 90+ population anticipated by 2043

35%
of residents live in the most deprived areas across our region

A rising demand in our services is driven by a high prevalence of long-term conditions and an ageing population.

Our people

8,500
combined workforce for WUTH and WCHC

6,700
staff employed by WUTH

1,800
staff employed by WCHC

Our locations

2
acute hospital sites: Arrowe Park and Clatterbridge

3
specialist units: Community Intermediate Care Centre (CICC), Cheshire and Merseyside Surgical Centre, Clatterbridge Diagnostics Centre

50
community sites operated by WCHC

Plus many more locations where services are delivered, such as care homes, schools, GP practices and people's homes.

Our resources

£630m
combined annual budget

£514m
budget for WUTH

£116m
budget for WCHC

830
acute hospital beds: Arrowe Park and Clatterbridge

71
beds at Community Intermediate Care Centre

500,000
outpatient appointments per year

275,000
community nurse visits per year

Performance highlights

- ✔ **CQC Good rating for WCHC (2023), with many areas described as Outstanding**
- ✔ **Trust of the Year finalist (WUTH) at HSJ Awards 2024**
- ✔ **Maternity Services CQC Good rating for WUTH, with areas of Outstanding practice**
- ✔ **Endoscopy JAG (Joint Advisory Group) accreditation for excellence in patient care (2025)**

Understanding our context

National NHS context

Our strategy is shaped by a changing national NHS landscape. **The 10-Year Health Plan**, published in 2025, sets out an ambition to build a health service fit for the future through three major shifts:

- **Moving care from hospital to community**
- **Accelerating the transition from analogue to digital**
- **Shifting the focus from sickness to prevention**

The plan also emphasises the importance of neighbourhood-based care, with local teams supporting communities to receive more proactive, preventative and personalised care closer to home.

The Health and Care Act 2022 established **Integrated Care Systems (ICSs)** to act as the framework for how health and care organisations work together across local areas. ICSs bring NHS organisations, councils and wider partners into a single structure for planning and improving care, placing a strong emphasis on collaboration and shared responsibility for population health.

Alongside these system changes, the recent development of **Advanced Foundation Trusts (AFTs)** aims to empower high-performing NHS providers with greater freedoms to lead improvements in population health, digital transformation and reducing inequalities.

Building on this, we will see the emergence of provider models using the **Integrated Health Organisations (IHO)** contract as a delivery mechanism. Under this approach, an Integrated Care Board (ICB) may award a trust a capitated, population-based contract, enabling coordinated improved outcomes across hospital, community, primary care and mental health services through a network of providers.

These reforms come at a time of significant pressure for the NHS, including long waits for planned care, sustained pressure on urgent and emergency services, persistent health inequalities, and ongoing workforce challenges.

What does this mean for us?

For our new joint organisation, the NHS 10-Year Health Plan creates a timely opportunity for our trust to join up hospital and community services, with a key focus on appropriately shifting care from hospital settings into the community.

Our strategy will strengthen neighbourhood and place-based partnerships and use our digital and workforce strengths to deliver sustainable, person-centred care for the people of Wirral and further afield. In doing so, we will strive to build the foundations to become an Advanced Foundation Trust, and in time, an Integrated Health Organisation model.

Cheshire and Merseyside context

Regional

As part of the Cheshire and Merseyside Integrated Care System (ICS), we operate within one of the largest ICSs in the country serving approximately 2.7 million people across nine places. The ICS brings together NHS organisations, local authorities and wider partners to improve health outcomes, tackle inequalities, enhance productivity and support social and economic development.

Our strategy recognises, supports and will align to meet Cheshire and Merseyside's **All Together Fairer: Our Health & Care Partnership Plan 2024-29.** The plan is the overarching strategy for Cheshire and Merseyside's integrated health and care system with a deliberate focus on reducing health inequalities and improving wellbeing using the eight key Marmot principles that encompass the social determinants of health.

Delivery of these eight themes will be grounded in the three All Together Fairer overarching principles focussing on:

- **Shifting investment to prevention and equity**
- **Embedding health equity and fairness in decision making to ensure social justice, health and equity is considered in all we do**
- **Increasing access to income, employment, benefits and economic opportunity through anti-poverty work**

Wirral context

Wirral is home to around 323,000 people and experiences some of the widest health inequalities in Cheshire and Merseyside. Life expectancy remains below the England average, with persistent east-west differences and gaps in healthy life expectancy. These inequalities are closely linked to deprivation: 35% of residents live in the 20% most deprived areas nationally, with around 83,000 people living in the 10% most deprived communities.

The borough has an ageing population, which is a major driver of demand for health and care services. More than 22% of residents are aged 65 and over, and the number of people aged 90+ is expected to double by 2043. While overall population growth has been minimal, growth in the oldest age groups will most likely place increased reliance on hospital, community and social care services. Long-term conditions, cancer, cardiovascular disease, mental health needs and alcohol-related harm continue to affect outcomes.

Wirral's population is diverse, though predominantly White, with 7.6% of residents from minority ethnic backgrounds and 1 in 20 born outside the UK. This diversity influences both health outcomes and how people access and experience services.

Alongside population need, the local health and care system faces ongoing performance pressures, particularly in urgent and emergency care, patient flow, planned access to services and timely discharge. While significant progress has been made through closer partnership working, these pressures continue to affect patient experience and system performance. The system also faces significant financial challenge, requiring difficult choices and a sustained focus on efficiency, productivity and value, alongside improving quality and outcomes.

While Wirral is our core place, our reach extends beyond the borough. We deliver children's and family services across Cheshire East, St Helens and Knowsley, and provide specialist care for patients from North Wales, reinforcing the importance of working both locally and at scale.

State of the Borough

78 **62**
Life expectancy has worsened in recent years and is lower than the England average

12 years
A child born today in Greasby can expect to **live 12 years longer** than a child born in Tranmere

18 years
People in Wirral are spending around **18 years of their lives in poor health**

115,000
1 in 3 people in Wirral live in areas reported as the **most 20% deprived in England**

1 in 4
people in Wirral will **die from cancer** - this is the leading cause of death

1 in 5
Wirral people have **Circulatory problems** such as heart disease - the 2nd highest cause of death

50%
Poor mental health accounts for more than half of all people out of work due to a health condition

1 in 3
working age adults in the most deprived area of Wirral, are **claiming out of work benefits**

Cancers
Circulatory & respiratory diseases are **more likely in Wirral people** compared with England overall

Children
achieving a good level of development in Wirral at the end of Reception has worsened

Lower
achievement of children receiving Free School Meals at Reception age

22%
of people in Wirral earn below the **Real Living Wage**, a fall in recent years, from 30% in 2018

Wirral context

Wirral Health and Wellbeing Strategy

The Wirral Health and Wellbeing Strategy (2022–2027) aims to improve health and reduce inequalities across Wirral through five key priorities. It focuses on using economic growth and regeneration to create jobs, develop skills, and improve living conditions, while also strengthening collaboration between health and care services to better support communities with poorer outcomes. The strategy emphasises giving children and young people the best start in life through strong family support, safe environments, and effective early years services. The strategy highlights the importance of creating safe and healthy places to live through improved housing, neighbourhood safety, and access to green spaces. It also promotes partnership working by encouraging organisations and residents to collaborate, ensuring local voices shape decisions and foster a culture of health and wellbeing.

Together, these priorities address both immediate health needs and the wider social factors that influence long-term wellbeing.

Wirral Provider Alliance

The formation of the Wirral Provider Alliance in 2025 has created a system decision-making and oversight group to respond to strategic commissioning decisions.

Alongside WUTH and WCHC, the Alliance has a membership of senior leaders from: Clatterbridge Cancer Centre, Cheshire Wirral Partnership (CWP), primary care providers including general practice, Voluntary, Community, Faith and Social Enterprise VCFSE providers, Wirral Council and Wirral Hospice.

The shared purpose of the Alliance is **Working in partnership for better health and care in Wirral**. It oversees priority system transformation programmes and is focused on the conditions for system development.

The Alliance will act as a key lever within the Wirral system to drive improvement and change for our population, working in partnership with key providers to ensure our priorities and strategic direction aligns with local population needs. This includes:

- **Shifting care from hospital into community and neighbourhood settings**
- **Tackling health inequalities and supporting healthier ageing**
- **Strengthening partnerships across health, care and the voluntary sector**
- **Making best use of our workforce, digital capability and scale**

Wirral context

Better Together – our shared future

The coming together of Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) marks a defining moment for health and care in Wirral. By combining our strengths, we are creating a single, integrated organisation that can deliver seamless services across hospital, community, and home.

Individually, both trusts have achieved a great deal. WUTH is a major acute teaching hospital providing emergency, surgical, and specialist services for Wirral and beyond. WCHC has built a strong reputation for high-quality, community-based care, prevention, and support for children, families, and adults across five Cheshire and Merseyside "Places". Together, we are greater than the sum of our parts.

Our new organisation brings:

- **Acute expertise** – delivering safe, specialist hospital care when it is needed most.
- **Community reach** – supporting independence and wellbeing at home and closer to home. A drive to ensure care is delivered within the community wherever possible.
- **Shared values;**
  - WUTH – Caring, Respect, Teamwork, Improvement
  - WCHC – Compassion, Open, Trust
- **System leadership and coordination** – working with partners across Wirral place and Cheshire & Merseyside ICS.

Better Together reflects more than our integration - it is our way of working. It means breaking down organisational barriers, putting people and communities at the centre, and building a culture where patients, staff, and partners feel part of a single team.

By uniting as one, we can strengthen services, tackle inequalities, and support the creation of a healthier future for our populations.

Better Together
for people in our care

How we developed this strategy

This strategy has been shaped by the voices of our patients, staff, partners, and communities. We believe that meaningful change can only be achieved when it is co-designed with those who deliver care and those who receive it.

Gaining understanding from our service users, members of the public and staff has been key in the development of our strategy. We sought views from our public and community partners across Wirral and the wider Cheshire and Merseyside system. This included local authority colleagues, Primary Care Networks, and the community and voluntary sector. Their insights highlighted the importance of access, equity, and joined-up services across hospital and community care.

Over recent months, we have carried out 1:1 conversations with colleagues and leaders, alongside a series of joint strategy focus groups involving clinical, nursing, allied health professionals, clinical scientists, operational, and staff-side representatives. These sessions gave staff a direct role in shaping our future priorities, ensuring that the strategy reflects both frontline experience and professional expertise.

The feedback we gathered has directly influenced our vision, objectives and priorities. Just as important, this approach sets a precedent: engagement, co-design and co-production will remain central to how we deliver our strategy.

Vision, values and strategic direction

Our vision and values

Our vision and values sit at the heart of our joint strategy, providing the shared foundation for how we will work together as one organisation. They have been shaped by the people who know our services best – our patients, families, carers, staff and partners across Wirral and beyond. Through conversations, workshops and wider engagement, they told us what matters most: care that is safe, compassionate, joined-up and easy to navigate, wherever and whenever someone requires our services.

WUTH and WCHC each have strong, well recognised values that continue to guide the way we work today. Values are more than statements – they shape how we behave, how we make decisions and the culture we create every day. As we become a single organisation, we will develop a new shared set of values through a dedicated engagement programme, ensuring they genuinely reflect the people who work with us and those we serve. Until then, our existing values remain in place.

Coming together gives us a unique opportunity to build on the strengths of both community and hospital care. Delivering the best outcomes depends on all of us working as one team, supporting each other and keeping people and communities at the centre of everything we do.

A key part of our strategy is strengthening collaboration across the wider health, care and community system, so that people experience care that feels connected and personalised, with fewer hand offs and clearer pathways.

Our shared vision and values reflect this ambition. They bring together what both trusts stand for today and what our communities have told us they need in the future. This direction aligns with national expectations for more integrated, community focused services and supports our aim to develop as a single, joined-up organisation that helps people live healthier lives and strengthens local communities.

Together, our vision and values define who we are and how we will work – **Better Together** – with a clear, shared purpose for the people we serve.

Vision

"Together we will create healthier lives and stronger communities"

Values

caring for everyone
respect for all
embracing teamwork
committed to improvement

NHS Wirral University Teaching Hospital NHS Foundation Trust

NHS Wirral Community Health and Care NHS Foundation Trust

Compassion – Supportive and caring, listening to others.

Open – Communicating openly, honestly and sharing ideas.

Trust – Trusted to deliver, feeling valued and safe.

Objectives

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

Our strategic objectives and priorities

Our **objectives** set out what we will focus on to achieve our vision and deliver the best outcomes for our populations.

Our strategic **priorities** describe the areas where we will focus our efforts to achieve our objectives. They reflect what we heard through engagement and align with local, regional, and national priorities.

	Delivering Excellence	Our People	Improve and Innovate	Healthier Communities	Collaboration & Partnerships	Advance Digitally
Objectives	**We will create the conditions for outstanding care and performance**	**We will nurture an inclusive, compassionate culture where people thrive**	**We will make improvement and innovation part of how we work**	**We will drive health equity and support healthier lives**	**We will work as one system and one organisation**	**We will develop a secure, connected digital ecosystem fit for the future**
Priorities	• Deliver consistently safe, high-quality, person-centred care across all settings. • Reduce variation and improve outcomes through evidence-based practice and shared standards. • Strengthen patient experience by improving access and coordination across pathways. • Embed a strong safety culture built on learning, openness and accountability. • Meet national standards to ensure timely and consistent care. • Use our estate well to provide safe, modern environments.	• Create a compassionate, inclusive culture that values diversity and supports every member of staff. • Continue to build a flexible, highly skilled, and future-ready workforce. • Provide our workforce with the tools they need to provide the best care and support. • Ensure we continue to provide safe working environments. • Empower our workforce through investment in education, leadership development, and wellbeing, to enable them to make a real difference.	• Embed improvement and innovation in everyday practice to enhance quality and outcomes. • Deliver medium and long-term financial sustainability through effective use of resources and sustainable ways of working. • Expand research participation and academic partnerships to translate learning into better care. • Develop a clear commercial offer that maximises value from our assets and expertise. • Progress our environmental sustainability goals, including towards Net Zero.	• Deliver care closer to home through integrated neighbourhood teams and local centres. • Ensure people in communities guide care through co-design using insight and lived experience to reduce health inequalities. • Remove barriers to equitable care with a focus on prevention and early intervention. • Leverage our role as an anchor institution to maximise social benefit for our communities.	• Conclude the integration between WCHC and WUTH to formally create a single organisation. • Work with partners as one system to design and deliver seamless pathways of care, making best use of our collective resources. • Strengthen partnerships and collective leadership with primary care, local authorities, NHS trusts, the voluntary sector and wider system partners. • Lever our experience and expertise to drive system working across Cheshire and Merseyside ICS.	• Create a single, secure digital ecosystem across hospital, community services, and system partners. • Empower staff with smart, user-friendly technology and strong digital skills. • Make effective use of data, artificial intelligence and automation to proactively enhance quality, safety and decision making. • Drive the expansion of digital inclusion and accessibility while recognising the importance of creating opportunities for the digitally disadvantaged. • Strengthen cyber-resilient infrastructure to protect services and maintain the trusts' cyber security.

Delivering the strategy

Our delivery approach

Our approach to delivery follows a simple and clear line of sight from our vision to the everyday actions that make a difference for our communities and our workforce.

It begins with our shared vision and values, which describe who we are and what matters most. The joint strategy sets out what we aim to achieve together as one organisation.

A set of enabling strategies will provide the key actions to deliver the tools, skills and resources needed to support this. These are translated into practical actions each year through our **Annual Strategic Priorities** with strong governance and oversight, ensuring we will stay on track and continue to improve.

Together, these elements form our strategic framework – a clear and connected way of working that will turn our ambition into real change.

Enabling strategies

Our enabling strategies will be developed across 2026/27 providing the foundations for delivery.

They describe the key areas we must strengthen and invest in to make our strategic priorities achievable. These include both our clinical service strategies and our supporting cross-cutting corporate strategies.

Enabling strategies

Clinical Service Strategy

The Clinical Service Strategy will bring together plans from more than 30 clinical specialties to guide how we improve care over the next six years to support healthier communities.

Working in partnership with other providers and people in our neighbourhoods we will create consistent, joined-up pathways, reduce variation and strengthen links between community and hospital services so people experience safe, effective and coordinated care.

Quality and Safety Strategy

Our Quality and Safety Strategy will ensure care is safe, reliable and continually improving.

We will reduce harm, strengthen clinical governance and build a culture where staff feel confident to speak up and learn from experience.

This will help us deliver consistently high-quality care across all services.

Patient Experience Strategy

The Patient Experience Strategy will strengthen how we listen to and act on feedback from patients, families and carers.

We will focus on improving communication and removing barriers that make services harder to use, while involving people in shaping how care is delivered.

This will help ensure that everyone receives a compassionate and positive experience in every setting.

People Strategy

Our People Strategy will create a supportive, inclusive workplace with a positive culture where everyone feels valued and able to thrive. We will be recognised as an organisation that actively provides career opportunities within all our divisions and across all our professions.

We will attract and retain talented people, strengthen leadership, enhance wellbeing and offer clear development opportunities.

This will build a flexible, skilled workforce that can meet the needs of our communities.

Improvement, Research and Innovation Strategy

This strategy will build a culture of improvement, research and innovation across our organisation.

We will support teams to test ideas, use evidence and address challenges in their services. By working with partners, universities and the people who use our services, we will bring new thinking into everyday practice and spread changes that strengthen safety and quality.

Estates and Facilities Strategy

The Estates and Facilities Strategy will create modern, safe and welcoming environments for patients and staff.

We will upgrade our buildings, improve accessibility and use space more efficiently. Planning our estate as one organisation will support high-quality care, staff wellbeing and a more sustainable future.

Digital Strategy

Our Digital Strategy will further develop our systems and improve how information is shared across services.

We will use technology – including AI, automation and digital devices such as wearables – to reduce manual work and support clinical decisions, while making it easier for people to access the care they need.

This will create more connected and efficient services for patients, carers and staff.

Financial Strategy

Our Financial Strategy will ensure we use our resources wisely to deliver safe, sustainable, high quality care.

As one organisation, we will cut duplication and improve value for money, directing investment to the areas where it can make the greatest difference. Strong financial planning and disciplined budgeting will support long-term stability and better outcomes.

Annual strategic priority cycle

Our strategy sets the long-term direction for our organisation, but we bring it to life through a structured, year round approach to planning and delivery.

Each quarter has a clear purpose: reviewing progress, refining our approach, celebrating achievements, and preparing for the year ahead.

This cycle ensures that our priorities remain focused and achievable, that we are accountable for the progress we make, and that we can respond to national, regional and local needs as they evolve.

By following this consistent rhythm of planning, review and improvement, we turn our strategic ambition into sustained, evidence-based real change.

Q1 Review progress against the current year's strategic priorities and confirm trust, divisional and enabling priorities for the year ahead. Launched formally at away day.

Q2 Review the effectiveness of the Strategic Planning Framework and Annual Strategic Priority Cycle, refining where necessary.

Q3 Provide an update on achievements and celebrate progress against the current year's strategic priorities at the strategic priorities away day half-year check-In.

Q4 Development of trust, divisional and enabling annual strategic priority templates for upcoming financial year (alignment with national, regional and local context, Trust Strategy and Enabling Strategies).

Roadmap for delivery

Our roadmap shows how we will move from strategy launch through to delivery. Year 1 will focus on building the foundations – developing our detailed clinical and enabling strategies – with subsequent years focused on integration, scaling, and long-term transformation.

April 2026

Formal launch of our Joint Strategy, including vision, values and objectives, delivery tracked through annual planning cycle

Joint Strategy

May - September 2026

Strategy workshops and engagement held to shape our Clinical Service Strategies

Clinical Service Strategies

October 2026 - April 2027

Development of our Enabling Strategies, setting out the tools, capability and resource needed to deliver the Joint Strategy

Enabling Strategies

2027 onwards

The full Strategic Framework brings together the Joint Strategy, Clinical Service Strategies and Enabling Strategies, and will be tracked through annual planning cycles to translate long-term priorities into clear, achievable actions each year

Annual Strategic Priority Cycle

Joint Strategy 2026 - 2032

Working with our partners

Thank you to our partners for your contributions and support in shaping this Joint Strategy. Working together will be essential in the years ahead, and we look forward to continuing our collaboration to improve health and care for our communities.

healthwatch Wirral

WIRRAL PRIMARY CARE COUNCIL
Working together for Wirral Health

NHS
Cheshire and Mersyside

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

NHS
England

Wirral CVS

NHS
Countess of Chester Hospital
NHS Foundation Trust

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Wirral Hospice St John's

WIRRAL

Wirral Primary Care Collaborative

Moving forwards

This joint strategy sets out our shared vision and the journey ahead. It will only succeed if we deliver it together – as staff, partners and communities. At its heart is a commitment to better care, healthier lives and reducing inequalities across Wirral and beyond.

Thank you to everyone who has contributed to shaping this strategy – including our patients, carers, staff, partners and community groups. Your insight and support show what is possible when we work as one team across hospital, community and system services.

"Together we will create healthier lives and stronger communities"

Appendices

To understand the environment we work in, we carried out a simple **Strengths, Weaknesses, Opportunities and Threats (SWOT)** exercise across a series of focus groups. Staff from different teams took part, and we also gathered views from senior leaders, board members and system partners.

Strengths

Compassionate, person-centred care – consistently highlighted across all engagement; teams focus on doing what's best for patients, with strong experiences in UCR, Home First, Virtual Wards, paediatrics and community pathways.

Our people – staff pride, kindness, resilience and commitment to going above and beyond underpin care delivery; teams describe colleagues as supportive, adaptable and motivated.

Integrated working already happening – successful joint pathways (HomeFirst, UCR/ED, cardiac rehabilitation, paediatrics, MSK) show integration is effective and improving flow, access and experience.

Positive organisational cultures – values of compassion, openness, teamwork and improvement shared across WCHC and WUTH, reinforced by strong CQC outcomes and national recognition.

Developing partnerships – trusted, evolving relationships with primary care, VCFSE, local authority and system partners that support effective transitions of care and population health approaches.

Breadth of services across settings – acute hospitals, neighbourhood teams, community clinics, diagnostics and home-based care form a comprehensive, place-based care footprint.

Improvement and innovation mindset – staff demonstrate adaptability, problem-solving, digital progress, and willingness to test new approaches, particularly in community and integrated teams.

Growing education, training and research capability – teaching hospital status and community education infrastructure strengthen professional development and attract future workforce talent.

Shared leadership and clear direction – Joint Board and governance through Integration Management Board create stability and alignment across both organisations.

Weaknesses

Fragmented digital systems – numerous IT platforms, dual recording, interoperability gaps, inconsistent documentation and data quality issues hamper seamless care.

Inconsistent internal communication and engagement – differing communication styles, unclear messages, and difficulty engaging all teams during operational pressure.

Variation across pathways and processes – different policies, guidelines, training expectations, governance processes and admin practices create inconsistency and inefficiency.

Estate limitations and infrastructure gaps – ageing buildings, lack of space, accessibility issues and variable facilities across acute/community sites constrain service redesign.

Workforce pressures – gaps in capacity, skills shortages, rota challenges and reliance on goodwill reduce resilience in both clinical and corporate areas.

Insufficient understanding across acute & community services – limited knowledge of each other's roles, pressures and pathways impacts coordination.

Staff change fatigue and anxiety – concerns about pace of integration, uncertainty about roles, bases and working patterns, and emotional impact of change.

Process duplication and inefficiencies – multiple assessments, duplicated referrals, repeated tests and unnecessary handoffs remain common issues.

Limited analytical integration – inconsistencies in data access, reporting and insight limit proactive population health management and improvement.

Opportunities

Seamless pathways across home, community and hospital – clearer transitions, fewer handoffs, reduced duplication, improved flow and faster access.

Neighbourhood-based and community-delivered care – expanding services closer to home, using community hubs and local estate to reduce hospital pressure.

Stronger primary care and VCFSE integration – deeper collaboration to support admission avoidance, discharge, chronic disease management and holistic care.

One integrated digital ecosystem – single patient record, shared documentation, common reporting and better data use to transform safety, quality and efficiency.

Digital innovation, virtual care and AI – expansion of virtual wards, remote monitoring, automation, ambient AI and digital-first models.

One workforce with shared careers and mobility – joint roles, rotational posts, unified training, widening participation, leadership programmes and talent development across the whole pathway.

Tackling health inequalities – neighbourhood insights and community partnerships supporting prevention, access and targeted interventions.

Optimising estates across the borough – using both trusts estates, neighbourhood clinics and GP practices to expand diagnostics and outpatient capacity.

Shared governance and standardised processes – unified guidelines, safer pathways, streamlined admin and clearer processes to improve efficiency and productivity.

Place-based commissioning and provider alliances – strategic commissioning at Place, deeper provider alliances and a unified approach to improving the health and outcomes of the Wirral population.

Threats

Financial constraints and limited capital – cost pressures, ageing equipment, estates investment needs and requirement to "invest to save."

Rising demand and complexity – increasing frailty, chronic disease, urgent care demand and social pressures risk overwhelming capacity.

Workforce shortages and retention risks – difficulties recruiting, wellbeing pressures, ageing workforce and potential loss of expertise.

Integration-related uncertainty – fears of loss of identity, cultural misalignment, inequity between organisations, or insufficient staff voice.

Estate and infrastructure constraints – limitations in diagnostic equipment, outdated spaces and access issues may hinder transformation.

Political and policy uncertainty – changes to national priorities, ICS commissioning approaches and regulatory expectations may affect local flexibility, resources and the pace of integration.

Digital and system risks – interoperability challenges, system downtime, training needs and complications during transition to unified systems.

Operational pressures limiting change capacity – urgent care flow, elective recovery and community caseloads reduce time for transformation.

Potential loss of community strengths – risk that valued WCHC community models could be diluted without careful management.

Stakeholder confidence and communication risks – insufficient public or partner engagement may affect trust in the integration.

PESTLEC

To understand the wider external context we operate in, we used a PESTLEC analysis. This helped us look at the political, economic, social, technological, legal, environmental and competitive factors that influence our organisation and the services we provide. The key external factors that informed the development of this Joint Strategy are summarised alongside.

P Political

- NHS 10 Year Plan: prevention, digital-first, community care
- Shift to DHSC-led national leadership and tighter performance/financial oversight
- Shift in care from hospital to home & community
- Establishment of Neighbourhood Health Centres
- Public Private partnerships (PPP)
- Key focus on prevention
- ICS and Place-based shared governance & accountability
- Place-based partnership working and delivery
- Changes to NHS trust regulation

E Environmental

- NHS Funding pressures with increased efficiency expectations
- Increased capital and maintenance constraints
- Increased demand on resources
- Continued growing cost of health and care
- Longer term impact of period of austerity, inflation and exchange rates

S Social

- Widening health inequalities
- Ageing population with more complex care needs
- Increase in informal caring
- Increase in reported addictions
- Strong community/VCFSE assets
- Workforce (wellbeing and retention)
- New skillsets and apprenticeships within the NHS sector
- Increasing digital expectations from citizens
- Shift from analogue to digital

T Technological

- Shared Care Record ambition
- Importance of understanding digital inclusion and exclusion
- National push for digital-first access and interoperability
- Emergence of Artificial Intelligence and automation
- Remote monitoring / telecare
- Digital-first outpatient models
- Personalised medicine and genomic advancements Remote monitoring / telecare / wearables
- Increased home-based care
- Technology training (equity, diversity and inclusion)
- Remote / mobile work expansion
- Robust data protection and cyber security
- Strong digital governance (i.e. AI and automation)

L Legal

- Governance, FT constitutional changes following transaction
- Evolving changes to NHS legislation
- Patient safety and safeguarding
- Professional regulation
- New CQC Single Assessment Framework
- Advanced Foundation Trust status

E Ecological

- Delivering a net zero National Health Service achieving 80% by 2032
- Impact on weather derived health issues
- Antimicrobial resistance and infection threats
- Climate impacts (heatwaves, winter storms, flooding)
- Energy costs - focus on green procurement
- Smoke-free estate
- Recognised Anchor Institution

C Competition

- Any Qualified Provider contracts to independent sector (whole service sustainability)
- Workforce competition
- Strategic commissioning developments
- Multiple provider alliance formations
- Developing group models
- Emerging Integrated Healthcare Organisations
- Partnership opportunities (universities, colleges, VCFSE, technology organisations)

P E S T L E C

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Arrowe Park Hospital, Arrowe Park Road, Wirral, CH49 5PE

wuth.nhs.uk @wuthnhs @wuthnhs

NHS
Wirral Community Health and Care
NHS Foundation Trust

St Catherine's Health Centre, Derby Road, Wirral, CH42 0LQ

wchc.nhs.uk @nhsbuzz @wchc_nhs

If you would like this information in another format or language, please contact the Your Experience Team on freephone 0800 694 5530. Alternatively, you can email wcnt.yourexperience@nhs.net

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Council of Governors **Item 9**

14 May 2026

Title	Statutory Transaction Update
Area Lead	M Swanborough, Chief Strategy Officer, WUTH
Author	M Swanborough, Chief Strategy Officer, WUTH

Purpose of the Report and Recommendation	
Report For	Information
It is recommended that the Council: • Note the presentation	

Key Points to Note

The attached presentation provides detail of the progress made with the WCHC/ WUTH integration following the Wirral System Review, and the WCHC/WUTH transaction approach, moving to a single organisation.

Key Risks

This report relates to these key risks:

- BAF 10 - Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

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

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

Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
21st April 2026	Integration Management Group	Deloitte Transaction Delivery Timeframes	Approved

	Narrative

1.1	**Background**
	• In March 2024, Value Circle LLP were commissioned by C&M ICB to undertake the review and deliver across two phases, with completion in September 2024, working with Wirral NHS providers.
	• Across the two phases of the Wirral System Review, Value Circle LLP developed a series of recommendations, primarily relating to integration and collaboration between WCHC and WUTH. This included the need to integrate clinical services and corporate function between WCHC and WUTH as well as move to single leadership across the two Trusts.
	• Following the publishing of the Wirral System Review and approval of the reports by the WCHC and WUTH Boards; the WCHC Council of Governors approved the appointment of the WUTH Chair as the Joint Chair across WCHC and WUTH in October 2024. This was followed by the WCHC Board approving the appointment of the WUTH Chief Executive as the Joint Chief Executive across WCHC and WUTH in November 2024.
	• To support the initial stages of integration and accelerate the joint working between WCHC and WUTH, an initial 100 Working Day Integration Plan was then developed and enacted. Across this period, the Trusts made significant progress in the initial stages of integration delivery and moving towards a single organisational form.
	• Following the conclusion of the 100 Working Day Integration Plan in April 2025, a longer term (2 Year) integration plan was developed, setting the strategic intentions for WCHC and WUTH on integration and a pathway towards becoming a single organisation. This plan included four main components:
	  • The development of a Joint Strategy for WCHC and WUTH
	  • A transaction approach between WCHC and WUTH
	  • Integrating governance arrangements
	  • Continued delivery of Integration Programme work areas
	• The Trusts have made significant delivery against this 2 Year Plan, between April 2025 and March 2026, across clinical services integration, governance, communication and engagement, leadership, workforce and estates.
	• The Trusts have also appointed Deloitte LLP to support the Trusts with the delivery of the transaction between WCHC and WUTH. Deloitte have developed a project plan with the aim to complete the transaction and form a single organisation in April 2027.

Transaction between WCHC and WUTH

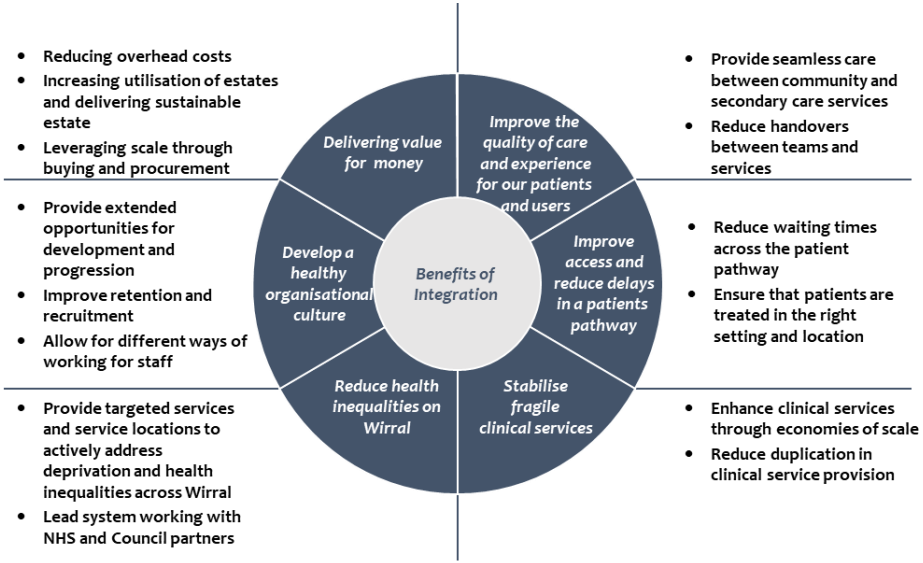
Council of Governors

May 2026

Background

Wirral System Review recommendations

- March 2024, C&M ICB commissioned an independent review of collaboration and integration opportunities across NHS provider services on Wirral.
- Value Circle was appointed to undertake Wirral System Review, with Report recommendations across two phases.
- Phase 1: focused on understanding the key opportunities of collaboration and integration across Wirral NHS providers, with a particular attention to a number of identified clinical pathways.
- Phase 2: focussed on describing the options for integration between WCHC and WUTH as well as recommending a model for integration and a high-level roadmap for implementation.
- The Review also identified a range of benefits from integration between WCHC and WUTH and move to single organisational form.



100 Working Day Integration Plan (Nov 24 - March 25)

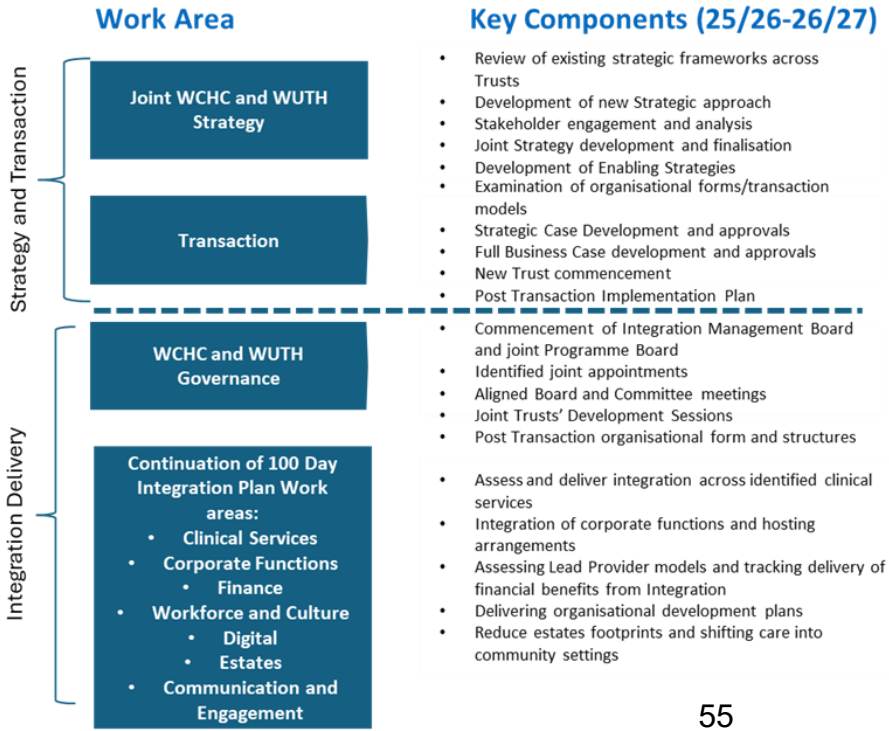
- To support the initial stages of integration and accelerate the joint working, an initial 100 Working Day Integration Plan was then developed and enacted.

- Across the first 100 working days (Nov 24 - March 25), the Trusts made significant progress in the initial stages of integration delivery.

Progress to date
Delivery of Two Year Integration Plan

Two Year Integration Plan delivery (April 25 – March 27)

- Following the conclusion of the 100 Working Day Integration Plan in April 2025, a longer term integration plan was developed, setting the strategic intentions for WCHC and WUTH on integration and a pathway towards becoming a single organisation.



Delivery of the Two Year Integration Plan

- Focus on delivery of the Two Year Integration Plan, with Year 1 Plan (25/26) delivering:
- **Governance**
  - Appointment of single Board and Executive across Trusts
  - Implementation of Partnership Agreement between WCHC and WUTH
  - Alignment of Board Committees and establishment of Integration Management Board
- **Clinical Services Integration**
  - Commenced service integration for Cardiology, Urgent Care, MSK bringing together teams across WCHC and WUTH
- **Corporate Functions**
  - TUPE of WCHC corporate staff and functions to WUTH
  - Commenced management of change for corporate functions across WCHC and WUTH

Delivery of the Two Year Integration Plan

- **Communication and Engagement**
  - Publishing of Case for Change
  - Delivery of internal and external communications plan and staff engagement activities – including staff and stakeholder briefings

- **Strategy**
  - Development and delivery of the 2026-32 Joint Strategy
  - Plan for delivery of enabling and clinical service strategies development across 26/27

- **Estates**
  - Review of Trusts estate and development of Estates Integration Plan
  - Commencement of service moves into community settings

Transaction between WCHC and WUTH

Longer Term Plan for Integration: transaction approach

Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

- In April 2025, the Trusts Boards approved the move to a single organisation for WCHC and WUTH, through an NHS England transaction process, with an aim to deliver by April-June 2027.
- This was based on the further delivery of clinical, quality and population benefits for the organisations and the direction of travel for many NHS Foundation Trusts who have, initially, put in place single leadership or group arrangements.
- The NHSE transaction process is multi-staged with significant approvals by ICB, NHSE and DHSC.

Stages

Strategic Case Development

Full Business Case Development

Due Diligence and Post Transaction Integration Plan

Transaction Set Up: Progress to date

- Since Board approval, the Trusts have progressed with the set up of the Transaction. This has included:

Assessment of statutory transaction type:

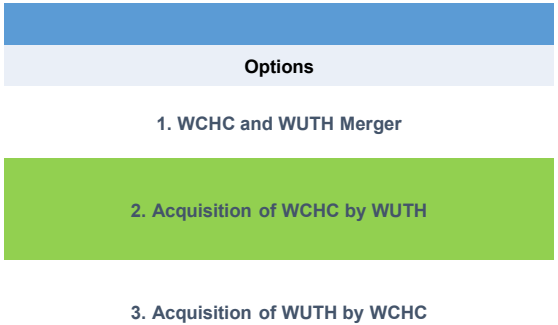
- Assessment was undertaken to propose the type of transaction between WCHC and WUTH, in line with NHSE Statutory Transaction Guidance.
- Following this process, Acquisition of WCHC by WUTH (Option 2) scored the highest and was selected as the preferred option. This Assessment and the preferred option was approved by the WCHC/WUTH Integration Management Board (Joint Committee) in June 2025.

Cheshire and Merseyside ICB Board Approval:

- In September 2025, C&M ICB Board supported WUTH and WCHC to progress with a transaction between the originations. The ICB also agreed to provide funding for the external support the transaction.

External Transaction support:

- Following a tender process, Deloitte LLP was appointed by the Trusts to support the development and delivery of the transaction, including SOC, FBC, DD and PTIP



Transaction timeframes and formation of new Trust

NHS Wirral Community Health and Care NHS Foundation Trust

NHS Wirral University Teaching Hospital NHS Foundation Trust

Transaction timeframes

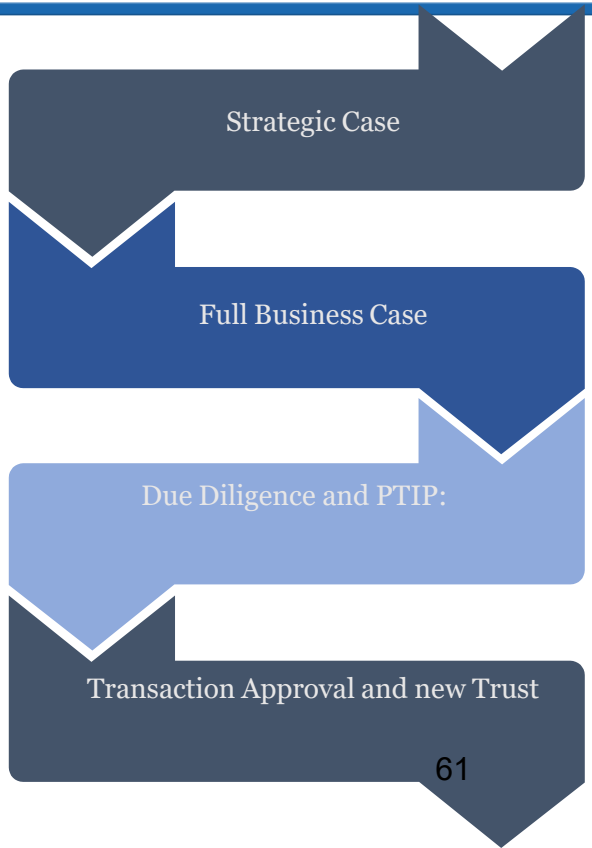
- Deloitte LLP commenced with the Trust in April 2026, and have worked with the Trusts to set out a transaction delivery plan and timeframes, including Board approvals and Council of Governors noting. These are set out below:

Strategic Case
- Strategic Case development: April – June 2026
- Trust Approvals: July 2026
- NHSE Review: August – September 2026

Full Business Case
- Full Business Case development: July – October 2026
- Trust Approvals: November 2026
- NHSE Review: December 2026 – February 2027
- DHSC & Secretary of State Review: February 2027 – March 2027

Due Diligence and Post Transaction Integration Plan
- DD and PTIP: July – October 2026
- Trust approvals: November 2026
- NHSE Review: December 2026 – February 2027

Formation of new Trust
- Establishment of new Trust: April 2027



Council of Governors
14 May 2026

Item No 10.1

Report Title	Committee Chairs Reports – WUTH Audit and Risk Committee
Date of Meeting	13 February 2026
Author	Lisa Greenhalgh, Chair of Audit and Risk Committee

Alert	The Committee wish to alert members of the Board of Directors that: • The Committee noted the increase in ID05 reflecting staff experience and the impact of organisational change on morale and culture. This would be discussed at People Committee. The Committee endorsed the risk and associated rating. • The Committee noted that the revised finance forecast represented a significant update to the position but did not change the risk score which was high. • The Committee approved the Joint Standing Financial Instructions and recommended the SFI's to the WUTH Board
Advise	The Committee wish to advise members of the Board of Directors that: • An advisory report was received in relation to Partnership and Governance Review by MIAA. The purpose was to map the governance arrangements in place at a divisional level against the Accountability and Performance Framework, and to consider the emerging group governance with mapping to support and strengthen arrangements. This will be used to assist in the development of new Governance arrangements • A report on Internal Audit Follow Up Summary by MIAA was received confirming good progress had been made on actions. Several actions had been marked as complete, but evidence was required and would be checked at the next review by MIAA. • An executive report was received to update on the progress of all internal audit recommendations noting of the 28 live actions, 9 had been completed, 7 in progress and within timeline and 12 overdue. Revised implementation dates were agreed for overdue recommendations. • The Committee received an overview of the compliance against the Functional Counter Fraud Standard and progress against the approved fraud plan, noting all areas were progressing as planned. • The 2026/27 Internal Audit plan was received by MIAA and approved. • The 2026/27 External Audit Plan is currently being developed by Azets and will be presented at the April meeting.
Assure	The Committee wish to assure members of the Board of Directors that: • A moderate assurance opinion was received in relation to Business Continuity Planning due to one high risk issue.

	Management will ensure that all corporate areas have a BCP and all BCPs are updated by Q1 26/27. MIAA will follow up. • A moderate assurance opinion was received in relation to WISE Ward accreditation Review due to the raising of one high risk issue and two moderate and one low. The resolution of this high-risk issue will be followed up by MIAA and the progress reviewed at the DQB meetings. • A substantial assurance was received in relation to User and Privileged User management Review.
Review of Risks	• The Committee discussed the current iteration of the BAF and confirmed it was content with the risks identified and the relevant risk ratings, particularly the highest rating relating to financial sustainability which the Board is sighted on.
Other comments from the Chair	• The annual review of the going concern statement, accounting policies and IFRS17 disclosure were noted and approved

Council of Governors
14 May 2026

Item No 10.2

Report Title	Committee Chairs Reports – Finance and Performance Committee
Date of Meeting	20 February 2026
Author	Meredydd David, Chair of Finance and Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ at the end of January, month 10, the Trust reported a deficit of £32.3m to date which excluding Deficit Support Funding (DSF) which is £13.6m adverse variance to plan with the most significant change compared to month 9 being the recognition of the loss of income due to the impact of the Sterile Services critical incident. ○ as approved by the Board, the Trust has confirmed to NHSE the revised forecast outturn for 2025/26. ○ that the Trust's most immediate finance risk remains the cash position and approved the CFO submits additional applications for cash support based on confirmed need. ○ urgent care performance particularly 4hr and 12hr has been significantly challenging during this period due to increased flow with this compounded due to the UECUP capital and refurbishment work underway
Advise	• The Committee wish to advise members of the Board of Directors that: ○ a revised capital budget of £24.8m was approved as additional capital funding of £0.4m had been allocated. ○ there are ongoing pressures from pay awards, industrial action, winter demand, and agency and bank usage, alongside continued reliance on some non-recurrent mitigations. ○ the three-year financial plan had been submitted to the ICB with this showing a trajectory to deliver the control total in 2028/29. ○ whilst improving, the cancer performance recovery plan will be presented to the next committee as it was a priority area. ○ the committee will receive regular deep dives into areas in future with the first in April agreed as the Surgery Division ○ the Trust had sought external capacity using a supplier to catch up on the backlog of coding completion which would prevent finance and clinical performance coding delays impacting income and KPI's ○ a recovery plan is being developed in partnership with WCHC to address the Subject Access Requests and FOI backlog. ○ a business case for an increase in Radiology workforce was discussed in detail and recommended to Board for approval ○ good progress is being made on the Green and Sustainability Plan delivery

	○ various capital projects underway are progressing well, on time and budget. This included the Emergency and Urgent Care Upgrade Project due to be handed over in early July 2026.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ financial recovery actions remain in place, including strengthened workforce controls, non-pay expenditure controls, and delivery of remaining CIP schemes in months 11 and 12. ○ Good progress is being made with estate safety and maintenance including statutory compliance and health and safety reporting and fire regulations. The aging estate was recognised as a challenge financially and for the team to maintain.
Review of Risks	FBPAC has oversight of five strategic risks with three of the risks scoring at high level (20). Risk mitigations and ratings were viewed as accurate.
Other comments from the Chair	The committee meeting emphasised the importance and challenges of moving to a break-even position within a plan that is agreed by the Board and supported by NHSE. In parallel with financial recovery the Trust must continue to drive improvements in clinical key performance indicators.

Council of Governors
14 May 2026

Item No 10.3

Report Title	Committee Chair's Report – WUTH Quality Committee
Date of Meeting	25 March 2026
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust had breached its agreed annual trajectory for Clostridioides difficile (C diff) infections. Although factors relating to high levels of attendance and admission meant that pressure on providing decant areas and the need for corridor care had been exceptionally material during winter months, there is a need for continued focus on fundamental infection control procedures. In addition, improving patient flow, through measures such as reserving Same Day Emergency Care (SDEC) facilities for designated patients, could also demonstrably improve C diff rates. A group of patients with recurrent C diff had been identified (about a third of cases), where highly effective controls would have a significant impact. ○ The continued incidence of higher-grade tissue ulcers remain a concern and, as such, will be a key component of both Trusts' quality improvement plans for 2026/27, lead through a "fundamentals of care" group. ○ Continued oversight, with a weekly executive-led meeting, of patients with extended lengths of stay is keeping focus on patients with no criteria to reside at the Trust.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ An update on the development of the Patient Safety Incident Response Framework (PSIRF) had been reviewed at Patient Safety Quality Board and it was felt that further work was required in relation to its policies and procedures. It had also been agreed that a specific approach would be required for Maternity and Neonatal services, which have a different external reporting methodology. This is in keeping with other organisations. ○ The action plan following the Care Quality Commission (CQC) inspection of Urgent and Emergency Care and Medicine Assessment was presented. Of the actions, 18/21 are complete. Two of the latter relate to the development and implementation of a trust-wide Standard operating Procedure for Safety Huddles. It has taken an appropriate amount of time to co-create that with all the relevant services. Piloting within the emergency department has anecdotally demonstrated positive impact, including on a supportive workforce culture.

	○ In concert with the findings of a Mersey Internal Audit Agency (MIAA) review (which gave moderate assurance), there has been reflection on the protocols and efficacy of our ward accreditation programme ("WISE"). As a result, pilots are to be conducted to shape the future of the programme. The MIAA action plan will be reviewed and tracked at the Audit and Risk and Quality Committees. ○ A previously large backlog of patients requiring treatment for acute macular degeneration had been greatly reduced and was now subject to ongoing monitoring. ○ Work is on-going to update the sepsis components within the electronic patient record to support effective and timely sepsis management. This has required a base upgrade to the system prior to the specific update. A manual audit each month, and the oversight of the Mortality Review Group are being used to monitor our effectiveness in sepsis management. ○ The Trust has completed the national Experience of Care Improvement Self-Assessment, formerly known as the Experience of Care Framework. The self-assessment consisting of 86 areas of focus was presented to the Executive Team March 2026. The results will be used to help the organisation understand how experience of care is embedded in our leadership, culture and operational processes, and inform ways to improve its ability to offer the best person-centred care and experience. These self-assessment outcomes alongside the anticipated publication in spring of the NHS Quality Schedule and NHS Experience Excellence Framework will provide valuable guidance for the progression of improvement and integration plans which will be shared with the Committee and Board in due course
Assure	• The Committee wish to assure members of the Board of Directors that: ○ It received a comprehensive quarterly report on Maternity and Neonatal Services and gained a high level of assurance. A recent external on-site review led by the North West Chief Midwifery Officer provided positive feedback and identified key strengths. It also highlighted further actions the services could take to continue to improve services. ○ Following the findings of the annual national cancer patient experience in 2025, which identified issues with patient experience in our urology service (on the background of large increase in referrals, post-pandemic), the Committee received a presentation outlining the significant actions taken to address the issues raised. The majority of the wide-ranging actions are complete. The next survey will likely be undertaken in the summer autumn when we will be able to fully judge the impact of the improvements made.

	○ Patient Safety and Quality Board reported that the Mortuary Access Policy and processes had been reviewed and strengthened.
Review of Risks	• The Committee reviewed BAF risk 3 (the delivery of outstanding care) and determined there was no need to advise modifying the risk rating. In reviewing the proposed integrated BAF risks for 2026/27, the Committee wished to ensure that the risk of compromise to quality of care by the level of cost improvement required by the medium term financial plan was identified within the BAF risk framework, so that controls and any gaps in control could be assessed by the Committee, in judging the level of assurance.
Other comments from the Chair	• The Committee benefited from receiving really clear and helpful reports that enabled it to conduct its business.

Council of Governors
14 May 2026

Item No 10.4

Report Title	Committee Chairs Reports – WUTH People Committee
Date of Meeting	22 January 2026
Author	Lesley Davies, Chair of People Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ **Workforce Performance**. The Committee discussed the alignment between workforce and finance plans, noting that workforce assumptions were impacted by the inability to fully deliver workforce transformation and by the non-recurrent achievement of Cost Improvement Programme (CIP) schemes. This continues to be a significant focus of work. ○ The Committee discussed the Freedom to Speak Up 6 monthly report and it was disappointing to learn that a Wirral social media group, external to the Trust, was writing about staff amid the current pressures. Posts have been reported to the police and Facebook and staff impacted are being supported.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ **Workforce Integration**. The Committee was provided with an update on the transfer of corporate services from WCHC to WUTH, which was completed on the 1st December 2025. The next stage in the process is to prepare staff for organisational change, and the Committee stressed the importance of good communication and a focus on staff experience noting that in the Staff Survey 2025, staff satisfaction had declined. ○ It was noted that the number of employee relations cases continue to reduce. A deep dive into this area of work highlighted the risk of potential delays in concluding cases which is influenced by case complexity, capacity and availability of key participants and resource constraints. The Committee will continue to keep a focus on this area of work. It was agreed that internal processes would be reviewed and a further update will be presented to the Committee at the June 26 meeting ○ The EDI and Gender Pay Gap annual reports were approved by the Committee. Both reports will be presented to the Board in the coming weeks and submitted for regulatory reporting. ○ **Workforce Performance Report.** The Committee considered mandatory training compliance, with particular focus on Level 1 Fire Safety. It was noted that compliance levels were expected to dip temporarily as fire safety training was refreshed and aligned to the Core Skills Framework, and as staff competencies were reassessed. The Committee noted that overall safety was maintained through Level 2 training coverage

	and that the Trust had a strong cohort of fire wardens compared to the previous year. ○ **Managing Behaviours that Challenge.** The Violence Prevention and Reduction Plan continues to be embedded across the Trust and an update was provided on the progress being made since the last meeting. The Trust is trialling the use of body-worn cameras in the Emergency Department which will commence at the end of January 2026. The trial will be evaluated to inform a possible future Trust-wide roll out.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ **Estates and Facilities Deep Dive.** Given the consistent level of high sickness absence, the Committee has requested frequent updates on the measures being taken to improve absence levels. The second deep dive provided an update on the work being undertaken to address sickness absence within the team, including details of a new initiative with the aim of making the transition back to work less daunting and help to develop coping strategies. There are early indications that this pilot and the work being undertaken to manage absence is having a positive impact; there has been a reduction in sickness absence for the past two months. The Committee took assurance from the focus on this division and of the work and the promising early improvements. ○ **Guardian of Safe Working Report**. The Committee noted that, in line with past reports, the majority of exception reporting were raised from the Medicine Division and from F1 doctors. It was also noted that although the expected changes to the report process is now being implemented, the preparation and readiness for implementation in being well-manage
Review of Risks	• The Committee agreed to propose changes to BAF Risk 5. The proposed increase is in the likelihood score from '3 - possible' to '4 - somewhat likely'. The Committee was advised this increase was specifically in relation to the staff experience element.
Other comments from the Chair	• It was noted that, given the integration between WUTH and WCHC, there is now considerable overlap of the agenda items and reporting. Committee members welcomed that the two Committees will fully integrate from April 2026.

Council of Governors **Item 11**

14 May 2026

Title	WUTH Integrated Performance Report – M11 (February 2026)
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 February 2026 (or latest available months data).

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

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	**1**	**3**	**-**	**4**
Operations	**3**	**14**	**1**	**18**
Quality and Safety	**9**	**11**	**4**	**24**

All Metrics For latest available data, where agreed targets have been defined, 17 metrics were achieving the agreed target and 33 were not achieving target.
N.B. There are 7 metrics without target at present.

It is recommended that the Council:

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

Key Risks

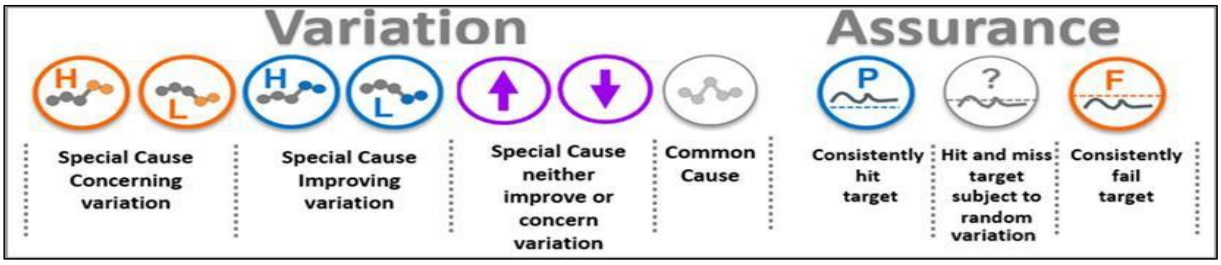
This report relates to the key risks of:

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.

All Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Feb 26	5.51%	≤5%			5.97%
Staff turnover % - in-month rate	Feb 26	0.50%	≤1%			87.76%
Mandatory training % compliance	Feb 26	89.13%	≥90%			92.31%
Appraisal % compliance	Feb 26	87.81%	≥88%			0.84%
4-hour Accident and Emergency Target (including APH UTC)	Feb 26	60.56%	≥95%			61.0%
Number of inpatients not meeting the Criteria to Reside	Feb 26	150	-			156
Patients waiting longer than 12 hours in ED from a decision to admit	Feb 26	758	≤0			649
Proportion of patients more than 12 hours in ED from time of arrival	Feb 26	20.12%	≤0%			18.3%
Ambulance Handovers: % < 30 mins	Feb 26	54.15%	≥95%			54.0%
Ambulance Handovers: % < 45 mins	Feb 26	78.06%	≥100%			72.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Feb 26	59.79%	≥92%			58.8%
Referral to Treatment - total open pathway waiting list	Feb 26	46197	≤47616			45326
Referral to Treatment - cases exceeding 52 weeks	Feb 26	978	≤536			1484
Referral to Treatment - cases waiting 78+ wks	Feb 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Jan 26	130	≤77			140
Cancer - Faster Diagnosis Standard	Jan 26	65.82%	≥77%			72.6%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jan 26	90.80%	≥96%			91.3%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Dec 25	90.20%	≥96%			92.6%
Cancer Waits - 62 days to treatment (monthly)	Jan 26	70.67%	≥85%			74.5%
Cancer Waits - 62 days to treatment (quarterly)	Dec 25	72.86%	≥85%			74.9%
Diagnostic Waiters, 6 weeks and over - DM01	Feb 26	96.95%	≥95%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Feb 26	186	≤79			168
Clostridioides difficile (healthcare associated)	Feb 26	16	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Feb 26	5	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Feb 26	0	≤0			0
Patient Safety Incidents	Feb 26	1326	-			1212
FFT Overall experience of very good & good: ED	Feb 26	75.9%	≥95%			75.8%
FFT Overall experience of very good & good: Inpatients	Feb 26	96.0%	≥95%			95.5%
FFT Overall experience of very good & good: Outpatients	Feb 26	96.1%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Feb 26	83.3%	≥95%			96.0%
Patient Experience: concerns received in month - Level 1 (informal)	Feb 26	284	≤173			230
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Feb 26	5	≤3			3
Falls – Moderate to Severe Harm	Feb 26	0.1	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Feb 26	91.0%	≥90%			88.9%
WUTH Average RN Night Staffing Fill Rates	Feb 26	95.0%	≥90%			90.6%
WUTH Average CSW Day Staffing Fill Rates	Feb 26	87.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Feb 26	97.0%	≥90%			99.6%
MRSA Cases	Feb 26	0	≤0			0
MSSA Cases	Feb 26	2	≤0			2
% of adult patients VTE risk-assessed on admission	Feb 26	96.4%	≥95%			97.2%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Feb 26	89.0%	≥90%			89.2%
Mortality (SHMI)	Oct 25	1.033	0.95-1.05			1.022
Number of studies open	Feb 26	44				
% of current studies meeting recruitment target	Feb 26	31.8%				
% of open studies with a commercial sponsor	Feb 26	6.8%				

Wirral University Teaching Hospital

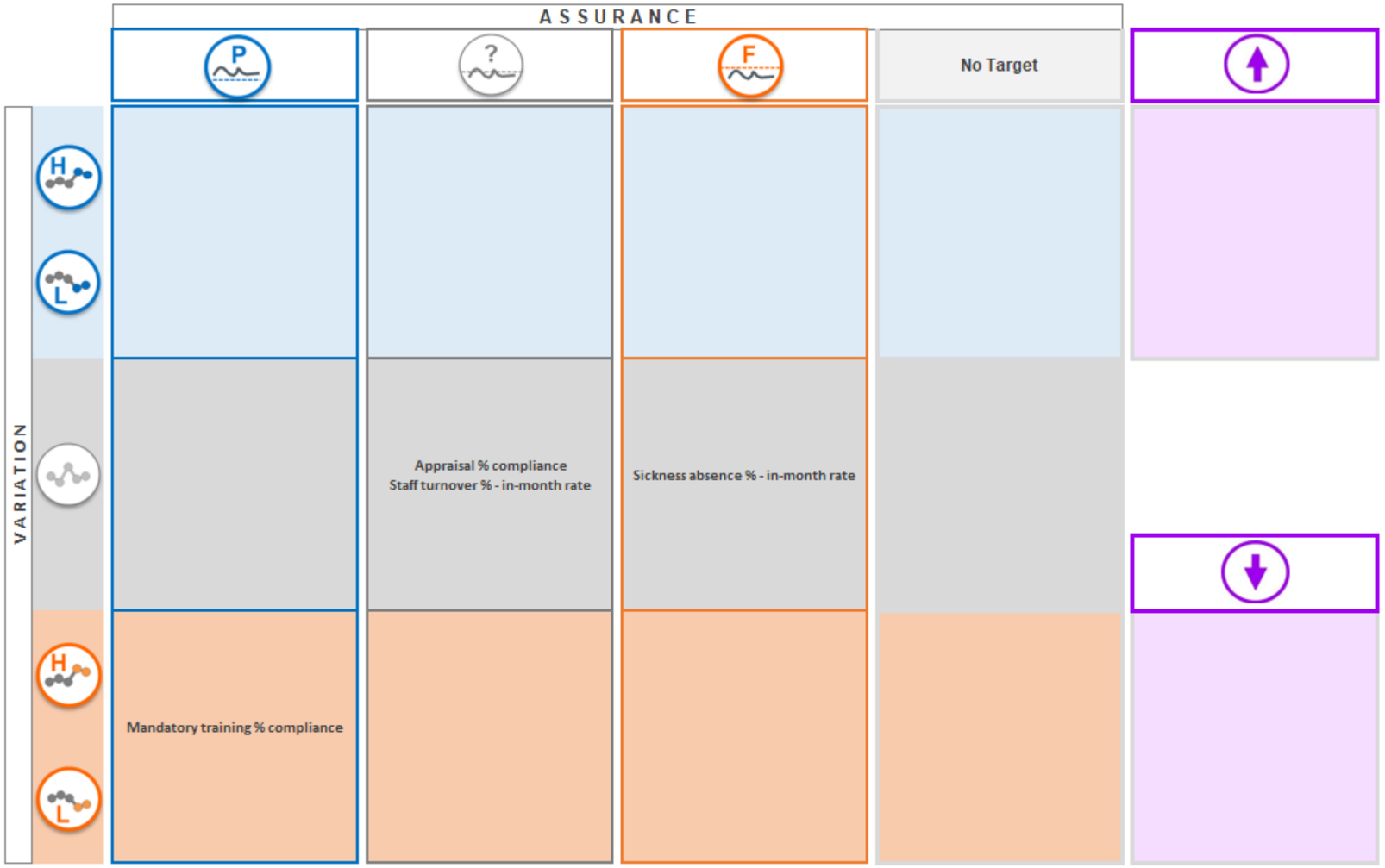
TABLE 1: SCORED METRICS (Contributing to Segmentation)

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

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

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	Feb 26	5.51%	≤5%			5.97%
Staff turnover % - in-month rate	Feb 26	0.50%	≤1%			87.76%
Mandatory training % compliance	Feb 26	89.13%	≥90%			92.31%
Appraisal % compliance	Feb 26	87.81%	≥88%			0.84%

Areas of Concern

Sickness absence levels are above the Trust's 5% threshold but continue to demonstrate improvement.

Latest performance is 5.51% in-month which is an improvement since January 2026, and an improved in-month position compared to both February 2025. This demonstrates an improved position beyond expected seasonal trends.

The current in-month top 3 reasons are mental health, Gastro and Cold/Cough/Flu.

Clinical Support Division ,Corporate Support and Medicine Division all performed within the threshold.

Estates and Facilities was the highest (7.51%), followed by W&C (6.51%), Surgery Division (6.19%) and ED (6.08%).

The three staff groups highlighted as areas of focus are:
Additional Clinical Services
Nursing and Midwifery
Estates and Ancillary

Additional Clinical Services and Nursing and Midwifery show improvements in-month compared to February 2025. Estates and Ancillary staff group have maintained a similar position.

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

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

Forward Look (Actions)

Proactively supporting physical health and wellbeing:

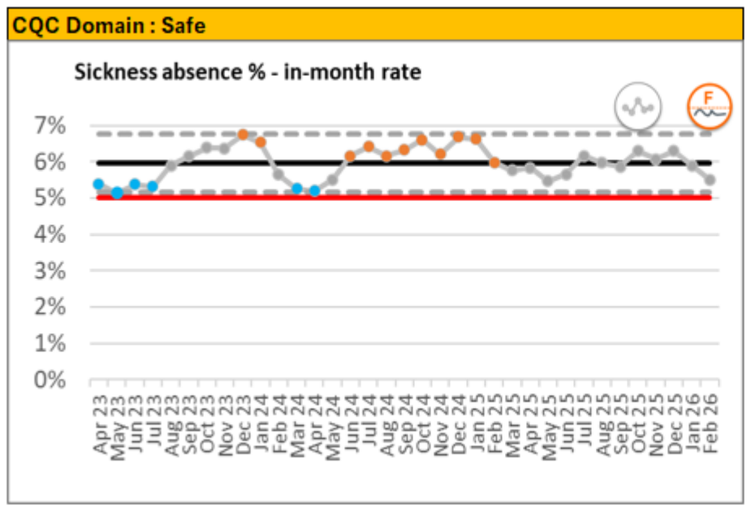
- Aligned with the top reason for sickness, Wellbeing Surgeries took place in both January and February focused on mental health across both Trusts with further dates to run in April and May.
- Continuation of the communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness, current focus on debt awareness.
- January Well WUTH & WCHC programme held.
- Advancement of the new Well WUTH & WCHC promotional video to increase uptake through both powerful individual stories and increased awareness.
- New staff smoking cessation clinic now starting in March.
- Cervical Screening Living Well Bus (mobile clinic) attended APH on 13 February and 4 March.
- New psychological intervention process, support and training being designed for managers to help staff post a significant event.
- Mental Health First Aid support session undertaken for MHFA Trained staff at both Trusts.

Managing Absence:

- New Sickness Transformation Project OD led Listening Events have been held to help shape the workgroup plans.
- Focus on Resident Doctors' sickness and finalisation of the new RTW SOP.
- Continuation of sickness absence training.
- High impact action plans for each Division focused on hot spots.
- HR drop-in sessions provide managers with access to dedicated HR resource to support with case management.
- The Attendance Management Policy continues to be embedded, and numbers of final stage hearings continue to increase.
- Local Sickness Audits remain on going and are reported into WSB as BAU within the Performance Report.

Sickness absence % in month rate

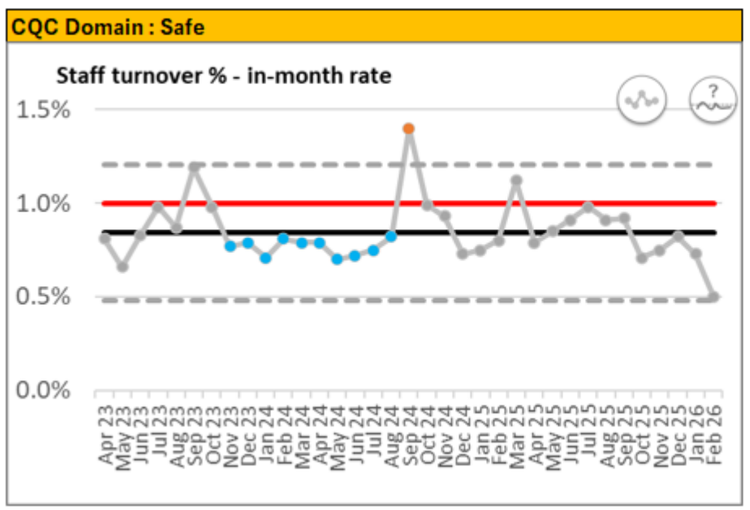
CQC Domain : Safe



Feb-26
5.5%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Consistently fail target

Staff turnover % in month rate

CQC Domain : Safe

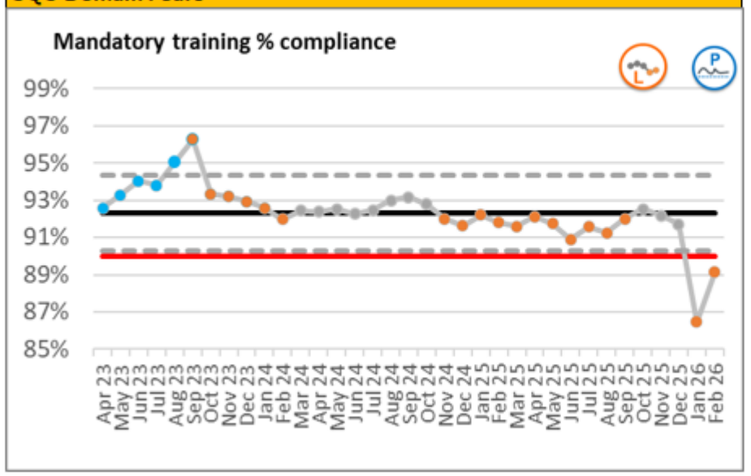


Feb-26
0.5%
Variance Type
Common cause variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance

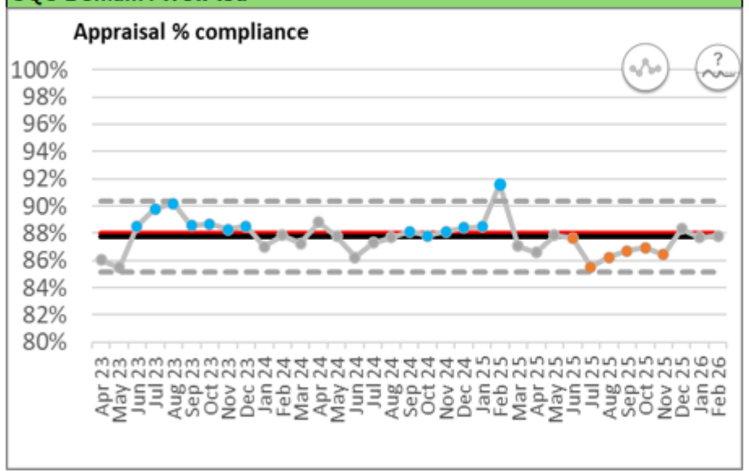
Appraisal % compliance

CQC Domain : Safe



Feb-26
89.1%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Consistently hit target

CQC Domain : Well-led



Feb-26
87.8%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

Mandatory Training % Compliance

Mandatory training compliance reduced below target in January 2026 due to a risk identified during alignment with Core Skills Training Framework. This project identified that Fire Awareness level 2 (practical element) was not meeting the learning outcomes for Fire Awareness (Level 1) and therefore reporting against Fire Awareness Level 1 was not previously accurate. At this point, Risk 2337 was raised and communicated throughout the Trust, outlining that overall mandatory training compliance was at risk of reducing below the trust Target of 90%. Adjustments were made within ESR to assign Fire Safety Level 1 e-learning separately to the Practical (Level 2) training and this message was communicated via various channels and governance groups. Risk 2337 has a forecast date of 30/04/2026 for the Trust to reach 90% overall compliance for Mandatory Training.

Mandatory Subject	Jan 2026 (%)	Feb 2026 (%)	Variance (%)	KPI	Compliance
Fire Safety Level 1	47.22	69.48	+22.26	90%	

In line with Risk 2337, the Trust's overall Mandatory Training compliance dropped below target to 86.46% in January 2026, with Fire Safety Level 1 reducing to 44.77%. Targeted action throughout January and February has resulted in a 22.26% increase to almost 70%. Mitigation remains in place via local fire wardens and local risk assessments.

Division	Jan 2026 (%)	Feb 2026 (%)	Variance (%)	KPI	Compliance
Clinical Support	89.71	91.69	+ 1.98	90%	
Corporate Support	90.62	90.81	+ 0.19		
Emergency	81.07	83.26	+ 2.19		
EF&C	84.63	81.23	- 3.4		
Medicine	85.94	90.06	+ 4.12		
Surgery	86.94	91.51	+ 4.57		
Women & Children's	82.95	88.32	+ 5.37		
Trust	**86.46**	**89.1**	**+ 2.64**		

Appraisal % Compliance

Organisational appraisal compliance has once again fallen beneath the 88% KPI (last met November 2025 at 93.92%) however, there are some divisions who do meet the KPI each month.

Data from February demonstrates a minimal increase in Trust compliance in comparison to January data (87.81% vs 87.7%), with improved compliance in Clinical Support, Corporate Support, Estates Facilities & Capital, Surgery and Medicine divisions. Data shows a reduction in compliance in Emergency and Women & Children's divisions. Divisional compliance data for February, compared to January, is below:

Division	Jan 2026 (%)	Feb 2026 (%)	Variance (%)	KPI	Compliance
Clinical Support	88.02	90.91	+ 2.89	88%	
Corporate Support	84.86	84.02	+ 0.84		
ED	74.22	71.75	- 2.47		
EF&C	83.47	83.58	+ 0.11		
Medicine	89.16	90.32	+ 1.16		
Surgery	92.35	94.03	+ 1.68		
W&C	90	89.62	- 0.38		
Trust	**87.7**	**87.81**	**- 0.11**		

Recent actions taken:

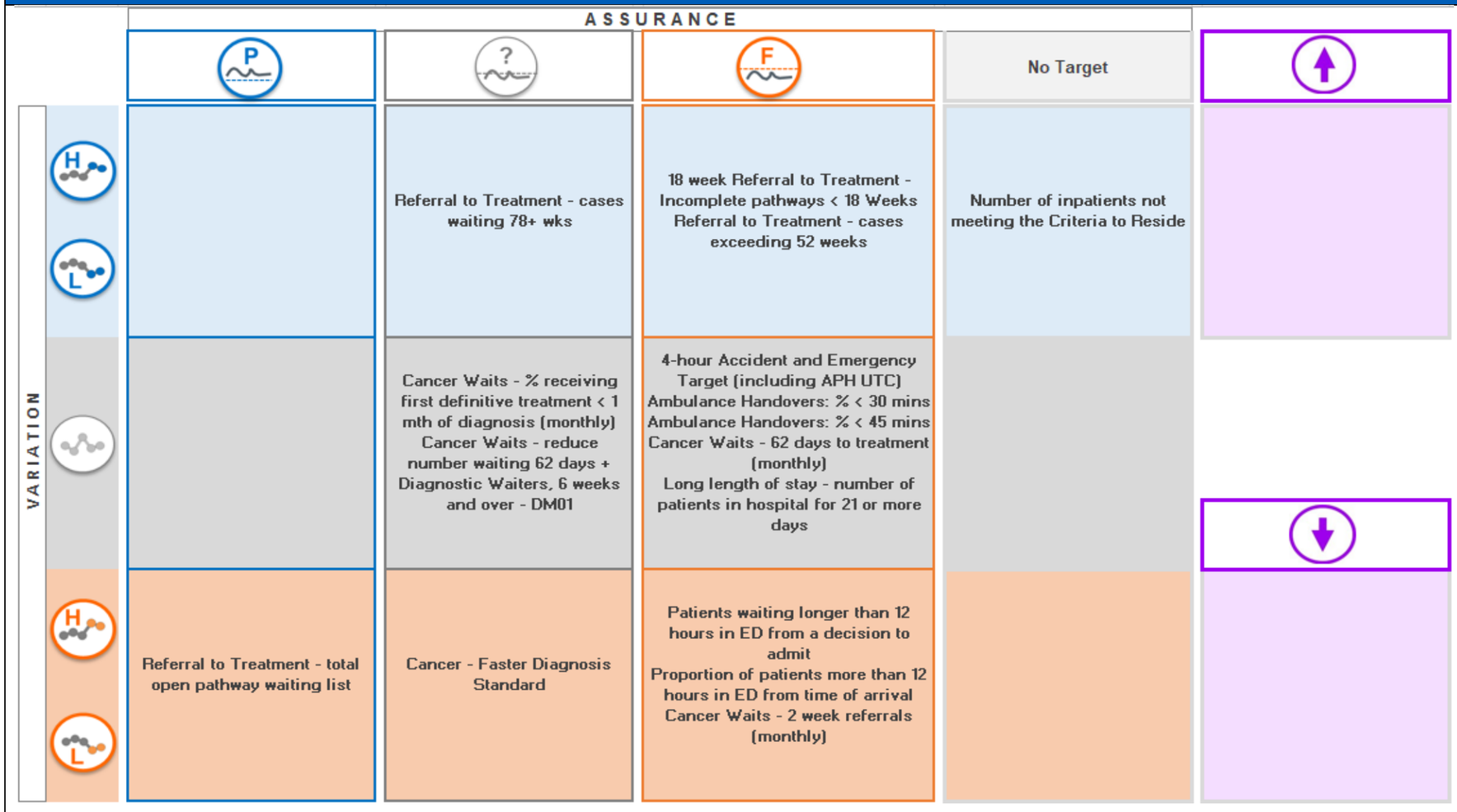
- A review of the training materials to include an increased focus on the effective recording of appraisals has been undertaken.
- Feedback has been sought to identify how well the new Appraisal and Check In documentation has been received since its launch in August. Generally, feedback is positive, indicating that it's more intuitive, that it flows better and that there's prompt questions to support both the reviewer and reviewee in having more meaningful conversation.
- Deep dive data to be made available per division monthly, in line with the production of the divisional monthly compliance reports.
- An e-learning package has been produced to support staff in engaging with and gaining more value from their appraisal meeting.
- Pilot of appraisal audit commenced within three areas in early March in collaboration with associated HRPB and directorate managers.

Look forward actions:

- Review of appraisal audit and associated improvements. Make improvements as required and present results to Workforce Steering Board with a view to making business as usual.
- Ongoing proactive targeting of appraisal compliance for outstanding and 'due' appraisals.
- HRBP's working with their respective divisional leadership teams to drive compliance improvement, with OD support, where required.
- Plans to undertake a further evaluation of the appraisal paperwork in Q1 2026, to identify additional opportunities for improvement.

Dashboard	Operations
Lead	Executive Managing Director

Operations Domain Matrix



Operations Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Feb 26	60.56%	≥95%			61.0%
Number of inpatients not meeting the Criteria to Reside	Feb 26	150	-			156
Patients waiting longer than 12 hours in ED from a decision to admit	Feb 26	758	≤0			649
Proportion of patients more than 12 hours in ED from time of arrival	Feb 26	20.12%	≤0%			18.3%
Ambulance Handovers: % < 30 mins	Feb 26	54.15%	≥95%			54.0%
Ambulance Handovers: % < 45 mins	Feb 26	78.06%	≥100%			72.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Feb 26	59.79%	≥92%			58.8%
Referral to Treatment - total open pathway waiting list	Feb 26	46197	≤47616			45326
Referral to Treatment - cases exceeding 52 weeks	Feb 26	978	≤536			1484
Referral to Treatment - cases waiting 78+ wks	Feb 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Jan 26	130	≤77			140
Cancer - Faster Diagnosis Standard	Jan 26	65.82%	≥77%			72.6%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jan 26	90.80%	≥96%			91.3%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Dec 25	90.20%	≥96%			92.6%
Cancer Waits - 62 days to treatment (monthly)	Jan 26	70.67%	≥85%			74.5%
Cancer Waits - 62 days to treatment (quarterly)	Dec 25	72.86%	≥85%			74.9%
Diagnostic Waiters, 6 weeks and over - DM01	Feb 26	96.95%	≥95%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Feb 26	186	≤79			168

Areas of Concern

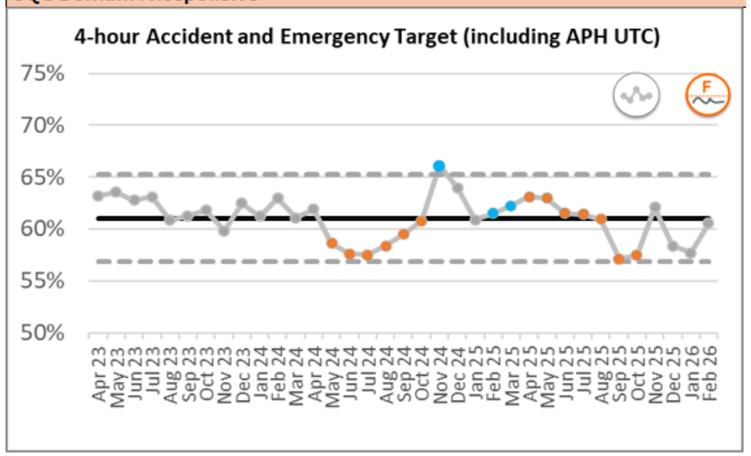
- Urgent and emergency care performance remains a risk in particular delivering improvements across 4 and 12 hours.
- Ambulance handover performance in February improved from January but remained a challenge with handover 45.

Forward Look (Actions)

- Executives along with the director triumvirate have been planning actions to improve performance for the March 4 hour sprint. Earlier indications show improved performance compared to the previous year.

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

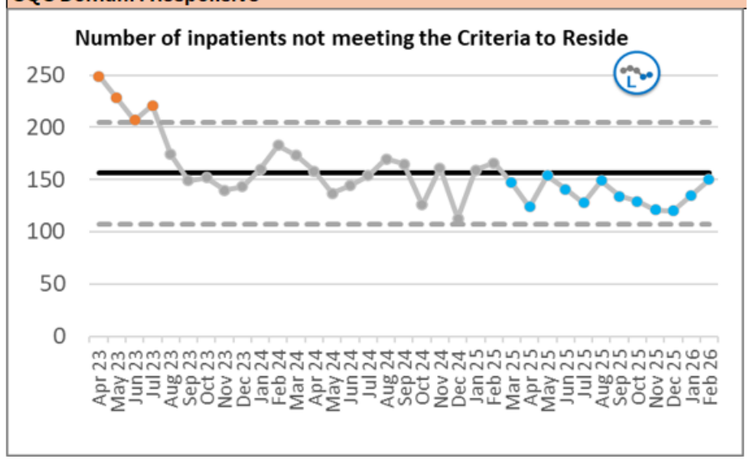
CQC Domain : Responsive



Feb-26
60.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

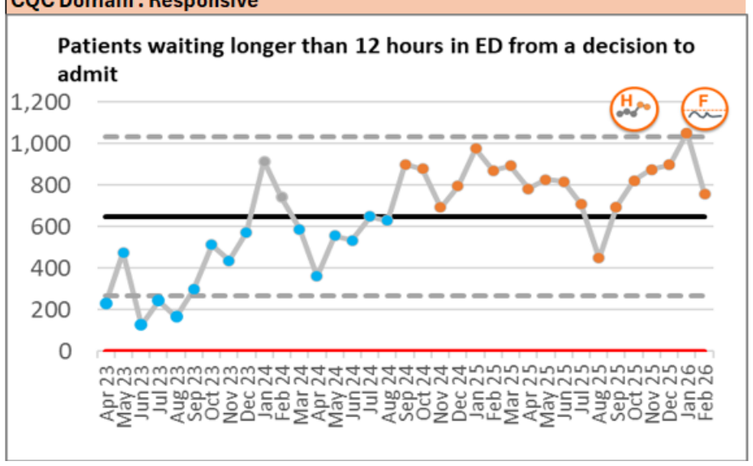
CQC Domain : Responsive



Feb-26
150
Variance Type
Special cause improving variation
Threshold
-
Assurance
Not applicable

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

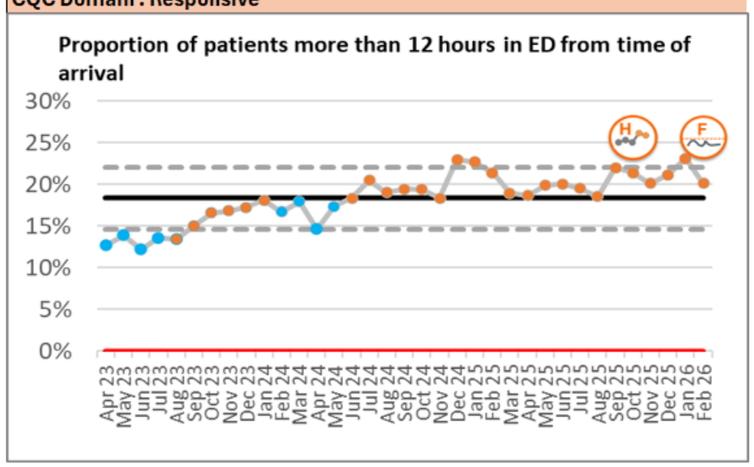
CQC Domain : Responsive



Feb-26
758
Variance Type
Special cause concerning variation
Threshold
≤0
Assurance
Consistently fail target

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

CQC Domain : Responsive



Feb-26
20.1%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

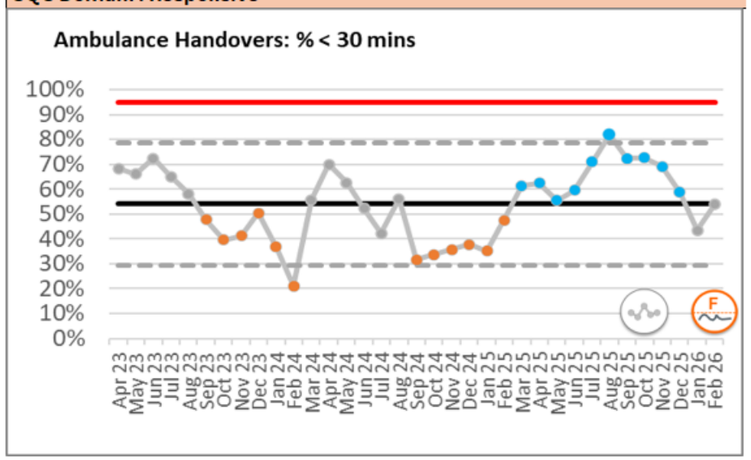
Commentary

4 Hour Standard- 4 hour performance for Arrowe Park site (Type 1 and 2) was 60.6% in February '26. This is an improvement from December and January but remains slightly below the mean performance of 61%. Actions are in place to support March sprint and further performance improvement is anticipated.

12 hour LoS/ DTA- The number of patients waiting more than 12 hours following a DTA and spending longer than 12 hours within ED has seen a positive improvement in February but remains outside of target. The improvement relates to a reduction in overall demand and demand for inpatient beds in February.

Ambulance handover % < 30 minutes

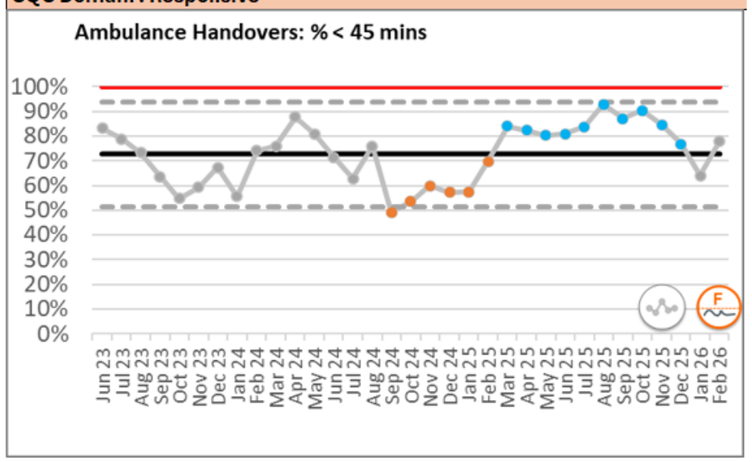
CQC Domain : Responsive



Feb-26
54.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

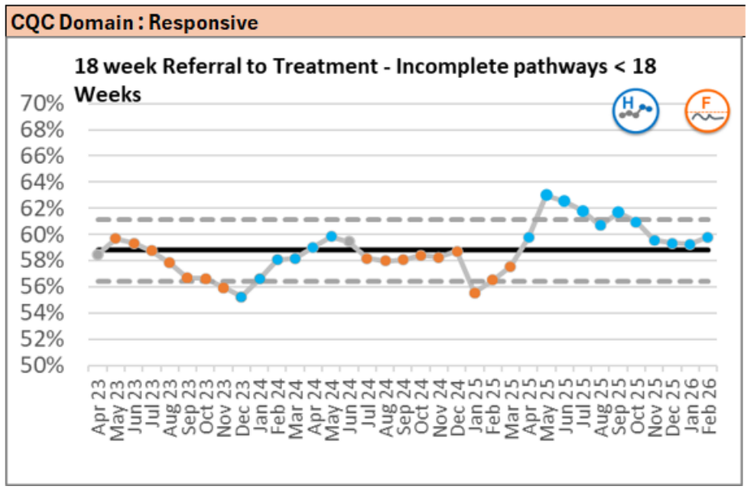
CQC Domain : Responsive



Feb-26
78.1%
Variance Type
Common cause variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

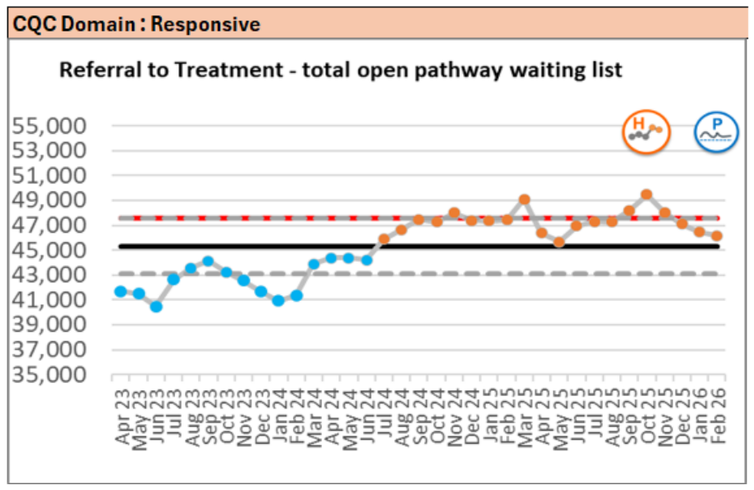
CQC Domain : Responsive



Feb-26
59.8%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



Feb-26
46197
Variance Type
Special cause concerning variation
Threshold
≤47616
Assurance
Consistently hit target

Commentary

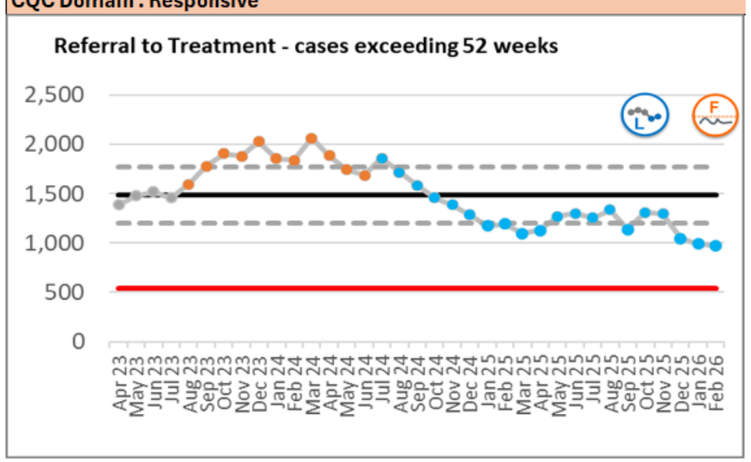
Ambulance Handover- Performance for handovers within 30 and 45 minutes improved in February to above the mean. Performance has been sustained above the mean since March 2025, except for the deterioration in January 2026. The new AAZ and associated processes has allowed for sustained improvements in delivering effective handover and releasing of ambulance crews.

RTT - The Trust RTT waiting list was lower than trajectory (positive position), but percentage of patients waiting 18 weeks or under was below trajectory (behind target level for February). This remains a risk for the March trajectory delivery.

RTT position remains below target since the impact of the sterile services incident, which saw the cessation of, and then a reduction in, the level of elective admitted activity through to January 2026. A range of initiatives are in place to support recovery of the position. This includes participating in the national outpatient sprint and continuation of the national validation sprint. Further to this, the ICB have funded triage of referrals (over 18 weeks) in Dermatology and ENT, seeing the discharge of inappropriate referrals in ENT. External validation support has also been sourced to support identification of additional clock stops (funded from national validation sprint monies). Insourcing is being focused on improving the RTT position in Dermatology and ENT, along with the use of outsourcing in ENT to create further capacity. Administrative and reporting processes have also been reviewed to address delays that negatively impact RTT performance.

Referral to Treatment – cases exceeding 52 weeks

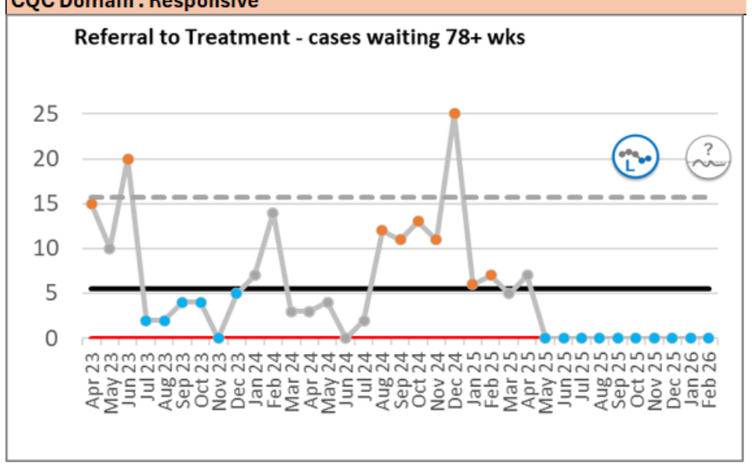
CQC Domain : Responsive



Feb-26
978
Variance Type
Special cause improving variation
Threshold
≤536
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

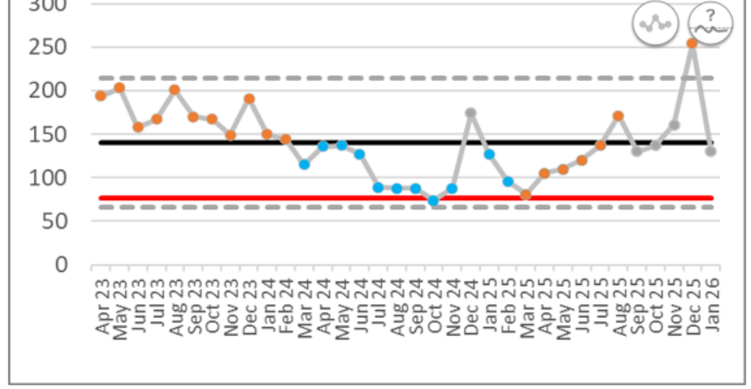
CQC Domain : Responsive



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

Cancer Waits – reduce number waiting 62 days +

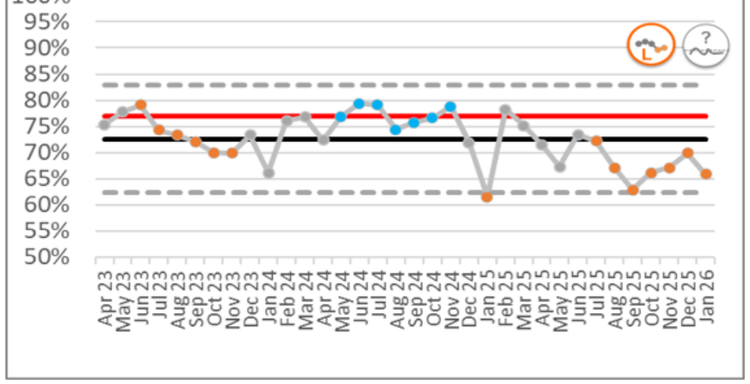
CQC Domain : Responsive



Jan-26
130
Variance Type
Common cause variation
Threshold
≤77
Assurance
Hit and miss target subject to random variation

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



Jan-26
65.8%
Variance Type
Special cause concerning variation
Threshold
≥77%
Assurance
Hit and miss target subject to random variation

Commentary

RTT - The Trust achieved 0 x 78-week and 0 x 65-week waiters in February, maintaining this position from December 2025.

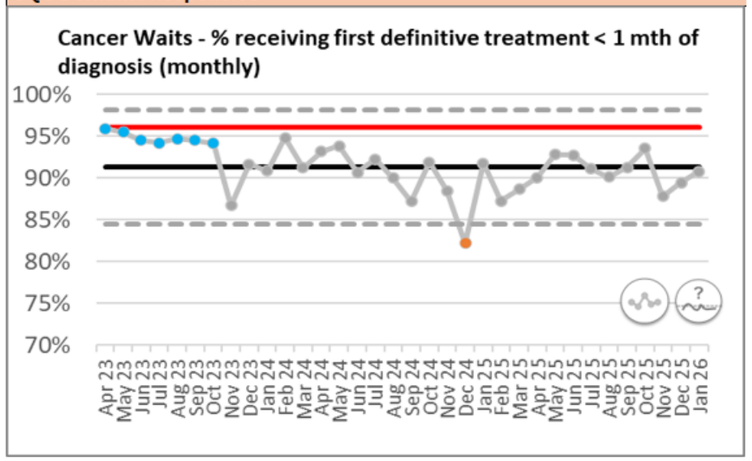
Cancer – The Trust has failed to meet the local trajectory for the Faster Diagnosis Standard (FDS), with January performance at 65.8% versus trajectory of 79.36%. The Trust is forecast to achieve the FDS standard by March 2026, as supported by weekly tracking of performance.

Skin cancer performance continues to impact on overall Trust performance, but is noted as continuing to improve from its lowest point in October as a result of insourcing (funded by the Cancer Alliance). Breast performance was also negatively impacted by locum availability in January, dipping below levels seen in November and December. The Breast locum consultant has been replaced in January, and performance is improving. Key milestones for the Skin pathway (time to first appointment, time for follow-up post-AI review and time to minor ops) have been recovered.

The number of patients waiting over 62-days increased as a result of the sterile services incident, and peaked at the end of December 2025. It subsequently continued to reduce, with weekly monitoring of this metric seeing it continue to decrease through February and March, to the lowest figure seen since December 2022. Achieving the % performance for 62 days for year end will be a challenge but the trajectory for the number of patients waiting longer than 62 days will be achieved.

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

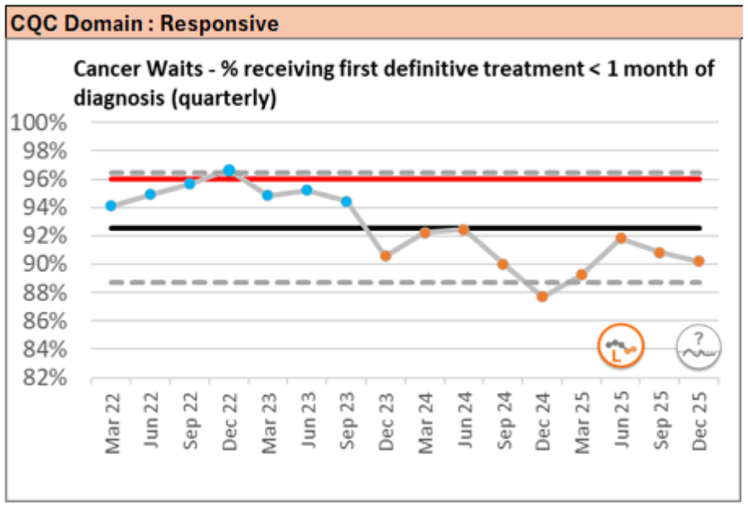
CQC Domain : Responsive



Jan-26
90.8%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

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

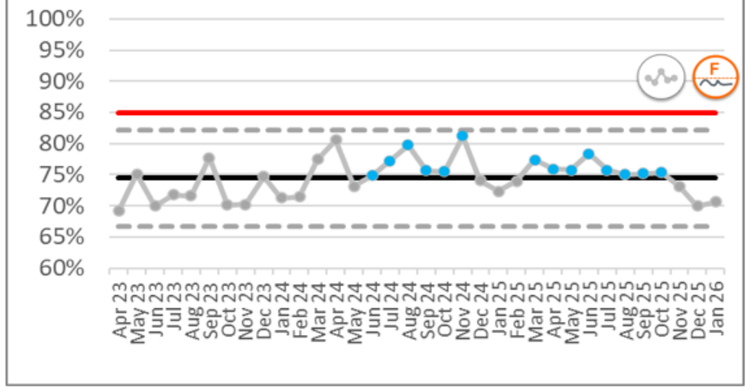
CQC Domain : Responsive



Dec-25
90.2%
Variance Type
Special cause concerning variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

Cancer waits - 62 days to treatment (monthly)

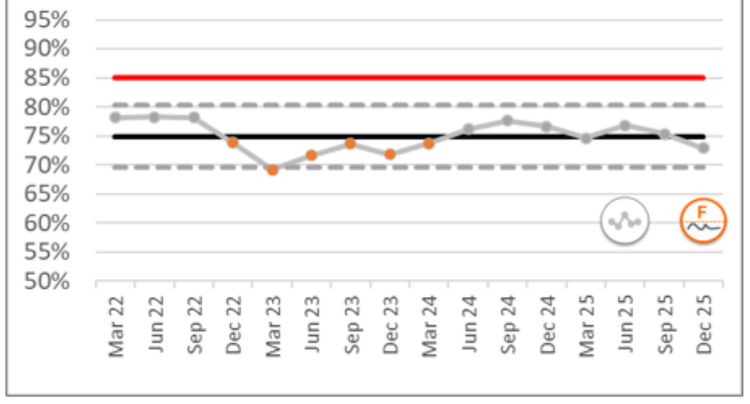
CQC Domain : Responsive



Jan-26
70.7%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

Cancer waits - 62 days to treatment (quarterly)

CQC Domain : Responsive



Dec-25
72.9%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

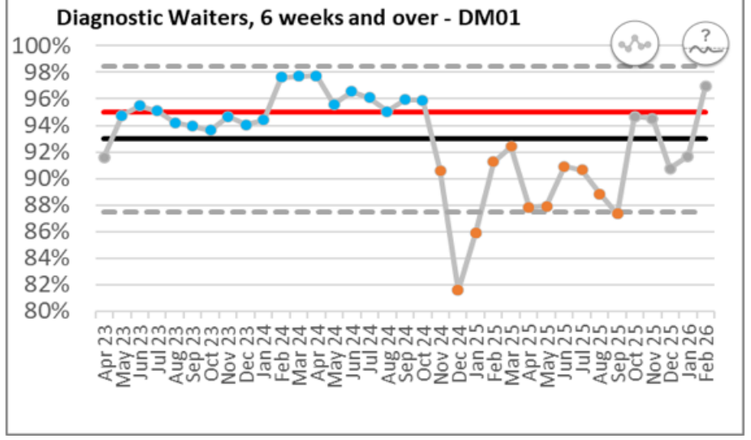
Commentary

31 Day Treatment Standard - The Trust failed to achieve local trajectory in January 2026 at 90.80% versus trajectory of 94.46%. Skin performance was seen to deteriorate, impacting the Trust overall position.

62 Day Treatment Standard - The Trust failed to achieve local trajectory in January 2026 at 70.67% versus trajectory of 77.34%. 62-day performance is noted as impacted by reduction in 28-day performance in earlier months and will improve as the impact of improved FDS performance is seen. There is a real risk to the delivery of the % target by year end but the volume of 62 wait breaches will be delivered by the year end.

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



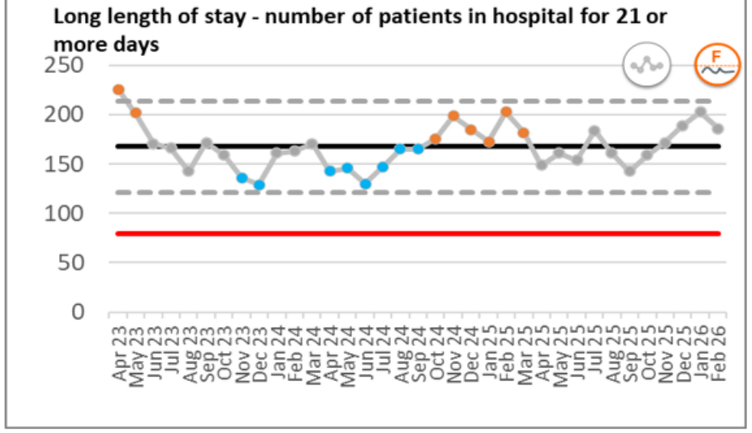
Feb-26
97.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

The Trust achieved 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 97.0% for February.

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

CQC Domain : Effective



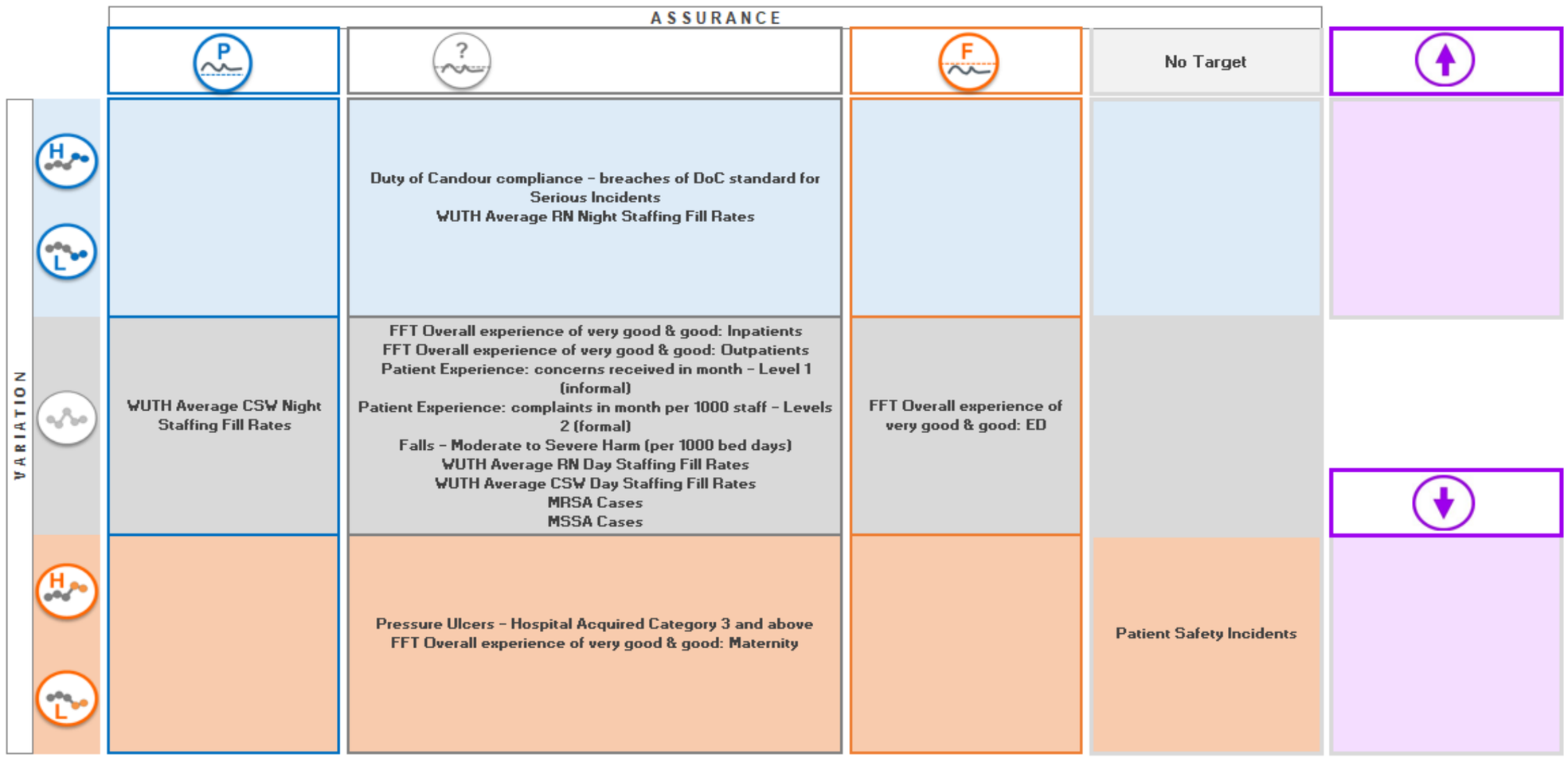
Feb-26
186
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

Commentary

The CEO has commenced an urgent task and finish group into the long stay patients. This has been launched during March and will continue into Q1.

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix



Quality and Safety Care Summary

Highlights

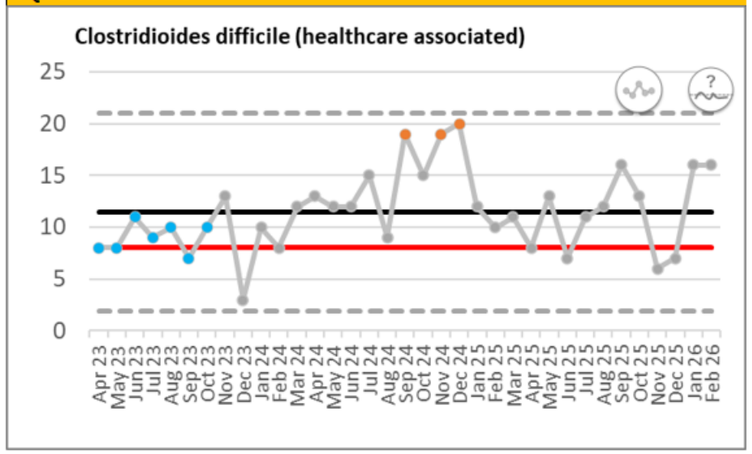
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Feb 26	16	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Feb 26	5	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Feb 26	0	≤0			0
Patient Safety Incidents	Feb 26	1326	-			1212
FFT Overall experience of very good & good: ED	Feb 26	75.9%	≥95%			75.8%
FFT Overall experience of very good & good: Inpatients	Feb 26	96.0%	≥95%			95.5%
FFT Overall experience of very good & good: Outpatients	Feb 26	96.1%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Feb 26	83.3%	≥95%			96.0%
Patient Experience: concerns received in month - Level 1 (informal)	Feb 26	284	≤173			230
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Feb 26	5	≤3			3
Falls – Moderate to Severe Harm	Feb 26	0.1	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Feb 26	91.0%	≥90%			88.9%
WUTH Average RN Night Staffing Fill Rates	Feb 26	95.0%	≥90%			90.6%
WUTH Average CSW Day Staffing Fill Rates	Feb 26	87.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Feb 26	97.0%	≥90%			99.6%
MRSA Cases	Feb 26	0	≤0			0
MSSA Cases	Feb 26	2	≤0			2

Areas of Concern

Forward Look (Actions)

Clostridioides difficile (healthcare associated)

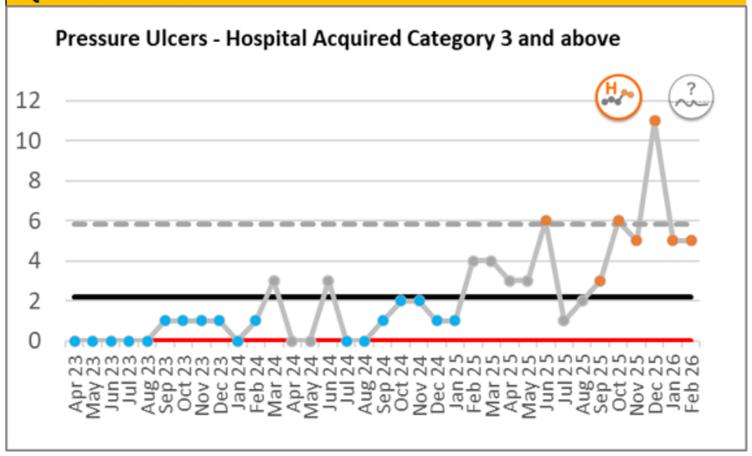
CQC Domain : Safe



Feb-26
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

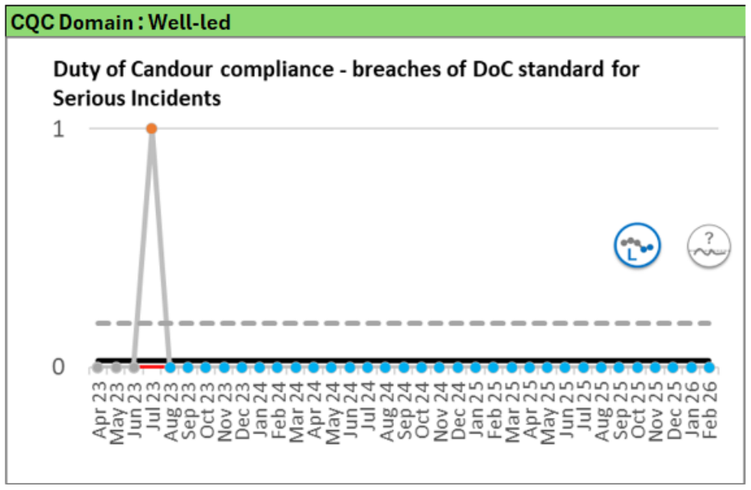
CQC Domain : Safe



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

Duty of Candour Compliance

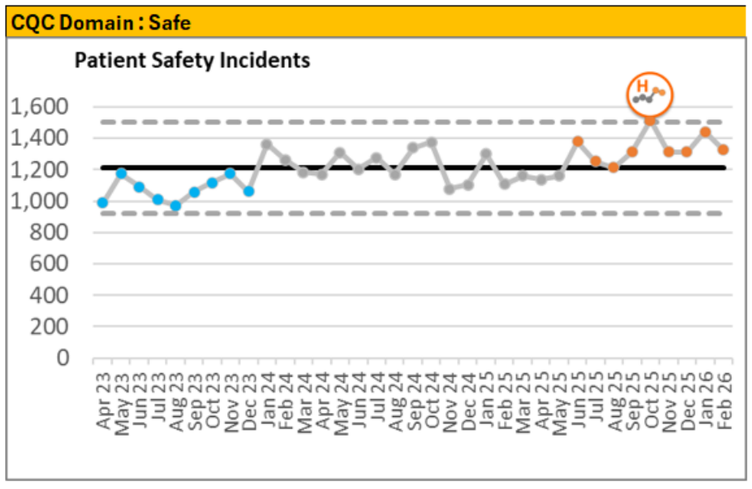
CQC Domain : Well-led



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

Patient Safety Incidents

CQC Domain : Safe



Feb-26
1326
Variance Type
Special cause concerning variation
Threshold
-
Assurance
Not applicable

Commentary

Clostridioides difficile

In February there were 14 HOHA and 2 COHA CDTs, which is the same as last month. At least 6 of these patients were on a Norovirus outbreak ward at the time of diagnosis. 4 patients were known to have a history of CDT/CDE, with most of the patients having had known exposure to CDT/CDE prior to diagnosis. However, there were only 4 patients where this was a delay in isolation.

Actions:

- IPC review patients in ED who require isolation to support assessment
- Missing stool sample report sent daily identifying patients with Type 5, 6 or 7 on the Bristol Stool Chart but no sample has been collected
- In-house reactive misting of bays following CDE/CDT, this requires patients to sit out on the ward due to no decant area
- Re-review of effectiveness of misting for CDI
- Continue to identify Norovirus outbreaks at the earliest opportunity to prevent onward transmission of infection
- Evaluate impact of the Wirral CDT strategy with system partners

Pressure Ulcers

During February 2026 there was 1 Hospital Acquired Pressure Ulcer (HAPU) Category 3 reported to Sacral Area, and 4 (Category 3 and above) Pressure Ulcers reported to Sacral Area that worsened in our care

Actions:

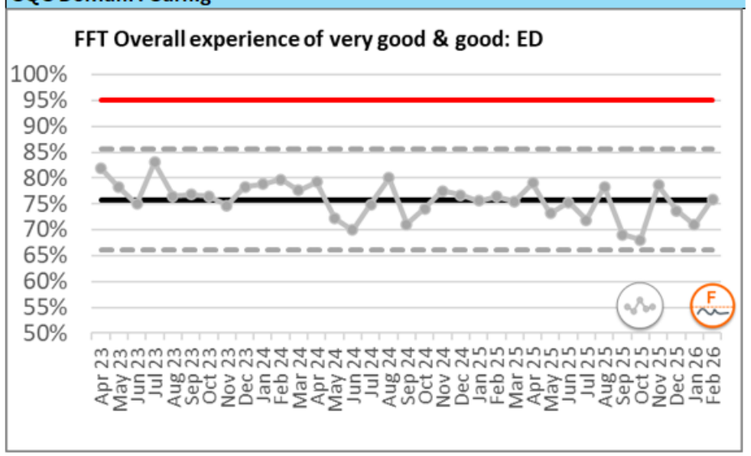
- Tissue Viability team validate all HAPU Category 3 and above.
- Tissue Viability boards to be completed within Medicine division
- Supporting Surgery division with HA Category 2 Pressure Ulcers and MASD
- Further mattress training to be completed on all wards
- Weekly meetings with Surgery and Medicine division to discuss Pressure Ulcers
- A Trust wide Wound care formulary has been developed
- CSW band 3 upskilling and Pressure Ulcer training being delivered
- Tissue Viability Team to support all divisions with improvement plans
- MASD audit to be completed within Critical Care

Risks to position and/or actions:

- Part time Tissue Viability Lead

FFT Overall experience of very good & good – ED

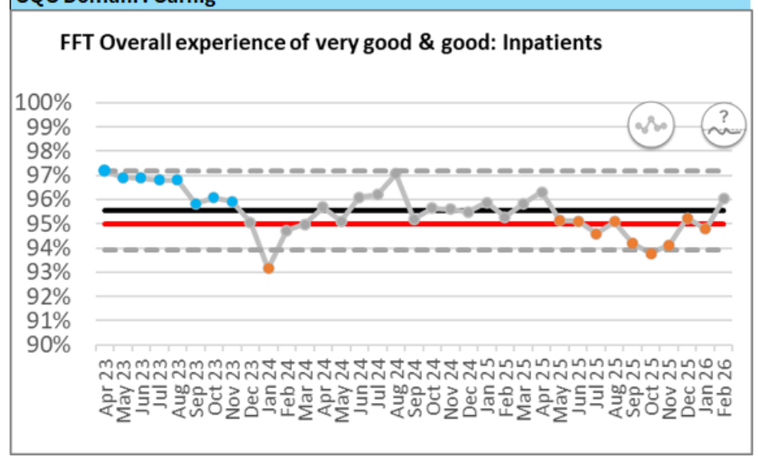
CQC Domain : Caring



Feb-26
75.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

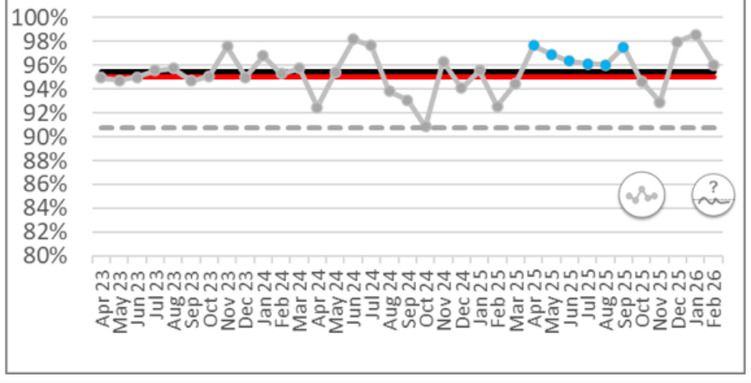
CQC Domain : Caring



Feb-26
96.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

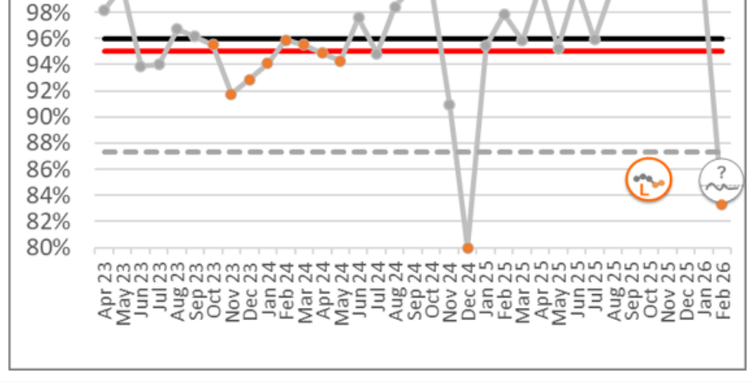
CQC Domain : Caring



Feb-26
96.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring



Feb-26
83.3%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

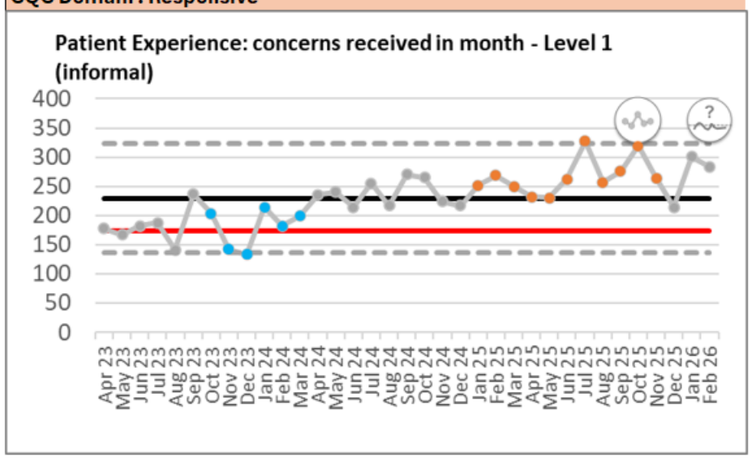
Commentary

ED FFT 75.9%. This is a 5% increase improvement following a 3 month decline in scores during a period of unprecedented increased activity. Timely feedback where concerns are raised via FFT continues to help support the department to identify themes which remains a focus on waiting times and enables ED to address additional required improvements. The new Divisional Director of Nursing commenced in post January and the ADN returned from maternity leave providing a strengthened leadership team to the department. Partnership working with Healthwatch Wirral has also commenced in the utilisation of the Redlines toolkit with a second meeting undertaken 19.03.26.

Maternity FFT 83.3%. This significant reduction in FFT performance is the first decline below the localised target since December 2024. A review of responses has identified 3 very / poor returns all with comments across the February period, 2 highlighting communication challenges and a feeling of being left, and the 3rd highlighted staff attitude and hand hygiene concerns. This reduction in FFT scores correlates with an increase in red flags reported via birth rate plus and presented within the CN safe staffing paper. The division continues to monitor closely and are focusing on increase the number of FFT returns to ensure that feedback is reflective. WUTH has a strong partnership with Wirral Maternity Neonatal Voice Partnership and will ensure increased communication with the community is provided to support responding to feedback and monitor additional sources of experiences.

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

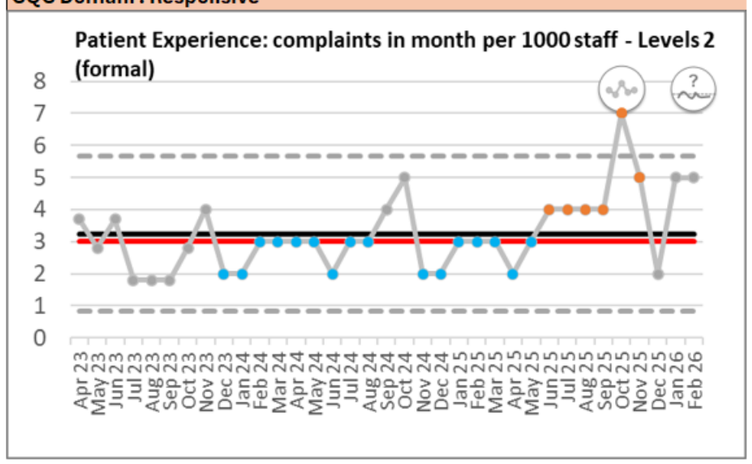
CQC Domain : Responsive



Feb-26
284
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit and miss target subject to random variation

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

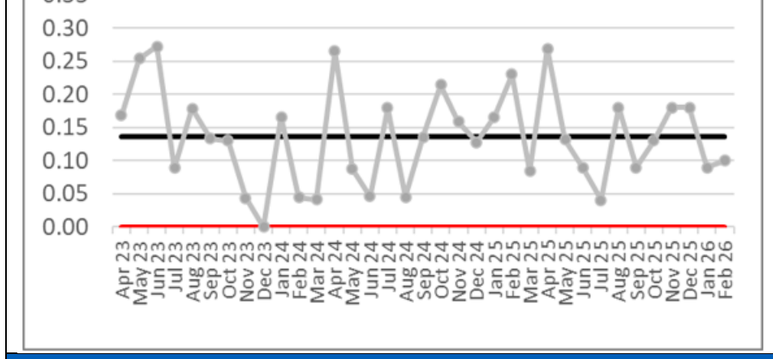
CQC Domain : Responsive



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

Falls – Moderate to Severe Harm

CQC Domain : Safe



Feb-26
0.1
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

Commentary

Complaints

In February 2026, the Trust recorded 284 informal concerns (Level 1) and 28 formal complaints (Level 2). Both figures represent a modest reduction from January (302 informal concerns; 33 formal complaints), with informal concerns down 6% and formal complaints down 15% month-on-month. Despite this improvement, activity remains above historical averages.

Informal concerns were highest in Medicine (85) and Surgery (73), with notable activity also in Women & Children's (58) and Diagnostics & Clinical Support (48). Across most divisions, informal concerns decreased compared with January, although Women & Children's (+38%) and Diagnostics & Clinical Support (+30%) recorded increases.

Formal complaints were concentrated in Women & Children's (10) and Emergency Care (9), with smaller volumes across Surgery, Medicine, and Diagnostics & Clinical Support. Month-on-month, complaints decreased in Medicine (-59%) and Emergency Care (-18%) but increased in Women & Children's (+400%), Diagnostics & Clinical Support (+100%), and Surgery (+14%).

At department level, in total 35 departments recorded both informal concerns and formal complaints, with the Emergency Department remaining the most consistent hotspot across both measures. Other departments demonstrating sustained activity across both reporting routes include Community Child Health, Colorectal and Upper GI, Trauma & Orthopaedics, and Urology (APH),
As to thematic categories, informal concerns were dominated by Access & Admission (110), Communication (87), and Treatment & Procedure (42), with ongoing pressures around appointment delays, patient flow, and staff communication.

Formal complaints were primarily related to Communication (23), Treatment & Procedure (14), and Access & Admission (6), with additional complaints across Documentation, Transfer & Discharge, Medication, and Infrastructure.

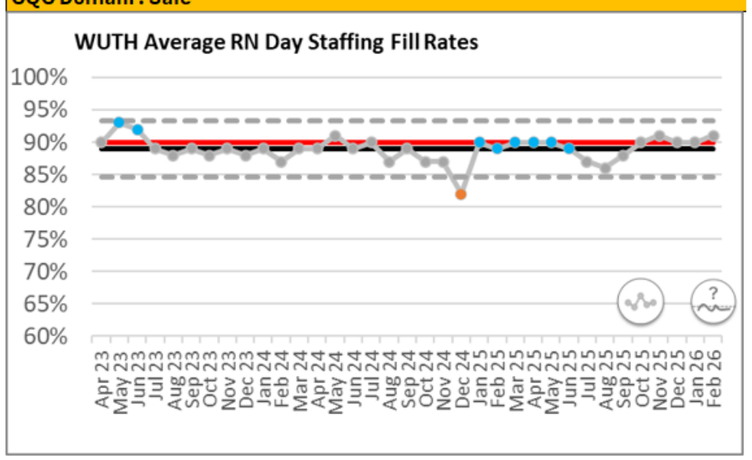
Overall, volumes in Access & Admission and Communication remain consistently high, reflecting ongoing operational pressures.

Timeliness of response remains a challenge. Only 15% of formal complaints were responded to within the 40-working-day target (down from 25% in January), with an average response time of 64 working days. At month-end, there were 87 open complaints, with 31 exceeding the target. Weekly closure activity was mixed, with net increases early in the month (+3 and +5) and partial progress in later weeks (-1 and +2).

Falls
In February we had 2 falls with harm – one patient experienced a fractured neck of femur and another had a fracture of T1 – National audit inpatient falls has been updated accordingly.
RECs have been undertaken with the clinical areas and learning and further training has been identified
67% of the patients that fell were deemed to level 1 supervision (independent) and 31% of patients who fell had some form of assistive technology in place.

Average Registered Nurse Day Staffing Fill Rates

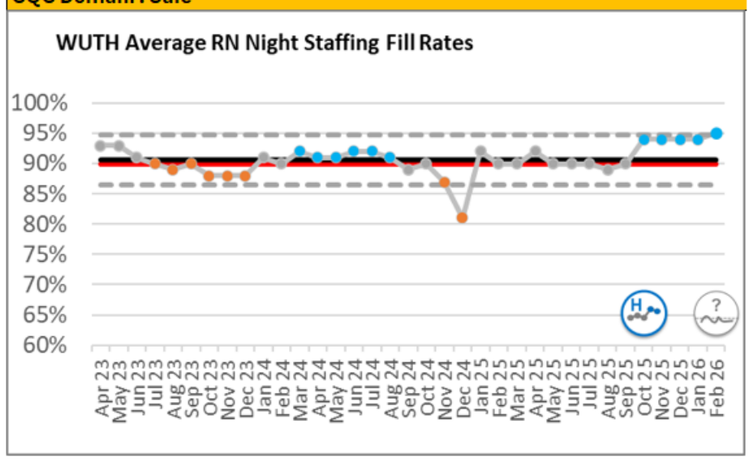
CQC Domain : Safe



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

Average Registered Nurse Night Staffing Fill Nurse

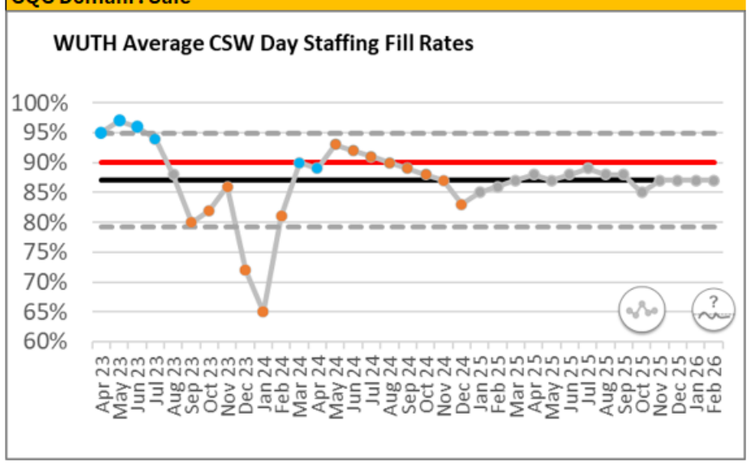
CQC Domain : Safe



Feb-26
95.0%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Day Staffing Fill Rates

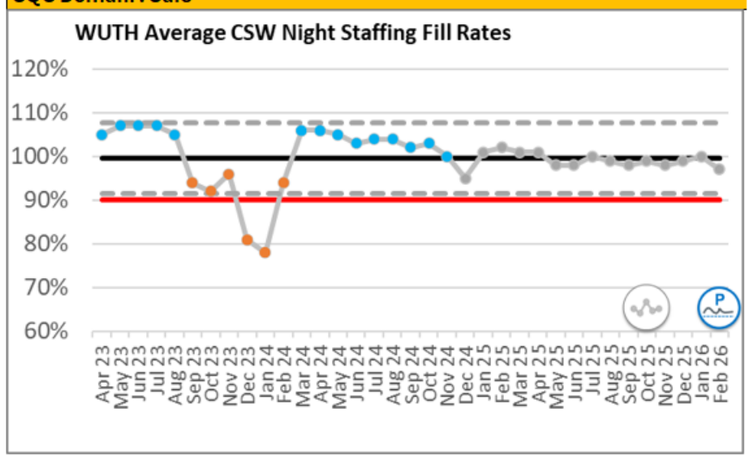
CQC Domain : Safe



Feb-26
87.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Night Staffing Fill Rates

CQC Domain : Safe



Feb-26
97.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Commentary

CSW day fill rate remains an ongoing concern.

Trust wide organisational change is concluding with revised establishments confirmed and system changes in progress to align ESR and budgets and ensure an accurate vacancy position can be reported.

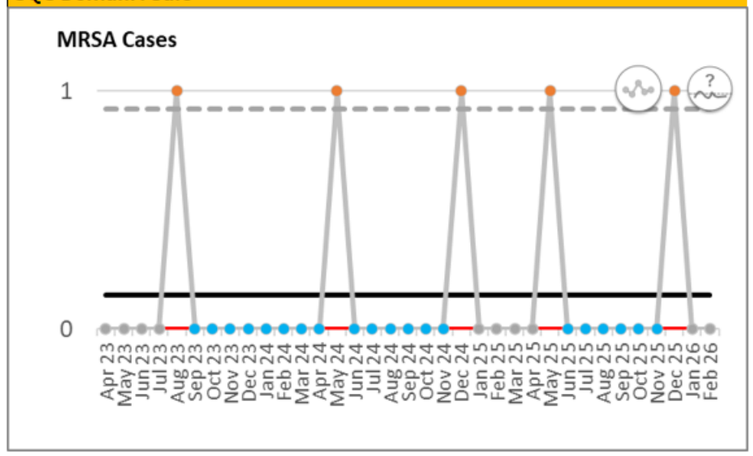
Focussed CSW recruitment opportunities are being explored alongside a training offer to improve staff experience and retention for current staff.

A CSW ‘deep dive’ led by the Deputy Chief Nurse is being presented to People Committee in March.

NHSP continue to support with temporary staffing and the CSWD programme is continuing.

MRSA Cases

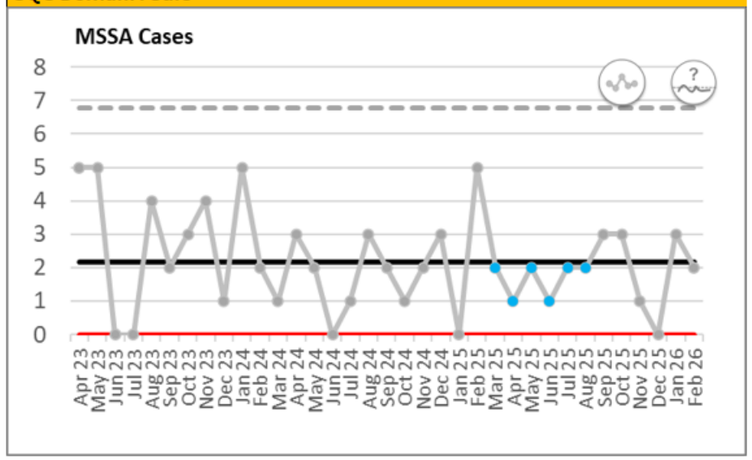
CQC Domain : Safe



Feb-26
0
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

MSSA Cases

CQC Domain : Safe



Feb-26
2
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

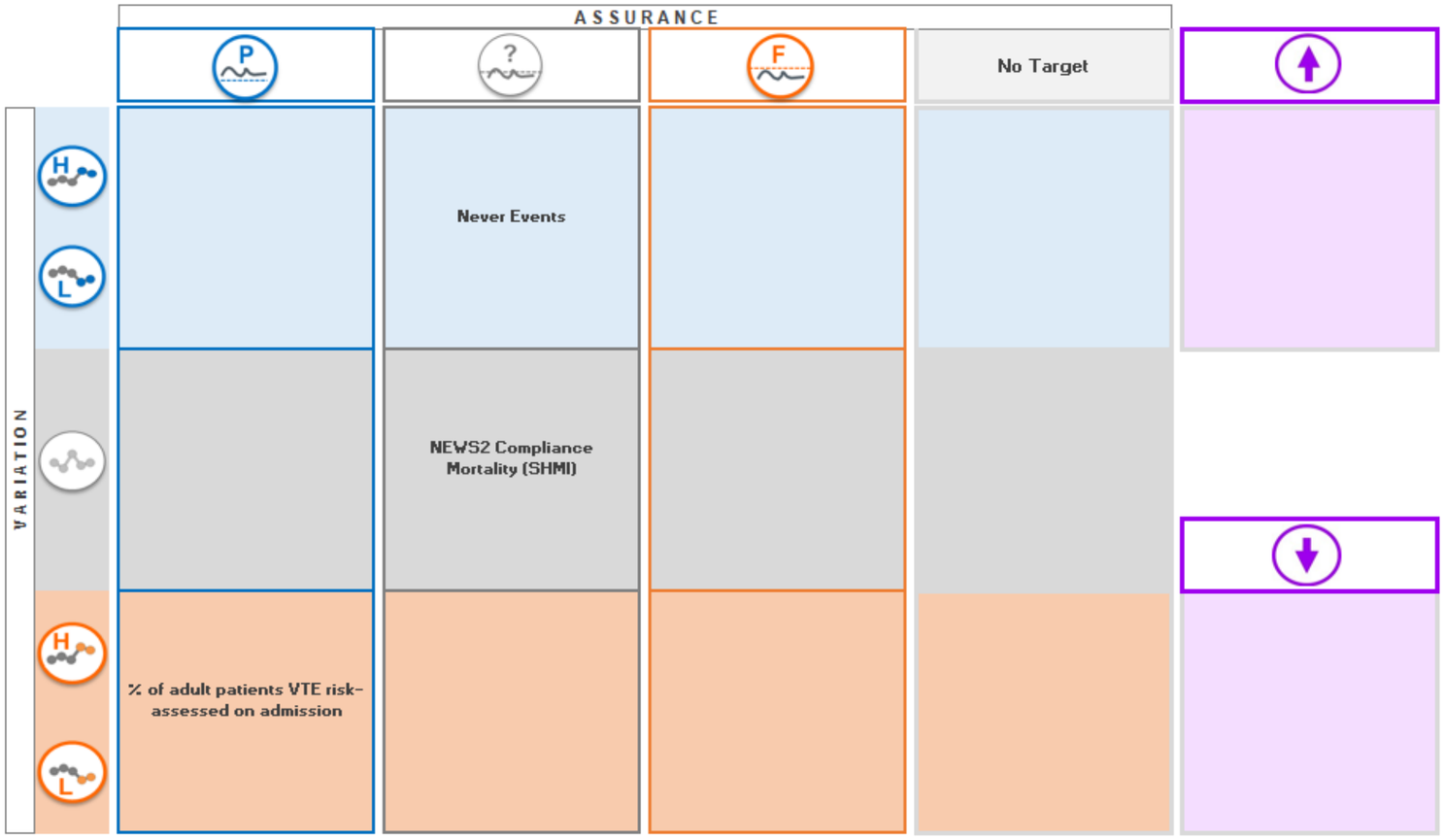
Commentary

MRSA
There were no MRSA bacteraemia reported in February.

MSSA
In February there were 2 MSSA bacteraemia reported, both were classed as COHA, therefore no reviews were undertaken.

Dashboard	Quality and Safety
Lead	Chief Medical Officer

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	Feb 26	96.4%	≥95%			97.2%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Feb 26	89.0%	≥90%			89.2%
Mortality (SHMI)	Oct 25	1.033	0.95-1.05			1.022
Number of studies open	Feb 26	44				
% of current studies meeting recruitment target	Feb 26	31.8%				
% of open studies with a commercial sponsor	Feb 26	6.8%				

Areas of Concern

4 Never Events during 25/26 financial year (last one in June 2025)

News 2 compliance-

VTE-

Forward Look (Actions)

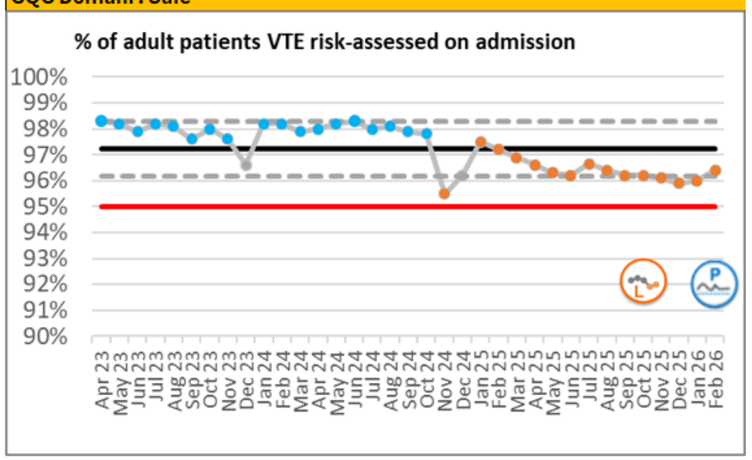
Locssips action plan complete apart from generic electronic Locssip which couldn't be built until Cerner upgrade completed.

News 2 compliance slightly below target. Ongoing Work on areas of non compliance monitored through Divisional DPR. Live reporting on BI portal accessible to all ward managers

VTE compliance remains above target but has dropped from previous value of 98%. Divisional deep dives to pick up areas of low compliance tracked through DPR

% of adult patients VTE risk assessed on admission

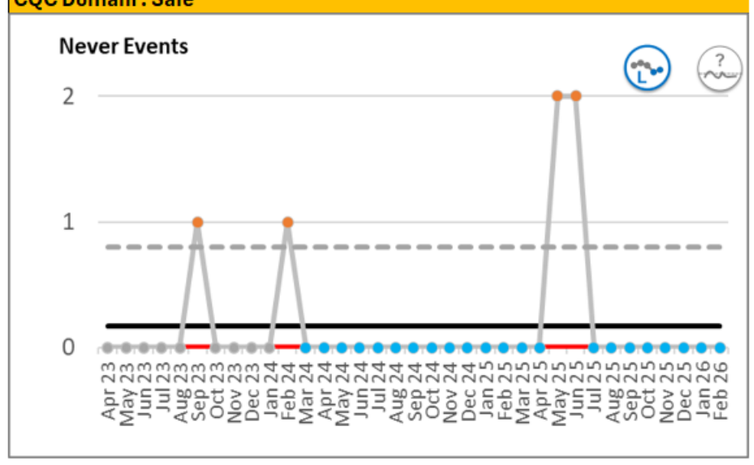
CQC Domain : Safe



Feb-26
96.4%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

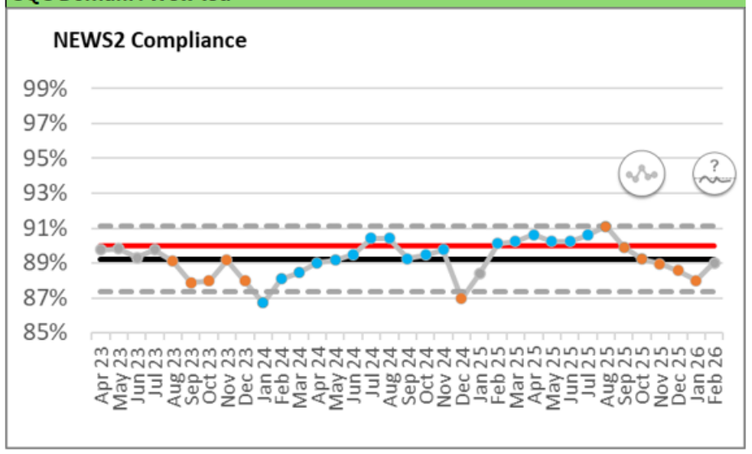
CQC Domain : Safe



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

NEWS 2 Compliance

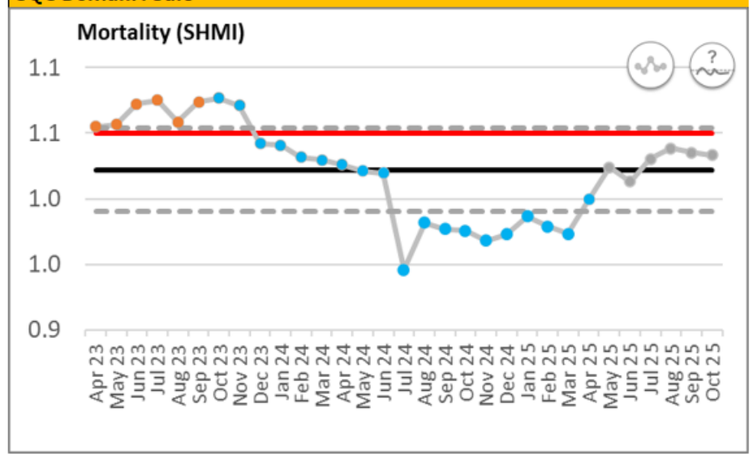
CQC Domain : Well-led



Feb-26
89.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Oct-25
1.0332
Variance Type
Common cause variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

Commentary

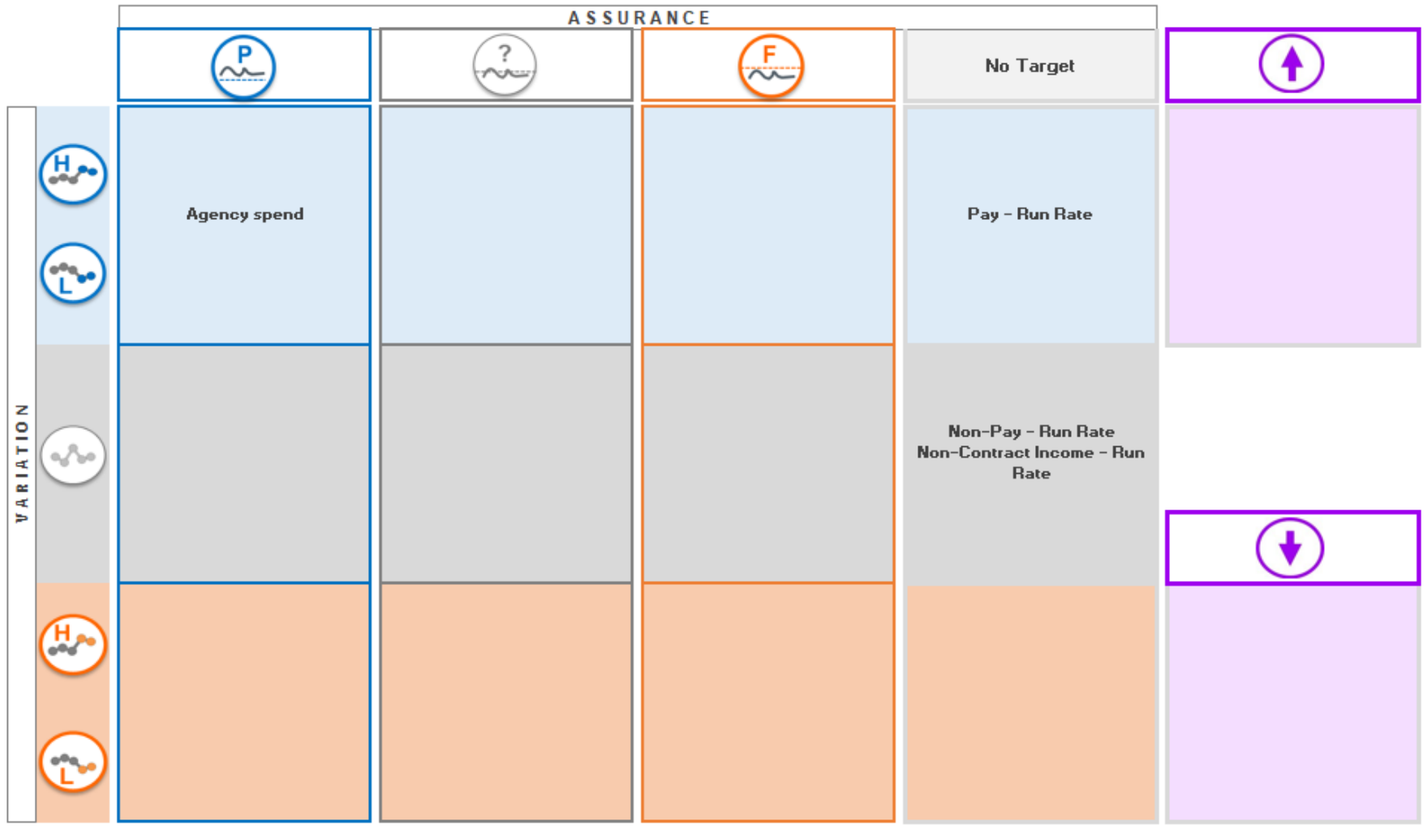
Number of studies open – Snapshot position	% of current studies meeting recruitment target – Snapshot position
44	31.8%

% of open studies with a commercial sponsor – Snapshot position
6.8%

Commentary

Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix



Finance Summary

Highlights

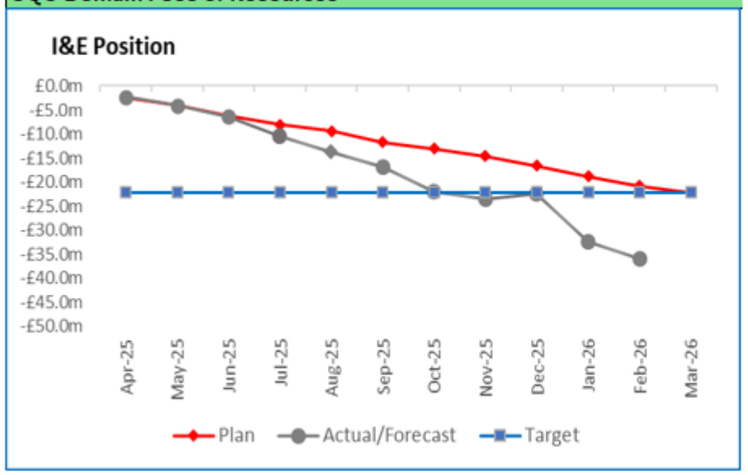
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Feb 26	1.4%	≤3.2%			2.6%
I&E Position	Feb 26	-£36.0m	-£22.2m			
Cumulative CIP	Feb 26	£29.3m	£29.3m			
Capital Expenditure	Feb 26	£18.2m	£26.1m			
Cash Position	Feb 26	£2.7m	£2.7m			

Areas of Concern

Forward Look (Actions)

I&E Position

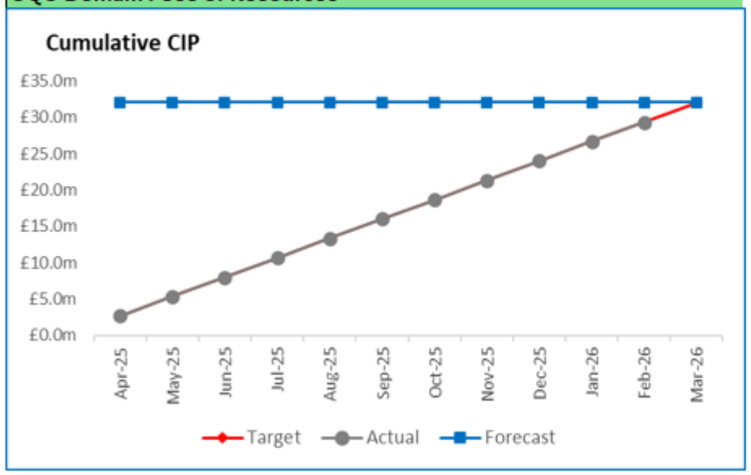
CQC Domain : Use of Resources



Feb-26
-£36.0m
Variance Type
Position doesn't meet the plan
Target
-£22.2m

Cumulative CIP

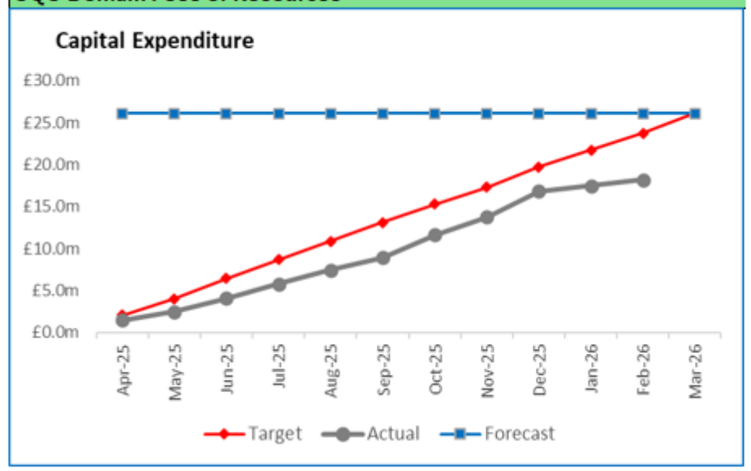
CQC Domain : Use of Resources



Feb-26
£29.3m
Variance Type
Position meets the plan
Target
£29.3m

Capital Position

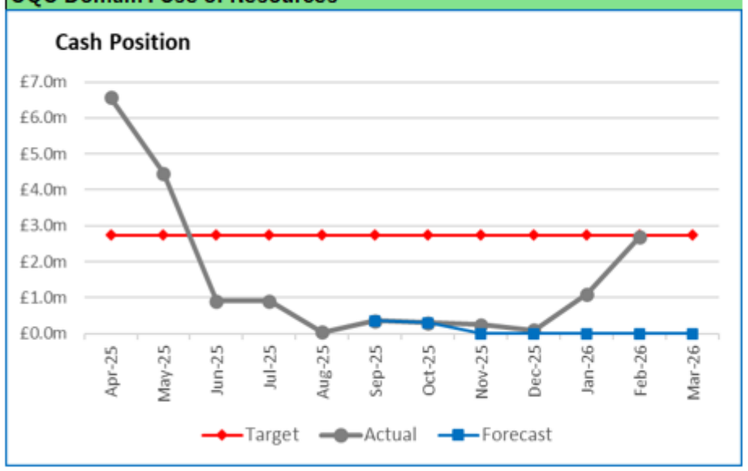
CQC Domain : Use of Resources



Feb-26
£18.2m
Variance Type
Position meets the plan
Target
£26.1m

Cash position

CQC Domain : Use of Resources

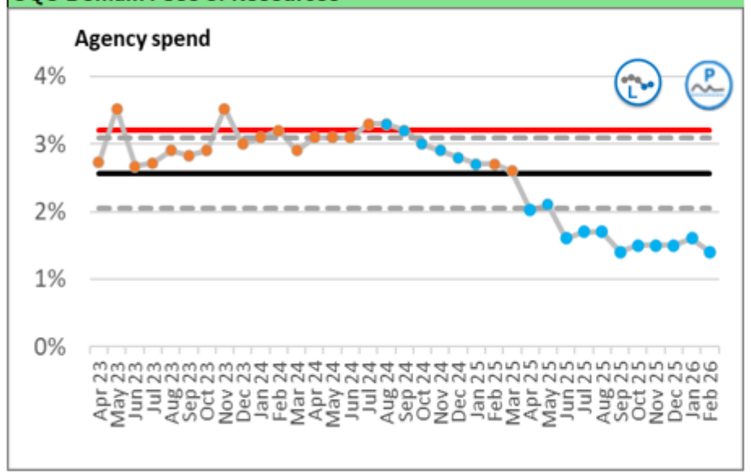


Feb-26
£2.7m
Variance
Position doesn't meet the plan
Target
£2.7m

Commentary

Agency spend %

CQC Domain : Use of Resources



Feb-26
1.4%
Variance Type
Special cause improving variation
Threshold
≤3.2%
Assurance
Consistently hit target

Commentary

Finance

Executive Summary

At the end of February 2026 (M11), the Trust is reporting a deficit of £36m, which, excluding DSF, is a £15.2m adverse variance to plan. Non-recurrent mitigations have been fully deployed to support delivery against the plan, including £2.6m of income in respect of Industrial Action, helping to partially mitigated the variance to plan.

Additional actions to support delivery of the agreed plan, excluding DSF, have been maintained, with enhanced controls across variable pay, non-core spend, discretionary non-pay, elective income, and a non-clinical vacancy freeze remaining in effect. These measures continue to mitigate the four key risks identified in the Trust plan:

- Full CIP Delivery: The primary risk to achieving the 2025–26 financial position persists. The risk-adjusted annual forecast remains below the required target, including delivery of ICS schemes (£11.2m).
- Activity / Casemix: After accounting for the impact of industrial action and the CSSD incident, elective income continues to be below plan at M11.
- Aseptic Pharmacy: This risk has materialized, with a significant reduction in income due to ongoing production compliance changes.
- Run-rate: 80% of targeted run-rate reductions have been identified and actioned, consistent with prior months.

As reported last month and in line with the “Financial Management Arrangements for the Remainder of 2025/26” and the North West regional protocol, the Board has reviewed the forecast outturn for WUTH in 2025/26 and written to NHSE to confirm a revision to £49.5m, representing a £27.4m adverse variance against the plan. This forecast includes:

- £13.1m of operational risks as reported in previous months through this report. The most significant factor being within this variance is that the Trust will deliver £37.8m efficiency against the £46.1m target required to achieve plan.
- £10.8m of additional impact through the ICB contract, of which the largest single item is £6.5m of income withdrawn as a result of the CSSD critical incident. These adjustments are agreed between the Trust and ICB and are not in dispute.
- £3.5m which is matched by an equivalent improvement in the WCHC revised forecast.

The deficit continues to exert significant pressure on both the Trust’s cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M11 was £2.7m, an improvement from M10 but only in line with NHSE’s stipulated minimum cash balance. The Trust is adhering to the agreed cash mitigation plan, but until a sustainable financial position is achieved, this remains a significant issue. The revenue support applications for March has been approved, and the application for April has been submitted.

It is important to note that management of risks against this plan alone does not deliver long-term financial sustainability. The significant improvement required for sustainability will be delivered through the medium-term finance plan (MTFP). The MTFP for 2026/27 to 2028/29 remains under development, with the Trust having submitted the initial version of the three-year plan beginning in 2026/27.

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

Statutory Financial Targets	RAG (M10)	RAG (Forecast)	Section within this report / associated chart
Financial Stability			I&E Position
Agency Spend			I&E Position
Financial Sustainability			N/A (quarterly update)
Financial Efficiency			Cumulative CIP
Capital			Capital Expenditure
Cash			Cash Position

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

The Board is asked to:

- Note the report including that the Trust has reported an adverse variance to plan.
- Note that the Trust's most immediate finance risk remains the cash position and approve that the CFO submits additional applications based on confirmed need.
- Note that, as approved by the Board, the Trust has confirmed to NHSE a revised forecast outturn for 2025/26 of a £49.5m deficit, representing a £27.4m adverse variance against the plan.

I&E Position

Narrative:

The table below summarises the M11 position:

	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£39.1m	£39.6m	£0.5m	£429.2m	£424.8m	-£4.4m
Other Operating Income	£2.9m	£3.5m	£0.6m	£32.4m	£36.2m	£3.8m
Total Income	**£42.0m**	**£43.0m**	**£1.1m**	**£461.6m**	**£461.0m**	**-£0.6m**
Employee Expenses	-£31.7m	-£33.0m	-£1.3m	-£349.0m	-£356.4m	-£7.5m
Operating Expenses	-£12.8m	-£13.2m	-£0.4m	-£141.1m	-£142.3m	-£1.1m
Non Operating Expenses	-£0.4m	-£0.4m	-£0.0m	-£4.5m	-£5.2m	-£0.7m
Recurrent CIP	£1.0m	£0.0m	-£1.0m	£12.2m	£0.0m	-£12.2m
Non Recurrent Mitigations	£0.0m	£0.0m	£0.0m	£0.0m	£6.9m	£6.9m
Total Expenditure	**-£43.9m**	**-£46.7m**	**-£2.8m**	**-£482.4m**	**-£497.0m**	**-£14.6m**
Month 11 position excluding DSF	**-£2.0m**	**-£3.7m**	**-£1.7m**	**-£20.8m**	**-£36.0m**	**-£15.2m**

Key variances within the YTD position are:

Clinical Income – £4.4m adverse variance, this reflects the exceptional income impact in respect of the CSSD critical incident.
Other Operating Income - £3.8m positive variance includes £2.6m from NHSE to mitigate the costs of Industrial Action.
Employee Expenses - £7.5m adverse variance relates to use of bank, agency, industrial action and undelivered vacancy factors.
Operating expenses – £0.7m adverse variance relates clinical supplies and depreciation.
Cost Improvement Programme – £12.2m under delivered in 25/26, offset by £6.9m of non-recurrent mitigations.

The Trust's agency costs remained at 1.5% of total pay bill for the month, which is significantly below the NHSE threshold of 3.2% of total staff costs.

Cumulative CIP

Narrative:
The Trust has transacted CIP with a part year effect of £30.4m at M11 of which, £6.9m has been delivered non-recurrently. The Trust has identified recurrent CIP with a full year effect of £31.8m, however, this figure reduces to £27.8m once risk adjusted reflecting a risk adjusted shortfall of £4.3m.

Review of the CIP position is ongoing through fortnightly CIP Assurance, now chaired by the Joint Turnaround & Transformation Director and monthly Productivity Improvement Board, chaired by the CEO. The Trust also meets frequently with colleagues from the ICB and across the ICS to identify and deliver the collectively agreed additional savings target (WUTH share £14.1m).

Elective Activity

Narrative:
Across Q3 and the start of Q4, the Trust elective programme has been significantly impacted by the CSSD critical incident. This was stepped down to a business continuity incident in November with the majority of specialties able to return to normal activity levels during December. The main exception is Trauma and Orthopedics which returned to planned activity levels from the end of M10.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2025/26 at M11:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M5	Revision to budget M6	Revision to budget M7	Revision to budget M8	Revision to budget M9	Revision to budget M10	Revision to budget M11	Revised Budget
CDEL										
Internally Generated	**£9.765m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£9.765m**
ICB/PDC/WCHC	**£14.550m**	**£0.516m**	**£0.056m**	**£0.058m**	**£0.069m**	**-£1.402m**	**£0.144m**	**£0.404m**	**£0.452m**	**£14.847m**
Charity	**£1.100m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£1.100m**
Confirmed CDEL	**£25.415m**	**£0.516m**	**£0.056m**	**£0.058m**	**£0.069m**	**-£1.402m**	**£0.144m**	**£0.404m**	**£0.452m**	**£25.712m**
Total Funding for Capital	**£25.415m**	**£0.516m**	**£0.056m**	**£0.058m**	**£0.069m**	**-£1.402m**	**£0.144m**	**£0.404m**	**£0.452m**	**£25.712m**
Capital Programme										
Estates, facilities and EBME	**£3.100m**	£0.516m	£0.056m	£0.000m	£0.000m	£0.782m	£0.000m	£0.000m	£0.000m	**£4.454m**
Operational delivery	**£8.440m**	£0.000m	£0.000m	£0.000m	£0.069m	£0.000m	£0.144m	£0.404m	£0.383m	**£9.440m**
Medical Education	**£0.080m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£0.080m**
Transformation	**£0.250m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£0.250m**
Digital	**£0.750m**	£0.000m	£0.000m	£0.058m	£0.000m	£0.000m	£0.000m	£0.000m	£0.069m	**£0.877m**
UECUP	**£7.800m**	£0.000m	£0.000m	£0.000m	£0.000m	-£2.078m	£0.000m	£0.000m	£0.000m	**£5.722m**
PDC commitments	**£0.304m**	£0.000m	£0.000m	£0.000m	£0.000m	-£0.106m	£0.000m	£0.000m	£0.000m	**£0.198m**
ICB hosted	**£3.591m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£3.591m**
Charity	**£1.100m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£1.100m**
Total Anticipated Expenditure on Capital	**£25.415m**	**£0.516m**	**£0.056m**	**£0.058m**	**£0.069m**	**-£1.402m**	**£0.144m**	**£0.404m**	**£0.452m**	**£25.712m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

In M11 the Trust received confirmation of £0.5m of additional funding for solar panels.

Cash Position

Narrative:

The cash balance at the end of M10 was £2.7m. Since August 2025 the Trust has been successful in accessing national cash support. The requirements are driven by; non-cash backed deficit, unplanned deficit, withheld deficit support.

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

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

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

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 28 January 2026
Location	Hybrid

Members present:

SI	Steve Igoe	Joint Chair
SR	Dr Steve Ryan	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
LG	Lisa Greenhalgh	Joint Non-Executive Director
NS	Dr Nikki Stevenson	Joint Chief Medical Officer & Deputy CEO
HK	Hayley Kendall	Joint Executive Managing Director
CBu	Carla Burns	Deputy Chief People Officer (deputising for DS)
MS	Matthew Swanborough	Joint Chief Strategy Officer
MC	Mark Chidgey	Joint Chief Finance Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications
JC	Joanne Chwalko	Joint Chief Integration and Partnerships Officer
JR	Julie Roy	WUTH Interim Chief Nurse

In attendance:

CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
CM	Chris Mason	WUTH Chief Information Officer
CW	Claire Wedge	Interim Chief Nurse
TC	Tony Cragg	WUTH Public Governor
LC	Lynn Collins	WCHC Lead Public Governor
KP	Karen Prior	WCHC Appointed Governor
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 18
MSa	Mustafa Sadiq	Consultant – item 18
CF	Claire Fitzpatrick	LMNS – item 18
CM	Catherine McCleannan	LMNS – item 18

Apologies:

LD	Lesley Davies	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
DS	Debs Smith	Joint Chief People Officer
JH	Janelle Holmes	Joint Chief Executive
SH	Sheila Hillhouse	WUTH Lead Public Governor

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

	SI welcomed members to the meeting, which was held jointly with the WCHC Board of Directors. Members of that Board are listed as attendees. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** LG stated in section 6 undergoing should be amended to undergoing. Subject to the amendment, the minutes of the previous meeting held on the 3 December 2025 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 Well WUTH pilot programme. The video story described the experience of 7 staff who had taken part in the pilot, including the positive experience it had on them and their successful return to work following a period of sickness absence. The Board discussed the video story, noting the positive outcomes and suggested sharing the video externally to highlight the impact of the programme. Members emphasised the importance of scaling up the programme in light of the current levels of high sickness absence and to effectively promote the programme to staff in order to increase uptake. The Board **NOTED** the video story.	
6	**Joint Chair Update** SI provided an update on recent matters and highlighted that he had introduced a monthly email to Lead Governors and Non-Executives Directors to update on matters in between meetings, which had received good feedback. SI highlighted the Trust remained focused on the financial position, noting meetings with PwC had taken place the previous week and was described as positive, with the Trust able to demonstrate strong engagement in relation to grip and control and robust forecasting. SI also confirmed that the Director of Transformation is due to commence in March.	

	SI explained a Cheshire and Merseyside Chairs meeting had taken place. Discussion covered the emerging system blueprint, the need to work in different ways across the system, and collaboration with neighbouring Trusts. SI added he and JH had met with Wirral Council. The meeting was helpful, noting the discussion focused on joint working and the role of the Trust as an Anchor institution. It was agreed that a joint schedule would be developed to identify and agree areas of collaborative work. The Board **NOTED** the verbal update.	
7	**Joint Chief Executive Officer Report** NS thanked members of staff for their continued hard work during an exceptionally busy period between December and January. NS stated Chris Douglas had been appointed Joint Chief Nurse. NS highlighted the Trust continued to engage in Financial Recovery Performance Management (FPRM) process with the NHSE regional team and PWC. NS reported the Trust remained in segment 4 of the NOF. NS stated a resident doctor peer lead had been appointed and updated on the impact of the recent industrial action, noting 841 outpatient appointments, of which 5 were cancer related, were cancelled during the period of industrial action. A total of 28 day case procedures, of which 1 was cancer related were cancelled. NS gave an update regarding Better Together - Journey to Integration, highlighting a new monthly all staff briefing had been launched, the TUPE transfer of corporate staff from WCHC had taken place and work was ongoing to establish a single corporate team from Q1 2026/27. NS add a stakeholder newsletter had also been published and would be provided quarterly. NS confirmed 2825 staff completed the 2025 NHS staff survey which represented a 42% response rate. NS thanked staff for their feedback. NS summarised the Cheshire and Merseyside Provider Collaborative meetings held in December and January and set out the key updates from these meetings. NS provided an overview of the various national developments in the last month, noting the role of the NHS new online hospital, the Mental Health Bill and referenced the two messages from NHSE Chief Executive.	

	NS reported at WUTH in October there was two RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework. NS highlighted the various WUTH and WCHC employee of the month and standout winners November and December. CD queried the uptake of the Clinical Assessment Service and if it had been successful diverting patients to appropriate community services. JC stated this was a scheme as part of the pre-hospital workstream and explained uptake could be higher and the Trust was continuing to work with NWAS to fully utilise the capacity available. HK added that the workforce model for this scheme required reviewing due to it using the same resource from within the ED. CB noted the Cheshire and Merseyside Provider Collaborative had approved the continuation of Dermatology AI. CB queried this in light of the of recent increase in referrals experienced by the Trust. NS advised this pilot initially led to an increase in referrals as the AI was learning and checks had to be made. NS added this was now looking to be expanded to solely rely on the AI and remove the clinical oversight element. The Board **NOTED** the report.	
8	**Integrated Performance Report** CBu highlighted sickness absence levels continue to improve but remain above the Trust's 5% target. The top 3 reasons are cold, cough, flu, gastro, and mental health (anxiety/ stress/depression). Notably cold, cough and flu were up by 5.46% from November and short term remained the key driver. JR reported that the number of C Diff cases continued to improve in December, however it was expected this would worsen in January due to the high acuity. JR added the number of hospital acquired pressure ulcers remained above trajectory and an action plan continued to be in place. JR noted fill rates remained positive. SR noted there had been 1 MRSA case in December and queried this. JR explained how this occurred and stated learning was due to due to be presented at the Infection Prevention and Control Group meeting.	

	NS advised there continued to be a reduction in NEWS 2 compliance and explained there were actions in place with individual areas to improve compliance. This is monitored through DQB and DPRs. AH referenced the Model Hospital data and NOF indicators which had been circulated to supplement the IPR. AH noted this will continue to evolve the presentation and format of this in the coming months. Members requested AH incorporate into the NOF the thresholds for the overall domain scores to understand the gap between segment scores. The Board **NOTED** performance to the end of December 2025.	Ali Hughes
9	**Joint Chief Finance Officer Report** MC reported at the end of December, month 9, the Trust is reporting a deficit of £22.3m to date which excluding Deficit Support Funding (DSF) is a £5.7m adverse variance to plan. MC added this variance was driven by industrial action, pay award pressures, the level of efficiency target challenge and the Sterile Services (SSD) critical incident which has impacted the Trusts elective programme. MC explained the Trust agreed additional actions to support delivery of the agreed plan which excluding DSF is a £22.1m deficit. These include enhanced controls across variable pay, non-core spends, discretionary non pay, elective income and a non-clinical vacancy freeze - all agreed controls have been enacted. MC added those measures are mitigations to the original 4 key risks within the Trust plan, which were: • Full CIP delivery; • Activity/case mix; • Aseptic pharmacy income; and • Run rate MC reported the deficit continues to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M9 was £0.1m. MC added further revenue support applications made for December and January have been approved and February's application is in progress. MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial	

	stability, financial sustainability, and financial efficiency were red, cash was amber, and agency spend, and capital was green. Members acknowledged the Board had held a number of meetings regarding the 2026/27 – 2028/29 plan already and during the Private Board meeting in the afternoon the Board would consider amending the 2025/26 forecast position. The Board: • **NOTED** the report including that the Trust has reported an adverse variance to plan. • **NOTED** that the Trust's most immediate finance risk remains the cash position and approve that the CFO submits additional applications based on confirmed need. • **NOTED** that the Trust Board has agreed a plan to deliver the 25/26 plan and significant risks to delivery of this plan remain to be fully mitigated. • **APPROVED** the revised capital budget of £24.812m.	
10	**Joint Executive Managing Director Report** HK noted that for planned care, sterile services had returned to full operation. Approximately 1% of patients were waiting over 52 weeks. It was reported that disruption to sterile services had resulted in around 1,500 cancelled appointments, with ENT most affected. Cancer 28-day performance was 67% in November, improved in December, and forecast to return to plan by January. Dermatology issues were confirmed as resolved. HK highlighted Urgent and Emergency Care pressures in December and January. Emergency Department performance in December was 44%, with peak attendances of up to 350 patients per day and a recovery period of approximately three days. Options to increase Emergency Department capacity were being explored to support patient safety and experience. HK explained 12-hour performance in December was reported at 21%. It was noted that actions agreed and implemented from Monday were expected to deliver improvement. Ambulance handover performance was reported as stable despite pressures and estate constraints, with average handovers of approximately 45 minutes. SR commented that it was positive the number of no criteria to reside patients remained stable despite the pressures and queried what was required to achieve 0 patients. HK stated 50 was the optimal number due a number of patients instead of 0, noting a number of patients required either 24hr case or 3-5 visits a day and this type of care package was difficult to secure.	

	SI commented that the Trust with local authority had made good progress reducing the number of patients with no criteria to reside from 270 initially to 90 currently. The Board **NOTED** the report.	
11	**Board Assurance Framework (BAF)** AH provided an overview the changes to the BAF, noting the People Committee had met and recommended increasing risk ID5 from RR9 to RR12 due to the current pressures and triangulation with key workforce metrics particularly in relation to sickness and staff engagement. AH advised of the 12 strategic risks, 6 were currently scoring 15 or above. AH noted the upcoming Committee meetings in February and March where the relevant strategic risks will be discussed and update provided to Board in April. AH also noted a revised BAF with shared strategic risks was also in development reflecting the position for both Trusts. Members discussed the BAF and agreed it accurately reflected the current position. The Board: • **RECEIVED** the update provided on the current position in relation to the strategic risks with assurance on the oversight from the sub-committees of the Board; • **NOTED** the position in relation to the six strategic risks scoring as high-level; • **APPROVED** the increase in risk rating for ID5 from RR9 to RR12; and • **APPROVED** the position for all other strategic risk positions	
12	**Lead Governor Report** AH provided a verbal update in absence of the Lead Governor, highlighting the appointment of LG had completed thanked Governors for their engagement during the appointment process. AH added the next Council of Governors meeting was scheduled for 26 February and included a development session updating on the integration journey and NHS Oversight Framework (NOF). The Board **NOTED** the verbal update.	
13	**Committee Chairs Report – Audit and Risk Committee**	

	MD alerted members that this year's core standards assessment has been assessed as compliant with this area being reviewed by MIAA and assurance levels reported are moderate. MD also alerted members that there are large backlogs with responding to subject access requests (SARs), which is an area impacted by vacancies and long-term sickness coupled with high demand. An improvement plan and business case to address the backlog has been developed. MD alerted members that clinical coding backlog has improved, and recent performance has been stronger than previous months, and there are mitigation plans to try to continue this. MD also alerted members that cyber security also remained an area of focus following the cyber incident in 2024. MD summarised the various "Advise" and "Assure" matters from the meeting on 10 December. The Board **NOTED** the report.	
14	**Committee Chairs Report – Research and Innovation Committee** SI provided a verbal update and explained previous meeting had held on 12 December, and it has been agreed that this Committee will be stepped down. SI added moving forward a research annual report will be provided to Patient Safety Quality Board which will travel to Quality Committee. Members agreed this was appropriate and agreed to step down the Research and Innovation Committee. The Board **NOTED** the verbal update.	
15	**Committee Chairs Report – Finance Business Performance Committee** MD noted that the Committee reviewed the month 8 financial position and the Trust's cash position, and this would be reported in the Chief Finance Officer Report. MD alerted members that the Committee discussed the 2026/27 plan and recognised the significant challenges associated with delivering the control total of £9.1m for next year, including a CIP target of 10%. The Trust's MTFP is clear on the drivers of deficit and the improvement programmes required to address these.	

	MD also alerted members that the referral to treatment position for October was significantly impacted by the sterile services incident which resulted in the cancellation of 1,378 elective cases in October and November. MD summarised the various “Advise” and “Assure” matters from the meeting on 15 December. The Board **NOTED** the report.	
16	**Committee Chairs Report – Quality Committee** SR alerted members that the Committee heard about a patient story received at Patient Safety Quality Board regarding a patient receiving corridor care. The Committee acknowledged this had been challenging for staff to hear and were assured that actions to address specific issues were being taken. SR also alerted members the ED continued to have high levels of attendance, up to 370 per day and this was leading to providing corridor care which the Trust did not wish to “normalise”. SR alerted members that due to these pressures additional escalation beds had been opened to deal with the high acuity. SR also alerted members that the Trust had reached its annual threshold for cases of hospital C Diff and very likely will pass the threshold. SR noted this will negatively impact its scoring of the NOF. SR summarised the various “Advise” and “Assure” matters from the meeting on 21 January. The Board **NOTED** the report.	
17	**Committee Chairs Report – People Committee** CBu provided a verbal update in the absence of LD, explaining the Committee had received a deep dive into the sickness absence within Estates and Facilities Division as well as the length of employee relations cases. CBu added the Committee also received a number of annual reports including the Gender Pay Gap, Equality Diversity, and Inclusion as well routine reports on Freedom to Speak Up and Guardian of Safe Working. CBu explained the Committee also received an update on the workforce integration and progress to date. The Board **NOTED** the report.	

18	**Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 7 Annual Declaration)** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of non-compliance for December. JL and MSa gave an overview of the ten Clinical Negligence Scheme for Trusts (CNST) Safety Actions as part of the Maternity Incentive Scheme Year 7. The presentation outlined how the ten safety actions, which have all been assessed as compliant, had been met and provided details of the evidence. NS stated this presentation had also been presented at Patient Safety Board and Quality Committee in January and acknowledged the strong evidence submission. NS queried the amber RAG rating for the metric related to midwifery staffing below the Birth Rate + acuity, noting the Board had approved a business case to increase the midwifery workforce in September 2025. JL stated the as recruitment to the business case takes place this RAG rating will change. HK queried the amber RAG rating for the metric related to recommendations from national reports not implemented. JL advised this related to triage and limitations of the current estate footprint, however mitigations were in place to address this. CB queried if any lessons had been learnt from last year in regard to collecting evidence for this year's submission. JL stated there was a good team in place to support this as well as strong support from LMNS who provided good assurance on the level of detail required for the submission. SR commented as NED Maternity Safety Champion he agreed with the compliance level and acknowledged the robustness of the process and data collection. SR added there was also a strong culture, and this is visible by the good leadership of the Divisional and consultant teams. Members thanked JL and MSa for their presentation and continued hard work in Maternity Services. Members of the LMNS agreed and added it was challenging to achieve all 10 safety actions and thanked JL, MSa and the team for their ongoing hard work and engagement. The Board: • **NOTED** the presentation; and	

	• **APPROVED** compliance for sign off to NHS resolution with the Maternity Incentive Scheme (MIS Year 7).	
19	**Gender Pay Gap Report** CBu summarised the key findings of the report, noting the increase in mean gender pay gap from 20.1% to 20.9% which continued to be in favour of males and an increased median gender pay gap from 2.8% to 4.4%. CBu added there had been a significant reduction in mean bonus pay gap from 30.1% to 10.2% reflecting changes in awarding of clinical excellence awards and discretionary points for medical staff. CBu advised a review of pay gaps within Divisions was being undertaken to identify any areas of additional concern/priority. SI queried how the Trust compared to another similar sized Acute Trusts and requested if it was possible to provide a benchmark. CB agreed to provide a comparative benchmark. The Board **APPROVED** the report, which will be shared on the Trust's public facing webpage, with data submitted to a national portal.	Debs Smith
20	**Freedom to Speak Up 6 Month Report** CBu highlighted during quarter 1-2 2025/26 24 staff raised a concern compared to 50 during the same period last year. CBu advised Q1 2024/25 seen an inflated number due to a large group of staff reporting from a specific area. CBu added concerns raised by theme show a decrease in bullying and harassment, although attitudes and behaviours along with bullying and harassment account for 84% of all concerns raised. No patient safety concerns were raised during the period. CBu reported Surgery raised the most concerns and accounted for 59% of total concerns raised during the period while admin and clerical staff accounted for 32% of all concerns raised. CBu noted 8% of staff raising concerns were Black, Asian, Ethnic Minority with one concern citing racism. The Board **NOTED** the report.	
21	**Guardian of Safe Working Report Q3 2025/26** NS provided an overview of the report, noting as usual the majority of exception reports raised were from the Medicine Division and from more junior staff, particularly F1s related to working hours.	

	NS added there had also been exception reports due to running departments at minimum staffing levels and the impact of this on complete tasks as well loss of educational opportunities due to rota issues. NS advised these issues were due to acuity, rota design, or staffing. NS highlighted there had also been a small number of fines raised for working hours breached due to not having secured a locum to cover shifts. NS explained the new framework for exception reporting was due to roll out in early February following the delay in September, and work was ongoing to ensure resident doctors where to able to submit exceptions using the new framework. The Board **NOTED** the report.	
22	**Learning from Deaths Report Q2 2025/26** NS summarised the mortality comparators, stating for the reporting period the Summary Hospital Level Mortality Indicator (SHMI) was within the expected range. NS added Hospital Standardised Mortality Ratio (HSMR) had increased and was now in the above expected range, noting this was due to the impact of coding backlogs which members had previously been made aware of. NS also provided a summary of the perinatal and neonatal deaths and the outcome of the PRMT reviews. NS provided a summary of adult in patient deaths and case reviews, noting of the 412 deaths 20 cases were escalated for review by the Medical Examiner and the Mortality Review Group reviewed a random selection of deaths to identify learning. NS indicated regarding external benchmarking data there were no statistical outliers this period. SI queried the HSMR coding issue and when this would be resolved. NS advised this would be resolved during quarter 1 2026/27 at the earliest. The Board **NOTED** the report.	
23	**Charity Annual Report and Accounts 2024/25** AH noted this was marked “To Follow” on the agenda and acknowledged that it had not yet been circulated to members.	

	AH advised members that LD, as Chair of the Charitable Funds Committee was aware and has agreed to approve the Annual Report and Accounts on behalf of the Committee. AH proposed this then be circulated to Board for ratification via electronic resolution later in the week, noting the submission was 31 January. Members agreed with this approach. The Board **NOTED** the update.	
24	**Questions from Governors and Public** No questions were raised.	
25	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute.	
26	**Any other Business** AH explained both the WUTH and WCHC Board would begin operating a Group Model from April 2026 and added the next meeting would take place in April 2026 and would be held bi-monthly.	

(The meeting closed at 11:50)