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| **Meeting** | WUTH and WCHC Council of Governors |
| **Date** | Monday 16 November 2026 |
| **Time** | 14:00 |
| **Location** | Clinical Skills Lab, St Catherine's Health Centre |

| Agenda Item | | Lead | Action |
|---|---|---|---|
| 1. | Welcome and Apologies for Absence | Steve Igoe, Chair | Note |
| 2. | Declarations of Interest | Steve Igoe, Chair | Note |
| 3. | Minutes of Previous Meetings<br>3.1) Minutes of the Previous Meeting – WUTH<br>3.2) Minutes of the Previous Meeting – WCHC | Steve Igoe, Chair | Approve |
| 4. | Action Log | Steve Igoe, Chair | Note |
| 5. | Chair Update – **Verbal** | Steve Igoe, Chair | Note |
| 6. | Lead Governors Update – **Verbal** | Tony Cragg & Eileen Hume, WUTH & WCHC Lead Governors | Note |
| **Items for Discussion and Decision** | | | |
| 7. | Board Assurance Framework (BAF) | Ali Hughes, Director of Corporate Affairs & Communications | Assure |
| 8. | Statutory Transaction Update | Matthew Swanborough, Chief Strategy Officer | Note |
| 9. | Outpatient Transformation Update | Hayley Kendall, Executive Managing Director | Note |
| 10. | Committee Updates | | Note |
| | 10.1) Joint Quality and Safety Committee | Professor Chris Bentley | |
| | 10.2) Joint People Committee – **Verbal** | Lesley Davies | |
| | 10.3) Joint Finance and Performance Committee | Meredydd David | |
| | 10.4) Joint Digital Committee | Haris Sultan | |
| | 10.5) WUTH Audit and Risk Committee | Lisa Greenhalgh | |
| | 10.6) WCHC Audit and Risk Committee | Lisa Greenhalgh | |
| | 10.7) WUTH Charitable Funds Committee – **Verbal** | Lesley Davies | |
| 11. | Integrated Performance Report | Executive Directors | Note |
| 12. | Fit and Proper Persons Annual Update | Cate Herbert, Board Secretary | Assure |

## Wallet Items for Information

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| 13. | Group Board of Directors Minutes | Steve Igoe, Chair | Note |

## Closing Business

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| 14. | Meeting Review | Steve Igoe, Chair |
| 15. | Any other Business | Steve Igoe, Chair |

## Date and Time of Next Meeting

Friday 26 February 2027, 14:00

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|---|---|
| **Meeting** | WUTH Council of Governors |
| **Date** | Thursday 23 July 2026 |
| **Location** | Clinical Skills Lab, St Catherine's Health Centre |

**Members present:**

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| SI | Steve Igoe | Joint Chair |
| SH | Sheila Hillhouse | WUTH Lead Public Governor |
| RT | Dr Robert Thompson | WUTH Deputy Lead Public Governor |
| PP | Peter Peters | WUTH Public Governor |
| TC | Tony Cragg | WUTH Public Governor |
| KJ | Keith Johns | WUTH Public Governor |
| DF | David Funston | WUTH Public Governor |
| PB | Philippa Boston | WUTH Staff Governor |
| AK | Anand Kamalanathan | WUTH Staff Governor |

**In attendance:**

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|---|---|---|
| GC | Geoffrey Caton | WCHC Public Governor |
| EH | Eileen Hume | WCHC Public Governor |
| FR | Freida Rimmer | WCHC Public Governor |
| NL | Nicola Fletcher | WCHC Public Governor |
| JB | Jenna Brassington (until 2:30) | WCHC Staff Governor |
| EC | Emma Carvell | WCHC Staff Governor |
| SR | Dr Steve Ryan | Joint Non-Executive Director |
| MD | Meredydd David | Joint Non-Executive Director |
| LG | Lisa Greenhalgh | Joint Non-Executive Director |
| JH | Janelle Holmes | Joint Chief Executive |
| NS | Dr Nikki Stevenson | Joint Chief Medical Officer |
| DS | Debs Smith | Joint Chief People Officer |
| MS | Matthew Swanborough | Joint Chief Strategy Officer |
| GR | Gareth Robinson | Joint Director of Turnaround & Transformation |
| RC | Robbie Chapman | Deputy Chief Finance Officer (deputising for MC) |
| CH | Cate Herbert | Board Secretary |
| JJE | James Jackson-Ellis | Corporate Governance Officer |

**Apologies:**

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|---|---|---|
| NW | Neil Wright | WUTH Public Governor |
| MP | Dr Manoj Purohit | WUTH Public Governor |
| AL | Andy Liston | WUTH Public Governor |
| IH | Ian Huntley | WUTH Public Governor |
| JJ | Julie Jellicoe | WUTH Staff Governor |
| SV | Sunil Varghese | WUTH Staff Governor |
| ABG | Andrew Bradley-Gibbons | WUTH Staff Governor |

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| GKH | Gary Kelly-Hartley | WCHC Public Governor |
| IC | Irene Cooke | WCHC Public Governor |
| GG | Gary Grady | WCHC Staff Governor |
| JD | Julie Dulson | WCHC Appointed Governor |
| KP | Karen Prior | WCHC Appointed Governor |
| LD | Lesley Davies | Joint Non-Executive Director |
| CB | Chris Bentley | Joint Non-Executive Director |
| HS | Haris Sultan | Joint Non-Executive Director |
| CD | Chris Douglas | Joint Chief Nurse |
| HK | Hayley Kendall | Joint Executive Managing Director |
| JC | Dr Joanne Chwalko | Joint Chief Integration and Partnerships Officer |
| AH | Ali Hughes | Joint Director of Corporate Affairs & Communications |
| MC | Mark Chidgey | Joint Chief Finance Officer |

| Agenda Item | Minutes | Action |
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| 2 | **Declarations of Interest**<br><br>No new interests were declared and no other interests in relation to the agenda items were declared. | |
| 3 | **Minutes of Previous Meeting**<br><br>The minutes of the previous meeting held on 14 May were **APPROVED** as an accurate record. | |
| 4 | **Action Log**<br><br>The Council of Governors **NOTED** the action log. | |
| 5 | **Joint Chair Update**<br><br>SI reported he had recently presented the long service staff awards, noting the importance of recognising staff for their commitment to both patients and the Trusts. He reported that the Urgent Emergency Care Upgrade Programme (UECIP) is in its final stages.<br><br>SI advised that statutory transaction was continuing and progressing well. Quarter 1 performance was on track and financial position for both Trusts was in line with plan.<br><br>SI highlighted he had visited a number of services across WUTH and WCHC, which had been beneficial. | |

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| | SI further advised that a regional meeting of Chairs and Chief Executives had recently been held and had been well attended, with positive engagement from those present.<br><br>RT asked whether the new urgent and emergency care pathways would be subject to audit.<br><br>NS stated that staff from both Trusts were already working together and that urgent care and GP out-of-hours services will be co-located and working alongside one another. NS added that the Trusts will remain separate entities and continue to operate through their own governance structures, with work ongoing to align governance processes where appropriate. NS confirmed that the pathways would be subject to audit.<br><br>RT asked whether there was a risk that members of the public could attend the Emergency Department who could be treated in another setting.<br><br>JH advised that the triage process would remain unchanged and that self-check-in arrangements are currently in place. She noted that future phases of development would provide opportunities to redirect patients where appropriate, directing them to alternative healthcare providers through clinically agreed pathways.<br><br>SH asked if this included clinicians at Arrowe Park Hospital being able to book GP appointments on the behalf of patients.<br><br>JH advised that the intention is to provide accessible appointment booking, including GP and cardiology appointments. She noted that this would require agreement with primary care partners and the necessary technology to support the process.<br><br>The Council of Governors **NOTED** the verbal update. | |
| **6** | **Appointment of Lead Governors**<br><br>CH requested approval to appoint Tony Cragg as Lead Governor, following the end of tenure of Sheila Hillhouse in September 2026 who had completed 9 years.<br><br>The Council of Governors **APPROVED** the appointment of Tony Cragg as Lead Governor, from the period 1 September 2026 to 31 March 2027. | |
| **7** | **Lead Governor Update**<br><br>SH provided an update on the national position regarding Governors, noting that Lead Governors had written both nationally and locally to the relevant regulators. Correspondence had also been sent to local MPs. | |

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| | SH acknowledged this was her last meeting and thanked everyone for their contributions and support.<br><br>The Council of Governors **NOTED** the verbal update. | |
| **8** | **Board Assurance Framework (BAF)**<br><br>CH introduced new strategic risks within the BAF for 2026-27, aligned with the new Joint Strategy approved in April 2026.<br><br>CH added the various Committees of the Board reviewed and approved strategic risks and risk appetites between April and June 2026, with specific risks assigned for oversight and amendments made to risk ratings and appetites as needed.<br><br>CH highlighted of 12 strategic risks, 9 have been reviewed by Committees; six currently have high risk ratings, including failures in managing unscheduled and planned care, workforce challenges, financial plan delivery, service transformation, and cyber infrastructure threats<br><br>SH asked what the highest risk was.<br><br>SI responded that all the risks included on the BAF were considered important and interrelated, noting the scoring varied between each with some rated high and amber.<br><br>RT noted the several risks scored as red and queried how concerned the Council of Governors should be given the high risk ratings.<br><br>SI explained that given the Trusts size and complexity this contributed to the risk profile of the organisations.<br><br>DS commented that ID01 had reduced from a score of 20 to 16 as a result of mitigation measures that had been implemented, noting the controls and actions were agile given the risk environment.<br><br>The Council of Governors:<br>• **NOTED** the detail shared in relation to each of the risks and the new format of the BAF agreed in April 2026; an<br>• **NOTED** that further work through the Committees of the Board will continue to monitor each of the risks | |
| **9** | **Statutory Transaction Strategic Outline Case**<br><br>MS gave an overview of the Transaction Strategic Outline Case (SOC), and highlighted the anticipated benefits, including improved patient outcomes and improved long-term financial sustainability. The proposal supports the delivery of local and national strategic priorities and provides a stronger platform to address health inequalities and population health needs. | |

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| | FR asked for an update on the work undertaken with Physiotherapy and Cardiology services.<br><br>MS reported good progress, with work focused on developing the case for change and aligning clinical pathways. As the transaction progresses, services will formally move together. Work is also continuing on the integration of corporate services.<br><br>JH requested that JC provide an update on clinical integration at the next meeting.<br><br>SH asked about patient involvement and the benefits being delivered.<br><br>MS explained that Allied Health Services had moved to St Catherine's, improving accessibility and enabling earlier intervention for patients. Cardiology services are now sharing waiting lists, which has contributed to improvements in waiting times.<br><br>GC asked whether service integration also included functions such as catering and if the hospital offered non-halal food to patients.<br><br>NS advised that the default provision is non-halal, with other dietary requirements catered for, including vegetarian, gluten-free, shellfish-free and soft diet options.<br><br>TC highlighted the annual PLACE assessment provided an opportunity for Governors to review the food being provided to patients.<br><br>EC reported that discussions are ongoing with the catering provider to ensure patient needs are supported and expressed hope that there would be no delays to the transaction process.<br><br>Members thanked MS and the team for their work and progress to date.<br><br>The Council of Governors **NOTED** the Transaction Strategic Outline Case. | Joanne Chwalko |
| **10** | **Cost Improvement Programme (CIP) and Drivers of the Deficit Update**<br><br>GR reported both Trusts face significant financial challenges and must deliver £36.7m of savings in 2026/27 (6% of its cost base) to maintain financial sustainability and autonomy. Savings opportunities totalling £42.5m have been identified, with a risk-adjusted value of £34.1m. The programme also targets deficit drivers representing £55.2m of improvement opportunities. | |

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| | GR reported key priorities include improving productivity, better matching capacity to demand, reducing sickness absence, and delivering efficiencies across urgent care, corporate services, estates, clinical services and procurement.<br><br>GR explained multiple workforce and service model options are being considered, with the recognition that difficult but necessary decisions will be required to secure high-quality, sustainable services for the future**.**<br><br>FR asked whether the sickness absence savings amounted to £1.5m or £4.5m<br><br>GR advised that the total opportunity identified was £6m for sickness absence with £4.5m for WUTH and £1.5m for WCHC.<br><br>DS reported that sickness absence levels were improving, with rates of 5.2% at WUTH and 5.5% at WCHC. Good controls and assurance measures were in place. A different approach was being taken through a population health methodology to better understand workforce needs and address the underlying causes of sickness absence. Work was also underway to analyse the reasons for absence, recognising that not all absence was directly related to ill health, with targeted interventions being developed for relevant staff groups.<br><br>SH noted the need to examine workforce models and acknowledged that difficult decisions would be required. SH asked how the Trust intended to support staff through the transition period and maintain enthusiasm during the merger process.<br><br>GR emphasised the importance of clear communication about the reasons for change and the benefits expected for patients and staff. It was noted that the changes were intended to deliver positive outcomes and financial benefits, with staff being actively involved and engaged throughout the process.<br><br>DS commented that the organisation was continually learning throughout the programme. Learning from reviews was being incorporated into the work, including lessons identified during Phase 2 of the Corporate Services Review, which had informed the approach to Phase 3.<br><br>RT commented about the urgent and emergency care pressures, noting that the Trust had limited control over attendance levels. RT highlighted the value of highly qualified, patient-focused staff and voiced concerns that pausing recruitment, increasing reliance on agency staff, or reducing workforce capacity could negatively affect clinical outcomes. RT sought reassurance that this was not part of the proposed approach and requested a progress update in six months' time. | Gareth Robinson |

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| | SI advised that this represented year one of a three-year plan. The Group Board had agreed clinical guardrails to ensure that patients, staff and quality of care would be protected throughout delivery of the programme.<br><br>GC noted that difficult decisions would sometimes be required regarding patients receiving treatment who may not be entitled to access services and queried this.<br><br>NS advised staff would continue to provide care when required, with recharging arrangements applied where appropriate. NS added this was a national process and not Trust decided.<br><br>The Council of Governors **NOTED** the presentation. | |
| **11** | **Committee Updates**<br><br>**11.1) Joint Digital Committee**<br><br>RC provided this update in the absence of HS.<br><br>RC alerted members that Freedom of Information and Subject Access requests for WUTH were non-compliant. The Committee received and supported an improvement plan, including additional resources, digital workflow improvements and performance dashboards to improve the position.<br><br>RC also alerted members that clinical coding capacity remains a significant risk nationally, and WUTH has been more acutely impacted than many other trusts. The Committee was assured there is no current financial impact and received a mitigation plan.<br><br>RC alerted members that cyber resilience and business continuity were an area of focus. The Committee sought and received assurance that lessons learned from the previous cyber incident have been reviewed and embedded.<br><br>RC summarised the various “Advise” and “Assure” matters from the meeting on 16 April.<br><br>**11.2) Joint Finance and Performance Committee**<br><br>MD alerted members that at the end of March 2026 (M12), WUTH is reporting a deficit of £49.5m. This is in line with the forecast that the Trust submitted to NHS England in February but, excluding DSF, is a £27.3m adverse variance to plan.<br><br>MD also alerted members that at the end of March 2026 (M12), WCHC is reporting a surplus of £5.1m, which was a £4.2m positive variance to plan, and this has been reported to NHSE. | |

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| | MD summarised the various “Advise” and “Assure” matters from the meeting on 22 April.<br><br>MD provided a verbal update from meeting held on 21 May, alerting members that cash remains WUTH’s most immediate risk, with a closing balance of £2.7m and continued reliance on national support. The Committee noted the June cash support application had been approved and authorised future submissions in line with the cash flow forecast.<br><br>MD advised members that the Committee noted that both Trusts were reporting in line with plan at Month 1, with WUTH reporting a £2.9m deficit and WCHC a £0.2m surplus. Good progress was reported against the £36.7m CIP target, with schemes equivalent to 105% of the target identified and work underway to achieve 120% coverage to reduce risk.<br><br>MD assured members that that Committee received an update on the future utilisation of the WUTH and WCHC estate, noting the focus on efficiency and alignment with the NHS 10-Year Plan. Further updates will be provided as the work progresses.<br><br>**11.3) Joint People Committee**<br><br>DS provided this update in the absence of LD.<br><br>DS noted the updated included in the pack was based on the March meeting and two meetings had taken place since.<br><br>DS provided a verbal update from the meeting held on 16 July, alerting members sickness absence had improved across both Trusts and a newly published NHS Staff Standards document had been published setting how the expectations for NHS staff. A detailed discussion had also taken place regarding the BAF and the relevant strategic risks for the Joint People Committee.<br><br>RT commented it was disappointing the staff survey response rate fell to 42% for WUTH and queried the reasons for this.<br><br>DS stated there was an element of survey fatigue but stressed the response rate was sufficient to act as reliable data to act on.<br><br>**11.4) Joint Quality and Safety Committee**<br><br>SR alerted members that demand continues to exceed capacity in some services, with staffing vacancies affecting access and flow. Previous backlogs in acute macular degeneration have reduced significantly. Current pressures remain in PEG services, resulting in longer stays for a small number of patients, and in inflammatory bowel disease follow-up appointments. Recruitment and business case development are underway to address these issues. | |

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| | SR also alerted members that following improvements in March and April, increased unscheduled care demand in May led to a deterioration in corridor care performance. A Trust-wide summit identified actions to improve flow and resilience, with the Committee continuing to monitor the impact on patient quality, safety and experience.<br><br>SR summarised the various "Advise" and "Assure" matters from the meeting on 29 May.<br><br>SH queried if there remained a high number of pressure ulcers being reported.<br><br>SR advised there had been a reduction and also formed a quality improvement priority for 2026/27 for both WUTH and WCHC.<br><br>NS confirmed that this is a key priority for both the Chief Medical Officer and Chief Nurse and is aligned across both Trusts. The Chief Nurse has committed to achieving zero Grade 4 pressure ulcers and a 20% reduction in Grade 2 and Grade 3 pressure ulcers. Work is ongoing to deliver these objectives, recognising the significant impact pressure ulcers have on patient care.<br><br>**11.5) WUTH Audit and Risk Committee**<br><br>LG explained there were no areas to alert members to and summarised the various "Advise" and "Assure" matters from the meeting on 23 April.<br><br>LG highlighted a subsequent meeting had been held in June whereby the Quality Account and Annual Report and Accounts were approved, with an unqualified audit option on the financial statement was received.<br><br>**11.6) WCHC Audit and Risk Committee**<br><br>LG explained there were no areas to alert members to and summarised the various "Advise" and "Assure" matters from the meeting on 23 April.<br><br>LG highlighted a subsequent meeting had been held in June whereby the Quality Account and Annual Report and Accounts were approved, with an unqualified audit option on the financial statement was received.<br><br>**11.7) WUTH Charitable Funds Committee**<br><br>CH provided this update in the absence of LD.<br><br>CH alerted members that the Charity has yet to agree a focus for its new campaign. The Committee asked the team to explore the options and bring a proposal to the next meeting. Current options | |

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| | include a wellbeing garden and improvements to the Trust's family bereavement area.<br><br>CH summarised the various "Advise" and "Assure" matters from the meeting on 9 April.<br><br>CH advised a subsequent meeting had been held in July whereby it had been agreed to progress in principle with a critical care garden appeal.<br><br>The Council of Governors **NOTED** the Committee Updates. | |
| **12** | **Integrated Performance Report**<br><br>NS reported a reduction in C. difficile cases between April and June. Work is continuing across both Trusts to address this multifactorial issue. NS explained that WUTH exceeded the national threshold in 2025/26, although a threshold has not yet been set by NHS England for 2026/27.<br><br>NS also noted that FTT for ED performance remain below the 95% target, with most performance measures around 80% due to access pressures. Good progress was reported at WCHC, and low incident reporting numbers were noted, reflecting the Trust's aim to maintain a strong reporting culture while minimising incidents.<br><br>NS reported that a Never Event at WUTH was declared in June relating to a nasal pack left in situ. No harm resulted, but the incident met the criteria for a Never Event. The matter is being managed through the PSIRF process, with learning identified and actions being taken forward.<br><br>RC advised that capital expenditure was below plan at the end of Month 1 but had recovered during Month 2. Cash pressures remain, with continued reliance on deficit support funding.<br><br>DS reported that mandatory training compliance at WUTH, including fire safety training, had returned to 90%. No significant concerns were reported regarding workforce metrics at WCHC, although rolling staff turnover remains higher than usual.<br><br>The Council of Governors **NOTED** | |
| **13** | **Group Board of Directors' Minutes**<br><br>The Council of Governors **NOTED** the Group Board of Directors Minutes. | |
| **14** | **Meeting Review**<br><br>Members agreed the first joint meeting had gone well and everyone had the opportunity to contribute. | |

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| **15** | **Any other Business**<br><br>CH stated there were vacancies on both the WUTH and WCHC Nominations Committee, explaining expressions of interest had been received from Ian Huntley to join the WUTH Nominations Committee and would be appointed.<br><br>CH encouraged any WCHC Public Governors who wish to join the WCHC Nominations Committee to contact the Corporate Governance team.<br><br>Members thanked SH for her contributions as Governor and to the Council of Governors during the last 9 years. | |

*(The meeting closed at 15:45)*

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| **Meeting** | WCHC Council of Governors |
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| **Location** | Clinical Skills Lab, St Catherine's Health Centre |

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| | The proposal supports the delivery of local and national strategic priorities and provides a stronger platform to address health inequalities and population health needs.<br><br>FR asked for an update on the work undertaken with Physiotherapy and Cardiology services.<br><br>MS reported good progress, with work focused on developing the case for change and aligning clinical pathways. As the transaction progresses, services will formally move together. Work is also continuing on the integration of corporate services.<br><br>JH requested that JC provide an update on clinical integration at the next meeting.<br><br>SH asked about patient involvement and the benefits being delivered.<br><br>MS explained that Allied Health Services had moved to St Catherine's, improving accessibility and enabling earlier intervention for patients. Cardiology services are now sharing waiting lists, which has contributed to improvements in waiting times.<br><br>GC asked whether service integration also included functions such as catering and if the hospital offered non-halal food to patients.<br><br>NS advised that the default provision is non-halal, with other dietary requirements catered for, including vegetarian, gluten-free, shellfish-free and soft diet options.<br><br>TC highlighted the annual PLACE assessment provided an opportunity for Governors to review the food being provided to patients.<br><br>EC reported that discussions are ongoing with the catering provider to ensure patient needs are supported and expressed hope that there would be no delays to the transaction process.<br><br>Members thanked MS and the team for their work and progress to date.<br><br>The Council of Governors **NOTED** the Transaction Strategic Outline Case. | Joanne Chwalko |
| **10** | **Cost Improvement Programme (CIP) and Drivers of the Deficit Update**<br><br>GR reported both Trusts face significant financial challenges and must deliver £36.7m of savings in 2026/27 (6% of its cost base) to maintain financial sustainability and autonomy. Savings opportunities totalling £42.5m have been identified, with a risk- | |

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| | adjusted value of £34.1m. The programme also targets deficit drivers representing £55.2m of improvement opportunities.<br><br>GR reported key priorities include improving productivity, better matching capacity to demand, reducing sickness absence, and delivering efficiencies across urgent care, corporate services, estates, clinical services and procurement.<br><br>GR explained multiple workforce and service model options are being considered, with the recognition that difficult but necessary decisions will be required to secure high-quality, sustainable services for the future**.**<br><br>FR asked whether the sickness absence savings amounted to £1.5m or £4.5m<br><br>GR advised that the total opportunity identified was £6m for sickness absence with £4.5m for WUTH and £1.5m for WCHC.<br><br>DS reported that sickness absence levels were improving, with rates of 5.2% at WUTH and 5.5% at WCHC. Good controls and assurance measures were in place. A different approach was being taken through a population health methodology to better understand workforce needs and address the underlying causes of sickness absence. Work was also underway to analyse the reasons for absence, recognising that not all absence was directly related to ill health, with targeted interventions being developed for relevant staff groups.<br><br>SH noted the need to examine workforce models and acknowledged that difficult decisions would be required. SH asked how the Trust intended to support staff through the transition period and maintain enthusiasm during the merger process.<br><br>GR emphasised the importance of clear communication about the reasons for change and the benefits expected for patients and staff. It was noted that the changes were intended to deliver positive outcomes and financial benefits, with staff being actively involved and engaged throughout the process.<br><br>DS commented that the organisation was continually learning throughout the programme. Learning from reviews was being incorporated into the work, including lessons identified during Phase 2 of the Corporate Services Review, which had informed the approach to Phase 3.<br><br>RT commented about the urgent and emergency care pressures, noting that the Trust had limited control over attendance levels. RT highlighted the value of highly qualified, patient-focused staff and voiced concerns that pausing recruitment, increasing reliance on agency staff, or reducing workforce capacity could negatively affect clinical outcomes. RT sought reassurance that this was not part of | |

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| | the proposed approach and requested a progress update in six months' time.<br><br>SI advised that this represented year one of a three-year plan. The Group Board had agreed clinical guardrails to ensure that patients, staff and quality of care would be protected throughout delivery of the programme.<br><br>GC noted that difficult decisions would sometimes be required regarding patients receiving treatment who may not be entitled to access services and queried this.<br><br>NS advised staff would continue to provide care when required, with recharging arrangements applied where appropriate. NS added this was a national process and not Trust decided.<br><br>The Council of Governors **NOTED** the presentation. | Gareth Robinson |
| **11** | **Committee Updates**<br><br>**11.1) Joint Digital Committee**<br><br>RC provided this update in the absence of HS.<br><br>RC alerted members that Freedom of Information and Subject Access requests for WUTH were non-compliant. The Committee received and supported an improvement plan, including additional resources, digital workflow improvements and performance dashboards to improve the position.<br><br>RC also alerted members that clinical coding capacity remains a significant risk nationally, and WUTH has been more acutely impacted than many other trusts. The Committee was assured there is no current financial impact and received a mitigation plan.<br><br>RC alerted members that cyber resilience and business continuity were an area of focus. The Committee sought and received assurance that lessons learned from the previous cyber incident have been reviewed and embedded.<br><br>RC summarised the various “Advise” and “Assure” matters from the meeting on 16 April.<br><br>**11.2) Joint Finance and Performance Committee**<br><br>MD alerted members that at the end of March 2026 (M12), WUTH is reporting a deficit of £49.5m. This is in line with the forecast that the Trust submitted to NHS England in February but, excluding DSF, is a £27.3m adverse variance to plan. | |

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| | MD also alerted members that at the end of March 2026 (M12), WCHC is reporting a surplus of £5.1m, which was a £4.2m positive variance to plan, and this has been reported to NHSE.<br><br>MD summarised the various "Advise" and "Assure" matters from the meeting on 22 April.<br><br>MD provided a verbal update from meeting held on 21 May, alerting members that cash remains WUTH's most immediate risk, with a closing balance of £2.7m and continued reliance on national support. The Committee noted the June cash support application had been approved and authorised future submissions in line with the cash flow forecast.<br><br>MD advised members that the Committee noted that both Trusts were reporting in line with plan at Month 1, with WUTH reporting a £2.9m deficit and WCHC a £0.2m surplus. Good progress was reported against the £36.7m CIP target, with schemes equivalent to 105% of the target identified and work underway to achieve 120% coverage to reduce risk.<br><br>MD assured members that that Committee received an update on the future utilisation of the WUTH and WCHC estate, noting the focus on efficiency and alignment with the NHS 10-Year Plan. Further updates will be provided as the work progresses.<br><br>**11.3) Joint People Committee**<br><br>DS provided this update in the absence of LD.<br><br>DS noted the updated included in the pack was based on the March meeting and two meetings had taken place since.<br><br>DS provided a verbal update from the meeting held on 16 July, alerting members sickness absence had improved across both Trusts and a newly published NHS Staff Standards document had been published setting how the expectations for NHS staff. A detailed discussion had also taken place regarding the BAF and the relevant strategic risks for the Joint People Committee.<br><br>RT commented it was disappointing the staff survey response rate fell to 42% for WUTH and queried the reasons for this.<br><br>DS stated there was an element of survey fatigue but stressed the response rate was sufficient to act as reliable data to act on.<br><br>**11.4) Joint Quality and Safety Committee**<br><br>SR alerted members that demand continues to exceed capacity in some services, with staffing vacancies affecting access and flow. Previous backlogs in acute macular degeneration have reduced significantly. Current pressures remain in PEG services, resulting | |

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| | in longer stays for a small number of patients, and in inflammatory bowel disease follow-up appointments. Recruitment and business case development are underway to address these issues.<br><br>SR also alerted members that following improvements in March and April, increased unscheduled care demand in May led to a deterioration in corridor care performance. A Trust-wide summit identified actions to improve flow and resilience, with the Committee continuing to monitor the impact on patient quality, safety and experience.<br><br>SR summarised the various "Advise" and "Assure" matters from the meeting on 29 May.<br><br>SH queried if there remained a high number of pressure ulcers being reported.<br><br>SR advised there had been a reduction and also formed a quality improvement priority for 2026/27 for both WUTH and WCHC.<br><br>NS confirmed that this is a key priority for both the Chief Medical Officer and Chief Nurse and is aligned across both Trusts. The Chief Nurse has committed to achieving zero Grade 4 pressure ulcers and a 20% reduction in Grade 2 and Grade 3 pressure ulcers. Work is ongoing to deliver these objectives, recognising the significant impact pressure ulcers have on patient care.<br><br>**11.5) WUTH Audit and Risk Committee**<br><br>LG explained there were no areas to alert members to and summarised the various "Advise" and "Assure" matters from the meeting on 23 April.<br><br>LG highlighted a subsequent meeting had been held in June whereby the Quality Account and Annual Report and Accounts were approved, with an unqualified audit option on the financial statement was received.<br><br>**11.6) WCHC Audit and Risk Committee**<br><br>LG explained there were no areas to alert members to and summarised the various "Advise" and "Assure" matters from the meeting on 23 April.<br><br>LG highlighted a subsequent meeting had been held in June whereby the Quality Account and Annual Report and Accounts were approved, with an unqualified audit option on the financial statement was received.<br><br>**11.7) WUTH Charitable Funds Committee**<br><br>CH provided this update in the absence of LD. | |

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| | CH alerted members that the Charity has yet to agree a focus for its new campaign. The Committee asked the team to explore the options and bring a proposal to the next meeting. Current options include a wellbeing garden and improvements to the Trust's family bereavement area.<br><br>CH summarised the various "Advise" and "Assure" matters from the meeting on 9 April.<br><br>CH advised a subsequent meeting had been held in July whereby it had been agreed to progress in principle with a critical care garden appeal.<br><br>The Council of Governors **NOTED** the Committee Updates. | |
| **12** | **Integrated Performance Report**<br><br>NS reported a reduction in C. difficile cases between April and June. Work is continuing across both Trusts to address this multifactorial issue. NS explained that WUTH exceeded the national threshold in 2025/26, although a threshold has not yet been set by NHS England for 2026/27.<br><br>NS also noted that FTT for ED performance remain below the 95% target, with most performance measures around 80% due to access pressures. Good progress was reported at WCHC, and low incident reporting numbers were noted, reflecting the Trust's aim to maintain a strong reporting culture while minimising incidents.<br><br>NS reported that a Never Event at WUTH was declared in June relating to a nasal pack left in situ. No harm resulted, but the incident met the criteria for a Never Event. The matter is being managed through the PSIRF process, with learning identified and actions being taken forward.<br><br>RC advised that capital expenditure was below plan at the end of Month 1 but had recovered during Month 2. Cash pressures remain, with continued reliance on deficit support funding.<br><br>DS reported that mandatory training compliance at WUTH, including fire safety training, had returned to 90%. No significant concerns were reported regarding workforce metrics at WCHC, although rolling staff turnover remains higher than usual.<br><br>The Council of Governors **NOTED** | |
| **13** | **Group Board of Directors' Minutes**<br><br>The Council of Governors **NOTED** the Group Board of Directors Minutes. | |

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| **14** | **Meeting Review**<br><br>Members agreed the first joint meeting had gone well and everyone had the opportunity to contribute. | |
| **15** | **Any other Business**<br><br>CH stated there were vacancies on both the WUTH and WCHC Nominations Committee, explaining expressions of interest had been received from Ian Huntley to join the WUTH Nominations Committee and would be appointed.<br><br>CH encouraged any WCHC Public Governors who wish to join the WCHC Nominations Committee to contact the Corporate Governance team.<br><br>Members thanked SH for her contributions as Governor and to the Council of Governors during the last 9 years. | |

*(The meeting closed at 15:45)*

**Action Log**
**WUTH and WCHC Council of Governors**
**16 November 2026**

| No. | Date of Meeting | Minute Ref | Action | By Whom | Action Status | Due Date |
|---|---|---|---|---|---|---|
| 2 | 23 July 2026 | 9 | To provide an update on the clinical services integration | Dr Joanne Chwalko | In progress. Scheduled for February 2027. | February 2027 |
| 3 | 23 July 2026 | 10 | To provide an update on the cost improvement programme and drivers of the deficit | Gareth Robinson | In progress. Scheduled for February 2027. | February 2027 |

**WUTH Council of Governors**

**WCHC Council of Governors** **Item 5**

**16 November 2026**

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

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

This report provides the Council of Governors with the new strategic risks in the Board Assurance Framework for review and approval, following work completed by Committees of the Board during September and October 2026.

It is recommended that the Council:

- Notes the risk ratings noting that there are 6 high-level strategic risks
- Notes the updates for each risk as reported
- Notes the recommendation from Integrated Management Board to increase the risk rating of ID09 to RR12
- Notes that further work through the Committees of the Board will continue to monitor each of the strategic risks with a particular focus during November and December on actions

## Key Points to Note

The Joint BAF has been developed to align with the strategic objectives set out in the new Joint Strategy. The Group Board approved the strategic objectives on 1 April 2026.

A new structure for the BAF has also been implemented and each of the Committees of the Board has maintained oversight of each of the relevant strategic risks.

## Key Risks

This report relates to these key risks:

- The BAF records the principal risks that could impact on the Trusts' ability in achieving their strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trusts being unable to achieve their strategic objectives or statutory obligations. There are opportunities through the effective development and use of the BAF, to enhance the delivery of the strategic objectives and effectively mitigate the impact of the principal risks contained within the BAF.

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

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

| Governance journey | | | |
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| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 1 April 2026 | Group Board | Board Assurance Framework 26-27 | The Group Board reviewed and approved the new strategic risks for monitoring through the BAF during 2026-27. |
| 16 April 2026 | Digital Committee | Board Assurance Framework 26-27 | The Committee reviewed strategic risk ID12 and agreed that ID11 should have dual oversight by the Committee (with the Finance Committee) for a cyber focus. The risk appetites and risk ratings were agreed and ID11 was amended to reflect a 'Seek' appetite |
| 22 April 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed strategic risks ID01, ID02, ID05, ID06 and ID11. The risk appetites and risk ratings were agreed and ID06 was amended to reflect a 'Seek' appetite. |
| 27 May 2026 | People Committee | Board Assurance Framework 26-27 | The Committee reviewed the two strategic risks, ID03 and ID04, and agreed to a further review of ID04 with a particular focus on the controls related to Staff Experience and Engagement and the current risk rating. The Committee also supported an amendment to the risk appetite of both risks to 'Seek' recognising the transformational change required across the Trust during 26-27. |
| 29 May 2026 | Quality Committee | Board Assurance Framework 26-27 | The Committee reviewed strategic risks ID01, ID02 and ID08 and supported the risk appetite statements and the current risk ratings and target risk ratings. |
| 19 June 2026 | Digital Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID11 and ID12. The correspondence from NHSE |

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

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| | | | of ID01 to RR20, and the recommendation to include a new strategic risk related to patient safety and quality governance. The Group Board noted the oversight by the Committees and the position in relation to all risks, with 6 scoring at a high level. |
| 10 September 2026 | WUTH Audit & Risk Committee<br><br>WCHC Audit & Risk Committee | Board Assurance Framework 26-27 | The Committees noted the recent approvals made by the Group Board and the updates for each risk as reported.<br>The Committees also received an update in relation to ID07 and agreed the current risk rating, controls and assurances.<br>It was agree that that the Audit & Risk Committees would receive the full BAF at future meetings to review the position in relation to all the strategic risks. |
| 16 September 2026 | Digital Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to risk ID11 (from a cyber perspective) and ID12 noting the current risk rating in the context of current controls. |
| 24 September 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to risk ID01, ID02, ID05, ID06 and ID11 noting the joint review and oversight of risks with both the Quality & Safety and Digital Committees.<br>The updates to the controls and assurance and particularly the strengthening of controls to reflect the recently updated EPRR core standards were noted.<br>There were no proposed changes to risk ratings. |
| 28 September 2026 | Quality & Safety Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to ID01, ID02 and ID08 noting the joint review and oversight of ID01 and ID02 (also as high scoring risks) with the Finance & Performance Committee.<br>The Committee also proposed an addition to ID03 (referred to the People Committee) to demonstrate the interdependency between culture and patient safety and quality and the importance of monitoring quality metrics as an indicator of culture.<br>There were no proposed changes to risk ratings. |
| 30 September 2026 | People Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to ID03 and ID04, noting that ID04 is one of the high scoring risks on the BAF. |

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

| 1 | Narrative |
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| **1.1** | The Group Board has in place a full Board Assurance Framework which has been developed to reflect the new Joint Strategy approved in April 2026.<br><br>Each of the Joint Committees of the Group Board maintains oversight of strategic risks relevant to the duties and responsibilities of the committee. |
| **1.2** | All of the strategic risks included in the BAF are detailed in **appendix 1** with alignment to strategic objectives, Executive Lead and committee oversight included. |
| **1.3** | Since the last meeting of the Committee, all 12 strategic risks have been reviewed by the relevant Committees.<br><br>The new strategic risk (ID13) recommended by the Quality & Safety Committee and approved by the Board in September 2026, is currently being developed and will be reviewed by the Committee at its next meeting in November 2026. |
| **1.4** | Of the 12 strategic risks, **six** remain **HIGH** scoring risks.<br><br>These are:<br><br>ID01 - Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience (RR20).<br><br>ID02 - Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience (RR16).<br><br>ID03 - Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high-quality care (RR16). |

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| | ID05 - Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability (RR15).<br><br>ID06 - Failure to embed service transformation and deliver sustainable efficiency gains (RR15).<br><br>ID11 - Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care (RR15). |
| **1.5** | At its October meeting, the Integration Management Board agreed to increase the risk rating of ID09 9, *Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce and financial) not being realise,* to RR12.<br><br>Both ID09 and ID10 will continue to be monitored at the Integrated Management Board, and have been included in these papers for completeness.<br><br>The Integrated Management Board will meet on the 11th November and will consider a further update to ID09 |
| **1.6** | The Joint Committees of the Board will continue to oversee the relevant strategic risks and assurance on process and tracking will be provided to each of the Audit & Risk Committees in September 2026. |

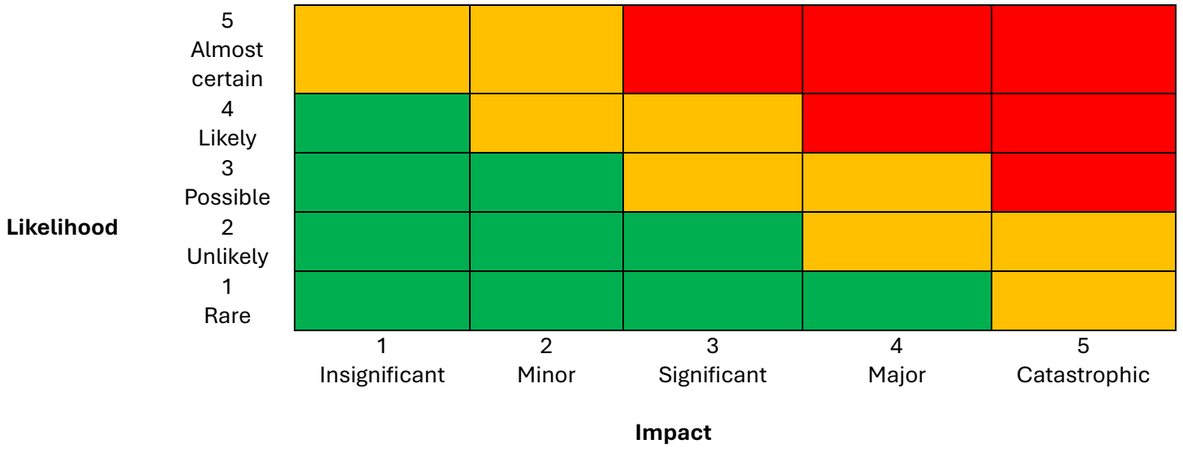
| **2** | **Implications** |
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| **2.1** | **Patients**<br>• Any gaps related to these strategic risks could have an impact on the provision of high-quality services, impacting on patient safety and patient experience.<br>• The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF. |
| **2.2** | **People**<br>• Any gaps related to these strategic risks could have an impact on other people strategic risks including the retention of a skilled workforce.<br>• The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF. |
| **2.3** | **Finance**<br>• Any financial or resource implications are detailed in the BAF for each strategic risk. |
| **2.4** | **Compliance**<br>• The BAF is key to effective governance and is subject to an annual Assurance Framework Review as per internal audit standards in order to inform the Head of Internal Audit Opinion (HOIA) each year. The strategic risks tracked through the BAF are reported annually through the Annual Governance Statement. |

| Risk Description | Risk Theme | Strategic Objective | Committee oversight | Exec Lead |
|---|---|---|---|---|
| 1. Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. | Operational effectiveness | **Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Quality<br>Finance & Performance | Chief Medical Officer<br>Executive Managing Director |
| 2. Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience. | Operational effectiveness | **Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Quality<br>Finance & Performance | Chief Medical Officer<br>Executive Managing Director |
| 3. Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care. | Workforce | **Our People**<br>We will nurture an inclusive, compassionate culture where people thrive | People | Chief People Officer |
| 4. Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported | Workforce | **Our People**<br>We will nurture an inclusive, compassionate culture where people thrive | People | Chief People Officer |
| 5. Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability. | Finance & Capital | **Improve and Innovate**<br>We will make improvement and innovation part of how we work | Finance & Performance | Chief Finance Officer |
| 6. Failure to embed service transformation and deliver sustainable efficiency gains. | Operational effectiveness | **Improve and Innovate**<br>We will make improvement and innovation part of how we work | Finance & Performance | Director of Turnaround & Transformation |
| 7. Failure to comply with relevant codes of governance, regulation and legislative requirements | Operational effectiveness | **Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Audit & Risk | Director of Corporate Affairs & Communications |
| 8. Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities. | Quality & Patient Experience | **Healthier Communities**<br>We will drive health equity and support healthier lives | Quality | Chief Nurse |
| 9. Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce and financial) not being realised. | System working & Collaboration | **Collaboration & Partnerships**<br>We will work as one system and one organisation | IMB | Chief Strategy Officer |
| 10. Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services | System working & Collaboration | **Collaboration & Partnerships**<br>We will work as one system and one organisation | IMB | Chief Integration Officer |
| 11. Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care. | Digital & Data<br><br>Operational Effectiveness | **Advance Digitally**<br>We will develop a secure, connected digital ecosystem fit for the future<br><br>**Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Finance & Performance<br><br>Digital (for cyber focus) | Executive Managing Director |
| 12. Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively. | Digital & Data | **Advance Digitally**<br>We will develop a secure, connected digital ecosystem fit for the future | Digital | Chief Finance Officer / SIRO |

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

| **Committee** | **Risks** | |
|---|---|---|
| Quality | 4 | 1, 2, 8 & 13 |
| People | 2 | 3 & 4 |
| Finance & Performance | 5 | 1, 2, 5 & 6, 11 |
| Digital | 1 | 12 |
| Audit | 1 | 7 |
| IMB | 2 | 9 & 10 |

| Risk Description | Committee oversight | Exec Lead | Risk appetite | Initial risk rating (April 2026) I x L | Current risk rating (October 26) I x L |
|---|---|---|---|---|---|
| 1. Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. | Quality<br>Finance & Performance | Chief Medical Officer<br>Executive Managing Director | Minimal | 4 x 5 (20) | 4 x 5 (20) |
| 2. Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience. | Quality<br>Finance & Performance | Chief Medical Officer<br>Executive Managing Director | Minimal | 4 x 5 (20) | 4 x 4 (16) |
| 3. Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care. | People | Chief People Officer | Seek | 4 x 4 (16) | 4 x 4 (16) |
| 4. Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported | People | Chief People Officer | Seek | 3 x 4 (12) | 3 x 4 (12) |
| 5. Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability. | Finance & Performance | Chief Finance Officer | Minimal | 5 x 4 (20) | 5 x 3 (15) |
| 6. Failure to embed service transformation and deliver sustainable efficiency gains. | Finance & Performance | Director of Turnaround & Transformation | Seek | 5 x 4 (20) | 5 x 3 (15) |
| 7. Failure to comply with relevant codes of governance, regulation and legislative requirements | Audit & Risk | Director of Corporate Affairs & Communications | Minimal | 4 x 3 (12) | 4 x 3 (812 |
| 8. Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities. | Quality | Chief Nurse | Open | 4 x 3 (12) | 4 x 3 (12) |
| 9. Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce and financial) not being realised. | IMB | Chief Strategy Officer | Open | 3 x 5 (15) | 3 x 4 (12)<br><br>*Increase to RR15 proposed to IMB* |
| 10. Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services | IMB | Chief Integration Officer | Seek | 3 x4 (12) | 3 x 4 (12) |
| 11. Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care. | Finance & Performance<br><br>Digital (for cyber focus) | Executive Managing Director | Seek | 5 x 4 (20) | 5 x 3 (15) |
| 12. Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively. | Digital | Chief Finance Officer / SIRO | Seek | 4 x 4 (16) | 4 x 3 (12) |
| 13. The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks. | Quality | Chief Nurse<br>Chief Medical Officer | | | |


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

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

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

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

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

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

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| **Risk ID** | 02 |
| **Risk theme** | Operational Effectiveness |
| **Risk appetite** | **Minimal** |
| **Link to strategic objectives** | Delivering Excellence - We will create the conditions for outstanding care and performance |
| **Executive lead** | Chief Medical Officer & Executive Managing Director |
| **Committee oversight** | Quality and Safety Committee<br>Finance and Performance Committee |
| **Consequences** | - Deterioration in patient outcomes due to delays in diagnosis and treatment<br>- Increased clinical risk, including avoidable harm<br>- Reduced patient confidence, satisfaction and overall experience<br>- Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times<br>- Increased complaints, PALS concerns and potential litigation<br>- Reduced confidence from staff, patients and stakeholders<br>- Failure to meet national standards and targets (e.g. RTT, cancer pathways, constitutional standards) (and impact on NOF rating)<br>- Reduced system flow and inefficiencies across pathways<br>- Increased pressure on unscheduled, urgent and emergency care<br>- Reduced staff morale, engagement and retention<br>- Greater reliance on temporary staffing, impacting continuity and cost<br>- Financial penalties or loss of income linked to performance breaches<br>- Increased scrutiny and intervention from regulators and system partners |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Risk Description | Consequences | Inherent risk score (I x L) | Controls | Board Assurance | | Current risk score (I x L) | Gaps in control / assurance | Actions | | Target risk score (I x L) | Estimated date of achievement of risk score |
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| | | | | Internal | External | | | Planned | Progress update | | |
| **Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability** | - Financial sustainability and damage to the Trusts reputations<br>- Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions<br>- Reduced flexibility to respond to operational pressures and demands<br>- Declining staff morale and engagement<br>- Reduced capacity to invest in workforce productivity and wellbeing initiatives<br>- Reduced confidence from staff, patients and stakeholders | 5 x 4 (20) | 1) Financial planning and financial governance arrangements | - New Joint Finance Committee<br>- Standing agenda item (private board) on delivery to plan<br>- Director of Transformation & Turnaround in post<br>- Clear executive accountability<br>- Exec-level SROs for Drivers of the Deficit programmes agreed | - MIAA grip and control review (moderate assurance)<br>- Engagement in FPRM processes (inc. with PWC)<br>- Letter received from NHSE (26.08) confirming MTFP accepted with conditions | 5 x 3 (15) | - WUTH in financial undertakings<br>- Agreement of exit criteria with NHSE<br>- CIP and financial performance accountability not consistently embedded at divisional and budget-holder level<br>- NHSE approval of revised plan and confirmation re: DSF<br>- Implementation of the NHSE NW Performance Accountability Framework | - Engagement with NHSE to define the metrics to remove all undertakings - **DCA / CFO**<br>- Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – **Director of Corporate Affairs**<br>~~- Regional oversight arrangements to be confirmed - **DCA / CFO**~~<br>- Implementation of recommendations from MIAA grip and control review - **CFO**<br>- ~~Further communication expected from NHSE re: DSF - **CFO**~~ | ~~- Meeting with NHSE on 22 April 2026 – complete~~<br>~~- NHSE performance oversight arrangements emerging – June/July 2026~~<br>~~- NHSE Director of Intensive Support & System Co-ordination to meet with DCA – August 2026 - **COMPLETE**~~ | 5 x 2 (10) | March 2027 |
| | | | 2) Board approved three-year MTFP aligned to system and ICB assumptions / priorities | - M1 & M2 & M3 financial plan delivered (WUTH & WCHC)<br>- Resubmitted plans approved by Board (WUTH)<br>- Response to national escalation letter (18.05.26)<br>- Compliant plan agreed (WCHC)<br>- Board Assurance statements confirming triangulation between workforce, finance and operational delivery<br>- Board papers and minutes – standing item with finance, CIP and regulatory oversight updates<br>- Triangulation with workforce, finance and operations<br>- Exec-level SROs for Drivers of the Deficit programmes agreed | - Ongoing monthly scrutiny through NHSE Financial Performance and Recovery Meetings (FPRM)<br>- Acceptance of MTFP by NHSE subject to conditions<br>- Alignment of plans with ICB / monitored via FPRM process<br>- Full engagement in monthly FPRM process<br>- NHSE support for redundancy funding<br>- Voluntary redundancy scheme approved by NHSE<br>- Letter received from NHSE (26.08) confirming MTFP accepted with conditions | | - Limited ability to influence system decisions that affect long-term affordability<br>- ICB support for decommissioning plans<br>- NHSE support to accelerate statutory transaction<br>~~- Resubmitted plans have a combined gap to national control totals of £14.9m~~<br>- Delivery of elective income - financial plan assumes sustained recovery and throughput<br>- Pressures in urgent care impacting on delivery of the financial plan<br>- Sufficient assurance that workforce productivity improvements, activity assumptions and other | ~~- Regional oversight arrangements to be confirmed - **DCA / CFO**~~<br>- *Elective recovery actions – see ID02*<br>- *Unplanned care recovery actions – see ID01*<br>- FRPM process supporting national conversations re: statutory transaction timeline – **CEO**<br>- Implement and monitor delivery of the workforce productivity programme aligned to MTFP assumptions - **CPO / CFO** | - NHSE performance oversight arrangements emerging – June/July 2026 – **in progress with NHSE** including new Performance Assessment Framework (PAF) | | |

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

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

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| **Risk ID** | 06 |
| **Risk theme** | Operational Effectiveness |
| **Risk appetite** | **Seek** |
| **Link to strategic objectives** | Improve & Innovate - We will make improvement and innovation part of how we work |
| **Executive lead** | Director of Transformation & Turnaround |
| **Committee oversight** | Finance and Performance Committee |

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

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

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| | | | - Weekly CIP Assurance Group monitoring delivery across both organisations<br>- CIP programme supported by quantified workforce reduction assumptions and month by month delivery tracking<br>- Financial Recovery Programme being aligned to CIP and Transformation programmes through FPG governance | | | | | |
| | 4) Integrated quality and safety controls | - New Joint Quality Committee ToRs<br>- Quality & Equality Impact Assessments approved and monitored through Quality Committee<br>- Clinical guardrails agreed with Board<br>- Share oversight of strategic risks (ID01 and ID02) between Quality and Finance Committee related to service delivery<br>- Monthly IPR reporting to Board (WUTH & WCHC)<br>- Tracking of NOF metrics<br>- Clinical guardrails in place | - NOF metrics<br>- On-going and proactive engagement with CQC<br>- On-going and proactive engagement with ECIST<br>- Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC) | | - Limited real-time quality monitoring linked to transformation activity. | - Quality Committee oversight of transformation-related change and outcomes to be strengthened - **DTT & CNO/CMO** | | |
| | 5) Workforce and operational controls | - New Joint People Committee ToRs<br>- Workforce report tracking People metrics<br>- EPCP with enhanced controls in place (chaired by CEO)<br>- Sickness absence programme forecast to deliver £875k of benefits through reduction in temporary staffing usage. - Further work underway to strengthen rostering grip-and-control arrangements | - Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements<br>- Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC) | | - Insufficient assurance that workforce reductions will be delivered at the scale and pace required | - Develop a workforce transformation recovery plan - **CPO/DTT** | | |

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

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

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

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

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

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

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| | 3) | Patient and public involvement frameworks | - Patient experience data (FFT, complaints, engagement feedback)<br>- Health Inequalities Waiting List Tool in place (WCHC)<br>- Your Voice Group (WCHC)<br>- Councils of Governors | - CQC inspection reports (WCHC and WUTH 2025)<br>- Compliance with AIS | | - Completion of all associated actions in CQC action plans (WCHC and WUTH 2025)<br>- Inconsistent community representation from some underserved or seldom-heard groups | - Develop and implement a clear Health Inequalities Improvement Plan aligned to national priorities (e.g. Core20PLUS5)<br>- Further embed waiting list tool | | |
| | 4) | Impact assessments | - Equality Impact Assessments / Health Inequalities Impact Assessments<br>- EIA/QEIA Standard Operating Procedures | - Audit programmes (clinical audit, equality audits, service reviews) | | | | | |
| | 5) | Workforce training | - Training in cultural competence and inclusive practice<br>- Leadership development and staff awareness sessions delivered to increase confidence in interpreting population health and inequalities data | | | - Lack of staff confidence in accessing and interpreting health inequalities data<br>- Health inequalities and inclusion considerations to be incorporated into service planning and quality improvement methodologies | - Enhance workforce training and leadership capability in population health and inclusion | | |
| | 6) | System collaboration | - Evolving trusted relationships with system partners (primary care, VCSFE, local authority) to support population health approaches<br>- Chief Integration Officer member of JTEG with local authority<br>- New joint strategy aligns with Cheshire and Merseyside's *All Together Fairer: Our Health & Care* | - Wirral Provider Alliance (WPA) with a shared purpose - *Working in partnership for better health and care in Wirral*<br>- CMPC blueprint / provider strategy<br>- National benchmarking data (e.g. Core20PLUS5, NHS England metrics) | | - Fragmentation across system partners<br>- Agreement of future governance arrangements for the WPA to support neighbourhood approaches and strategic commissioning | - Wirral-wide approach to neighbourhood development plans including multiple partners<br>- Joint programmes with local authority and primary care partners to address identified inequalities in priority communities | - WPA governance review in progress - **Chief Integration & Partnerships Officer / DCA** | |

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

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| **Risk ID** | 10 |
| **Risk theme** | System Working & Collaboration |
| **Risk appetite** | **Seek** |
| **Link to strategic objectives** | Collaboration & Partnerships – We will work as one system and one organisation |
| **Executive lead** | Chief Integration Officer |
| **Committee oversight** | Integrated Management Board |

| Risk Description | Consequences | Inherent risk score (I x L) | Controls | Board Assurance | | Current risk score (I x L) | Gaps in control / assurance | Actions | | Target risk score (I x L) | Estimated date of achievement of risk score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Internal | External | | | Planned | Progress update | | |
| **Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services** | - Inefficient service delivery and delays in patient flow (admissions, discharge, transfers of care)<br>- Widening health inequalities<br>- Poor care coordination<br>- Inability to meet system demands collectively<br>- Non-delivery of financial plans<br>- Reputational impact as an ineffective partner organisation (WUTH & WCHC) | 3 x 5<br>15 | 1) System Governance & Relationships | - Wirral Provider Alliance established with key leadership from both Trusts<br>- Trust leadership involvement in CMPC arrangements – professional groups and Leadership Board<br>- Committee in Common arrangements available for CMPC business<br>- Feedback from system partners meetings fed through to Group Board (CMPC Leadership Board)<br>- Development of joint strategic priorities through the Joint Strategy and Integration Programme.<br>- Integration Management Board providing oversight of pathway integration and provider collaboration opportunities across Wirral<br>- Development of the WUTH/WCHC/COCH case for change supporting future collaborative opportunities across key service lines – reviewed and | - Established place-based partnership arrangements<br>- Active participation by WUTH & WCHC in Wirral and C&M governance forums and partnerships (i.e. Wirral Provider Alliance, HWB, CMPC)<br>- Memorandum of Understanding in place for WPA will all members<br>- WPA programmes of work agreed with SRO identified from system partners<br>- ICB Place Lead appointed and engaged with Trusts and WPA arrangements<br>- Continued engagement of the ICB Place Lead in Wirral Provider Alliance arrangements<br>- Support from Cheshire and Merseyside ICB for place-based provider collaboration and neighbourhood development | 3 x 4<br>12 | - Need for greater clarity regarding future place governance arrangements in response to emerging neighbourhood requirements and evolving ICB responsibilities<br>- Evolution of governance supporting WPA to align with new roles for ICB/HWB to respond to Neighbourhood requirements<br>~~- Governance arrangements to support collaboration with COCH~~<br>- Variability in effectiveness of relationships across different partners<br>- Lack of fully embedded shared accountability for system outcomes<br>- Ambiguity or lack of decision-making authority across system forums | ~~- Design, agree and clarify revised governance arrangements for WPA~~<br>~~- WUTH_WCHC_COCH case for change to Boards in Q2, 26-27 in development – **COMPLETE**~~<br>- CMPC CiC arrangements to be explored for WUTH_WCHC_COCH collaboration on key service lines - **CSO - COMPLETE**<br>- Agree and implement revised Wirral Place governance arrangements including relationship between the Health & Wellbeing Board, Place Based Partnership Board, Wirral Provider Alliance and neighbourhood structures – **DCA** - **ON-GOING** | ~~- Engagement with LA, system partners is on-going - HWB workshop on 17/08/26~~<br>- Revised governance framework in development with ICB, and place partners<br>- DCA to attend Place Based Partnership Board in November 2026 for paper re: future arrangements and ICB/LA oversight | 3 x 2<br>6 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | accepted by Group Board in November 2026 | | | | | |
| 2) | Operational collaboration | - WUTH & WCHC supporting multi-agency operational ways of working (i.e., discharge, urgent care, neighbourhood teams)<br>- System Integration, Information Sharing and Digital Alignment<br>- Collaborative work underway across partners<br>- Neighbourhood development programmes supporting collaborative delivery models across organisational boundaries | - Joint planning initiatives including BCF allocation (with joint reporting to HWB) | | - Improve shared escalation processes for system pressures across all partners<br>- Limited real-time system-wide performance intelligence<br>- Resource constraints limiting ability to engage fully<br>- Greater focus on population health approaches and addressing health inequalities<br>- Improve interoperability, information sharing and access to systems supporting joined-up care | - Improve data sharing and interoperability (Digital Committee)<br>- ~~Development of Neighbourhood Boards~~<br>- Establish agreed metrics and reporting for neighbourhood and place-based outcomes – **CIPO**<br>- Strengthen system-wide operational intelligence and escalation arrangements - **CIPO**<br>- Agree a small set of place-based population health and inequality measures for reporting through WPA - **CIPO/CSO** | **COMPLETE** | |
| 3) | Workforce engagement and communication | - Monthly All Staff Briefings providing regular updates<br>- Collaboration between clinical teams in WUTH & WCHC<br>- Corridor Care Summit | - ECSIT engagement<br>- Place governance meetings inc. HWB | | - Inconsistent staff understanding of system priorities<br>- Limited opportunities for staff engagement across organisations<br>- Cultural differences between partner organisations | - Develop a shared communication and engagement approach for system transformation priorities - **CIPO/CSO/DCA** | | |
| 4) | Stakeholder engagement | - Active engagement across all sectors in Wirral (inc. VCSFE)<br>- Active engagement with other providers across CMPC | | | - Variability in effectiveness of relationships across different partners<br>- Limited structured feedback mechanisms from partners<br>- Lack of evidence of diverse groups / voices influencing decision-making | - Implement a structured stakeholder engagement and feedback framework for key place-based programmes – **CIPO/DCA** | | |

| | |
|---|---|
| **Risk ID** | 11 |
| **Risk Theme** | Digital & Data |
| **Risk Appetite** | **Seek** |
| **Link to strategic objectives** | Advance Digitally - We will develop a secure, connected digital ecosystem fit for the future<br>Delivering Excellence - We will create the conditions for outstanding care and performance |
| **Executive Lead** | Chief Finance Officer / SIRO |
| **Committee oversight** | Finance and Performance Committee & Digital Committee (cyber focus) |

| Risk Description | Consequences | Inherent risk score (I x L) | Controls | Board Assurance | | Current risk score (I x L) | Gaps in control / assurance | Actions | | Target risk score (I x L) | Estimated date of achievement of risk score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Internal | External | | | Planned | Progress update | | |
| **Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care** | - Poor quality of care and compromised patient safety<br>- Disruption to clinical systems<br>- Reduced access to patient information<br>- Inability to sustain critical services (due to loss of IT, estates or digital infrastructure)<br>- Breach of data protection legislation and IG requirements leading to potential financial penalties and reputational damage<br>- Enforcement action<br>- Reduced staff productivity<br>- Reduced staff morale<br>- Loss of income<br>- Loss of confidence from patients, staff, partners and commissioners<br>- Reduced system and stakeholder trust in the Trust's leadership and governance | 5 x 4 (20) | 1) Clear board accountability and reporting | - Named Executive Leads accountable for digital, cyber security, estates and business continuity - i.e., SIRO, CIO, EPRR in each Trust<br>-Clear reporting and escalation routes through Board and relevant committees (Audit, Quality and Finance) and relevant sub-groups in each Trust (IGDS and IAG)<br>- Annual EPRR Core Standards self-assessment completed and approved through Trust governance arrangements. WUTH declared compliance with 59 of 62 applicable standards (95% compliance; substantially compliant<br>- Annual EPRR Core Standards self-assessment completed and approved through Trust governance arrangements. WCHC declared compliance with 54 of 58 | - NHSE cyber security guide for executive and non-executive directors<br>- Compliance assessed against the NHS England EPRR Framework and Civil Contingencies Act requirements | 5 x 3 (15) | - Board approved Digital Strategy<br><br>- Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested. | - Finalise Digital Strategy - **CFO/CIO**<br><br>- Develop report structure based on NHSE guidance (issued June 2026) - **CIO** | - Enabling strategy to be completed in H2, 26-27 | 5 x 2 (10) | - Q4, 26-27 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | applicable standards (95% compliance; substantially compliant)<br>- Quarterly EPRR reporting through Trust governance structures and Executive Assurance and Risk Committee<br>- Monthly EPRR assurance reporting provided to NHS Cheshire and Merseyside<br>- Service Line Reporting implementation providing improved clinical, operational and financial information to support decision-making | | | | | | |
| | | 2) Cyber Security Controls - implementation of nationally mandated cyber security standards and controls | - Compliance with NHS Data Security and Protection Toolkit (DSPT) requirements via self-assessment in each Trust - both Trusts met applicable minimum standard for 25/26 for 6 of 7 foundational cyber security outcomes<br>- Identity, authentication and access controls in place<br>- Role based access controls implemented<br>- Documented vulnerability management process<br>- Regular vulnerability scanning reporting through IT/security governance groups<br>- Organisational risk registers (WUTH & | - Internal audit plan covering cyber security controls, access management and patching compliance for both Trusts<br>- NHS England / national cyber assurance feedback<br>- External penetration testing or cyber maturity assessments | | ~~- Assessment against NHSE 7 foundational outcomes that have the greatest impact on organisational cyber resilience~~<br><br>-Lack of single overarching cyber plan for each Trust (WUTH & WCHC)<br>- 25/26 DSPT/CAF supply chain assurance assessed as below the required standard for both Trusts | -Complete assessment following NHSE letter (June 2026) on board assurance on cyber security risks - **CFO**<br><br>- Adopt new and updated NHSE directive cyber policies to be included in the 2027 next DSPT - **CIO**<br>- Develop single cyber plan for each Trust (from separate plans and records) to include DSPT improvement plans - **CIO**<br>-Review link between strategic risk and operational risks on cyber security | - Paper to Digital Committee in September 2026 setting out evidence for both Trusts - **complete** | | September 2026 |

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

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

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

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

| Risk Description | Consequences | Inherent risk score (I x L) | Controls | Board Assurance | | Current risk score (I x L) | Gaps in control / assurance | Actions | | Target risk score (I x L) | Estimated date of achievement of risk score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Internal | External | | | Planned | Progress update | | |
| **Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively** | - Reliance on systems that are not fit for purpose impacting on service quality and patient<br>- Reduced level of skills in the workforce<br>- Insecurities within systems present vulnerability to cyber-attacks<br>- Poor staff experience<br>- Impact on the pace of clinical transformation and clinical improvement outcomes | 4 x 4 (16) | 1) Executive and Board Oversight of Digital and Information Risk | - Defined accountability through the SIRO, CIO/ CNIO in each Trust<br>- SIRO responsibility included JD<br>- SIRO reports to Board and CIO attends Board<br>- New Joint Digital Committee established to oversee digital delivery and risk<br>-CIO report to Digital Committee<br>- BAF oversight (ID12) by Joint Digital Committee<br>- Digital Governance arrangements established with minutes and action log tracking in each Trust (IGDS and IAG)<br>- Annual Information Governance Annual Report / Statement<br>- Channel 3 Digital Systems and Functions Review (on track) | - SIRO network and annual training<br>- NHSE cyber security guide for executive and non-executive directors | 4 x 3 (12) | - Board approved Digital Strategy to align with new Joint Strategy<br>- Digital Strategy delivery roadmap<br>- Alignment to MTFP<br>- Capital constraints impacting pace of delivery<br>- Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested.<br>- Dual running of teams across WUTH & WCHC<br>- Co-dependencies related to two corporate teams | - New strategy to be developed as part of the programme of work to develop enabling strategies (*linked to Channel 3 review)* - **CFO**<br>- Develop report structure based on NHSE guidance (issued June 2026) - **CIO**<br>- Establishment of single Digital Team across WUTH & WCHC | - Project scope for Q1, 26-27<br>- Channel 3 Digital Systems and Functions Review (on track) | 4 x 2 (8) | - Q4, 26-27 |

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

**WUTH Council of Governors** **Item 8**

**WCHC Council of Governors**

**16 November 2026**

| | |
|---|---|
| **Title** | Transaction Progress Update |
| **WCHC/WUTH Lead** | M Swanborough, Chief Strategy Officer |
| **Author** | M Swanborough, Chief Strategy Officer |
| **Report for** | Information |

## Executive Summary and Report Recommendations

The attached paper sets out the progress with delivery of the Transaction between Wirral University Teaching Hospital NHS FT and Wirral Community Health and care NHS FT.

It is recommended that the Council:

- Note the update

## 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 |

## Governance journey

| Date | Forum | Report Title | Purpose/Decision |
|---|---|---|---|
| 4th Nov 2026 | Trust Board | Transaction Update | Noted |

| 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 |

| | Narrative |
|---|---|
| 1.1 | **Background**<br><br>• In April 2025, the Trusts examined the future organisational forms for WCHC and WUTH, with the Trust Boards approving the move to a single organisation, through an NHSE transaction process.<br>• 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 joint leadership or group arrangements.<br>• It was noted that the transaction process would take time, with a number of stages including the development of the Strategic Outline Case (SOC) and Full Business Cases (FBC), ensuring adherence to NHSE Statutory Transaction Guidance and HM Treasury Green Book standards.<br>• As part of this process, the Trusts set out a proposed timeline for the transaction, with an aim to commence as a new Foundation Trust by Q1 (April-June) 2027/28.<br>• Examination of the transaction process identified the need for resourcing and expertise across the stages, specifically relating to Strategic Outline Case and Full Business Case development, due diligence and Post Transaction Integration Planning.<br>• In September 2025, WCHC/WUTH gained support from Cheshire and Merseyside ICB Board, to proceed with the Transaction and for ICB funded external consultancy and legal support across the transaction stages.<br>• In April 2026, the Trusts appointed Deliotte LLP to support with the delivery of the Transaction. To support Deloitte with the Transaction, a Task and Finish Group has been established, meeting monthly, with a detailed programme plan developed setting out the transaction process and planned approval by April 2027. |
| 1.2 | **Transaction Strategic Outline Case development**<br><br>• In line with the NHSE Transaction Guidance, the first stage requirement is the development of a Transaction Strategic Outline Case.<br>• Deloitte LLP have supported the Trusts in developing the SOC. This approach has included Executive and Board interviews, engagement sessions with Task and Finish Group members, information and document review, analysis and case construction. |
| 1.3 | **Transaction Strategic Outline Case**<br><br>• The Transaction Strategic Outline Case, set out over 13 chapters, presents the rationale for the integration of Wirral University Teaching Hospital NHS |

| | |
|---|---|
| | Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) into a single, unified organisation.<br>• The new entity will be dedicated to creating healthier lives and stronger communities across Wirral, delivering comprehensive, seamless health and care services across the full care continuum. Currently, both Trusts operate independently, which has presented challenges in delivering truly integrated care pathways and optimising resource allocation.<br>• The document demonstrates how a unified organisation will effectively address these issues, leveraging combined strengths and expertise to enhance patient experience, improve health outcomes, and ensure long-term sustainability within the Wirral health economy.<br>• This document was approved by Councils of Governors in July 2026. |
| **1.4** | **Strategic Outline Case Rating**<br><br>• NHSE & NHSE NW assessment of the SOC was completed between July and October 2026. The Trusts receiving the Strategic Outline Case letter and formal assignment of SOC ratings as well as recommendation of Transaction timelines.<br><br>• NHSE have approved the Strategic Outline Case and assigned an Amber Rating. This allows the Trust to proceed with the development of the Full Business Case.<br>• NHSE will indicate a DHSC transaction approval date of July 2027 was more achievable for the Trusts, than end of March 2027, to allow for greater time to assess integration progress and delivery of financial sustainability.<br>• NHSE have requested that the Trusts work to a transaction approval date of July 2027, allowing for new Trust commencement on 1st September 2027. |

# Transaction between WCHC and WUTH

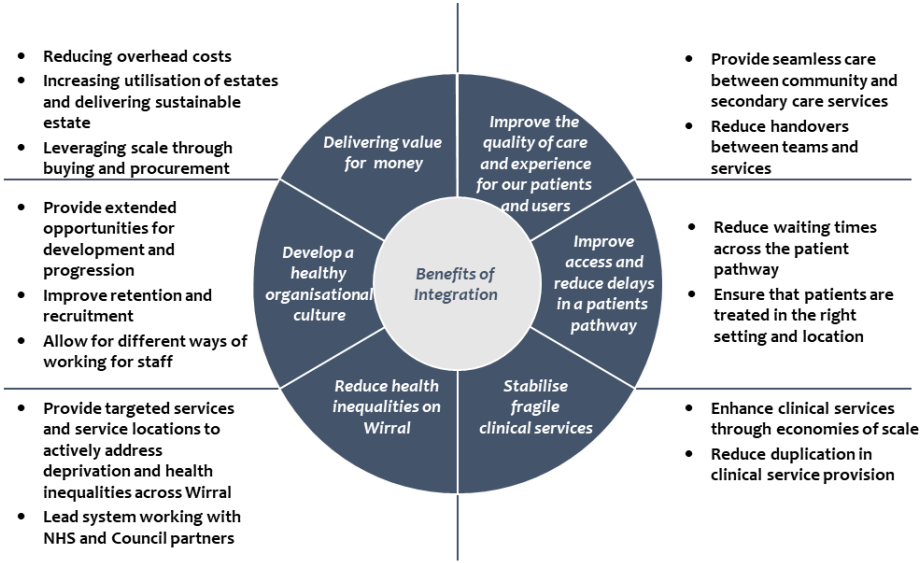
***Transaction Progress Update***

***Council of Governors***

## November 2026

# Wirral System Review recommendations

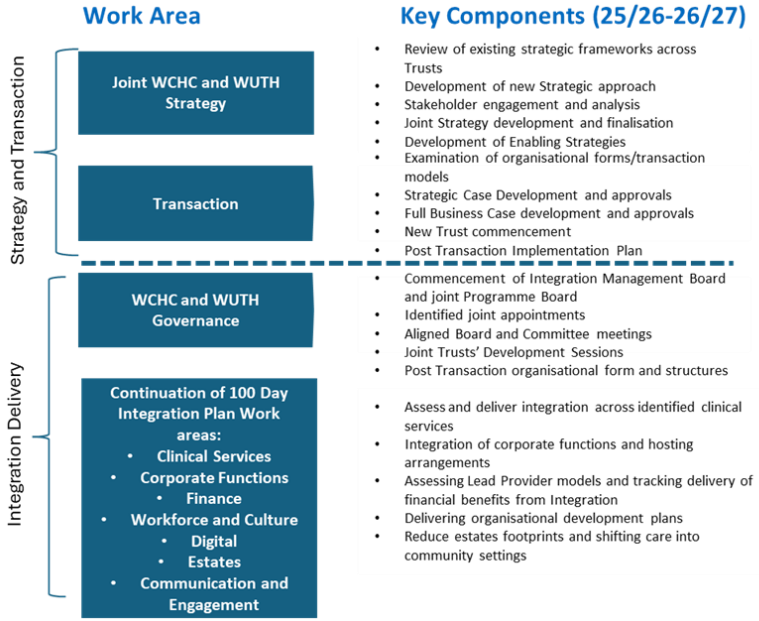
- March 2024, C&M ICB commissioned an independent review of collaboration and integration opportunities across NHS provider services on Wirral.
- Value Circle was appointed to undertake Wirral System Review, with Report recommendations across two phases.
- Phase 1: focused on understanding the key opportunities 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.



# Integration approach

- 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.

- 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 WCHC/WUTH Integration to date

- 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 and 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, with majority of teams now integrated.

- **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



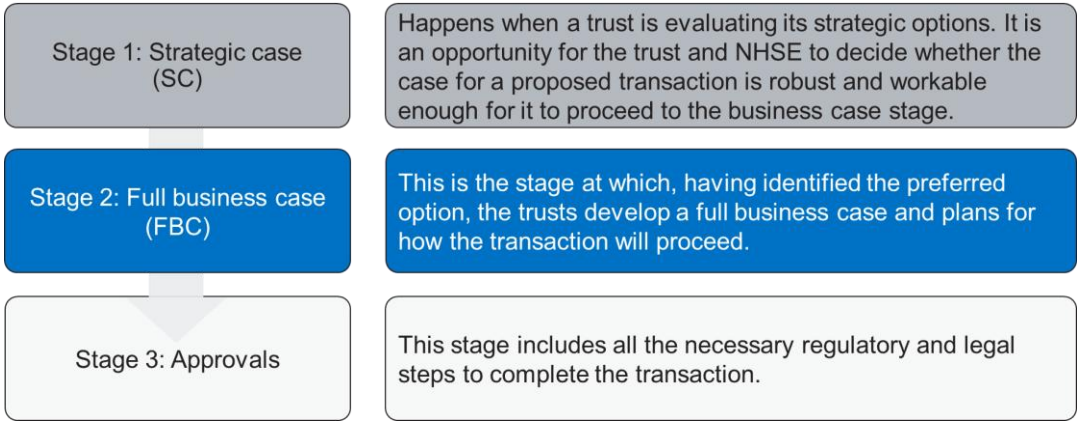






# Transaction approach

- 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 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 a multi-staged with approvals by Trust Boards, COGs, ICB, NHSE and DHSC.



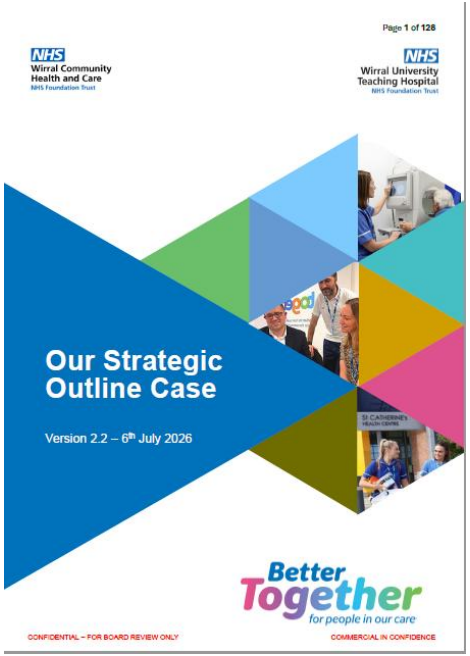
# Strategic Outline Case (SC)

- The Transaction Strategic Outline Case, set out over 13 chapters, presents the rationale for the integration of Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) into a single, unified organisation.

- The new entity will be dedicated to creating healthier lives and stronger communities across Wirral, delivering comprehensive, seamless health and care services across the full care continuum. Currently, both Trusts operate independently, which has presented challenges in delivering truly integrated care pathways and optimising resource allocation.

- The document demonstrates how a unified organisation will effectively address these issues, leveraging combined strengths and expertise to enhance patient experience, improve health outcomes, and ensure long-term sustainability within the Wirral health economy.

- Its primary purpose was to secure approval for proceeding with the development of a Full Business Case (FBC), undertaking Due Diligence (DD) and completing further integration planning and delivery.



# Strategic Outline Case – Rating by NHSE

Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

## NHSE SOC Assessment progress update

- NHSE & NHSE NW assessment was completed between July and October 2026.
- The Trusts receiving the Strategic Outline Case letter and formal assignment of SOC ratings as well as recommendation of Transaction timelines.
- NHSE have approved the Strategic Outline Case and assigned an Amber Rating. This allows the Trust to proceed with the development of the Full Business Case.
- NHSE will indicate a DHSC transaction approval date of July 2027 was more achievable for the Trusts, than end of March 2027.
- NHSE have requested that the Trusts work to a transaction approval date of July 2027, allowing for new Trust commencement on 1st September 2027.



# Outpatient services reimagined

A future model for planned care in the NHS, aligned to the 10 Year Health Plan and GIRFT

# Outpatient Improvement vision

| Outpatients Improvement |
| --- |
| Project lead: Paul McNulty |
| Date: September 2026 |

**“The Outpatients Improvement Programme is focused on delivering accessible, digitally enabled outpatient care, making best use of resource and providing services in the most convenient locations (or virtually) for our patients”**

# Future Vision of Outpatient Services

**Outpatients Improvement**

Project lead: Paul McNulty

Date: September 2026

## THE PROBLEM WE IDENTIFIED

Outpatient Services have fundamentally been unchanged since its inception. Clinical and Operational modifications have been incorporated, but without a seismic shift in the model of delivery patients will continue to wait longer and risk clinical deterioration while waiting resulting in unplanned attendances.

Currently 116m patients on an active waiting list nationally. With a 3 % growth per year this will be 150m in 2034/5

## WHO WAS INVOLVED – OPD Summit

Clinical and Operational leads from across all divisions, including corporate services.

Key areas of focus:

**Single Point of Access – SPoA**
**Advice and Guidance – A&G**
**Patient Initiated Follow Ups – PIFU**
**Ambient Voice Technology - AVT**

> *"A great collaborative session. With a clearer understanding of the national agenda, challenges to consider and overcome, with a curiosity on how far AVT can be used.".*
>
> *— Post-session staff feedback*

## WHAT WE DID

Delivered an interactive session cover 4 main topics, including a presentation from a National GIRFT Lead on the current outpatient challenge and the driver for change.

Following each topic each table answer 4 thematic questions.

1. What actions do you need to take to deliver XXX?
2. What barriers do you foresee, and what support is required to resolve?
3. What risks do we need to be aware of?
4. What support do you need to deliver this vision?

## MAPPING and NEXT STEPS

The outputs to each topic from each of the tables is to grouped by themes.

The themes will be prioritised to the National ask, with resource aligned accordingly.

Each specialty is expected to drive their own improvements, with progress, risks and issues being brought to the OPD improvement group for support and resolution.

## WHAT CHANGES FOR THE PATIENT?

**TODAY**

Referral → wait → hospital appointment → separate test → follow-up → repeat follow up appointment

**FUTURE**

Digital / GP / community entry → clinical triage → one-stop or local pathway → results + decision → discharge / PIFU

**KEY LEARNING: We need to fundamentally change the delivery of Outpatients both pre-attendance and to reduce follow ups**

Better Together for people in our care

# Future Vision of Outpatient Services

**Outpatients Improvement**

Project lead: Paul McNulty

Date: September 2026

1

## Single front door (SPoA)

Referral, advice & guidance and patient-initiated access converge.

2

## Advice & guidance or Right-first-time triage

Clinical & digital triage directs patients to the right pathway.

3

## One-stop resolution

Consultation, diagnostics and treatment are combined where feasible.

4

## Remote / local by default

Virtual, community and neighborhood (Tier2) options replace avoidable hospital visits.

5

## Planned discharge

PIFU, self-management and clear safety-netting replace routine follow-up.

Better Together for people in our care

# GIRFT provide the building blocks for delivery

**Outpatients Improvement**

Project lead: Paul McNulty

Date: September 2026

## Standardise clinic templates

Create capacity, improve predictability and prioritise new patients.

## High-flow outpatient clinics

For low-complexity cohorts: history, examination, diagnostics and treatment in one streamlined attendance.

## Standardise follow-up

Discharge when clinically appropriate; use PIFU where safe. Use digital tools to safety net, DIFU, CIFU, Continuous monitoring

## Advice & Guidance

Resolve more cases before referral and improve referral quality.

Create the capacity through reduced Follow ups

## Further Faster

Clinically-led pathway redesign, peer learning and rapid adoption of best practice.

## Data & digital

Measure utilisation, access, conversion rates, DNAs and PIFU rates; make variation visible through intelligent dashboards



Better Together for people in our care

# Digital Enablers and benefits

**Outpatients Improvement**

Project lead: Paul McNulty

Date: September 2026

## NHS APP

Default tool for patient communication, information sharing (PILs, Maps, Questionnaires), and enaction of PIFU

## Ambient Voice Technology

Reduced admin with the streamlining of the process to have letters to patients and GP's, better use of time that would have previously been taken up by documentation

## Virtual Appointments / Attend Anywhere

Virtual Appointment Software is due to be rolled back out within the organisation to allow virtual consultations to take place rather than patients attending face-to-face appointments

## Integrated Appointments in Patient Portal

Integrated Appointments in the Patient Portal, means patients will be empowered to reschedule their own appointments. Results in reduced DNA rates, reduced short notice cancellations and improved OP utilisation.

## Digital Calling Boards

Provide patients with information on current waiting times and opportunities to promote NHS App, PIFU, Virtual appointments

## BI Dashboards

Realtime information on clinic and room utilisation, conversion rates, DNAs, PIFU rates, SNCs, Call abandonment rates; make variation visible through intelligent dashboards



Better Together for people in our care

**WUTH Council of Governors**
**WCHC Council of Governors**
**16 November 2026**

**Item No 10.1**

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

| | |
|---|---|
| **Alert** | • Performance in managing Complaints is an issue being addressed in both Trusts. This is apparent in their Annual Reports for 2025/26 included in this Board agenda. At WUTH, the rise in numbers outpaced the growth in completed responses, with a substantially larger open and overdue caseload at year end. Assurance was given that quality of responses is good, and process enables safety issues to be picked up and acted on early. A prioritised action plan is addressing clearance of backlogs and reducing clearance times. At WCHC there are smaller numbers, and assurance on handling and learning from complaints has been good. However, a recent MIAA review identified concerns about consistent process, and an action plan is being tracked. The issues were addressed as part of the WCHC Quality and Patient Experience Report to QSC this month.<br>• Other issues raised through the WUTH PSQB as receiving priority attention for Committee included: challenges in the temporary escalation spaces supporting ED; delays in radiology reporting; shortfalls in phlebotomy workforce, and ongoing challenges of the number of children on the waiting list for neurodiversity assessments.<br>• Discussion of WCHC High Level Risks, and the BAF, with a number of staffing pressures in a range of community services, raised a question as to whether the Guardrails for protecting key elements of service were balanced in relation to community services. This, to maintain current activity, and to have the foundation to absorb the strategic plans for hospital to community shifts. CMO and CNO agreed to review. |
| **Advise** | • The review of BAF risks ID01, ID02 and ID08 proposed no further controls, assurances or gaps. Committee supported that continuing development of the governance process should establish a set of criteria used to systematically judge change of risk scores towards target.<br>• The ongoing concern at WCHC about inconsistent clinical supervision and its recording was raised. This is being tracked by the Committee via the MIAA internal audit recommendations. |
| **Assure** | • WCHC Quality and Patient Experience Report for August evidenced a positive position across Trust quality and safety metrics. The exception was 2 severe harms falls at CICC, investigation of which is proceeding through PSIRF. There had |

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

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| | • WCHC Policy Schedule updates were received with 2 extensions to approval dates |
| **Review of Risks** | • The relevant strategic risks tracked through the BAF were reviewed as described above.<br>• 5 of the 61 WCHC organisational risks are scored as high level. Discussing the mitigations necessary it was agreed that in three of these, staffing concerns were a significant part of the situation, and these were referred across to the People Committee for attention.<br>• Moderate risk was raised in both organisations concerning assuring leadership around Equality, Diversity and Inclusion through transaction period, and identification of a Patient Experience lead. |
| **Other comments from the Chair** | This was a very full agenda, taken forward with substantial interactive discussion, both challenging and supportive. Thanks to contributors for adjusting to substantial and necessary reordering of agenda items, |

**WUTH Council of Governors**
**WCHC Council of Governors**
**16 November 2026**

**Item No 10.3**

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

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

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

**WUTH Council of Governors**
**WCHC Council of Governors**
**16 November 2026**

**Item No 10.4**

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

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

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| | Board, including measures on the timeliness of patient letters. Funding is secured until May 2027. The future approach depends on the Cheshire and Merseyside funding arrangements and a longer-term strategic solution. The Committee will receive a briefing on benefits realisation at its next meeting.<br>• **Cyber Security -** From the next meeting, the cyber plan, the cyber risks and the cyber risk register will be a standing item.<br>• **Internal audit tracker** – Proposed extensions to due dates were reviewed and where appropriate agreed. |
| **Assure** | ○ **Review of Digital Systems and Functions** - The discovery and design phase is complete across both digital teams. A draft report is due at the end of September and will go to Executives and this Committee in October. The Committee has asked for a high-level roadmap of recommendations and timescales,<br>○ **Preventing unlawful access to patient records -** This responds to the NHS England national letter. Audit trails record both when information is entered and when a record is opened. Proactive and reactive access audits are run from the EPR, with more proactive auditing around high-profile cases.<br>○ **WCHC Information Governance Annual Report 2025/26 -** IG performance was strong overall. The Committee endorsed the 2026/27 IG priorities. Supplier assurance, records storage, FOI timeliness and integration-related change will stay under oversight. |
| **Review of Risks** | • **BAF ID11 -** The Committee oversees this risk from a cyber perspective. The appropriate risk appetite was reviewed.<br>• **BAF ID12 -** The score is unchanged pending the completion of the digital review. |
| **Other comments from the Chair** | • Future agendas will be split into two sections, so each area gets proper focus. Digital: Transformation and Impact will come first, covering digital strategy, portfolio delivery, benefits realisation and AI, which is now a standing item. IT, IG and Cyber Assurance will follow, covering information governance, data protection, compliance and cyber security. The new structure will be used from the next meeting.<br>• The digital review report at the November meeting will be the main input for setting the future shape of digital services across both Trusts.<br>• The Committee noted the MHRA report from the National Commission into the Regulation of AI in Healthcare and its recommendations for a future regulatory framework which has been endorsed in full by the Government |

**WUTH Council of Governors**
**16 November 2026**

**Item 10.5**

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

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

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| | The Committee agreed that the full internal audit tracker should be presented, with greater challenge regarding the setting of recommendation completion dates and ongoing monitoring by the Committee. Consideration was also given to establishing a tracker for external audit actions. |

**WCHC Council of Governors**
**16 November 2026**

**Item 10.6**

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

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

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| | Committee. Consideration was also given to establishing a tracker for external audit actions. |

**WUTH Council of Governors**

**WCHC Council of Governors** **Item 11**

**16 November 2026**

| | |
|---|---|
| **Title** | Integrated Performance Report |
| **Area Lead** | Executive Directors |
| **Author** | Executive Directors |

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

It is recommended that the Council:

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

## Key Points to Note

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of July 2026 (or latest available months data). Performance is represented in SPC chart format to understand variation and a summary table indicating performance against standards. The metrics are grouped into Executive Director portfolios with individual metrics showing under each domain identified in this report. Commentary is provided at a general level and by exception on metrics not achieving the standards set.

## Key Risks

This report relates to these key risks:

- All BAF Risks

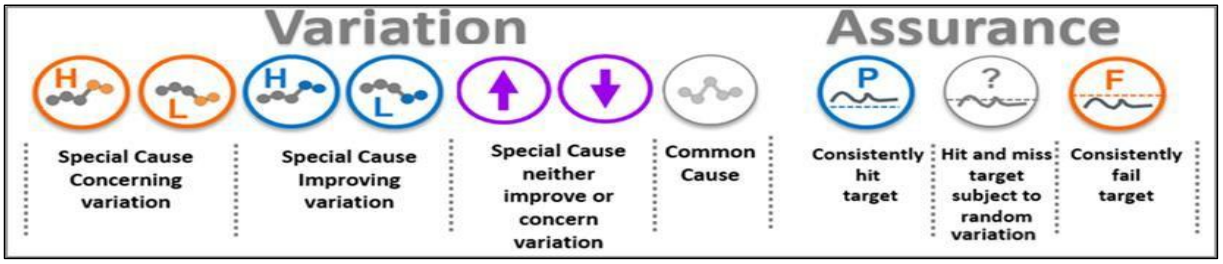
| **Contribution to Integrated Care System objectives (Triple Aim Duty):** | |
|---|---|
| **Better health and wellbeing for everyone** | Yes |
| **Better quality of health services for all individuals** | Yes |
| **Sustainable use of NHS resources** | Yes |

| **Contribution to strategic objectives:** | |
|---|---|
| Delivering Excellence – We will create the conditions for outstanding care and performance | Yes |
| Our People – We will nurture an inclusive, compassionate culture where people thrive | Yes |
| Improve & Innovate – We will make improvement and innovation part of how we work | Yes |

| | |
|---|---|
| Healthier Communities – We will drive health equity and support healthier lives | Yes |
| Collaboration and Partnerships – We will work as one system and one organisation | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | Yes |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| November 2026 | Group Board of Directors in Public | As above | As above |

| 1 | Narrative |
|---|---|
| 1.1 | This is the joint Integrated Performance Report for the Board, bringing together the two Trust's performance reports. A few amends have been made to the format, including an overall matrix for both Trusts showing all indicators, rather than individual portfolio matrices, and each Executive Director's portfolio now includes a section for WUTH and WCHC, where relevant. |

| 2 | General guidance and Statistical Process Charts (SPC) |
|---|---|
| 2.1 | <br>**Orange dots signify a statistical cause for concern. A data point will highlight orange if it:**<br>• Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.<br>• Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.<br>• Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.<br>**Blue dots signify a statistical improvement. A data point will highlight blue if it:**<br>• Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.<br>• Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. |

| | |
|---|---|
| | • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.<br><br>Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots. |

# WUTH Indicators Dashboard

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

**WUTH Scorecard Matrix**

| | | Assurance | | | |
|---|---|---|---|---|---|
| | | **Consistently Hits Target**  | **Hit and Miss Target, subject to random variation**  | **Consistently Fails Target**  | **No target set/insufficient data points** |
| **Variation** | **Special Cause improving**  | - Mortality (SHMI)<br>- WUTH Average CSW Night Staffing Fill Rates | - Clinical coding completeness (Freeze)<br>- NEWS2 Compliance<br>- FFT Overall Experience of very good & good : Inpatients<br>- FFT Overall Experience of very good & good : Outpatients<br>- WUTH Average CSW Day Staffing Fill rates<br>- Cancer waits – 62 days to treatment (monthly)<br>- Cancer – Faster Diagnosis Standard<br>- RTT – total open pathway waiting list<br>- RTT – cases waiting 65+ wks<br>- | - 18 week RTT - Incomplete pathways < 18 wks<br>- Cancer waits – reduce number waiting 62 days +<br>- % of 52+ wk waiters | - Corridor Care – average daily number of patients in month<br>- Corridor Care – total number of patients in month |
| | **Common Cause**  | - % of adult patients VTE risk-assessed on admission<br>- 12 hr waits from decision to admit in ED | - Staff turnover % in month rate<br>- Never Events<br>- Clostridioides difficile (healthcare associated)<br>- Pressure Ulcers – Hospital Acquired Cat 3 and above<br>- FFT Overall experience of very good & good: Maternity<br>- Patient Experience – complaints in month per 1000 staff – Level 2 (formal)<br>- Falls – Moderate to Severe Harm (per 1000 bed days)<br>- WUTH Average RN Day Staffing Fill Rates<br>- WUTH Average RN Night Staffing Fill Rates<br>- MRSA Cases<br>- MSSA Cases<br>- Number of inpatients not meeting the criteria to reside<br>- 12 hr waits from arrival in ED<br>- Cancer waits - % receiving first definitive treatment within 31 days of decision to treat<br>- Diagnostic Waiters, 6 weeks and over – DM01<br>- Ambulance Handovers % > 15mins | - Sickness absence % - in month rate<br>- Ambulance Handovers % > 45 mins | |
| | **Special Cause Concerning**  | - | - Appraisal % Compliance<br>- Mandatory Training % compliance<br>- Duty of Candour compliance – breaches of DoC standard for serious incidents<br>- Patient Experience: Concerns received in month – Level 1 (informal)<br>- 4-hour ED Target (including APH UTC) | - Staff Vacancy as % of workforce<br>- FFT Overall experience of very good & good: ED<br>- Long length of stay – number of patients in hospital for 21 or more days | - Patient Safety Incidents |

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

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

## WCHC Indicators Dashboard

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

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

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

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

## Wirral Community Health and Care NHS Foundation Trust

TABLE 1: SCORED METRICS (Contributing to Segmentation)

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

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

## CMO Quality and Safety Summary - WUTH

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

### Highlights

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

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

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

### Areas of Concern

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

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

### Forward Look (Actions)

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

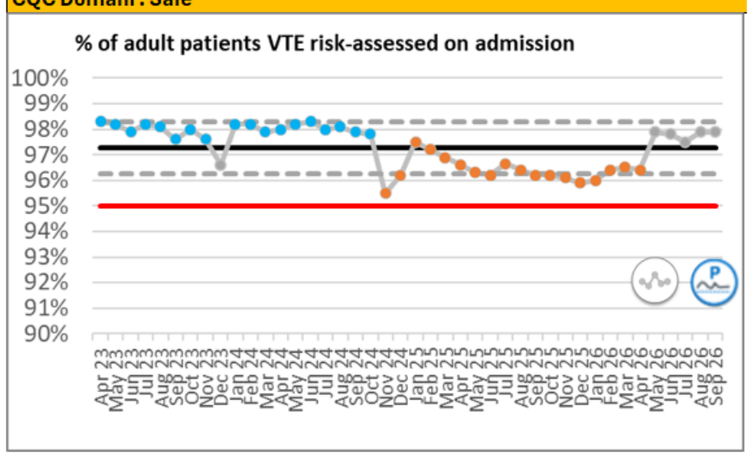
• Continue targeted improvement work to achieve and sustain reliable NEWS2 assessment, documentation and escalation, with focused support for clinical areas demonstrating unwarranted variation. New digital solution planned for Q4 will help with oversight and real time escalation.

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

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

## % of adult patients VTE risk assessed on admission

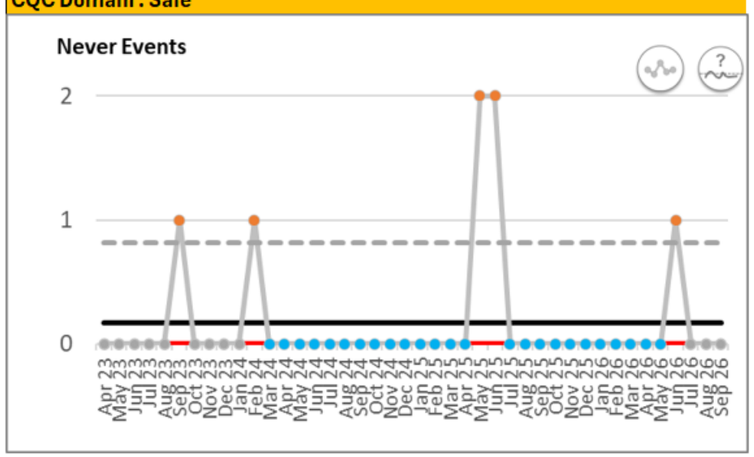
CQC Domain : Safe




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

## Never Events

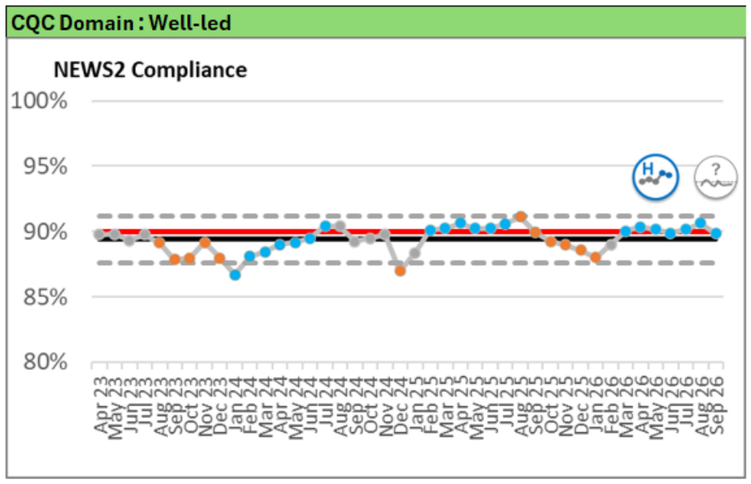
CQC Domain : Safe




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

## NEWS 2 Compliance

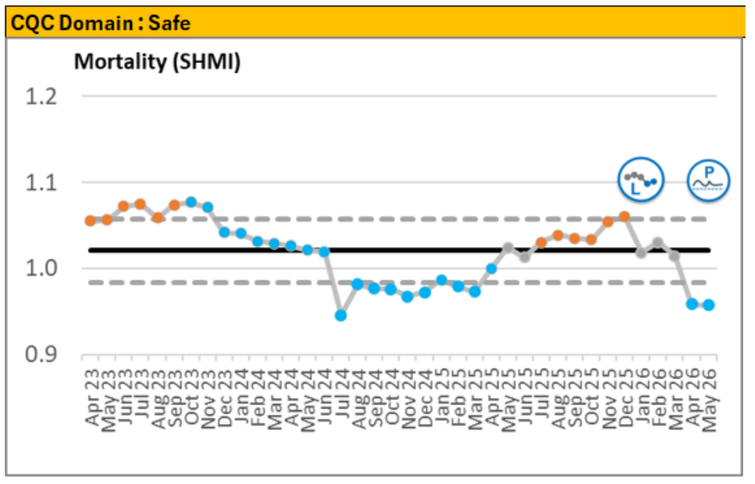
CQC Domain : Well-led




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

## Mortality (SHMI)

CQC Domain : Safe




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

## CNO Quality and Safety Summary - WUTH

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

### Clostridioides difficile (healthcare associated)

**Highlights**

CDT cases reduced in September, with 3 HOHA and 4 COHA cases.
Despite this improvement, there remains a risk that the Trust will exceed the NHSE threshold.

**Areas of Concern**

- Prompt isolation can be impacted by the location and availability of appropriate side rooms
- Environmental condition in some ward areas affects effective cleaning
- A more consistent approach to patient hand hygiene is required, including appropriate wipes for patients unable to mobilise independently.

**Forward Look (Actions)**

- CDT QI workshop held on 19 October 2026, with immediate improvement actions to be identified and implemented
- Review the PSIRF approach for IPC hospital-associated infections to ensure appropriate learning and oversight.

### Pressure Ulcers Hospital acquired Category 3 and above

**Highlights**

Two Category 3 pressure ulcers worsened in care and one new Category 3 pressure ulcer was reported during September.

**Areas of Concern**

- Inconsistent completion of PURPOSE-T
- Inconsistent skin assessment within six hours of admission
- Incorrect pathway and mattress selection
- Gaps in wound assessment documentation.

**Forward Look (Actions)**

- Continue delivery of education and competency assessment through the Pressure Ulcer QI improvement plan
- Extend Pressure Ulcer Quality Improvement practices across the organisation
- Work with the Cerner team to strengthen tissue viability documentation.

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

**Highlights**

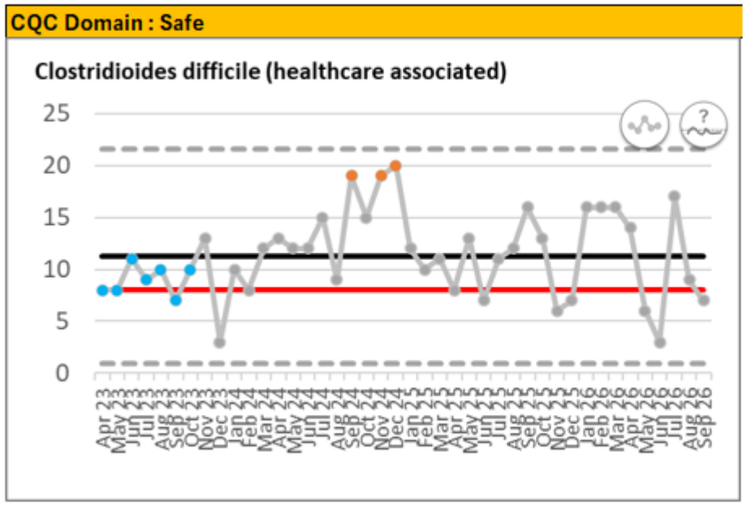
**Areas of Concern**

**Forward Look (Actions)**

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

## Clostridioides difficile (healthcare associated)

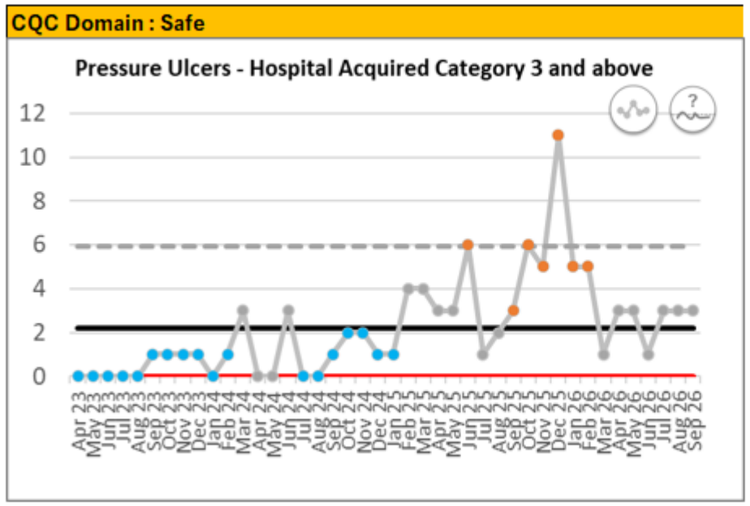
**CQC Domain : Safe**




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

## Pressure Ulcers – Hospital Acquired Category 3 and above

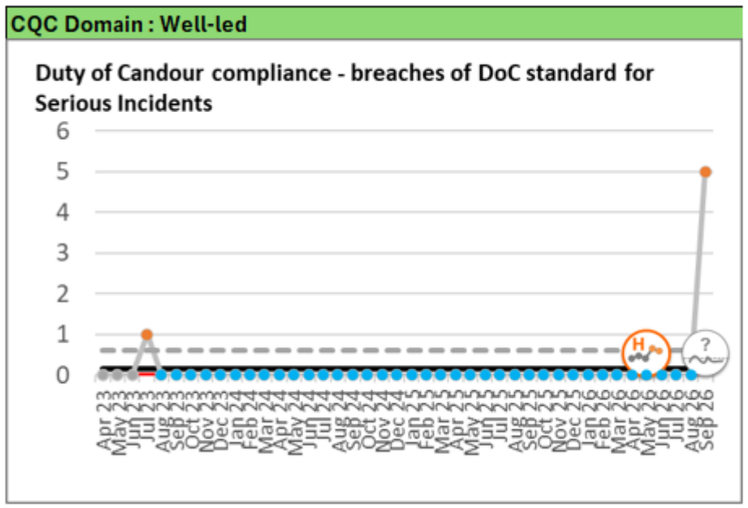
**CQC Domain : Safe**




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

## Duty of Candour Compliance

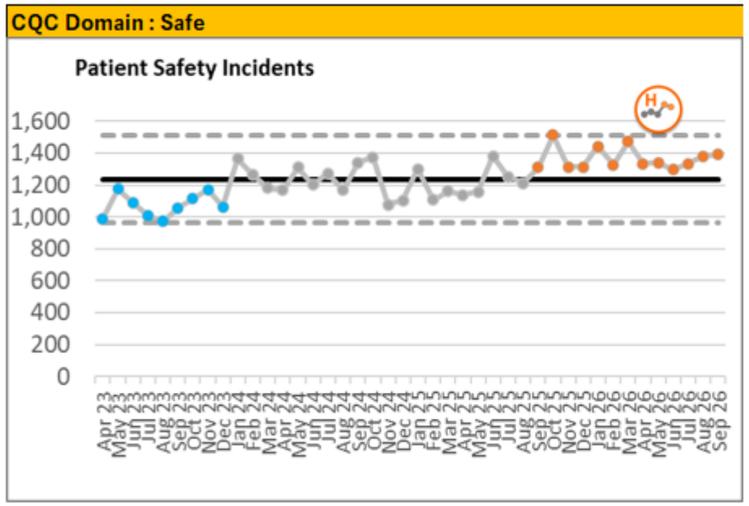
**CQC Domain : Well-led**




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

## Patient Safety Incidents

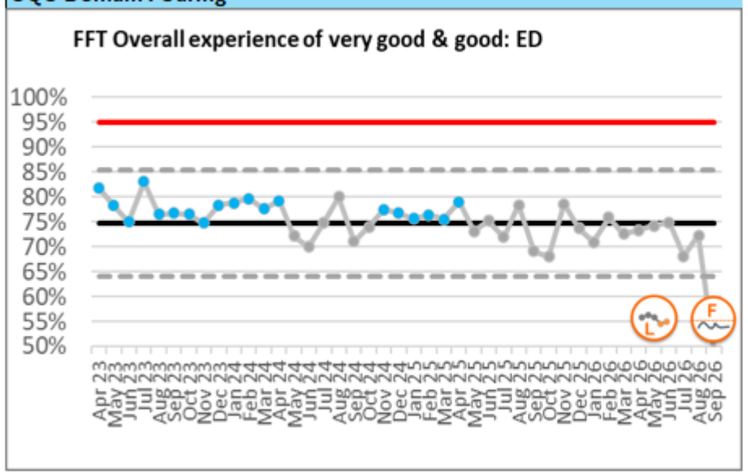
**CQC Domain : Safe**




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

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

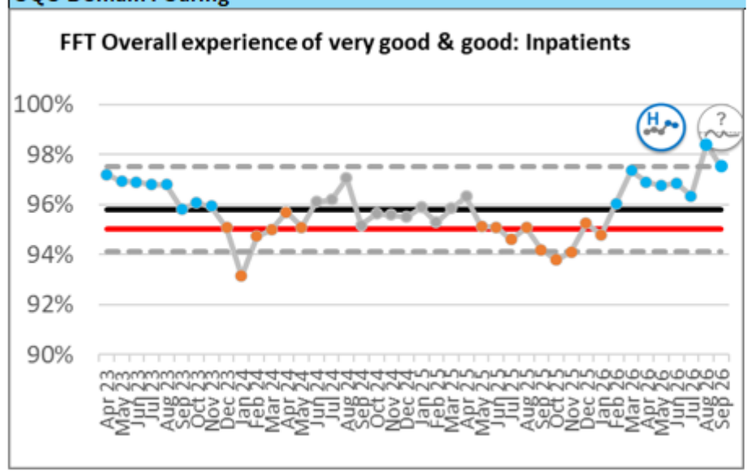
**CQC Domain : Caring**




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

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

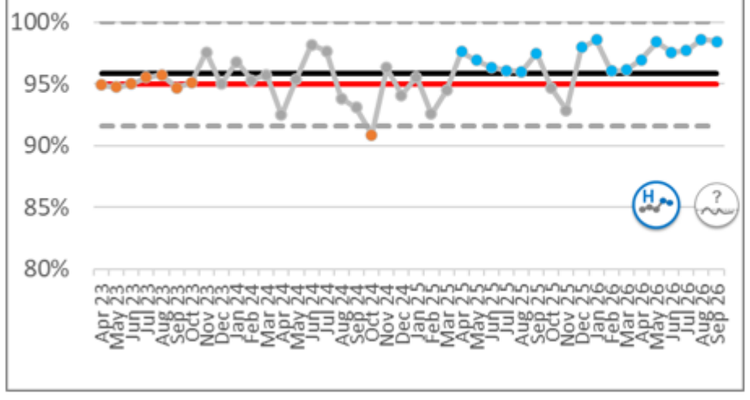
**CQC Domain : Caring**




| Sep-26 |
|---|
| 97.5% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit and miss target subject to random variation |

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

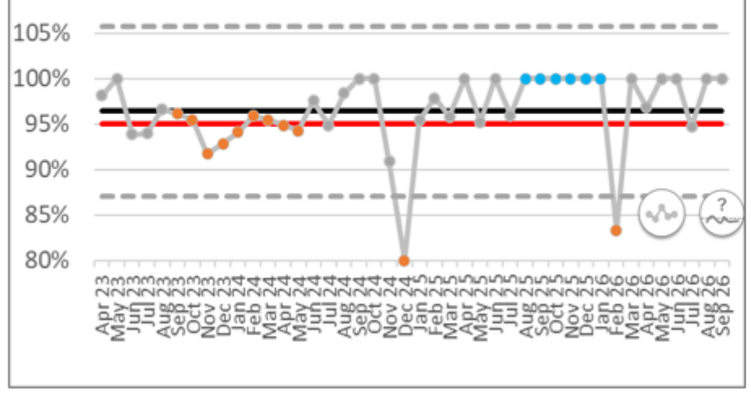
**CQC Domain : Caring**




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

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

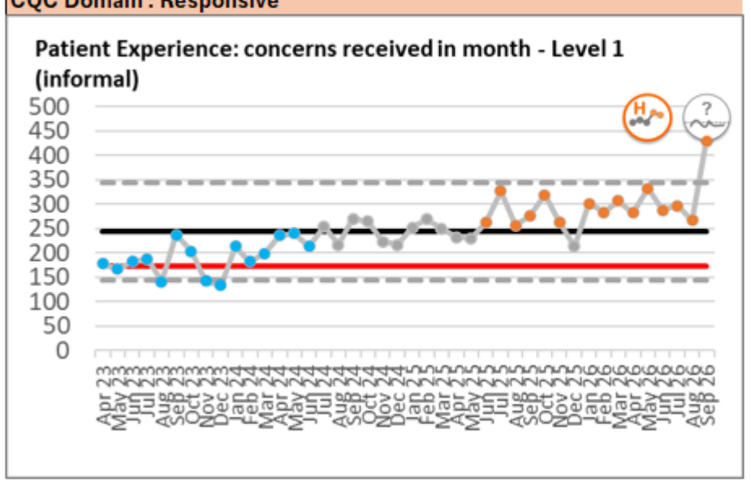
**CQC Domain : Caring**




| Sep-26 |
|---|
| 100.0% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit and miss target subject to random variation |

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

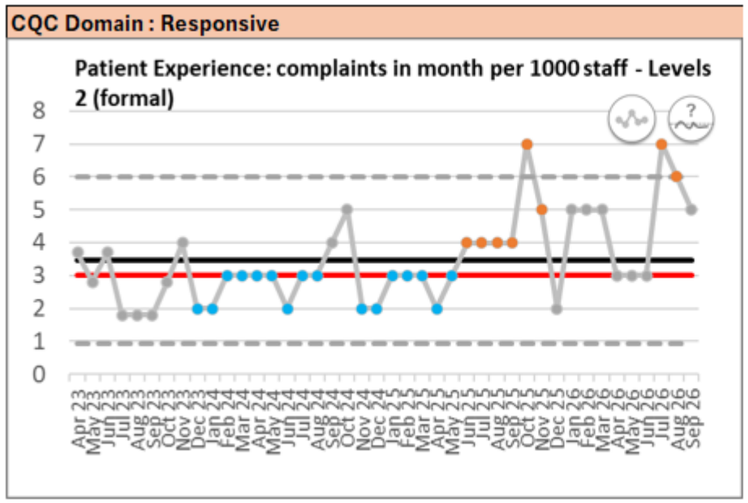
CQC Domain : Responsive




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

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

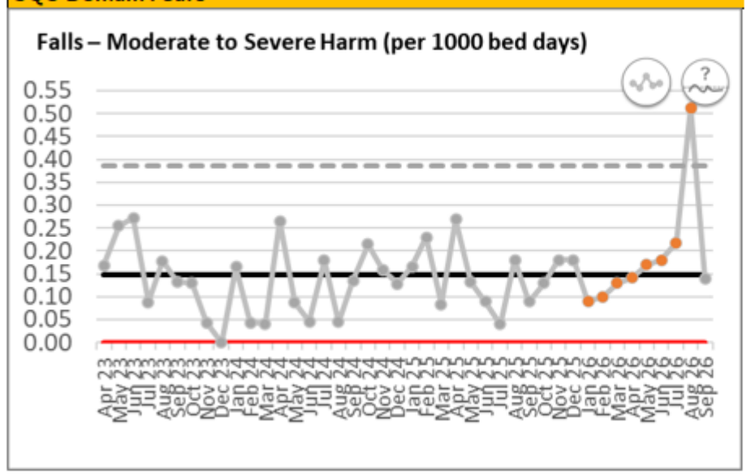
CQC Domain : Responsive




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

## Falls – Moderate to Severe Harm

CQC Domain : Safe



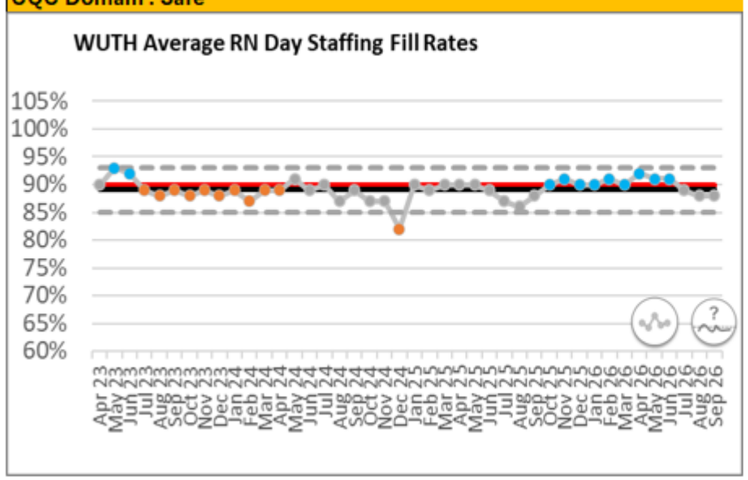

| Sep-26 |
|---|
| 0.14 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

## Average Registered Nurse Day Staffing Fill Rates

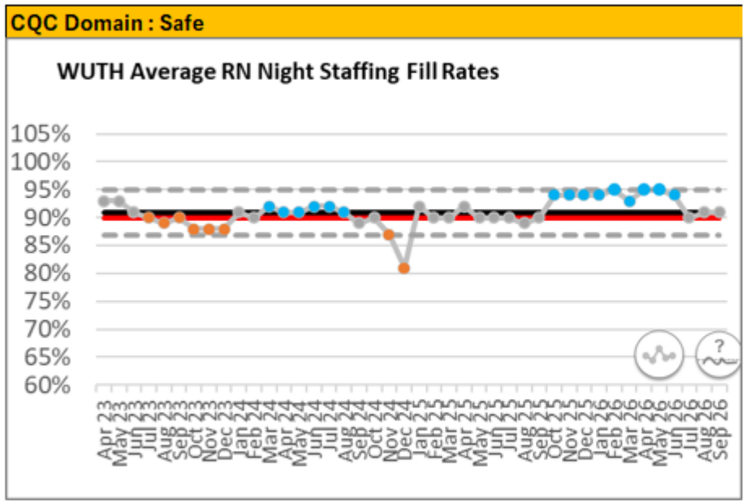
**CQC Domain : Safe**




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

## Average Registered Nurse Night Staffing Fill Nurse

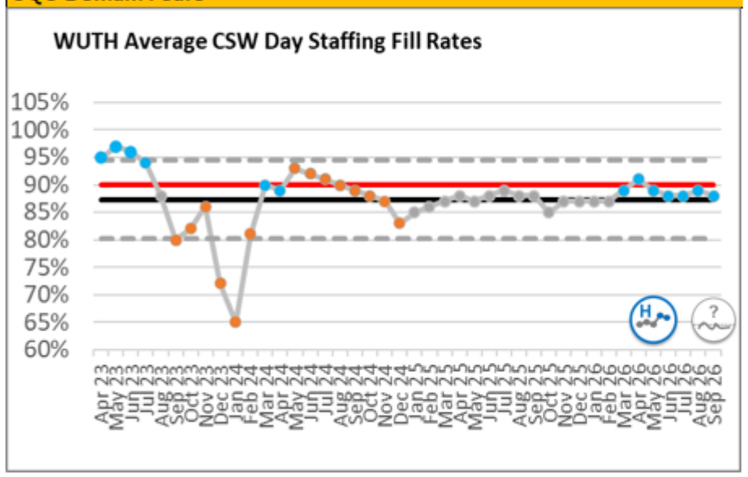
**CQC Domain : Safe**




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

## Average Clinical Support Worker Day Staffing Fill Rates

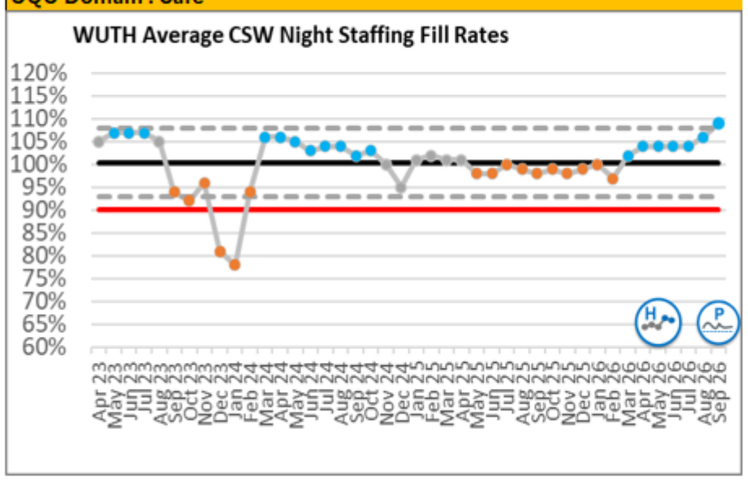
**CQC Domain : Safe**




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

## Average Clinical Support Worker Night Staffing Fill Rates

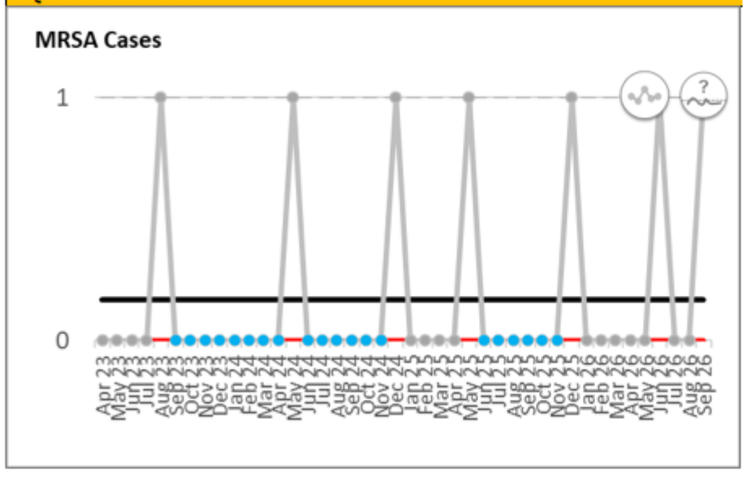
**CQC Domain : Safe**




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

## MRSA Cases

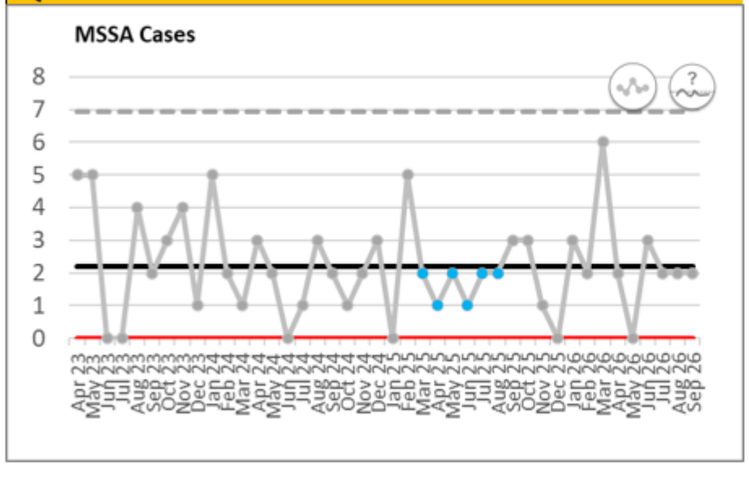
**CQC Domain : Safe**




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

## MSSA Cases

**CQC Domain : Safe**




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

# Quality and Governance Summary - WCHC

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

**Highlights**

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

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

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

**Areas of Concern**

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

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

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

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

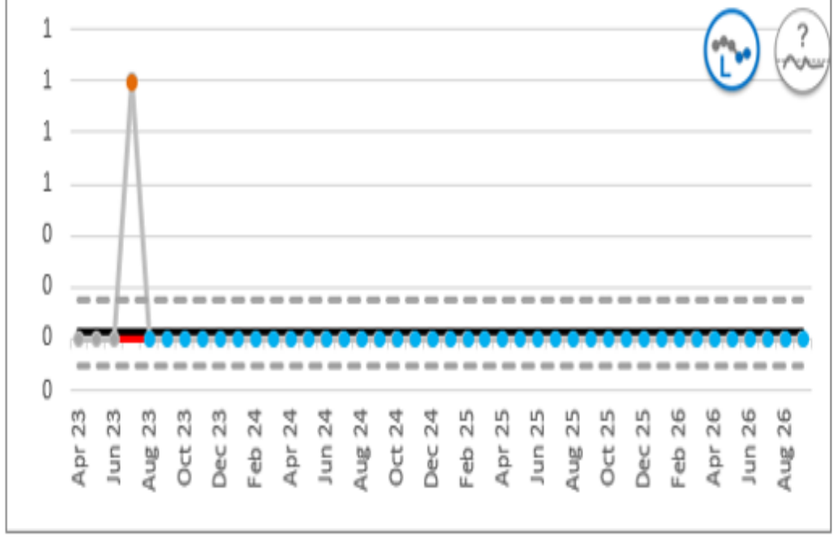
**Forward Look (Actions)**

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

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

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

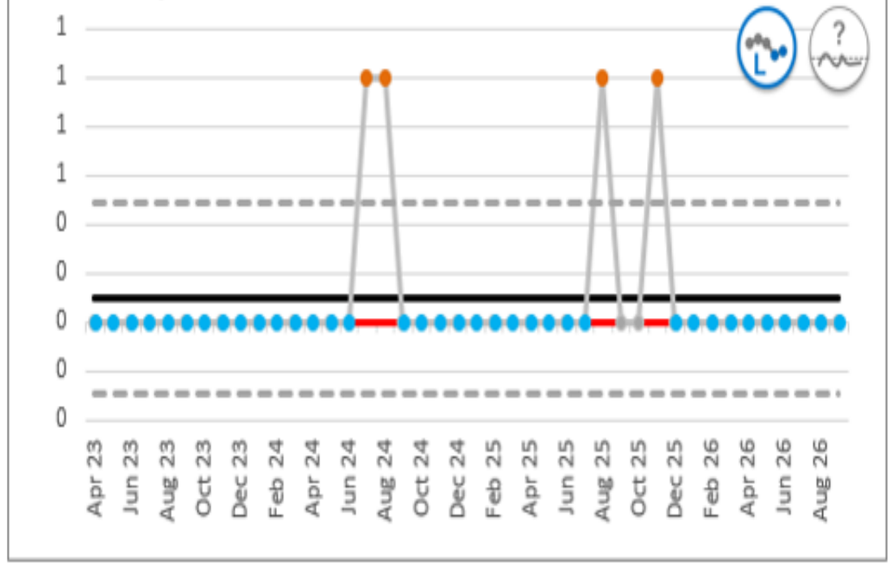
CQC Domain : Safe




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

## No. of ICO reportable IG incidents

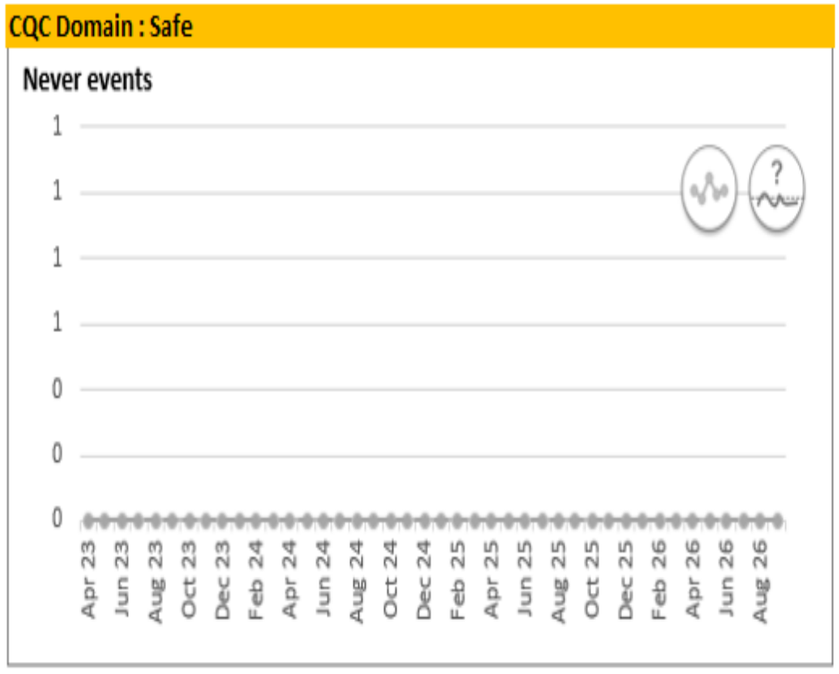
CQC Domain : Safe




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

## Never events

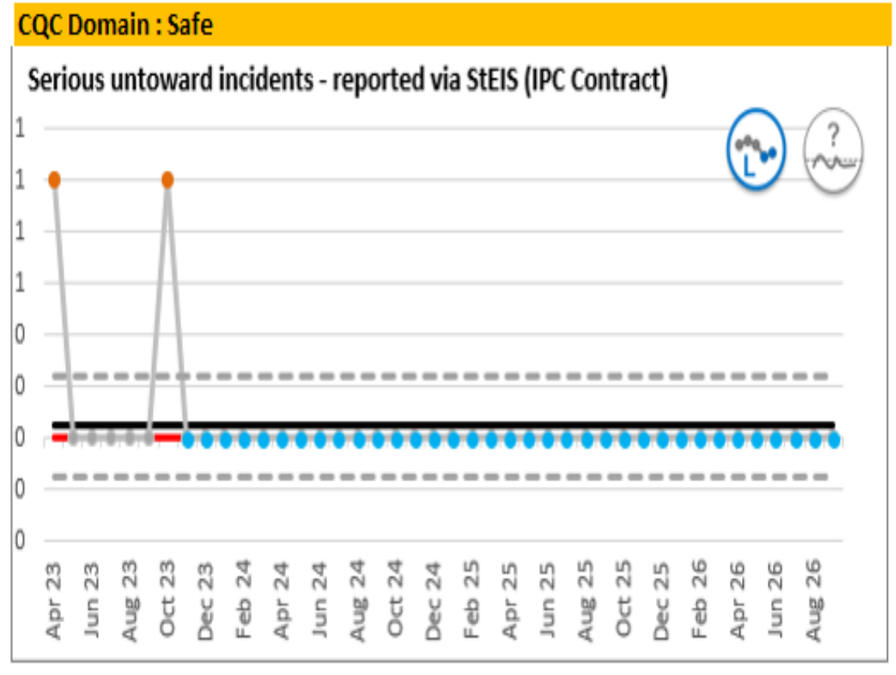
CQC Domain : Safe




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

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

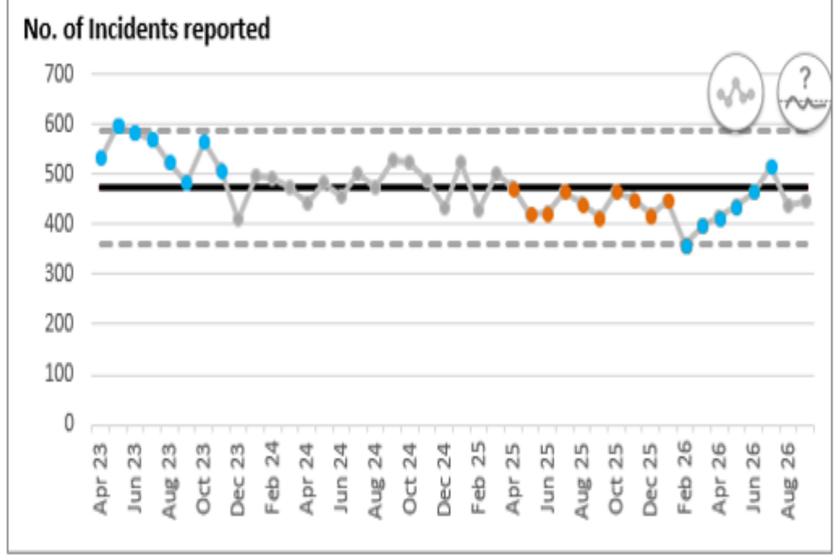
CQC Domain : Safe




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

## Number of Incidents reported

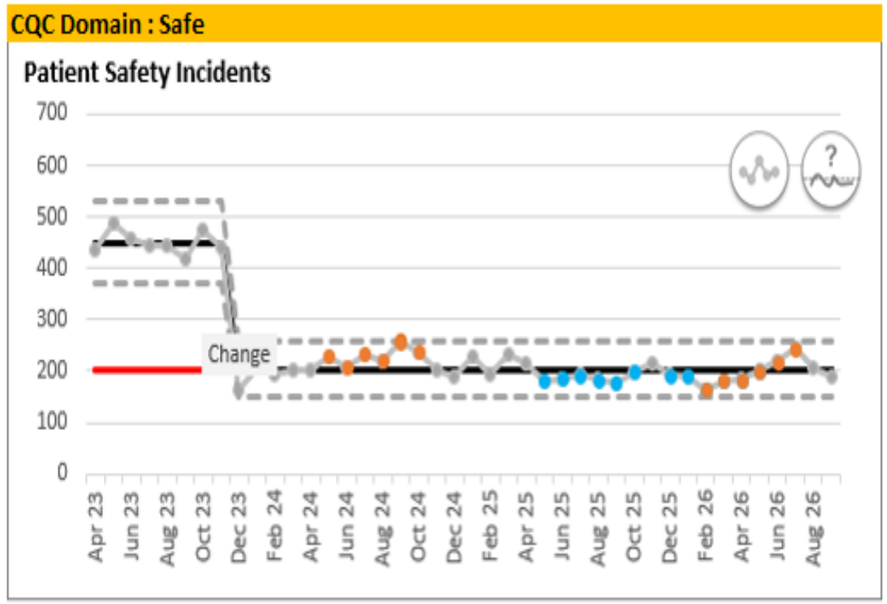
CQC Domain : Safe




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

## Patient Safety Incidents

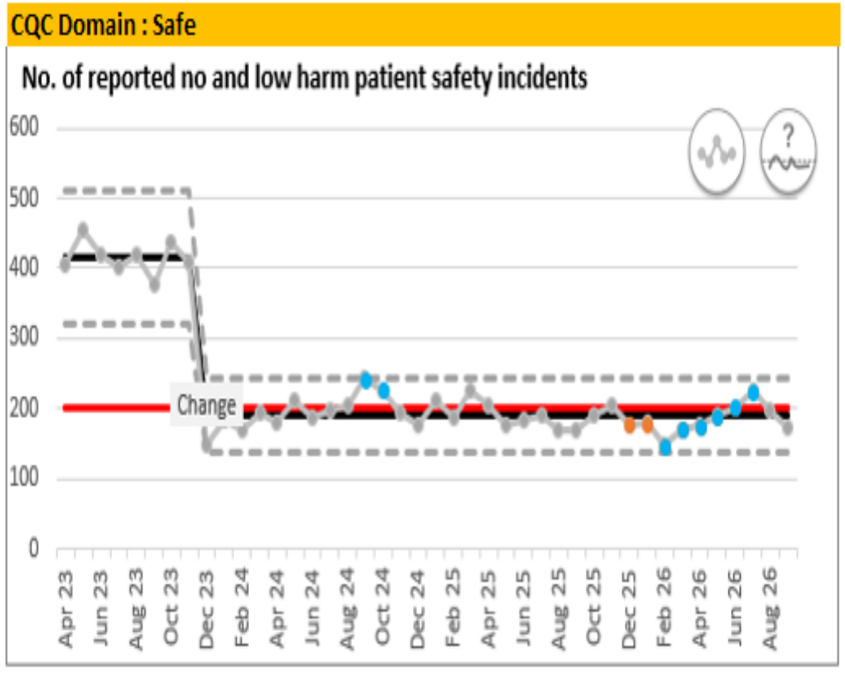
CQC Domain : Safe




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

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

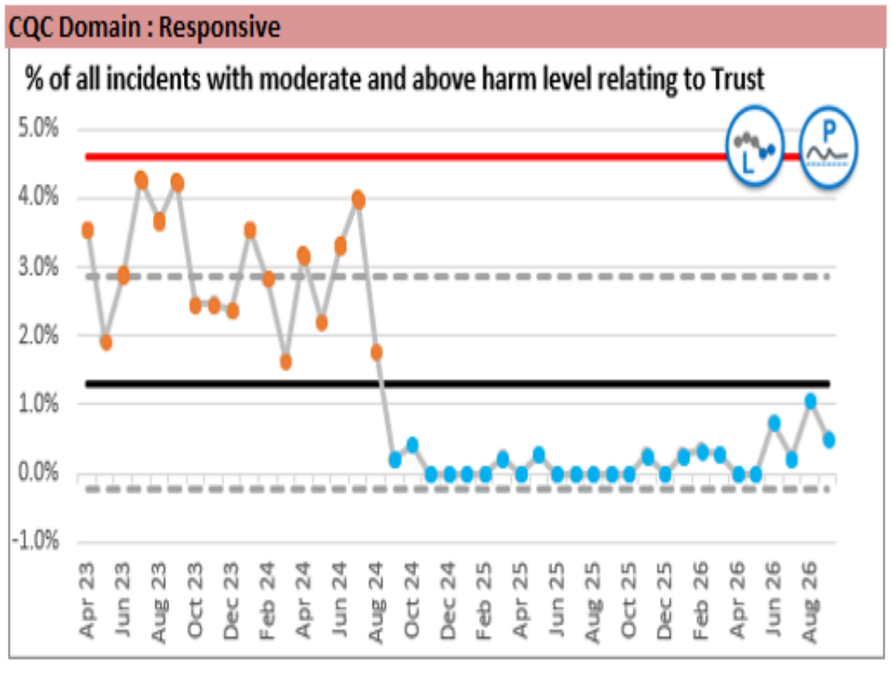
CQC Domain : Safe




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

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

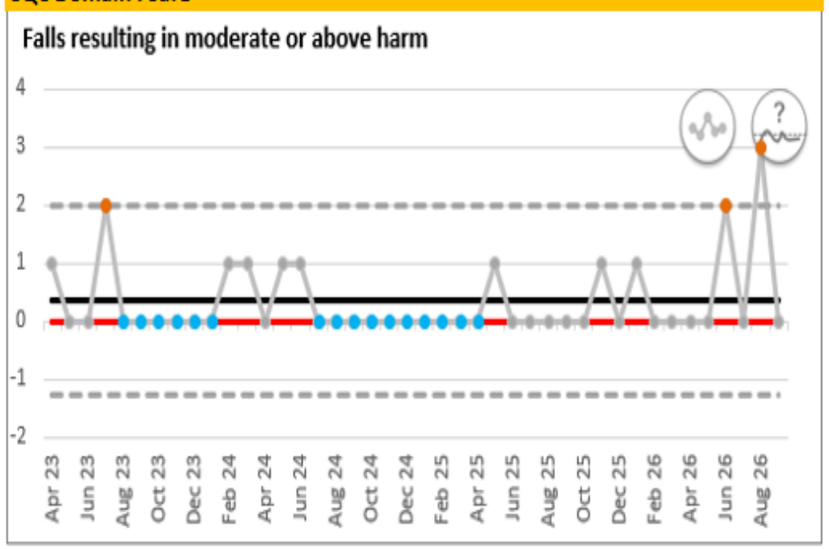
CQC Domain : Responsive




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

## Falls resulting in moderate or above harm

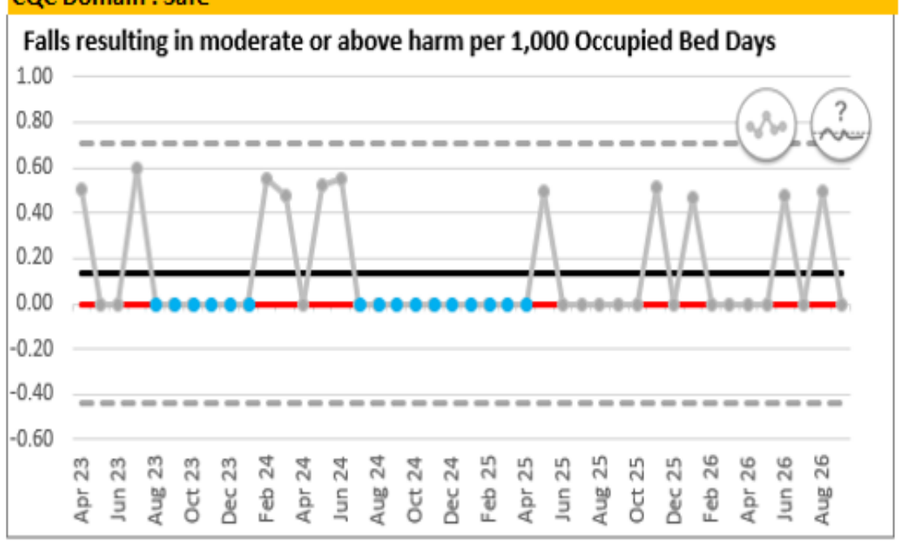
CQC Domain : Safe




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

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

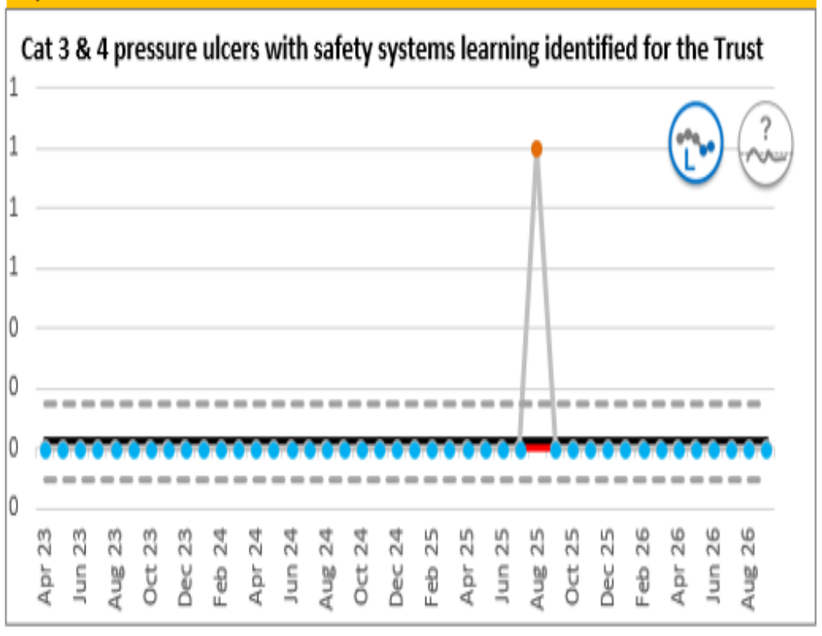
CQC Domain : Safe




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

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

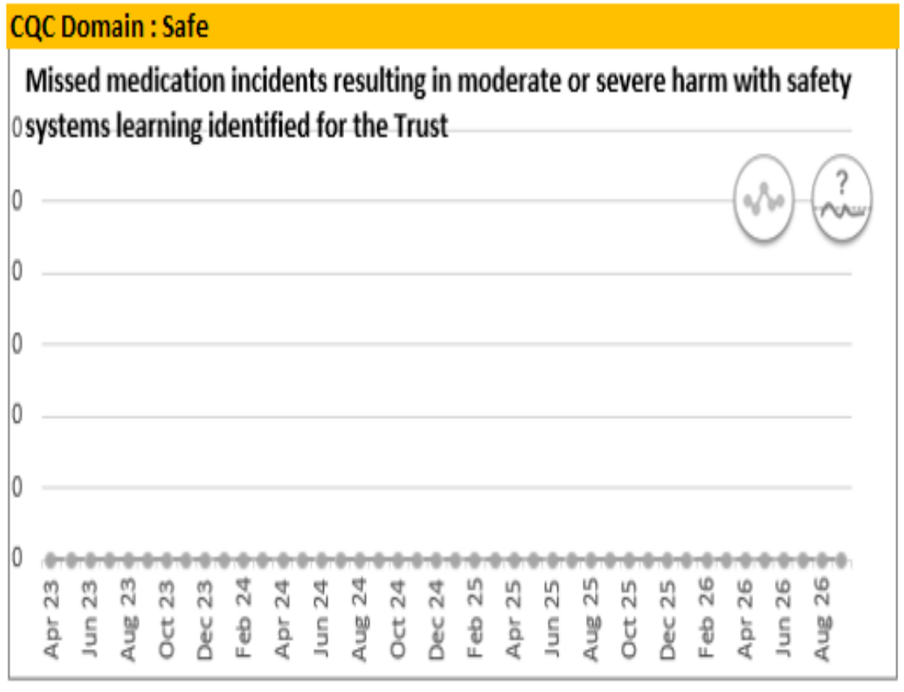
CQC Domain : Safe




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

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

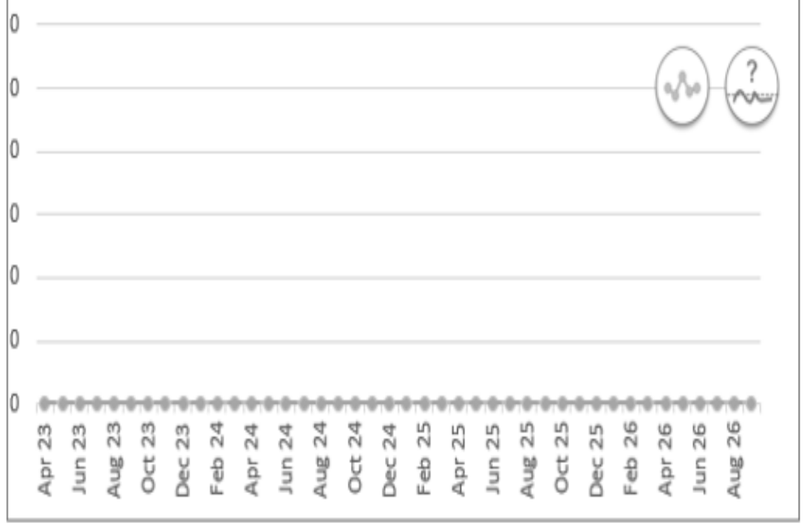
CQC Domain : Safe




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

## MRSA infections with learning identified for the Trust

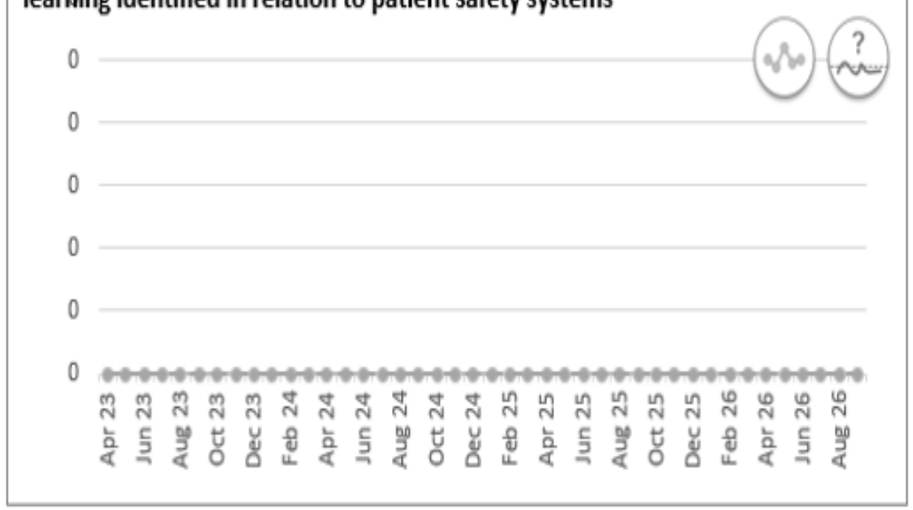
CQC Domain : Safe




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

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

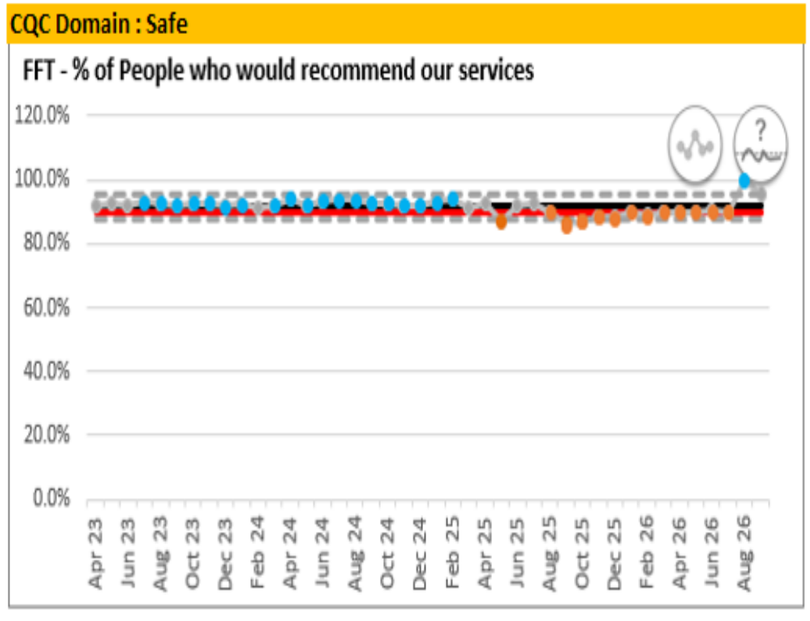
CQC Domain : Safe




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

## FFT - % of People who would recommend our services

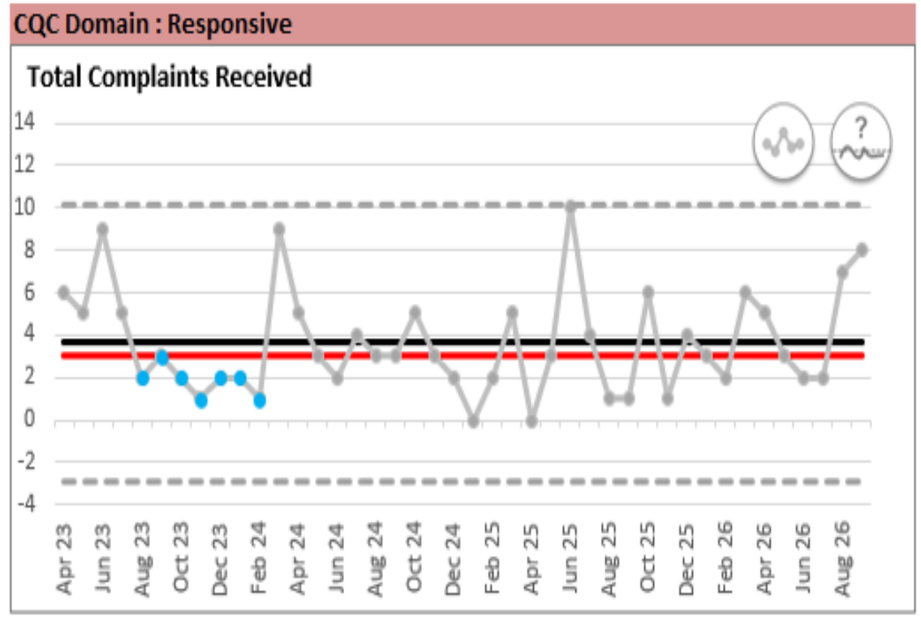
CQC Domain : Safe




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

## Total Complaints Received

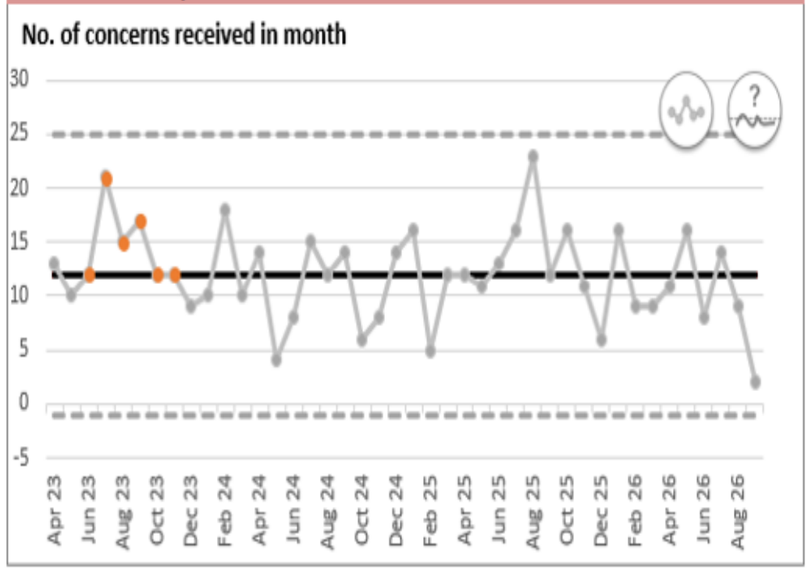
CQC Domain : Responsive




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

## No. of concerns received in month

CQC Domain : Responsive




| Sep-26 |
| --- |
| 2 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 12 |
| **Assurance** |
| Hit & miss target subject to random variation |

## EMD Operations Summary - WUTH

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

**Highlights**

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

**Areas of Concern**

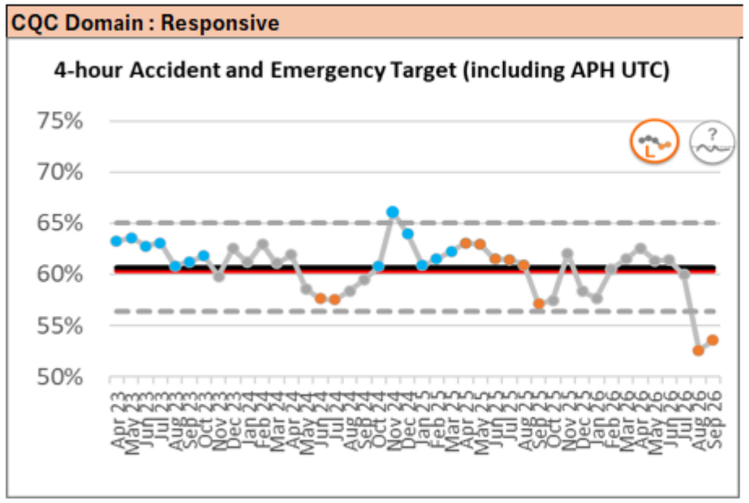
- 4-hour performance remains a significant concern, with deterioration following implementation of the Single Front Door.
- 12-hour performance improved marginally but remains above trajectory.
- DM01 was below plan due to the anticipated in-month endoscopy capacity gap.
- Ambulance handover performance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

**Forward Look (Actions)**

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

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

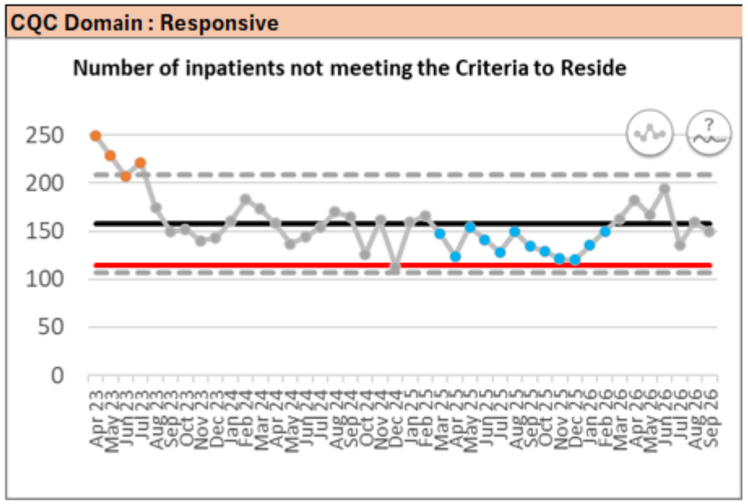
**CQC Domain : Responsive**




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

## Number of inpatients not meeting the Criteria to Reside

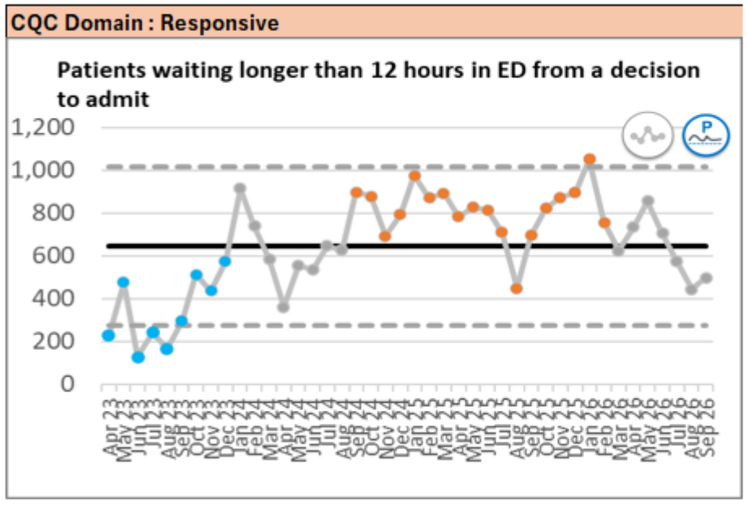
**CQC Domain : Responsive**




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

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

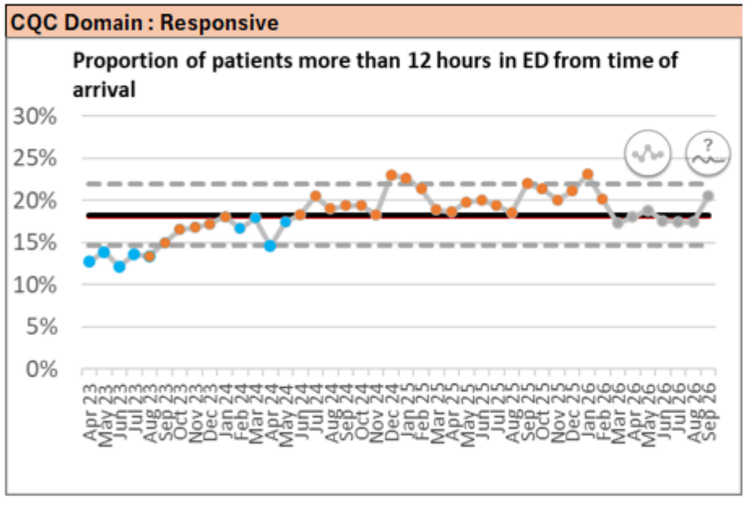
**CQC Domain : Responsive**




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

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

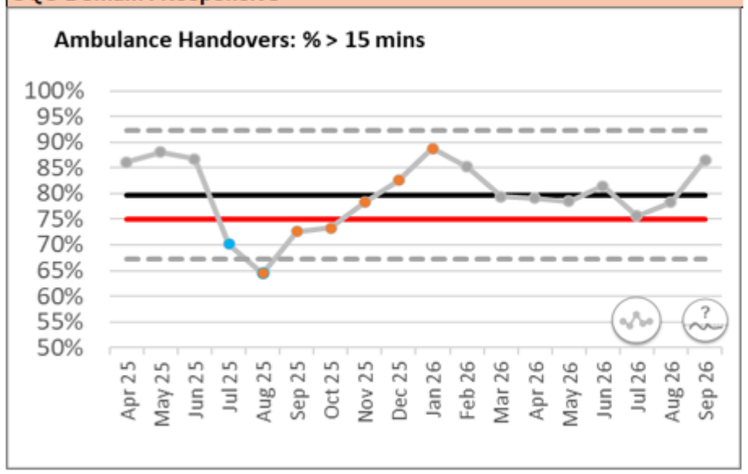
**CQC Domain : Responsive**




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

## Ambulance handover % < 30 minutes

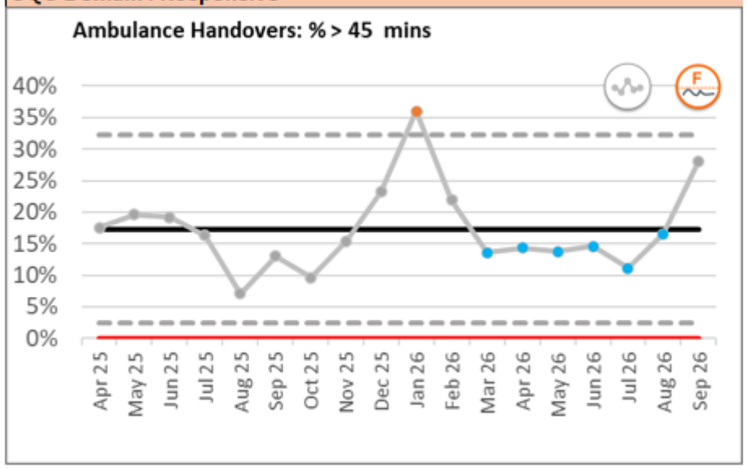
**CQC Domain : Responsive**




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

## Ambulance handover % < 45 minutes

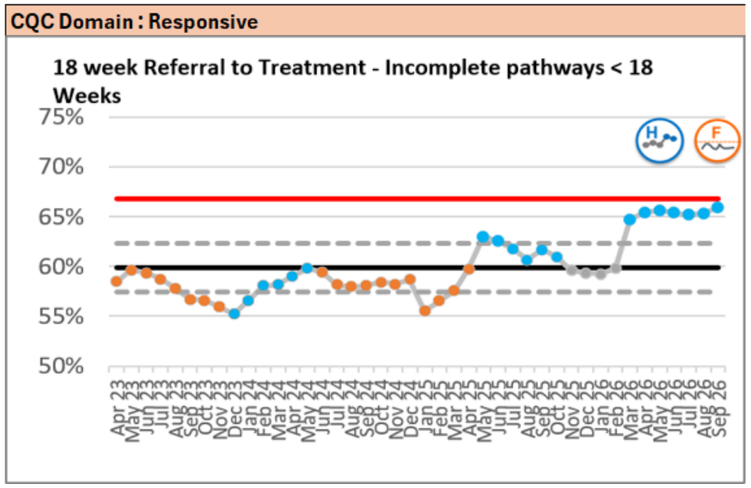
**CQC Domain : Responsive**




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

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

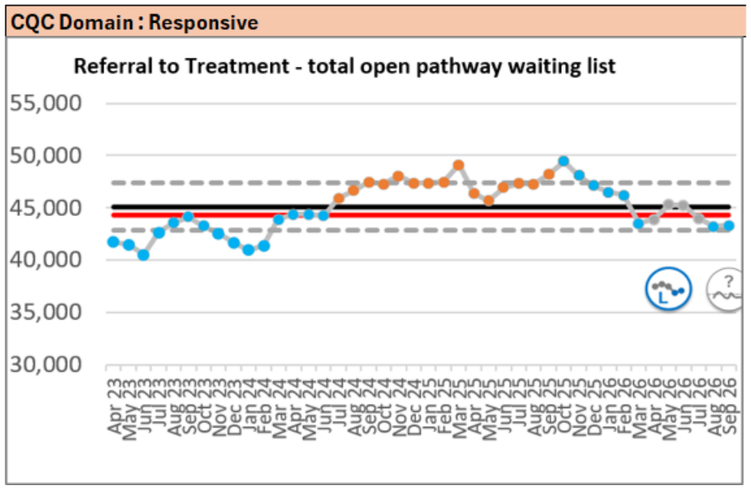
**CQC Domain : Responsive**




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

## Referral to Treatment – total open pathway waiting list

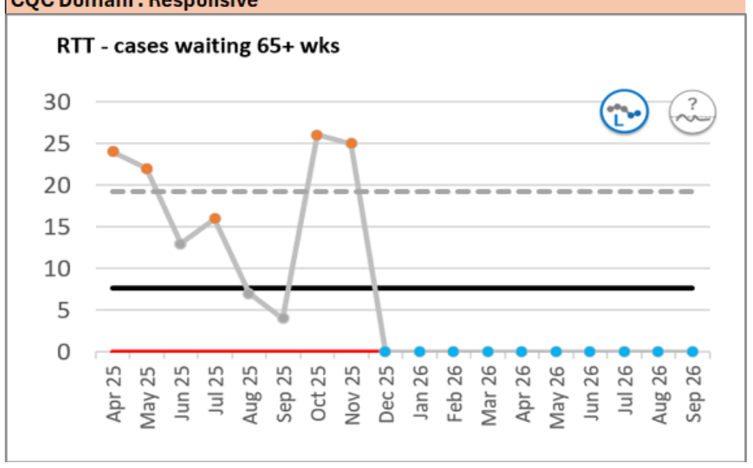
**CQC Domain : Responsive**




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

## Referral to Treatment – cases exceeding 52 weeks

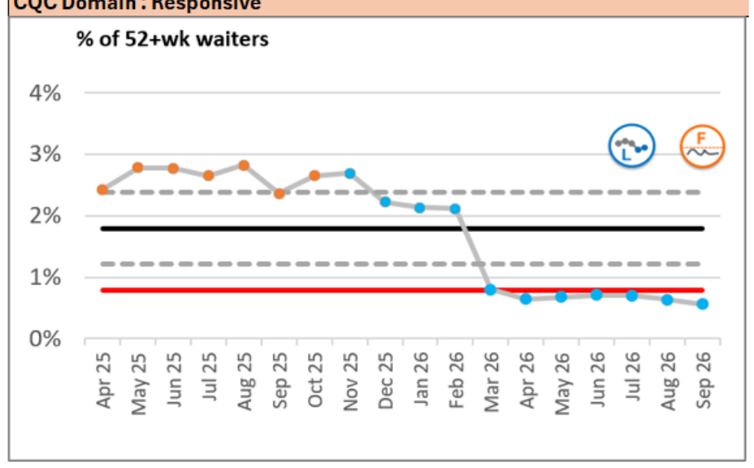
**CQC Domain : Responsive**




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

## Referral to Treatment – cases waiting 78+ weeks

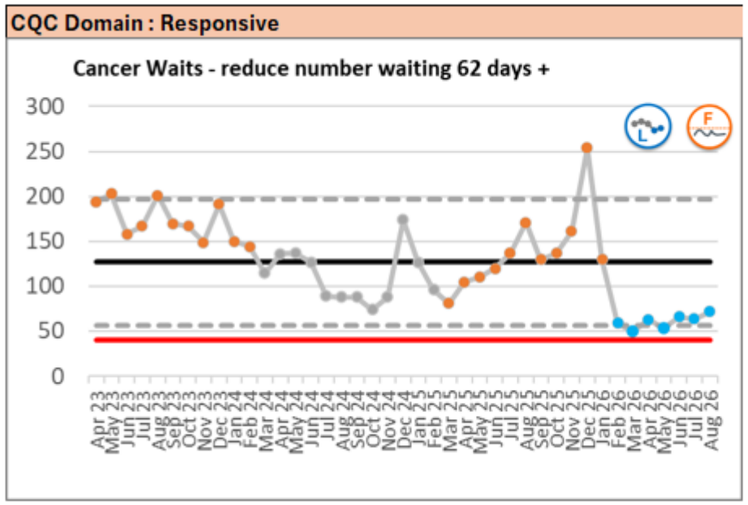
**CQC Domain : Responsive**




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

## Cancer Waits – reduce number waiting 62 days +

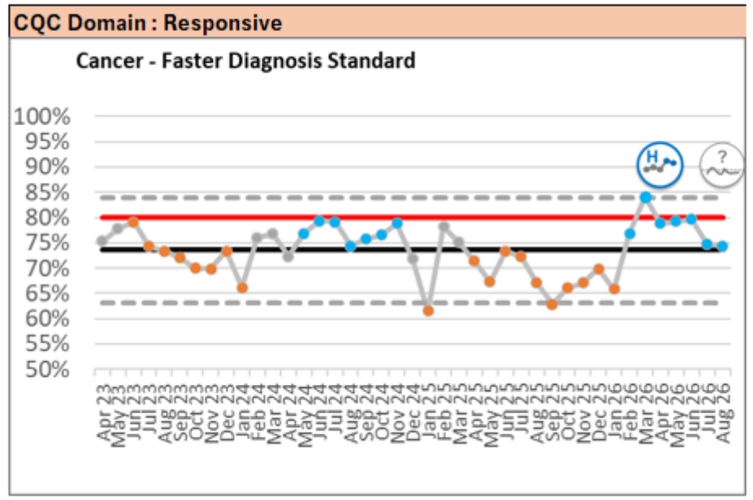
**CQC Domain : Responsive**




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

## Cancer – Faster Diagnostic Standard

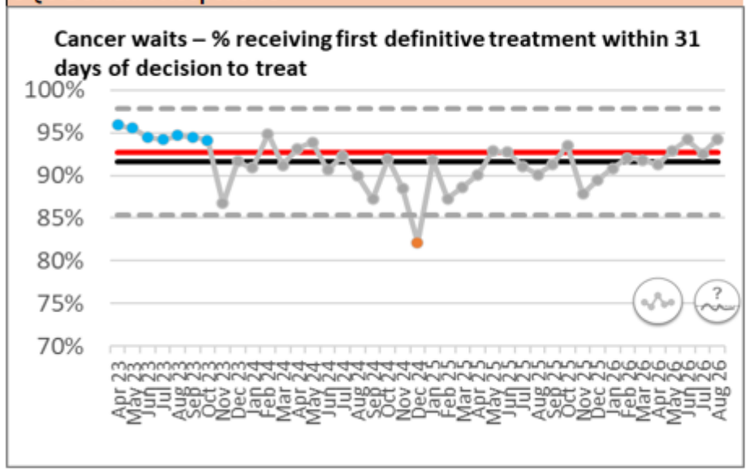
**CQC Domain : Responsive**




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

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

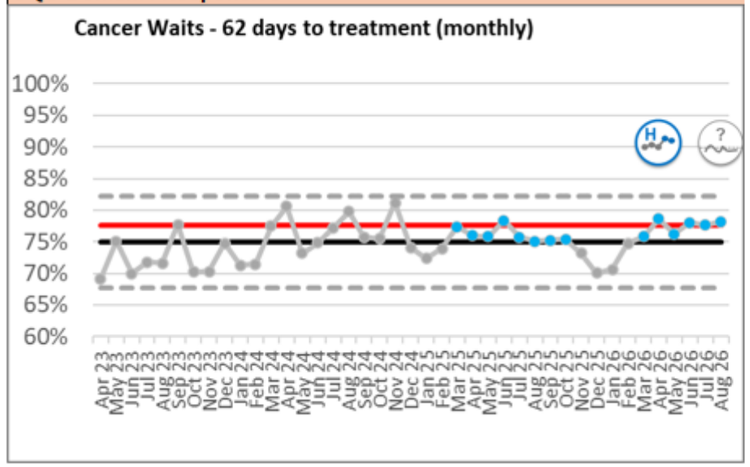
**CQC Domain : Responsive**




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

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

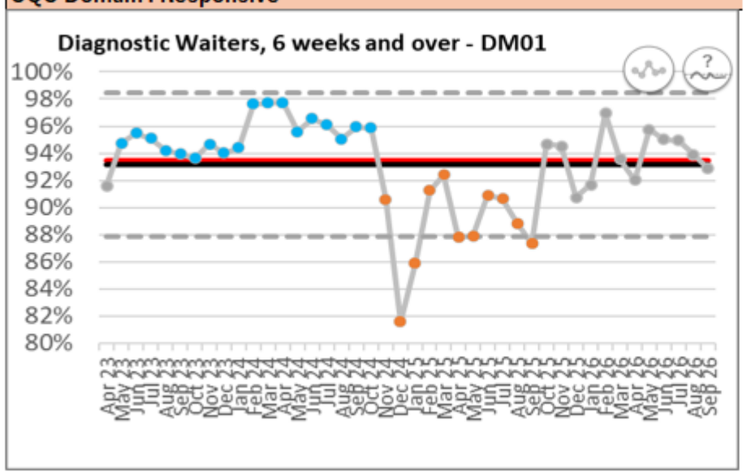
**CQC Domain : Responsive**




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

## Diagnostic Waiters – 6 weeks and over – DM01

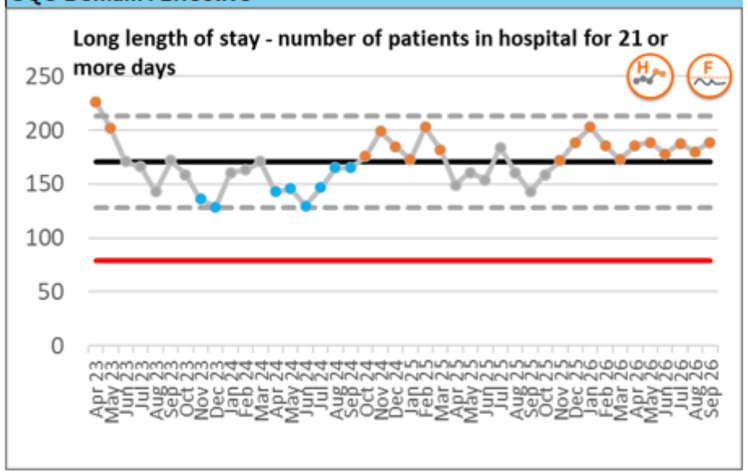
**CQC Domain : Responsive**




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

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

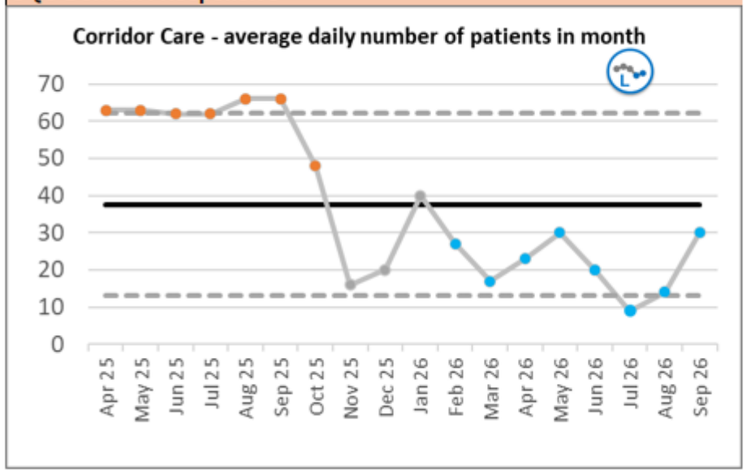
**CQC Domain : Effective**




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

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

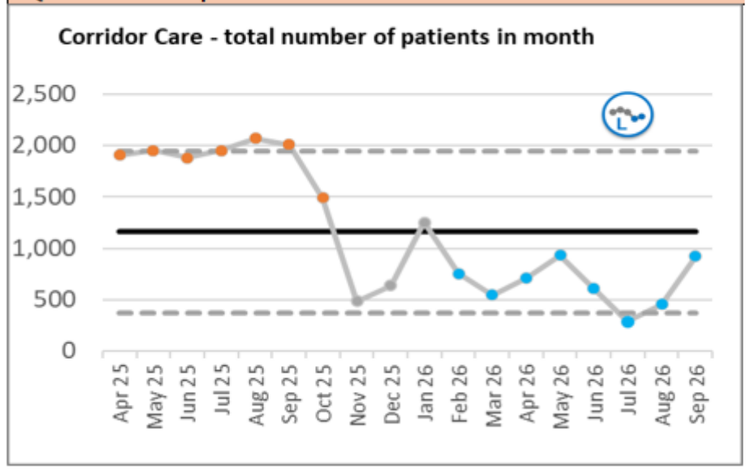
**CQC Domain : Responsive**




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

## Corridor Care – total number of patients in month

**CQC Domain : Responsive**




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

## Operational Summary - WCHC

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

### Highlights

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

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

Highlights by exception:

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

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

### Areas of Concern

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

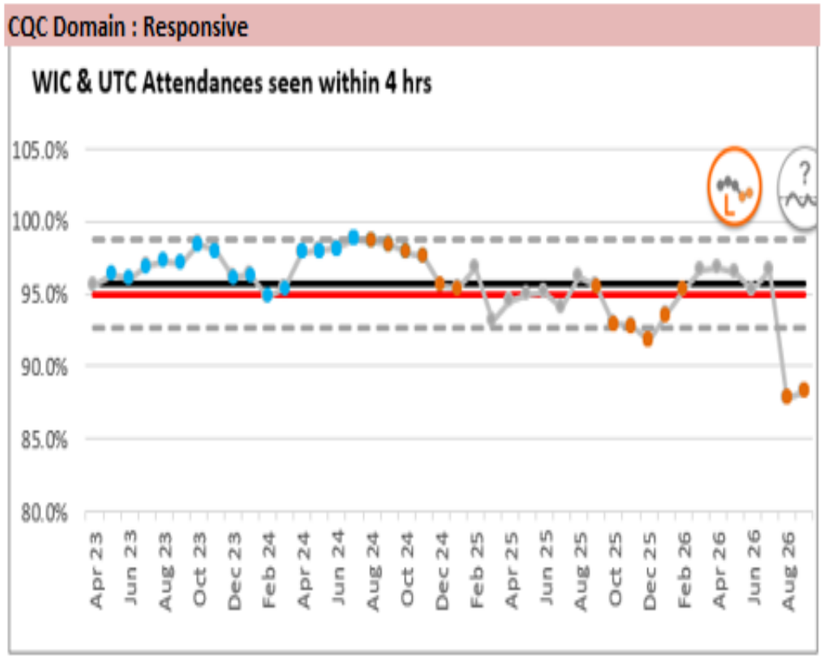
### Forward Look (Actions)

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

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

## WIC & UTC Attendances seen within 4 hrs

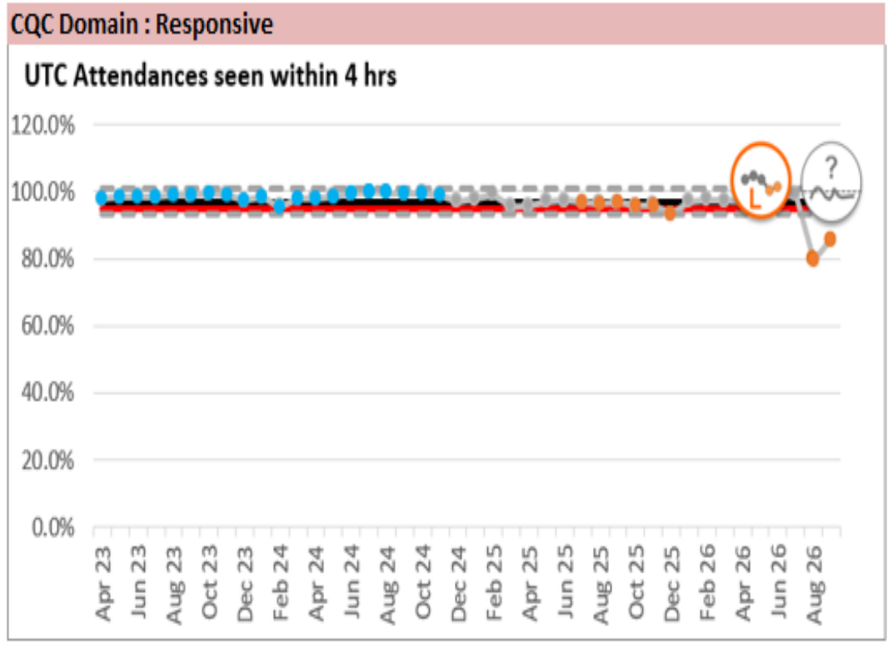
CQC Domain : Responsive




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

## UTC Attendances seen within 4 hrs

CQC Domain : Responsive

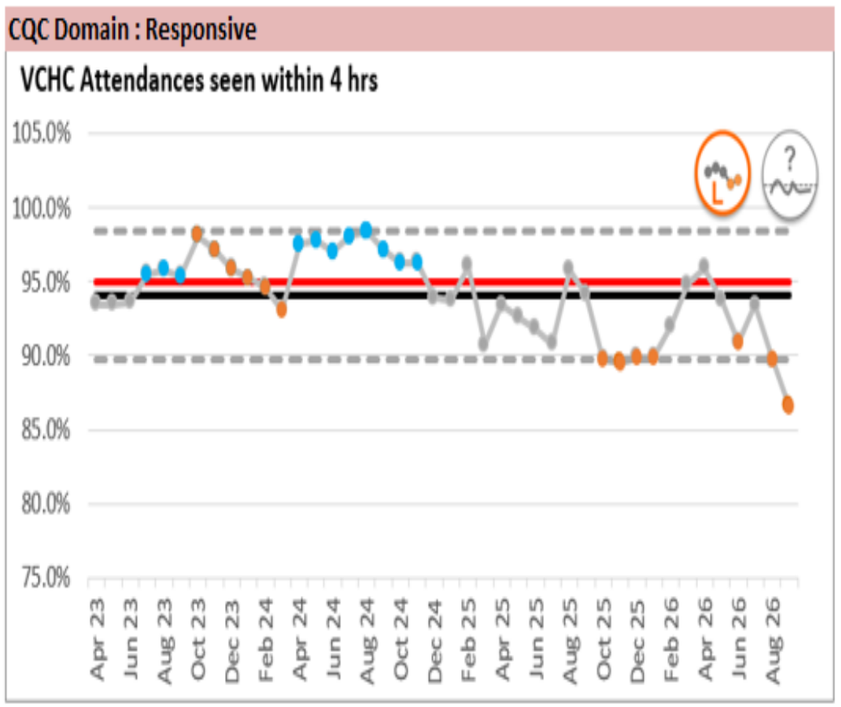



| Sep-26 |
|---|
| 85.5% |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit & miss target subject to random variation |

## VCHC Attendances seen within 4 hrs

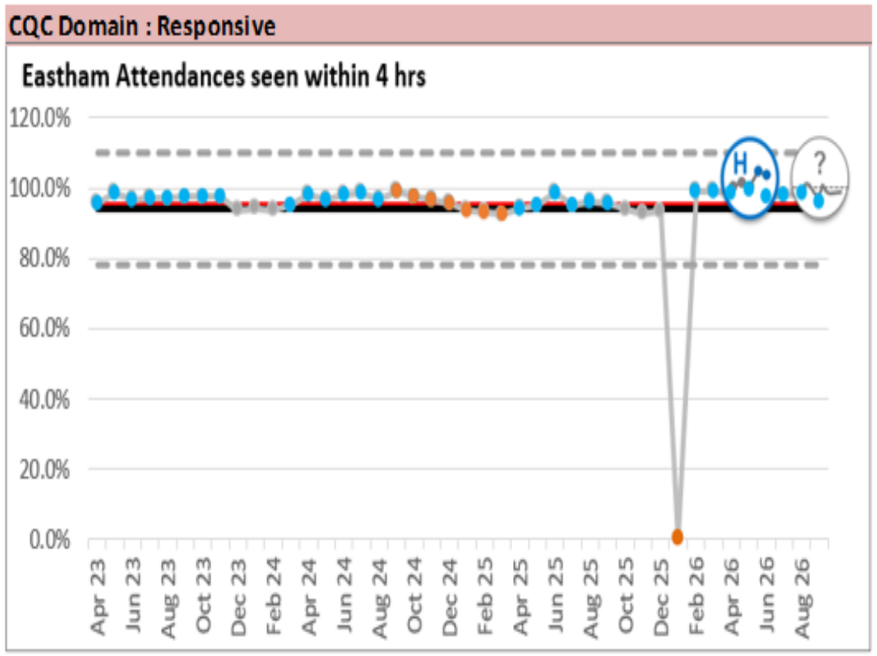
## Eastham Attendances seen within 4 hrs

CQC Domain : Responsive




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

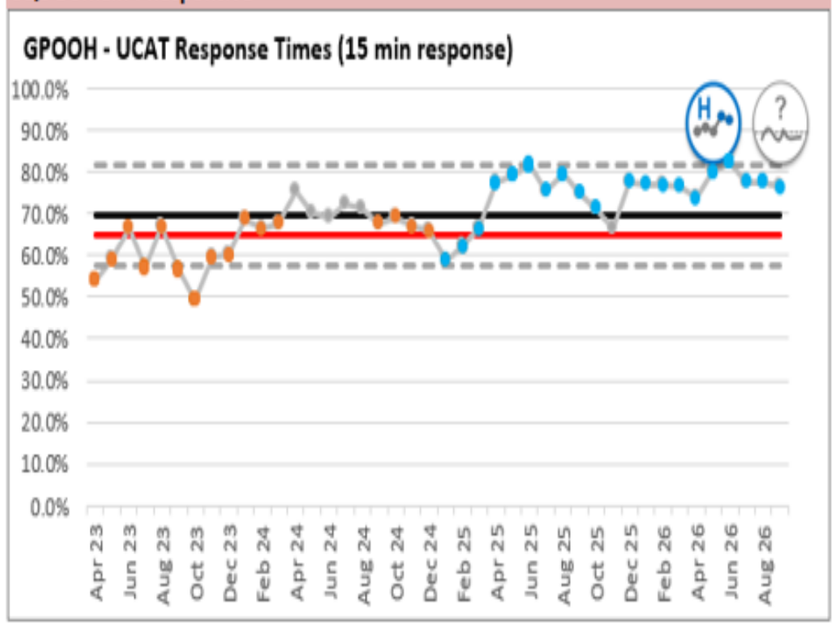
CQC Domain : Responsive




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

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

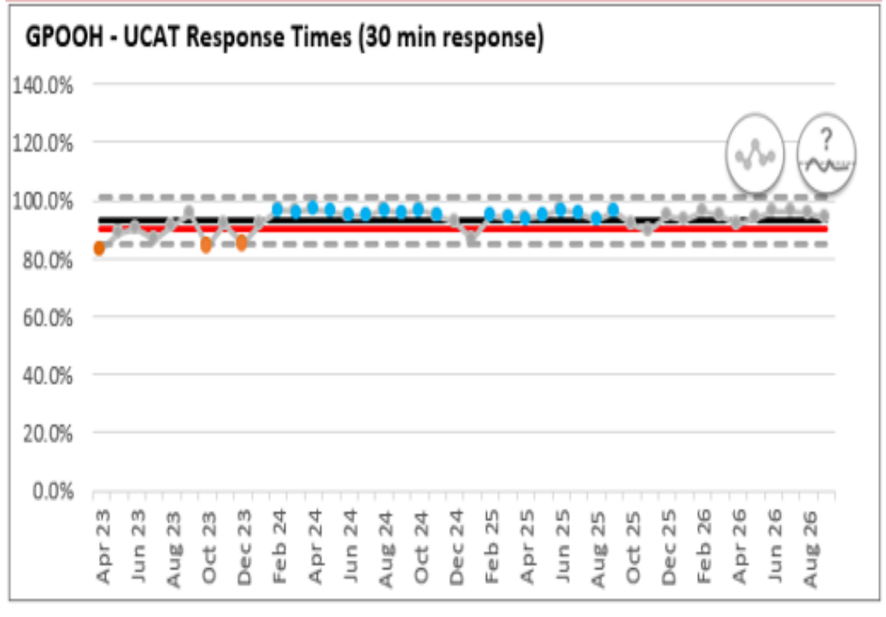
CQC Domain : Responsive




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

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

CQC Domain : Responsive

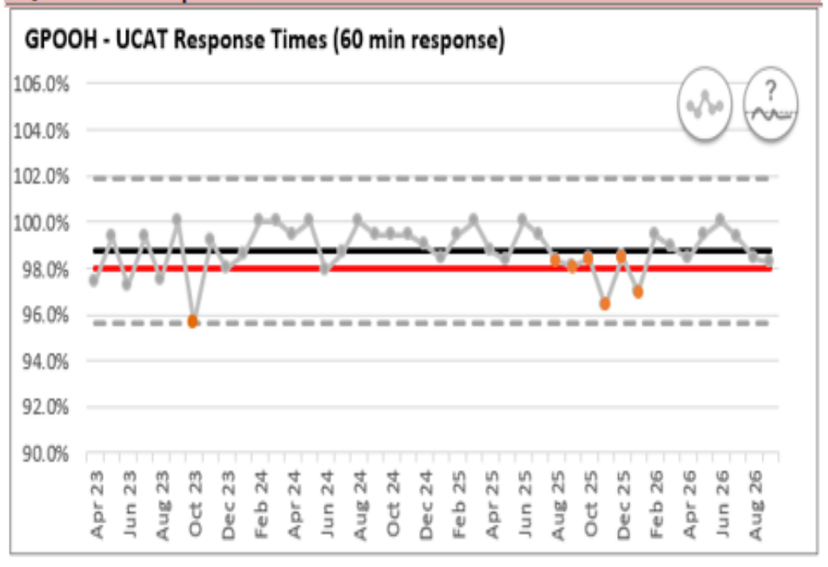



| Sep-26 |
|---|
| 93.6% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit & miss target subject to random variation |

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

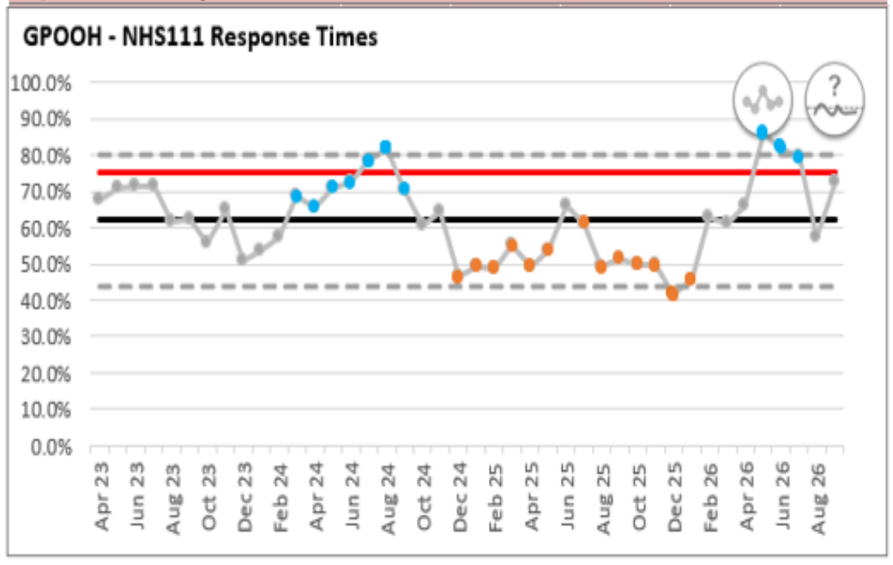
## GPOOH – NHS 111 Response Times

**CQC Domain : Responsive**




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

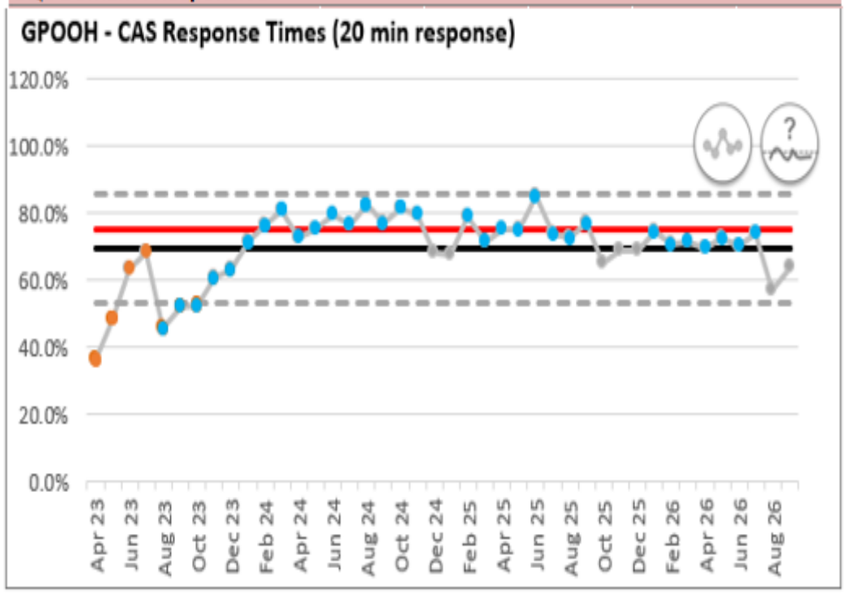
**CQC Domain : Responsive**




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

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

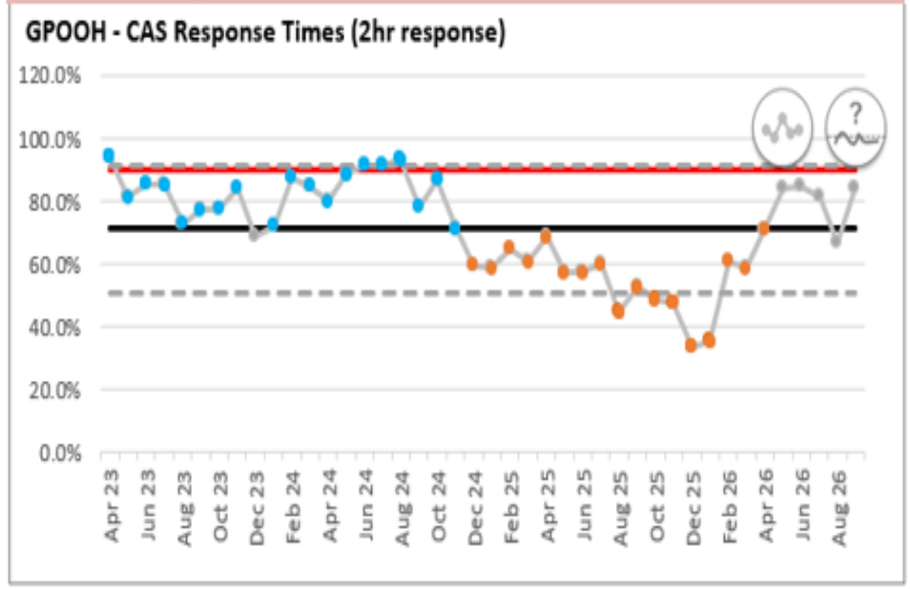
CQC Domain : Responsive




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

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

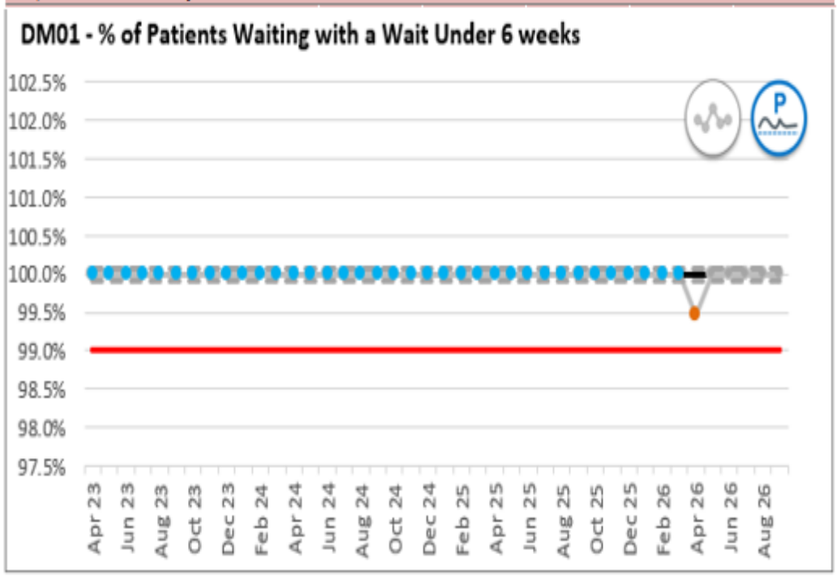
CQC Domain : Responsive




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

## DM01 - % of Patients Waiting under 6 weeks

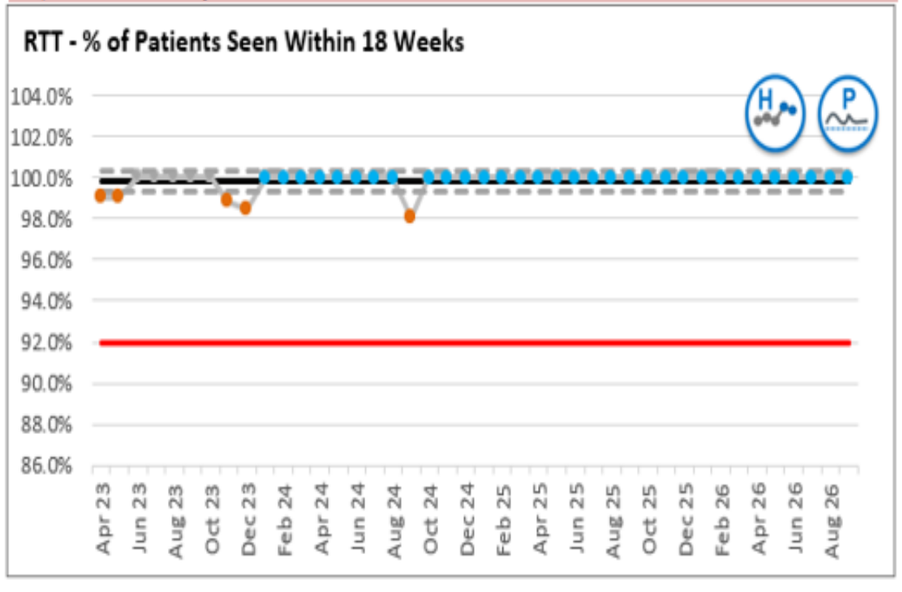
CQC Domain : Responsive




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

## RTT- % of Patients seen within 18 Weeks

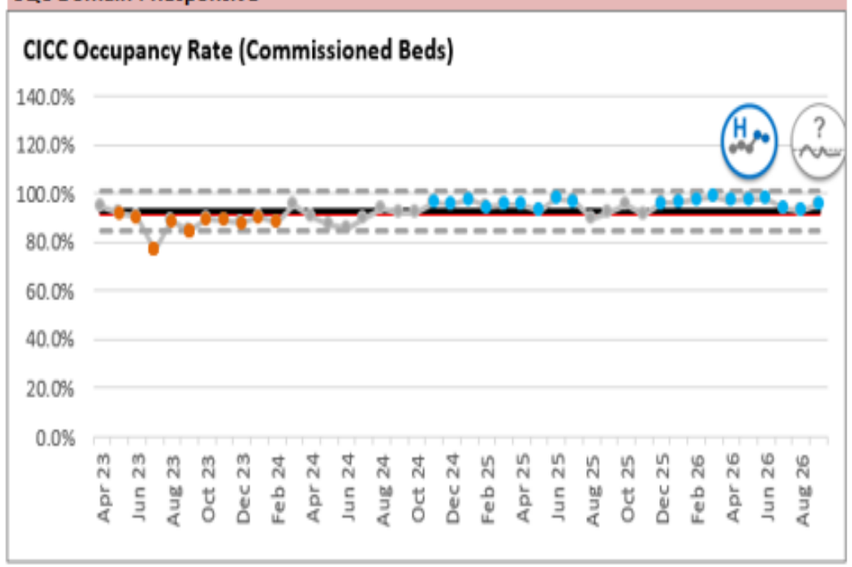
CQC Domain : Responsive




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

## CICC Occupancy Rate (Commissioned Beds)

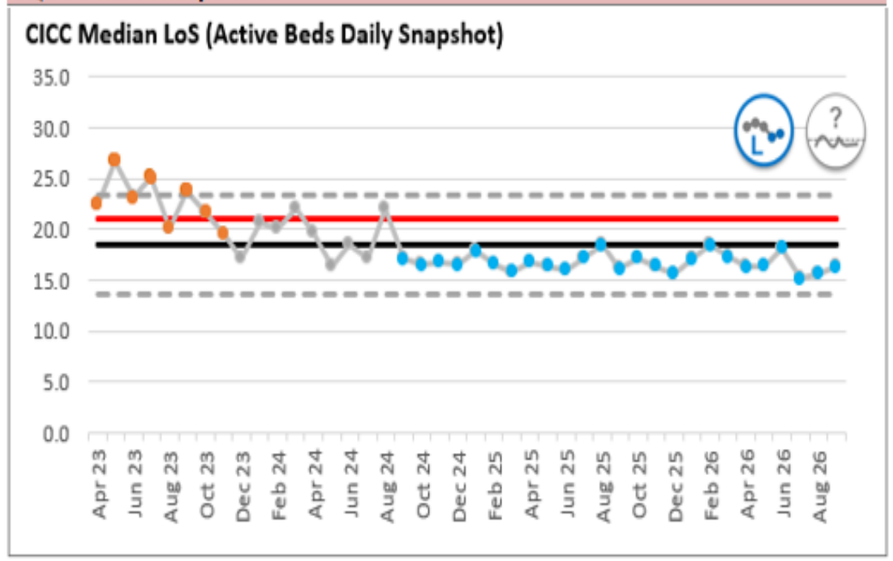
CQC Domain : Responsive




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

## CICC Median LoS (Active Beds Daily Snapshot)

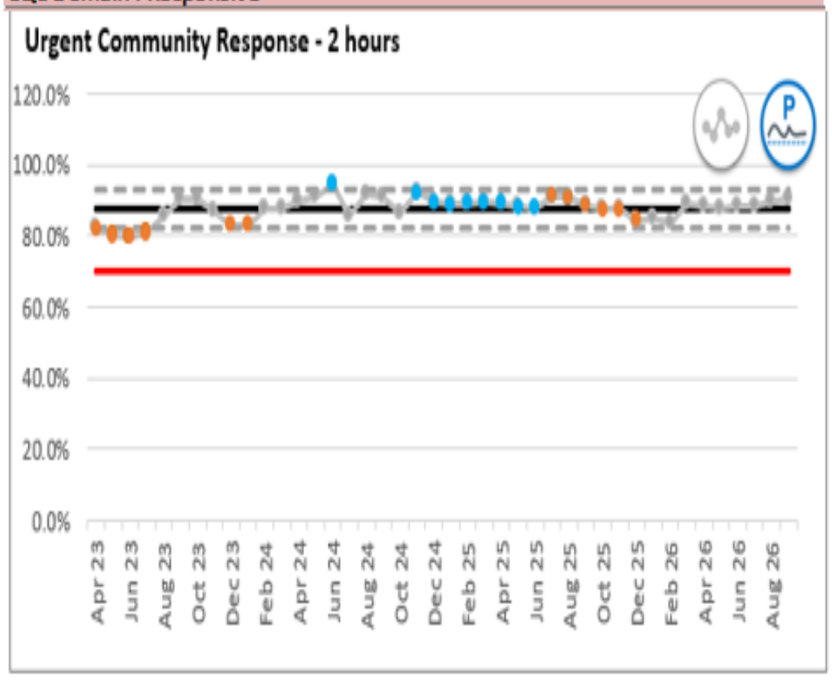
CQC Domain : Responsive




| Sep-26 |
|---|
| 16 |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| 21 |
| **Assurance** |
| Hit & miss target subject to random variation |

## Urgent Community Response - 2 hours

CQC Domain : Responsive




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

## Waiting Lists

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

## 0-19/25 Performance

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

## Finance Summary - WUTH

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

The Trust identified three key risks in the Trust plan:

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

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

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

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

**Highlights**

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

**Areas of Concern**

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

**Forward Look (Actions)**

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

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

### I&E Position

**Narrative:**

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

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

Key variances within the YTD position are:

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

.

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

## Cumulative CIP

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

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

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

## Elective Activity

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

## Capital Expenditure

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

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

The principal variances are:

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

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

## Cash Position

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

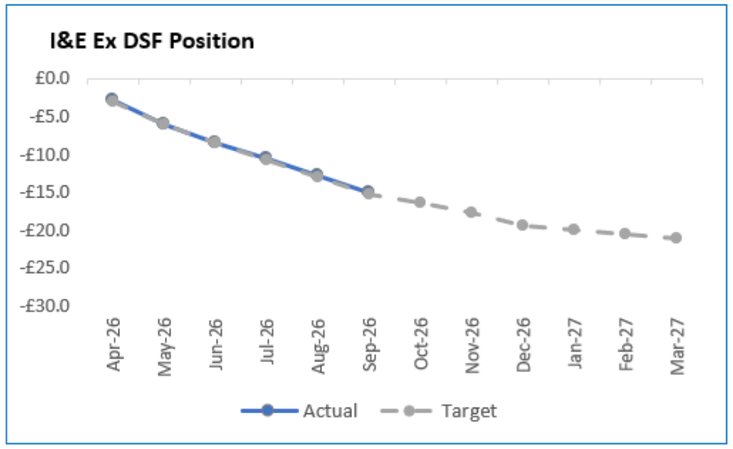
In M6 NHSE confirmed that the Trust would receive Deficit Support Funding for Q3. The Trust continues to maintain strict controls in respect of cash.

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

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

## I&E Position

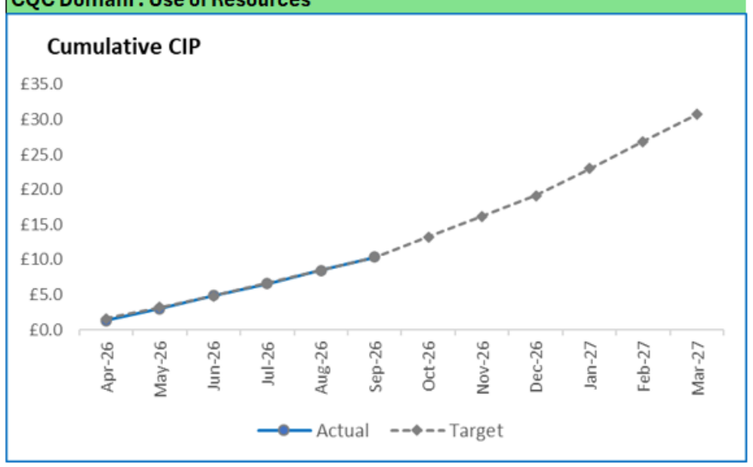
**CQC Domain: Use of Resources**




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

## Cumulative CIP

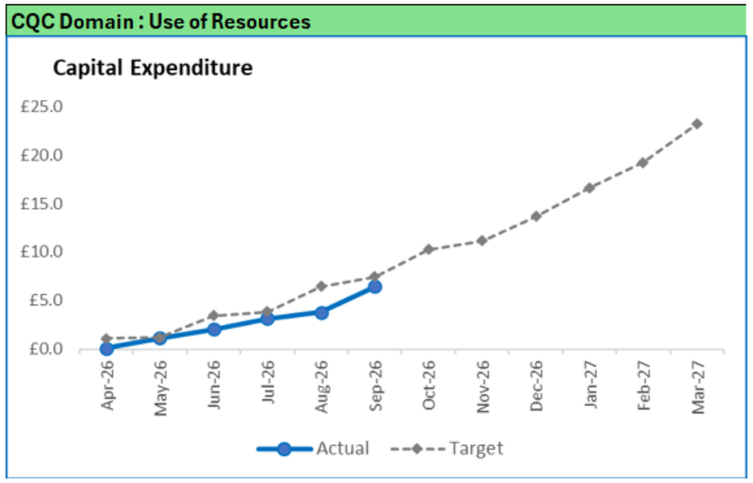
**CQC Domain : Use of Resources**




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

## Capital Position

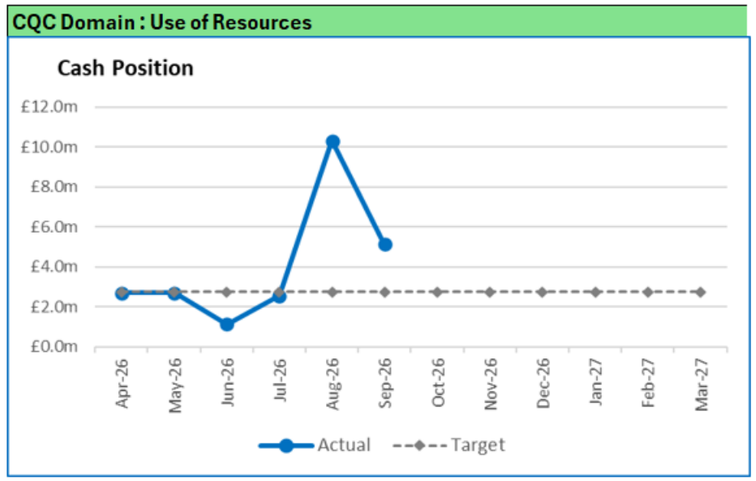
**CQC Domain : Use of Resources**




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

## Cash position

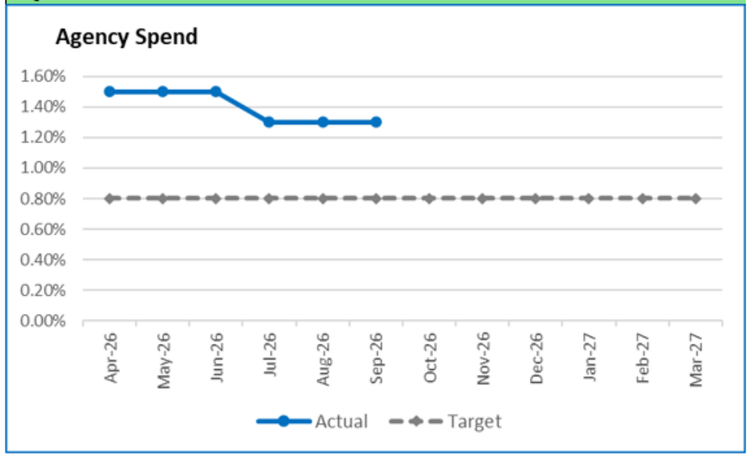
**CQC Domain : Use of Resources**




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

## Agency spend %

**CQC Domain : Use of Resources**




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

## Finance Summary - WCHC

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

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

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

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

**Highlights**

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

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

**Areas of Concern**

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

**Forward Look (Actions)**

Convert the CIP programme into formally transacted and sustainable savings.

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

## Commentary

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

The principal factors within the position are:

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

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

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

## Capital

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

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

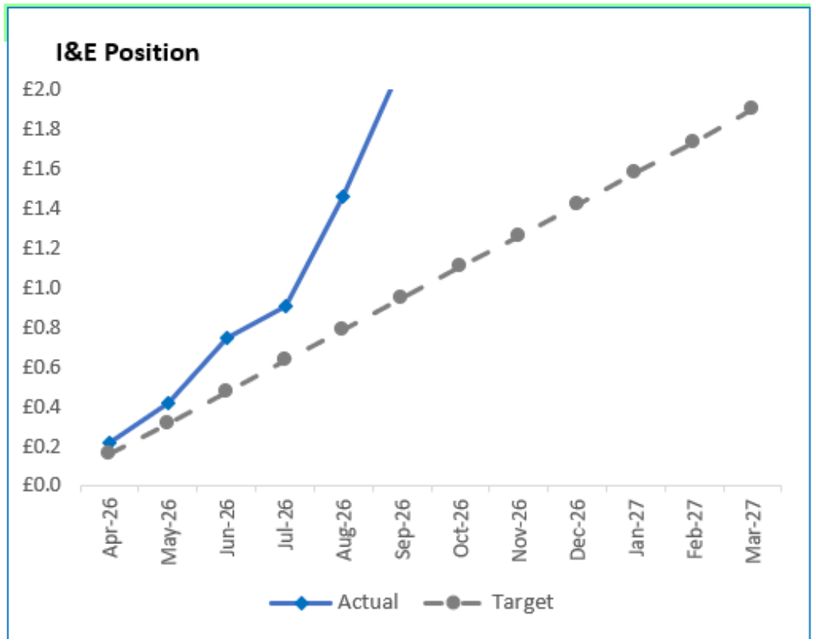
The principal variances are:

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

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

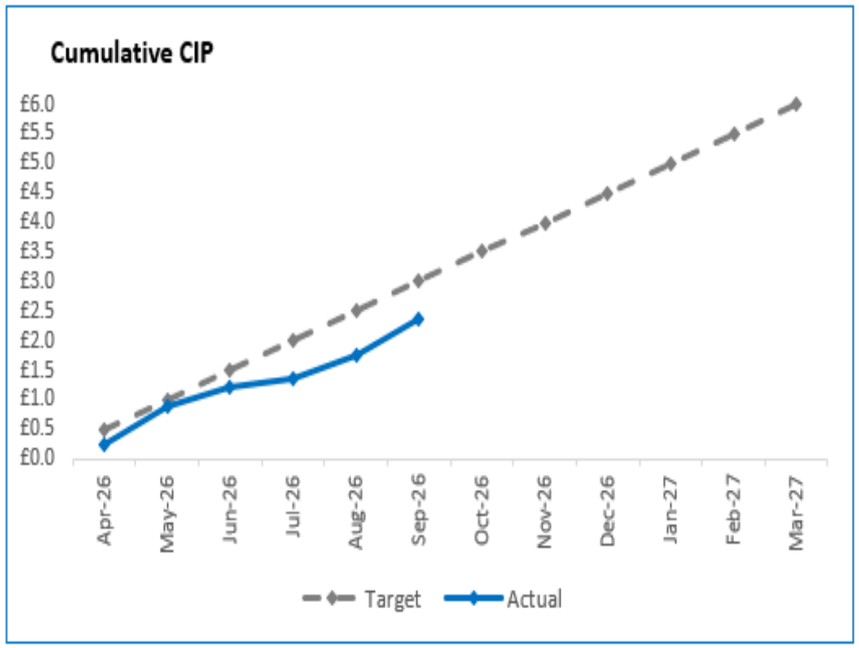
The reported year-to-date variance is principally a phasing issue associated with IFRS 16 and PDC commitments. Delivery of transformation, estates and operational schemes will require continued monitoring over the remainder of the year.

## I&E Position



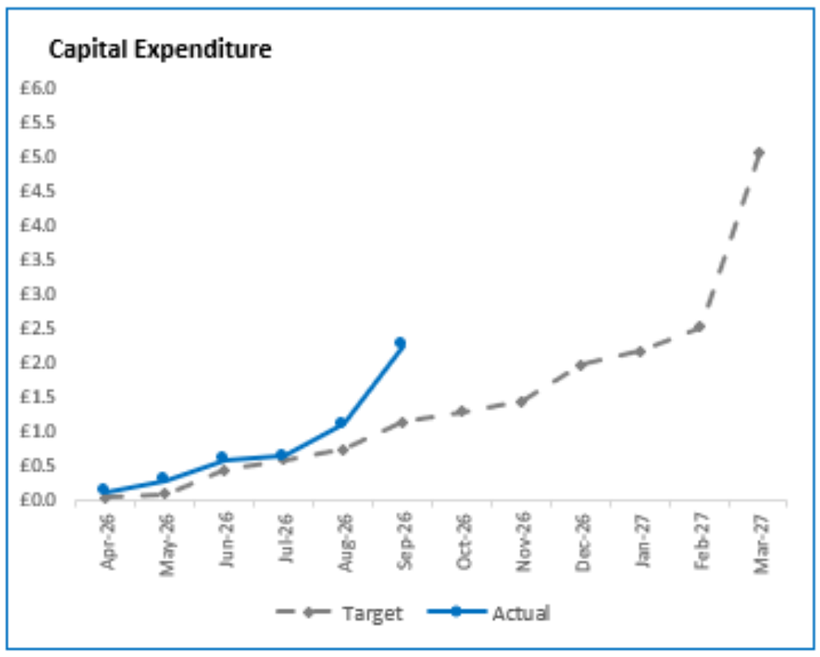

| Sep-26 |
|---|
| £2.1m |
| **Variance Type** |
| Position better than plan |
| **Target** |
| £0.9m |

## Cumulative CIP



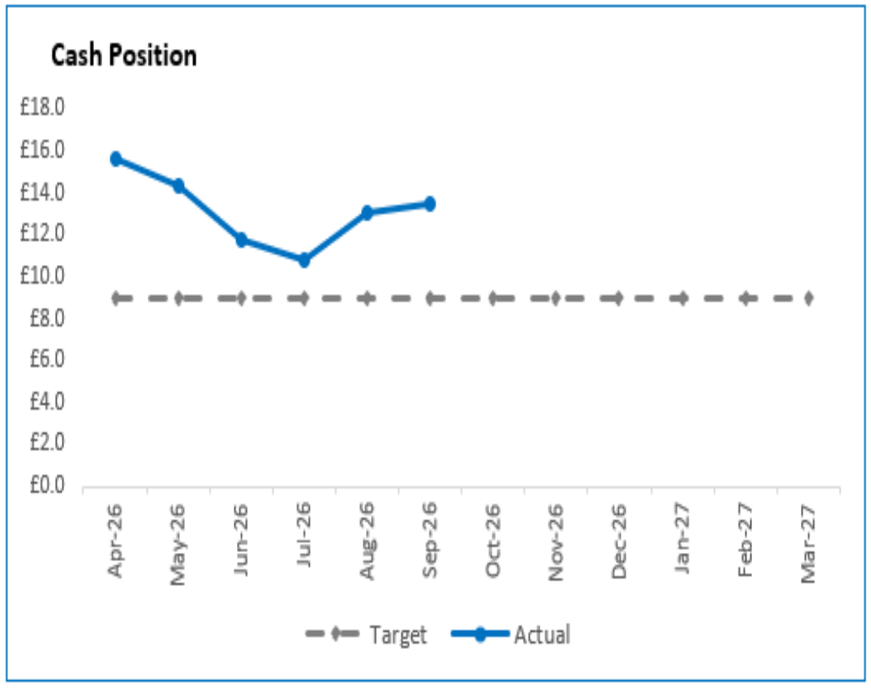

| Sep-26 |
|---|
| £2.4m |
| **Variance** |
| Position worse than plan |
| **Target** |
| £2m |

## Capital Expenditure



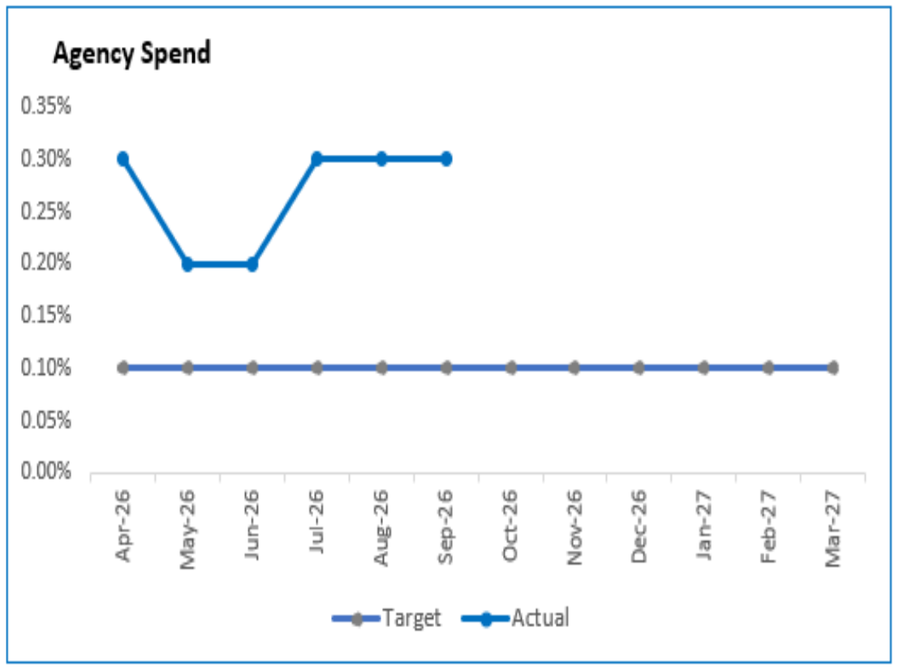

| Sep-26 |
|---|
| £2.3m |
| **Variance Type** |
| Position higher than plan |
| **Target** |
| £1.1m |

## Cash Position




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

## Agency Spend




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

## CPO Workforce Summary - WUTH

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

### Highlights

**Appraisal Compliance:**

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

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

**Sickness Absence:**

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

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

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

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

### Areas of Concern

**Appraisal Compliance:**

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

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

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

**Sickness Absence:**

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

The highest divisional sickness rates are:

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

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

### Forward Look (Actions)

**Appraisal Compliance:**

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

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

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

**Sickness Absence:**

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

Delivery continues through four key workstreams:

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

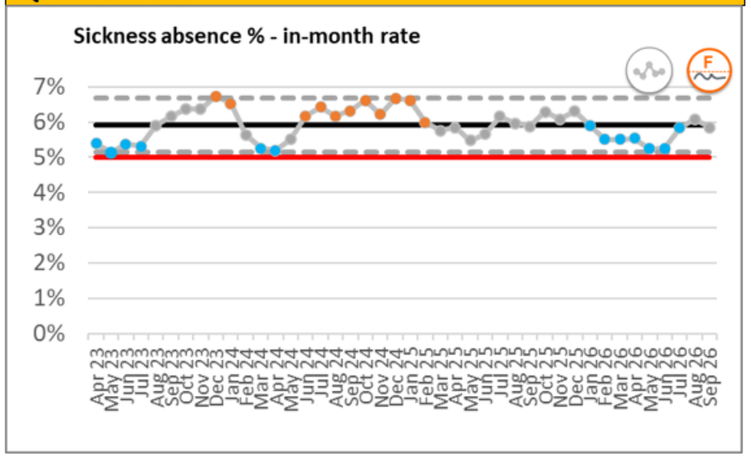
Targeted support continues for areas with the highest levels of sickness, alongside proactive health and wellbeing interventions including the Well in Work Programme, Well Wirral Return to Work Programme, improved mental health referral triage and targeted psychological support.

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

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

## Sickness absence % in month rate

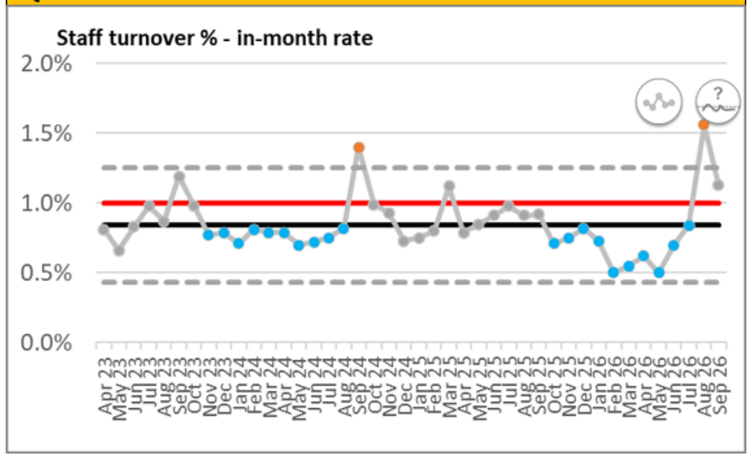
CQC Domain : Safe




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

## Staff turnover % in month rate

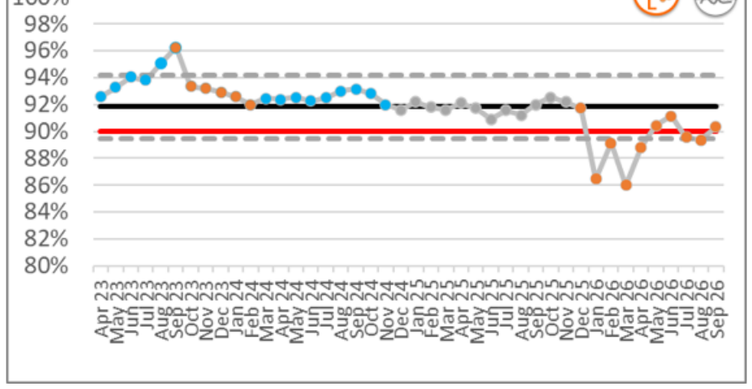
CQC Domain : Safe




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

## Mandatory training % compliance

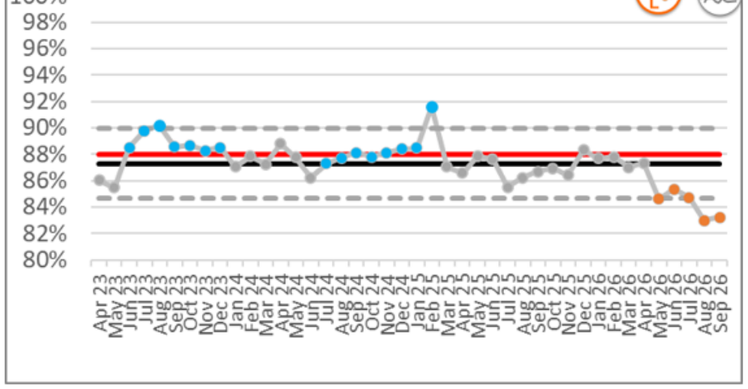
CQC Domain : Safe




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

## Appraisal % compliance

CQC Domain : Well-led




| Sep-26 |
|---|
| 83.2% |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≥88% |
| **Assurance** |
| Hit and miss target subject to random variation |

# Workforce Summary - WCHC

| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Turnover Rolling 12 Months | Sept 26 | 10.5% | 12.0% | | | 12.4% |
| Mandatory Training Compliance | Sept 26 | 94.3% | 90.0% | | | 95.0% |
| Sickness Absence | Sept 26 | 6.9% | 5.0% | | | 6.5% |
| Sickness Absence (Short Term) | Sept 26 | 2.4% | 2.0% | | | 1.6% |
| Sickness Absence (Long Term) | Sept 26 | 4.6% | 3.0% | | | 4.9% |
| Agency usage | Sept 26 | 0.2% | 1.0% | | | 0.9% |
| Variance to Agency Cap (£) | Sept 26 | -206461 | - | | | -177197.8 |
| % of Agency Usage against Funded WTE | Sept 26 | 0.0% | - | | | 0.6% |
| % of Bank Usage against Funded WTE | Sept 26 | 4.3% | - | | | 3.5% |
| % of Contracted FTE Vacancies | Sept 26 | 4.8% | 6.0% | | | 5.0% |

## Highlights

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

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

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

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

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

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

## Areas of Concern

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

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

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

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

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

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

## Forward Look (Actions)

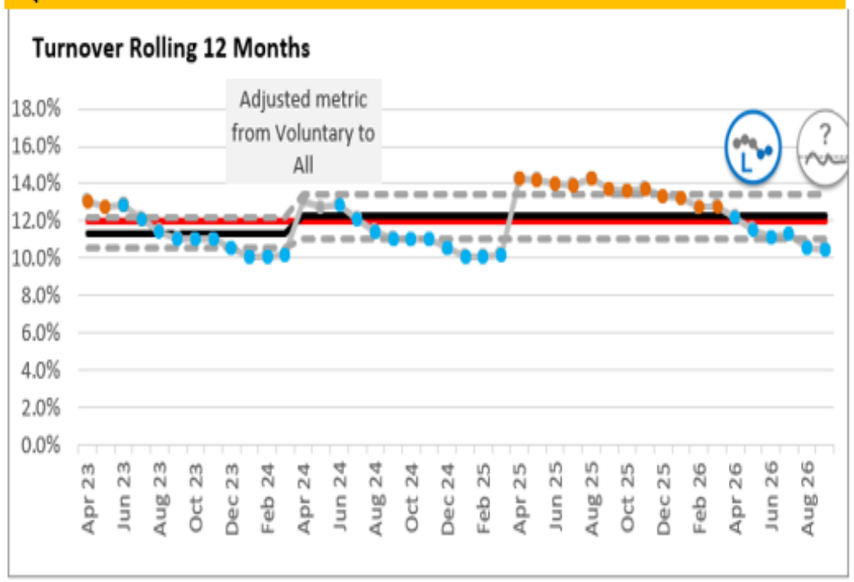
**Strengthened performance reporting and accountability**
Enhanced sickness absence reporting to the WCHC SLT, providing clearer visibility of performance against the 5% target, including long and short term absence trends and service hotspots. This enables earlier identification of deterioration and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

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

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

## Turnover – Rolling 12 Months

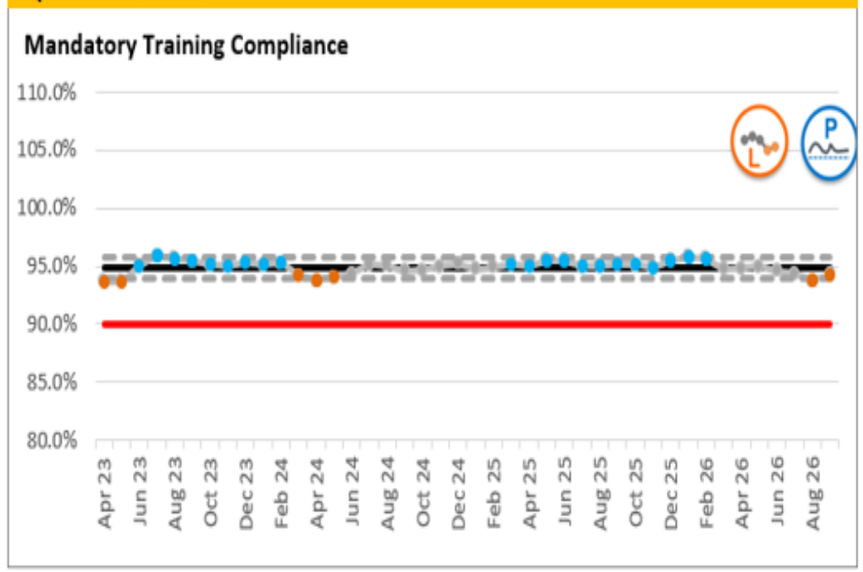
CQC Domain : Safe




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

## Mandatory Training Compliance

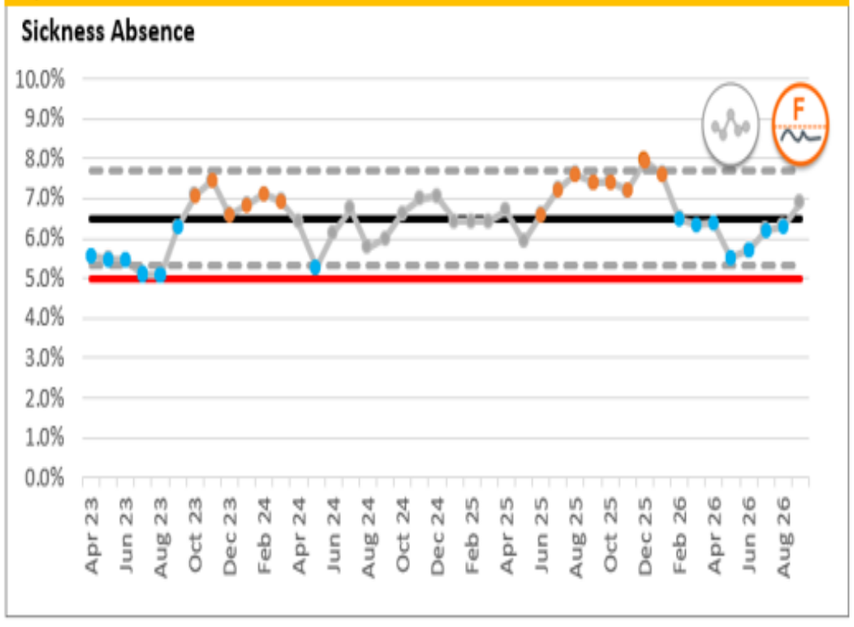
CQC Domain : Safe




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

## Sickness Absence

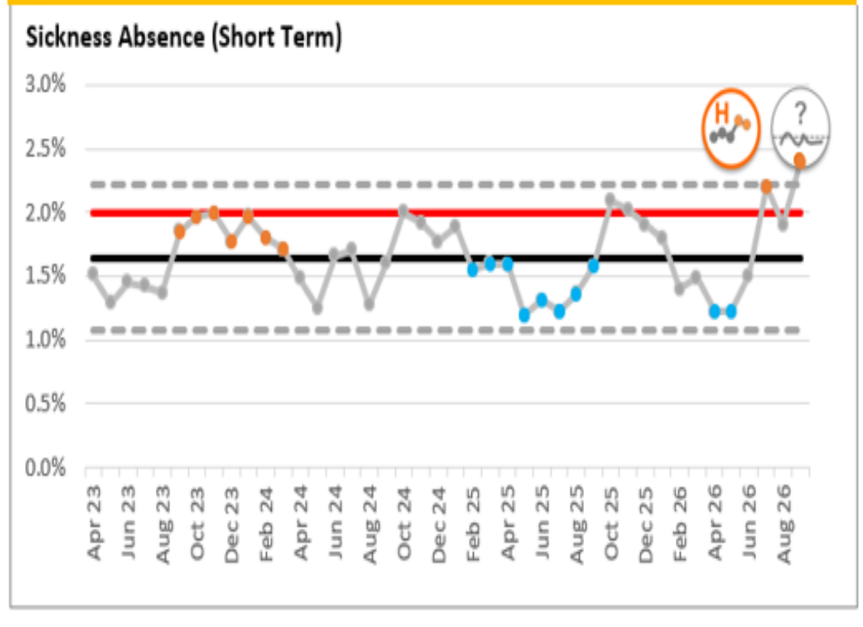
CQC Domain : Safe




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

## Sickness Absence (Short Term)

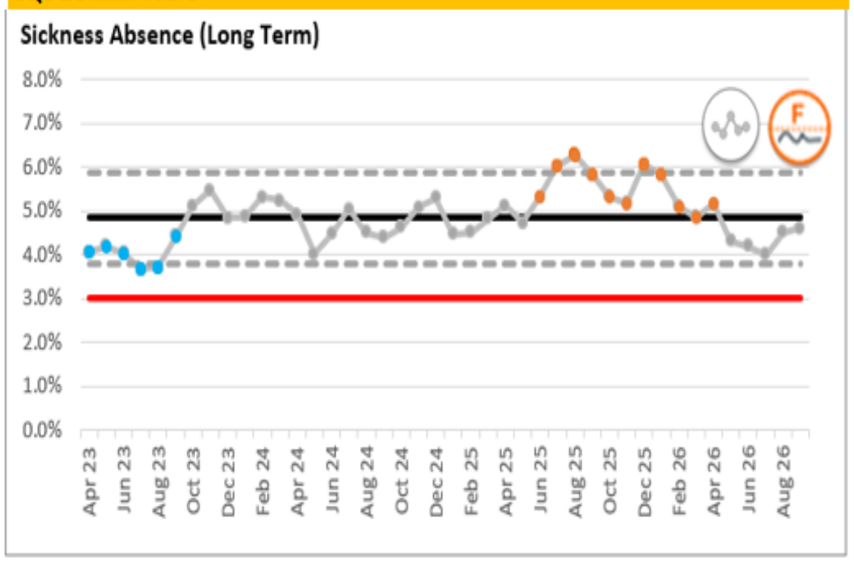
CQC Domain : Safe




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

## Sickness Absence (Long Term)

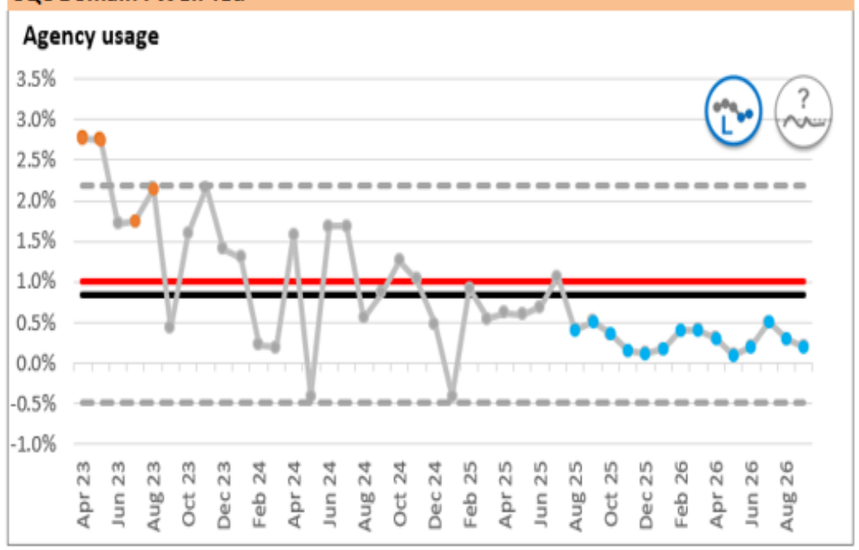
CQC Domain : Safe




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

## Agency usage

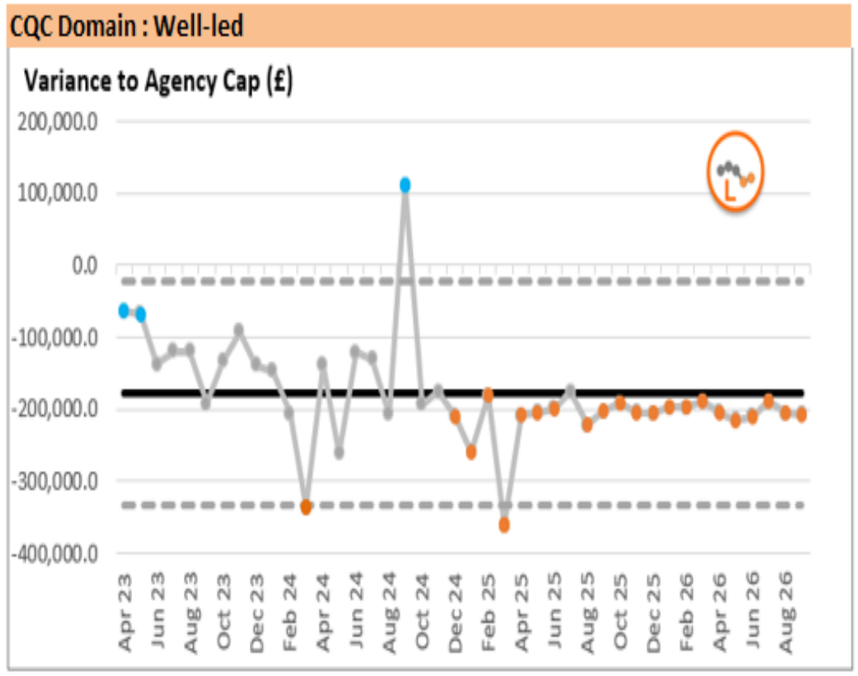
CQC Domain : Well-led




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

## Variance to Agency Cap (£)

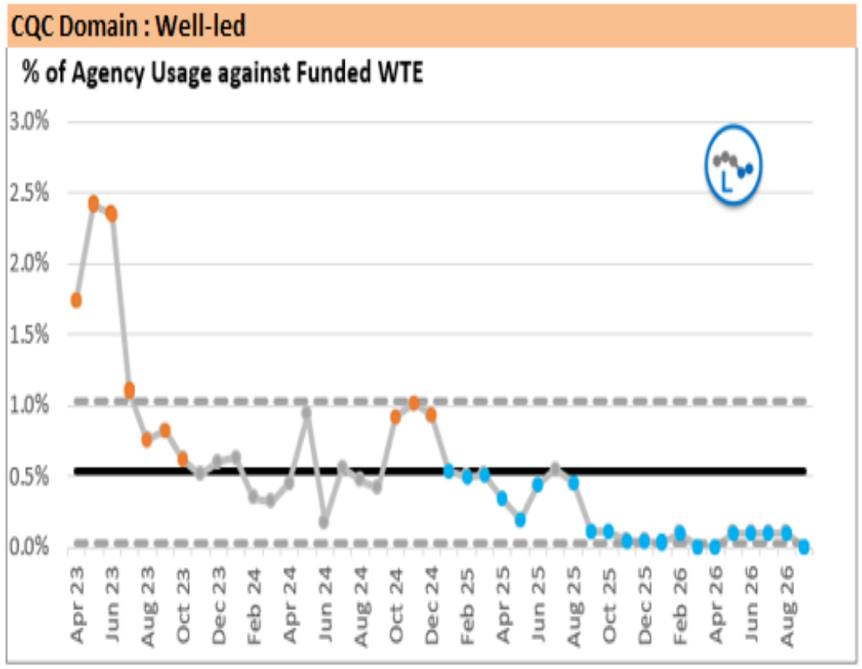
CQC Domain : Well-led




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

## % of Agency Usage against Funded WTE

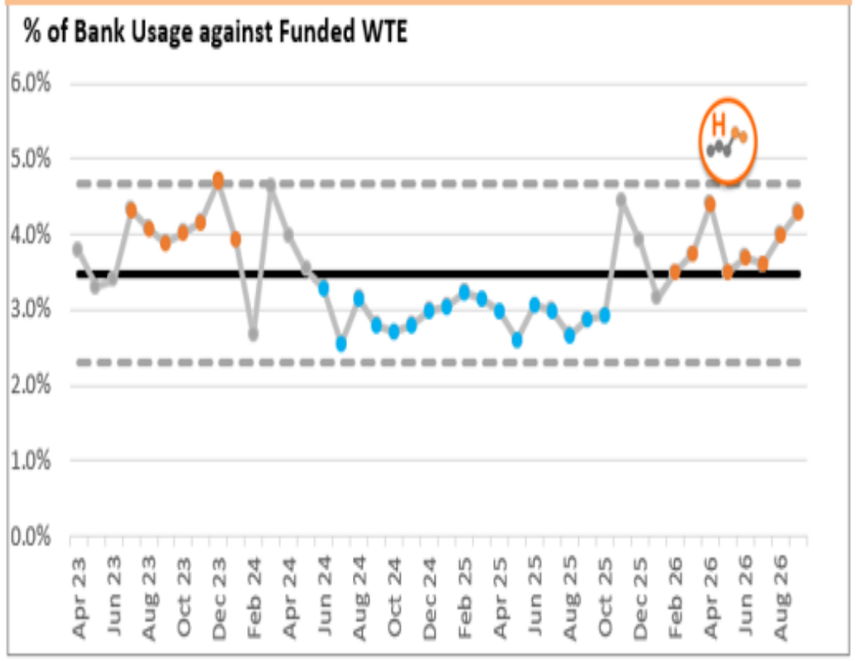
CQC Domain : Well-led




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

## % of Bank Usage against Funded WTE

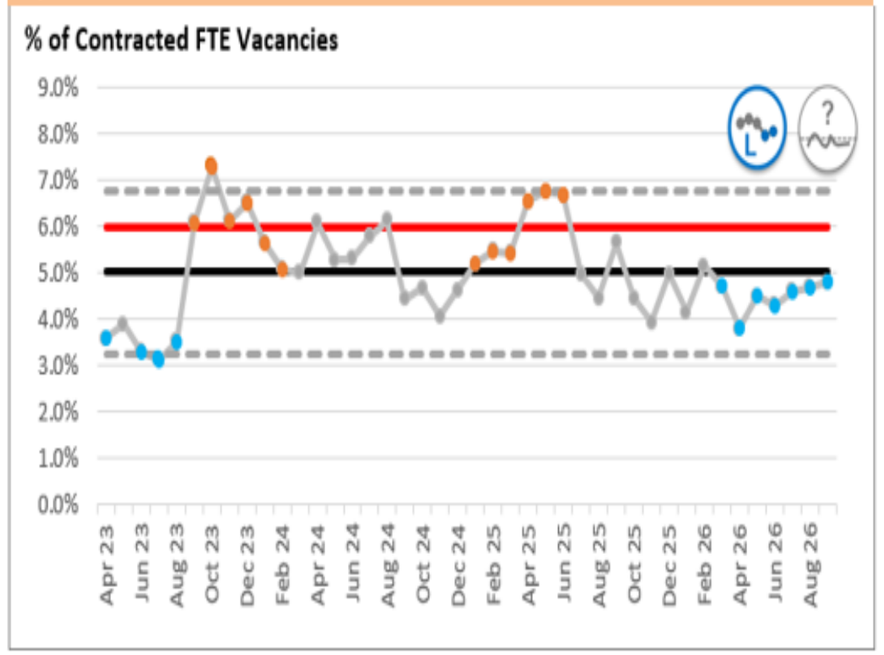
CQC Domain : Well-led




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

## % of Contracted FTE Vacancies

CQC Domain : Well-led




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

**WUTH Council of Governors** **Item No 12**

**WCHC Council of Governors**

**16 November 2026**

| | |
|---|---|
| **Title** | Fit and Proper Persons Annual Update |
| **Area Lead** | Ali Hughes, Joint Director of Corporate Affairs and Communications |
| **Author** | Cate Herbert, Company Secretary |

| **Purpose of the Report and Recommendation** | |
|---|---|
| **Report For** | Assurance |
| This report provides an annual update confirming completion of the Fit and Proper Persons checks and ongoing compliance, as well as the joint policy for approval.<br><br>It is recommended that the Council:<br>• Takes assurance that the Fit and Proper Persons annual tests have been completed and submitted successfully | |

| **Key Points to Note** |
|---|
| All members of the Board and any individual with "significant influence" over Board decision making are subject to the Fit and Proper Persons Test. The annual cycle of tests has been undertaken for all individuals and no areas of concern have been highlighted. The annual return was submitted to NHSE within the timescale of 30 June 2026. |

| **Key Risks** |
|---|
| This report relates to these key risks:<br>• BAF ID07 - Failure to comply with relevant codes of governance, regulation and legislative requirements |

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

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

| | |
|---|---|
| Improve & Innovate – We will make improvement and innovation part of how we work | No |
| Healthier Communities – We will drive health equity and support healthier lives | No |
| Collaboration and Partnerships – We will work as one system and one organisation | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | No |

| **Governance journey** | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 16 July 2026 | People Committee | Draft Fit and Proper Persons Policy | Approval of draft policy for submission to staff consultation |
| 30 September 2026 | People Committee | Fit and Proper Persons Annual Update and Policy | Approval of policy for submission to the Board. Assurance of completion of checks. |

| **1** | **Narrative** |
|---|---|
| **1.1** | **Fit and Proper Persons Annual Checks**<br>The Fit and Proper Persons Test consists of a series of checks that must be carried out on senior decision makers to ensure their integrity and fitness to discharge their office. The requirements were revised in 2023 to strengthen the NHS approach following the Kark review, and both WUTH and WCHC have policies which comply with these requirements. |
| **1.2** | The Fit and Proper Persons requirement applies to all permanent and interim Executive and Non-Executive appointments, and those who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>WCHC has historically interpreted the requirement and Regulation 5 to mean all Board members, and WUTH has extended the definition to include deputies to Executives.<br><br>All Executive and Non-Executives, and all Deputies who are employed by WUTH, are therefore subject to this requirement. These individuals were tested at the point either of recruitment or TUPE to WUTH, and then again as part of the annual cycle undertaken in May/June 2026. |
| **1.3** | The annual series of checks was undertaken in May/June 2026, in line with the WUTH and WCHC policies. Each individual's checks were signed off by the Director of Corporate Affairs and Communications and the Senior Independent Director (or the CEO and Chair for those two post holders). No concerns were raised as part of the process.<br><br>The annual return confirming compliance was provided to NHSE on 25th June 2026, meeting the deadline of the 30th June. The return has been acknowledged, with no further queries raised at the time of writing this report. |

| **2** | **Implications** |
|---|---|

| | |
|---|---|
| **2.1** | **Patients**<br>• Supports the delivery of safe, effective and well-governed services by ensuring that individuals in Board-level positions are suitably qualified, competent and fit to undertake their responsibilities. |
| **2.2** | **People**<br>• Provides a fair, transparent and consistent framework for the recruitment, assessment and ongoing review of Board members and senior leaders. |
| **2.3** | **Finance**<br>• No direct financial implications. |
| **2.4** | **Compliance**<br>• Assists the Trust to meet its statutory obligations under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and aligns with NHS England, CQC and internal audit expectations relating to the Fit and Proper Persons Test. |

| | |
|---|---|
| **Meeting** | Group Board of Directors in Public |
| **Date** | Wednesday 3 June 2026 |
| **Location** | Hybrid |

**Members present:**

| | | |
|---|---|---|
| SI | Steve Igoe | Joint Chair |
| SR | Dr Steve Ryan | Joint Non-Executive Director |
| LD | Lesley Davies | Joint Non-Executive Director |
| MD | Meredydd David | Joint Non-Executive Director |
| CB | Professor Chris Bentley | Joint Non-Executive Director |
| LG | Lisa Greenhalgh | Joint Non-Executive Director |
| JH | Janelle Holmes | Joint Chief Executive |
| CD | Chris Douglas | Joint Chief Nurse |
| HK | Hayley Kendall | Joint Executive Managing Director |
| JC | Dr Joanne Chwalko | Joint Chief Integration and Partnerships Officer |
| DS | Debs Smith | Joint Chief People Officer |
| MS | Matthew Swanborough | Joint Chief Strategy Officer |
| MC | Mark Chidgey | Joint Chief Finance Officer |
| AH | Ali Hughes | Joint Director of Corporate Affairs & Communications |
| GR | Gareth Robinson | Joint Director of Transformation & Turnaround |

**In attendance:**

| | | |
|---|---|---|
| CH | Cate Herbert | Board Secretary |
| JJE | James Jackson-Ellis | Corporate Governance Officer |
| CM | Chris Mason | Chief Information Officer |
| JL | Jo Lavery | Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 19 |
| AA | Dr Alice Arch | Guardian of Safe Working – item 23 |
| AArm | Alistair Armstrong | Cellular Pathology Manager and HTA Designated Individual – item 24 |
| SH | Sheila Hillouse | Lead Public Governor |
| TC | Tony Cragg | Public Governor |
| MT | Mark Taylor | Observer |

**Apologies:**

| | | |
|---|---|---|
| HS | Haris Sultan | Joint Non-Executive Director |
| NS | Dr Nikki Stevenson | Joint Chief Medical Officer |

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

| | | |
|---|---|---|
| | No interests were declared and no interests in relation to the agenda items were declared. | |
| **3** | **Minutes of Previous Meeting**<br><br>The minutes of the previous meeting held on 1 April were **APPROVED** as an accurate record. | |
| **4** | **Action Log**<br><br>The Group Board **NOTED** the action log. | |
| **5** | **Patient Story**<br><br>The Board received a video story from Paula highlighting her experience of end of life and bereavement care provided to her wife, Claire. The story described Claire's cancer diagnosis, which was not operable, and outlined a number of lapses in communication on the ward during the final days of her life.<br><br>SR reflected on a positive discussion at Joint Quality and Safety Committee, noting that a number of observations had been made, including positive feedback regarding the palliative care team and enhanced training. However, concerns were raised following comments from Paula that confidence had been lost due to the way individuals had been spoken to.<br><br>LD asked whether staff are able to see these stories.<br><br>CD confirmed that the stories have been shared with the Patient Safety and Quality Board (PSQB) and with the Divisional Director of Nursing (DDN).<br><br>JH commented on the challenges faced by those early on in their nursing career, particularly where individuals are dealing with death with limited prior experience. JH emphasised the importance of considering how junior staff can be better supported in these situations.<br><br>SI highlighted that these discussions often take place when people are at their most vulnerable and involve particularly challenging conversations. SI emphasised the importance of values, culture and treating patients with dignity, noting that hospitals can sometimes be organised around organisational needs rather than those of the patient.<br><br>The Group Board **NOTED** the video story. | |
| **6** | **Chair Update** | |

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| | SI reported on the Cheshire and Merseyside Provider Collaborative meeting, noting the progress made in regard to the regional blueprint.<br><br>SI advised that he had met with Deloitte regarding the statutory transaction programme. Discussions focussed on the drivers of the deficit and the importance of integration as a key factor in addressing these challenges.<br><br>SI also reported on a meeting with the NHS North West Regional Chairs, describing it as positive and helpful. Discussions covered the concerns regarding wider regional challenges, pressures and opportunities for system working in line with the regional blueprint.<br><br>SI advised that he had met with the St Helens 0-19 Team and welcomed the opportunity to engage with community-based staff and hear their views directly. SI also reported undertaking a visit to the Frailty SDEC service.<br><br>The Group Board **NOTED** the verbal update. | |
| **7** | **Joint Chief Executive Officer Report**<br><br>JH reported both Trusts maintain positive performance despite demand pressures, with improvements in referral to treatment, emergency care, cancer waits, and community services, monitored through the National Oversight Framework.<br><br>JH updated on the Hantavirus response, noting the Trust provided safe isolation accommodation for UK citizens repatriated from a cruise ship due to Hantavirus. JH added the Trust had received praise for rapid and effective mobilisation and strong partnership with national and local agencies.<br><br>JH referenced the Corridor Care Summit, highlighting this was a joint summit for teams from both Trusts to address corridor care, focusing on patient flow improvements and collaborative solutions to eliminate delays and enhance patient experience.<br><br>JH stated the WUTH Charity was named Merseyrail Charity of the Year, creating fundraising and engagement opportunities through community involvement and events.<br><br>JH updated on the NHS Cheshire and Merseyside Provider Collaborative Leadership Board meetings, noting focusses on management of change, financial recovery, integrated referral models, care coordination hubs, and system-wide digital platforms to support neighbourhood health frameworks and urgent care reform.<br><br>JH reported at WUTH one RIDDOR reportable event was investigated between March and April, with no new Patient Safety | |

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| | Incident Investigations opened, ensuring continuous safety reviews.<br><br>JH gave an oversight of staff recognition and engagement, noting the monthly all-staff briefings continue with strong attendance; events marked World Administrative Day, International Nurses Day, and Dying Matters Week; and multiple staff and volunteer awards recognised outstanding contributions across clinical and support services.<br><br>CB queried the plans on neighbourhood health frameworks and the associated governance arrangements, notably who would be the Accountable Officer and what governance arrangements would be put in place.<br><br>JH advised that, from a Wirral perspective, work was further ahead due to Wirral Provider Alliance and ICB changes. Clare Watson is leading this work, with partners considering future models and associated commissioning arrangements, which remain to be determined.<br><br>JC explained that neighbourhoods are being explored through the Wirral Provider Alliance, using the national framework. Six footprints have been agreed with partners. Work is also progressing to identify and assess potential neighbourhood health centre locations, including Arrowe Park, St Catherine's and Health on the High Street options.<br><br>JC advised that governance and compliance arrangements would sit with the ICB, while overall responsibility in Wirral would rest with the Health and Wellbeing Board. JC was satisfied with progress to date and noted that neighbourhoods are a system responsibility rather than being Trust-led.<br><br>LD asked whether partners outside the health sector would be included as part of neighbourhood arrangements and referenced the hub model.<br><br>JC confirmed that this detail is being worked through, including representation from the Council. There is sufficient representation around the table to inform discussions and support development of the model.<br><br>SR asked about the Frontis building, including its role in COVID and hantavirus responses, and whether future use of the building had been considered.<br><br>JH advised that discussions had taken place with the national team and that the building remains a valuable asset capable of supporting these functions. A business case is being developed to determine how best to take the proposal forward. | |

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| | The Group Board **NOTED** the report. | |
| **8** | **Joint Integrated Performance Report**<br><br>RM reported that as of April 2026 there were zero Never Events. All LOCSSIP actions had been completed. SHMI remained within the expected range, although an upward trend had been identified due to a coding backlog. This had now been corrected, and improvements would be reflected in forthcoming quarters.<br><br>CD explained C Diff cases had a slight reduction from the previous month, there were zero hospital-acquired category 3 or 4 pressure ulcers, staffing fill rates above thresholds with recruitment efforts, and zero MRSA but two MSSA bloodstream infections, reflecting ongoing quality and safety monitoring efforts at WUTH.<br><br>SR asked about the isolation of patients and whether improvements had been seen through reducing corridor care.<br><br>CD advised that there had been a reduction in May, with six cases recorded. Appropriate recognition of cases and prompt isolation remained key priorities. Work had also moved towards the use of HPV cleaning rather than ward misting.<br><br>HK reported continued improvements in four-hour performance, with the year finishing ahead of all trajectories. RTT performance had improved, and the Trust remained on track to achieve the 28-day Faster Diagnosis Standard by year-end. Type 1 performance remained a significant challenge. Although only small increases had been seen, these were important in supporting sustainability. Attendances were 15% higher than planned, with walk-in activity contributing significantly to demand. New pathways introduced from July onwards were expected to deliver further improvements.<br><br>HK added twelve-hour performance remained challenged, although new Divisional leadership team were in place and improvements to SDEC processes were being implemented. Elective RTT pathway improvements were being delivered through the Q2 programme. DM01 performance was below the 95% target due to non-obstetric ultrasound activity but was expected to be compliant for May.<br><br>SR asked what was driving the increasing number of patients meeting criteria to reside.<br><br>HK explained that increasing patient numbers continued to impact on 12-hour waits. The most complex pathways were primarily within Pathway 3, where patients were often unsuitable for CICC. Improvements had been seen in recent weeks, with ongoing work alongside the Council. Opportunities were also being explored | |

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| | within Pathway 2, including greater utilisation of M1 capacity at Clatterbridge.<br><br>SI queried the long lengths of stay.<br><br>HK highlighted efforts were focused on balancing this work with streaming activity from ED. Looking ahead, changes through the urgent care programme were planned for September, alongside collaboration with the ICB on a wider review of urgent care services. It was also noted that an appointment had been made to the new GP Led to support workforce development within the department.<br><br>MD welcomed the increase in green-rated indicators and acknowledged the improvements that had been achieved.<br><br>MC reported at the end of April 2026, month 1, WUTH is reporting a balanced position against plan year to date. The M1 position includes the impact of industrial action, which is assumed to be funded from a combination of local and national mitigations. The Trust's financial plan is yet to be agreed with NHSE and therefore remains subject to revision.<br><br>MC confirmed the identified three key risks in the WUTH plan were full CIP delivery, activity/case mix and maintaining grip and control.<br><br>MC stated the cash balance was £2.7m at month end, meeting NHSE minimums but posing ongoing challenges to payment practices; mitigation actions include payment management, CFO oversight, debt recovery, and national cash support applications.<br><br>MC reported at the end of April 2026, month 1, WCHC is reporting a £0.1m surplus to plan, with the overall year to date position presented with no variance to plan. MC stated the reported position reflects favourable performance across pay and non-pay expenditure, partially offset by an early shortfall in delivery of the Cost Improvement Programme (CIP).<br><br>MC noted while the reported financial position is positive at this early stage, the planned workforce and CIP positions for 26/27 are not yet realised and therefore the Trust has not yet delivered the required fully sustainable underlying improvement.<br><br>LG asked whether the costs associated with high-cost drugs and devices within M1 were expected to continue throughout the year.<br><br>MC explained that under Payment by Results these costs were passed through to the ICB. New changes had been introduced regarding the definition and exclusion of certain drugs and devices, and the position within M2 was currently under review.<br><br>DS reported that sickness absence remained above target but was under control and continuing to improve. The sickness absence | |

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| | programme remained a key element of the deficit reduction programme. Work was underway to better understand the root causes of sickness absence within specific staff groups where issues were not directly related to illness. Feedback from Clinical Support Workers indicated that ward movements were a contributing factor. Mandatory training compliance remained below target, primarily due to Level 1 Fire Safety Awareness training, although improvement work continued. Appraisal compliance was less than 1% below target.<br><br>DS noted that appraisal processes were not yet fully embedded across the Trust to the same degree as mandatory training. A strategic programme of work over the next two years would incorporate appraisal delivery as part of wider cultural improvement initiatives.<br><br>Members agreed that the improvements in sickness absence were positive and aligned with the objectives of the drivers of the deficit programme.<br><br>DS further reported that from a WCHC perspective, turnover remained in line with the workforce plan. Sickness absence continued to exceed the threshold at 6.4%. As previously reported to the Board, this would take time to address, with the same programme and principles now being targeted within WCHC.<br><br>MD noted that turnover reporting combined controlled and uncontrolled turnover and asked whether future presentations could separately identify turnover resulting from planned WTE reductions.<br><br>DS advised that this was difficult to present clearly. However, from a Board perspective, turnover remained in line with plan and was not considered a concern.<br><br>The Group Board:<br>• **NOTED** performance to the end of April 2026 (or latest available months data);<br>• **NOTED** the summary position reflecting the latest publication of the NOF is also included in the IPR;<br>• **NOTED** that the WUTH plan has not been approved by NHSE and that further measures are required to meet the mandated control total;<br>• **NOTED** that WUTH's most immediate finance risk remains the cash position, that the Trust continues to follow the agreed processes for mitigating this issue and therefore to;<br>• **APPROVED** that the CFO submits additional applications based on confirmed need for WUTH;<br>• **APPROVED** the revisions to WUTH's capital budget; and<br>• **NOTED** that full CIP delivery is required to achieve the planned sustainable financial position for WCHC | |

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| **9** | **Board Assurance Framework (BAF)**<br><br>AH reported multiple Joint Committees reviewed and agreed on risk appetites and ratings for various strategic risks between April and May 2026, with ongoing oversight planned.<br><br>AH added of twelve strategic risks, nine have been reviewed; six currently score as high-level risks, including management of unscheduled and planned care, workforce challenges, financial plan delivery, service transformation, and cyber-attack risks.<br><br>In light of current organisational performance, JH suggested that the risk ID01 should be reviewed again by the relevant Committee and expressed the view that the current score of 16 may need to be increased.<br><br>CB welcomed the progress being made and highlighted the importance of having visibility of WCHC controls and assurance arrangements.<br><br>JH agreed and noted that the BAF should be reviewed to ensure WCHC mitigations are clear. JH also highlighted the reputational perspective, noting that all NOF1 measures on the BAF were currently rated red.<br><br>AH advised that a Joint Strategy was in place and that organisational risks were being mapped. It was noted that these points would be considered as part of the next iteration of the BAF.<br><br>CB sought assurance regarding internal audits perspective on the approach being taken.<br><br>AH confirmed that internal audits had already reviewed and tested the arrangements and that there was a level of assurance with the current approach.<br><br>MD commented that there had been robust discussions within the Committees and that assurance was being triangulated effectively across both organisations.<br><br>CB commented that risks from each Trust are currently discussed in different forums, making alignment more challenging across the two Trusts.<br><br>AH explained that risks are presently considered through Executive Assurance and Risk Committee at WUTH and Integrated Performance Board at WCHC. Work had commenced to improve consistency in thematic reporting, with the next ambition being the development of a single report bringing together organisational risks across both Trusts.<br><br>The Group Board: | |

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| | • **REVIEWED** the detail shared in relation to each of the risks and the new format of the BAF agreed in April 2026; **REVIEWED** the risk ratings noting that there are currently 5 high-level strategic risks;<br>• **APPROVED** the position reported; and<br>• **NOTED** that further work through the Committees of the Board will continue to monitor each of the risks | |
| **10** | **Lead Governors Report**<br><br>SH provided an update on the Cheshire and Merseyside Lead Governors Network, noting its proactive approach to discussions regarding the future of governor roles and the continued importance of the governor function. Work was underway at both national and local levels, including the development of a storyboard to raise awareness of the governor role in partnership with WCHC.<br><br>SH highlighted concerns that important elements of the role, including the scrutiny of Non-Executive Directors and governor involvement in NED appointments, could be lost through future changes.<br><br>SH asked what arrangements were being considered in relation to member participation and what level of risk any changes may pose to the Board's accountability and scrutiny functions.<br><br>AH advised that NHS Foundation Trusts were currently awaiting guidance regarding the implications of the forthcoming Health Bill. Work was being undertaken to consider the potential impact should the legislation progress and to ensure compliance with any new requirements.<br><br>AH confirmed that a range of engagement and accountability mechanisms were already in place, but these would need to be reviewed once further national guidance was available.<br><br>LD expressed appreciation for SH's contribution, particularly through attendance at the People Committee, and noted that the advisory and scrutiny link provided by Governors would be missed.<br><br>CB commented on the valuable internal contribution Governors make to Committee discussions and organisational oversight.<br><br>SI thanked SH and the Governors for their contributions, engagement and constructive discussions, recognising the value they had brought to the Trusts.<br><br>The Group Board **NOTED** the verbal update. | |
| **11** | **Joint Committee Chairs Reports – Quality and Safety Committee** | |

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| | SR alerted members that demand continues to exceed capacity in some services, with staffing vacancies affecting access and flow. Previous backlogs in acute macular degeneration have reduced significantly. Current pressures remain in PEG services, resulting in longer stays for a small number of patients, and in inflammatory bowel disease follow-up appointments. Recruitment and business case development are underway to address these issues.<br><br>SR also alerted members that following improvements in March and April, increased unscheduled care demand in May led to a deterioration in corridor care performance. A Trust-wide summit identified actions to improve flow and resilience, with the Committee continuing to monitor the impact on patient quality, safety and experience.<br><br>SR summarised the various "Advise" and "Assure" matters from the meeting on 29 May.<br><br>The Group Board **NOTED** the report. | |
| **12** | **Joint Committee Chairs Reports – Digital Committee**<br><br>MC provided this update in the absence of HS.<br><br>MC alerted members that Freedom of Information and Subject Access requests for WUTH were non-compliant. The Committee received and supported an improvement plan, including additional resources, digital workflow improvements and performance dashboards to improve the position.<br><br>MC also alerted members that clinical coding capacity remains a significant risk nationally, and WUTH has been more acutely impacted than many other trusts. The Committee was assured there is no current financial impact and received a mitigation plan.<br><br>MC alerted members that cyber resilience and business continuity were an area of focus. The Committee sought and received assurance that lessons learned from the previous cyber incident have been reviewed and embedded.<br><br>MC summarised the various "Advise" and "Assure" matters from the meeting on 16 April.<br><br>SR asked about the implementation of AI.<br><br>MC advised that elements of AI development are included within the 2026/27 plan. It was agreed that there is a need for an AI policy covering acceptable use and the handling of confidential information. MC noted that AI is a key element of the Trust's strategy, with a digital review forming part of the wider transformation programme. | |

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| | The Group Board **NOTED** the report. | |
| **13** | **Joint Committee Chairs Reports – Finance and Performance Committee**<br><br>MD alerted members that at the end of March 2026 (M12), WUTH is reporting a deficit of £49.5m. This is in line with the forecast that the Trust submitted to NHS England in February but, excluding DSF, is a £27.3m adverse variance to plan.<br><br>MD also alerted members that at the end of March 2026 (M12), WCHC is reporting a surplus of £5.1m, which was a £4.2m positive variance to plan, and this has been reported to NHSE.<br><br>MD summarised the various "Advise" and "Assure" matters from the meeting on 22 April.<br><br>The Group Board **NOTED** the report. | |
| **14** | **Joint Committee Chairs Reports – Finance and Performance Committee**<br><br>MD provided a verbal update from meeting held on 21 May, alerting members that cash remains WUTH's most immediate risk, with a closing balance of £2.7m and continued reliance on national support. The Committee noted the June cash support application had been approved and authorised future submissions in line with the cash flow forecast.<br><br>MD advised members that the Committee noted that both Trusts were reporting in line with plan at Month 1, with WUTH reporting a £2.9m deficit and WCHC a £0.2m surplus. Good progress was reported against the £36.7m CIP target, with schemes equivalent to 105% of the target identified and work underway to achieve 120% coverage to reduce risk.<br><br>MD assured members that that Committee received an update on the future utilisation of the WUTH and WCHC estate, noting the focus on efficiency and alignment with the NHS 10-Year Plan. Further updates will be provided as the work progresses.<br><br>The Group Board **NOTED** the report. | |
| **15** | **Joint Committee Chairs Reports – People Committee**<br><br>LD provided a verbal update from the meeting held on 27 May.<br><br>LD alerted members that sickness absence remained an area of focus, with interventions being implemented across both Trusts. It was noted that issues had been identified within Surgery Division and a deep dive had been requested on their workforce performance indicators. | |

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| | LD advised members that integration work was progressing well. However, there remains a risk that the planned implementation timetable could move from April 2027 to August 2027, with associated implications for financial delivery and workforce establishment reductions. The Committee also received the Nursing and Midwifery workforce report, noting shortages in Clinical Support Workers (CSWs). Recruitment activity was reported as positive, with 13 appointments having been made within the Emergency Department.<br><br>LD assured members that the Committee had received the end-of-year People Strategy report for 2025/26 and had also considered priorities for the 2026/27 People Strategy. Employee relations activity remained low as a proportion of the workforce. The Committee also received assurance regarding the work of the Guardian of Safe Working and staffing oversight arrangements.<br><br>LD reported that the Committee had discussed the BAF and considered opportunities to strengthen the way staff experience and culture is reflected. It was agreed that further detail on this aspect would be brought to the July meeting.<br><br>SI highlighted the need to manage staff morale in the context of workforce changes.<br><br>DS agreed and advised that this must be Board-led, noting that employee experience had already been affected by organisational pressures and uncertainty at the time of the staff survey.<br><br>DS acknowledged that integration would bring change and, given the NHS financial position. She noted that colleagues across both Trusts were keen to work together clinically to improve patient care and services and emphasised that organisational culture must be owned and led by the Board.<br><br>MD emphasised the importance of communication at every level of the Trust and highlighted the need for managers to be well developed and trained in change management. He also noted the importance of having a consistent script and message.<br><br>DS referenced the corporate services organisational change as a relevant example for this.<br><br>LG suggested sharing a staff story on integration.<br><br>AH reported that work was being progressed using case studies from Cardiology and MSK to demonstrate both clinical improvements and impacts on employee experience, involving colleagues from both Trusts. | |

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| | SI concluded by emphasising the importance of not losing sight of the impact on staff during these conversations and maintaining open and honest communication throughout the process.<br><br>The Group Board **NOTED** the report. | |
| **19** | **WUTH Quarterly Maternity and Neonatal Services Report**<br><br>JL provided the Perinatal Quality Oversight Model report, noting this was in a new slide format with clearer format for presenting key quality and safety metrics aligned with national and regional expectations.<br><br>JL advised there were no Patient Safety Incident Investigations (PSIIs) were declared in maternity or neonatal services in April 2026, with ongoing transparent reporting and governance processes for cases under review.<br><br>JL provided an update regarding the Maternity Incentive Scheme Year 8, highlighting the Trust is progressing towards full compliance with the six revised MIS Safety Action Standards for 2026, supported by strengthened governance and monthly assurance reporting.<br><br>JL explained for Saving Babies', the Trust achieved 100% compliance with all six elements as of March 31, 2026, marking an increase from the previous quarter and ongoing internal monitoring.<br><br>JL confirmed for Ockenden, the full review confirms that WUTH remains fully compliant with the 15 Immediate and Essential Actions from the Ockenden Review, maintaining a stable RAG-rated position.<br><br>JL stated for the Three-Year Delivery Plan focus areas include compassionate engagement with women and families, workforce growth and retention, safety culture development, and equitable personalised care, with progress monitored via the Maternity and Neonatal Quality Assurance Board.<br><br>JL updated on the maternity workforce, reporting the maternity service operates two care models, including six Continuity of Carer teams, meeting Birth Rate Plus workforce standards.<br><br>JL referenced the annual joint visit by NHSE and LMNS in March 2026 provided initial positive feedback, with written feedback included for Board reference, supporting ongoing neonatal service improvements.<br><br>JL referenced the Perinatal Mortality Review Tool reports for Q3 and Q4 of 2025/26 and the MBRRACE-UK Perinatal Mortality Report for Arrowe Park Hospital are included, supporting continued mortality oversight. | |

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| | CD welcomed the new slides and the clear display of information, noting that it provided the Board with useful assurance and enabled appropriate scrutiny.<br><br>HK queried whether there were any concerns regarding Standard 4 compliance, specifically the Tier 1 and Tier 2 staffing gaps referenced and sought clarification on the risks associated with these gaps.<br><br>JL advised that further work was required and suggested exploring whether rota arrangements could be amended before increasing the establishment. JL noted that an approved workforce action plan was required and suggested this should align with forthcoming inquiry recommendations.<br><br>LG queried the reference in section 9.1 regarding reductions in maternity staffing and sought assurance that no headcount reductions were taking place.<br><br>DS agreed to confirm if there were any planned maternity headcount reductions.<br><br>SR acknowledged the implementation of the new MOSS system, noting that it is an external alerting system and does not generate organisational alerts.<br><br>JL agreed and stated that a MOSS test had been undertaken successfully.<br><br>JH highlighted the importance of staff morale and asked how staff could be reassured that the organisation remains a safe place to have babies.<br><br>JL advised that communications with staff focus on positive developments and improvements, with the role of the Maternity Champion being a key element of this approach.<br><br>The Group Board:<br>• **NOTED** the report and associated appendices.<br>• **NOTED** the Quality Oversight Model (PQOM) report.<br>• **NOTED** the position of the Maternity and Newborn Safety Investigations (MNSI) and any declared PSII's.<br>• **NOTED** the position of MIS Year 8 and the board oversight requirements supported by the Quality Committee and Maternity and Neonatal Assurance Meeting.<br>• **NOTED** compliance of 100% with Saving Babies Lives v3.<br>• **NOTED** continued compliance with Ockenden, the Three-Year Delivery Plan and the Maternity Programme on-line Portal (MPOP). | Debs Smith |

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| | • **NOTED** the position with the maternity self-assessment requiring annual Board oversight.<br>• **NOTED** the maternity staffing paper and compliance with Birthrate plus recommendations.<br>• **NOTED** the neonatal staffing paper required to the Board 6 monthly and the improvements required to be BAPM compliant.<br>• **NOTED** the PMRT reports for Q3 and Q4 25/26.<br>• **NOTED** the MBRRACE UK Perinatal Mortality Report for 2024; and<br>• **NOTED** the official feedback from the NHSE visit held in March 2026. | |
| **20** | **WUTH Biannual Establishment Review**<br><br>CD set the outcome of the biannual review which used the adult safer nursing care tool, noting most adult inpatient wards maintain current staffing levels, with some skill mix changes and a few proposed adjustments.<br><br>CD added Maternity uses Birthrate Plus tool with full establishment recruited, Children's services face risks related to staffing and patient transfers, Neonatal and Critical Care units follow national guidance with some gaps in supportive roles noted.<br><br>CB asked whether there is an equivalent process for WCHC and, as services move towards a neighbourhood-based model, how neighbourhood baselines will be established and how a similar evaluation approach could be applied to community services and WCHC.<br><br>CD advised that the Safe Nursing Staffing Tool has been applied in three wards in WCHC. However, the tool is designed for acute settings and does not translate well to community environments. Work is underway to explore how the tool can be adapted for intermediate care settings.<br><br>CD noted that there is currently no national tool for assessing community workforce requirements and that opportunities to develop this are being explored. From next year, a combined establishment review will be undertaken.<br><br>SR asked whether this work feeds into WISE accreditation as a means of demonstrating to the public where high-quality care is being provided.<br><br>CD confirmed that WISE is currently under review and that this work could be incorporated as part of that review.<br><br>The Group Board **NOTED** the report. | |

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| **21** | **Joint Patient Safety Incident Response Policy and Framework Plans**<br><br>CD provided the Joint Patient Safety Incident Response Policy, noting this aligns with the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how WUTH and WCHC will develop and monitor effective safety systems to improve patient safety culture.<br><br>CD advised the joint policy and individual PSIRF plans will support identifying patient safety learning across shared pathways, aiding future service integration, reflecting jointly agreed priorities and robust monitoring mechanisms.<br>CD noted the policy and PSIRF Plans have undergone approvals through multiple forums including Patient Safety Quality Board and Joint Quality and Safety Committee.<br><br>CB raised a query regarding incidents, noting that not all incidents are hospital-related and may involve community incidents. He asked whether incidents managed on a system partner basis are included.<br><br>CD advised that incidents spanning a number of organisations would be included within the reporting. She noted that this area could be strengthened further and would be reviewed and developed over the next year.<br><br>JH commented that where incidents involve different system partners, it is for those organisations to determine how they wish to take matters forward.<br><br>The Group Board:<br>• **APPROVED** the Joint Patient Safety Incident Response Policy;<br>• **NOTED** the WUTH Patient Safety Incident Response Plan; and<br>• **NOTED** the WCHC Patient Safety Incident Response Plan | |
| **22** | **WCHC Infection Prevention and Control (IPC) Annual Report**<br><br>CD provided an overview of the Trust's compliance with infection prevention standards and regulatory requirements. CB reported in respect of the IPC BAF six criterions were fully compliant and four partially compliant.<br><br>CD stated Trust-wide compliance reached 98.4% for Level 1 IPC training and 90.3% for Level 2 IPC training, alongside 88.9% completion of the hand hygiene audit program.<br><br>CD added the Trust recorded zero cases of C Diff infection and MRSA bacteraemia attributed to the Community Trust. | |

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| | The Group Board:<br>• Were **ASSURED** that IPC systems and processes continue to be robustly implemented to effectively evidence compliance with The Code of Practice on the Prevention and Control of Infections, Care Quality Commission Health and Social Care Act 2008, Regulation 12; and<br>• **APPROVED** the report. | |
| **23** | **WUTH Guardian of Safe Working Annual Report (including Q4 2025/26)**<br><br>AA provided an overview of the exception reports, noting for Q4 2025/26, 281 exception reports were raised regarding working hours, and all were closed across various departments and grades, with no outstanding reports. Annual data shows 278 reports raised and closed with no outstanding.<br><br>AA stated exception report response times remained strong with most reports being closed within 48 hours and within 7 days.<br><br>AA added there were 16 training-related exception reports raised and all were closed in Q4, with annual figures showing 68 raised and closed, indicating active monitoring of educational issues.<br><br>AA highlighted two work schedule reviews led to adjustment. However, significant resident-level vacancies continue to impact staffing, causing increased exception reports related to short staffing and shift coverage.<br><br>AA noted there had been increase in exception reports since August 2025 reflects both heightened awareness and implementation of a new reporting framework in February 2026.<br><br>LG queried the 31-50 days taken to address an exception report and why this occurred.<br><br>AA advised that this is being addressed through clinical supervisors. A new framework has been introduced, with issues initially managed through the Central Resourcing Team and escalated to GOSW where there are problems with the validation of reports.<br><br>HK acknowledged the concerns regarding the vacancies and advised that a business case is being developed to increase the number of resident doctors. This is expected to support mitigation of the high-level risk associated with the medical rota.<br><br>The Group Board **NOTED** the report. | |
| **24** | **WUTH Mortuary Services Annual Report 2025/26** | |

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| | AArm provided an overview of the report, noting the Trust remains compliant with the Human Tissue Authority licensing standards and its accreditation.<br><br>AArm stated in December 2025 UKAS inspection produced four mortuary-related findings, all of which have now been addressed.<br><br>AArm referenced the serious security breach in December 2025, no harm or interference with the deceased occurred, but unauthorised access was identified. It was the first reported security breach since the revised HTA security standards were introduced in 2022, and there had been no reported security incidents before that. AArm added several immediate and longer-term security improvements have been introduced.<br><br>AArm summarised the Fuller Inquiry phase 2 recommendations with the Trust's response to date to meet and embed these recommendations.<br><br>SR commented there had been discussion in Joint Quality and Safety Committee regarding who the accountable Executive Director should be for the mortuary, as the guidance states this should be the Chief Nurse, but the licence holder is the CMO. It was agreed this would be clarified and confirmed to satisfy the Fuller recommendations.<br><br>HK commented that the security breach had been thoroughly investigated and queried if regular and ongoing audits where now in place to ensure appropriate access controls remained in place.<br><br>AA confirmed that these audits are programmed into the work plan and that there is effective collaboration with the Head of Security.<br><br>The Group Board:<br>• Were **ASSURED** that the processes and governance in place in the mortuary are robust and compliant with the HTA and license conditions;<br>• Were **ASSURED** around the response to the recommendations in the Fuller inquiry phase 2 report that directly affect the mortuary and the role of designated individual;<br>• **NOTED** the specific recommendations from the Fuller inquiry phase 2 report that require action/assurance from the executive board; and<br>• Were **ASSURED** from the actions implemented in the mortuary to improve security following a serious security breach incident. | Dr Nikki Stevenson/Chris Douglas |
| **24** | **WUTH Registers of Interest and Hospitality Annual Update**<br><br>CH reported the end of year position, stating as of 31 March, there were 1672 staff who fall within the categories outlined in the Trust | |

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| | policy and 1444 of those have completed their annual declaration/review.<br><br>CH highlighted this is 86% of those required which remains better than the sector best practice figure of 85%.<br><br>Members acknowledged this was a positive position for the Trust.<br><br>CH added the hospitality register had also been included and regular comms was scheduled throughout the year to remind staff to declare this.<br><br>The Gorup Board **NOTED** the Register of Interests at Appendix 1, and the Register of Gifts and Hospitality at Appendix 2. | |
| **25** | **Modern Slavery Statements**<br><br>CH provided the Modern Slavery Statements for approval, noting this year's statements have been updated in discussion with the Joint Director of Corporate Affairs & Communications and the Assistant Director of Finance – Head of Procurement.<br><br>CH added following approval, both statements will be signed by the Chair and the CEO and published on the Trust websites.<br><br>**The Group Board:**<br>• **APPROVED** the WUTH Modern Slavery Statement; and<br>• **APPROVED** the WCHC Modern Slavery Statement | |
| **26** | **Questions from Governors and Public**<br><br>No questions were raised. | |
| **27** | **Meeting Review**<br><br>Members agreed it had been a good meeting with strong triangulation of risk and performance between the Integrated Performance Board and the BAF. | |
| **28** | **Any other Business**<br><br>Members thanked DS and SH for their contributions and support, who were leaving the Trust. | |

*(The meeting closed at 12:15)*

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

**Members present:**

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

**In attendance:**

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

**Apologies:**

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

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

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| **2.** | **Declarations of Interest**<br><br>No interests were declared and no interests in relation to the agenda items were declared. | |
| **3.** | **Minutes of Previous Meeting**<br><br>The minutes of the previous meeting held on 3 June were **APPROVED** as an accurate record. | |
| **4.** | **Action Log**<br><br>The Group Board **NOTED** the action log. | |
| **5.** | **Patient Story**<br><br>The Board received a video story from Clare highlighting her experience as a birthing partner and retired midwife. The story described Clare's her positive experience of being a birthing partner during a birth in the maternity and neonatal wards.<br><br>Members agreed this was a positive patient story.<br><br>The Board **NOTED** the video story. | |
| **6.** | **Chair Update**<br><br>SI thanked the Executive Team for robustness and level of detail provided in the reports.<br><br>SI advised that an Extraordinary Board meeting was held to discuss the Winter Plan Board Assurance Statements which had been submitted to NHSE. SI also encouraged staff to take up the offer of vaccination.<br><br>SI advised that the Urgent and Emergency Care Upgrade Programme (UECUP) had finished and the new facility was open.<br><br>SI reported that various meetings had taken place with the NHSE regarding the statutory transaction Statement of Case. SI had also joined a national meeting to discuss issues relating to neonates and maternity.<br><br>SI reported that further Finance Performance Recovery Meetings had taken place, with work progressing at pace to deliver the required outcomes.<br><br>The Board **NOTED** the verbal update. | |
| **7.** | **Chief Executive Officer Report**<br><br>JH highlighted positive performance across both Trusts despite sustained demand, including improvements in elective, urgent and emergency care, cancer and community services. | |

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

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

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| | activity, with continued focus required on capacity, resources, grip and control. Performance for Type 1 remained below the required level, while ambulance handover performance needed to be maintained.<br><br>HK advised that work within UEC included zoned clinic teams, nursing and medical teams and daily huddles. Executive performance reviews were considering ongoing issues, with stronger Executive presence in the department to provide a visible presence. August RTT performance was expected to be achieved, although September remained a risk.<br><br>LD welcomed the positive position regarding patients waiting over 12 hours and queried gaps in the resident doctor rota out of hours.<br><br>HK advised that the August rotation had resulted in some staff being unavailable. The rota was also being considered in the context of financial recovery.<br><br>LD queried preparations for winter and ambulance handovers.<br><br>HK advised that work was ongoing for this winter in line with the winter plan. An Urgent Care Coordination Centre for Wirral was planned from the following year, which was expected to support greater impact.<br><br>SR queried the current position for mental health patients, noting previous issues.<br><br>HK advised that changes in processes and capacity within the mental health provider had resulted in a small proportion of 12-hour breaches.<br><br>SR queried whether harm reviews were undertaken for patients experiencing long waits, including within elective care.<br><br>NS advised that dynamic risk assessments were undertaken based on prolonged waits. Formal risk assessment arrangements were in place for elective pathways but for urgent care. Cases involving moderate harm or above were reported through the governance structure and considered through the Patient Safety Response Panel, linking with PSIRF.<br><br>HK provided an update on WCHC. UEC, walk-in and UTC performance had been maintained, with improvement at VCH. CICC performance compared well with others, alongside progress on waiting lists and RTT.<br><br>HK advised areas of concern included CAS response times, which had increased in July, although progress had subsequently been made with further work required. Community dental services and seven-day ECGs remained areas of focus. | |

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

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

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

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

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

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| | LD summarised the various “Advise” and “Assure” matters from the meeting on 9 July.<br><br>The Board **NOTED** the report. | |
| **16.** | **WUTH Maternity and Neonatal Services Report**<br><br>JL and MSa provided assurance on the quality, safety, performance, risks, and improvement work across maternity and neonatal services.<br><br>JL and MSa stated no maternity or neonatal Patient Safety Incident Investigations were declared in July 2026, and there were no new Maternity and Newborn Safety Investigation referrals or active investigations. The Perinatal Quality Oversight Model continues to provide structured oversight of incidents, outcomes, workforce, patient experience, risks, and improvement activity.<br><br>JL and MSa explained Maternity Incentive Scheme Year 8 delivery remains on track, with the Training Compliance Touch Point achieved. The Trust has strengthened evidence tracking to support compliance with all six Safety Action Standards.<br><br>JL and MSa updated on workforce and service capacity, noting consultant obstetric attendance standards remain compliant, and planned Caesarean birth capacity is sufficient to meet demand. However, neonatal workforce standards remain non-compliant, requiring Board approval of a three-year improvement plan; additional funding and recruitment opportunities are also supporting maternity workforce sustainability.<br><br>JL and MSa reported the Trust maintains 100% compliance with all six elements of the Saving Babies’ Lives Care Bundle Version 3, while the Maternal Care Bundle is 50 percent compliant and targeted for full implementation by March 2027.<br><br>JL and MSa explained the Trust has developed action plans responding to the Nottingham Ockenden Review and AMOS findings, addressing governance, incident learning, staffing, training, fetal surveillance, risk assessment, documentation, and engagement with women and families.<br><br>MD raised whether, given the increasing number of national requirements and guidance, there was a point at which existing requirements could be removed rather than continually adding further expectations.<br><br>JL advised as recommendations were removed or embedded into practice, further requirements were often added. She noted the importance of sustaining improvements once embedded. | |

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

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| | • **NOTED** MIS Year 8 delivery remains on track, with successful achievement of the Training Compliance Touch Point and continued progress towards final submission in March 2027.<br>• **NOTED** compliance has been maintained with Saving Babies' Lives Care Bundle Version 3 and consultant obstetric attendance standards.<br>• **NOTED** the planned Caesarean Birth Capacity Mapping confirms capacity remains sufficient to meet demand, supported by two additional elective Caesarean section sessions introduced during 2025.<br>• **NOTED** the Homebirth Service Safety and Quality Review confirmed that WUTH continues to provide a safe, sustainable, and well-governed homebirth service.<br>• **NOTED** Neonatal workforce standards remain non-compliant; a three-year workforce improvement plan requires Board approval.<br>• **NOTED** Progress continues across the Maternal Care Bundle, Perinatal Equity and Anti-Discrimination Programme (PEADP), maternity triage improvements, organisational development programme, and workforce initiatives.<br>• **NOTED** The Trust has reviewed the findings of the Nottingham Ockenden Review and the AMOS Review and has established action plans to address identified recommendations.<br>• **NOTED** PMRT reviews have identified learning opportunities, with strengthened multidisciplinary review processes now in place for all neonatal deaths. | |
| **17.** | **WUTH Infection Prevention and Control Annual Report 2025/26**<br><br>CD highlighted that the report explains how the Trust demonstrated compliance with Regulation 12 of the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the ten associated criteria, the National IPC Board Assurance Framework, and IPC standards.<br><br>CD explained although the Trust exceeded the NHS threshold for C Diff in 2025/26, it recorded 16 fewer cases than in the previous year. An IPC improvement plan is to support targeted work during 2026/27, with the aim of preventing further cases and avoiding exceedance of the next threshold.<br><br>CD added significant changes occurred in IPC leadership during 2025/26 and anticipates that a more stable structure in 2026/27 will strengthen the integration of IPC into organisational decision-making.<br><br>The Board were **ASSURED** that IPC systems and processes continue to be robustly implemented to effectively evidence | |

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

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

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

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

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

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

*(The meeting closed at 12:45)*