NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

1 October 2025

09:00 GMT+1 Europe/London

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1. BOARD OF DIRECTORS IN PUBLIC

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Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community Health and Care NHS Foundation Trust

Notice of Meeting

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

Meeting	WUTH and WCHC Board of Directors in Public
Date	Wednesday 1 October 2025
Time	09:00 – 12:30
Location	Hybrid

Page		Agenda Item	Lead	Presenter
	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
9 24	3.	3.1 Minutes of the Previous Meeting – WUTH 3.2 Minutes of the Previous Meeting – WCHC	Sir David Henshaw	
35	4.	Action Logs	Sir David Henshaw	
	Standing Items			
	5.	Staff Story	Debs Smith	
	6.	Joint Chair Update – **Verbal**	Sir David Henshaw	
37	7.	Joint Chief Executive Officer Report	Janelle Holmes	
45	8.	WCHC Integrated Performance Report	Executive Directors	
70	9.	WUTH Integrated Performance Report	Executive Directors	
95	10.	WUTH Chief Finance Officer Report	Mark Chidgey	
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113	12.	WUTH Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
140	13.	WCHC Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
	14.	WUTH Lead Governor Report – **Verbal**	Sheila Hillhouse	
	15.	WCHC Lead Governor Report – **Verbal**	Lynn Collins	

	Committee Chairs Reports			
184	16.	WUTH Charitable Funds Committee	Sue Lorimer	
186	17.	WUTH Audit and Risk Committee	Steve Igoe	
188	18.	WUTH Research and Innovation Committee	Dr Steve Ryan	
190	19.	WUTH Quality Committee	Dr Steve Ryan	
192	20.	WUTH Finance Business Performance Committee	Sue Lorimer	
194	21.	WCHC Quality and Safety Committee	Professor Chris Bentley	
	Regulatory Reports			
197	22.	WUTH Monthly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
205	23.	WUTH 2024/25 Annual Submission to NHS England North West: Appraisal and Revalidation	Dr Ranj Mehra	
245	24.	WUTH Antimicrobial Stewardship Annual Report	Sam Westwell	Chris Green
264	25.	WUTH Accountable Officer Controlled Drugs Annual Report	Dr Ranj Mehra	Chris Green
274	26.	WUTH Safeguarding and Complex Care Annual Report	Sam Westwell	Kal Shaw
316	27.	WUTH Infection Prevention and Control (IPC) Annual Report (including IPC BAF)	Sam Westwell	Jay Turner-Gardner
434	28.	WUTH Biannual Establishment Review	Sam Westwell	
	Closing Business			
	29.	Questions from Governors and Public	Sir David Henshaw	
	30.	Meeting Review	Sir David Henshaw	
	31.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 5 November 2025, 09:00 – 12:30			

Meeting	WUTH Board of Directors in Public
Date	Wednesday 3 September 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
SR	Dr Steve Ryan	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
SI	Steve Igoe	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
HR	Hayley Rigby	Deputy Chief People Officer (deputising for DS)
CH	Dr Catherine Hayle	Deputy Medical Director (deputising for RM)
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
SW	Sam Westwell	Chief Nurse
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer & Interim Deputy CEO

In attendance:

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

Apologies:

NS	Dr Nikki Stevenson	Medical Director & Deputy CEO, WUTH
DM	David McGovern	Director of Corporate Affairs, WUTH
DS	Debs Smith	Joint Chief People Officer
RM	Dr Ranj Mehra	Interim Joint Medical Director

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

	DH welcomed members to the meeting, which was held jointly with the WCHC Board of Directors. Members of that Board are listed as attendees. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 2 July were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** Due to technical difficulties this was not played. The Board **NOTED** the video story.	
6	**Joint Chair Update** DH provided an update on recent matters and highlighted that both Trusts had been fully engaged with the ICB in financial performance and review meetings following the Cheshire and Merseyside ICS being put into financial turnaround by NHS England. DH also updated members on work being driven by Cheshire and Merseyside Chairs and Chief Executives to take a proactive approach in becoming a more effective and sustainable System. DH added a draft action plan had been developed and was awaiting sign off. DH thanked Emma Robinson, Associate Non-Executive Director at WCHC who had stepped down from her role to focus on securing a new substantive role. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meetings in July and August, noting key discussions took place on financial improvement and the opportunities as part of the efficiency at scale programme. JH advised members about the upcoming NHS Oversight Framework (NOF) changes, including the six domains for assessment and that each provider would receive an individual	

	organisational sore which will range from 1-4. JH added both Trusts were engaging with NHSE on a process of data validation and the scores would be published imminently. JH also advised members about the NHS England approach to assessing provider capability, stating this would be used alongside the NOF score and each Trust would be required to complete a self-assessment template before October. JH explained the impact of the recent resident doctor industrial action, noting 584 outpatient appointments and 141 surgical procedures had been cancelled. No cancer procedures had been cancelled. JH reported about the impact of the recent outbreak of measles across Cheshire and Merseyside and the Trusts response to his. JH gave an update regarding Better Together - Journey to Integration, noting the recent Joint Non-Executive Directors appointments and the ongoing work to develop a Joint Strategy. JH reported at WUTH in July there was two RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and one Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH highlighted Sexual Health Wirral has been shortlisted for the Innovation and Improvement category in reducing Healthcare Inequalities Award at the Health Service Journal Awards 2025. The team had also been successful in securing £20,000 from the Magenta Housing Community Fund. JH explained WCHC welcomed Mission Delivery Unit from Number 10 in August to hear about the work happening locally to give children the best start in life. Feedback from the visit had been positive. JH reference the WUTH Leadership for All Conference which took place in July and recapped what took place. JH highlighted the various WUTH and WCHC employee of the month and standout winners for June and July. SR commented that it was positive to hear about the good work WCHC was doing in regard to 0-19 services and ensuring children receive the best start in life. HS asked about the resident doctor industrial action, specifically if the Trust had assessed the wider impact of this.	

	JH advised the focus had been assessing both the patient and staff impact. HK added the majority of outpatient appointments or surgical procedures cancelled would have been lower priority status patients, suggesting the health inequality impact would be low. DH referenced the drug addiction problem for children and young people in Liverpool and queried about the Wirral position. JC stated the 0-19 service, and the safeguarding team would identify and support any children and young people at risk of drug addiction on the Wirral. The Board **NOTED** the report.	
8	**Integrated Performance Report** HR reported sickness absence had increased by 0.5% in month but was an improvement compared to July 2025, the main drivers were gastro, anxiety/stress and cold/flu. HR added key actions related to proactively supporting health and wellbeing and manging absences. HR also reported that appraisal compliance had reduced in all areas with the exception of Surgery Division and set out the measures taken to improve compliance. LD asked about measing the impact of the appraisal processes and if mechanisms were now in place for this to happen. HR stated a new feedback mechanism had been implemented via a QR code on form which would provide data to establish the effectiveness of the refreshed appraisal paperwork. SW explained there had been 11 C Diff incidents in month and a refreshed improvement plan for infection, prevention and control had been launched. There had been 1 grade 3 healthcare associated pressure ulcer, a reduction on the previous month and 350 mattresses had been received to reduce pressure ulcers. SW added there had been a 22% increase in the number of level 1 concerns received in month. CH highlighted 4 Never Events had occurred since April and explained these related to Local Safety Standards for Invasive Procedures (LocSSIPs). CH set out the range of actions taken to raise awareness of LocSSIPs, including a revised policy, generic templates on Cerner and a “right from the start” staff campaign. SI referenced the LocSSIPs internal audit recommendations discussed at Audit and Risk Committee, which he had requested by shared with Quality Committee for further discussion.	

	DH asked about the culture towards patient safety. SW stated the there was a good patient safety culture and multidisciplinary huddles took place before procedures. SW added an audit programme was being undertaken to assess the use of huddles and application of LocSSIPs. The Board **NOTED** performance to the end of July 2025.	
9	**Chief Finance Officer Report** MC reported at the end of July, month 4, the Trust is reporting a deficit of £6.2m which is a £3.8m adverse variance to plan. MC advised that as part of the Cheshire and Merseyside finance review process the Trust has submitted a mid-case forecast which is an adverse variance to plan. MC noted during September the Trust will both review this forecast and consider additional actions to deliver the agreed plan of a £22.1m deficit (or £5.2m deficit including national deficit support funding (DSF)). MC reported two additional and material factors relating to the financial position were: • Withheld DSF across Cheshire and Merseyside for M4-M6, negatively impacting on the Trust's I&E and cash positions by £1.4m per month; and • Industrial action in M4, negatively impacting expenditure and elective income by £1.2m MC also reported the original 4 key risks identified within the Trust plan remained and these were: • Full CIP delivery • Activity/case mix • Aseptic pharmacy income • Run rate MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability, financial sustainability were red, financial efficiency and cash were amber and agency spend, and capital was green. Members noted there was an opportunity to discuss the financial position during the Private Board meeting during the day. The Board: • **NOTED** the report including that the Trust has reported an adverse variance to plan	

	• **NOTED** the risk to delivery of the annual plan is £13.0m and to approve processes for identification and implementation of additional mitigations; and • **NOTED** that the Trust's most immediate finance risk remains the cash position and that a request for provider revenue support has been submitted	
10	**Chief Operating Officer Report** HK highlighted in July the Trust attained an overall performance of 100% against plan for outpatients and an overall performance of 92% against plan for elective admissions. HK summarised the referral to treatment (RTT) standard and current performance against this, noting the Trust achieved trajectory for RTT caseload, percentage of patient waiting 18 weeks or under, but was over trajectory for the number and percentage of 52-week waiters in July 2025. HK set out the number of patients waiting 65+ weeks, noting of the 16 patients these were a mix of complex, ophthalmology gift and capacity. ENT remains the biggest risk to achievement and outsourcing was due to commence in September. HK summarised cancer performance against trajectories, noting the number of 62 day and 104 day waiters has increased as a result of pressure on 28 day performance. HK highlighted in July type 1 unscheduled care performance was 46.38% and was marginally below trajectory and the Trust continued to maximise flow and utilisation of alternative urgent care pathways. HK stated the most significant risk to urgent emergency care performance remained achieving a sustained reduction in patients waiting over 12 hours in the Emergency Department. HK noted a new mental health area within the Emergency Department had opened as part of the final phase of the Urgent and Emergency Care Upgrade Programme. HK added mental health demand remains consistently high, with July seeing a further increase in patients conveyed under Section 136. HS noted the pressure in dermatology as a result of the introduction of artificial intelligence and queried this. HK advised there had been a significant increase in referrals because of the new regional system introduced and this outstripped capacity. There were more referrals being classified as urgent or suspected cancer which was over inflating demand.	

	DH asked about and type of patients who could be redirected to other NHS services to receive care instead of the Emergency Department and if this analysis could be provided. HK agreed to provide this at the next meeting given there had been work on this already undertaken. JH advised it was important to ensure clinical teams considered it safe for patients when considering redirecting them to other NHS services to maintain a high patient safety culture. SL asked about the operating capacity of the Emergency Department while ensuring the building was safe during busy periods. HK advised the capacity was generally 250 patients and this regularly exceeded during surges in demand. HK added the capacity had also been reduced because of current building work which was hampering the ability for the clinical teams to see patients in a timely manner. LD asked about ambulance handovers and if these could be redirected to other hospitals when necessary. HK stated the regional position was that the Trust had responsibility to resolve the issues identified. HK added the Trust also met regularly with the ambulance service to review performance and assess areas for collective improvement. JH explained there was no urgent and emergency care improvement workstream at a regional level and this was impacting performance and patient experience across Cheshire and Merseyside. HS also asked if patients accessing the mental health area were aware of the mental health crises line before attending the Emergency Department. HK stated this aspect was included in the Trust's winter plan and Cheshire and Wirral Partnership planned to increase capacity for this. The Board **NOTED** the report.	Hayley Kendall
11	**Board Assurance Framework (BAF)** AH provided an overview the BAF, explaining there had been no changes to each of the strategic risk scores since June. AH noted a new shared strategic risk with WUTH was being developed in relation to failing to develop a Joint Strategy and	

	deliver the 2 year integration plan and this would be considered by the Integration Management Board in September. The Board **APPROVED** the BAF.	
12	**Lead Governor Report** This was not discussed as the Lead Governor was absent.	
13	**Committee Chairs Reports – Quality Committee** SR alerted members that the Committee received an update on healthcare associated C Diff incidents, noting this was a national issue but Wirral and the Trust had a high prevalence, and the Committee requested a further update on this for the next meeting to ensure robust plans were in place. SR also alerted members that the Divisional Director of Nursing and Midwifery for Women's and Children's presented a gap analysis and action plan associated with the independent review of maternity and neonatal services. Committee welcomed this and acknowledged the Trust had received good external assurance of its maternity services. SR alerted members to the assurance it was provided with in regard to the recent Never Events and the plans in place to raise awareness and compliance of Local Safety Standards for Invasive Procedures (LocSSIPs). SR summarised the various "Advise" and "Assure" matters from the Committee meeting on 4 August. Members noted Wirral has a high rate of residents passing away in hospital and queried this why this was. CH agreed to clarify why Wirral has one of the highest rates of its residents passing away in hospital instead of in other settings. The Board **NOTED** the report.	Catherine Hayle
14	**Committee Chairs Reports – Estates and Capital Committee** DH provided a verbal update and alerted members that the Committee received a health and safety update and subsequently requested a deep dive into fire safety to understand the fire risks and mitigations across the hospital. DH also alerted members that the Committee received a presentation detailing the progress with the delivery of the estate's integration and the development of the estate strategic priorities for integration.	

	DH alerted members that the Committee were provided with good assurance on the capital finance position and delivery of capital projects for this financial year. The Board **NOTED** the report.	
15	**Committee Chairs Reports – Charitable Funds Committee** SL provided a verbal update and alerted members that the Committee received a presentation from members of the Critical Care fund which detailed their ambition to raise funds for a critical care garden at Arrowe Park Hospital. SL added the Committee considered this a worthy cause for supported their plans. SL also alerted members that the Committee considered a proposal for closing the Tiny Stars appeal fund and agreed to close the fund by 30 November 2025. SL noted further approval of this was required by the Board as the Trustee of the Charity. SL alerted members that the Committee also received the finance report, detailing the funds available and the fundraising report which summarised the upcoming charity activity. The Board **NOTED** the report.	
16	**Committee Chairs Reports – Finance Business Performance Committee** SL noted the Committee had received the Finance Report which summarised the finance position and had been reported in the Chief Finance Officer agenda item earlier. SL alerted members that the Cheshire and Merseyside finance system review continued and that the Trust had fully engaged in the external reviews covering finance governance, forecasted risk and CIP processes. SL also alerted members that the risk of a low cash balance remains, and the Trust had applied to NHS for £16.5m of cash support in September. SL advised that the Committee had considered and supported the Trust's request for cash support and the Board also expressed its support as well. SL alerted members that the Trust had been placed into tier 1 for its performance in urgent and emergency care, resulting in regular oversight meetings and potential support for improvement. SL summarised the various "Advise" and "Assure" matters from the Committee meeting on 28 August. The Board **NOTED** the report.	

17	**Estates Compliance and Sustainability Annual Report** HK highlighted this was a new annual report provided to Estates and Capital Committee and the Board to provide assurance on the Trusts estates compliance. HK provided an overview of the report, explaining how the Trust had adhered to the various statutory legislation and health technical memoranda spanning water safety, fire safety and electrical safety etc. HK reported how the Trust was reporting carbon emissions and summarised this against scope 1, 2 and 3 for 2024/25 against 2023/4, noting this had increased the past two years. HK gave an overview of the Premises Assurance Model (PAM) audit outcome, noting the majority were rated as good with 27 requiring minimal improvement and 1 requiring moderate improvement. HK added an improvement plan has been developed outlining the evidence required to move the these to a good rating. The Board: • **NOTED** the report; and • **APPROVED** the PAM Self-Assessment scoring for submission to NHS England	
18	**Green Plan** HK recapped the various achievements during 2022-25 and set out the nine focus areas for 2025-28, noting the Trust remained committed to ensuring it was net zero by 2040. HK stated this Green Plan would run for 4 years and work would commence to develop a Joint Green Plan with WCHC when the organisations become a single one. HS queried the scope 3 carbon emissions and if the Procurement Team considered this as part of procurement exercises. HS also queried if the Trust was also working towards the United Nations (UN) Sustainable Development Goals. HK stated the Procurement Team did consider this as part of procurement exercises and the Trust was working towards this the UN goals. MD noted the carbon emissions had increased during the year because of increased use of the Trust's Combined Heat and Power (CHP) system. MD commented it was important to consider the impact on the financial position when assessing whether to retro fit alternative power systems which would reduce carbon emissions.	

	HK agreed and added the transition towards net zero had to be considered alongside value for money. CB commented about the importance of maintaining a focus on health inequalities, noting the challenges between this and net zero. The Board **APPROVED** the Trust's refreshed Green Plan.	
19	**Quarterly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise for July. JL stated there were no Patient Safety Investigation Incidents (PSIIs) declared for Maternity Services in May, June or July. There was one PSII in May for Neonatal Services related to the displacement of a nasogastric tube. JL gave an update on the Maternity Incentive Scheme (MIS) Year 7 and the ten safety actions, noting progress to date and that this was being routinely tracked through the Divisional Quality Assurance meeting. JL referenced the Perinatal Mortality Reviews Summary Report (PMRT) for quarter 4 2024/25 and quarter 1 2025/26 which summarised the number of stillbirths and perinatal deaths. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 94% compliance against the 6 elements based on evidence as of 30 June 2025. JL summarised the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services. JL referenced the Maternity and Neonatal Rapid National Investigation and summarised the Trust's current position against each of the statements, along with a gap analysis against the key themes and actions to work towards. JL provided an update on the midwifery workforce utilising the Birth Rate + workforce tool which was recommending the increase in midwifery establishment. JL set out the progress of the Maternity Portal Online Programme (MPOP), Maternity Self-Assessment Tool and noted the annual	

	maternity and neonatal culture report had been provided for assurance. JL highlighted work continued in regard to the redevelopment of the Neonatal Unit with completion expected in November 2025. MD commented it was positive to hear the Trust was rated highly in the North West for providing care to newly born babies. MD queried about the midwifery staffing changes. JL advised using the Birth Rate + methodology there was a variance of 9.14 whole time equivalents (WTE) and a business case had been accepted to fund the recruitment of 4.3 WTE Band 5 Midwives and 2.96 WTE Maternity Support Workers, resulting in a shortfall of 1.88 WTE. SR commented that culture, leadership and compliance were important, and these behaviours were noticeably visible by the team and staff. Members thanked JL and the team for their continued work. The Board: • **NOTED** the report and associated appendices. • **NOTED** the Perinatal Clinical Surveillance Assurance report • **NOTED** the position of the Maternity and Newborn Safety Investigations (MNSI) and declaration of one PSII for Neonatal Unit • **NOTED** the position with the Maternity Incentive Scheme Year 6 and launch of Year 7 requirements • **NOTED** the PMRT reports for Q4 24/25 and Q1 25/26. • Note the progress of the Trust's position with Saving Babies Lives v3 • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals" • **SUPPORTED** the recommendations and action plan within the Maternity and neonatal inquiry report and appendices • **SUPPORTED** the recommendation in the midwifery staffing workforce paper. • **NOTED** the Neonatal Unit medical and nursing staffing position in accordance with BAPM. • **NOTED** the progress with the Maternity Portal Online Programme. • **NOTED** the continued outstanding practices with the Maternity and neonatal Voices Partnership (MNVP), • **SUPPORTED** the recommendations within the Maternity and Neonatal Annual report; and • **NOTED** the compliance with consultant presence on the labour ward in line with the RCOG guidance.	

20	**Guardian of Safe Working Annual Report 2024/25** AA provided an overview of the report, noting during the year General Medicine had the highest number of exception reports by department and foundation 1 doctors had the highest number of exception reports by grade. AA added the response time for addressing exception reports remained positive, noting the majority were dealt with within 48 hours or 7 days. AA summarised the changes to the exception reporting process, which was due to take effect from 12 September and has been delayed. JH stated the Executive Team were aware of the upcoming changes to the exception reporting, specifically the potential increase in fines and the financial implications of this. JH added a gap analysis of the upcoming changes had been requested to assesses what further work was required. HS commented that it was positive the number of fines were low and explained resident doctors considered WUTH a good location for their placement. The Board **NOTED** the report.	
21	**Learning from Deaths Report Q4 2024/25** CH summarised the mortality comparators, stating for the reporting period the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) were both within the expected range. CH noted WUTH continues to have a higher than average number of patients who have a palliative care code and this can result in a higher SHIMI. CH provided a summary of adult in patient deaths and case reviews, noting of the 487 deaths 15 cases were escalated for review by the Medical Examiner and the Mortality Review Group reviewed a random selection of 26 deaths. CH also provided a summary of the perinatal and neonatal deaths and the outcome of the PRMT reviews. CH explained the learning identified through the review of mortality reviews and added a CUSUM alert was identified for deaths due to pneumonia.	

	The Board **NOTED** the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.	
22	**Complaints Annual Report** SW provided a summary of the report, indicating during 2024/25 the Trust logged 221 formal complaints – an increase of 9% on 2023/24 and 2885 level 1 concerns – an increase of 32% on 2023/24. SW reported the most frequently cited theme in formal complaints remained communication, featuring in 63% of cases and aligned with national trends and Medicine Division received the highest number of complaints. SW explained for level 1 concerns access and admission was the leading theme (32%) and Medicine Division recorded the highest number of informal concerns. SW reported 6 PHSO cases had been opened in 2024/25, and one case had been upheld/partially upheld. HS queried the learning from complaints and sought an example. HS also suggested utilising a "you said, we did" approach to demonstrate to patients the Trust was learning from complaints. SW stated one example was installing a map in the Emergency Department to understand their patient journey and typical wait times. SW added the Trust had a Patient Experience Strategy and was a mechanism for patients to get involved in improvement. The Board **NOTED** the report.	
23	**NHS 10 Year Health Plan** MS explained that in July NHS England published the 10 Year Health Plan which outlined three key shifts in healthcare delivery, notable from hospital to community, from analogue to digital and from treatment to prevention. MS added a presentation had been appended to the report to brief members on this, including the supporting reforms and noted there was a Board Away Day in September to further discuss the opportunities. The Board **NOTED** the report.	
24	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common**	

	AH advised that two Cheshire & Merseyside provider collaboratives had come together to form the Cheshire and Merseyside Provider Collaborative (CMPC) from 1 May 2025. AH added a Joint Working Agreement and Committee in Common Terms of Reference had been produced for each provider in Cheshire and Merseyside for approval. AH noted once approved this would be signed by the Joint Chief Executive. The Board: • **ENDORSED** and **APPROVED** the CMPC Joint Working Agreement and Committee in Common as proposed; • **ADOPTED** the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership; and • **COMMITTED** to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making	
25	**Questions from Governors and Public** No questions were raised.	
26	**Meeting Review** Members agreed that the agenda structure of the meeting continue to evolve positively and suggested using the BAF to influence the agenda items.	
27	**Any other Business** No other business was raised.	

(The meeting closed 12:30)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 3 September 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
LD	Lesley Davies	Joint Non-Executive Director
SI	Steve Igoe	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
HR	Hayley Rigby	Deputy Chief People Officer (deputising for DS)
CH	Dr Catherine Hayle	Deputy Medical Director (deputising for RM)
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
DM	Dave Murphy	Chief Digital Information Officer
RC	Robbie Chapman	Interim Chief Finance Officer

In attendance:

SW	Sam Westwell	WUTH Chief Nurse
MC	Mark Chidgey	WUTH Chief Finance Officer
SR	Dr Steve Ryan	WUTH Non-Executive Director
SL	Sue Lorimer	WUTH Non-Executive Director
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
KP	Karen Prior	WCHC Appointed Governor
LC	Lynn Collins	WCHC Lead Public Governor
TC	Tony Cragg	WUTH Public Governor

Apologies:

DS	Debs Smith	Joint Chief People Officer
RM	Dr Ranj Mehra	Interim Joint Medical Director
PS	Paula Simpson	Chief Nurse

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

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 2 July were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** Due to technical difficulties this was not played.	
6	**Joint Chair Update** DH provided an update on recent matters and highlighted that both WUTH and WCHC had been fully engaged with the ICB in financial performance and review meetings following the Cheshire and Merseyside ICS being put into financial turnaround by NHS England. DH also updated members on work being driven by Cheshire and Merseyside Chairs and Chief Executives to take a proactive approach in becoming a more effective and sustainable System. DH added a draft action plan had been developed and was awaiting sign off. DH thanked Emma Robinson, Associate Non-Executive Director at WCHC who had stepped down from her role to focus on securing a new substantive role. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meetings in July and August, noting key discussions took place on financial improvement and the opportunities as part of the efficiency at scale programme. JH advised members about the upcoming NHS Oversight Framework (NOF) changes, including the six domains for assessment and that each provider would receive an individual organisational sore which will range from 1-4. JH added both Trusts were engaging with NHSE on a process of data validation and the scores would be published imminently. JH also advised members about the NHS England approach to assessing provider capability, stating this would be used alongside	

	the NOF score and each Trust would be required to complete a capability self-assessment before October. JH explained the impact of the recent resident doctor industrial action, noting 584 outpatient appointments and 141 surgical procedures had been cancelled. No cancer procedures had been cancelled. JH reported the impact of the recent outbreak of measles across Cheshire and Merseyside and the Trust's response to this. JH gave an update regarding Better Together - Journey to Integration, noting the recent Joint Non-Executive Directors appointments and the ongoing work to develop a Joint Strategy. JH reported at WUTH in July there were two RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and one Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH highlighted Sexual Health Wirral has been shortlisted for the Innovation and Improvement category in reducing Healthcare Inequalities Award at the Health Service Journal Awards 2025. The team had also been successful in securing £20,000 from the Magenta Housing Community Fund. JH explained WCHC welcomed Mission Delivery Unit from Number 10 in August to hear about the work happening locally to give children the best start in life. Feedback from the visit had been positive. JH referenced the WUTH Leadership for All Conference which took place in July and recapped what took place. JH highlighted the various WUTH and WCHC employee of the month and standout winners for June and July. SR commented that it was positive to hear about the good work WCHC was doing in regard to 0-19 services and ensuring children and young people receive the best start in life. HS asked about the resident doctor industrial action, specifically if the Trust had assessed the wider impact of this. JH advised the focus had been assessing both the patient and staff impact. HK added the majority of outpatient appointments or surgical procedures cancelled would have been lower priority pathway patients, suggesting the health inequality impact would be low.	

	DH referenced the drug addiction problem for children and young people in Liverpool and queried about the Wirral position. JC stated the 0-19 service and the safeguarding team would identify and support children and young people at risk of drug addiction on the Wirral. The Board **NOTED** the report.	
8	**Integrated Performance Report** HR explained sickness absence had increased to 7.4% in July and an urgent review of the approach to wellbeing and absence management has been undertaken. HR set out the 4 themes requiring improvement and monitoring. LD sought clarity on the management roles and responsibilities theme. HR clarified that this related to the managers role in managing sickness absence and the variance in practice currently. HR added the team were making clear the expectation of the managers role in this and providing the skills for managers where necessary. SL asked about what was driving this sickness absence. HR advised it was predominately long term sickness absence arising from anxiety/stress whereas in WUTH it was short term arising instead from gastro, anxiety/stress and cold/flu. HR added the occupational health provision was provided by an external provider and this was being reviewed. SI queried if processes were in place to dismiss staff where necessary on grounds of long term ill health. HR stated this was correct and one of the actions implemented was for senior HR case management of long term sickness cases to review this. JC reported 4 hour performance was under the 95% target and remedial actions plans were in place to support performance improvements. JC added performance against GPOOH CAS and 111 response times varied and targeted improvement actions were underway including a review of the operational model. DH asked about the strategic commissioning for GP out of hours and if this responsibility lay with Wirral Place. JC stated these metrics were a mix of local and national targets with the local ones set by Wirral Place. JC gave an example of the challenges with the coding of priority response times, suggesting GPs had implied the response times for some 111 calls were	

	incorrect. JC commented that a System improvement plan was needed to address this. CW reported all of the quality and governance metrics had been met in month and there were no specific areas of concern identified. LD commented this demonstrated a high level of compliance and suggested it would be beneficial to understand the levels of good practice and culture, so that this can be replicated across teams. RC reported at the end of July, the Trust was reporting a surplus of £0.4m. This is an improvement on plan for M4 but there is no change to the projected year end surplus of £0.9m. At M4 the Trust has transacted £4.98m of CIP in year, £5.051m full year effect, against its revised target of £6.6m. MD asked if the underspend on staff costs correlated with the high level of long term sickness absence related to anxiety/stress. RC explained these underspends were not in areas were sickness absence occurred. The Board **NOTED** performance to the end of July 2025.	
9	**Board Assurance Framework (BAF)** AH summarised the changes to the BAF, noting a new risk had been added (ID05) and this was associated with cyber security and emergency preparedness, resilience, and response (EPRR) which would be monitored via the Finance & Performance Committee. The risk appetite for ID06 had been amended from Cautious to Moderate. AH noted a new shared strategic risk with WUTH was being developed in relation to failing to develop a Joint Strategy and deliver the 2 year integration plan and this would be considered by the Integration Management Board in September. CB suggested that the risk description also included the potential failure to deliver the benefits to patient experience and outcomes. The Board: • **RECEIVED** the update provided on the current position in relation to the strategic risks; and • **APPROVED** the proposal to change the risk appetite for ID06 from Cautious to Moderate, as recommended by the Finance & Performance Committee	
10	**Lead Governor Report** AH stated she would present the report on behalf of LC who was observing remotely.	

	AH summarised the work undertaken between WCHC and WCHC Governors to appoint the Joint Non-Executive Directors, namely Haris Sultan, Steve Igoe, Meredydd David, Chris Bentley and Lesley Davies AH stated a WCHC and WUTH Council of Governor Development session had been held in July and set out the topics which were discussed. AH referenced the recent Your Voice group meeting in July, which included updates on the NHS Sexual Safety Charter as well as an update on the Rehab at Home Service. The Board **NOTED** the report.	
11	**Committee Chairs Reports – Quality and Safety Committee** CB alerted members that the Chief Nurse had provided an update on recent System meetings, noting at the Local Area SEND Partnership Board the SEND inspection report and action plan had been approved by Ofsted and the CQC. CB added regionally work was ongoing at the ICB regarding agency and overtime for nurses and bank pay rates had been standardised. CB also alerted members that an issue had been referred to the People and Culture Committee, specifically regarding the appropriate induction and policy adherence when staff were working under the Workforce Sharing Agreement. CB alerted members that a discussion took place regarding the BAF and the current mitigation for risks ID01 and ID02. CB summarised the various “Advise” and “Assure” matters from the Committee meeting on 9 July. The Board **NOTED** the report.	
12	**Chairs Reports – Finance and Performance Committee** SI alerted members that failure to deliver the cost improvement programme (CIP) continues to be a high risk to delivery of the 2025/26 financial plan. SI also alerted members that a new risk related to cyber security and EPRR had been added to the BAF to mirror the WUTH BAF. SI alerted members to the various operational risks, including challenges in neurodevelopment pathway, staffing in the maintenance team and the management of health and safety due to staffing issues.	

	SI summarised the various “Advise” and “Assure” matters from the Committee meeting on 7 August. The Board **NOTED** the report.	
13	**Committee Chairs Reports – People and Culture Committee** MD alerted members that during the period sickness absence was 6.7% which was too high and was mainly driven by long term sickness absence linked to stress, accounting over 40% of absences. MD added appraisal compliance was lower than expected at just over 40% and the appraisal window had been extended to the end of the month. MD also alerted members about the ongoing dispute with the British Medical Association regarding resident doctors and local unions, however acknowledged the good relationships at the Trust. MD added the nursing and midwifery job profiles had been updated nationally and this was a risk for the Trust. MD alerted members that there was a need to reduce agency staff usage at CICC, however it was acknowledged good agency spend controls were in place across the Trust. MD summarised the various “Advise” and “Assure” matters from the Committee meeting on 13 August. The Board **NOTED** the report.	
14	**Information Governance Annual Report** DM provided an overview of the report, noting the Trust’s Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) was submitted on 30 June 2025 with 11 out of the 12 outcomes meeting the minimum achievement level. DM reported one outcome (A4A) Supply Chain) did not meet the minimum requirement and work was ongoing to implement the necessary recommendations. An action plan was in place to address this. DM noted 359 Freedom of Information (FOI) requests had been received and 85% were managed within 20 working days. 419 Subject Access Requests (SARS) had also been received and 95.5% were managed within one calendar month. DM added 120 information governance incidents were attributed to the Trust compared to 142 during 2023/24 and DM set out which services these incidents arose from. DM indicated 96.48% of staff had completed the mandatory data security awareness e-learning module.	

	Members thanked DM for the report and to pass this onto the relevant teams. The Board **NOTED** the report.	
15	**Complaints and Concerns Annual Report** CW provided an overview of the report, noting 35 complaints had been received during the annual period and 32 (91%) were acknowledged within 3 working days. 100% had not been achieved due to capacity within the complaints team. CW noted of the 35 complaints received, 20 (57%) were responded to within 40 working days and 15 (43%) were responded to outside of this. CW added the key themes arising from complaints related to all aspects of clinical treatment and patients being unhappy with assessment/level of support. CW explained of the closed complaints 24 were upheld, 11 were not upheld and 4 were partially upheld. SL asked about the not upheld language and if this was common practice across NHS providers. CW advised that this was included in the report for transparency and that all patients and/or relatives are provided with an apology regardless of the outcome. CW added from April 2025 WCHC was no longer using this language and had aligned with WUTH complaints terminology for consistency. HS suggested including in the next report the ethnicity of the Wirral population to accompany the ethnic origin chart to demonstrate it was reflective of the local demographic. Members thanked CW for the report and to pass this onto the relevant teams. The Board **NOTED** the report.	
16	**Safeguarding Annual Report** CW provided an overview of the report, noting commissioning standards were rated green in 62 areas and amber in 1, and WCHC was one of the few Trusts not required to have an improvement plan in place. CW noted 18 audits had been completed over the year, in addition to partnership audits to measure continuous quality improvement, identify any learning and provide assurance.	

	CW added 19 staff were designated as Safeguarding Champions, with a further six were about to be approved and 11 were currently on undergoing training. CW referenced the additional work undertaken by the Safeguarding Team and this ranged from working with HR colleagues to implement the Sexual Safety Charter, a new policy, e-learning package, and a reporting structure. CW summarised the areas of focus for 2025/26, highlighting these related to the Multi-Agency Risk Assessment Conference (MARAC) and working with the ICB around the Multi-Agency Safeguarding Hub (MASH). Members thanked CW for the report and to pass this onto the relevant teams. The Board **NOTED** the report.	
17	**Infection Prevention and Control (IPC) Annual Report** CW provided an overview of the report, noting in the IPC BAF there were no areas of non-compliance and 8 areas of partial compliance across 4 criteria's, with the remaining 6 criteria's being fully compliant. CW noted in instances of partial compliance mitigations were in place and actions have been incorporated into the IPC annual work programme for 2025/26. CW summarised the compliance with mandatory and role essential IPC training, noting level 1 and level 2 were 97.1% and 98.5%, respectively. CW added during the year there had been no C Diff or MRSA cases attributed to the Trusts services. CW referred to Health Service Journal Patient Safety awards, status the Trust had been shortlisted for the collaborative work on UTI improvement and hydration. LD noted there had been 12 inoculation incidents and asked about the themes and trends relating to injuries sustained as part of self-administration. CW agreed to clarify and provide an update for the next meeting. Members thanked CW for the report and to pass this onto the relevant teams. The Board **NOTED** the report.	Claire Wedge

18	**NHS 10 Year Health Plan** MS explained that in July NHS England published the 10 Year Health Plan which outlined three key shifts in healthcare delivery, notable from hospital to community, from analogue to digital and from treatment to prevention. MS added a presentation had been appended to the report to brief members on this, including the supporting reforms and noted there was a Board Away Day in September to further discuss the opportunities. The Board **NOTED** the report and presentation.	
19	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common** AH advised that two Cheshire & Merseyside provider collaboratives had come together to form the Cheshire and Merseyside Provider Collaborative (CMPC) from 1 May 2025. AH added a Joint Working Agreement and Committee in Common Terms of Reference had been produced for each provider in Cheshire and Merseyside for approval. AH noted once approved this would be signed by the Joint Chief Executive. The Board: • **ENDORSED** and **APPROVED** the CMPC Joint Working Agreement and Committee in Common as proposed; • **ADOPTED** the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership; and • **COMMITTED** to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making	
20	**WCHC Annual Declarations of Interests - Board of Directors 2025/26** AH explained that the annual declaration of interests refresh had been undertaken and the register of interests for 2025-26 for all Board members was appended to the report. AH added the register includes all newly appointed joint NEDs and any interim joint Director roles. AH noted as per Trust policy, after expiry, any interest remains on the register for a minimum of 6 months, and a private record of historic interests will be retained for a minimum of 6 years.	

	The Board: • **APPROVED** the register of interests for members of the Board for 2025-26; and • **NOTED** that the register, as presented, will be published on the Trust's website	
21	**Questions from Governors and Public** No questions were raised.	
22	**Meeting Review** Members agreed that the agenda structure of the meeting continue to evolve positively and suggested using the BAF to influence the agenda items.	
23	**Any other Business** No other business was raised.	

(The meeting closed at 12:30)

Action Log
Board of Directors in Public
1 October 2025

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1.	3 September 2025	10	To provide an analysis of the number and type of patients who could be redirected to other NHS services to receive care instead of the Emergency Department	Hayley Kendall	Verbal update to be provided.	October 2025
2.	3 September 2025	13	To clarify why Wirral has one of the highest rates of its residents passing away in hospital instead of in other settings	Dr Catherine Hayle	The Chair of Quality Committee will provide a verbal update at the meeting.	October 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1.	4 June 2025	7	To provide an overview of the neurodevelopment pathway, to include the changes to manage demand and the timeframe to reduce the backlog	Paula Simpson	Complete. Scheduled for October Private Board.	October 2025
2.	3 September 2025	14	To clarify the themes and trends relating to injuries sustained as part of inoculation self-administration	Claire Wedge	Completed. In 2024/25 there were 12 inoculation injuries reported; seven were within Community Nursing. Of these incidents, four related to self-	October 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
					administration of insulin, all reported within Q4. A task and finish group was rapidly established to evidence responsive action to the cluster of incidents. This resulted in the delivery of a targeted quality improvement plan led by the IPC Service. There have been zero inoculation injuries related to insulin administration during Q1 of 2025/26. This will be robustly tracked throughout Trust governance to evidence sustainability of the improvements achieved. There were no other incident clusters, themes or trends identified.	

Board of Directors in Public **Item 7**
1 October 2025

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

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

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

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

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

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

	Urgent and emergency care performance at WUTH remains challenged. Improvement work supported by ECIST continues in line with the agreed plan with specific focus on 4 & 12 hours. Work continues with the system on financial turnaround initiatives, and internally, the Trust maintains a constant focus on cost improvement, productivity & efficiency to support the required year-end position. At WCHC operational performance remains strong with improvements in 4-hour performance for Walk-in Centres / Urgent Treatment Centre and Urgent Community Response Service performance. CICC occupancy continues to be above 90% and GPOOHs has improved response times against target. Waiting lists continue to improve in terms of volume and access times across all services and all key metrics for the 0-19 services across the four regional teams are performing above target. WCHC is ahead of financial plan at M5 and the focus on transformation and efficiency across services remains. Across both Trusts I would like to recognise this performance and acknowledge the efforts of staff who contribute to this strong position and support those in our care.

1.2	**Local News and Developments**
	
	Cheshire and Merseyside Provider Collaborative (CMPC) Update
	
	The CMPC Leadership Board met on Friday 5th September and discussed a number of system wide issues.
	
	The Board noted Ann Marr's resignation from the ICB Board and her contribution to provider collaboration within C&M and took the opportunity to consider the next steps for provider collaboration within C&M while CMPC leadership choices were considered by Trusts during the early part of September. These discussions took two parts a Provider Collaborative reset and the development of a provider strategy - an NHS provider Trust blueprint.
	
	On the opportunity for a CMPC reset discussions focussed upon:
	• Leadership and alignment with our Trust execs
	• Alignment with the ICB and establishment of a recovery cell with the ICB
	• Reset of our priorities focussing on:
	  ○ Planned care including elective and diagnostics
	  ○ Community services standardisation and patient flow
	  ○ Clinical pathways and fragile services
	  ○ Efficiency at scale including corporate services opportunities
	
	In respect of the draft and in development NHS provider Trust blueprint opportunities discussed included:
	• Fragility of clinical services - exploring creation of service chains for specialist services
	• Number and scale of NHS Trust providers - development of provider groups and sub regional partnerships
	• Variation in service integration across the ICS - alignment of community services with Places
	• Multiple corporate and clinical support services - consolidation

Finally, the Board were provided with a brief of the 65 week wait position and the need for individual Trust clarity in relation to these positions and expected reductions.

Update papers were also provided on the following areas:

- System financial report
- System performance update

NHS Oversight Framework publication

In early September the new NHS Oversight Framework was published. For the first time, members of the public and NHS leaders can explore league tables that show how local Trusts compare with others across England.

The dashboard is accessible via the NHSE Data Dashboard - NHS England » Segmentation and league tables and will be published quarterly providing a view of how NHS Trusts are performing in key areas including urgent and emergency care, elective services, mental health and more. It also includes areas such as finance, staff sickness and staff engagement.

Each Trust has been placed into one of four core segments. Segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. Any Trust in financial deficit is limited to segment 3, regardless of wider performance.

WCHC has currently been place in segment 1, demonstrating strong performance across the community services delivered by colleagues across the Trust.

WUTH has currently been placed in segment 4 and while this is not where we want to be, it is in line with a number of other acute Trusts in the region. We know where we need to make improvements, and we have plans in place to achieve this. This includes our continued focus on financial recovery, urgent care patient flow, data quality & sickness absence

The integration of both Trusts is already bringing benefits through closer working and collaboration across the whole Wirral system to make improvements that will greatly benefit our patients and enhance our staff experience.

Our staff across both Trusts continue to work hard for our patients every single day, providing the best possible care and services for patients and I would like to recognise their efforts, hard work and compassion.

Provider Capability Rating

As noted in September, NHS England has confirmed that, alongside the NOF, all Trusts will also be assessed according to their capability based on a self-assessment.

The focus on provider boards' awareness of the challenges facing organisations, and what is needed to address them, is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for their engagement with providers.

The self-assessment will be completed annually against the six oversight domains, as set out in The Insightful Board;

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

It is intended that the capability rating of Trusts will be published alongside the NOF segmentation.

Both WCHC and WUTH will be completing the self-assessment and submitting to NHSE following Board meetings in November 2025.

WCHC Care Quality Commission (CQC) Inspection - Walk-in Centre and Urgent Treatment Centre (UTC)

CQC conducted an announced inspection of the Urgent Treatment Centre (UTC) and Eastham Walk-in Centre on 17 & 18 September 2025, and we await the draft report. Thanks to all staff across the Trust who supported the inspection and made the inspection team feel so welcome.

Patients praise WUTH in national CQC inpatient survey

Patients have praised the care they received at WUTH in the latest CQC Adult Inpatient Survey, with the Trust performing strongly across key areas of inpatient experience. One of the highest-scoring areas was kindness and compassion, where the trust scored 9.2 out of 10

Patients also reported feeling supported when planning for discharge and rated their interactions with doctors and nurses highly. These results reflect the dedication of our staff and their commitment to providing high-quality, patient-centred care.

Better Together - Journey to Integration

Our programme of integration between both Trusts is making good progress and in the last month we have shared important updates with staff particularly in relation to the statutory transaction type which will support us coming together as one organisation.

In a video update shared with all staff, I spent time with WCHC's Head of Quality & Patient Experience responding directly to questions being asked by staff in both Trusts. In this update I also confirmed that we are now progressing with a 'merger by acquisition'; a process we expect to conclude by April 2027. In sharing this information, I wanted to provide clarity but also important context for staff in so far as the transaction is the legal process, but the work we are doing to integrate our teams and services is already bringing benefits and having a positive impact.

We have also recently confirmed that corporate services across both Trusts will come together sooner and before the statutory transaction concludes, enabling us to work better together, more efficiently and to alleviate some pressures. This will be through a process

	of TUPE with staff in corporate services at WCHC transferring to WUTH in December 2025. There are already many examples of staff working together across clinical and corporate services to improve services and learn from each other, and we look forward to this work continuing and sharing further updates in future reports. Matthew Swanborough, Joint Chief Strategy Officer and I presented an update on our progress with the integration to the Cheshire & Merseyside ICB Board on 25 September 2025. It was useful to have the opportunity to share our progress with regional colleagues and gain their support for our direction of travel. The ICB were complimentary of the progress made to date & confirmed their support of the agreed next steps **Staff Flu Campaign** From 1 October the WUTH and WCHC staff flu vaccination campaigns will begin. Staff and students across both Trusts will be able to get vaccinated to protect themselves, their loved ones, colleagues and patients from getting and passing on flu. Last year 50% of staff in both Trusts had their vaccine, and this year we are encouraging an increased uptake in line with the national ask For six weeks from 1 October staff will be able to get their vaccine at drop-in clinics at locations across the Trusts estates and localities, from roaming vaccinators, at the vaccine hub, or from peer immunisers. The staff flu campaign is an important part of our staff wellbeing programme and also supports our Winter Plans to ensure our staff remain well to care for the people in our communities during the winter period.
1.3	**National News and Developments** **Martha's Rule rolled out to all acute hospitals** Martha's Rule is being expanded to every acute hospital in England, the NHS has announced, as new data shows hundreds of patients have benefitted from potentially life-saving changes to their care thanks to the scheme. Between September 2024 and June 2025, there were 4,906 calls made to Martha's Rule helplines to escalate concerns about care - leading to 241 potentially life-saving interventions being triggered. The positive results from the first year have led the NHS to expand its use to an additional 67 sites - meaning all 210 acute inpatient sites in England will offer the service. We were pleased to be one of the 143 pilot sites for Martha's Rule across the country and it is now in place in all in-patient areas across Arrowe Park Hospital and a dedicated 24/7 phone line went live in April 2025. **Getting the basics right for resident doctors: 10 Point Plan** On 29 August NHS England published this Plan setting out 10 ways in which we are improving resident doctors working conditions over the next 12 weeks. This plan sets out actions for NHS England and individual trusts. To ensure meaningful progress, it will be

	formally incorporated into the new NHS Oversight Framework. Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work. The outcomes will be included in the annual report to demonstrate accountability and progress. **Failure to Prevent Fraud Offence** On 1st September 2025 a new fraud offence came into force. This is a corporate offence of *'failure to prevent fraud'*, which is part of the Economic Crime and Corporate Transparency Act 2023. This new type of fraud occurs where someone connected with the organisation (what the Act calls an 'associated person') commits a fraud offence that intentionally benefits the Trust, or a related body, rather than just the individual, and where the Trust should have had reasonable procedures in place to prevent this from happening. In these circumstances the legislation holds large organisations (including NHS organisations) criminally liable. Both WUTH and WCHC takes its responsibilities very seriously and we have been working with our anti-fraud provider (MIAA) to ensure all associated persons know their responsibilities in this area and that robust arrangements to prevent all forms of fraud, bribery or corruption are in place. Should you wish to read about the new legislation in more detail, the NHS Counter Fraud Authority has provided specific guidance, failure to prevent fraud offence | NHS Counter Fraud Authority. A statement is also available on our Trusts websites.
1.4	**WUTH Health and Safety** There was zero Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in August. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There was one Patient Safety Incident Investigations (PSII) opened in August under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance.
1.5	**Published Reports of Interest** The following are some reports recently published and of interest to members of the Board, staff and public. • **NHS England - clustering arrangements.** Clustering arrangements for integrated care boards (ICBs) have been agreed by NHSE's Executive team and by ministers. The agreed clusters will be implemented during Q3 of 2025/26 but not every ICB is involved in clustering arrangements. While clustering ICBs will

	work together through shared leadership and combined teams, they will remain separate legal entities. NHS England » More about each integrated care system • **Nursing and Midwifery Council – Principles for supporting women's choices in maternity care.** These principles have been developed in response to a changing maternity landscape, with more women seeking personalised care and, in some cases, making choices outside standard care pathways. Grounded in real-world practice, these evidence-based principles provide supportive information for midwives and employers navigating complex care scenarios. This will help ensure professionals can support women's individual choices while delivering safe, high-quality, person-centred care in line with the NMC code and standards. https://www.nmc.org.uk/standards/guidance/principles-for-supporting-womens-choices-in-maternity-care/ • **Parliamentary and Health Service Ombudsman – Promoting a just culture.** This guide sets out how to develop an organisation-wide culture that openly welcomes complaints and is accountable when mistakes happen. It explains how to embed the most important cultural values that encourage colleagues to view complaints as a vital tool for getting feedback from the people who use your service; and use this feedback to improve colleagues' and organisational performance. https://www.ombudsman.org.uk/organisations-we-investigate/complaint-standards/uk-central-government-complaint-standards/uk-central-government-good-complaint-handling-guides/promoting-just-culture
1.6	**Communications and Engagement** **Joint Chair visits Research and Innovation Centre** Sir David Henshaw, Joint Chair, visited Wirral Research and Innovation Centre recently to take a tour of the facilities and lead a round-table discussion on the future of research at WUTH. He emphasised the importance of research at the Trust, highlighting the vital role it plays in delivering outstanding patient care and creating rewarding career opportunities for staff. Sir David highlighted that one of the Trust's key priorities is to embed research into everyday practice across wards and departments and grow the number of studies and participants. **WCHC Cyber Awards Finalist** Congratulations to Phil Lang, Cyber Security Officer at WCHC who has been selected as a Finalist for the NHS England Award entry at this year's National Cyber awards. Being selected from hundreds of nominations is an exceptional accomplishment. The winner will be announced on Monday 29 September at the National Cyber Awards ceremony. Congratulations, Phil and good luck! **WUTH Employee/Team of Month Awards - August 2025** A huge well done to the Maternity Ward who won Team of the Month - Patient Care, Kara Dulson who is Employee of the Month - Support Services and a special congratulations go to Sarah Deus on winning the CEO Star Award.

	WCHC Standout Winners - August 2025 - Louise McAdam, Sarah Chadwick, Sarah Condran and Jo O'Neill (St Helens Safeguarding Team) Congratulation to the Standout Winners who were announced at the Trust's Get Together at the end of August 2025. In her nomination, Katherine Hill, Named Nurse Safeguarding Children St Helens said; *"I thank my lucky stars every day that I get to work alongside such motivated, caring and compassionate nurses, who support 0-19 practitioners with complex safeguarding work. Despite increased demands in August, they stepped up to redact records for court, ensuring deadlines were met. Their dedication, teamwork, and unwavering support make a huge difference. They truly are unsung heroes".* **WUTH and WCHC Annual Members Meeting** WUTH and WCHC will hold their respective Annual Members Meetings on Thursday 23 October. Further information including times, locations and how to register will be made available on the website.

Board of Directors in Public **Item 8**

01 October 2025

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

Executive Summary and Report Recommendations

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

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

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

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

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

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

NHS Oversight Framework (NOF)

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

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

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

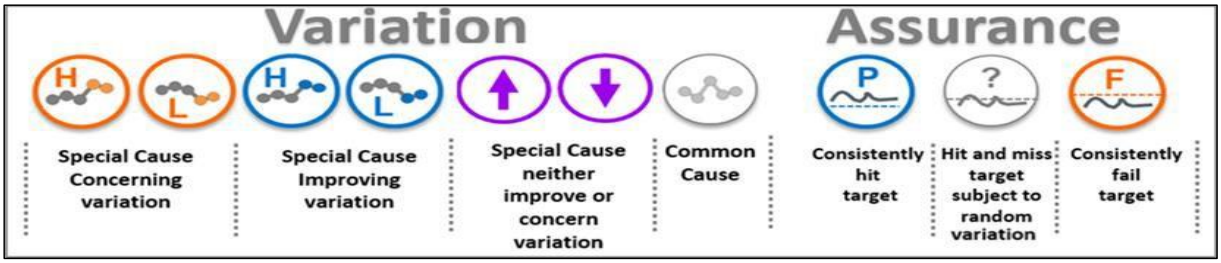
Key Risks
Strategic (Board Assurance Framework- BAF) and operational Risk and opportunities: The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the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

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

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

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

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

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

NHS
Wirral Community Health and Care
NHS Foundation Trust



Integrated Performance Report - August 2025

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

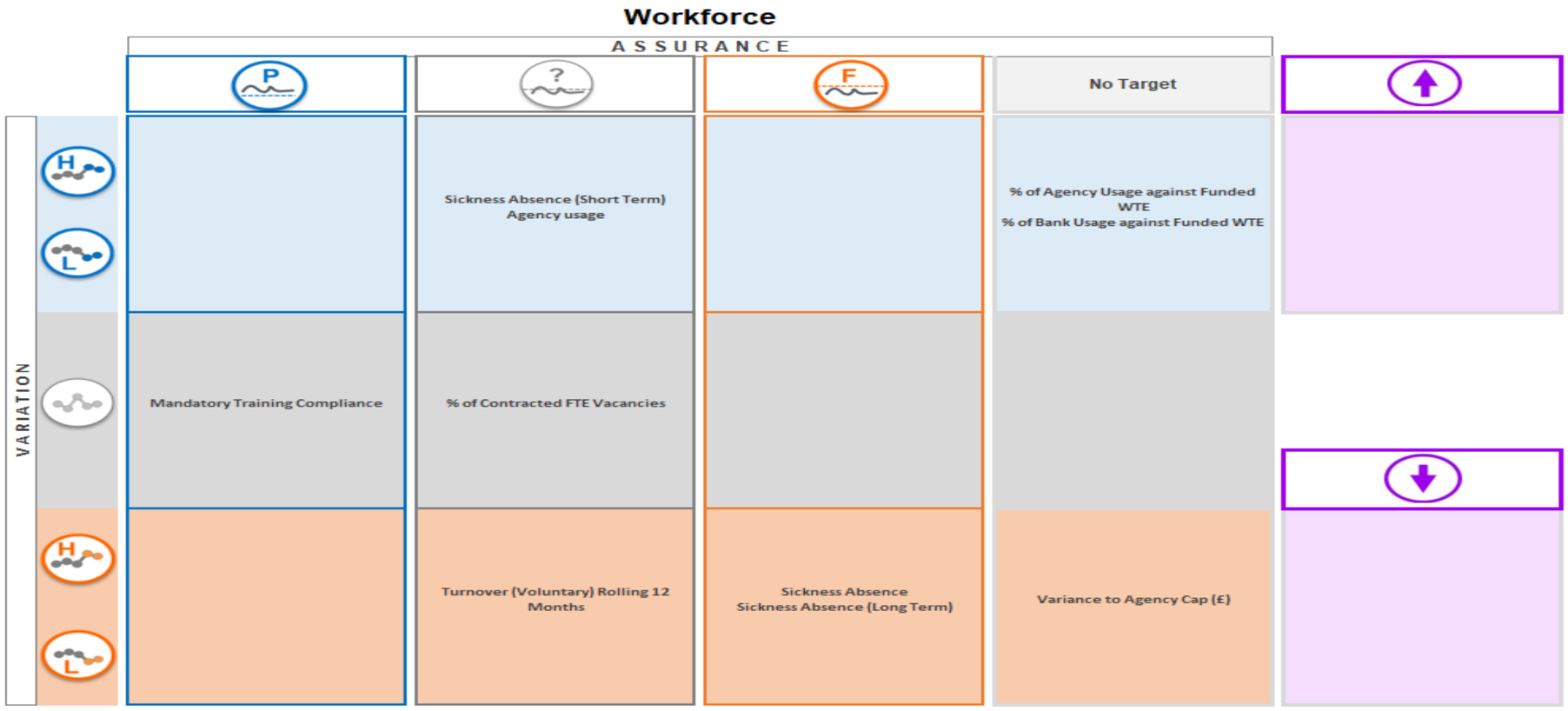
Voluntary turnover has continued to increase, up to 10.1%, up from 9.5% the previous month. It is likely that turnover will continue to increase in line with workforce plans to manage headcount reductions, vacancy scrutiny processes and the Trust's Mutually Agreed Resignation Scheme.

Mandatory training maintained a similar position as last month at 94.6%. July was 94.7%. Trend is consistent and stable, and all localities are reporting over 90% target. For context, previous months achievements for May 25 were 95.2% and June 25 was 95.3%.

Agency use showed a slight increase in July at 0.5% (against funded WTE) however this has now dropped to 0.4% (May 25 was 0.2%, June 25 was 0.4%). This is significantly below the regional 3.2% target. Greatest expenditure remains in Ophthalmology, GP Out of Hours, CICC, and Speech and Language.

Sickness absence levels continue to be above the Trust ≤5% tolerance. Sickness absence has been an area of concern for several months and latest performance is 7.7% (an increase of 0.3% since July 25). The Trust threshold of ≤5% was last achieved in August 2023. The current YTD sickness position is 6.9%. The absence challenges are driven mainly by long term sickness. Both short and long-term sickness have increased. Short term is within tolerance at 1.6% (0.1% increase), however long-term sickness is the area of focus at 6.2% (increase of 0.3%).

Workforce Domain Matrix



Workforce Summary

Highlights

Mandatory Training

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

Turnover

Turnover has steadily reduced in line with national agenda to retain staff in line with the NHS People Promise and is below target rate, however this is likely to increase in line with plans, therefore target under review.

Agency Use

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

Bank Use

Use of Bank staff has reduced over the past 2 years and has fluctuated between 2-3% and has been trending down since Jan 25 and standing at 2.6% in August.

Areas of Concern

Sickness absence remains a cause for concern as it is above the target level at 7.7%.

The top 3 reasons remain as mental health (Anxiety/stress/depression), Gastro and Cold Cough and Flu. Recorded RTW interview have also dipped by 6% to 78% in August 25, although this has been an improving picture since April 25.

Localities with the highest sickness absence were Community Response (8.8%), 0-19/25 (8.2%) and Specialist Medical (8%). During August 25 the Chief People Officer, Deputy Chief Operating Officer and Head of HR held a series of engagement sessions with each service Director and HR Business Partner to review local intelligence, understand their approach, identify good practice and make recommendations to urgently address the challenge.

Work is in progress in relation to the 4 thematic areas:

- Managers roles and responsibilities,
- HR Support,
- Absence Management and;
- Reporting and Recording.

This commenced and was undertaken during August and into September. Whilst the effective management of sickness absence remains challenging it also offers an opportunity for positive change.

Forward Look (Actions)

Proactively supporting heath & wellbeing:

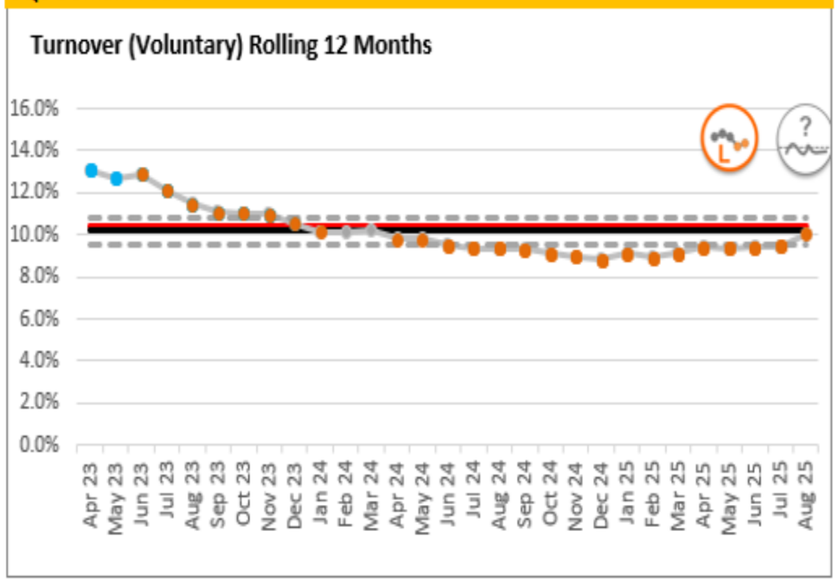
- The new stress and burn out sessions led by WUTH's psychotherapist have also been extended to the Trust and sessions are planned through to October.
- New Communication campaign has been approved to increase awareness and impact of sickness - 'Every Day Counts'
- Extensive review of the output of the PAM Occupational Health service and improvement actions
- NHSE wellbeing conversation training dates scheduled through to December 25
- Roles and responsibilities clarified
- Mental Health first aid training launched - 5 new cohorts
- New roadmap to wellbeing produced and will launch in line with the integration
- The winter flu campaign set to commence 1st October

Managing Absence:

- PAM OH providing training to improve management referrals and improve quality of associated OH reports to effectively manage sickness
- Case conferences reinvigorated for complex cases
- Pilot of 'line by line' active LT sickness cases
- Re-prioritisation of HR team responsibilities to support and drive sickness
- New HR Advisor recruited to support sickness absence management and will undertake local sickness Audits from October

Turnover (Voluntary) – Rolling 12 Months

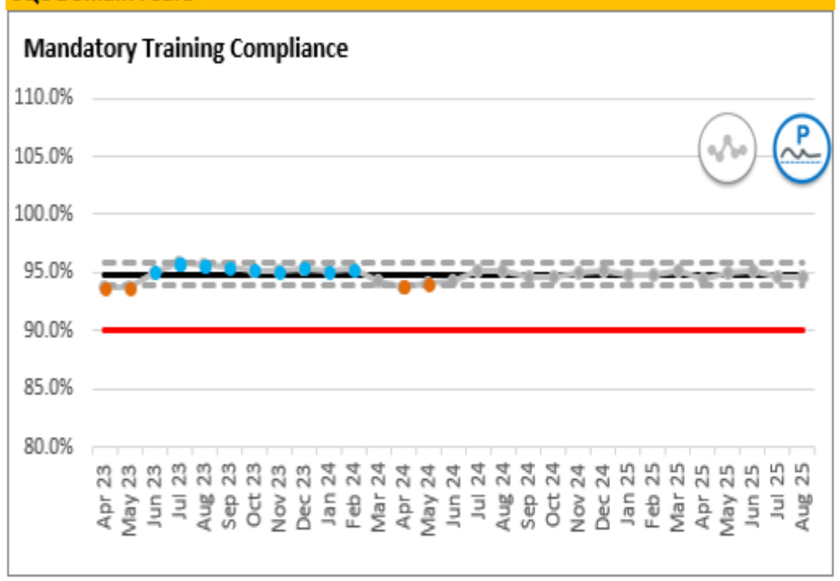
CQC Domain : Safe



Aug-25
10.1%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

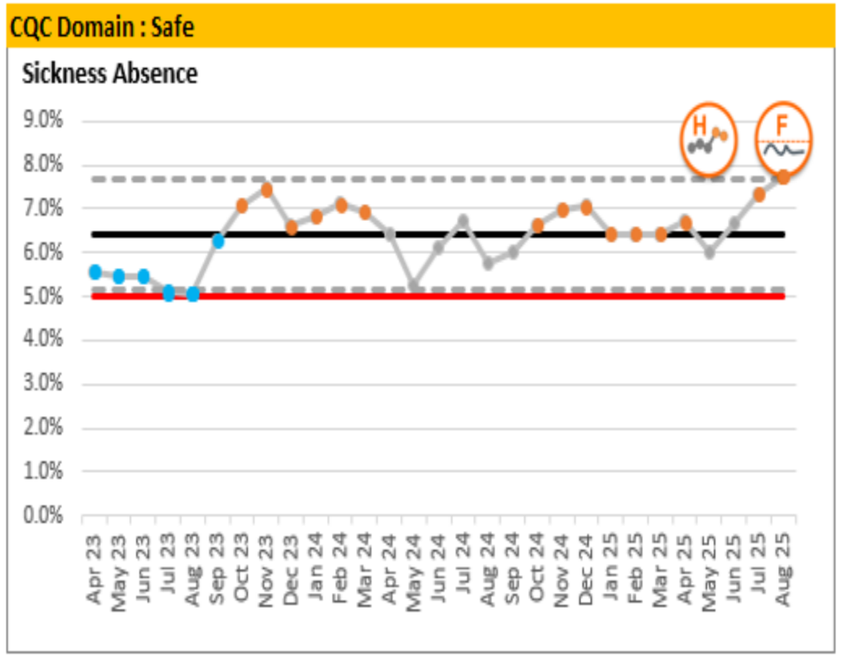
CQC Domain : Safe



Aug-25
94.6%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

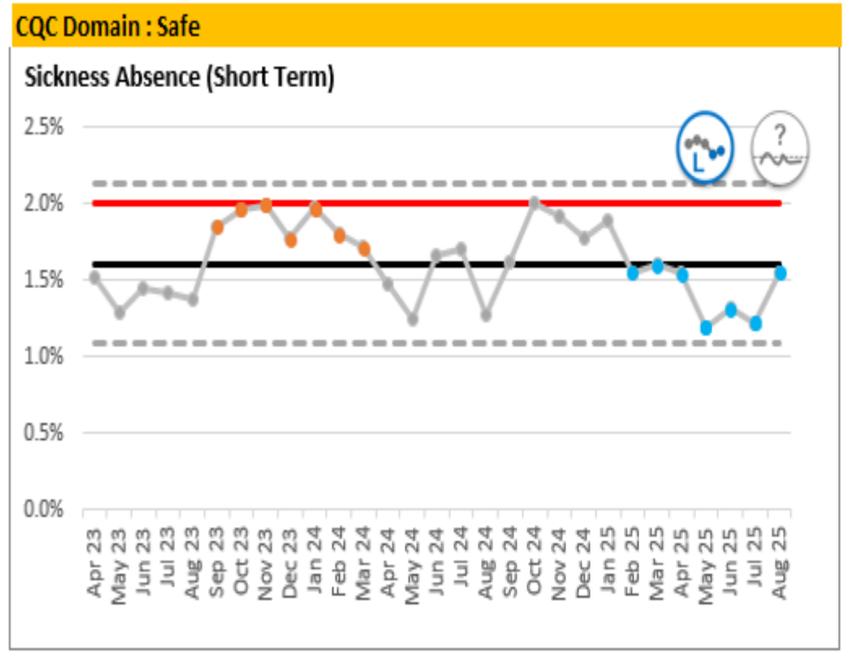
CQC Domain : Safe



Aug-25
7.7%
Variance Type
Special cause variation - Concerning
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

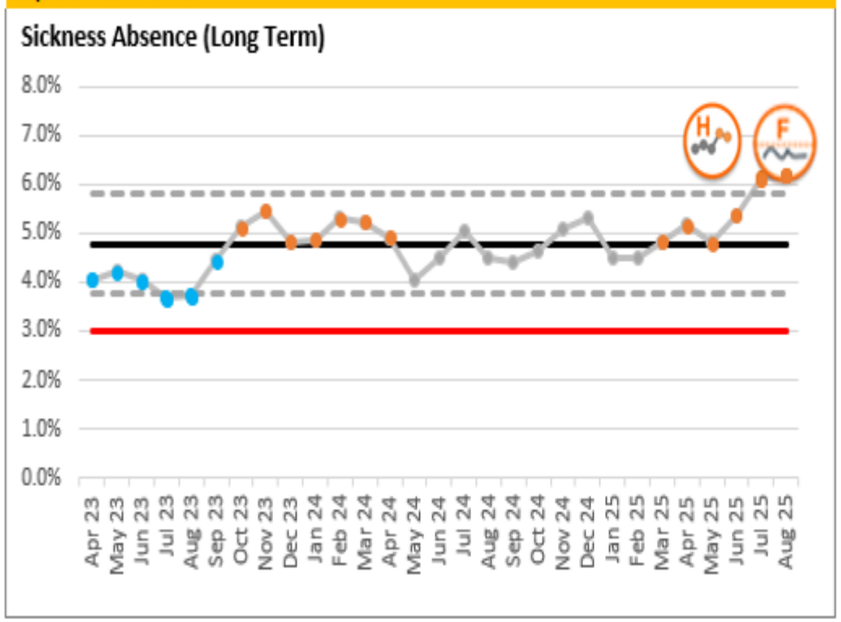
CQC Domain : Safe



Aug-25
1.6%
Variance Type
Special cause variation - Improving
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Sickness Absence (Long Term)

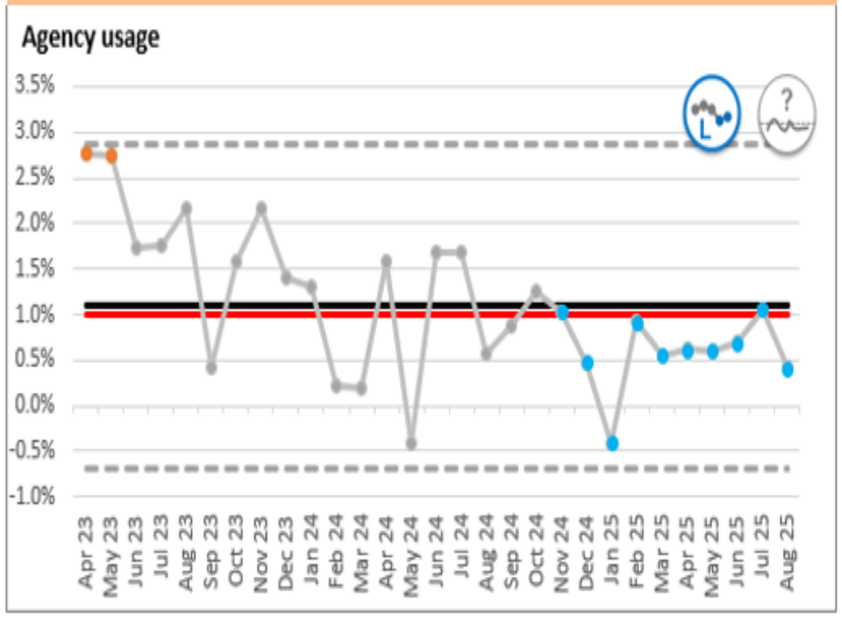
CQC Domain : Safe



Aug-25
6.2%
Variance Type
Special cause variation - Concerning
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

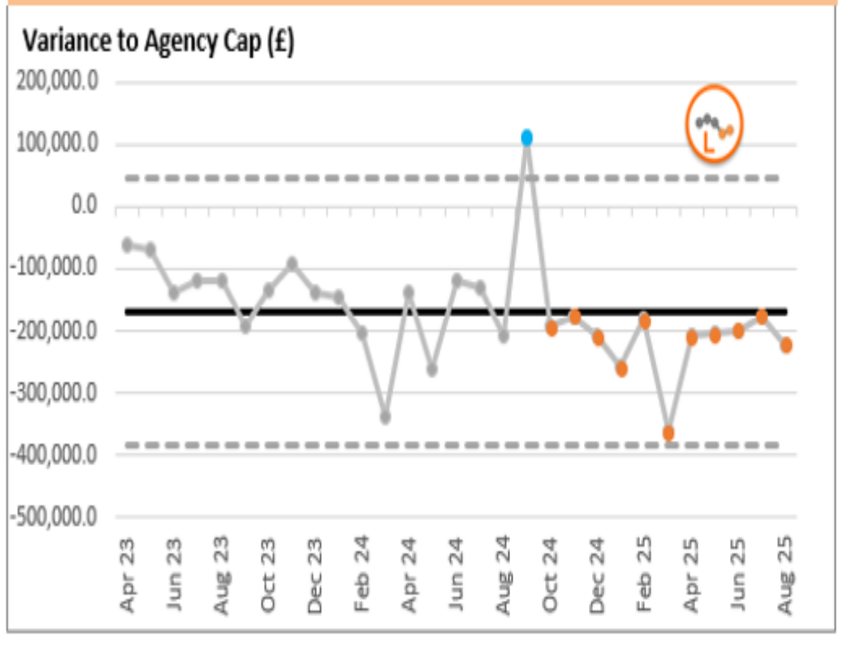
CQC Domain : Well-led



Aug-25
0.4%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

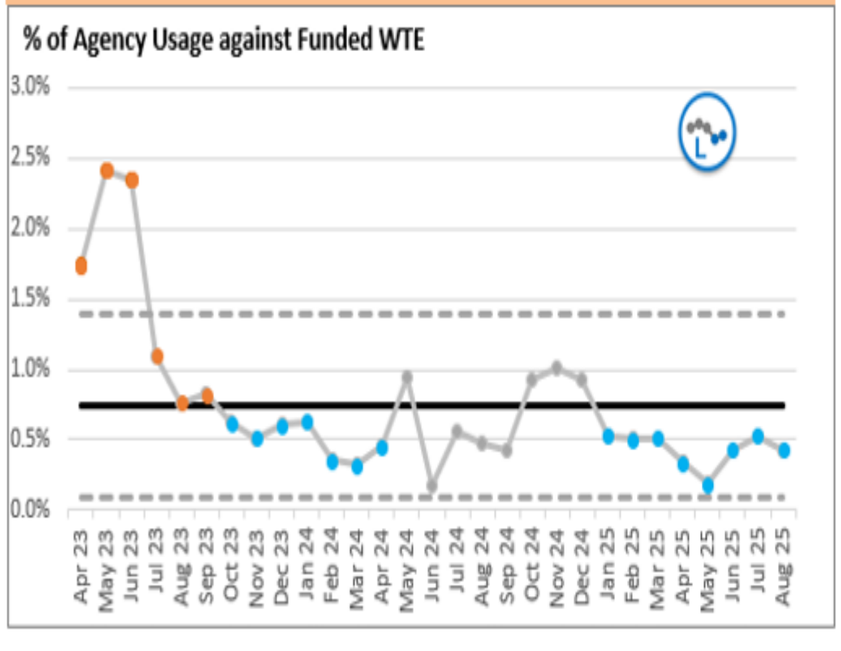
CQC Domain : Well-led



Aug-25
-£221,702.81
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

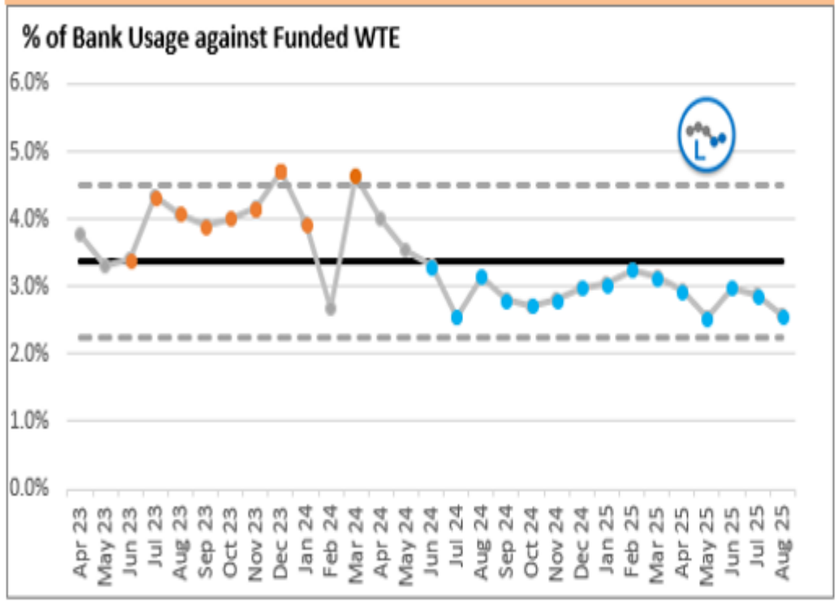
CQC Domain : Well-led



Aug-25
0.43%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Bank Usage against Funded WTE

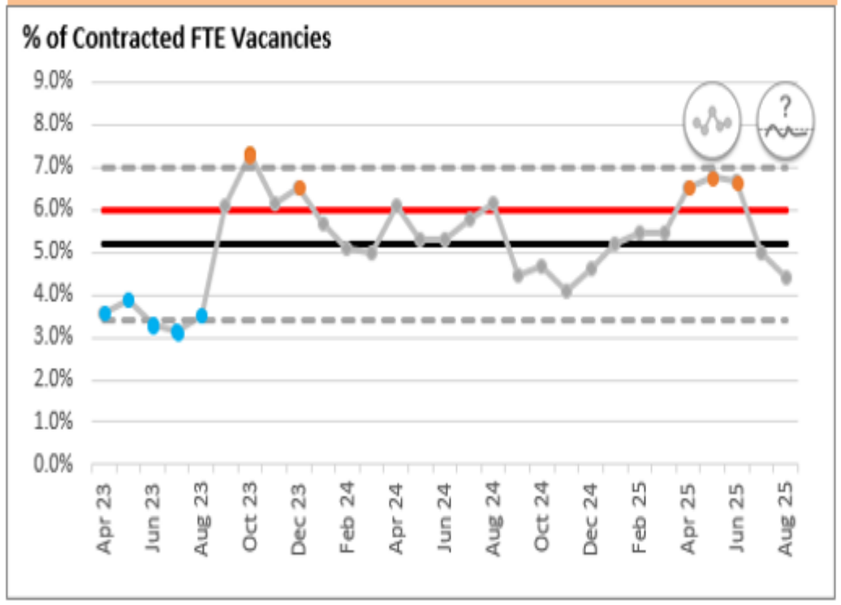
CQC Domain : Well-led



Aug-25
2.6%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led



Aug-25
4.44%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Dashboard	Operations
Lead	Chief Operating Officer

Chief Operating Officer Update

Operational performance remains strong. There are 91 operational KPIs reportable to commissioners and the position for M5 25-26 is:

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

Highlights:

- Improvements in 4-hour performance for WIC/UTC to 96.2%, back above 95% target
- UCR performance 90.7% against a 70% target
- Intermediate care - CICC occupancy continues above 90% and length of stay remains strong at 18 days against a 21-day target
- GPOOH UCAT 30 min response above target. UCAT 15 min improved in month to 64.3% against a target of 65%.
- Waiting lists – RTT and DM01 100% and majority non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times. Paediatric SALT achieved its target of all patients to be below an 18 week wait by September 2025 as per the trajectory agreed with local SEND Board.
- 0-19/25 services – all key metrics across the four regional teams performing above target

Areas for improvement:

- GPOOH – remedial action plans are still in place to support performance improvements in GPOOH metrics. Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies, reductions in sickness absence, daily huddles to review breach themes to drive learning, L&OD support.

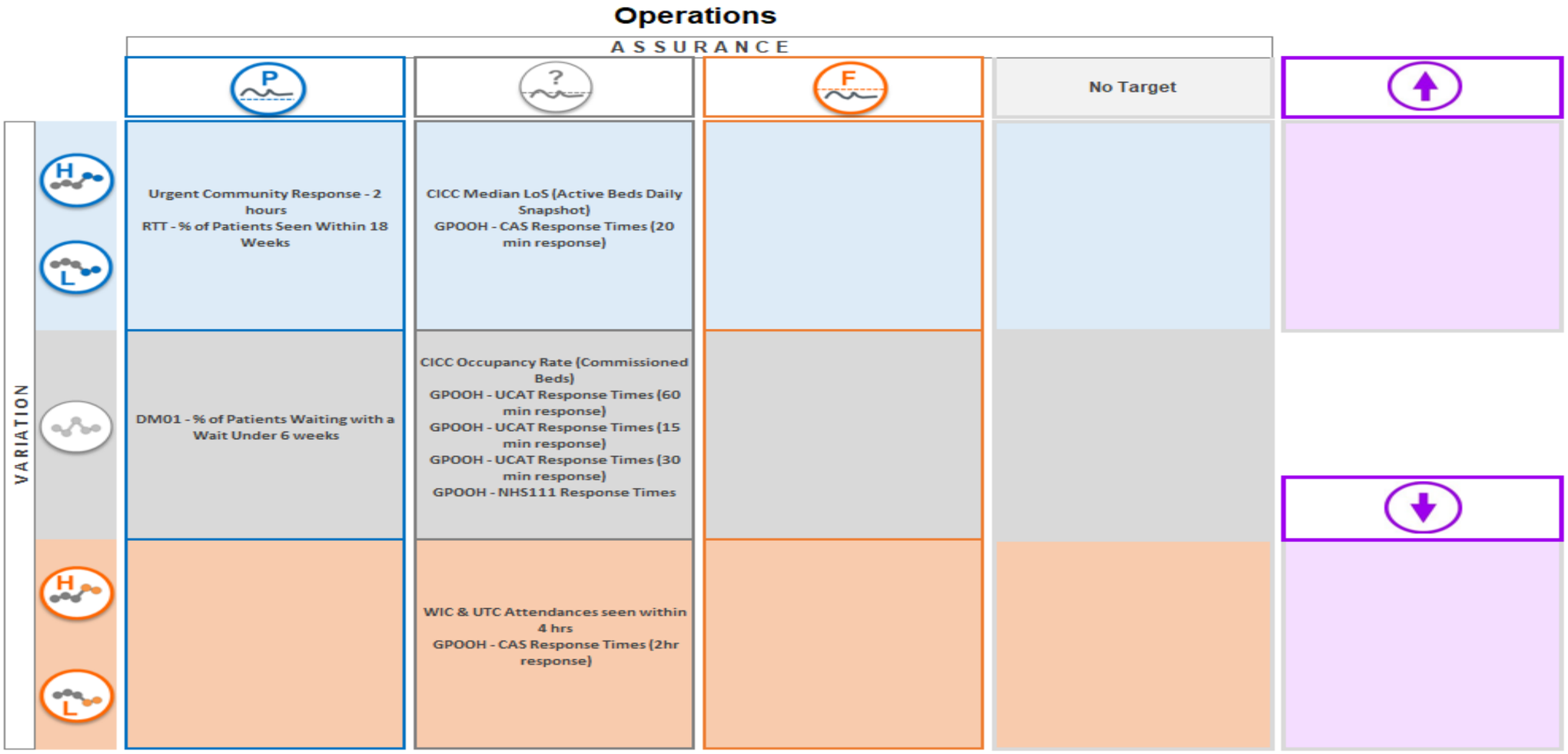
- Waiting lists: remedial action plans in place for Dental and Cardiology services.

  Dental waits are related to volume of patients awaiting paediatric exodontia. Significant improvements in reducing the backlog and wait times since commencing the action plan in January 2025 and slight further improvement in-month. Achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH.

  Cardiology performance challenges relate to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. A joint action plan has been agreed collaboratively with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH (using Community Diagnostic Centre capacity). ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long-term solution. Significantly improved performance in August compared to previous months, on track to achieve KPI by December 2025.

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

Operations Domain Matrix



Operations Summary

Highlights

- Improvements in 4-hour performance for WIC/UTC to 96.2%, back above 95% target
- UCR performance 90.7% against a 70% target
- CICC occupancy continues above 90% and length of stay remains strong at 18 days against a 21-day target
- GPOOH UCAT 30 min response above target. UCAT 15 min improved in month to 64.3% and just shy of 65% target.
- Waiting lists – RTT and DM01 100% and non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times
- 0-19/25 services – all key metrics across the four regional teams performing above target

Areas of Concern

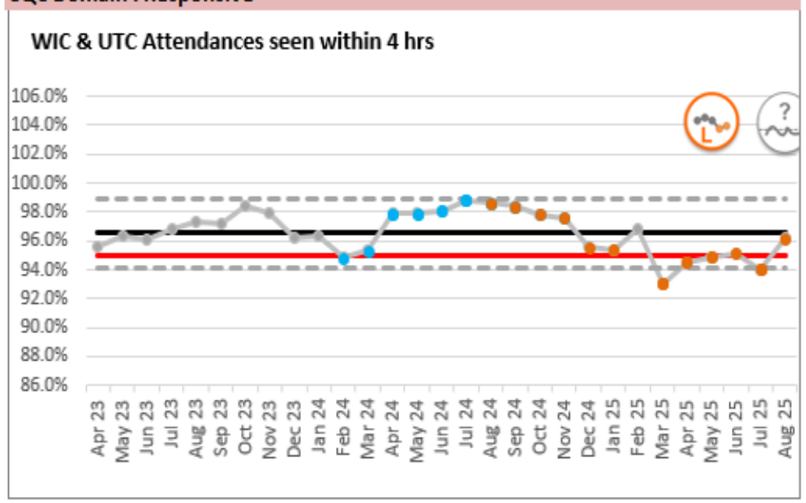
- GPOOH CAS and 111 response times.
- Waiting lists: Dental, Cardiology

Forward Look (Actions)

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

WIC & UTC Attendances seen within 4 hrs

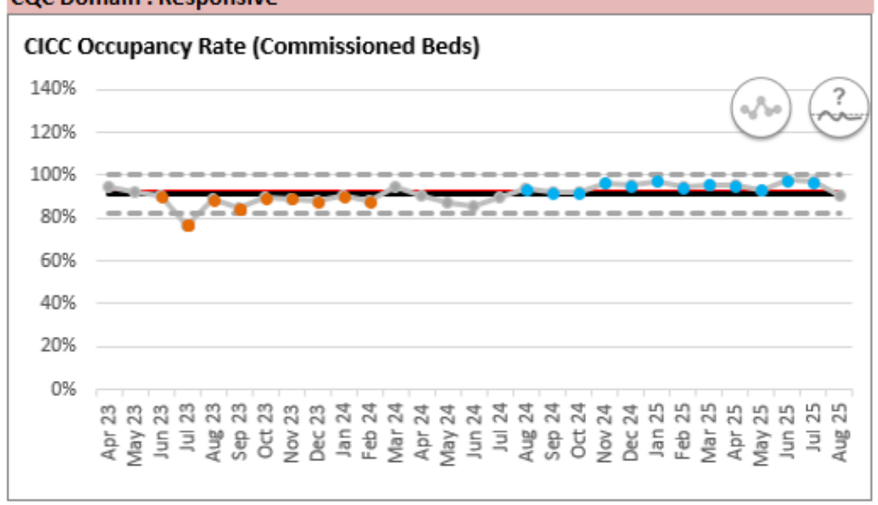
CQC Domain : Responsive



Aug-25
96.2%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CICC Occupancy Rate (Commissioned Beds)

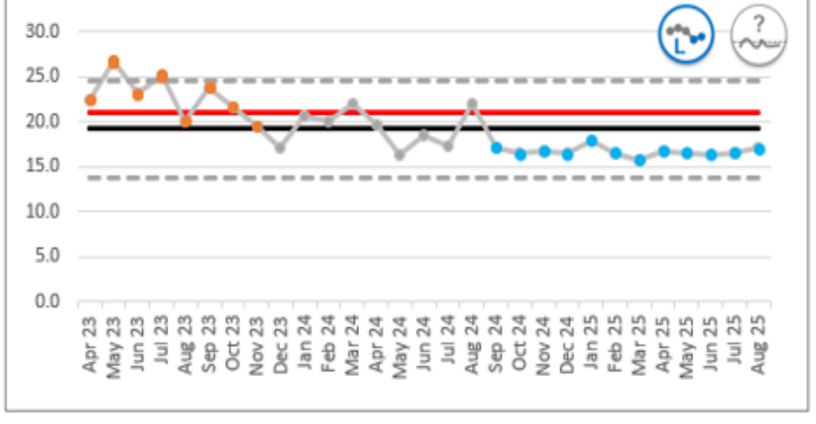
CQC Domain : Responsive



Aug-25
90.4%
Variance Type
Common cause variation
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

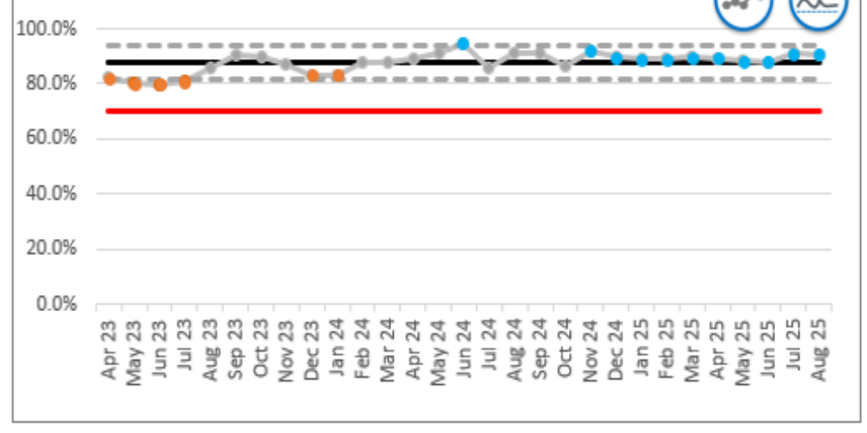
CQC Domain : Responsive



Aug-25
18
Variance Type
Special cause variation - Improving
Threshold
21
Assurance
Hit & miss target subject to random variation

Urgent Community Response - 2 hours

CQC Domain : Responsive



Aug-25
90.7%
Variance Type
Special cause variation - Improving
Threshold
≥70%
Assurance
Consistanly hit target

Commentary

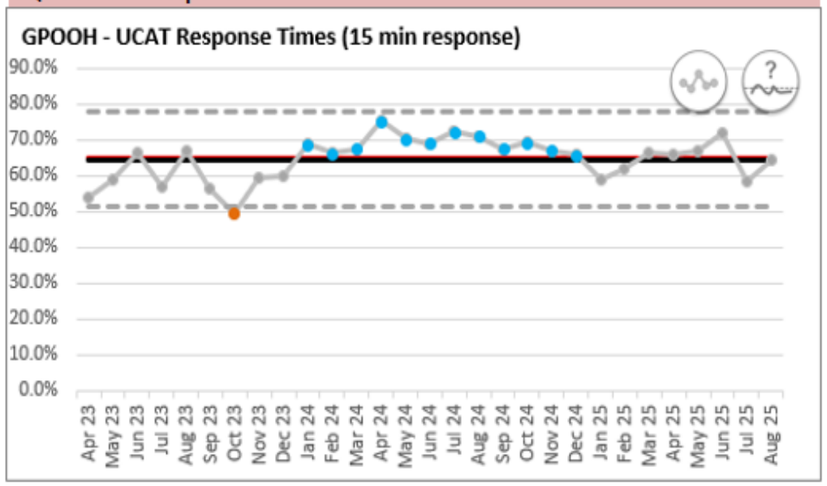
4-hour performance now above the 95% target, however, continue with remedial action plans to sustain performance improvements. Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies,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

CICC achieving performance against targets, no concerns

UCR achieving performance against targets, no concerns

GPOOH - UCAT Response Times (15 min response)

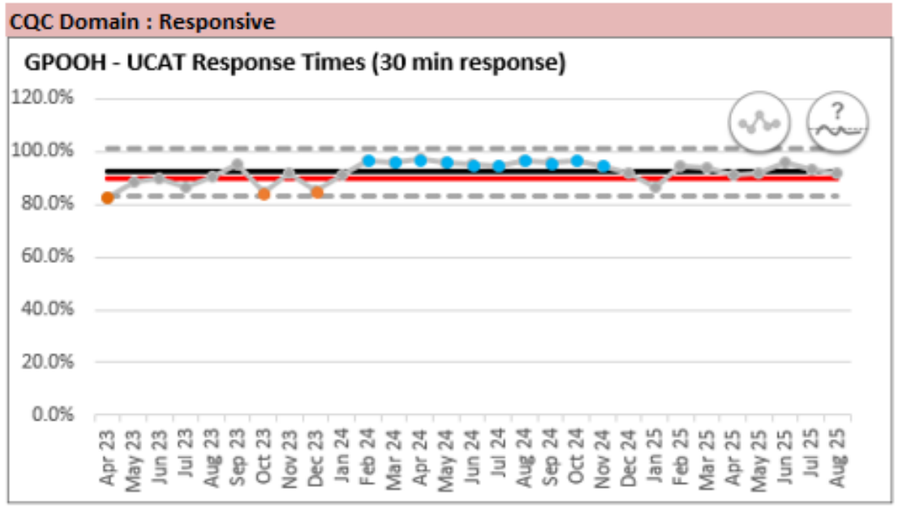
CQC Domain : Responsive



Aug-25
64.3%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

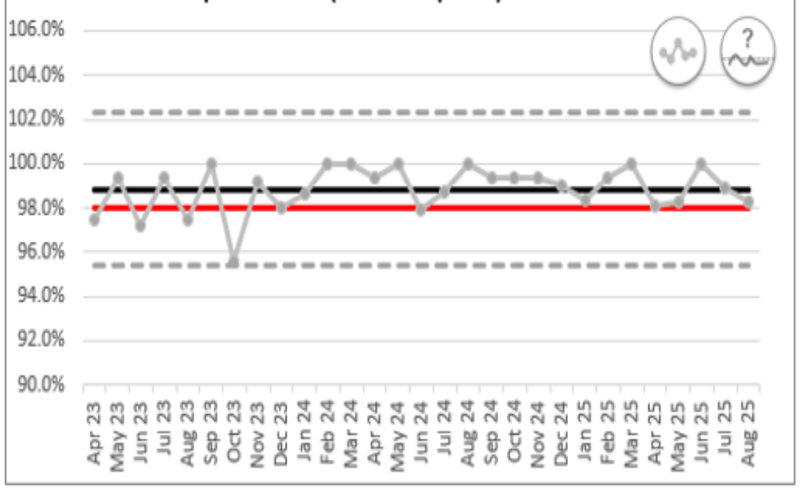
CQC Domain : Responsive



Aug-25
92.2%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

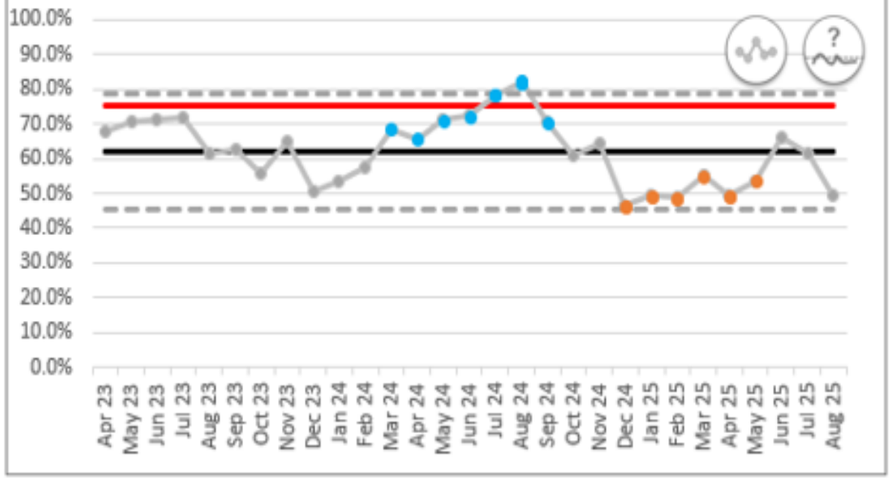
CQC Domain : Responsive



Aug-25
98.3%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive



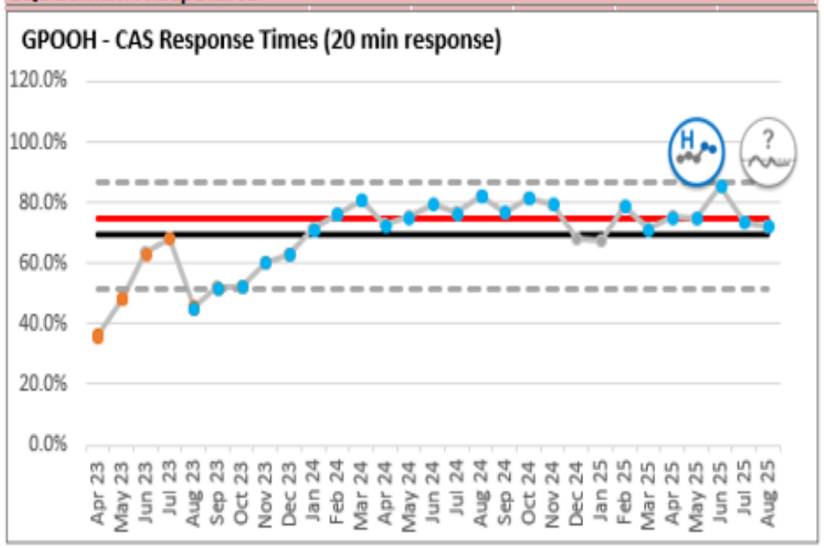
Aug-25
49.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

GPOOH CAS and 111 response times. UCAT 30- and 60-minute standards continue to be achieved, with further improvement noted this month against the UCAT 15-minute target. Performance against CAS 20 minutes, CAS 2 hours and NHS 111 remains below target, with in-month challenges driven by a 38% rise in CAS 2-hour referrals (compared to last month) and compounded by ongoing nursing and medical staff sickness. The risk is reflected on the operational risk register (ID 3227), with mitigation and action plans actively in place and progress monitored through daily oversight and monthly reporting.

GPOOH - CAS Response Times (20 min response)

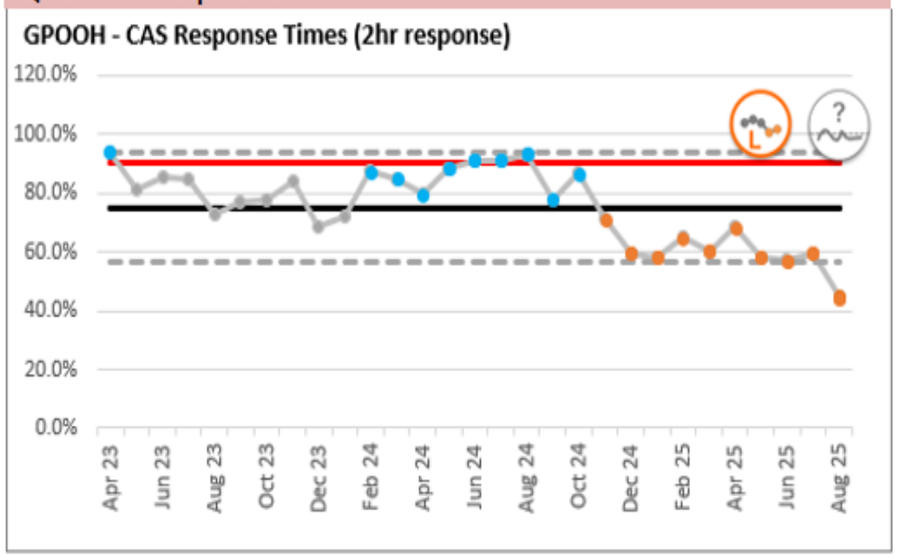
CQC Domain : Responsive



Aug-25
72.3%
Variance Type
Special Cause variation - Improving
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

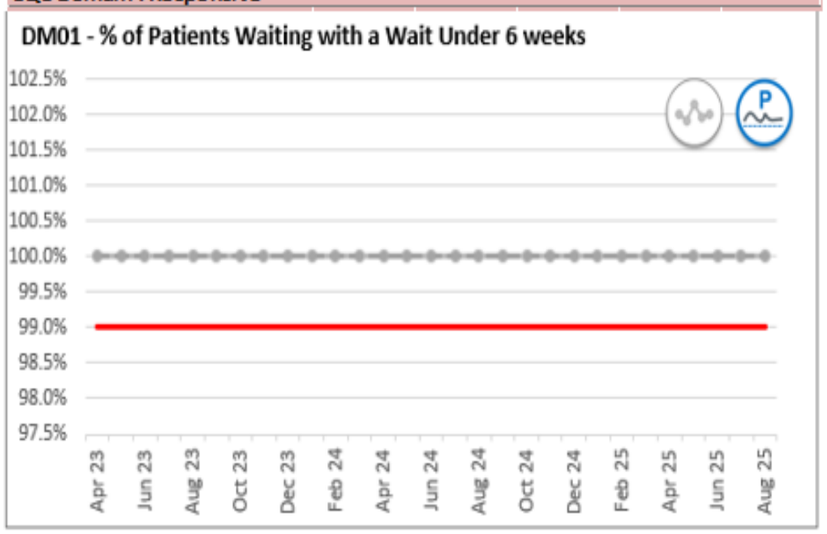
CQC Domain : Responsive



Aug-25
44.4%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

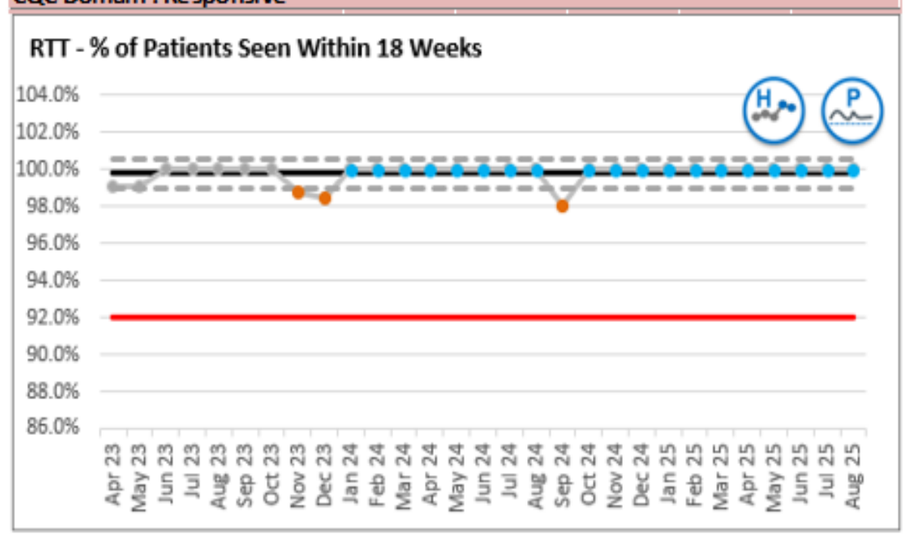
CQC Domain : Responsive



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

RTT- % of Patients seen within 18 Weeks

CQC Domain : Responsive



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

Commentary

DM01/RTT - 100% no concerns

Waiting Lists

Waiting list movement in Month - August 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	74% (-8%)	99% (-1%)	100% (0%)	445 (+16)
Specialist Medical	92% (4%)	99% (0%)	100% (0%)	1729 (-394)
Specialist Medical - Dental	26% (-7%)	58% (-4%)	79% (-3%)	185 (-48)
Therapies	56% (-2%)	80% (1%)	88% (-1%)	4689 (+126)

0-19/25 Performance

0-19/25 Services - August 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	90.6%	88.8%	83.9%	88.8%	91.6%	94.1%	96.0%	94.6%
12 month reviews	89.9%	89.6%	86.8%	89.8%	97.2%	97.0%	89.7%	91.2%
2.5 year reviews	88.2%	88.4%	87.8%	88.7%	95.7%	93.9%	91.8%	90.3%
Breastfeeding 6-8 weeks	56.2%	56.6%	42.8%	35.7%	38.8%	39.9%	45.2%	46.1%

Commentary

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

There has been a slight increase in the number of patients waiting for first appointments in the Nursing Directorate. This is due to an increase in referrals the Adult and Paediatric Bladder and Bowel service, however this is within normal variation and is not impacting significantly on access times.

There has also been an increase in the Therapies Directorate due to an increase in the number of patients awaiting Podiatry appointments. Activity delivered in-month was lower than previous due to sickness absence and vacancies. The service is out to recruitment and managing sickness in line with policy.

Paediatric SALT achieved its target of all patients to be below an 18 week wait by September 2025 as per the trajectory agreed with local SEND Board

Remedial action plans remain in place for Dental and Cardiology services. Dental waits are related to volume of patients awaiting paediatric exodontia. Significant improvements in reducing the backlog and wait times since commencing the action plan in January 2025 and slight further improvement in-month. The recovery plan remains on track, with improvements continuing to be delivered through the action plan. Work is ongoing with WUTH to secure the additional theatre capacity required to ensure recovery milestones are achieved

Cardiology performance challenges relate to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. A joint action plan has been agreed collaboratively with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH (using Community Diagnostic Centre capacity). ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long-term solution. Significantly improved performance in August compared to previous months, the service is aiming to be compliant with KPI waiting times for ECGs by December 2025.

0-19/25 services. All key metrics across the four regional teams performing above target with exception of Knowsley birth visits in month (83.9% against an 85% target). Slight underperformance due to staff sickness, patient choice factors and DNAs.

Dashboard	Quality and Governance
Lead	Chief Nurse

Chief Nurse Update

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

During the M5 reporting period, there have been no reported never events or StEIS reportable incidents.

There has been one Information Commissioner Office (ICO) reportable incident during M5, relating to a personal data breach due to an e-mail error. The data subject has been fully informed of the data breach and all immediate, appropriate action has been completed. The incident has progressed to an investigation to identify learning; this will be shared with the ICO and data subject on completion for assurance.

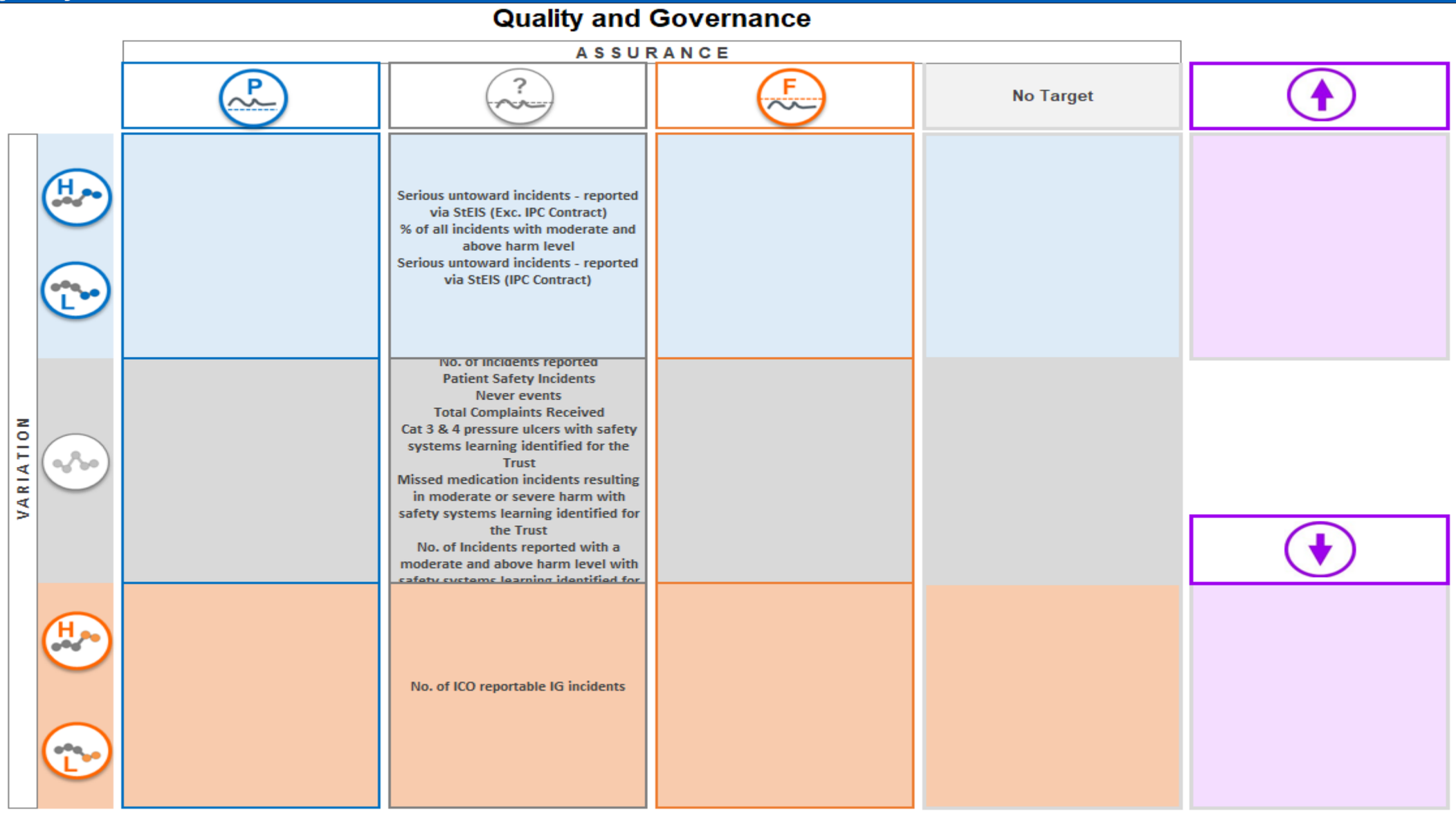
In accordance with the Patient Safety Incident Response Framework (PSIRF) the Trust monitors all patient safety incidents, including those resulting in no or low harm. During M5, 93.3% of patient safety incidents reported were no or low harm incidents. This reflect a positive reporting culture and high level of thematic learning resulting from these incidents which is aligned to PSIRF principles.

During the M5 reporting period, there have been zero falls at CICC resulting in moderate harm, zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning for the Trust. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained. These clinical quality metrics continue to be prioritised and have been incorporated into the refresh of the Trust's 2025/26 Patient safety incident response plan.

The Trust-wide Friend and Family Test continues to achieve a green RAG rated position, with a M5 position of 90.1% based on 2,040 positive responses. Whilst remaining within normal variation, the M5 position is -2 standard deviations from the mean. This has been highlighted for further analysis at the Trust's SAFE Operational Group to identify areas of improvement based on learning from experiences of care.

One complaint has been received by the Trust in M5, however, there has been a continued increase in concerns identified during the reporting month. A robust governance framework remains embedded across Trust services to evidence the effective management of all complaints and concerns, supporting the identification of learning to continuously improve the quality of care delivered. Whilst the number of concerns received in M4 and M5 is above the Trust's in-month threshold, no themes or trends have been identified. The increase in concerns will continue to be monitored at the Trust's SAFE Operational Group, reporting to the Integrated Performance Board and Quality and Safety Committee by exception.

Quality and Governance Domain Matrix

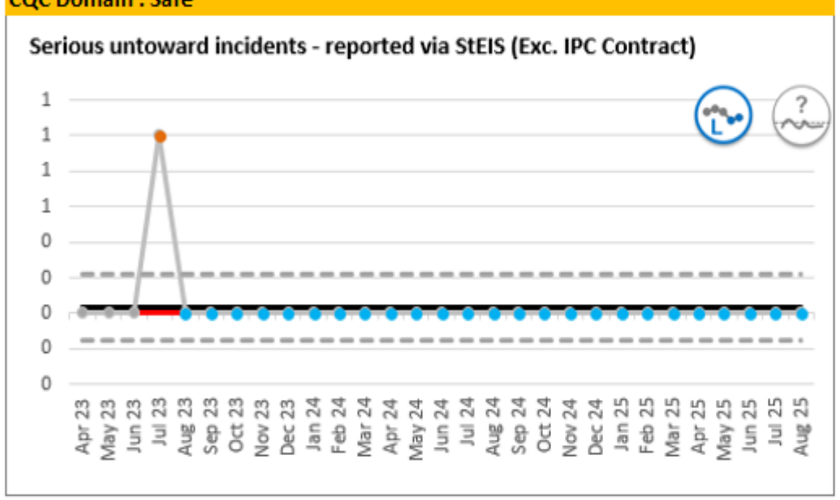


Quality and Governance Summary

The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust governance framework.	There has been one Information Commissioner Office (ICO) reportable incident during M5, relating to a personal data breach. All immediate, appropriate action has been completed, including open, transparent reporting and support to the data subject. The incident has progressed to an investigation to identify learning; this will be shared with the ICO and data subject on completion for assurance.	Clinical Risk Management Group continue to track improvement plans relating to falls prevention on inpatient units, safe administration of medications, wound care management and end of life improvements. A new plan was added during 2025/26 for monitoring indwelling urinary catheter devices. All plans have demonstrated improvements in Trust wide safety systems and their consistent application.

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

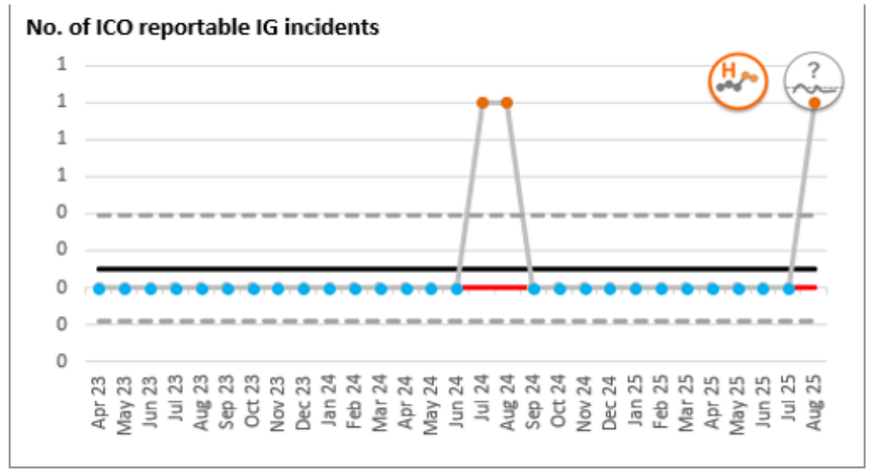
CQC Domain : Safe



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

No. of ICO reportable IG incidents

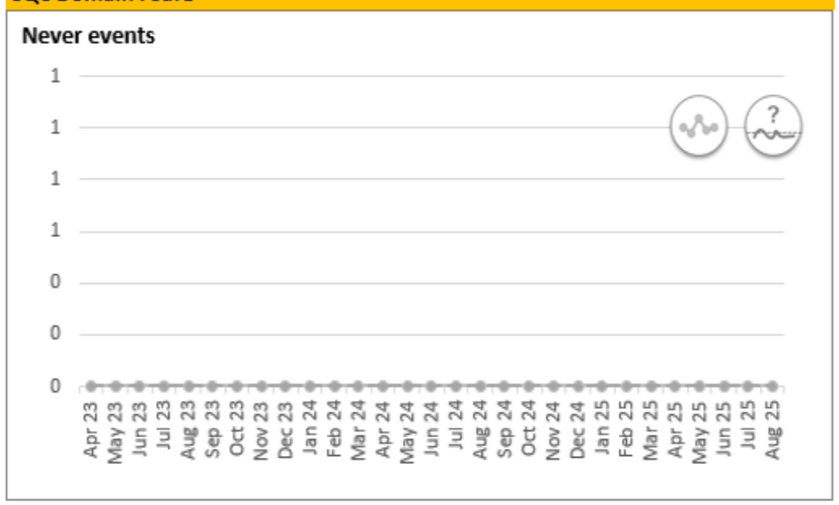
CQC Domain : Safe



Aug-25
1
Variance Type
Special cause variation - Concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events

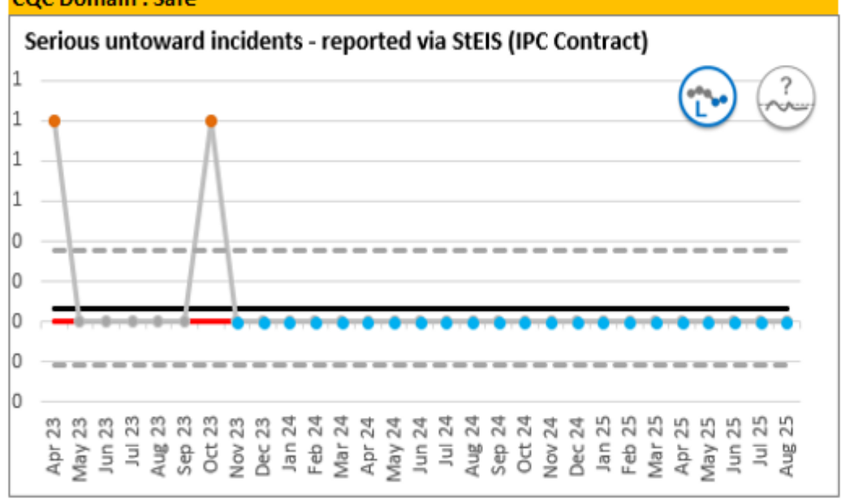
CQC Domain : Safe



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

Serious untoward incidents – reported via StEIS (IPC Contract)

CQC Domain : Safe



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

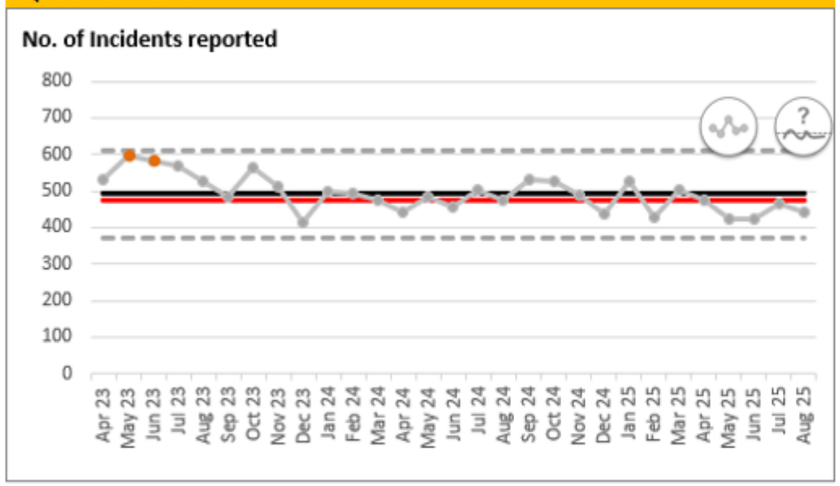
Commentary

During the M5 reporting period, there has been one Information Commissioner Office (ICO) reportable incident relating to a personal data breach due to an e-mail error. The data subject has been fully informed of the data breach and all immediate, appropriate action has been completed. The incident has progressed to an investigation to identify learning; this will be shared with the ICO and data subject on completion for assurance.

There have been no reported StEIS or Never Event incidents during the reporting period, demonstrating the effectiveness of the Trust's clinical safety systems, which are robustly tracked throughout the governance of the organisation, with clear delivery of sustained outcomes.

Number of Incidents reported

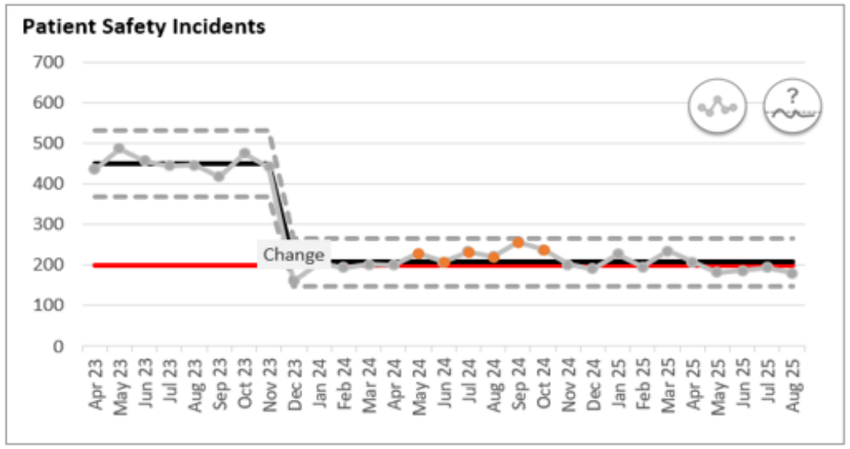
CQC Domain : Safe



Aug-25
442
Variance Type
Common cause variation
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

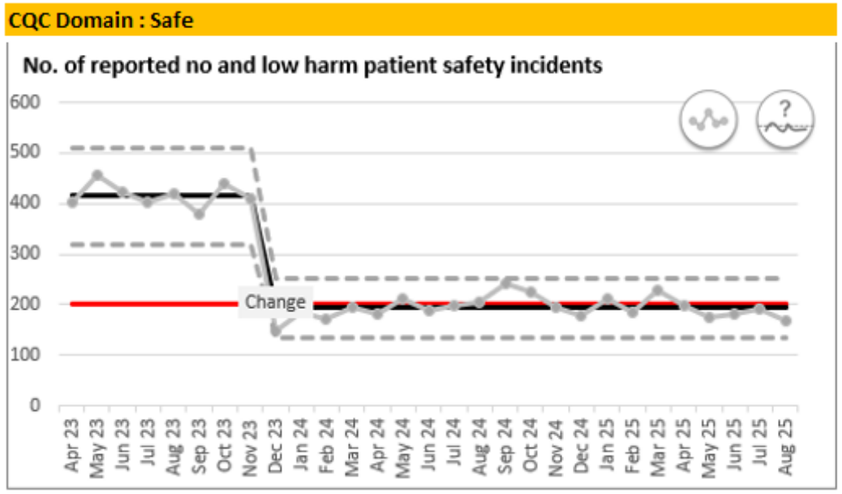
CQC Domain : Safe



Aug-25
180
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

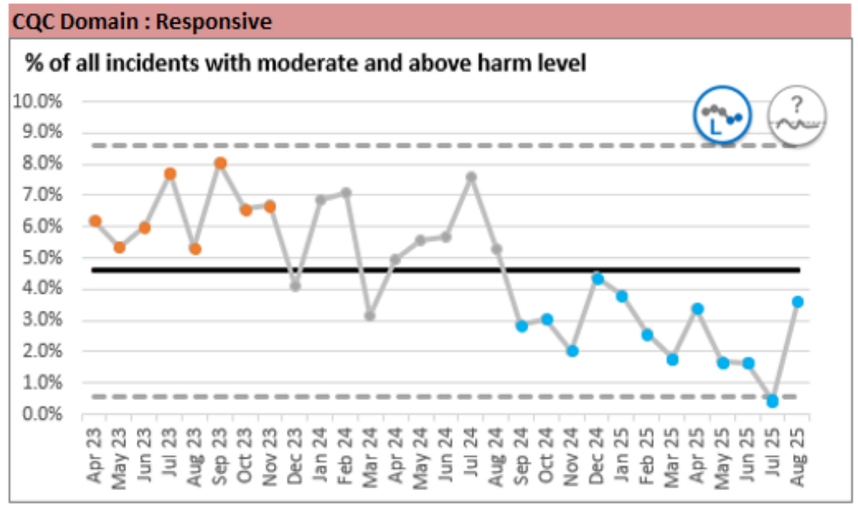
CQC Domain : Safe



Aug-25
168
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

% of all incidents with moderate and above harm level

CQC Domain : Responsive



Aug-25
3.6%
Variance Type
Special cause variation - Improving
Threshold
4.6%
Assurance
Hit & miss target subject to random variation

Commentary

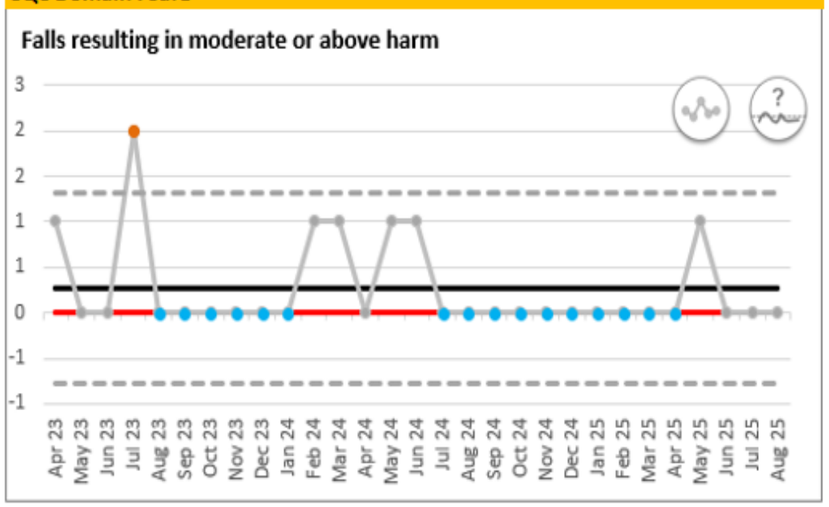
Incident reporting is an effective measure of safety culture across an organisation. The data above indicates that incident reporting has remained within normal variation throughout the reporting period. Dissemination of a Trust-wide communication is planned for early Q3 to support a proactive and positive culture of safety, evidencing lessons learned to continually identify and embed good practices across Trust services. This is aligned to the principles of the Patient Safety Incident Response Framework.

The number of low and no harm incidents remains within common cause variation and represents 93.3% of patient safety incidents reported during M5.

A validated M5 position of 3.6% of all incidents reported reached the threshold of moderate and above harm. These incidents were all referred to the Trust and have highlighted opportunities to support integrated system quality improvements, for example relating to pressure ulcer care.

Falls resulting in moderate or above harm

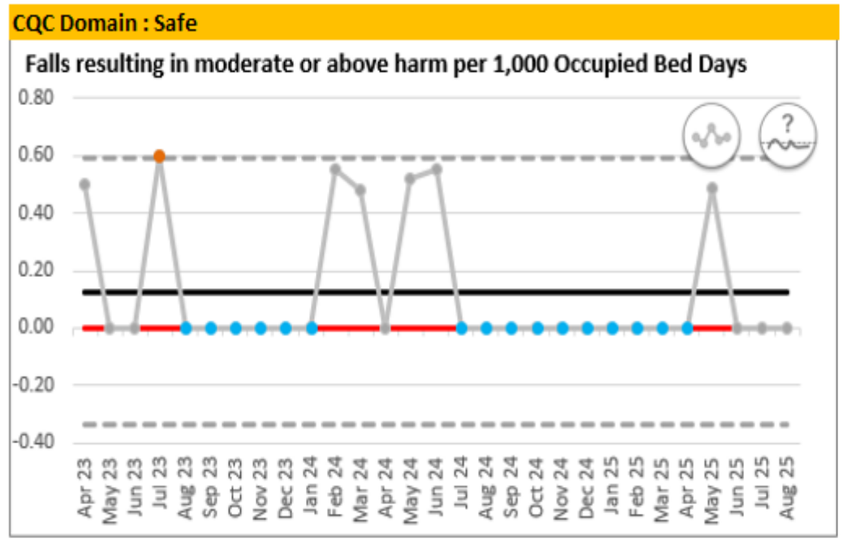
CQC Domain : Safe



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

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

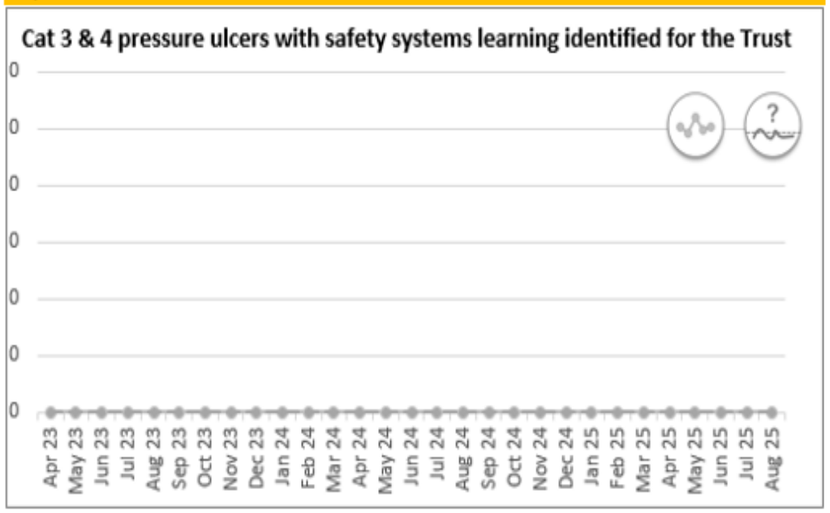
CQC Domain : Safe



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

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

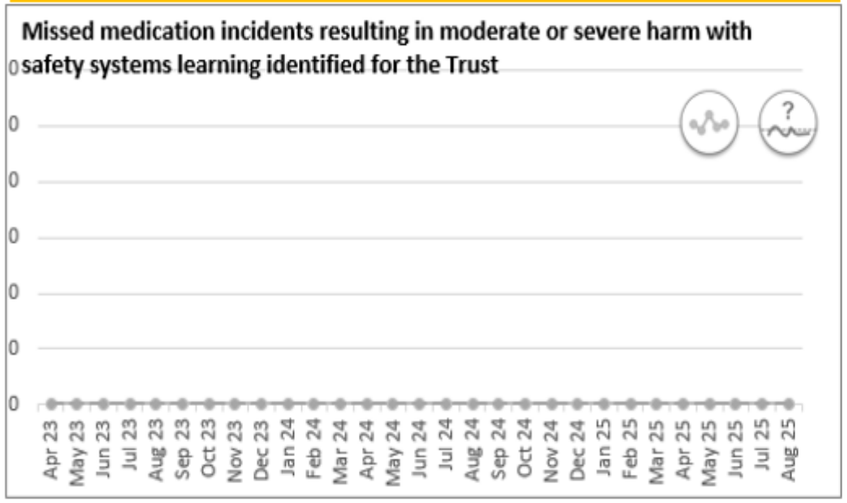
CQC Domain : Safe



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

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

CQC Domain : Safe



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

Commentary

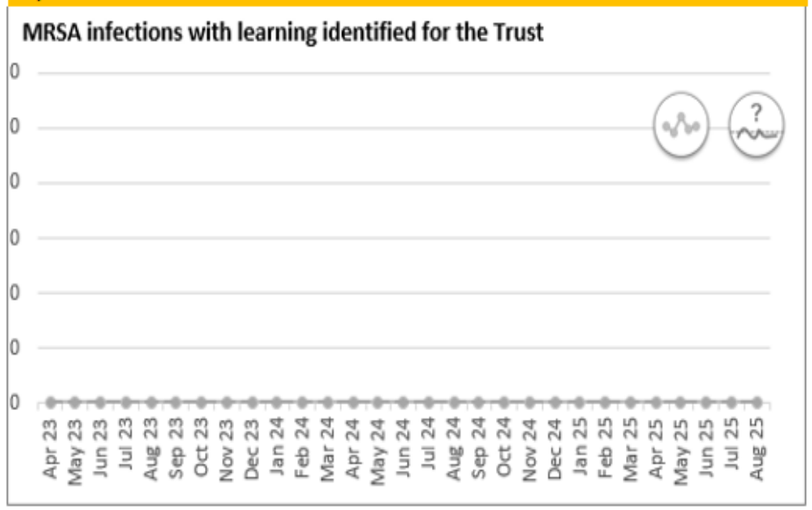
In accordance with the Patient Safety Incident Response Framework the Trust has embedded a robust governance structure to identify safety systems learning for all moderate and above harm incidents.

During the M5 reporting period, there have been zero falls at CICC resulting in moderate harm, zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning for the Trust. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained.

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

MRSA infections with learning identified for the Trust

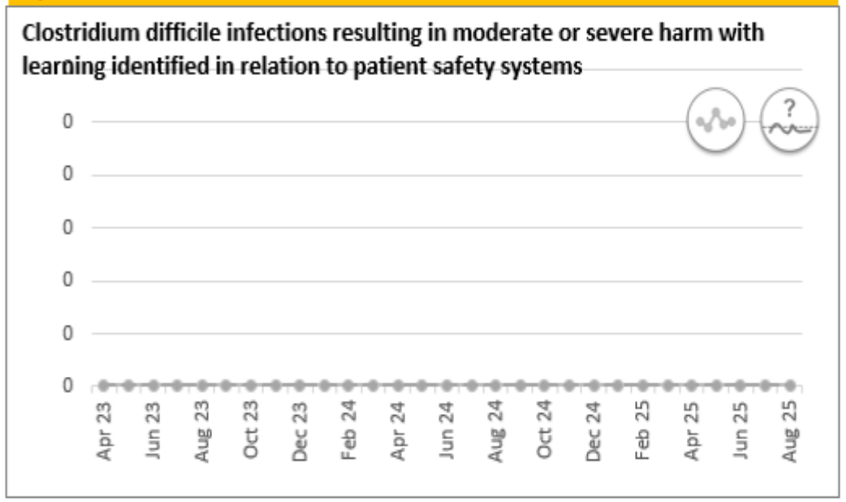
CQC Domain : Safe



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

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

CQC Domain : Safe



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

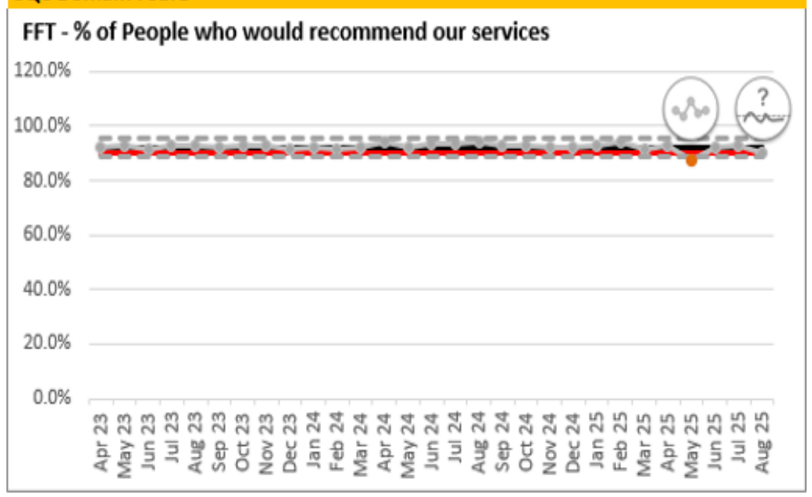
Commentary

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

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

FFT - % of People who would recommend our services

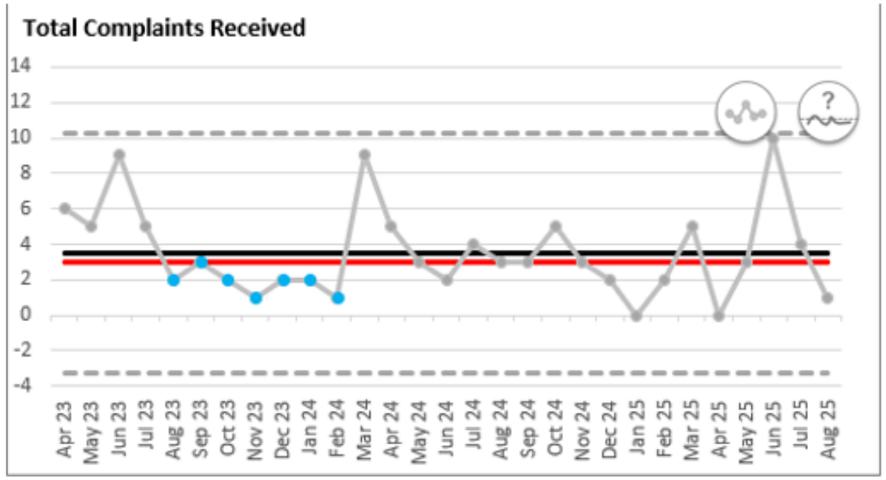
CQC Domain : Safe



Aug-25
90.1%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Total Complaints Received

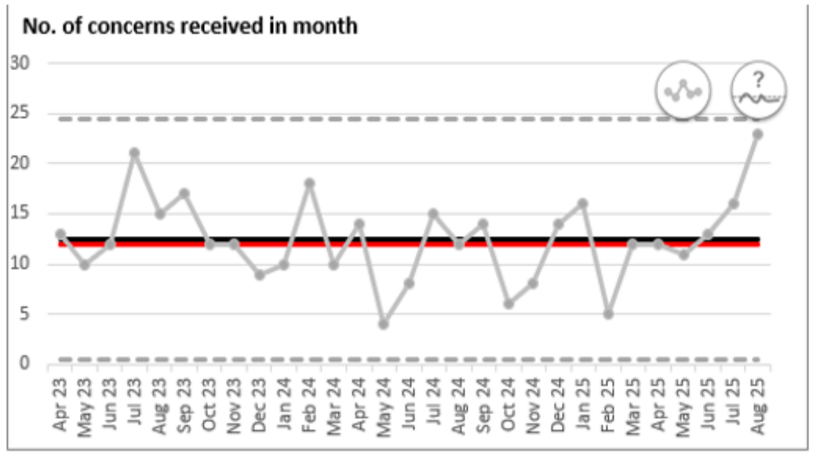
CQC Domain : Responsive



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

No. of concerns received in month

CQC Domain : Responsive



Aug-25
24
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

Commentary

The Trust-wide Friend and Family Test continues to achieve a green RAG rated position, with a M5 position of 90.1% based on 2,040 positive responses. Whilst remaining within normal variation, the M5 position is -2 standard deviations from the mean. This has been highlighted for further analysis at the Trust's SAFE Operational Group to identify areas of improvement based on learning from experiences of care.

One complaint has been received by the Trust in M5, however, there has been a continued increase in concerns identified during the reporting month. A robust governance framework remains embedded across Trust services to evidence the effective management of all complaints and concerns, supporting the identification of learning to continuously improve the quality of care delivered. Whilst the number of concerns received in M4 and M5 is above the Trust's in-month threshold, no themes or trends have been identified. The increase in concerns will continue to be monitored at the Trust's SAFE Operational Group, reporting to the Integrated Performance Board and Quality and Safety Committee by exception.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of August, the Trust is reporting a surplus of £0.5m. This is an improvement on plan for M5 but there is no change to the projected year end surplus of £0.9m.
At M5 the Trust has transacted £4.98m of CIP in year, £5.051m full year effect, against its revised target of £6.6m.

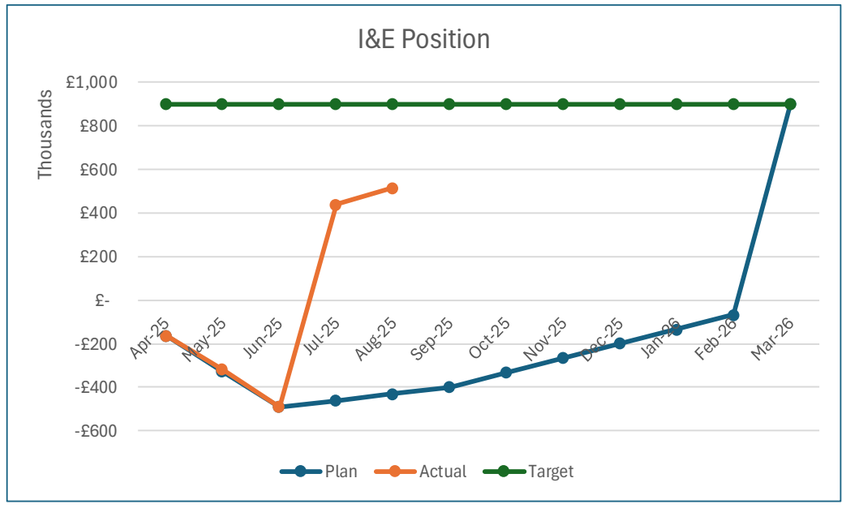
Finance Domain Matrix

Statutory Financial Targets	RAG (M5)	RAG (Forecast)
Financial stability	🟢	🟢
Agency spend	🟢	🟢
Financial sustainability	🟢	🟢
Financial Efficiency	🟡	🟢
Capital	🟡	🟢
Cash	🟡	🟢

Finance Summary

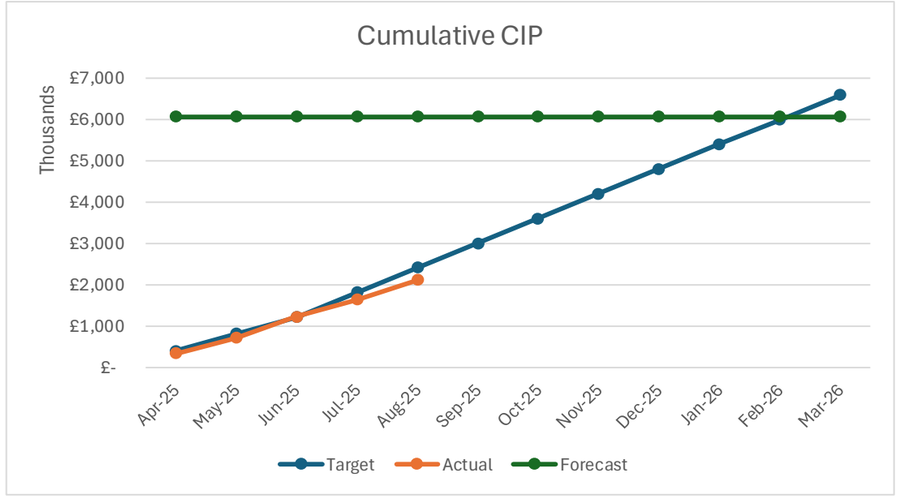
Highlights	Areas of Concern	Forward Look (Actions)
The Trust is ahead of plan at M5. Overspends in non-pay are fully mitigated by underspends on staff costs.	The key risks facing the Trust remain the negotiations around the 0-19 service and the CIP stretch target.	The Trust continues to look at identify additional CIP schemes.

I&E Position



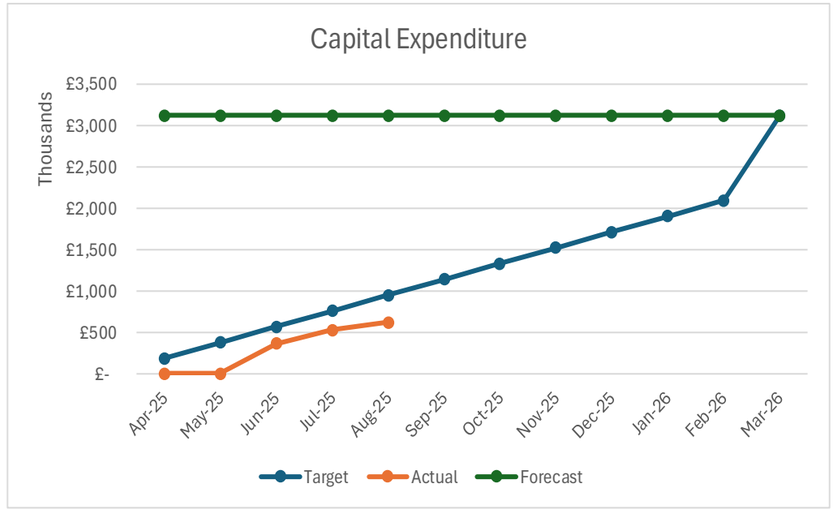
Aug-25
£515k
Variance
Position better plan
Target
£900k

Cumulative CIP



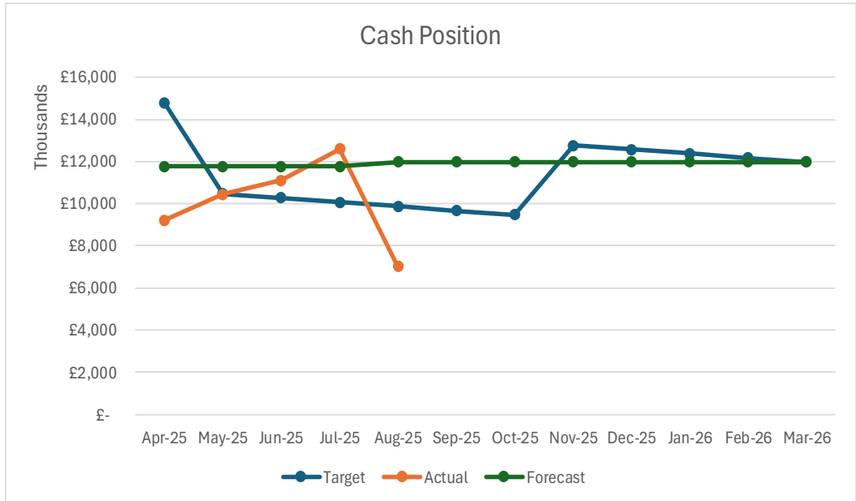
Aug-25
£2,114k
Variance
Position worse than plan
Target
£2,412k

Capital Expenditure



01/08/2025
£623k
Variance
Position worse than plan
Target
£952k

Cash Position



Aug-25
£7,011k
Variance
Position worse than plan
Target
£9,871k

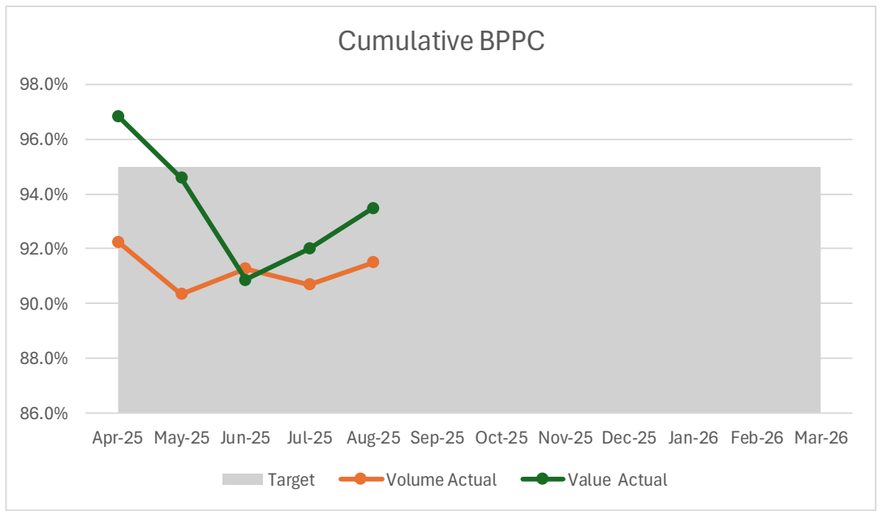
Commentary

The Trust is ahead of plan at M5. Non-pay costs are overspent due to pressures in respect of premises costs and purchase of healthcare. However, this is fully mitigated by underspends on pay driven by vacancies across the Trust.

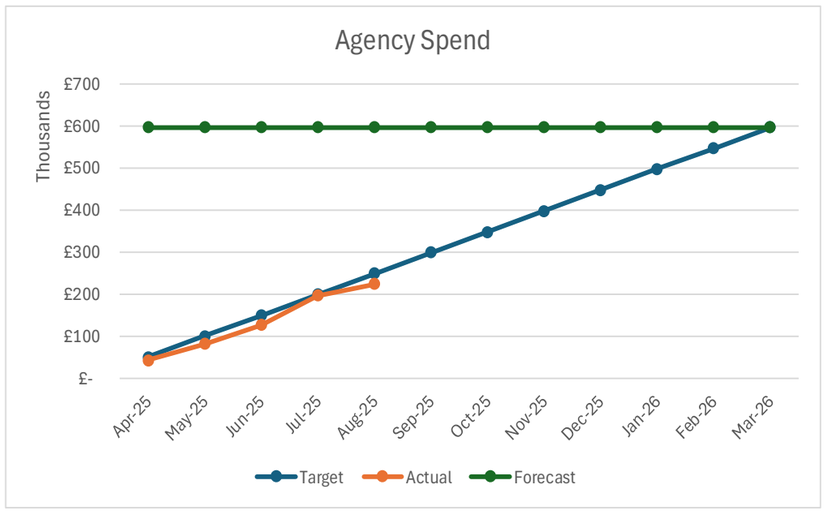
CIP transacted at M5 is £2.114m which is £0.298m behind plan.

The cash balance is lower than plan at M5 due to a contractual payment being made to Wirral University Teaching Hospital NHS FT. This will be repaid in October, and the cash balance should return to normal levels. The underlying increase in cash is linked to staff vacancies and the increase in creditors and corresponding underperformance on BPPC to date.

Cumulative BPPC



Agency Spend



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

Commentary

At Month 5 the Trust is 3.5% (volume) and 1.5% (value) behind target. The number of invoices on hold continues to create a problem and this underperformance is reflected in the increase in the creditor position.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

01 October 2025

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

Executive Summary and Report Recommendations
This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of August 2025 (or latest available months data). It is recommended that the Board: • Note performance to the end of August 2025 (or latest available months data).

Key Risks
This report relates to all BAF strategic risks.

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

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

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

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

Summary of latest performance by Domain

Domain	Number achieving	Number not achieving	Total
Workforce	**1**	**3**	**4**
Operations	**1**	**16**	**18**
Quality and Safety	**9**	**11**	**24**

For latest available data, where agreed targets have been defined, 11 metrics were achieving the agreed target and 36 were not achieving target (there are 7 metrics without target at present).

1.2 **NHS Oversight Framework (NOF)**

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

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

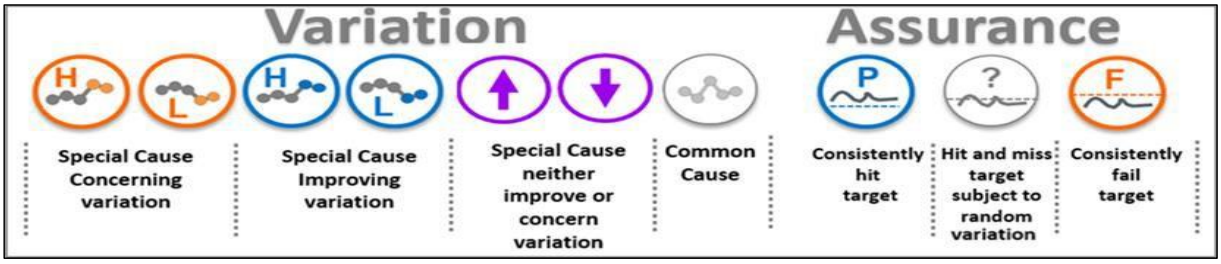
WUTH has been placed in to segment 4 and further information is available on the NHS Data Dashboard - NHS England » Segmentation and league tables.

2 Implications

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

3 General guidance and Statistical Process Charts (SPC)

3.1



Orange dots signify a statistical cause for concern. A data point will highlight orange if it:

- Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.

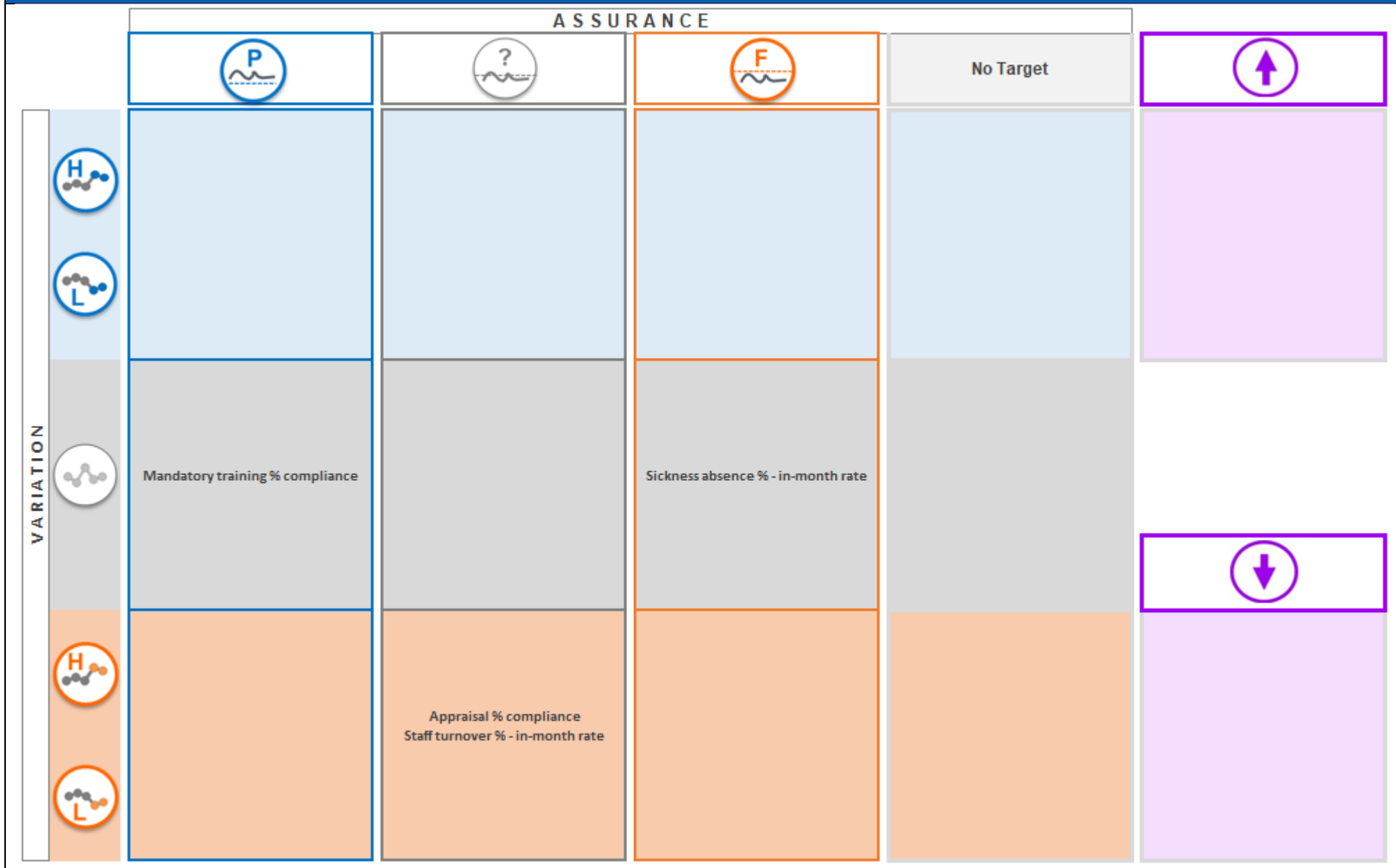
	• Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.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

Dashboard	All Indicators
Lead	All Execs

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Aug 25	5.91%	≤5%			5.96%
Staff turnover % - in-month rate	Aug 25	1.50%	≤1%			87.85%
Mandatory training % compliance	Aug 25	93.20%	≥90%			92.72%
Appraisal % compliance	Aug 25	86.25%	≥88%			0.93%
4-hour Accident and Emergency Target (including APH UTC)	Aug 25	60.96%	≥95%			61.5%
Number of inpatients not meeting the Criteria to Reside	Aug 25	149	-			161
Patients waiting longer than 12 hours in ED from a decision to admit	Aug 25	450	≤0			608
Proportion of patients more than 12 hours in ED from time of arrival	Aug 25	18.56%	≤0%			17.7%
Ambulance Handovers: % < 30 mins	Aug 25	82.03%	≥95%			52.4%
Ambulance Handovers: % < 45 mins	Aug 25	92.90%	≥100%			71.0%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Aug 25	60.68%	≥92%			58.5%
Referral to Treatment - total open pathway waiting list	Aug 25	47271	≤47111			44859
Referral to Treatment - cases exceeding 52 weeks	Aug 25	1335	≤931			1558
Referral to Treatment - cases waiting 78+ wks	Aug 25	0	≤0			7
Cancer Waits - reduce number waiting 62 days +	Jul 25	137	≤77			135
Cancer - Faster Diagnosis Standard	Jul 25	72.24%	≥77%			73.9%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jul 25	91.07%	≥96%			91.5%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Jun 25	91.83%	≥96%			92.8%
Cancer Waits - 62 days to treatment (monthly)	Jul 25	75.78%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Jun 25	76.82%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Aug 25	88.84%	≥95%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Aug 25	161	≤79			166
Clostridioides difficile (healthcare associated)	Aug 25	12	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Aug 25	2	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Aug 25	0	≤0			0
Patient Safety Incidents	Aug 25	1214	-			1179
FFT Overall experience of very good & good: ED	Aug 25	78.4%	≥95%			76.5%
FFT Overall experience of very good & good: Inpatients	Aug 25	95.1%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Aug 25	96.0%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Aug 25	100.0%	≥95%			95.7%
Patient Experience: concerns received in month - Level 1 (informal)	Aug 25	257	≤173			220
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Aug 25	4	≤3			3
Falls – Moderate to Severe Harm	Aug 25	0.18	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Aug 25	85.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Aug 25	88.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Aug 25	86.0%	≥90%			87.0%
WUTH Average CSW Night Staffing Fill Rates	Aug 25	99.0%	≥90%			99.8%
MRSA Cases	Aug 25	0	≤0			0
MSSA Cases	Aug 25	2	≤0			2
% of adult patients VTE risk-assessed on admission	Aug 25	96.4%	≥95%			97.5%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Aug 25	91.1%	≥90%			89.3%
Mortality (SHMI)	Apr 25	1.000	0.95-1.05			1.020
Number of studies open	Aug 25	47				
% of current studies meeting recruitment target	Aug 25	29.8%				
% of open studies with a commercial sponsor	Aug 25	4.3%				

Dashboard	Workforce
Lead	Chief People Officer

Workforce Domain Matrix



Workforce Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Aug 25	5.91%	≤5%		F	5.96%
Staff turnover % - in-month rate	Aug 25	1.50%	≤1%	L	?	87.85%
Mandatory training % compliance	Aug 25	93.20%	≥90%		P	92.72%
Appraisal % compliance	Aug 25	86.25%	≥88%	H	?	0.93%

Areas of Concern

Sickness

Sickness absence levels continue to be above the Trust's 5% threshold. Latest performance is 5.97%, which is an improvement compared to August '24 which was 6.17%. For the first time in 12 months anxiety/stress/depression is the main reason for sickness, followed by Gastro and Cold, Cough, Flu.

Estates, Facilities and Capital had the highest long term (3.80%) and short term (6.42%) absence rates.
Clinical Support, Corporate Support and Emergency were all below the Trust threshold.

Turnover

Whilst the in-month turnover rate was 1.50%, the pattern is consistent with the annual trend for August driven by rotational staff.

Appraisal

Appraisal have performed below target for the past 6-months, in spite of ongoing focus at Workforce Steering Board and a recent review and refresh of the appraisal paperwork and improved recording guidance.

Forward Look (Actions)

Sickness

Proactively supporting physical health and mental wellbeing:

- New Occupational Health Physician now in post.
- New CBT therapist due to commence in November 25.
- The winter flu campaign set to commence 1st October delivered by a mixed delivery model including roaming, peer and drop-in clinics to mitigate spread of flu.
- New Violence and Aggression post incident management checklist to ensure appropriate and consistent support.
- New 'wellbeing through change' workshops led by Trust's psychotherapist to commence from October 25.
- Wirral CiC continue to offer health checks for Trust staff and have completed Surgery Division and are currently supporting Medicine Division.

Managing Absence:

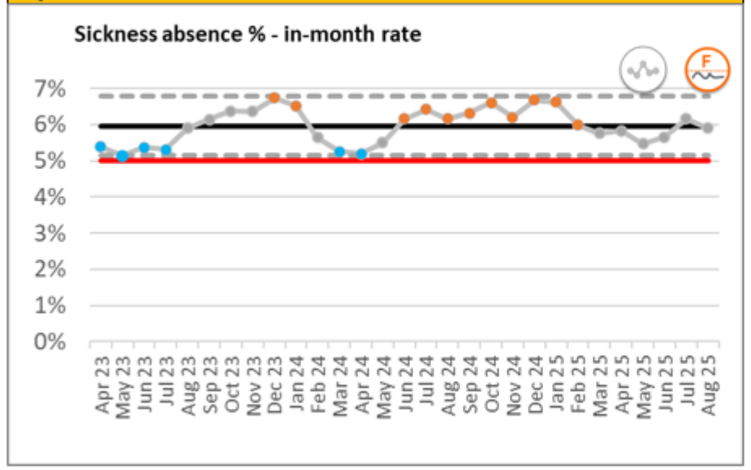
- Sickness remains a key focus of the Workforce Workstream 25/26 programme with a project dedicated to tackling sickness absence.
- Improved OH Clinical system to support managers to make referrals and monitor progress of OH support to aid their management of sickness absence.
- Daily HR drop-in sessions provide managers with access to dedicated HR resource to support with case management.
- The new attendance management policy continues to be utilised well, and numbers of final stage hearings continue to increase.
- Local Sickness Audits remain on going and are reported into WSB.
- Additional attendance management development sessions are being conducted with revised content and focus on case studies to bring policy to life.
- Additional absence data being made available to Departments.

Appraisal:

- The updated paperwork together with training continue to be targeted in areas of lower performance.
- Areas of under performance will remain an area of focus with additional reporting at WSB by divisional leads.
- Campaign on why appraisals are important will launch in October 2025.
- Launch of new Appraisal and Check-in e-learning module
- Ongoing offer of bespoke support for divisions.
- Appraisal and Check-in education sessions.
- Assurance via Divisional Performance Reviews; accompanied by dedicated personnel and time for support to service that are struggling.
- Collaboration between OD Team and HRBP to monitor appraisal compliance and quality feedback to target resource for support.

Sickness absence % in month rate

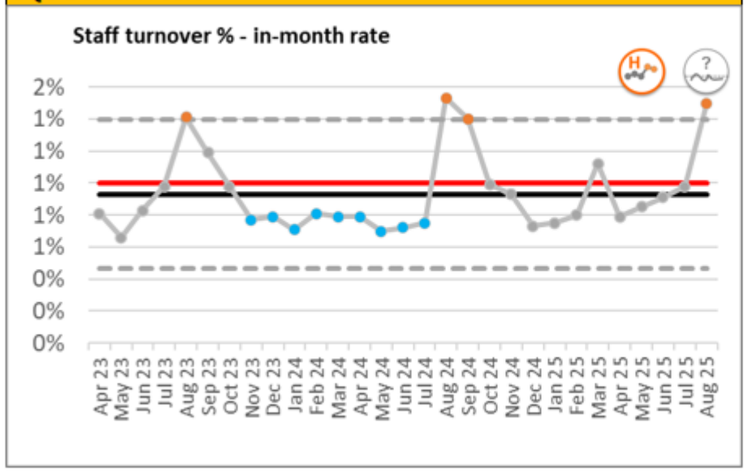
CQC Domain : Safe



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

Staff turnover % in month rate

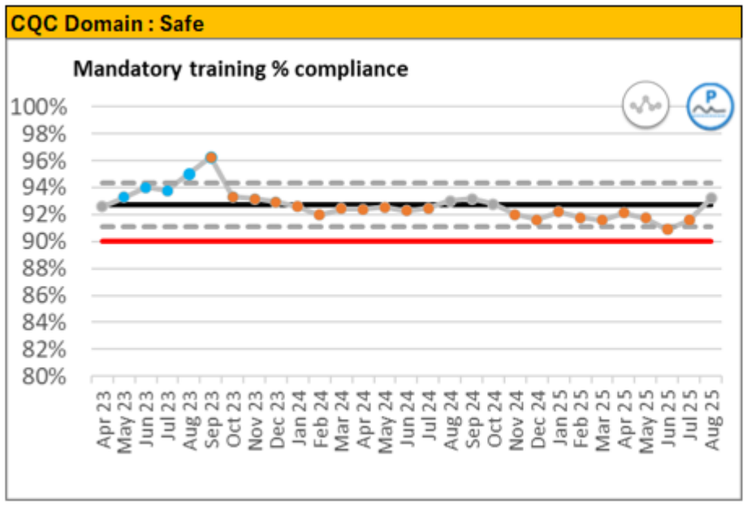
CQC Domain : Safe



Aug-25
1.5%
Variance Type
Special cause concerning variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance

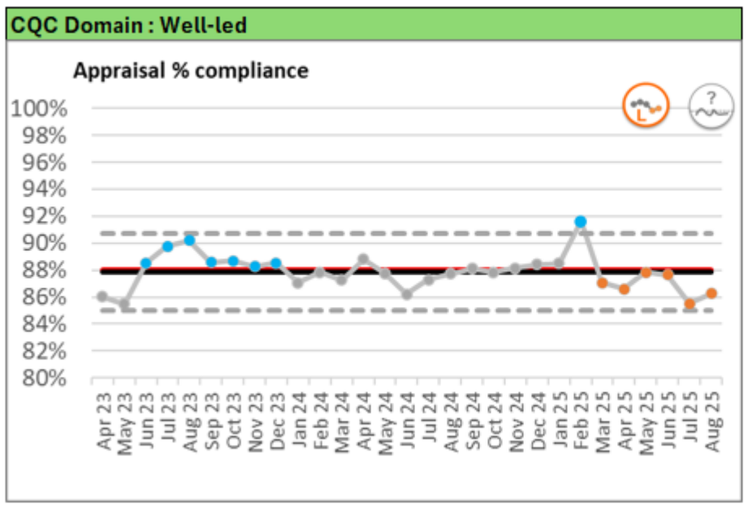
CQC Domain : Safe



Aug-25
93.2%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Appraisal % compliance

CQC Domain : Well-led



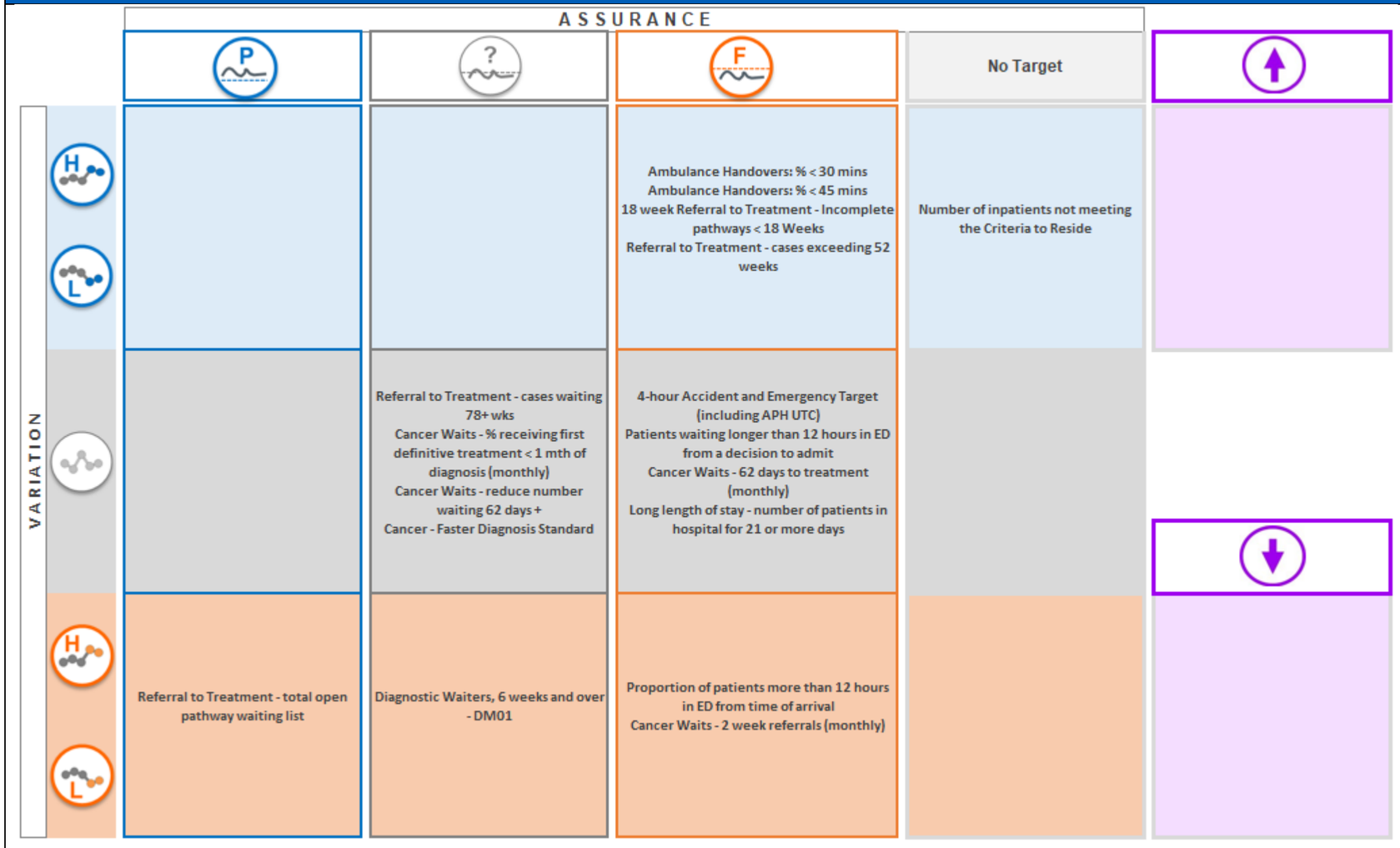
Aug-25
86.3%
Variance Type
Special cause concerning variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

As above.

Dashboard	Operations
Lead	Chief Operating Officer

Operations Domain Matrix



Operations Summary

Highlights

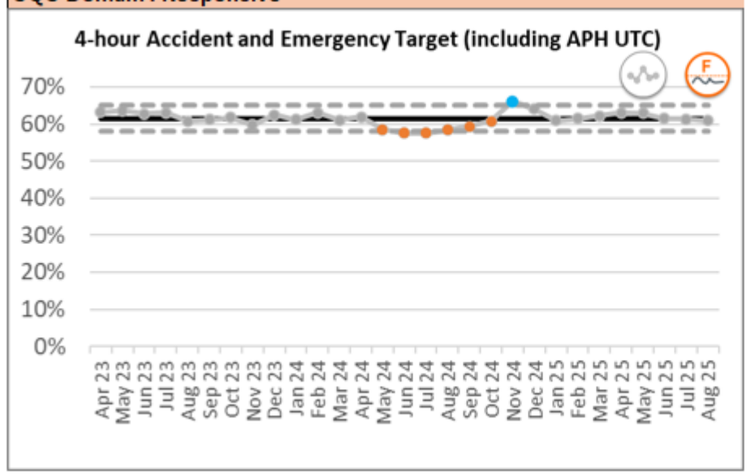
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Aug 25	60.96%	≥95%			61.5%
Number of inpatients not meeting the Criteria to Reside	Aug 25	149	-			161
Patients waiting longer than 12 hours in ED from a decision to admit	Aug 25	450	≤0			608
Proportion of patients more than 12 hours in ED from time of arrival	Aug 25	18.56%	≤0%			17.7%
Ambulance Handovers: % < 30 mins	Aug 25	82.03%	≥95%			52.4%
Ambulance Handovers: % < 45 mins	Aug 25	92.90%	≥100%			71.0%
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Referral to Treatment - cases waiting 78+ wks	Aug 25	0	≤0			7
Cancer Waits - reduce number waiting 62 days +	Jul 25	137	≤84			135
Cancer - Faster Diagnosis Standard	Jul 25	72.24%	≥77%			73.9%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jul 25	91.07%	≥96%			91.5%
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Diagnostic Waiters, 6 weeks and over - DM01	Aug 25	88.84%	≥95%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Aug 25	161	≤79			166

Areas of Concern

Forward Look (Actions)

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

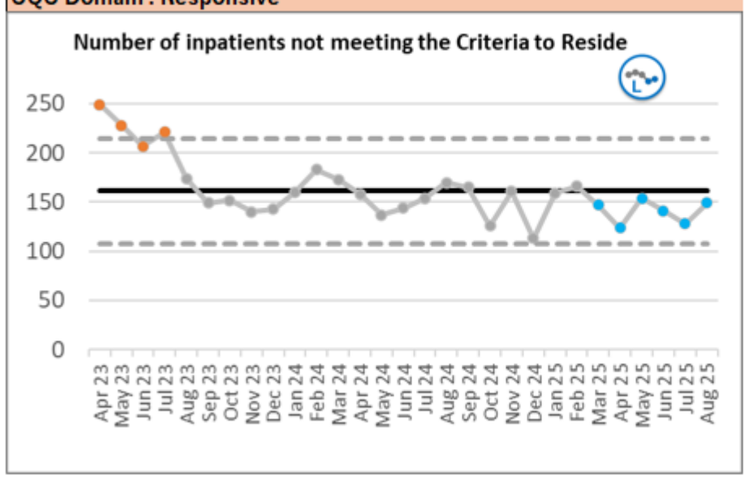
CQC Domain : Responsive



Aug-25
61.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

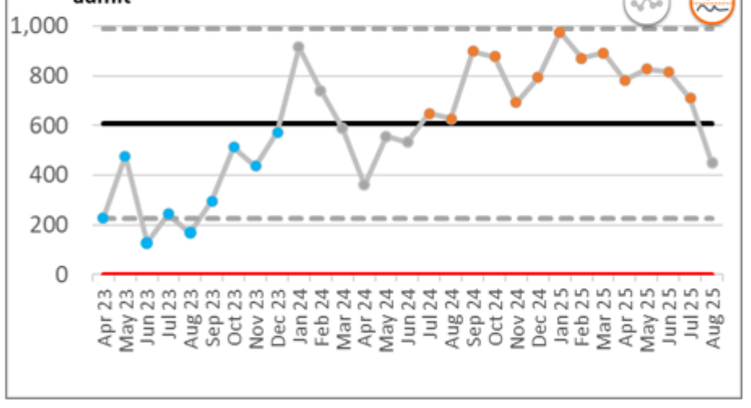
CQC Domain : Responsive



Aug-25
149
Variance Type
Special cause improving variation
Threshold
-
Assurance
Not applicable

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

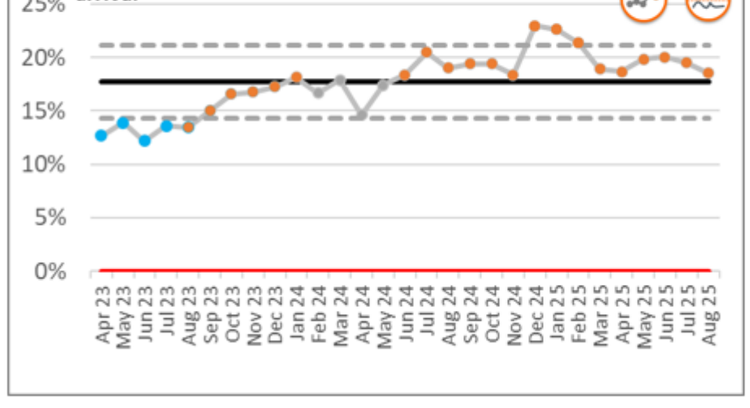
CQC Domain : Responsive



Aug-25
450
Variance Type
Common cause variation
Threshold
≤0
Assurance
Consistently fail target

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

CQC Domain : Responsive



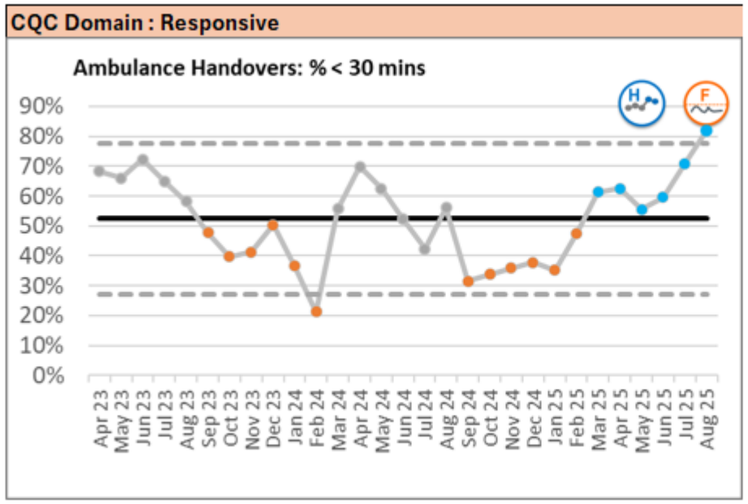
Aug-25
18.6%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

Commentary

Included in the COO report.

Ambulance handover % < 30 minutes

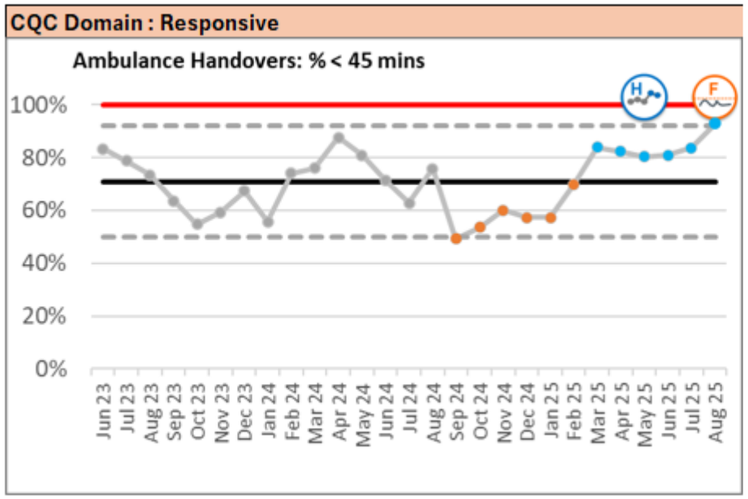
CQC Domain : Responsive



Aug-25
82.0%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

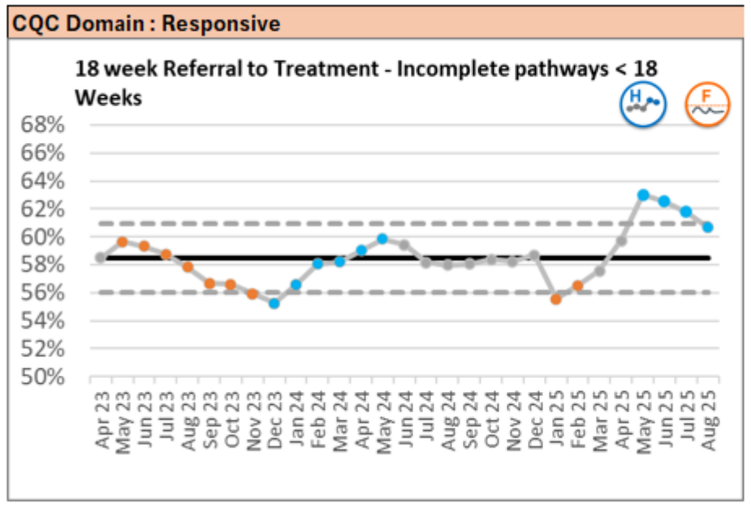
CQC Domain : Responsive



Aug-25
92.9%
Variance Type
Special cause improving variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

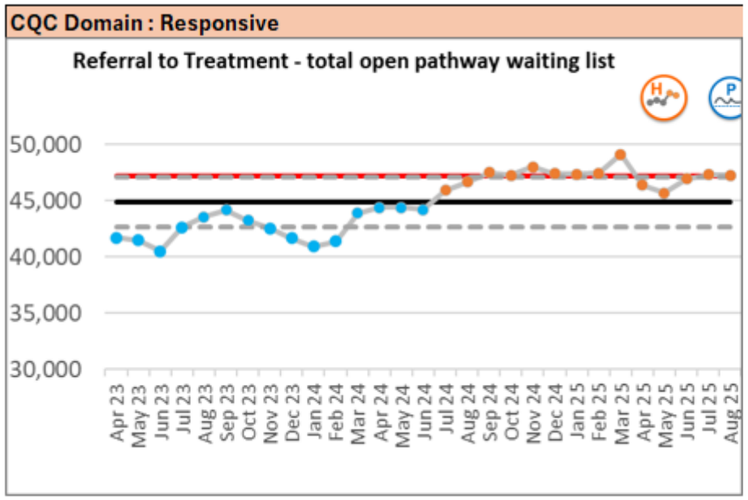
CQC Domain : Responsive



Aug-25
60.7%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



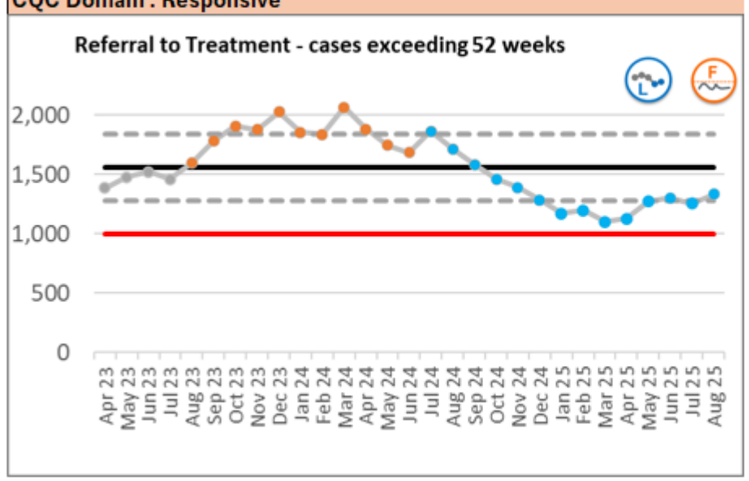
Aug-25
47271
Variance Type
Special cause concerning variation
Threshold
≤47111
Assurance
Consistently hit target

Commentary

Included in the COO report.

Referral to Treatment – cases exceeding 52 weeks

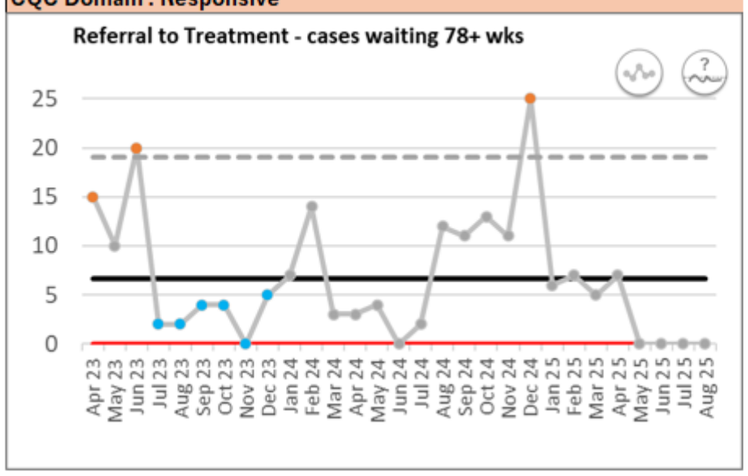
CQC Domain : Responsive



Aug-25
1335
Variance Type
Special cause improving variation
Threshold
≤931
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

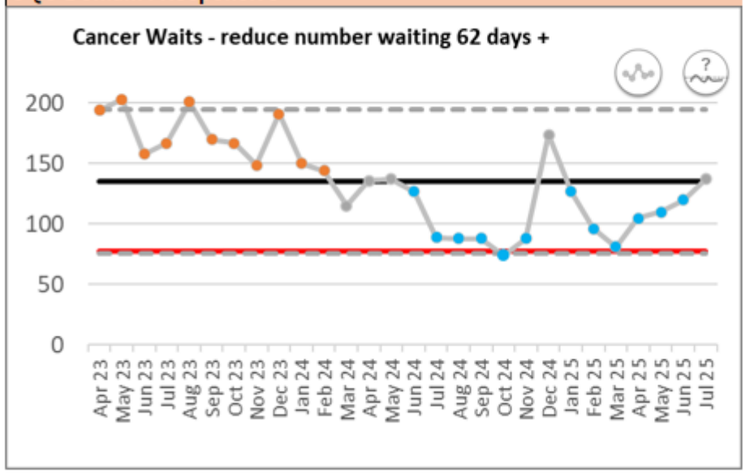
CQC Domain : Responsive



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

Cancer Waits – reduce number waiting 62 days +

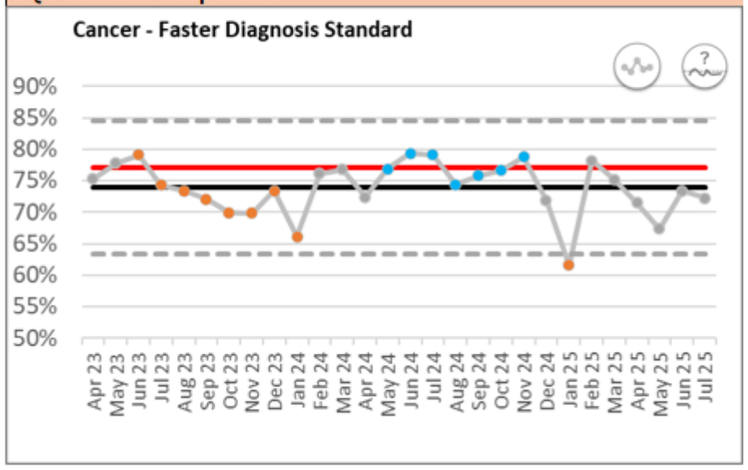
CQC Domain : Responsive



Jul-25
137
Variance Type
Common cause variation
Threshold
≤77
Assurance
Hit and miss target subject to random variation

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



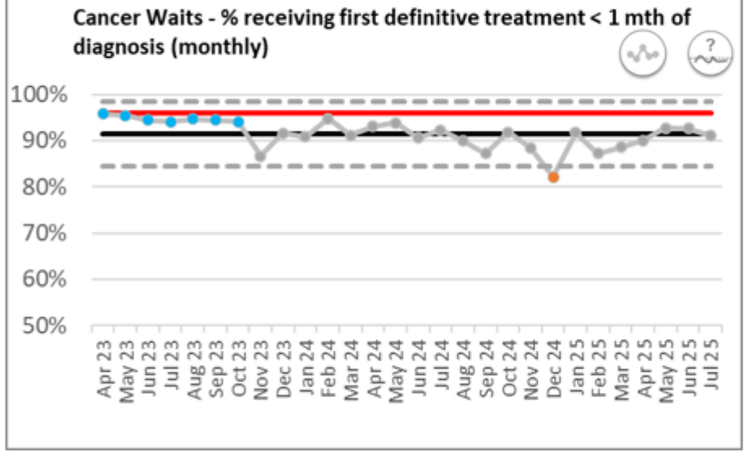
Jul-25
72.2%
Variance Type
Common cause variation
Threshold
≥77%
Assurance
Hit and miss target subject to random variation

Commentary

Included in the COO report.

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

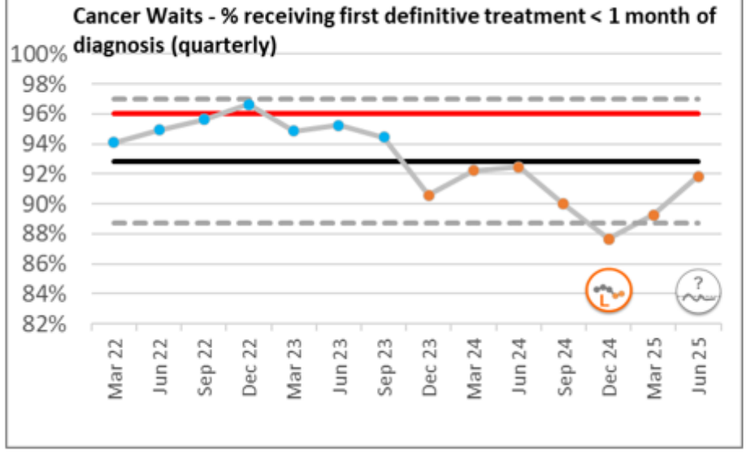
CQC Domain : Responsive



Jul-25
91.1%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

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

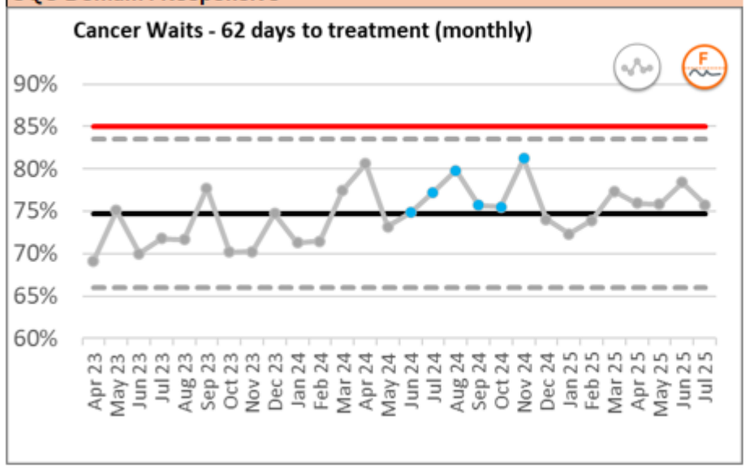
CQC Domain : Responsive



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

Cancer waits - 62 days to treatment (monthly)

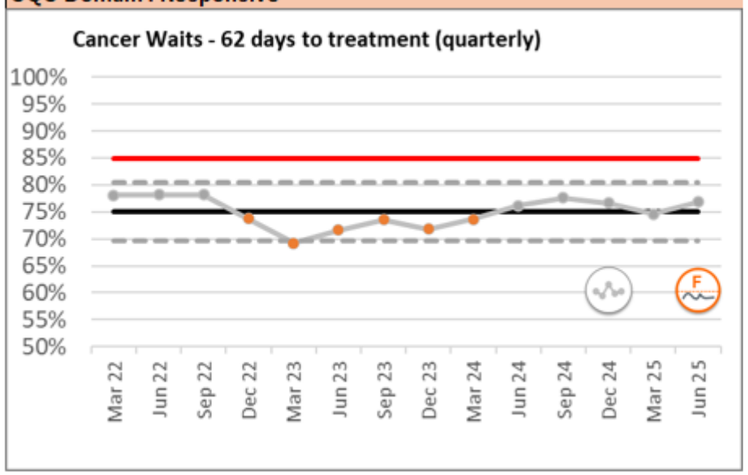
CQC Domain : Responsive



Jul-25
75.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

Cancer waits - 62 days to treatment (quarterly)

CQC Domain : Responsive



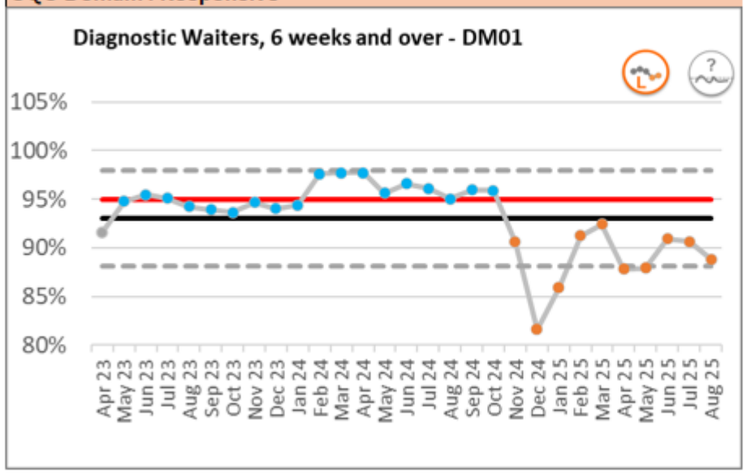
Jun-25
76.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

Commentary

Included in the COO report.

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



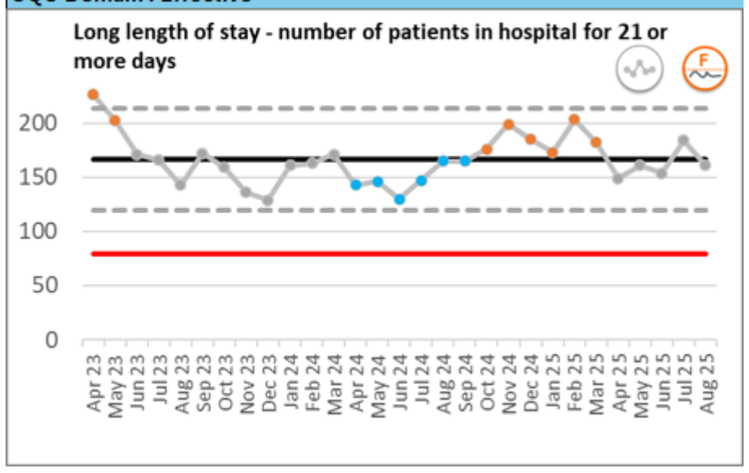
Aug-25
88.8%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

Included in the COO report.

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

CQC Domain : Effective

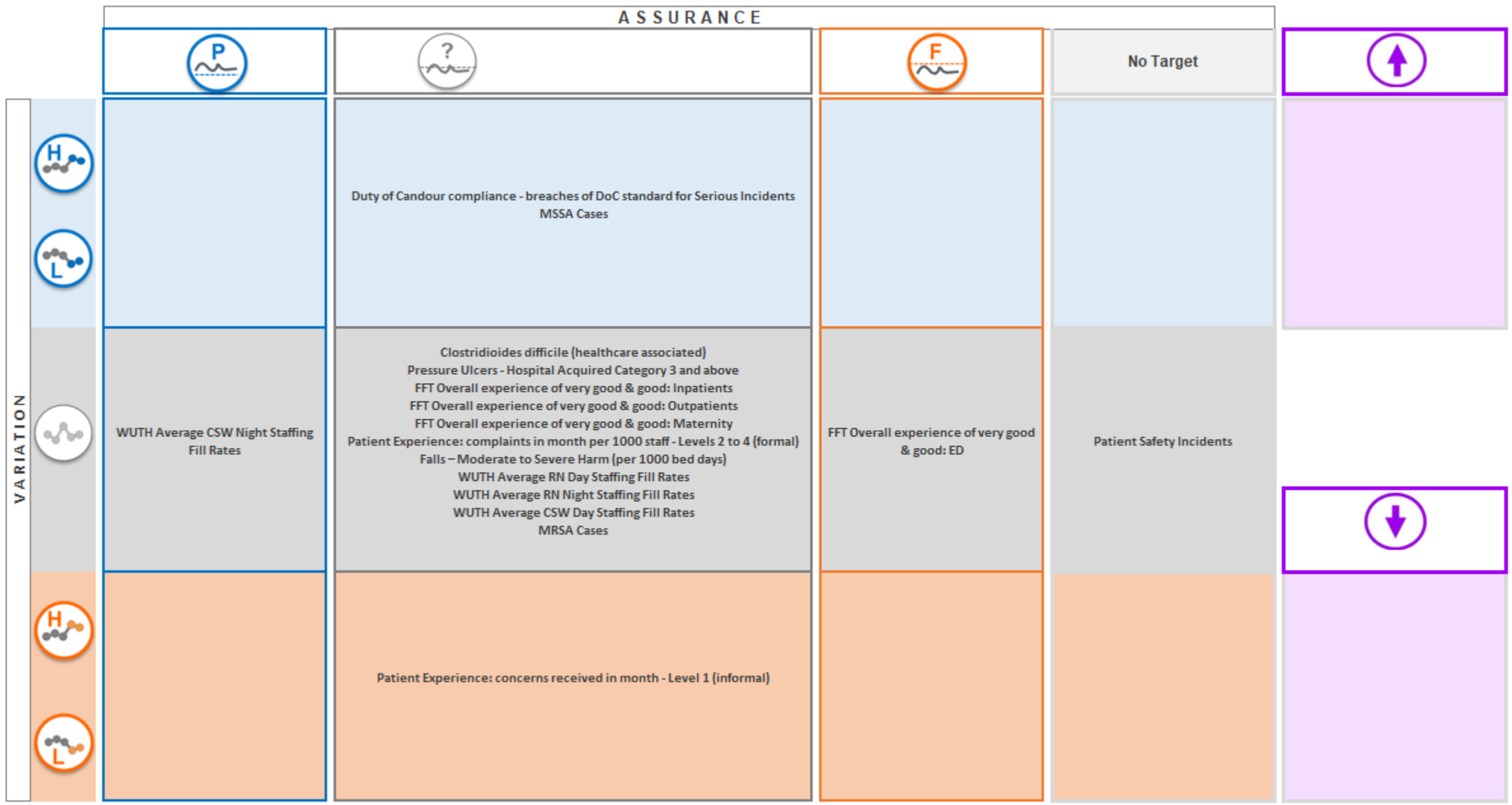


Aug-25
161
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

Commentary

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix



Quality and Safety Care Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Aug 25	12	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Aug 25	2	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Aug 25	0	≤0			0
Patient Safety Incidents	Aug 25	1214	-			1179
FFT Overall experience of very good & good: ED	Aug 25	78.4%	≥95%			76.5%
FFT Overall experience of very good & good: Inpatients	Aug 25	95.1%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Aug 25	96.0%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Aug 25	100.0%	≥95%			95.7%
Patient Experience: concerns received in month - Level 1 (informal)	Aug 25	257	≤173			220
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Aug 25	4	≤3			3
Falls – Moderate to Severe Harm	Aug 25	0.18	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Aug 25	85.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Aug 25	88.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Aug 25	86.0%	≥90%			87.0%
WUTH Average CSW Night Staffing Fill Rates	Aug 25	99.0%	≥90%			99.8%
MRSA Cases	Aug 25	0	≤0			0
MSSA Cases	Aug 25	2	≤0			2

Areas of Concern

Healthcare associated pressure ulcers, grade 3 and above

Patients diagnosed with CDT toxin: 7 HOHA, 5 COHA
Patients diagnosed with CD equivocal: 9 HOHA,

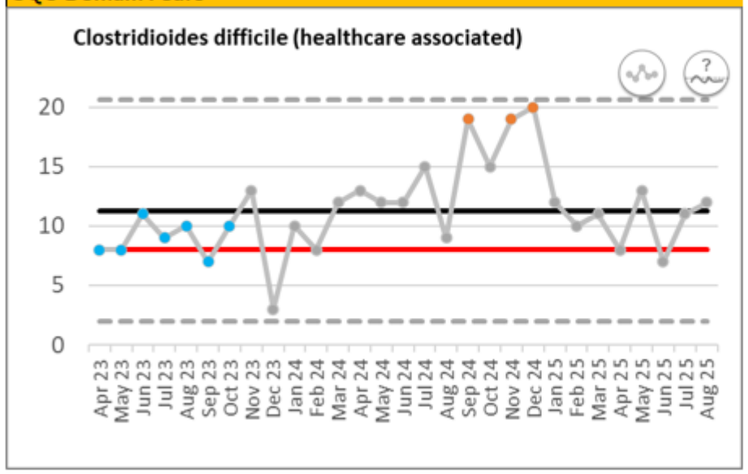
Forward Look (Actions)

Acute and community teams working closely to support an integrated approach.
C+M have agreed a dressing formulary, with a Wirral dressing formulary in development.
Training dates have now been circulated across the Trust for all staff at Band 3 and above. Stop the Pressure Day is approaching, with this year's theme focused on "Listening." Plans are underway in collaboration with our community teams to help share this important message across wider staff groups. New fleet of 350 mattresses introduced across the trust.

Review of side room usage and prioritisation, Themes, Decanting process and Cleaning,

Clostridioides difficile (healthcare associated)

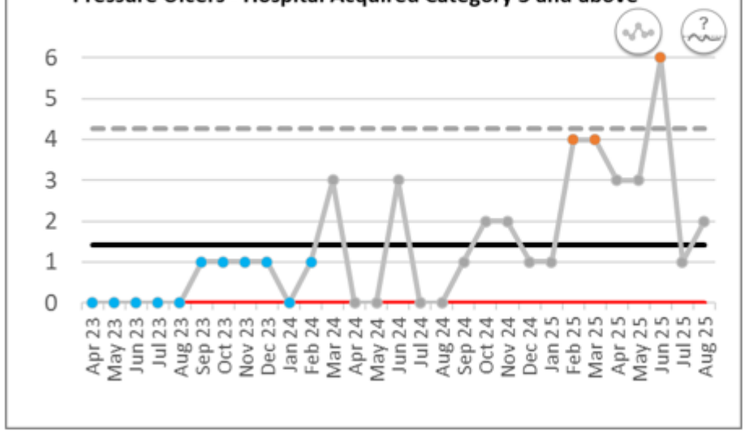
CQC Domain : Safe



Aug-25
12
Variance Type
Common cause variation
Threshold
≤8
Assurance
Hit and miss target subject to random variation

Pressure Ulcers – Hospital Acquired Category 3 and above

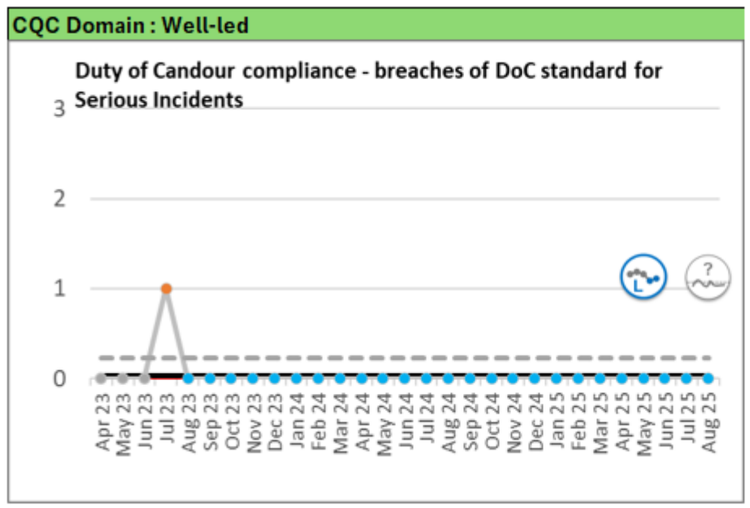
CQC Domain : Safe



Aug-25
2
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Duty of Candour Compliance

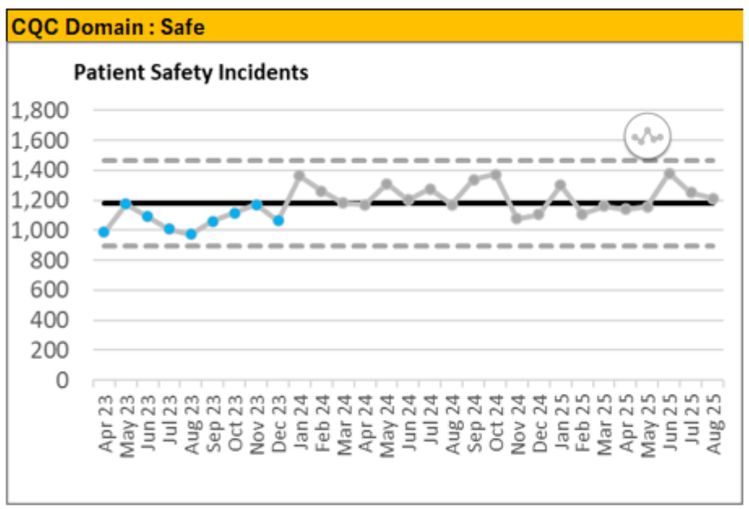
CQC Domain : Well-led



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

Patient Safety Incidents

CQC Domain : Safe



Aug-25
1214
Variance Type
Common cause variation
Threshold
-
Assurance
Not applicable

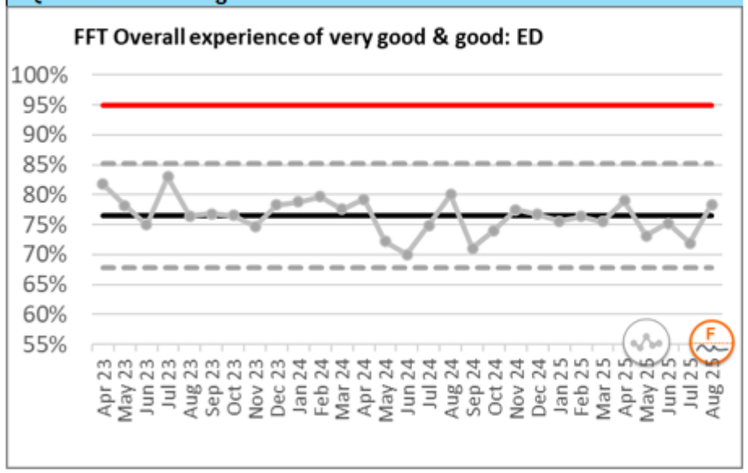
Commentary

CDT

12 patients diagnosed in August, this gives a cumulative value of 51 at the end of August against the threshold of 103 which exceeds the proposed monthly threshold of 8. Patients catagorised as COHA's appear to be slowly increasing so preventative plans are focusing on isolation of symptomatic patients when symptoms start not on diagnosis. Cleaning frequencies are being reviewed in high risk areas.

FFT Overall experience of very good & good – ED

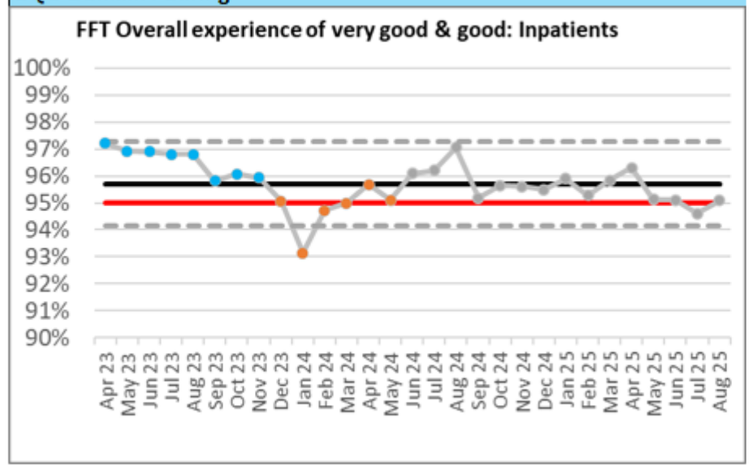
CQC Domain : Caring



Aug-25
78.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

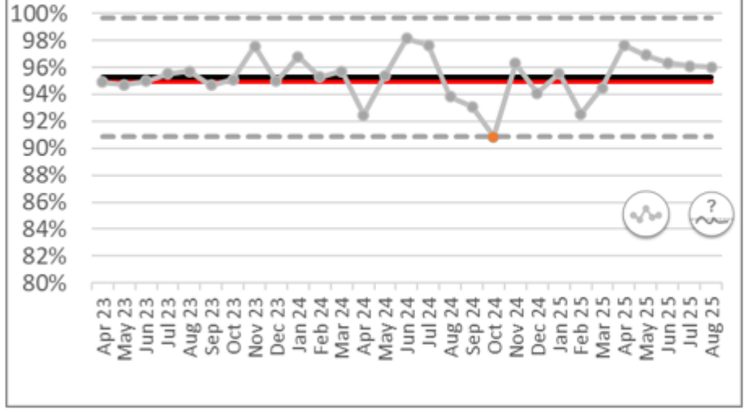
CQC Domain : Caring



Aug-25
95.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

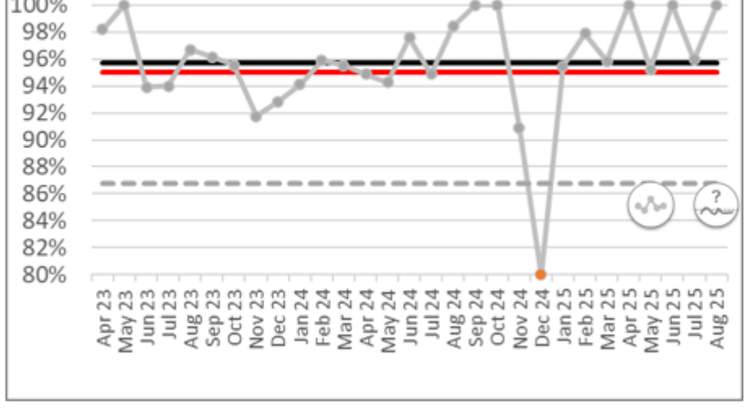
CQC Domain : Caring



Aug-25
96.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring



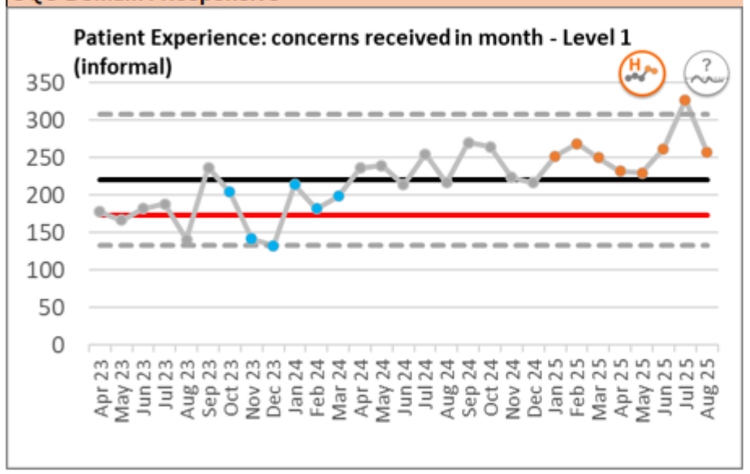
Aug-25
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

No significant change in the FFT outcome of % of patients that would rate their experience as very good or good. ED remains the lowest indicator however in line with other departments across C+M and reflective of the waiting times, which are the theme through the commentary.

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

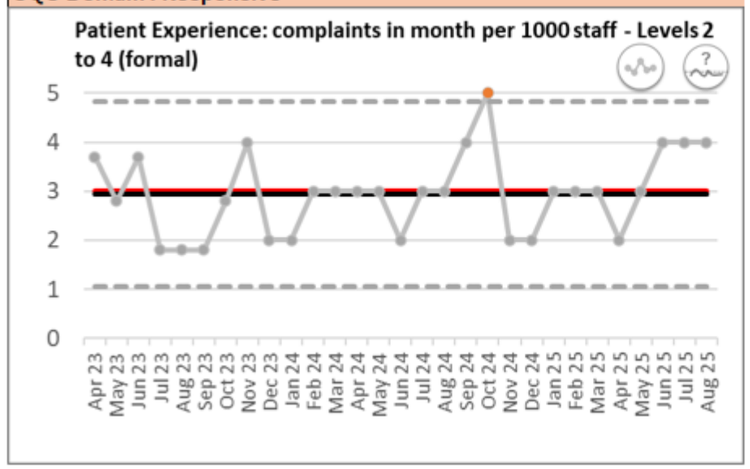
CQC Domain : Responsive



Aug-25
257
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)

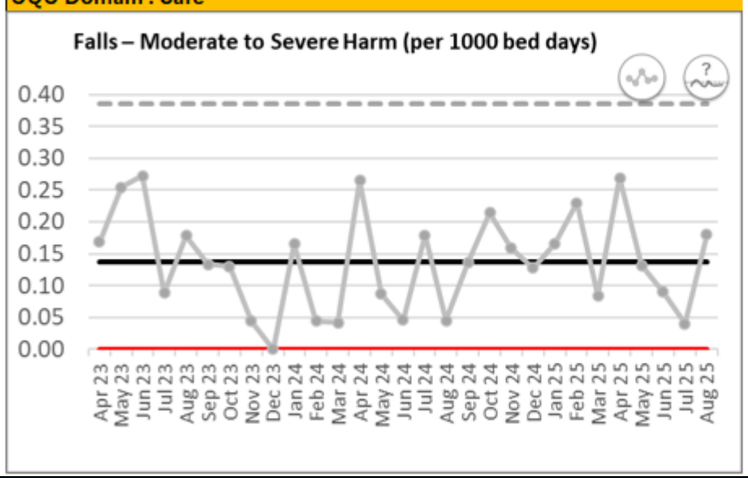
CQC Domain : Responsive



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

Falls – Moderate to Severe Harm

CQC Domain : Safe



Aug-25
0.18
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

Commentary

Concerns/ complaints

In August, the Trust received 25 formal complaints and 257 informal concerns, with activity returning toward year-to-date averages.

Complaints remained concentrated in Medicine, Surgery, Emergency Care, and Women & Children's, while concerns were highest in Surgery, Medicine, Women & Children's, and Emergency Care, with no new departmental hotspots.

Key themes continued to focus on clinical care, communication, and access, with formal complaints emphasising treatment and diagnosis, and informal concerns dominated by appointment delays and process issues.

Timeliness improved, with 57% of complaints responded to within 40 working days and average response time reducing to 42 days; however, fewer responses were sent overall, leaving 66 complaints open, including 24 breaches, and a growing backlog.

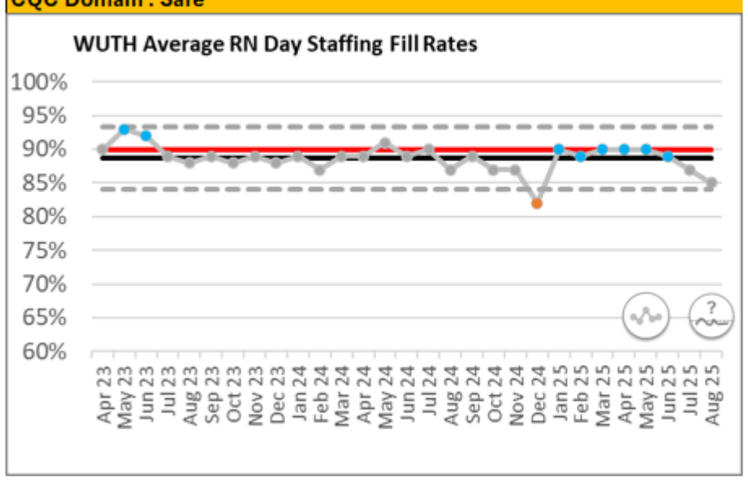
Ongoing oversight, weekly divisional meetings, and staff training continue, though operational pressures and variable investigation quality remain risks to performance.

Falls – moderate to severe harm

3 falls with moderate harm across the Trust, all of whom suffered short term harm only. To support reducing harm in the future Yellow wristbands have been introduced throughout the Trust which identifies to staff those patients who are at risk.
A new training package on falls prevention and post falls care is delivered as part of the corporate nursing patient safety updates training. The Falls Matron is also working with identified divisional leads to ensure that each division has an up to date falls action plan that reflects and responds to the divisions themes and trends in relation to falls and evidences the work being undertaken to improve patient safety.

Average Registered Nurse Day Staffing Fill Rates

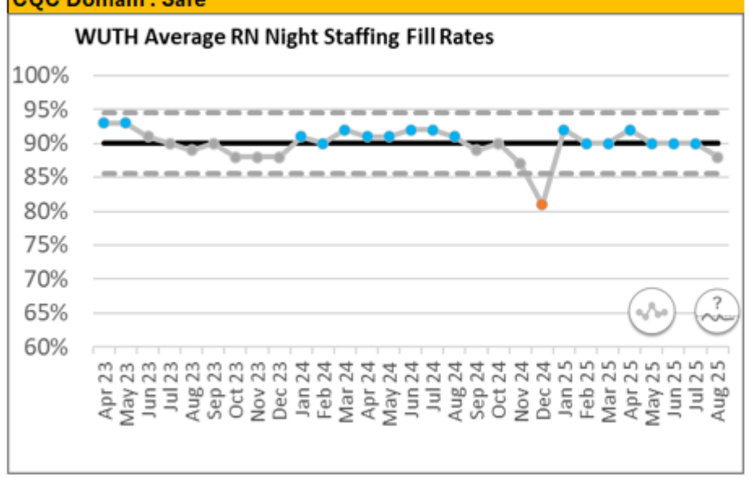
CQC Domain : Safe



Aug-25
85.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse

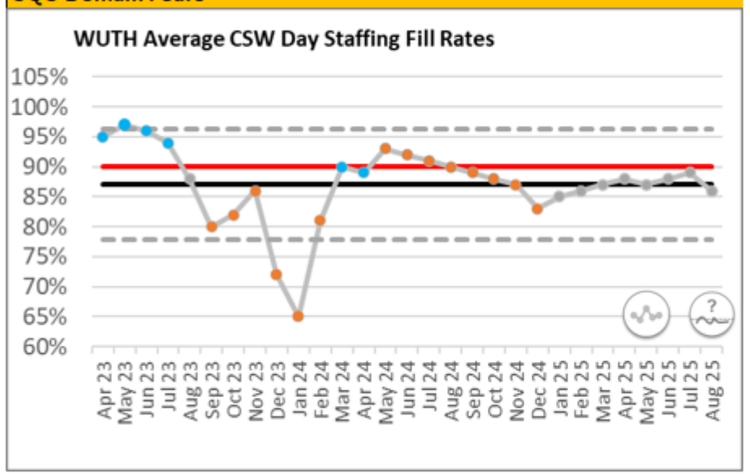
CQC Domain : Safe



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

Average Clinical Support Worker Day Staffing Fill Rates

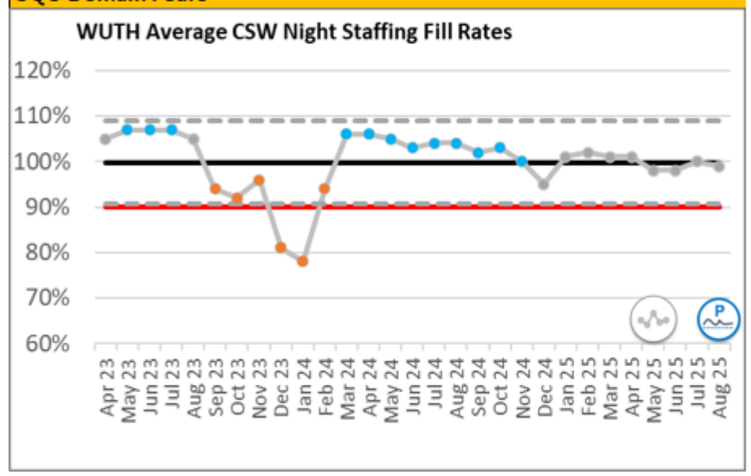
CQC Domain : Safe



Aug-25
86.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Night Staffing Fill Rates

CQC Domain : Safe



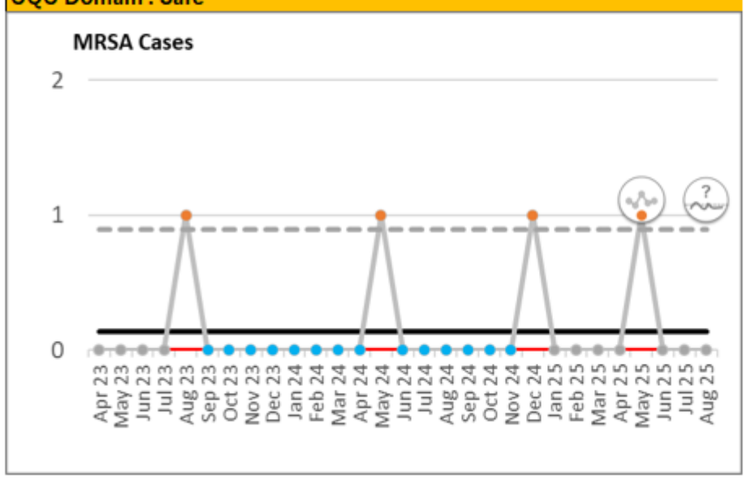
Aug-25
99.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Commentary

Slight decrease in fill rates in August across RNs, potentially impacted by peak AL period. All RN vacancies recruited to and CSW recruitment to be area of focus following implementation of new ward models post organisational change.

MRSA Cases

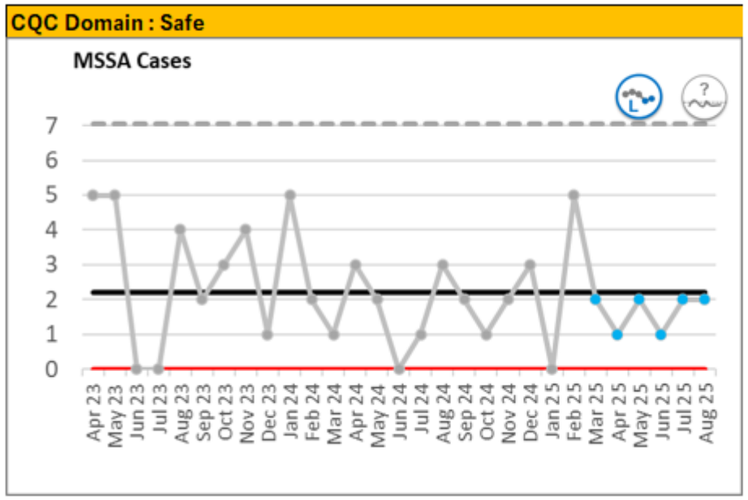
CQC Domain : Safe



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

MSSA Cases

CQC Domain : Safe



Aug-25
2
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Commentary

MRSA

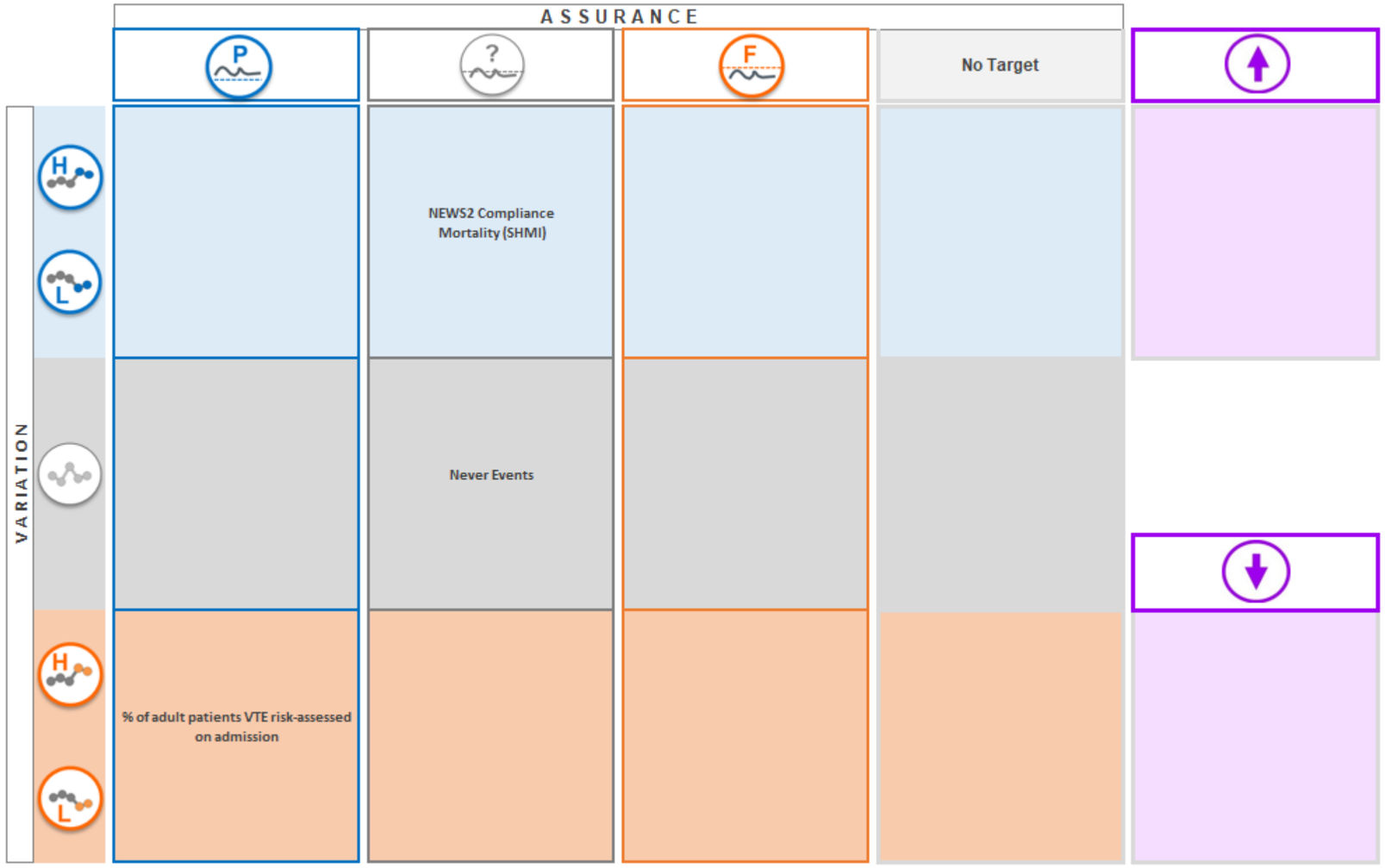
No bacteraemias recorded for August , giving a cumulative total of 1 against a zero tolerance approach.

MSSA

2 patients have been diagnosed with MSSA in August, 1 HOHA - linked to a UVC line on a neonate and 1 COHA - ? related to a deep seated abscess. There has been a cumulative total of 8. There is currently no annual threshold.

Dashboard	Quality and Safety
Lead	Medical Director

Quality and Safety Domain Matrix



Quality and Safety Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Aug 25	96.4%	≥95%			97.5%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Aug 25	91.1%	≥90%			89.3%
Mortality (SHMI)	Apr 25	1.000	0.95-1.05			1.020
Number of studies open	Aug 25	47				
% of current studies meeting recruitment target	Aug 25	29.8%				
% of open studies with a commercial sponsor	Aug 25	4.3%				

Areas of Concern

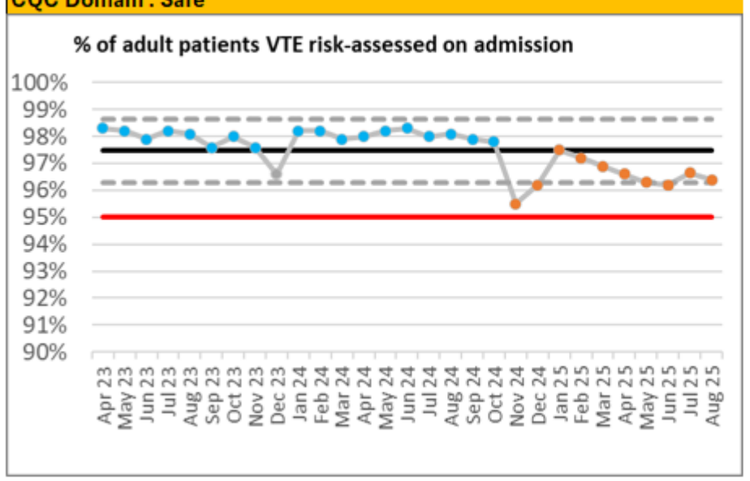
4 Never Events for this financial year

Forward Look (Actions)

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

% of adult patients VTE risk assessed on admission

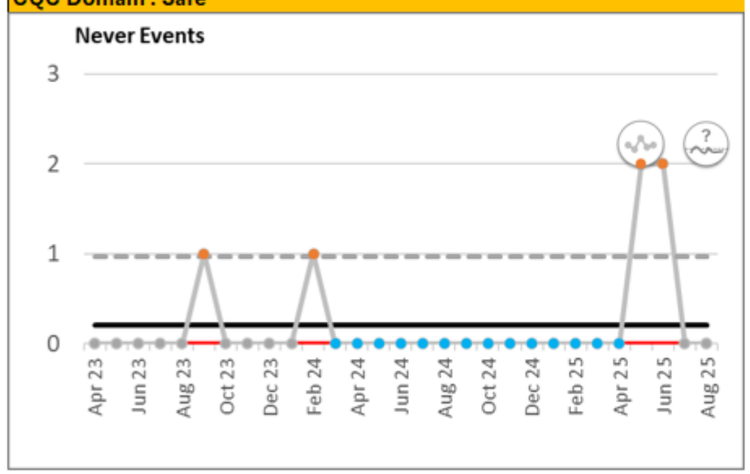
CQC Domain : Safe



Aug-25
96.4%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

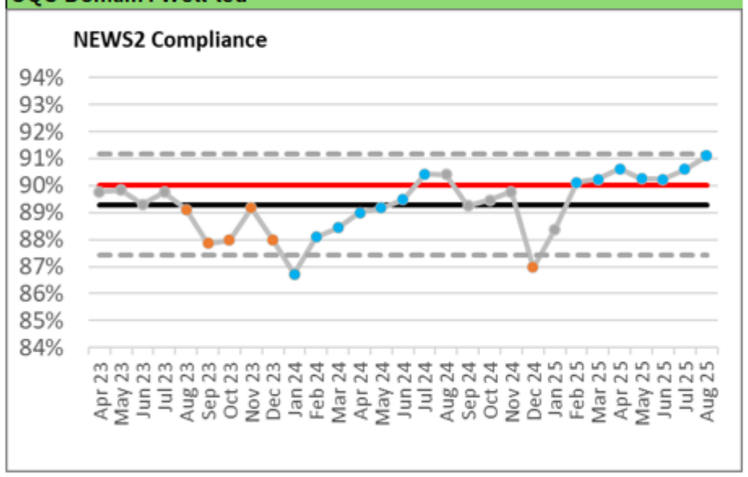
CQC Domain : Safe



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

NEWS 2 Compliance

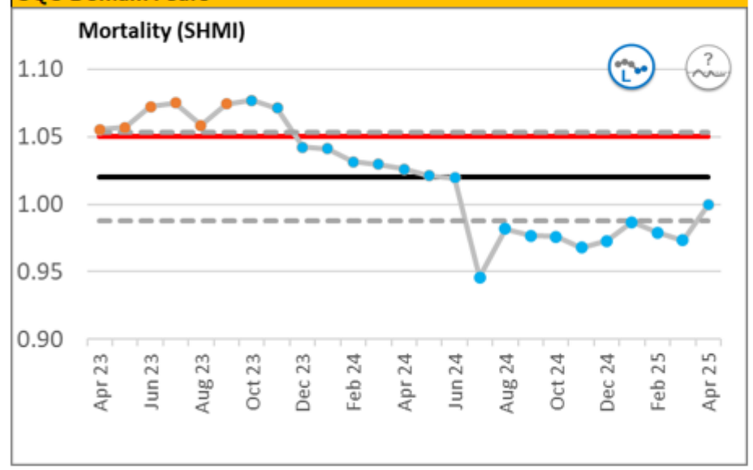
CQC Domain : Well-led



Aug-25
91.1%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Apr-25
0.9995
Variance Type
Special cause improving variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

Commentary

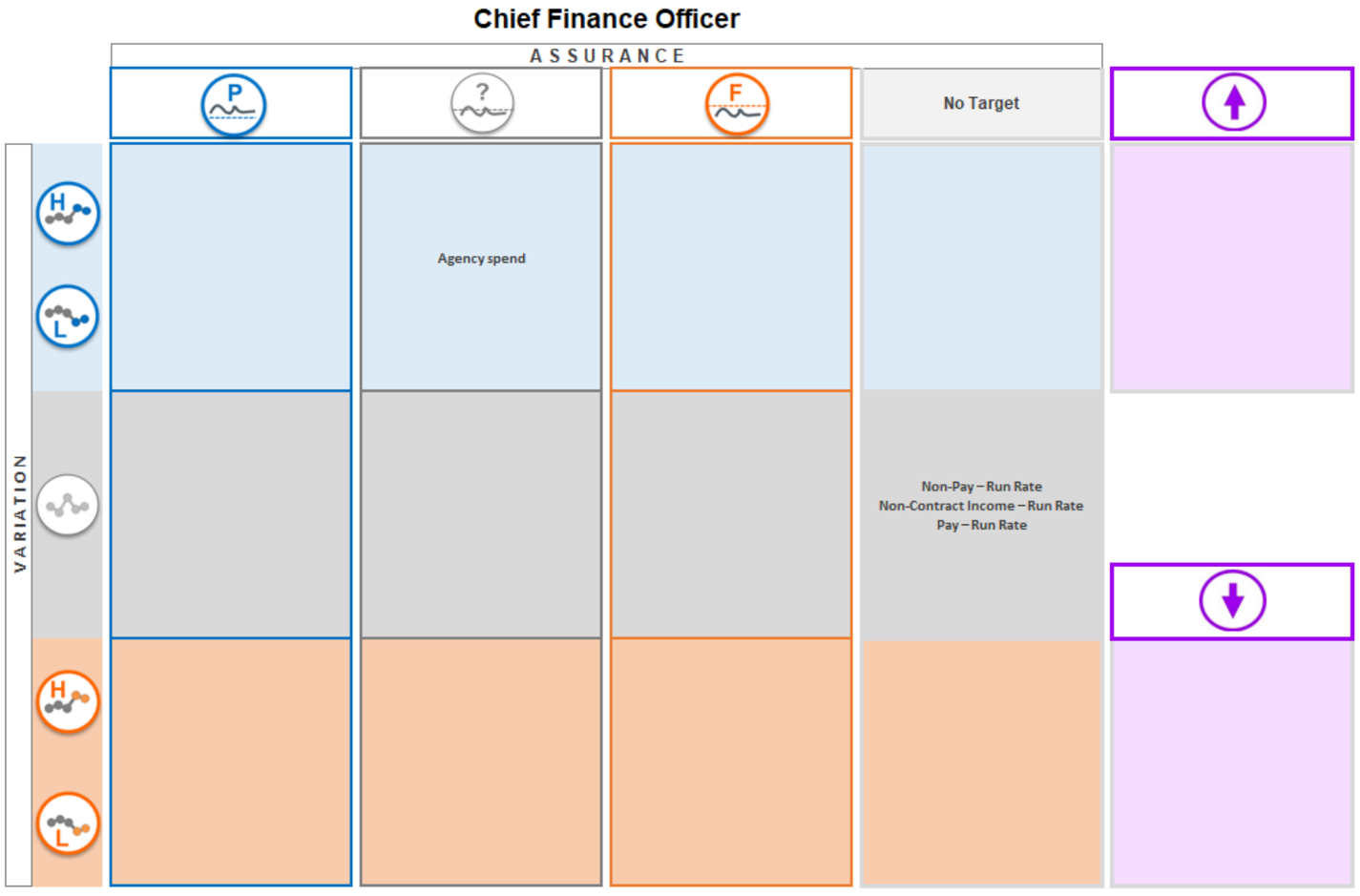
Number of studies open – Snapshot position	% of current studies meeting recruitment target – Snapshot position
47	29.8%

% of open studies with a commercial sponsor – Snapshot position
4.3%

Commentary

Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix



Finance Summary

Highlights

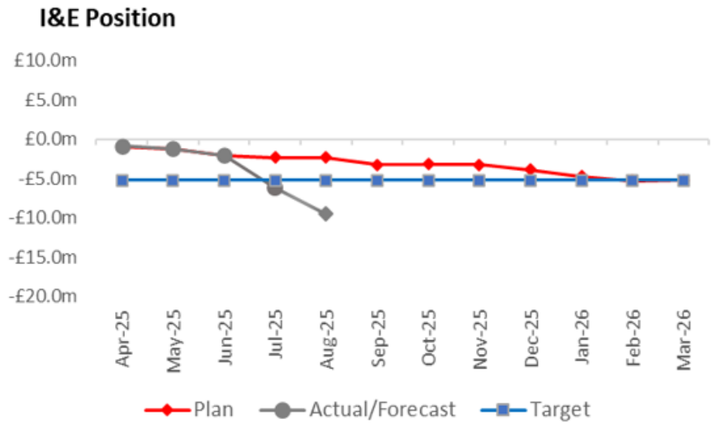
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Aug 25	**1.7%**	≤3%			2.8%
I&E Position	Aug 25	**-£9.6m**	-£5.2m			
Cumulative CIP	Aug 25	**£16.0m**	£16.0m			
Capital Expenditure	Aug 25	**£7.4m**	£10.8m			
Cash Position	Aug 25	**£0.0m**	£1.6m			

Areas of Concern

Forward Look (Actions)

I&E Position

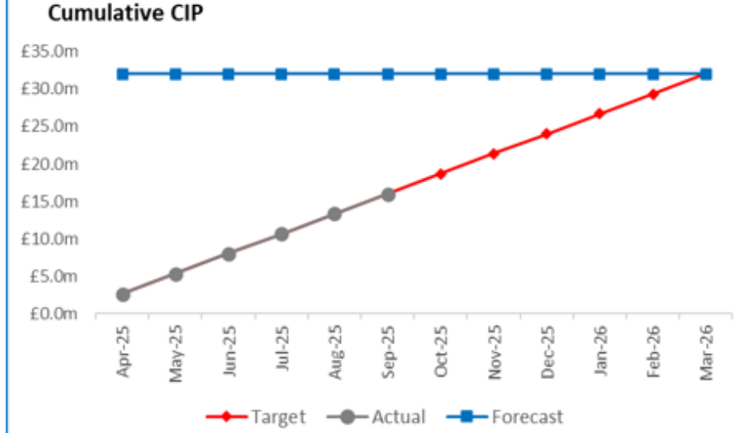
CQC Domain : Use of Resources



Aug-25
-£9.6m
Variance Type
Position doesn't meet the plan
Target
-£5.2m

Cumulative CIP

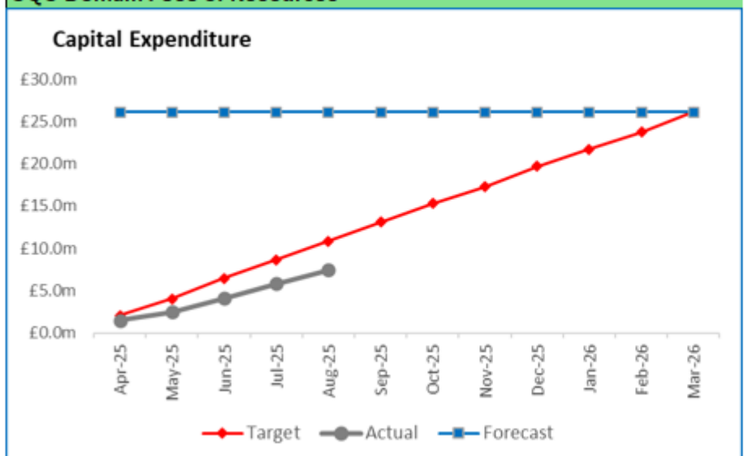
CQC Domain : Use of Resources



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

Capital Position

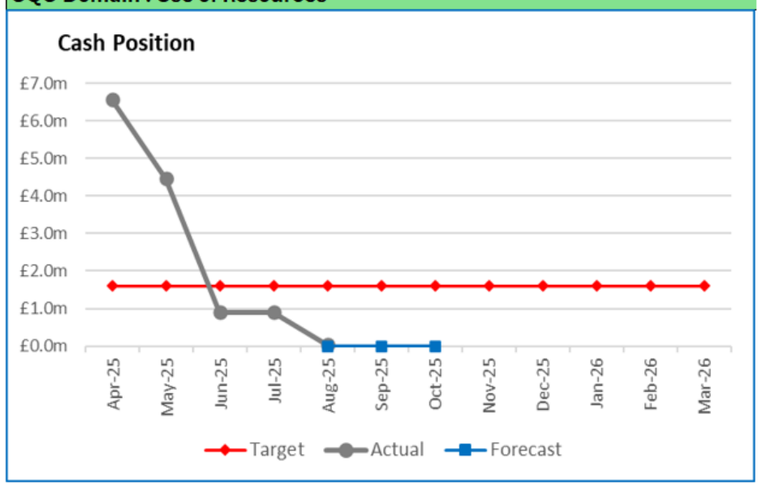
CQC Domain : Use of Resources



Aug-25
£7.4m
Variance Type
Position meets the plan
Target
£10.8m

Cash position

CQC Domain : Use of Resources

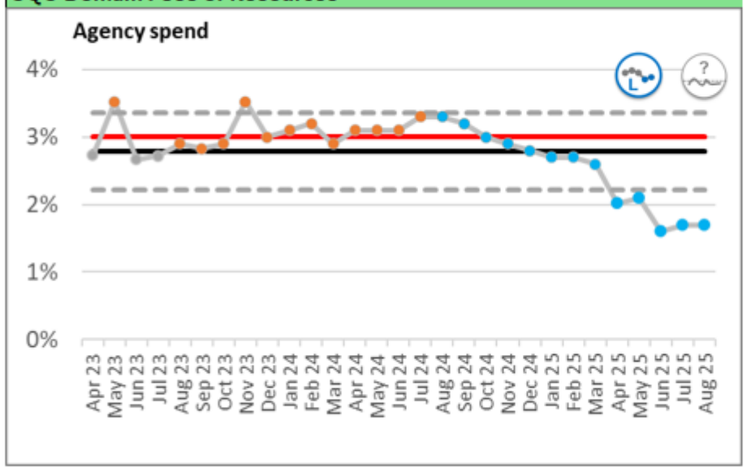


Aug-25
£0.0m
Variance
Position doesn't meet the plan
Target
£1.6m

Commentary

Agency spend %

CQC Domain : Use of Resources



Aug-25
1.7%
Variance Type
Special cause improving variation
Threshold
≤3%
Assurance
Consistently hit target

Commentary

Chief Finance Officer

Executive Summary

At the end of August 2025 (M5) the Trust is reporting a deficit of £9.6m which is £7.3m adverse to plan driven by the withholding of Deficit Support Funding (DSF), industrial action, pay award pressures and system stretch target. As part of the C&M ICS finance review process the Trust has submitted a mid-case forecast which, excluding DSF, is a £13.0m adverse variance to plan.

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

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

- Full CIP delivery – This is the primary risk to achieving the 2025–26 financial position. The risk adjusted annual forecast is below the required target. This risk includes the delivery of the ICS schemes (£14.1m).
- Activity / Casemix – Adjusting for the impact of IA, elective income remains below plan at M5.
- Aseptic Pharmacy – This risk is materialising with a significant reduction in income resulting from production compliance changes.
- Run-rate – 80% of targeted run-rate reductions have been identified and actioned.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M5 was £0.34m. During M5 the Trust requested £16.5m of cash support in September. of which £10.0m was approved. The Trust has agreed a cash mitigation plan for September but the cash position will continue as a significant issue until the Trust has returned to a sustainable financial position.

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

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

Statutory Financial Targets	RAG (M5)	RAG (Forecast)	Section within this report / associated chart
Financial Stability	🔴	🔴	I&E Position
Agency Spend	🟢	🟢	I&E Position
Financial Sustainability	🔴	🔴	N/A (quarterly update)
Financial Efficiency	🟡	🔴	Cumulative CIP
Capital	🟢	🟢	Capital Expenditure
Cash	🟡	🔴	Cash Position

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

The Board is asked to:

- Note the report including that the Trust has reported an adverse variance to plan.
- Note that the Trust's most immediate finance risk remains the cash position.
- Endorses the increase in capital budget of £0.034m.
- Notes the risk to delivering the 25/26 plan, that this risk is not fully addressed by the approved mitigation plan and the requirement to identify additional actions.

I&E Position

Narrative:

The table below summarises the M5 position:

	Year to Date			Forecast		
Cost Type	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£202.1m	£197.2m	-£4.9m	£468.0m	£466.9m	-£1.2m
Other Operating Income	£14.7m	£13.9m	-£0.8m	£34.9m	£32.8m	-£2.1m
Total Income	**£216.8m**	**£211.0m**	**-£5.7m**	**£503.0m**	**£499.7m**	**-£3.3m**
Employee Expenses	-£159.1m	-£161.3m	-£2.3m	-£380.4m	-£387.9m	-£7.5m
Operating Expenses	-£64.3m	-£64.2m	£0.1m	-£153.7m	-£156.3m	-£2.6m
Non Operating Expenses	-£2.0m	-£2.1m	-£0.1m	-£4.9m	-£5.0m	-£0.1m
Recurrent CIP	£6.3m	£0.0m	-£6.3m	£13.9m	£2.1m	-£11.8m
Total Expenditure	**-£219.1m**	**-£227.7m**	**-£8.6m**	**-£525.1m**	**-£547.1m**	**-£22.0m**
Unmitigated Forecast Risk 25-26	**-£2.3m**	**-£16.6m**	**-£14.3m**	**-£22.1m**	**-£47.4m**	**-£25.3m**
Non Recurrent Mitigations		**£7.0m**			**£7.0m**	
PFR Reported Position Month 5	**-£2.3m**	**-£9.6m**	**-£7.3m**	**-£22.1m**	**-£40.4m**	**-£18.3m**
Mitigation Plan	**£0.0m**	**£0.0m**	**£0.0m**	**£0.0m**	**£5.3m**	**£5.3m**
Forecast risk	**-£2.3m**	**-£9.6m**	**-£7.3m**	**-£22.1m**	**-£35.1m**	**-£13.0m**

Key variances within the YTD position are:

Clinical Income – £4.9m adverse variance relates to elective underperformance including industrial action and loss of DSF.
Employee Expenses - £2.3m adverse variance relates to use of bank, agency, industrial action and undelivered vacancy factors.
Operating expenses – £0.1m adverse variance relates to outsourcing and loss of CNST incentive.
Cost Improvement Programme – £6.3m underdelivered at month 5 which is fully offset by non-recurrent mitigations.

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

Cumulative CIP

Narrative:
The Trust has transacted CIP with a part year effect of £27.8m at M5 of which, £7m has been delivered non-recurrently. The Trust has identified recurrent CIP with a full year effect of £31.3m, however, this figure reduces to £25.5m once risk adjusted reflecting a risk adjusted shortfall of £6.5m.

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

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £44.9m at Month 5 (M5), reflecting an adverse variance of £1.7m. This underperformance is primarily driven by the Surgical Division, specifically Trauma & Orthopedics (T&O). The division has provided a recovery plan which means that the Trust forecast remains full delivery of elective income.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2025/26 at M5:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M5	Revised Budget
CDEL				
Internally Generated	**£9.765m**	**£0.000m**	**£0.000m**	**£9.765m**
ICB/PDC/WCHC	**£14.550m**	**£0.656m**	**£0.034m**	**£15.240m**
Charity	**£1.100m**	**£0.000m**	**£0.000m**	**£1.100m**
Confirmed CDEL	**£25.415m**	**£0.656m**	**£0.034m**	**£26.105m**
Total Funding for Capital	£25.415m	£0.656m	£0.034m	£26.105m
Capital Programme				
Estates, facilities and EBME	**£3.100m**	£0.656m	£0.034m	**£3.790m**
Operational delivery	**£8.440m**	£0.000m	£0.000m	**£8.440m**
Medical Education	**£0.080m**	£0.000m	£0.000m	**£0.080m**
Transformation	**£0.250m**	£0.000m	£0.000m	**£0.250m**
Digital	**£0.750m**	£0.000m	£0.000m	**£0.750m**
UECUP	**£7.800m**	£0.000m	£0.000m	**£7.800m**
PDC commitments	**£0.304m**	£0.000m	£0.000m	**£0.304m**
ICB hosted	**£3.591m**	£0.000m	£0.000m	**£3.591m**
Charity	**£1.100m**	£0.000m	£0.000m	**£1.100m**
Approved Capital Expenditure Budget	**£25.415m**	**£0.656m**	**£0.034m**	**£26.105m**
Total Anticipated Expenditure on Capital	£25.415m	£0.656m	£0.034m	£26.105m
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

In M5 the Trust has received an additional £0.034m for Electrical Vehicle chargers which is now included within the Capital Plan.

Spend at M5 totals £7.445m which is £3.387m below plan mainly across backlog and operational schemes.

Cash Position

Narrative:

The cash balance at the end of M5 was £0.34m. This includes the impact of a £2.8m reduction in planned Deficit Support Funding; the impact of which will continue at least until Month 6 (September). As previously reported, an application was submitted in August 2025 for cash support totaling £16.5m of which £10.03m has been approved. The Trust has enacted additional mitigation which will enable a positive cash balance to be maintained in September. The Trust follows a structured and robust approach to cash management. Once all available mitigations have been deployed the Trust will require further revenue support and as such a further application for cash support in October has been submitted.

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

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

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11**
September 2025

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

Report Purpose and Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times but the continued challenge in achieving reduced waiting times in several specialities, outlined in the paper.

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

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

It is recommended that the Board of Directors:

- note the report

Key Risks

This report relates to these key risks:

- Delivering timely and safe care for patients awaiting elective treatment
- Performance against the core UEC standards

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

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. In addition cancer services and many surgical specialities have seen unexpected levels of increases in demand. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by AQuA on improving the 4 hour performance standards and is entering into discussions on tier one support from central teams.

2	Planned Care
2.1	**Elective Activity** In August 2025, the Trust attained an overall performance of 102% against plan for outpatients (95% for new outpatient attendances), and an overall performance 93% against the plan for elective admissions, as shown in the table below: **Activity Type / Target for August / Actual for August / Performance** Out pt New: 10,759 / 10,162 / 94.5% Out pt Follow up: 23,153 / 24,070 / 104.0% Out pt procedures: 3,454 / 3,792 / 109.8% Total Out pts: 37,367 / 38,024 / 101.8% Day case: 4,113 / 3,818 / 92.8% Inpatients: 506 / 456 / 90.1% Total - Elective and Daycase: 4,619 / 4,274 / 92.5% The Trust underachieved plan for outpatient new appointments and elective/daycase, but overachieved follow-ups and outpatient procedures. Underachievement for elective / daycase activity was seen in Medicine, Surgery and Women's and Children's. Surgery underachievement was seen largely in ENT and Oral Surgery due to consultant sickness. In Medicine Dermatology and Cardiology saw the largest underachievement against plan. In Women's and Children's, whilst daycase activity was under plan in Gynaecology, elective overnight activity was over plan giving a positive income position in month.
2.2	**Referral to Treatment (RTT)** The Trust's performance at end of August 2025 against RTT metrics was as follows *(RAG rated versus monthly trajectories from Trust planning submission)*:

	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Total RTT Caseload	46,400	45,691	46,939	47,312	47,271
% RTT	59.74%	63.01%	62.54%	61.80%	60.68%
52 weeks	1,128	1,272	1,302	1,255	1,335
52 weeks % of caseload	2.43%	2.78%	2.77%	2.65%	2.82%
104+ Week Wait Performance	0	0	0	0	0
78+ Week Wait Performance	7	0	0	0	0
65+ Week Wait Performance	24	22	13	16	7

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

The overall RTT waiting list decreased in size in August 2025 but remains higher than levels seen for April to June. Increases in caseload are attributed to Physiotherapy, where activity remains above plan but referrals numbers have increased, and Dermatology due to ceasing of ICB funding for advice and guidance alongside introduction of a new AI pathway seeing referrals increase significantly. Plans are being developed with Divisions to address these issues.

There were 0 x patients waiting 78+ weeks at the end of August 2025, this position has been maintained since May 2025.

The number of patients waiting 65+ weeks has reduced to 7. Of the 7 patients waiting, 1 x was complex, 1 x was a graft, 1 x patient choice and 4 were due to capacity. Gynaecology as previously a challenged area in relation to numbers of long waiting patients, achieved 0 x 65 week waiters which is a great achievement.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2:

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

National Standards:

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

Sub Standards:

Standard	Indicator	Threshold	July-25	August-25	September-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	72.24%	N/A	N/A
28 Day Wait	Breast >=90%	90.00%	84.35%	N/A	N/A
28 Day Wait	Skin >=90%	90.00%	77.02%	N/A	N/A
31 Day Wait	Individual Trust Provider Trajectory	Per Month	91.07%	N/A	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.78%	N/A	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	July-25	August-25	September-25
14 Day Wait	GP USC Referral to First Appointment	93.00%	53.16%	N/A	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for July 2025. Areas of pressure include Dermatology as a result of impact of regional ceasing of A&G / introduction of AI, Breast and Gynaecology.

- *62-day treatment* - The Trust did not achieve local trajectory in July 2025 with performance 75.78% versus trajectory of 76.12%. The impact of pressures on 28-day performance is seen to impact 62-day treatment delivery.

- *62-day waiters* – the number of waiters increased as a result of pressure on 28-day performance.

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

- *104-day long waiters* – the number of waiters has increased.

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

Performance in Urology, Gynaecology, Breast and Dermatology tumour sites is having a significant impact on overall 28-day FDS performance at Trust level.

Dermatology cancer performance remains a significant pressure having deteriorated following implementation of an AI pathway (WUTH go-live 14 April 2025) and regional ceasing tele-dermatology (region-wide from end of 31 May 2025). This deterioration is also reflected across the region. Demand now significantly exceeds capacity impacting FDS performance which has dropped below 50%, with a corresponding impact expected to be seen against the 62-day referral to treatment standard. Changes in the pathway have also led to an increase in the proportion of patients being listed, meaning that whilst the main bottleneck in the pathway is currently the initial appointment, if additional resource is identified to clear this backlog, further resource will also be needed to accommodate the increase in demand for excision and biopsy. Opportunities to create additional resource are currently being explored – but performance against cancer standards within skin will not improve before January 2026.

Following implementation of pathway Gynaecology pathway changes in September, performance is improving as planned, with performance forecast to meet tumour site trajectory in October. The Breast Service is proceeding with plans to provide additional capacity, and is forecast to improve FDS performance in October and meet tumour site trajectory in November.

Urology continue to focus on optimising the cancer pathway with additional triage capacity and improved escalation for diagnostics. Performance has been impacted by equipment failure which has now been replaced with plans in place to address the resulting backlog.

2.4 **DM01 Performance – 95% Standard**

The Trust did not achieve 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 88.8% for August.

Non-obstetric ultrasound remains the area of greatest pressure despite increased capacity and ongoing use of mutual aid, with an improved position forecast for September.

2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. The main areas of concern are recovery of cancer performance. Cancer improvement plans have been developed by divisions, including tumour site level trajectories, as well as plans to address more immediate performance issues. The new monthly cancer performance meeting is supporting focus on longer term improvement actions. The Trust has been supported with regional recovery funding in Gynaecology and Breast and has made the case for support within Dermatology.

3.0	**Unscheduled Care**
3.1	**Performance** In August, Type 1 performance was reported at 46.50%, with a combined performance across all Wirral sites reaching 73.41%, which was a small improvement from previous month.

Type 1 ED attendances: • 7,987 in July (avg. 258/day) • 7,822 in August (avg. 252/day) 2% decrease from previous month	Type 3 ED attendances: • 3,413 in July (avg. 110/day) • 3,075 in August (avg. 99/day) 9% reduction from previous month

In August, Emergency Department (ED) attendances were in line with the previous month, however activity remained above the same period last year by an in month increase in attendances of over 400 patients. Demand therefore continues to be high and places sustained pressure on the department.

A number of actions are in place to improve Type 1 performance, though delivery of the recovery plan remains challenging. One of the main constraints continues to be the ongoing estates works for the new ED build, which reduces available space and limits flexibility in the current footprint. At times of peak demand this impacts flow, slows the patient journey and contributes to delays in achieving performance standards.

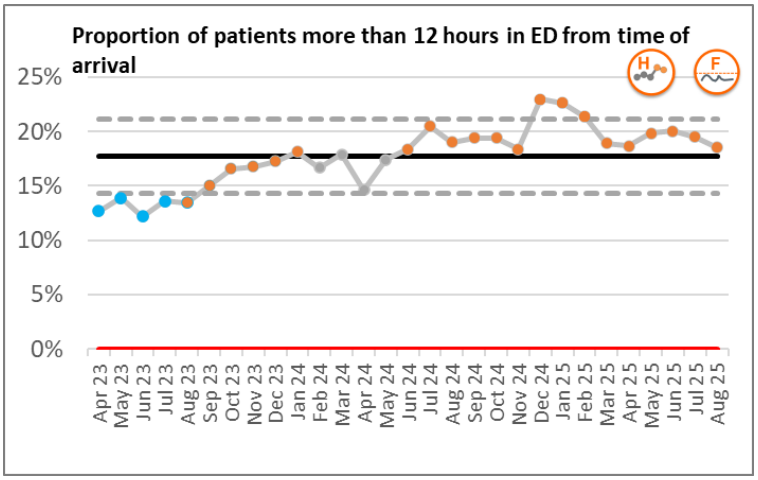
Mitigations have been introduced to offset this position, including strengthened internal escalation, use of alternative pathways with support from community services, and system-wide support to improve discharge timeliness. These have helped reduce some of the immediate risks, but the overall loss of capacity cannot be fully absorbed within the existing department layout.

The most significant risk to UEC performance remains achieving a sustained reduction in patients waiting over 12 hours in the ED. A system-wide focus led by NHSE and the ICB is in place, with active collaboration across all acute providers and the two mental health providers in the region. Recent actions within the Trust include the introduction of escalation cards, changes to referral pathways into SDEC services, and strengthened oversight through the development of a new business intelligence portal. Escalation cards are continuing to be embedded into daily practice, supporting a more consistent approach of tracking patients and ensuring early intervention is in place to reduce the wait time.

A recovery action plan is also being developed to bring together the various improvement actions and is being shaped by learning from progress made in other trusts.

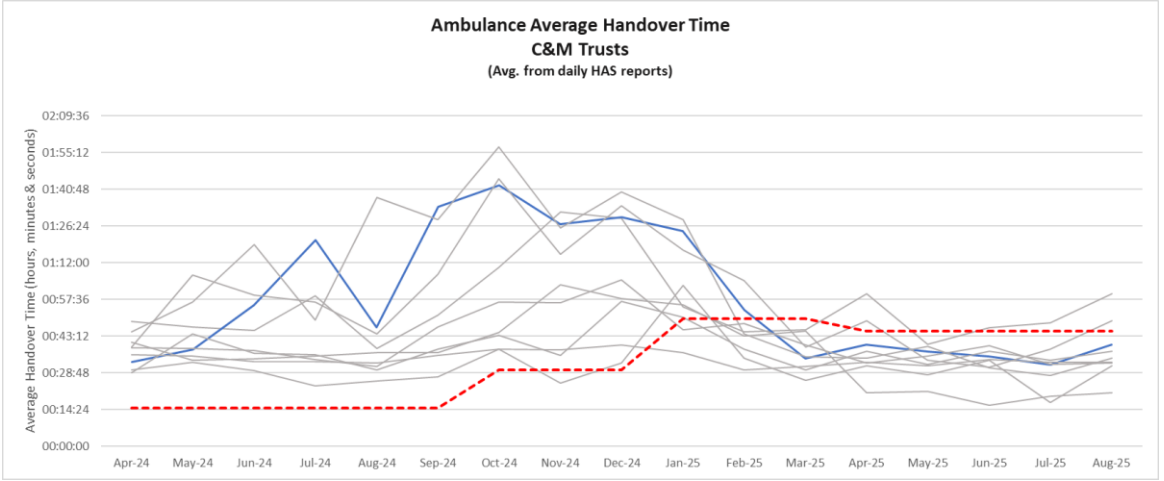
Following the announcement that the Trust has been placed in Tier 1 for UEC by NHSE, work is now underway to confirm the support programme with ECIST colleagues. This will add further external focus and ensure the recovery plan is aligned to actions that will deliver the greatest impact on patient flow and experience.

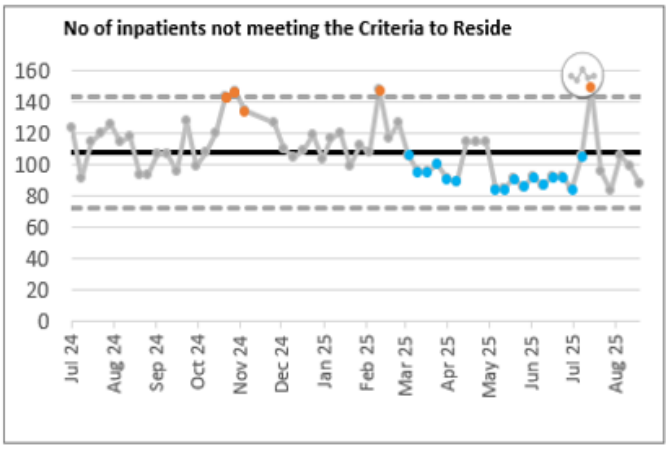
Accountability for delivery sits with Divisions, supported through the UEC Board, with assurance provided to the Board of Directors through regular reporting. The next phase of work will therefore be centred on embedding the changes already introduced, ensuring escalation processes are consistently applied, maximising use of alternative pathways, and aligning with wider system actions planned for Q3 and Q4.



Ambulance handover performance contains to remain compliant. Although handover time had a slight increase in month, the Trust handover was below 30 minutes. The implementation of the new rapid assessment triage model continues to ensure that patients receive the diagnostics upon arrival to the ED before being streamed to the most appropriate area.

The Trust is continuing to embed urgent and emergency services from Wirral Community Trust, such as the Urgent Care Response (UCR) team. Members of the UCR team are present in the ambulance arrival area, working with the triage nurse to identify patients that could be supported back in the place of residence, avoiding a long stay in the department.



3.2	**Transfer of Care Hub development and no criteria to reside (NCTR).** In August 2025, performance improved, returning to levels seen earlier in the year. The focus remains on achieving the target of no more than 10% of patients in acute beds with no criteria to reside by March 2026. Encouragingly, the number of days within the month where this position was achieved has increased. Key challenges continue, with most recent delays centred on patients with complex housing needs or those without a fixed abode. Closer joint working with the Local Authority Housing team has recently been established, enabling delays to be identified and addressed earlier in the patient's pathway. This approach is expected to support a reduction in overall length of stay, with progress monitored closely over the coming months.  The Trust performance for NCTR remained in a strong position in comparison to other Trusts in Cheshire & Merseyside. The most recent position shows a performance of 13%. | Provider	Current
Countess	21.2%
East Cheshire	40.6%
LUHFT	22.4%
Mid Cheshire	14.9%
MWL	19.2%
W&H	21.7%
WUTH	13.0%
Total	**20.4%** | **3.3** **Mental Health** Extended waits for mental health patients in the Emergency Department remain a significant challenge and are subject to the same level of scrutiny as those affecting acute patients. The Trust continues to work closely with mental health partners to ensure escalation takes place earlier in the day and that assessments and care plans are progressed at an earlier stage in the patient's pathway. Despite this, the Trust continues to experience prolonged stays in ED, with some patients waiting over 72 hours within the mental health unit. These long waits are now reported through the weekly Cheshire and Merseyside UEC Improvement Meeting, chaired by the ICB Chief System Improvement and Delivery Officer, ensuring visibility and accountability at a system level.

	The Trust is also awaiting the outcome of a capital funding bid for a dedicated Mental Health Crisis Hub on the Wirral. If approved, this development would increase local capacity and provide an alternative to the Emergency Department for patients detained under s136 who do not require acute medical care. This would help reduce pressure on the department, improve patient flow, and deliver better outcomes for patients.
3.4	**Risks and mitigations to improving urgent care performance** Although the Trust continues to make progress in delivering the actions set out within the Urgent Care Improvement Plans, this has not yet translated into the required level of improvement in performance standards. A number of schemes have delivered operational benefits and strengthened processes, but the scale and consistent high demand means these have not yet resulted in a consistent or sustained shift in overall performance. Key risks remain: • Increased attendances and ambulance conveyances • higher patient acuity, sustained demand for beds and high conversion rates, continue to create significant pressure across urgent care. These factors directly impact patient flow, contribute to congestion in the Emergency Department, and limit the delivery of improvements linked to reduced length of stay, avoidance of corridor care and reduction in 12-hour breaches. Further pressure is anticipated as a result of the challenging financial position for the Trust and across Cheshire and Merseyside system. The introduction of new financial controls is likely to increase the risk with delivering a robust workforce with UEC for winter. Controls such as reduced payment rates for bank nursing shifts and the planned extension of these measures to medical staff could see a reduction in fill rates for gaps in rotas due to sickness or vacancies. In addition, no funding has been allocated for escalation capacity and no additional resource is available to support winter resilience. This presents a risk to sustaining current progress and to delivering the recovery trajectories agreed with NHSE, particularly around 4-hour performance and elimination of 12-hour breaches. Mitigations are being developed locally and at system level, with a focus on maximising efficiency within existing resources, improving patient flow through earlier discharge planning, and strengthening escalation processes. However, the financial constraints reduce the flexibility previously available to respond to periods of peak pressure, and this will require continued focus and close collaboration with system partners in the coming months.

4	**Implications**
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.

4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

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

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 3 2025/26

Item

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1. Introduction

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. We have adopted a '3 lines of defence' approach which highlights the levels of control in place and assurance obtained, both internally and externally, along with clear identification of those accountable for further actions to be taken in order to reduce risk.

The successful and sustained achievement of your organisation's mission and objectives are reliant on robust governance, risk management and assurance.
processes. This means the board needs to be clear about what it wants to achieve, knows what the measures of success will look like, is open and honest. in its dealings and alive to the key risks being faced within and outside of its operating environment, both at strategic and operational level.

Baker Tilly 2021

2. Vison, Strategy and Objectives

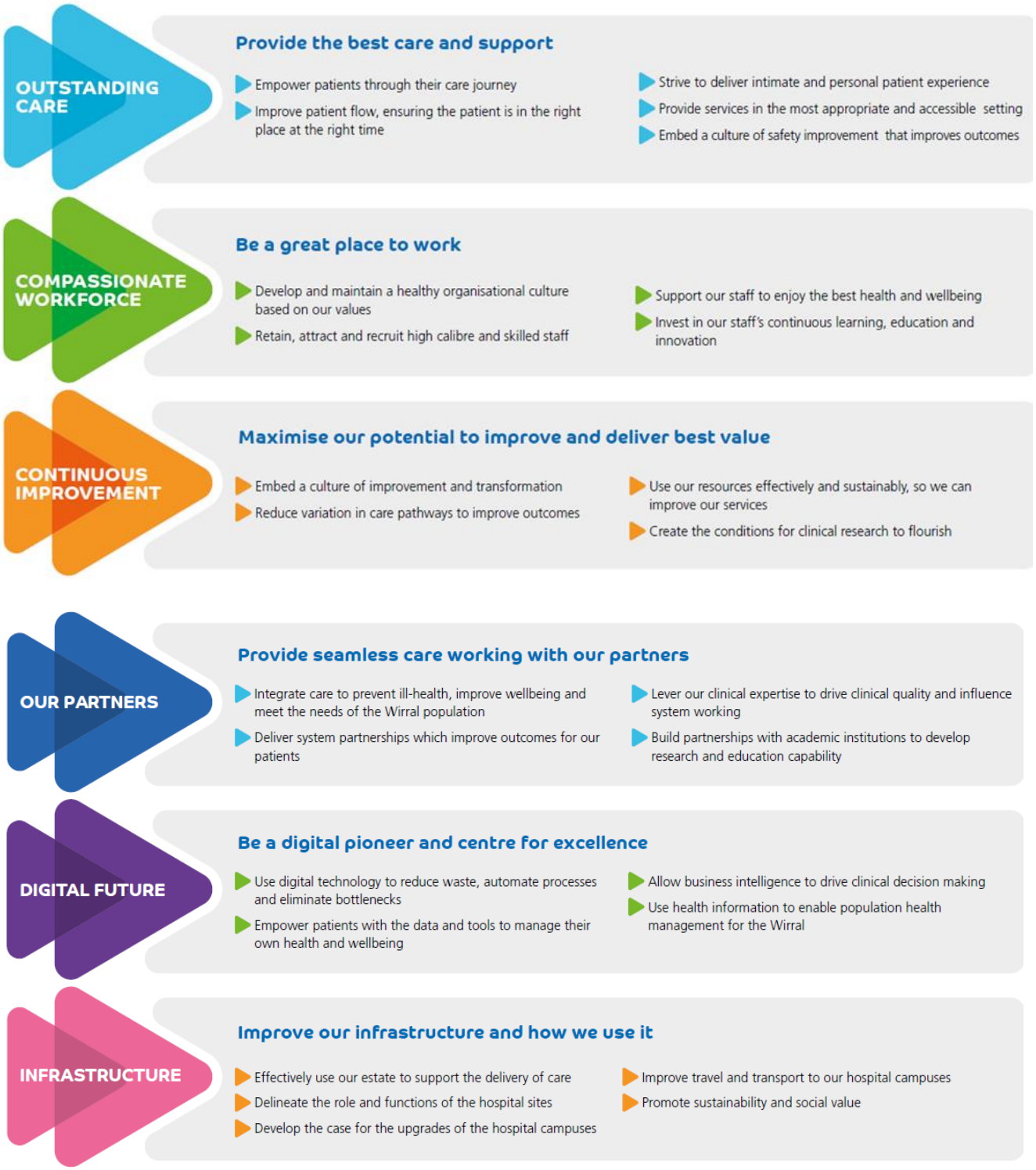
2.1 Our Vision

For us to realise our ambition it is essential that all business and work programmes are clearly aligned to our Vision, Values, Strategic and Corporate Objectives. Clear lines of sight from these down to individual objectives will support all staff in identifying how to contribute to overall achievement. Our Vision is:



2.2 Our Strategic Objectives

The BAF is derived from our overarching six strategic objectives and priorities which demonstrate our intension to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. We will be a Hospital Trust that patients, families, and carers recommend, and staff are proud to be part of.



3. Our Risk Appetite

3.1 Risk Appetite Statement

The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

The Trust recognises that its long term sustainability and success depends on the delivery of its strategic objectives and, its relationships with service users and families, the public and strategic partners. Patient and staff safety is paramount however such risks have to be tolerated within specific boundaries. Risks which impact on regulatory compliance and reputation will not be accepted and will be managed through robust risk management mechanisms.

The Trust wishes to maximise opportunities for developing and improving its activity by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Trust Strategy.



Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some risks where there is a requirement to mitigate risks to patient safety or quality of care. We will ensure that all such responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an **OPEN** risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept and have an **OPEN** appetite in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and productivity.

		The Trust Board has a **MINIMAL** appetite for any risks that affect sound financial control and management.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an **OPEN** risk appetite and is eager to pursue infrastructure options which will benefit the efficiency and effectiveness of services.

4. Operational Risk Management

4.1 Operational Risk Management

The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities and threats. Uncertainty of outcome is how risk is defined. The Trust's approach to Risk management includes identifying and assessing risks and responding to them. The Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

The Trust's governance framework is supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

The overall purpose of risk management at the Trust is to:

- Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
- Ensure the Trust complies with all relevant statutory provisions.
- Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

The Trust has established an effective risk management system which ensures that:

- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust.
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management.

- Management is held to account for the effective operation of controls.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across divisions, directorates and within corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust shall achieve this by:

- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process.
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations.
- Providing training to keep risk under prudent control.
- Investigating thoroughly, learning and acting on defects in care.
- Liaising with enforcing authorities, regulators and assessors.
- Effective oversight of risk management through team and committee structures.
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings.
- Effective reporting and arrangements to hold staff to account.

In order to support the Risk Management Process the Trust (via the Risk Management Committee) gives consideration to the latest set of significant risks at each meeting.

In order to further align this process the current list of significant risks is now included as an appendix to this BAF.

4.2 Risk Categorisation

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

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

4.3 Link to Strategic Objectives

All BAF risks are aligned to the relevant Strategic Objectives in the Corporate Plan and highlighted in the dashboard.

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The BAF is updated on a Quarterly basis and subject to a full refresh on an annual basis. The BAF was refreshed and discussed at a Board workshop in May 2025.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be subject to regular monitoring, it was noted that the schedule had been designed to help highlight the BAF and

its content and widen engagement across the Trust. Having achieved this aim it is now proposed that the schedule will revert to that originally in place and in line with sector norms as follows:

- Is Updated on a quarterly basis.
- Reports to the Board at every meeting.
- Reports to every meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every meeting of relevant Board Committees. This will include scheduled strategic risk 'Deep Dives' to each Committee.
- Reporting to every meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.
- Will be subject to an annual report and refresh in March each year.

The Annual Review of the BAF will take place as follows:

- January – Divisional review of BAF and recommendations for amendments/additions.
- January/February – Committee review, close down, deep dive and recommendations for next year.
- March – Board Review, close down and approval of next year.
- March – Board review of Risk Appetite and Risk Management Strategy.

6. Update Report

6.1 Purpose

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

The controls, assurance, and actions for most of the current strategic risks have been, or are being, reviewed with Executive Team members and further iterations will be reflected in future reports to Board.

6.2 Changes to the previous version

Following the annual review of the BAF the Board has approved the strategic level risk that will be monitored for the year 2025/26. Work is continuous to update previous risks and populate newer risks.

Including in the key changes for this report are as follows:

- A proposal for a refreshment to risk 9 is included. It should be noted that this has been aligned to the same risk added to the Community Trust BAF and will be populated with actions overseen by the Integration Management Board.

6.3 Risk Appetite and Risk Maturity

The report includes the current position of the Trust in relation to Risk Appetite and Maturity. This includes a refreshed assessment and statement in regard to Risk Appetite following the Board workshop in May.

6.4 Recommendations

Board is asked to:

- Note and comment on the current version of the BAF.

12 Month – Dashboard and Current and Quarterly Trend

Impact x Likelihood

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

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

Strategic Priority	Outstanding Care				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action, **although the actions do not mitigate the demand and capacity gap.** • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. **With Executive Triumvirate.** • Business Continuity and Emergency Preparation planning and processes in place. **This includes escalations to Critical Incident as required.** • Winter plan initiated that includes additional resource and capacity to aid strong UEC flows and performance • Full review of post take model to ensure sufficient resource is allocated to manage volumes • Implementation of continuous flow model to improve egress from ED.	• EARC Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO • Trust wide response to safe staffing of ED when providing corridor care

Gaps in Control or Assurance
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.

Action	Responsible	Deadline
There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post.		
Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023.		
System 4 hour performance response to deliver 76% in March.		
External support into ED from Aqua reviewing 4 hour and 12 hour performance – recommendation report received and local action plan in development with urgent actions.		
Full engagement with the national Rapid Improvement Offer (RIO) from the national ECIST.		

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

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

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

Gaps in Control or Assurance
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Impact of the Cyber-attack was significant and deteriorated the Trust's progress with recovering elective waiting times. • 2 specialities are challenged in delivery of 65 and 75 weeks. • One specialty is challenged in delivering 65 weeks by the end of the financial year given the impact of the cyber-attack.

Action	Responsible	Deadline
Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation.		
Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients.		
Utilisation of the LLP to deliver the gap in recurrent capacity.		
Cyber-attack recovery plan.		

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

Strategic Priority	Outstanding Care
Risk Appetite	Minimal
Review Date	Q3 2025/26
Lead	Medical Director and Chief Nurse

Initial Score	Last Quarter	Current	Target
16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

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

Gaps in Control or Assurance
• **Fully complete and embedded patient safety and quality strategies.** • **Current operational impacts and organisational pressure.** • **Capital availability for medical equipment.** • **Medical workforce gaps.** • **Impact of unscheduled care demand.** • **Significant financial controls in place.** • **Update required to WISE accreditation programme *- see action below.*** • **Lack of BI capacity impacting on patient outcome data** • **Delays in incident investigation** • **Inconsistent learning from complaints and incidents** • **MiAA IPC Review - completion of action plan to mitigate identified risks**

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

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

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

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

• Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.	

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

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

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

Strategic Priority	Compassionate Workforce				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Just and Learning Culture work delivered and embedded as 'business as usual'. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum. • Just and Learning Plan implemented. • Provision for mediation and facilitated conversations as part of new Fairness in Work Policy • New approach to coaching and mentoring • New supervision and appraisal process • Talent Management approach launched • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool • Business as usual support continues to be in place such as FTSU. OH&WB, HR and line manager support • CPO working with local networks	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance
• **Full understanding of the experience of Multi-Cultural staff across the Trust** • **Impact of financial pressures** • Impact of large scale organisational change (integration)

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

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

Strategic Priority	Continuous Improvement				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • **25/26 plan approved.** • **WUTH fully engaged with C&M Finance review**	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • FBPAC meeting more frequently. • **24/25 risk Mitigated from 21m to 3m.** • **Board briefed on 25/26 plan and drivers of the gap to control total.** • **PWC programme in final stages and completion of handover.** • **Board considered additional actions in relation to finance and associated risk.** • **PWC review meeting completed**

Gaps in Control or Assurance
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • Mitigated forecast of 7m variance to plan. • Unmitigated forecast of 29m variance to plan. • **Significant variance for 25/26 to approved control total.** • **Full mitigation plan for approval**

Action	Responsible	Deadline
Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing.		
Complete benchmarking and productivity opportunities review pack.		
Develop 3-year CIP Plan to include all trust wide strategic and transformational plans.		
Expand current mitigation plan to measure risk.		
Exec meetings with divisions to consider additional actions to mitigate gap control total.		

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

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

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

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

Action	Responsible	Deadline
Delivery of DHT annual plan.		
Prioritise delivery of Digital workload with Executives.		

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

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

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

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

Action	Responsible	Deadline
Delivery of 24/25 improvement projects to plan	Chief Strategy Officer	March 2026
Strong Governance through PMO working of all schemes, risk and outputs		
Detail improvement staff training approach and programme		
Implementation of Improvement for All approach and training to staff		
Development of Improvement Programme for 25/26		

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

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

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

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

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

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

Strategic Priority	Infrastructure				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

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

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

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

Strategic Priority	Infrastructure				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)	15 (5 x 3)	10 (5x2)

Controls	Assurance
• Implementation of the national Business Continuity Toolkit with a process underway to re-write all Business Continuity Plans (BCP) in the Trust. • Full risk assessment undertaken on critical infrastructure and mitigations for major failure in these areas. • Full engagement and adaptation of regional and national EPRR guidance and alerts. • Submission of Data Security and Protection Toolkit (DSPT) Annual assessment and associated audit. • Privileged Access Management (PAM) for external providers accessing systems. • **Additional controls in place with Multi Factor Authentication.**	• Trust command and control framework in place and tested thoroughly the Covid pandemic and industrial action over the last 12 months. • Regional core standards self-assessment process and central peer review. • Planned exercise programme in place to test BCPs. • Quarterly updates provided to the Risk Management Committee. • Annual report to the Board of Directors and updates in between as required. • Estates and Capital Committee sighted on the risk relating to the critical infrastructure • Trust received substantial assurance received from the MIAA DSPT audit. • Trust policy is to follow Privileged Access Management – preventing unauthorised access to 3rd parties.

Gaps in Control or Assurance
• System BCPs raised as a gap in the core standards self-assessment and a Wirral wide discussion on this is lacking. • Internal resource limited to cover the large spectrum of EPRR assurance - 1 WTE working to the Accountable Emergency Officer (AEO) • Issues identified as part of Dionach, Penetration testing conducted on Trust Network. • Some 3rd parties and national providers have not adopted PAM

Action	Responsible	Deadline
Continue with the actions highlighted in the core standards peer review assessment.		
Engage with the regional Local Health Resilience Forum (LHRP) ensuring the Trust is up to date with the latest guidance and central notifications.		
Operational Cyber programme addressing the risks raised within the Dionach, Penetration test.		
Working with suppliers to irradicate legacy connections, expressing importance of the standards.		
Cyber incident action plan		

BAF RISK 12	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.

Strategic Priority	Our Partners				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	All Executive Directors	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

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

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

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

Appendix - Risk Scoring Matrix

Table 1 - Impact scores

Consequence scores can be used to assess actual and potential consequences: -

- The actual consequence of an adverse event e.g. incidents, claims and complaints.
- The potential consequence of what might occur because of the risk in question e.g. risk assessments, and near misses.

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

Consequence	Patient	Reputational	Financial	Workforce	Legal / Regulatory*
5 Catastrophic	**Prolonged failure or severe disruption** of **multiple** services Multiple deaths caused by an event**; major impact** on patient experience	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability. Hospital closure	**>£5m** directly attributable loss / unplanned cost / reduction in change related benefits	Workforce experience / engagement is **fundamentally undermined** and the Trust's reputation as an employer damaged	Breach of regulation Trust put into Special Administration / Suspension of CQC registration. Civil/Criminal **Liability > £10m**
4 Severe	**Prolonged failure or severe disruption** of a **single** patient service Severe permanent harm or death caused by an event. **Significant impact** on patient experience	**Prolonged** adverse social / local / national media coverage with **serious impact** on patient trust and public confidence	**£1m - £5m** directly attributable loss / unplanned cost / reduction in change related benefits	**Widespread material impact** on workforce experience / engagement	Breach of regulation likely to result in enforcement action. Civil/Criminal **Liability < £10m**
3 Moderate	**Operation of a number** of patient facing services is disrupted Moderate harm where medical treatment is required up to 1 year. Temporary disruption to one or more CSUs Resulting in a poor patient experience	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**£100k - £1m** directly attributable loss / unplanned cost / reduction in change related benefits	**Site material impact** on workforce experience / engagement	Breach of regulation or other circumstances likely to affect our standing with our regulators. Civil/Criminal **Liability < £5m**
2 Minor	**Operation of a single** patient facing service is disrupted. Minor harm where first aid required up to 1 month. **Temporary service restriction** **Minor impact** on patient experience	**Short lived** adverse social / local / national media coverage which **may impact** on patient trust and public confidence in the short term	**£50k - £100k** directly attributable loss / unplanned cost / reduction in change related benefits	**Department / CSU material impact** on workforce experience / engagement	Breach of regulation or other circumstances that may affect our standing with our regulators, with minor impact on patient outcomes. Civil/Criminal **Liability < £2.5m**.
1 Limited	**Service continues with limited/no patient impact**	**Short lived** adverse social / local / traditional national media coverage with **no impact** on patient trust and public confidence	**£Nil - £50k** directly attributable loss / unplanned cost / reduction in change related benefits	**Material impact** on workforce experience / engagement for a **small number of colleagues**	Breach of regulation or other circumstances with limited impact on patient outcomes. Civil/Criminal **Liability < £1m**.

Table 2 – Likelihood

The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.



In considering the likelihood, the following supports the conversations and assessment from British Standards Institution (BSI) (2011) Risk management – Code of practice and guidance for the implementation of BS ISO 31000:

In risk management terminology, the word "likelihood" is used to refer to the chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively and described using general terms or mathematically [such as a probability or a frequency over a given time period].

Appendix – Risk Appetite



Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some risks where there is a required to mitigate risks to patient safety or quality of care. We will ensure that all such responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an **OPEN** risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept and have an **OPEN** appetite in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and productivity. The Trust Board has a **MINIMAL** appetite for any risk that effect sound financial control and management.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an **OPEN** risk appetite and is eager to pursue infrastructure options which will benefit the efficiency and effectiveness of services.



Appendix – Significant Operational Risks

Current Month Highest Scoring Risks

536	Med	Clinical, Quality, Safety and Access risks associated with poor patient flow	(4 x 5) 20	⇔
2151	D+CS	Limitations of OP speech and language therapy workforce to deliver the out patient service.	(5 x 4)) 20	é
2007	Surg	Replacement of portable anaesthetic ventilators that are no longer supported by the manufacturer.	(4 x 5)) 20	↑
2086	EF & C	Potential failure of APH medical/surgical air assets (compressors, receivers and controls) serving operating theatres, Critical Care and Neonatal Unit.	(5 x 4)) 20	↑
1547	Corp	Cash Management	(5 x 5) 20	↑
1756	Corp	Clostridioides difficile	(4 x 5) 20	⇔

Appendix – Monitoring Schedule

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

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

Public Board of Directors **Item 13**

01 October 2025

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

Executive Summary and Report Recommendations

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

This update provides the position following review during September 2025.

It is noted that due to the change of date for the Board of Directors meeting, the meetings of the Finance & Performance Committee and the People & Culture Committee have not taken place. Both committees will meet in early October 2025 where each of the relevant strategic risks will be discussed, and an update provided to the Board in November. It is noted that the update provided to the Board in September 2025 included recent updates in relation to finance, operational and workforce strategic risks.

A new risk (ID11) has been included as recommended by the Integration Management Board, reflecting the integration programme between WCHC and WUTH.

The recently published NHS Oversight Framework and confirmation of WCHC being placed in segment 1 has also been added to the relevant strategic risks as core mitigation.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks
- Approves the addition of a new risk - ID11 related to integration noting continued oversight by the Integration Management Board.

Key Risks

This report relates to the following key risks:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
11/12/24	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the recommendation from the Finance & Performance Committee that ID06 had achieved its target risk rating and would be kept under review for the remainder of the financial year.
19/02/25	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also

			approved the MIAA Assurance Framework Report 2024/25.
19/03/25	Informal Board	BAF	The members of the Board supported an informal discussion to review current and emerging risks for 2025-26 and to inform the position presented to the committees and the Board in April and May 2025.
23/04/25	Board of Directors	BAF	The Board of Directors approved the recommendation for new risks for 2025-26.
04/06/25	Board of Directors	BAF	The Board of Directors received the update provided on the current position in relation to the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress. It was noted in particular that the meeting of the Finance & Performance Committee and the People & Culture Committee would take place (the following week) to review relevant risks.
03/09/25	Board of Directors	BAF	The Board received the updates provided on the current position in relation to the strategic risks and approved the proposed change to the risk appetite for ID06 from Cautious to Moderate as recommended by the Finance & Performance Committee. The Board also noted inclusion of the new risk (ID05) associated with cyber security and EPRR monitored by the Finance & Performance Committee.

1	Narrative
1.1	The Board has in place a full Board Assurance Framework which is reviewed annually to reflect the strategic priorities of the Trust. Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the committee.

1.2	At the meeting of the Board of Directors in September 2025 an update was provided on each of the strategic risks.
1.3	The summary table at **appendix 1** confirms the current position of strategic risks as reviewed during September 2025. This includes a new risk (ID11) associated with cyber security and EPRR which is monitored via the Finance & Performance Committee.
1.4	A revised risk description for ID11 to reflect the Partnership Agreement established between both WCHC and WUTH and the risk of failing to develop a Joint Strategy and deliver the 2-year plan to realise the benefits of integration has been agreed and recommended to the Board by the Integration Management Board. This risk is currently scoring RR9 (3x3) with an Open Risk Appetite and a target risk rating of RR6 (2x3).
1.5	The BAF now includes 9 strategic risks, none of which is currently scoring at a high-level. The highest scoring risks are RR12. No risk has achieved its target risk rating.
1.6	It is anticipated that as the development of the Joint Strategy progresses, shared strategic risks and Board Assurance Frameworks between WCHC and WUTH will emerge.
1.7	**Wirral Place Delivery Assurance Framework** The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF was last presented to the Place Based Partnership Board in March 2025, and can be accessed via the following link - Agenda for Wirral Place Based Partnership Board on Thursday, 27th March 2025, 10.00 a.m. | Wirral Council

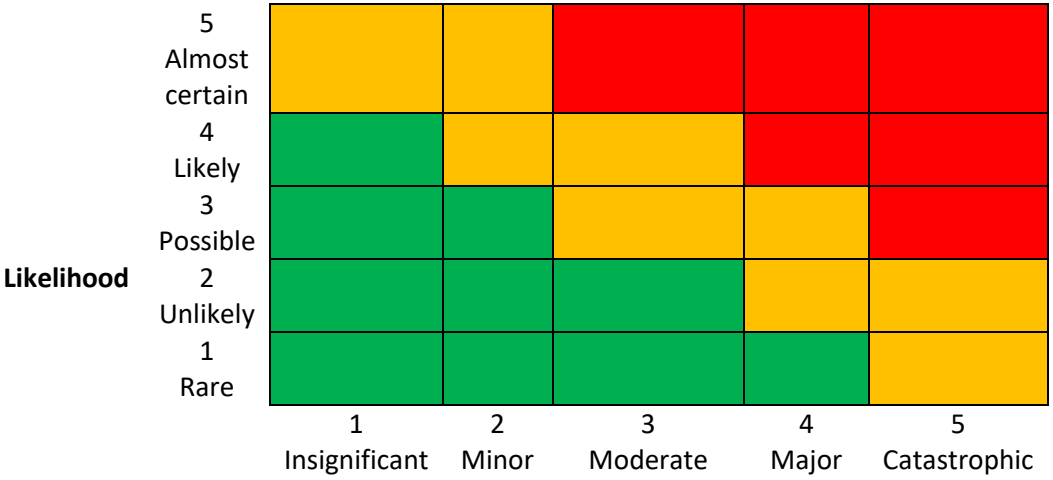
2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF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

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

Strategic risk summary 2025-26

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC) (September 2025)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Averse
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change.	Quality & Safety Committee	Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Averse
Previous ID03 archived at end of 2023-24.						
ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 3 (12)	3 x 4 (12)	2 x 4 (8)	Cautious
ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber-attack impacting on the quality of patient care	Finance & Performance Committee	Safe care and support every time Make most efficient use of resources to ensure value for money	3 x 3 (12)	3 x 4 (12)	2 x 4 (8)	Cautious
ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Moderate
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.	People & Culture Committee	Improve the wellbeing of our employees	2 x 4 (8)	2 x 4 (8) ↔	1 x 4 (4)	Moderate

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



Consequence

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

Board Assurance Framework 2025-26

Strategic risks with oversight at Quality & Safety Committee

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

Corporate Governance

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

Quality Governance

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

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

PSIRF

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

FTSU

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

Safeguarding governance

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

Infection prevention and control governance

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

Medicines governance

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

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

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

System Governance

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

Monitoring quality performance

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

QEIA process

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

<table>
<tr><td colspan="6">ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Safe care and support every time

Organisational risk - ID3137 (RR16 - 4 x 4) - CICC call bells, ID3201 (RR16 - 4 x 4)</td></tr>
<tr><td colspan="7">Consequence;
• Poor experience of care resulting in deterioration and poor health and care outcomes
• Non-compliance with regulatory standards and conditions
• Widening of health inequalities</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Actions to ensure safe care and support every time to prevent variation of standards across localities and teams.
- NOF segment 1
Headline measures in-month (M04)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 0 fall (moderate & above harm) (YTD = 1) - QUAL17
- 92.9% FFT (YTD 92.3%) - QUAL22
- 4 complaints received (YTD = 17) - QUAL08</td><td>- Supervision Training Strategy - Head of L&OD
- PSIRF learning cafes roll-out Q4 - delayed to 25-26 (included in Delivery Plan - wider roll out to teams will commence during 2025/26 and have an emphasis on system learning with WUTH and beyond) - Head of Quality & Patient Experience
- QI programme to address waiting lists in specialist speech</td><td>- NOF rating / segmentation
- Sustained performance against quality metrics
- FFT response rate and satisfaction rate
- Low number of complaints
- Mandatory training sustained compliance maintained at 90%
- Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee</td><td colspan="2">- Supervision Training Strategy approved - TBC
- Reporting on expected outcomes from 4 joint high priority clinical risk areas (based on PSIRF analysis) - October 2025
- Delivery of 4 joint QI programmes based on high priority clinical risks - March 2026</td></tr>
</table>

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

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

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

- Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Silver award in the Armed Forces Covenant Employer Recognition Scheme - Veteran Aware accreditation achieved for the Trust. - ~~EDS2 assessment criteria agreed and completed for 2022-23 - achieving across all areas including Domain 1 commissioned services (community cardiology and bladder and bowel)~~ - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. Included as an action from EDS domain 1. **Actions to ensure safe demobilisation of services.** - ~~Demobilisation plan in progress for Lancashire 0-19+ contract.~~ - ~~Long-COVID services demobilisation in progress~~ - ~~School aged immunisation service demobilisation~~			

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

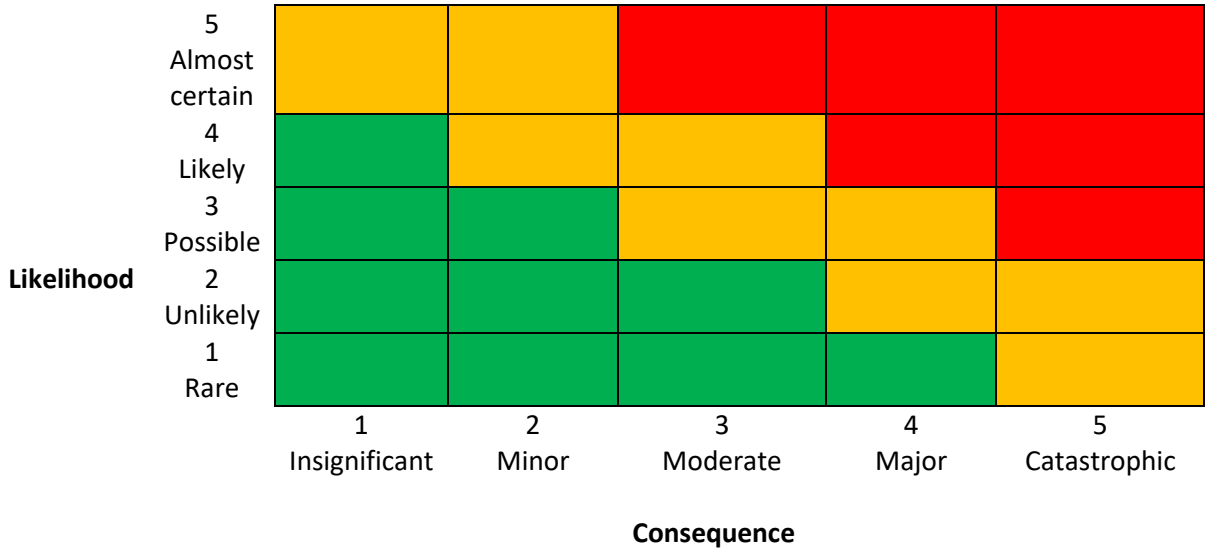
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Actions to ensure collaboration and co-design with community partners.
- EDI training compliance - 96.8%
- Quality Strategy Delivery Plan including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

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

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

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

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



Board Assurance Framework 2025-26

Strategic risks with oversight at Finance & Performance Committee

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

Financial Governance

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

System Governance

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

Monitoring performance

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

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

<table>
<tr><td colspan="6">ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Poor financial performance in the Wirral health and care system leads to a negative impact and increased monitoring and regulation

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full and ID3186 (RR12 - 3 x 4) - A significant underlying deficit financial position at both North West and C&M ICB has been reported. The ask of each system is to deliver financial balance within 3 years. C&M currently has a deficit plan of £178m. The Trust has submitted a £0.9m surplus plan for 25-26 which includes at £5.7m CIP that will be challenging making the delivery of the 25-26 financial plan a risk.</td></tr>
<tr><td colspan="7">Consequence;
Financial sustainability impact
Negative reputational impact for the Trust and system
Enhanced financial control from ICB and NHSE</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Cautious</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>Pending</td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e. processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">NOF segment 1
Board approval of financial plan 2025-26 and subsequent revised forecast (18.7.25) linked back to current run rate and extrapolates current financial position to year-end</td><td colspan="2">Impact of ICB turnaround process is not clear - expectation to improve forecast to mitigate the risk associated with WUTH forecast.
NHSE approval of C&M financial plan</td><td>Delivery of recurrent CIP to achieve the target for 2025-26
Delivery of revised financial forecast 2025-26</td><td>CIP target delivered - March 2026
Financial plan delivered or mitigated position with ICB - March 2026</td></tr>
</table>

• Full participation in C&M ICS reviews - ICS Director Turnaround, NHSE review of CIP and establishing forecast risk for 25-26 and PWC/Stephen Hay diagnostic / financial governance • Bi-monthly updates to Finance & Performance Committee • Monthly oversight at Finance, Resources Oversight Group, chaired by interim CFO • Financial plan delivery (at M4) in line with plan • Robust CIP plan in place for 2025-26 with identification of recurrent schemes • Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board • CIP workstreams established with SRO Leads at Executive level • Trust continued engagement in ICB turnaround process (NOTED as an emerging issue at private board on 4.6.25) • M3 financial plan - reported deficit of £489k against a planned deficit of £493k • M3 CIP position - £1,220k delivered against plan of £1,213k • Membership and participation in Place Finance and Investment Group • System collaboration across NHS provider organisations • Relevant organisational risks (e.g., CIP, Capital, Financial Performance) tracked	• CIP delivery to support delivery of improved position - **Interim Chief Finance Officer** • Further implementation and use of model health data in clinical and corporate services - **Chief Strategy Officer / Interim Chief Finance Officer** • Develop 3-year rolling capital programme - **interim Chief Finance Officer**		

on Datix and through governance structures (as per Risk Policy) • EPCP process established jointly between WCHC and WUTH • Enhanced controls established for vacancy control and non-pay discretionary spend and communicated trust-wide with supporting SOP - improved position reported in two months since established.			

<table>
<tr><td colspan="6">NEW ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Wirral system partners are unable to deliver the priority programmes within the Wirral Health and Care Plan which will result in poorer outcomes and greater inequalities for our population (RR8).

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full</td></tr>
<tr><td colspan="7">Consequence;
Poor service user access, experience and outcomes
Poor contract performance - financial implications (Trust and system)
Negative reputational impact</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by month of committee)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Moderate</td><td rowspan="2">2 x 4 (8)</td></tr>
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(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">NOF segment 1
Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board
CIP workstreams established with SRO Leads at Executive level</td><td colspan="2">CIP delivery to support delivery of improved position - Interim Chief Finance Officer
Community Nursing Development Programme to</td><td>Delivery of the benefits of integration as described for each service
Staff experience and staff morale</td><td>Implementation of new Community Nursing model - Q4 2025-26
Key deliverables for Y1 of 2-year integration plan achieved - March 2026</td></tr>
</table>

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

<table>
<tr><td colspan="6">NEW ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber attack impacting on the quality of patient care</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - (Populations) Safe care and support every time, (Place) Make most efficient use of resources to ensure value for money</td></tr>
<tr><td colspan="7">Consequence;
• Delivery of patient care and patient experience
• Staff morale
• Financial impact
• Negative reputational impact for the Trust and system</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by month of committee)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Cautious</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>-</td><td>-</td><td>3 x 4 (12)</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e. processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">• EPRR arrangements in place including business continuity plans for all services
• EPRR lead reporting to COO
• Annual EPRR report presented to Board with regular monitoring at FPC
• Major Incident Plan approved by Board
• EPRR work plan agreed and endorsed by Board</td><td>• Achievement of substantial compliance against the EPRR core standards self-assessment - Chief Operating Officer
• Alignment of EPRR functions with WUTH - Chief Operating Officer
• Implementation of recommendations from DSPT/CAF</td><td>• EPRR core standards self-assessment - substantial compliance</td><td colspan="2">• EPRR core standards self-assessment - substantial compliance - March 2026
• Implementation of all recommendations from DSPT/CAF audit review - Q1, 26-27</td></tr>
</table>

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

Board Assurance Framework 2025-26

Strategic risks with oversight at People & Culture Committee

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

Corporate Governance

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

Workforce Governance

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

- National NHS Staff Survey reporting via PCC and to Board of Directors.

System Governance

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

Monitoring workforce performance

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

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

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

• Senior Leaders Briefings established monthly to support dissemination of messages • Appraisal window 2025 opened and extended to September 2025 • Training packages in place via ESR to support managers to undertake effective appraisals. • Freedom To Speak Up Guardian and >100 champions. • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • Reduction in vacancy rates (data on TIG) • Refresh and relaunch of MDT preceptorship programme. • Behavioural standards framework launched trust-wide • Internal and external communications plans to support integration developed - Better Together branding launched • Workforce Sharing Agreement agreed between both Trusts • Engagement plan developed for staff as part of the integration plan • OD plan developed including managers 'toolkit' to support service integration • Joint Strategy development between WCHC and WUTH to include staff engagement • Better Together - case for change document published internally and externally			

• Multiple channels for staff to ask questions - Ask ELT, monthly Get Together, monthly Leaders In Touch, Senior Leaders Briefing			

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

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

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

• NHS Rainbow Pin Badge scheme - achieved bronze status • Armed Forces Covenant community inclusion initiatives - covenant signed, silver DERS achieved and VCHA accreditation achieved • Recruitment and Retention Policy includes positive action in respect of increasing diversity at senior roles (8a and above). • Chief executives, chairs and board members have specific and measurable EDI objectives to which they are individually and collectively accountable (6 high impact actions for EDI) • Behavioural standards framework launched trust-wide • EDS 2024 completed (jointly with WUTH) with Board approval in February 2025 - Overall attainment level = **Achieving**		• Delivery of NHSE EDI High Impact Actions • Achieve Bronze Level status for the NW BAME Assembly Anti-Racist Framework	

<table>
<tr><td colspan="6">ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Grow, develop and realise employee potential
Better employee experience to attract and retain talent
Link to PDAF - The Wirral health and care system is unable to recruit, develop and retain staff to create a diverse health and care workforce with the skills and experience required to deliver the strategic objectives (RR12).</td></tr>
<tr><td colspan="7">Consequence;
Poor outcomes for the people working in the Trust
Reduced staff engagement
Increase in staff turnover and recruitment challenges</td></tr>
<tr><td colspan="4">Current risk rating (LxC)
(by month by committee)</td><td>Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Open</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Measures remain under review and in development following committee discussions in August 2024.</td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">People Strategy Delivery Plan Year 4 developed and includes;
Actions deferred from Year 3
Alignment to existing national priorities
Key themes of the People Promise
4 x actions in Year 4 delivery plan aligned to ambition 1 ‘Growing for the Future’</td><td>Review operational service requirements in relation to career pathways, clinical apprenticeships and advanced practice - L&OD</td><td colspan="2">Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v’s 2024 results 7.02
NSS uptake Year 4 target ≥ 55% v’s 2024 result 51%
Q25c in NSS “I would recommend my organisation as a place to work” Year 4 target ≥ 63% v’s 2024 result 63.21%</td><td colspan="2">See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
Completion of actions in Year 4 PSDP ‘Growing for the Future’ - March 2026</td></tr>
</table>

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

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

Board Assurance Framework 2025-26 – new strategic risk

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

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

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

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 16**
1 October 2025

Report Title	Chairs Report – Charitable Funds Committee
Date of Meeting	27th August 2025
Author	Sue Lorimer, Chair of Charitable Funds Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Charity Team requested that the Tiny Stars appeal be formally closed on 30th November 2025. This is in line with the expected completion date of the Neonatal refurbishment. Subsequent donations would be credited to a ringfenced Neonatal pot within the Children's fund. Subject to Board approval, the closure would be communicated in October 2025. The Committee approved this course of action and were keen to see the Neonatal refurbishment publicised so that donors, in particular the Incubabies charity could see how the fund has been spent. The funding position of the scheme as at 31st July 2025 is as follows: Tiny Stars including Incubabies donation £914.3k Patient Wish fund contribution £185.7k Trust capital £197k. Any donations to Tiny Stars between 31st July and 30th November will be credited to the scheme with a corresponding reduction in the Patient Wish contribution.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Net fund balances increased by £242k to the end of July taking total funds to £1686k. The Committee noted that the Tiny Stars appeal formed a sizeable proportion of the total and excluding Tiny Stars the balance was £772k. Fundraising had started slowly in the early part of 2025/26 but the team presented plans to the Committee to make good the shortfall of £9k and achieve the forecast for the year of £366k. ○ The Committee received a presentation from Paul McNulty and Dr Sarah White on the benefits to patients of a garden for Critical Care. The outline cost would be circa £350k. The divisional representatives sought approval to undertake fundraising and to seek sponsorship and this was agreed. The Committee agreed that this would be a good purpose for the next Trust-wide appeal and would be considered along with other bids from services. The division had identified a potential location and confirmed that the garden would be available to other services in addition to Critical Care. ○ The Committee agreed that in view of 2 extensions having been given there would be a cut off date of 30th September for

	requisitions arising from funding approvals from the League of Friends' funding.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee reviewed the Charity risk register and requested that scoring be reviewed as scores were considered to be unduly high. ○ The Committee approved the draft Annual Report and Accounts for the Charity for 2024/25.
Review of Risks	• The Committee noted that it is important that the fundraising programme be implemented effectively in order that fund balances are increased following the withdrawal and closure of the Tiny Stars fund.
Other comments from the Chair	• The Charity Team are doing a good job in a difficult environment and the Committee will continue to support them as they develop.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 17**
1 October 2025

Report Title	Committee Chairs Reports – Audit and Risk Committee
Date of Meeting	1st September 2025
Author	Steve Igoe – Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Committee undertook a deep dive into BAF risk 6: Financial sustainability. It is clear as the Board is aware of the challenging financial position the Trust and other Acute Trusts find themselves in. Despite having transacted over £54m in recurrent CIP over the past 2 years there is a requirement to drive out further efficiencies although it is accepted that any "low hanging" fruit will have been realised. Cash remains a key challenge with monthly requests being sent and DSF not being available, exacerbating the position due to the parlous state of the C&M finances. ○ The above is analysed in detail in the Auditors final report.
Advise	• The Committee wish to advise members of the Board of Directors that: • Work in relation to Information Governance continues with issues raised being resolved on a timely basis. The issue of coders remains a challenge however mitigations are in place, and the position appears to have stabilised. • The Committee received a positive Anti-Fraud progress report with all areas related to: Assure, Understand and Prevent and Respond all being rated green. The detail consists of 12 subsections of assurance assessed on a monthly basis. • Work in relation to the Tracking of Audit actions is monitored as a standing item. As at the time of this meeting, 2 high level actions remain outstanding and as referenced below assurance is being sought on resolution via the Quality Committee. These are not yet quite out of date with a revised implementation date of end October 2025.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ In dealing with the significant financial challenges the Trust was able to clearly set out the strong grip and challenge in place to manage the finances alongside the regional and national intervention process in the C&M ICS. ○ A positive final Auditors report was received and other for a few drafting comments was accepted and endorsed by the Committee. The final version will be shared with Governors at the annual members meeting.

	○ A moderate assurance opinion was received in relation to Infection Prevention and control due to the raising a one high risk issue. The resolution of this will be tracked by both MIAA and the Trust and the matter referred to the Quality Committee for its oversight. ○ The Trust received a positive assurance on its overall approach to the Data Protection and Security toolkit. There were several new areas to audit this year, and this highlighted further work to do in relation to the supply chain. The Trust recognises the work and has committed to address the issues by the end of this calendar year.
Review of Risks	• The Committee discussed the current iteration of the BAF and confirmed it was content with the risks identified and the relevant risk ratings, particularly the highest rating relating to financial sustainability which the Board is sighted on. • The Committee noted the new risk nine relating to the failure to realise the benefits of the WCHC integration (clinical, operational, workforce and financial). The Committee endorsed the risk and associated rating.
Other comments from the Chair	Two specific control issues were referred to the Quality Committee: 1) The resolution of two high risk recommendations related to LOCSIP's control issues. 2) The resolution of one high risk recommendations related to Infection, Prevention and Control.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 18**
1 October 2025

Report Title	Committee Chairs Reports – Research and Innovation Committee
Date of Meeting	15 September 2025
Author	Dr Steve Ryan, Non-Executive Director and Meeting Chair

Alert	• The Committee had no issues to which it needed to alert the Board.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ There are an increasing number of research active clinicians across the Trust, with evidence of how these roles are promoting increased research activity of high quality. These roles are supported by access to personal development opportunities which are being untaken by colleagues enthusiastically ○ Some constraints within the Trust's diagnostic services have limited the Trust contributing to studies within the Wirral Research Collaborative (led from the Marine Lake Medical Practice in West Kirby). The Committee asked for a more detailed understanding of these limitations and how they could be overcome in the light of likely research focus of the Collaborative. ○ The Committee also identified an opportunity evolving out of a review of Wirral Place-based governance to align research governance processes with our partners ○ The Committee had a detailed discussion around a metric from the cancer national patient survey which indicated that a limited number of our patients reported being aware of research opportunities involving their own cancers. While not straightforward (given that a high proportion of cancer pathways involving other Trusts), the Committee identified number of ways of promoting research - even if that research was undertaken by partner organisations. ○ The Committee is aware of the planned stepping down of our senior research leaders and agreed the importance of timely appointment of successors. ○ The Committee revisited a theme around the opportunities for increasing our research partnership with Higher Education Institutions & agreed that the Trust would look into this.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ It received, noted and approved the Research and Innovation Annual Report for 2024/2025, which outlined a successful year delivery across the research portfolio. There was increased visibility, an increase in research active staff (the research champion initiative being a notable success), the

	opening of the Research and Innovation centre and the continued networking and building of our research partnership approach. The report acknowledges the complexity of the rapidly changing external research environment, but the Trust has able leadership that enables us to be as responsive as possible to these changes.
Review of Risks	• The Committee did not feel that any matters would materially impact on the likelihood or impact of risks in the Board Assurance Framework within its purview. However, the Committee recognised the risks around the rapidly changing national and regional research environment and the challenges that this could bring.
Other comments from the Chair	• The Committee benefitted from receiving clear and helpful reports that enabled it to conduct its business.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 19**
1 October 2025

Report Title	Committee Chairs Reports – Quality Committee
Date of Meeting	17 September 2025
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It continues to monitor the action plan following 4 never events that have occurred this year. It received a thematic review and was assured that the action was pertinent to the themes identified and that there would be mapping to the risk register to support the plan and its governance. The Committee will continue to seek assurance that all actions are tracked and completed in an appropriate timely way. The Committee noted and supported a decision to delay Cerner Millennium LocSSIPs template implementation until January, when there is a more comprehensive update of the clinical system. ○ The Committee received an internal audit review from Mersey Internal Audit Agency which identified some governance concerns including the use and status of the Infection Prevention and Control Board Assurance Framework (BAF) within the Trust's strategic BAF. It was agreed that the IPC-BAF would be an element identifying controls (and gaps) and actions in BAF risk 3. The Committee will continue to have a high level of scrutiny of IPC including for Clostridioides difficile and gram-negative organisms. The Committee received the IPC Annual Report for 2024/2025 which will be fully shared with the Board.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The review of the Patient Safety Incident Response Framework is nearing completion with an emphasis on improving the learning and improvement arising from insight and involvement. ○ That is received the updated action plan in relation to the immediate actions identified following the unannounced CQC inspection of Urgent and Emergency Care and Medicine in March. All actions are complete or on track and the Committee were able to interrogate an example action to test that. At its next meeting, the Committee expected to be able to give full assurance to the Board that the actions are complete.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ It was assured that there is a well-managed effective legal claims system at the Trust. This is demonstrating that the Trust's incident management and learning arrangements have

	improved in the last years, given that a majority of subsequent claims have already been identified for learning by these arrangements. There was a notable in-year reduction in the number of claims submitted. ○ It was noted that appropriate action had been taken to deal with backlog of patients waiting for treatment of Acute Macular Degeneration. Planning is underway to consider how the Trust will deal with the future growing demand for this service. ○ There is full compliance in our duty of candour in relation to reported patient harm incidents (PSIRF). ○ The Committee received the Accountable Officer Controlled Drugs Annual Report which gave a high level of assurance about arrangements for the control of scheduled drugs. The Committee did ask for more specific details about increasing levels of reporting in recent years; some of which relates to increased clinical need and to drugs which have been added to the controlled schedule. The Committee also noted the increased use of visible preventative measures including communication with clinical teams and had some suggestions for how this could be built on. ○ The Committee received the Annual Report on Antimicrobial Stewardship, noting that all but one improvement metric had been achieved. The other metric - reducing the use of wider spectrum antibiotics - was not as straightforward to meet. Early treatment of sepsis (another important quality metric) requires the use of such antibiotics. The Committee identified opportunities for work across Wirral Place and with Primary Care to support stewardship. ○ The Committee Noted the Safeguarding Annual report, which the Board will receive directly, and which gave assurance of action and progress in a range of areas including child protection, Oliver McGowan training and statutory health checks in looked after children.
Review of Risks	• The Committee did not feel that any matters would impact on the likelihood or impact of risks in the Board Assurance Framework within its purview.
Other comments from the Chair	• The Committee benefitted from receiving clear and helpful reports that enabled it to conduct its business.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
1 October 2025

Item No 20

Report Title	Finance Business Performance Committee
Date of Meeting	17 September 2025
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust ended month 5 with a deficit of £9.6m which is an adverse variance to plan of £7.3m and includes the benefit of £7.0m non-recurrent mitigations. The mid-case forecast remains an adverse variance of £13.0m and contains significant risk. The Committee emphasised the importance of delivering both the mitigation actions and the original approved plan. It is critical that measures necessary to improve the run rate back to the planned levels are agreed and implemented. ○ Income performance is £5.7m behind plan, primarily due to withheld deficit support funding. However, £1.6m relates to elective activity, principally in Trauma and Orthopaedics. The Committee requested that a detailed elective recovery plan be circulated to members before the next Board of Directors meeting and that the elective recovery plan is a focus for the next FBPAC meeting. ○ Pay, including underachievement of CIP and ICS savings target, is £3.5m overspent. Staffing is 103wte above plan which is an improvement of 9wte since month 4. Planned vacancy factors have not been fully achieved and renewed scrutiny of vacancy authorisations is required. ○ The total CIP target is £46.1m comprising an internal CIP of £32m and an ICS savings target with the ICB of £14.1m. Of the internal CIP target of £32.0m, £31.0m has been identified which reduces to £25.3m after adjusting for risk. The ICB coordinates the identification and delivery of system wide savings schemes. £3.6m of the £14.1m target has been identified non-recurrently with a further £1.6m included within the Trust's mitigation plan.
Advise	• The Committee advises members of the Board of Directors that:

	○ Cash support of £10m has been received in September and this, combined with an agreement with WCHC on contract income phasing, means that immediate cash risk for September has now been significantly de-escalated. However, even in a best case scenario the Trust requires further cash support of £14m between October 2025 and March 2026. The Committee expressed their thanks to the finance team for their hard work with regard to managing the cash position and were pleased to see that the timeliness of supplier payments would now be improved.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ A report on the Trust's mitigation plan has been received from Simon Worthington. This provides some assurance but also makes recommendations for additional actions which the Executive Team will now review and respond to. The response and action plan will be brought to the next meeting of FBPAC.
Review of Risks	• There is a significant risk to the achievement of the financial plan. Ability to achieve the plan or at a minimum the revised forecast of £35m deficit is a key priority for the ICB and the Trust's position within that.
Other comments from the Chair	• The Committee noted the pressure on the Trust to deliver improved service performance and to deliver the financial plan.

Board of Directors in Public **Item 21**
1st October 2025

Report Title	WCHC Quality and Safety Committee
Date of Meeting	10th September 2025
Author	Dr Chris Bentley

Alert	• The Quality and Safety Committee wish to alert members of the WCHC Board that: ○ Committee requested clarification on the proposed changes to its place in the **emerging joint governance structures,** and particularly its relation to IMB. Updates will be received at each meeting, and next following discussions at the September Boards' Awayday ○ Committee was informed of the **forthcoming CQC inspections** commencing 16 – 18 September, separately for Urgent Treatment Centre and Eastham Walk In Centre. Both were to be aligned to key lines of enquiry using new approach quality indicators. A pre-meeting with CQC had taken place. Committee was assured by the preparations in place, and confidence in the position.
Advise	• WCHC QSC wish to advise members of the Board that ○ The **Trust Quality Strategy Action Pla**n, which is reported on for assurance at each meeting, has been rationalised to 6 (from 9) Quality Goals for 2025/26, partly recognising the need for some flexibility as the joint working with WUTH develops. However, the Committee has asked that we need to clarify actions that have been paused or revised in terms of focus to ensure there is a clear audit trail. The agreed Plan was noted to be progressing well in Q2. ○ **IPC Q1 Assurance** reports 4/10 ratings continue at amber. When challenged as to when these would be resolved to green it was noted that this would be dependant on work to bring together with WUTH process. Committee noted that this didn't apply to all elements and requested to see what actions could be completed sooner, that were not dependent on aligning approaches. This would be addressed by next meeting. Meanwhile the Team continue to strengthen integration opportunities with WUTH IPC colleagues. ○ Committee asked for a review of managing the **Learning from Deaths** statutory requirements for quarterly reporting as we work to align with WUTH
Assure	• The WCHC QSC wish to assure members of the Board that: ○ The **Quality and Patient Experience Report** was discussed using the Trust Information Gateway (TIG) with its Integrated Performance Dashboard and the dedicated Patient Experience Dashboard. There were no open actions. A very positive position included zeros for: serious incidents and never events; falls with

	moderate or above harm; pressure ulcers cat 3 and above; IPC incidents of note; missed medication incidents with moderate or above harm. A technical issue for Friends and Family Test (FFT) reporting had been resolved, and in July there were positive responses from 2,761 people. Committee was fully assured by the presentation and discussion. ○ Detailed consideration was given to the very detailed **Q1 Safeguarding Report** including covering services in Cheshire East, St Helens and Knowsley, as well as Wirral. After discussion it was agreed to provide trend analysis in subsequent report to simplify the presentation and interpretation of the data. The committee was pleased to receive case studies, as requested, which provided some good appreciation of the nature of the complex work, augmenting the structured data. Together with the usual quarterly report, committee received the **Q1 Report on the Trust's Strategic Delivery Plan Goals** and the **Training Needs Analysis and Strategy for 2025.** Committee was assured by considerable ongoing work. ○ **PSIRF Q1 Assurance Report** covered continuing action on the identified 10 priorities in Q1 and Q2. Refresh of priority areas conducted alongside WUTH and triangulated with available data has led to identification of 8 priority areas for action now in Q3. A Trust governance plan had been completed, and the priorities shared with Health Watch. This will subsequently travel on to the ICB. Committee was assured by the report on progress, and that PSIRF is being well embedded throughout the organisation. ○ Committee were assured by its 6 monthly oversight review of the **Trust's Standard Operating Procedures (SOPs**), which are routinely managed through Safe Operations Group (SOG). Reinforced the need for a lead person to be named responsible for each in documentation for the process. ○ **Review of the Policies** overseen by the Committee confirmed that 55 of 59, were up to date and confirmed fit for purpose. 3 extensions were approved, and one further approved later following verifications.
Review of Risks	○ It was noted that the **Place Based Risks** had not been reviewed since July 2024 ○ One high level risk escalated to committee was ongoing **ID 3137 (RR16)** Call bell system on Bluebell Ward. This had been ongoing for an unacceptable period. A detailed discussion explored the complex issues involved. Funding is available when a realistic plan is agreed. Championed by COO, who would now be involved, committee pressed for a deadline for resolution. Meanwhile mitigations are in place and overseen. ○ **ID 2830** related to demand for assessments for children with EHCPs risk was reduced from **RR 15 to 12** as commissioned resource has increased. A new risk associated with waiting list backlog is under consideration.

	○ There were no significant changes to the **BAF risks ID01 and ID02**. Committee were assured by the update and approved onward referral to Board. There was a useful discussion of the mechanisms being gradually brought in to facilitate the aligning with the WUTH BAF and work towards an eventual joint BAF.
Other comments from the Chair	• None

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 22**

01 October 2025

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

Report Purpose and Recommendations

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

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

This paper provides a specific update on the Maternity Incentive Scheme (MIS) Year 7, Safety Action 5 of the MIS scheme and the forthcoming Maternity and Neonatal Inquiry.

It is recommended: -

- Note the report
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of the Maternity and Newborn Safety Investigations (MNSI) and PSII's
- Note the position with the Maternity Incentive Scheme Year 7 requirements.
- Note the update on the Maternity and Neonatal Inquiry.

Key Risks

This report relates to these key Risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

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

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (August 2025) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services.

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

3	**Maternity Incentive Scheme (MIS) Year 7**
	Now in its seventh year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards

	Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the monthly maternity paper in November 2025 reports utilising the audit tool.

4	**Maternity and Neonatal Inquiry**
	The Department of Health and Social Care (DHSC) have named the 14 NHS Trusts that will be part of the new national inquiry into maternity and neonatal services. The Chair has also been appointed, and interim recommendations are expected as early as December 2025. The details of the inquiry are outlined below:- **1. What is the Investigation & Why** • In June 2025, the UK Government, led by the Department of Health and Social Care & NHS England, launched a rapid national investigation into NHS maternity and neonatal services. • It aims to bring together findings of multiple past reviews (e.g. local trust reviews, CQC inspections, etc.), not just focus on individual trusts. It seeks to identify systemic failings in safety, leadership, culture, and inequalities. • The investigation is being led by Baroness Valerie Amos, who will work closely with expert advisers and, importantly, with bereaved or harmed families, to set the terms of reference. **2. Scope & Selected Trusts** The investigation will include **14 NHS trusts** selected for more detailed local investigation. Trusts have been chosen based on indicators like perinatal mortality, previous inspection or review outcomes, and family feedback. **3. Timelines & Reporting** • The work began in the summer of 2025. • Initial findings are expected by December 2025, with a full national set of recommendations following in spring 2026. • For example, at Trust level, site visits are expected between October–December 2025 in many cases. **4. Key Themes & Challenges Identified** **Inequalities and variable outcomes**

- Perinatal mortality remains markedly higher for Black and Asian babies compared to white babies. Rates of stillbirth, neonatal death and maternal deaths show variations by deprivation and ethnicity.

Stalling progress

- Despite targets set (e.g. to halve rates of stillbirth, neonatal death, maternal death etc.), progress has not been uniform. Some metrics have improved, but others (such as neonatal mortality in certain years, or pre-term birth rates) show stagnation or worsening.

Culture, safety, listening to families

- Issues around "not listening" to women, lack of compassion, failures in leadership or accountability, and inconsistent treatment of concerns from staff/families are repeatedly highlighted.

Red flag trusts

- Some trusts consistently appear in "red / amber" categories for perinatal mortality over multiple years. These are being prioritised for investigation.

5. Immediate Actions & Related Initiatives

Taskforce

- Alongside the investigation, a National Maternity & Neonatal Taskforce has been established, to help ensure that momentum for change is maintained, best practice shared, and that recommendations are implemented.

Funding to support voice partnerships

- £3 million additional funding for Maternity & Neonatal Voice Partnerships (MNVPs) for 2025/26 and 2026/27. Helps ensure parents' experiences are more systematically built into planning and improvement.

Learning from HQIP / MBRRACE-UK data

- Studies have used surveillance and perinatal mortality data to identify recurring red-flag trusts, which can help target where local improvement may be most needed.

6. Implications

- Trusts included in the investigation will need to prepare for site visits, documentation requests, engagement with families as part of the investigation. There is likely to be scrutiny not just of clinical outcomes, but of culture, leadership, staff support, and how concerns are escalated and handled.
- All Trusts will likely come under some degree of spotlight via the national recommendations, even if not directly investigated. There will be pressure to demonstrate that local data is accurate, that staffing, safety protocols, training, reporting, and learning systems are robust.
- There may be resource implications — for example, to upgrade systems for listening/responding to families, to accelerate progress on ethnic disparities, or to invest in workforce growth, support and retention.
- Monitoring will become more granular; Trust boards will likely be expected to see detailed reporting by outcome, including equity stratifies (ethnicity, deprivation, etc.), safety incidents, and trust-level performance against national benchmarks.

7. Outstanding or Key Next Steps

- Finalising the terms of reference and expert advisory group structure with family involvement.

	• Publishing initial national recommendations by December 2025. • Ensuring that all Trusts (not only the 14) engage with learning from the investigation and begin implementing known lessons, particularly around inequalities, listening and safety culture. • Ensuring that other ongoing or overlapping inquiries (e.g. Nottingham / Donna Ockenden Review) feed into the national work, avoiding duplication and ensuring the recommendations are coherent.

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

6	Implications
6.1	**Patients** • The report and appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
6.2	**People** • Maternity services at Wirral University Teaching Hospital (WUTH) continue to deliver high quality patient care to the women and birthing people we care for.
6.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity workforce is required and funding options continue to be explored. A statement of case and associated paper regarding Safety Action 5 have been prepared for consideration by the Board of Directors. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Author	Jo Lavery, Director of Midwifery & Nursing - Women and Children's Division
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Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	1		REC completed and referred to PMRT/MNSI; Attended Triage with Reduced Fetal Movements and No Fetal Heart on admission (36+3 weeks gestation); Two MTOP's were recorded, but not added to this statistic
	Number of neonatal deaths (before 28days) at WUTH	1		Extreme prematurity, all governance process initiated
	Number of maternal deaths (up to 28 days following delivery)	0		No maternal deaths
	Post partum haemorrhage >1500mls	9		x 9 reported; all have had full reviews via the CIF process and have been managed in line with policy
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report received in March 2025 and staffing levels suboptimal; business case required to support an increase in establishment
	Midwifery staff absence rate in month (sickness)	6.17%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target; national rate 5.0% and reported as below
	Midwifery vacancy rate	9.00%		Low vacancy rate consistently reported; 9.32wte remaining out to advert;
	Midwife : Birth ratio	01:27		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0		Nil
	BAPM compliance - Neonatal medical staff	Yes		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil; mutual aid requested
	Total number of Red Flags reported	12		Theme: delay in providing pain relief; improvement noted from previous months
Service user /	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement; action plan produced with key priorities; focus on 2025 survey and objective to increase response rate
	CQC National survey	Yes		Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
	SCORE Survey	Yes		Participated in 2024; facilitated workshops and ongoing action plan
	Feedback via Deanery, GMC, NMC	No		Nil of note
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Leadership and relationships	New leadership within or across maternity and/or neonatal services	Yes		Q&S Lead Matron starting 26/9/25
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 6 submitted by 3/3/25; appeal relaing to data transcription error with Safety Action 1 - appeal rejected; MIS Year 7 launched April 2025
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	No		Nil of note
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	No		Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No		Robust governance processes
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	No		Learning shared internally and via MNSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No		Nil of note
	Maternity/Neonatal Safety Champion concern; negative feedback; escalation	Nil		Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes		CQC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Incident reporting	Number of PSIRF reported incidents graded moderate or above	12		Reporting for July 2025; high incidences relating to staffing issues and acuity levels; home birth service required suspension
	Number of Maternity or Neonatal PSII's	0		No new PSII's for maternity; x 1 ongoing for NNU
	Number of cases referred to MNSI	1		x 1 New referral
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Reported Never Events	0		Nil for maternity
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safery action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governance processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes		Maternity and Neonatal services responded to a major incident with
	Number of maternity/neonatal risks on the risk register overdue	0		Nil overdue
	Number of maternity/neonatal risks on the risk register with a score >12	29		NNU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No		Nil to report this month
	Coroner Regulation 28 made direct to Trust	No		CQC reports published in April 2023 'GOOD' for maternity services
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No		N/A
	CQC Rating overall	GOOD		N/A
	Been issued with a CQC warning notice	No		N/A
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No		N/A
	Been identified to the CQC by HSIB with concerns	No		N/A
	Red indicates not-compliant			
	Amber indicates partial compliance / work underway			
	Green indicates meets compliance			
	Blue indicates for information and no metric parameter			

Trust Board sign-off requirements for MIS year 7

n.b. 'Completed' set to 'No' as default
Change to 'Yes' and add date when complete.

	Requirement		Completed	Date
SA1	A quarterly report should be received by the Trust Executive Board each quarter on an ongoing basis that includes details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.	*Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.	By 30/11/25	No	
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/25	No	
	Trusts must ensure compliance with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate full compliance through	By 30/11/25	No	
	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	No	
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	By 30/11/25	No	
SA6	If the SBL Implementation tool is not in use, Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/25	No	
SA8	For rotational medical staff that commenced work on or after 1 July 2025 a lower training compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	By 30/11/25	No	
SA9	Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)	By 30/11/25	No	
	Evidence that a quarterly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data setas outlined in the PQSM . This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	

What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly identified, and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision making processes within a Trust, and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of these sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a Quality Governance Committee will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The Quality Governance Committee should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern. **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	NHS Providers Board Assurance Toolkit Quality Governance in the NHS
***What do you mean by Q1 on this table?**	Please note that this does not refer to a specific date-range quarter within the year (unless an explicit date is specified), but instead relates to the total number of quarterly reports that should have been received during the MIS period.

	identified and is being implemented.	Oct/Nov	No	
	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/25	No	
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/25	No	
	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/25	No	
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/25	No	

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 23**

01 October 2025

Title	2024-2025 Annual Submission to NHS England Northwest Appraisal and Revalidation
Area Lead	Dr Paul Jeanrenaud, Medical Appraisal Lead
Authors	Dr Paul Jeanrenaud, Medical Appraisal Lead & Cheryl Chaffe, Medical Appraisal & Revalidation Manager.
Report for	Ratification

Executive Summary and Report Recommendations

The purpose of this report is to provide assurance to the Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies.

WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2024 - March 2025.

It is recommended that the Board

- Ratify the report

Key Risks

This report relates to these key risks:

- None to note.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
9th July	RO Meeting	As above	As above

1	Narrative
1.1	On an annual basis, Designated Bodies have been required to complete an Annual Organisational Audit (AOA) which is an element of the Framework of Quality Assurance for responsible officers. Each designated body is expected to submit a report to their own board or equivalent management team; where a Responsible Officer and supporting team have responsibility for more than one designated body, separate reporting is required to ensure each board is sighted on the information specific to their organisation. In essence, one separate report should be completed for each individual Designated Body as registered with the General Medical Council. Attached at Appendix 1 is the report due to be submitted on behalf of WUTH. The report has been designed to: • Help the designated body in its pursuit of quality improvement • Provide the necessary assurance to the higher-level responsible officer, and act as evidence for CQC inspections. • This template for an Annual Submission to NHS England Northwest is used as evidence for the Board of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to own board report where a local template exists, to give clear guidance on the structure, roles and process to deliver an appraisal system which is quality assured and fit for revalidation. Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service and training. Regular successful annual appraisal will provide the foundation stone upon which a positive affirmation of continued fitness to practice can be made every five years by the doctor's Responsible Officer to the General Medical Council. For the individual, appraisal is based on the domains in "Good Medical Practice" (General Medical Council) [1]. This describes the standards of competence, care and conduct expected of doctors in all aspects of their professional work. These seven domains are: • good clinical care • maintaining good medical practice • teaching and training • relationship with patients • working with colleagues • probity • health

	To be revalidated a doctor must collect a folder of supporting information, participate in annual appraisal in the workplace and collect independent feedback from colleagues and patients (where applicable). This multi-source feedback or 360 degree feedback must be completed at least once in a 5 year revalidation cycle. The doctor must declare all the roles they have and organisations they work in as the appraisal must cover all aspects of their work (Whole Practice Appraisal). Supporting information must be provided for all roles so that the appraiser can review this. This is the appraisal process which over a five year period will enable the Responsible Officer to make a positive recommendation of fitness to practise to the General Medical Council.
1.2	The statement of compliance should be signed off by the Chief Executive of the Designated Body's Board and submitted by 31st October 2025.

2	Implications
2.1	**Patients** • This document focuses on assurance and improvement of professional standards processes for doctors, plus a responsibility to undertake continuous quality improvement to enhance patient care. Equality, diversity, and inclusion are at the centre of the Good Medical Practice. www.gmc-uk.org/guidance
2.2	**People** • The Responsible Officer has a duty under the RO regulations to assure and improve professional standards function for doctors with whom they hold prescribed connections.
2.3	**Finance** • Ongoing funding will be required to maintain the electronic revalidation management system (L2P) which was implemented in June 2022.
2.4	**Compliance** • The Framework of quality assurance and improvement will help the RO and organisation to provide assurance that our professional standards processes meet the relevant statutory requirements and support quality improvement.

NHS England North West
Medical Directorate
Professional Standards Team

2024-2025 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Wirral University Teaching Hospital, NHS Foundation Trust.
What type of services does your organisation provide?	Wirral University Teaching Hospital is a busy Acute NHS Foundation Trust. The Trust comprises of Arrowe Park and Clatterbridge Hospitals, and the Wirral Women and Children's Hospital.

	Name	**Contact Information**
Responsible Officer	Dr Catherin Hayle	catherine.hayle@nhs.net Direct dial: 0151 604 7710 Internal extension: 8912
Medical Director (interim)	Dr Ranj Mehra	ranjeevmehra@nhs.net Direct dial: 0151 604 7710 Internal extension: 8912
Medical Appraisal Lead	Dr Paul Jeanrenaud	p.jeanrenaud@nhs.net 0151 678 5111 Internal extension: 8993
Appraisal and Revalidation Manager	Cheryl Chaffe	cheryl.chaffe@nhs.net Medical Appraisal & Revalidation Team. Ext:2740 DD 0151 604 7461
Additional Useful Contacts	Anita Kane Medical Staff Appraisal Coordinator	anitakane@nhs.net Appraisal and Revalidation Team DD 0151 604 7461

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: Wirral Hospice St John's.

Please describe arrangements for Responsible Officer to report to the Board:

Dr Hayle is also Responsible Officer for Wirral Hospice St John's. An RO Board Report is prepared each year, in collaboration with the Medical Director of Wirral Hospice St John's (Dr Emma Longford). Dr Hayle visits Wirral Hospice St John's periodically to meet with Dr Longford and review the Hospice's clinical governance processes.
Date of last RO report to the Board: November 2024

Action for next year: None required.

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Wirral University Teaching Hospital, NHS Foundation Trust.
can confirm that:

1A(i) an appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Ongoing engagement with RO Network events.
Comments:	Dr Hayle has accessed all necessary training and engages regularly with the Responsible Officers Network via NHSE/I North as well as the GMC RO Reference Group.
Action for next year:	Ongoing engagement with RO Network events.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	
Comments:	We have a well-resourced Appraisal & Revalidation Department, comprising the Medical Appraisal Lead (3PA), Appraisal & Revalidation Manager (1.0 WTE), 3 Senior Appraisers (1PA each) and an Appraisal Administrator (0.6WTE).
Action for next year:	

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	
Comments:	The Trust Workforce Information Dept provides a monthly starter & leavers report taken from ESR to ensure accuracy. The Recruitment team also provide the A&R dept a weekly starters report taken from Trac for all medical starters, in addition a monthly pipeline report is run at the beginning of every month. With the above processes in place a SOP has been created for accurately managing connections, which are reviewed at least monthly.
Action for next year:	To continue to monitor agreed processes.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	
Comments:	WUTH's Senior Medical Staff Appraisal Policy was updated, ratified, and approved in 2023. All appraisers and doctors were informed of the changes to the policy via email, and in-person updates at Appraiser Support Groups. The Medical Appraisal Lead speaks to Medical Board annually and sought feedback on proposed changes in advance. A copy was emailed to all senior medical staff and uploaded on the Trust

	Intranet site, also under the resource section of L2P. The policy is regularly monitored for accuracy along with local processes and standard operating procedures (SOPs).
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To reinstate the quality assurance process for appraiser performance through appraiser performance excellence tool.
Comments:	We have reinstated the quality assurance process for appraiser performance using our excellence tool. A SOP has been produced and agreed to ensure consistency of quality assurance. This covers performance reviews of new appraisers and annual reviews of trained appraisers. We are participating in a 3-way peer support process with local Trusts, Mid Cheshire & CoCH. Completing self-assessments against the RO Regulations and identifying key themes with a commitment to challenge each other. Sharing internal QA / internal audit outcomes Cases for discussion/learning. We also have close links with Clatterbridge Cancer Centre and provide appraisal training for their appraisers.
Action for next year:	

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	
Comments:	The ARCP SOP has been completed, discussed, and ratified at the Medical Education Oversight Group. The A&R Team has joined together with the Medical Education team to deliver a joint education session for our locally employed doctors. Locally Employed Doctors (LEDs) within WUTH participate in an Annual Review of Competency Progression (ARCP) as part of yearly appraisal process. This includes review of consultant supervisor report, personal development plan, participation in CPD, reflection on clinical cases (including clinical incidents if applicable) and learning events attended, yearly multi-source feedback, participation in quality improvement and review of mandatory training. Additionally, if in revalidation year, a patient survey. LEDs receive induction through

	medical education department and subsequent local departmental induction processes.
Action for next year	A&R team will continue to work closely with the Trust Medical Education team to ensure all doctors are included in their appropriate appraisal system. Review feedback from the joint delivered education session for our locally employed doctor and consider any updates to the programme appropriately.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	N/A
Comments:	The doctor must declare all the roles they have and organisations they work in, as the appraisal must cover their whole scope of work (i.e., a whole practice appraisal). Supporting information must be provided for all roles. Doctors should maintain an evidence log or portfolio relating to their whole scope of practice and use this to populate their appraisal documentation. The A&R Team will upload risk management reports for each doctor. The report covers a two-year window detailing any reported incidents, complaints, and legal claims. Evidence for external roles must also be provided, if not included in appraisal documentation the appraisal will be referred back until provided. If a doctor has been involved in a clinical incident or received a complaint relating to their practice, they should provide a written reflection on this in advance of the appraisal meeting. If this is not done, a verbal reflection within the appraisal meeting must be carefully recorded by the appraiser. Any doctor undergoing an MHPS investigation, GMC investigation or participating in a grievance procedure will be asked to reflect on this in their appraisal. The appraisal also offers an important opportunity to ensure that doctors going through these often-stressful processes are provided with the appropriate level of support.
Action for next year:	

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	
Comments:	If the appraisal cannot go ahead within the timescales described in the Trust policy, the A&R Team are informed as soon as possible. The Medical Appraisal Lead will consider whether the appraisal month should be adjusted (due to exceptional circumstances), or whether an 'approved missed' appraisal should be recorded (e.g., due to sickness absence or maternity leave). Detailed records are kept by the A&R Team in relation to delayed and missed appraisals. If it becomes apparent during the appraisal that there is a serious health, performance or conduct issue (not previously identified) that requires further investigation, the appraisal meeting is stopped. The appraiser confirms the reason why the meeting is being stopped, and that the matter will be referred to the CL, AMD or the Medical Director/RO immediately. The Medical Appraisal Lead or a Senior Appraiser may also be informed. Maintaining the safety of patients, the doctor and other staff members is paramount. It is crucial that the doctor is provided with immediate support from their line manager (or other appropriate medical manager), a trusted colleague or mentor, and healthcare services as appropriate (including Occupational Health).
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Review and update Senior Medical Staff Appraisal.
Comments:	Senior Medical Staff Appraisal - Policy Reference: 215 Ratified By: Joint Local Negotiating Committee, February 2023. .
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	
Comments:	WUTH has 76 trained medical appraisers. All appraisers attend a locally delivered one-day training course before they can appraise. Training days are scheduled twice a year to ensure appraiser capacity is maintained. The current ratio at WUTH is 5.60 appraisal per year for each trained appraiser.
Action for next year:	To maintain delivery of Appraiser Training Workshops twice a year. To continue to invest in quality CPD opportunities for Medical Appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	N/A
Comments:	There are several quality assurance and performance measures in place under the WUTH system. The appraiser's outputs are reviewed by either a senior appraiser or the medial appraisal lead for Appraisal and Revalidation for quality, and to assess for revalidation, feedback is given as appropriate. All appraisers receive an excellence tool review annually, in addition to a performance review report. This should be used as supporting information in the appraiser's own appraisal. New appraisers undergo a face-to-face performance review with a senior appraiser after their first three appraisals and are observed once by the A&R Manager. All appraisers must attend at least one of the two ASG meetings annually. Quality CPD is provided at least twice a year at the Trust's Appraiser Refresher Training days, of which all appraisers are encouraged to attend. The same day is run twice to maximise attendance.
Action for next year:	Training and Development: Provide regular training, quality CPD opportunities and updates for our Medical Appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	N/A
Comments:	An annual report is presented at Trust Board each year, and progress is reviewed monthly at the monthly Responsible Officer's meeting.
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	N/A
Comments:	GMC Connections are monitored regularly by the Trust's A&R Manager via GMC Connect. Revalidation dates are also recorded on L2P and flag on the L2P dashboard via a traffic light system. Revalidation evidence is reviewed 4 months in advance of submission date with the RO to ensure timely recommendations are submitted.
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	
Comments:	Revalidation evidence is reviewed 4 months in advance of submission date with the RO to ensure timely communication. If a deferral is suggested, reasons are recorded and the doctor is written to inviting to meet and discuss with the MAL prior to the recommendation being submitted. During this meeting an action plan will be put in place to support the doctor take the appropriate action.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	N/A
Comments:	Annual audit plan, Mandatory training, incident reporting system with a high reporting culture, active risk management with BAF regularly updated. Quality Improvement training and QI programme. Annual appraisal for all permanent medical staff. Freedom to speak up champions embedded and a commitment from the Trust Board to leadership development and creating an open and honest culture.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	N/A
Comments:	The Trust has a policy in place - Procedure for handling concerns about the conduct, performance and health of medical and dental

	staff'. This implements the framework as set out in 'Maintaining High Professional Standards in the Modern NHS', issued under the direction of the Secretary of State for Health on 11 February 2005. This policy has been agreed between the Trust and the Local Negotiating Committee outlining the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability. The Trust has a Responsible Officer Advisory Group (ROAG) which reports to the People Committee via the Head of HR. The statutory responsibilities remain with the Responsible Officer with regards to the Medical Workforce. This relates to the appraisal, revalidation, and fitness to practise concerns. The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. The advisory group will support the role of the RO and provide the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the decision-making with regard to appraisal, revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO. The Responsible Officer Advisory Group will consider key items requiring decision-making to support the role of the RO, including: Concerns regarding a doctor and the application of the Trusts MHPS or other, relevant policies, including but not limited to: • Police investigations • Safeguarding • Behaviour/Conduct • Fitness to practise • Health matters • Capability The Appraisal and Revalidation Team are made aware of any concerns regarding an individual doctor during the monthly RO Meeting and they ensure that this is covered during their appraisal. Furthermore, if required, a letter is sent from the RO requiring the individual to reflect on a specific incident or concern, this is uploaded on to their appraisal record in L2P.
Action for next year:	

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	
Comments:	The A&R team populate L2P six weeks in advance of the appraisal month with relevant appraisal Trust reports; i.e, Risk Management / Research reports. The appraisal platform is web based and accessible to doctors to populate at any time.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice. concerns.

Action from last year:	
Comments:	Procedure for handling concerns about conduct, performance, and health of Medical and Dental staff – reviewed and up-dated 24th June 2022, next review – 24th June 2025 Medical Staff Remediation Policy (Medical Staff) – published in 14th February 2024 and is currently under review. ROAG meet quarterly and extraordinarily if required.
Action for next year:	Review and publish the Medical Staff Remediation Policy

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	N/A
Comments:	The Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff has been reviewed and updated. The policy sets out the role of the RO Advisory Group, who meet

	quarterly. The policy is consistent with the application of 'just culture principles'. Between 1 April 2023 to 31 March 2024 there were no MHPS investigations. Therefore, a meaningful analysis is not possible.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	N/A
Comments:	Under WUTH Policy, information flows to support governance and Responsible Officer Statutory Function are facilitated by the A&R Team via the NHS Medical Practice Information Transfer form. A welcome letter is sent out to all new doctors joining the Trust from the RO informing them of the specific responsibilities to obtain information about doctors taking up new posts and as such, the need to formally request confirmation of the following details from their previous Responsible Officer: • Revalidation date • The date of your last appraisal • Any previous concerns that have now been resolved • Any current investigation about your practice in progress • Any current restrictions on practice Any unresolved actions/referrals in relation to the GMC
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	N/A
Comments:	All serious concerns are raised with the RO as per the WUTH MHPS Policy and discussed at the Responsible Officer Advisory Group (ROAG). The Trust MHPS Policy was recently updated in May 2022 and is consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps. Formal meetings are supported by HR for example support management to ensure reasonable adjustment are in places as required and help identify and remove barriers which may impact on

	engagement. Policies and practices are also reviewed in line with current and emerging EDI challenges and risks. The Trust has an incident reporting process where any concerns raised including concerns raised via Appraisal and Revalidation process are investigated. The Trust has Safeguarding, LADO (Local Authority Designated Officer) in place and staff are made aware that they can raise concerns via this route.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	N/A
Comments:	WUTH has policies in place to ensure we are compliant with national guidelines. Regular Clinical Advisory Group that reviews latest guidance/ reports and incorporates learning into Trust policies and procedures. Annual appraisal for all doctors where CPD is reviewed and a PDP set for following year based on individual and organisational development needs.
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	N/A
Comments:	WUTH recognises the importance of an effective induction for all new employees into the Trust. A structured induction programme consisting of both Corporate and Local induction elements ensures that new employees receive the essential information they require to enable them to operate effectively as quickly as possible and in doing so ensures their safety, the safety of patients and minimises the risk to the organisation. Our Trust values and expected behaviours are emphasised throughout. The Trust believes that harnessing the talents of our workforce is essential to providing the best care and being a great place to work. Since the launch of our People Strategy in 2022 we have invested in talent management and development in a range of ways, all aligned to our Leadership for All principle. Leadership for All means that every member of staff in the Trust has the potential to develop and display the qualities that make great leaders at WUTH. The Trust's Leadership Development programme is inspired the principles of 'Leadership for All' and aligned to our Leadership Qualities Framework (LQF) our leadership development programmes offer something for everyone. • Leading Self Programme: Cultivate self-awareness, the cornerstone of effective leadership. • Leading Team: Unite and inspire colleagues. • Leading Service Programme: Elevate patient care with excellence. • Leading Organisation Programme: Thinks strategically and act decisively. • Leading System Programme: Collaborating for system transformation. • Management Essentials: Foundation knowledge and skills for all managers. • Leadership Master Class: Bitesize development opportunities from a diverse range of experts. Good quality appraisal and check in conversations help our staff to identify development needs and aspirations. There is a huge offering that staff can choose from to meet their needs. Based on staff feedback, and in response to the findings in the 2022 staff survey, a collaborative team of people from different parts of the workforce have come together and designed an approach to Appraisal and Management Supervision (Check In) that focusses on Contribution, Wellbeing and Development. The process is person centred, with lots of flexibility, enabling meaningful discussions about performance in the areas that most matter. The EDI strategic commitment has also

	been developed to ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported, and celebrated, as referenced further in this report under section 1F(ii). As we continually strive to be a high performing Trust we follow the NHS England, Executive Support Offer Guidance, for senior leadership onboarding and support. Exploring national onboarding resources that have been curated for newly appointed Chairs and Non-Executive Directors. These resources are designed to support senior leaders in developing leadership in a complex and changing landscape.
Action for next year:	• - Continue to follow the actions as set out in the People Strategy

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Full review of the Safe Employment Policy (192).
Comments:	As a result, the introduction of the Safe Recruitment and Selection Policy (392) and the revised Safe Employment Policy (136) reflects WUTH's commitment to maintaining high standards of safety, fairness, and transparency in its employment practices. By aligning these policies with NHS Employers guidelines and vetting requirements, WUTH ensures the recruitment and retention of competent and trustworthy staff, ultimately contributing to the provision of high-quality patient care. Through the Safe Recruitment and Selection Policy Wirral University Teaching Hospital (WUTH) adheres to the NHS Employers recruitment guidelines and vetting check requirements, ensuring all recruitment processes align with national standards. Conditional Employment Offers: After interviews, all employment offers at WUTH are made on a conditional basis. This means that offers are contingent upon the completion and verification of all necessary checks within the Trust before new employees can commence their posts. Minimum Standards for Safe Employment: The Safe Recruitment and Selection Policy (392) outlines the minimum standards for due diligence in terms of safe employment, ensuring comprehensive pre-appointment screening. The standards include: Satisfactory References: Obtaining and verifying references from previous employers to assess the candidate's work history and

	reliability. Occupational Health Clearance: Ensuring candidates are medically fit to perform the role through health assessments. Qualification and Professional Registration Checks: Validating the candidate's educational qualifications and professional registrations to confirm their eligibility for the role. Disclosure & Barring Service (DBS) Clearance: Conducting DBS checks to ensure candidates are suitable to work in environments involving vulnerable groups. Legal Right to Work in the UK: Verifying that candidates have the legal authorisation to work in the UK. WUTH's Safe Recruitment and Selection Policy (392) sets rigorous pre-appointment standards to ensure the safety and reliability of all employees. By adhering to NHS Employers guidelines and conducting thorough checks on all new and temporary staff, WUTH maintains high standards of care and safety within the organisation. Wirral University Teaching Hospital (WUTH) is committed to the continuous review and improvement of its pre-employment practices. This ongoing process ensures that the recruitment and selection procedures remain robust and effective, aligning with the latest standards and requirements.
Action for next year:	To maintain compliance with the evolving legal and regulatory landscape, WUTH will: Regular Policy Reviews: Conduct periodic reviews of the Safe Recruitment and Selection Policy (392) and the Safe Employment Policy (136) to identify areas for improvement and ensure they reflect current best practices and legal requirements. Legislative Updates: Monitor changes in employment legislation, NHS Employers guidelines, and other relevant regulatory updates. This proactive approach will ensure that any new legal requirements are promptly incorporated into the Trust's policies and procedures. Stakeholder Involvement: Engage with key stakeholders, including HR personnel, legal advisors, and department managers, to gather insights and feedback on the effectiveness of current policies and identify any gaps or areas needing adjustment. Training and Development: Provide regular training and updates for HR staff and managers involved in recruitment. This will ensure they are well-informed about any changes in legislation and understand how to implement new requirements effectively.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	The Trust attaches the greatest importance to the continuing education and training of its professional staff and values education as an integral part of delivering excellent care. The Trust has a study / professional leave policy for medical staff. There is a robust system in place across all specialties to manage requests for study/ professional leave in line with Trust policy. The Director of Education (DME) is supported by the deputy DME and three Clinical Tutors work alongside Educational Supervisors and Senior Clinicians, to ensure all training grade staff receive the support and guidance they require. Teaching sessions are run within the Education Centre, in addition to a full lunchtime teaching programmes open to all postgraduate trainees. The hospitals Clinical Skills Lab offer dedicated training programmes to all trainees. An OD Development Programme has been launched in 2024 which is available to all clinical leaders. Training days have been scheduled covering the below topics. • Essentials for Management • Duty of a Doctor Programme WUTH encourages a wide range of general and professional training opportunities for all our staff. For all the many and varied educational events taking place we have excellent facilities spread across the two sites of Arrowe Park Hospital and Clatterbridge Hospital. As a Trust we want to make sure everyone has access to leadership development, so we have created a Leadership Qualities Framework (LQF). This Framework will provide the basis for our extensive development opportunities, not only for staff in management roles, but for all staff to be able to broaden their personal leadership skills or who aspire to progress into a management role. We want to nurture our future leaders and ensure we grow and support leadership talent. WUTH Improvement launched as an approach to team-working for our Trust's ambitious programme of developing services, patient experience, clinical quality, and ways of working. This project comprises of three teams handing different aspects of service transformation, quality improvement, efficiency and change projects across the Trust.
Action for next year:	Consider completing medical engagement survey.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	A number of aspects are in place at WUTH including: • Trust core values are 'Caring for everyone', 'Respect for all', 'Embracing Teamwork' and 'Committed to Improvement'. These were developed following extensive engagement with staff across the organisation, with behavioural expectations of our staff, also developed and regularly promoted. • Trust core values are embedded in all aspects of the Trust, including recruitment and selection processes – with interview questions to be aligned to our values and behaviours • The Trust People Strategy 2022 – 2026 is underpinned by the Core values and NHS People Plan with equality, diversity and inclusion embedded as a golden thread. An EDI strategic commitment has also been developed to 'ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated'. • A leadership qualities framework has been developed which comprises of a suite of programmes aimed at leaders of all level 'leadership for all'. The framework focusses on key themes of supporting leaders to become 'compassionate and inclusive', 'self-aware', 'transformational', 'outcome focussed' and 'enabling people', to support and develop leaders in role modelling the required behaviours and supporting others to do the same. Dedicated EDI sessions are held on all leadership and management programmes, with an introduction to EDI also contained on our induction programme for all new starters. • A robust governance structure is in place for monitoring and reviewing progress of the EDI agenda and shaping the Trust's future direction and key priorities. From a workforce perspective, this includes the EDI Steering Group that comprises of a range of key stakeholders to lead and shape the EDI agenda, with biannual EDI update reports shared with the group on a variety of key areas including national and statutory reporting regulations, Public Sector Equality Duty and activities to advance the EDI agenda at WUTH. The EDI Steering Group feeds into the Workforce Steering Board, with final assurance and oversight provided by the People Committee. Biannual reports are shared at Board meetings, with Board seminars held to focus on key areas of focus. Five staff networks are also currently in place, to allow additional opportunities for staff feedback to be shared as part of the EDI steering group. As part of the Trust's People Strategy, a focus was placed on supporting

	staff with disabilities and long-term conditions for 2023-24. As such, an additional Action on Disability Task and Finish group was established and also reported progress into the EDI Steering Group. • From a patient perspective, EDI is also integrated within the Trust's Patient Experience Strategy, with Inclusion identified as one of its main pillars. As part of this strategy, a number of task and finish groups have been established to focus on key priorities, all feeding into an Inclusive Promise Group. This group is accountable to the Patient and Family Experience Group which reports into a wider Patient Safety and Quality Board and is included as part of the biannual EDI update to Board. • An Annual EDI calendar of events is maintained with regular Trust-wide promotion of information, support, activities and events. • Staff experiences are also monitored via the annual staff survey and quarterly pulse surveys and as part of a range of engagement and feedback events held across the Trust. • A new staff engagement framework has been developed, with enhancements made in our staff recognition schemes. Compassion, respect diversity and inclusion have been integrated as part of the criteria for our annual awards, with a new dedicated EDI award category introduced this year. A new monthly staff recognition scheme has also been launched, with areas also included as part of the criteria. • All staff must also complete their mandatory training module on equality and diversity, with compliance monitored and currently achieving compliance.
Action for next year:	Continue as above

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	At WUTH, we are committed to achieving the highest possible standards of service for the benefit of our patients and staff. However, where standards are not meeting demands, we expect staff to be able to raise concerns. We are supportive of colleagues who have concerns regarding possible dangers, risks, wrongdoing, or malpractice in the workplace. Therefore, we promote an open and transparent culture which encourages staff to act promptly, and report concerns appropriately.

	We have a number of support mechanisms for staff who would want to raise a concern, all of which are outlined in the Trusts Raising Concerns Policy. This policy is for all staff. The NHS People Promise commits to ensuring that 'we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words'. Trust employees are required to complete the eLearning modules on speaking up, which can be found within their electronic staff record (ESR). In relation to our Freedom to Speak Up (FTSU) processes: • The Trust has a Lead FTSU Guardian with a network of FTSU champions in place. • A tracking system is in operation by the Lead FTSU Guardian who monitors a range of elements, including the number and themes of people speaking up, occupational groups, demographics and whether there are patient safety concerns, elements of bullying, harassment or abuse and whether staff have suffered detriment as a result of speaking up. This data is monitored regularly for themes and trends and forms part of a lessons learned forum, where data is triangulated with other sources to identify wider areas of learning or intervention needed. • Biannual FTSU reports are produced and shared as part of the Workforce Governance structure. This includes presentation by the FTSU Guardian at Workforce Steering Board, People Committee and at Board. • Regular meetings are held with the FTSU Guardian and both Executive and non-Executive FTSU Leads to review the FTSU agenda and further actions needed. • All staff must complete mandatory training that encompasses Duty of Candour along with role essential sessions on the FTSU agenda. WUTH have integrated the national learning package as part of our role essential training matrix with compliance continuing to increase. • The Lead FTSU Guardian delivers dedicated speak up sessions from induction of new recruits (including Junior Doctors) and on all leadership and management programmes. • Staff experience data is regularly reviewed, with annual staff survey data and quarterly pulse survey information reviewed and themes identified and triangulation of key areas of focus. • Regular walkabouts are undertaken by Lead FTSU Guardian and support within departments / service areas as necessary to promote speaking up. • Lead FTSU Guardian is a member of the regional and National Guardians Office forum and submits quarterly data for national review as part of agreed reporting requirements.
Action for next year:	Continue as above

1F(iv) Mechanisms exist that support feedback about the organisation'

professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	All doctors are invited to provide formal structured feedback at the conclusion of the appraisal process. This is collated, and anonymised data is provided to appraisers at the end of the appraisal year. If any significant issues were raised in this way, the A&R Team would take appropriate action at the time. The mechanism for raising concerns about the appraisal process is described within the 'Senior Medical Staff Appraisal Policy'. The 'Fairness At Work Policy' applies to all staff employed by WUTH, including connected doctors. This provides a clear mechanism for raising such issues. All doctors being investigated under the 'Procedure for Handling Concerns about the Conduct, Performance, or Heath of Medical and Dental Staff' are given the name of a Non-Executive Director to whom they can escalated concerns or delays.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	A disciplinary register is kept of all cases. The register logs the nature of allegation, the case manager, names of investigators, welfare and support contact, a record of the case progress and outcome along with the ED&I information. The country of primary medical qualification is not currently reported via the disciplinary register however this information can be provided if required as it can be obtained from the GMC register. All concerns are discussed at ROAG, to ensure a consistent and fair approach across the organisation. In addition, the RO discusses any concerns which may result in a disciplinary process with a Practitioner Performance Advice (PPA) advisor, who supports the RO in ensuring a consistent approach across the NHS.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	
Comments:	We have close links with Clatterbridge Cancer Centre and provide appraisal training for their appraisers. We also work closely with the A&R team at the Countess of Chester hospital. We recently welcomed the MAL & A&R Manager from CoCH who attended our Appraiser Training Day to observe. We routinely complete a review of our departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation. NHS England North West RO Network events are regularly attended by the RO, MAL & A&R Manager. The A&R Manager has joined the regional A&R Network group. The group meets four times a year for 2-3 hours at various locations/via

	teams. Members are required to attend at least two meetings per year. The role of the Appraisal and Revalidation Managers/Administrators Network Group is: • To act as a forum to discuss issues surrounding medical appraisal and revalidation for doctors working in any health care environment in the region to encourage consistency in approach. • To foster and assist NHS England and the GMC's work around Medical Appraisal and Revalidation compliance and quality improvement. Keeping up to date, accessing updates via NHS England North West Professional Standards Practitioners Hub.
Action for next year:	Ongoing attendance at regional meetings, working closely with our neighboring Trusts and sharing best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 to 31 March 2025.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	489

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	361 consultants, associate specialists, specialty doctors, senior fellows (post CCT) and locum consultants. 100 Locally Employed Doctors – ARCP process. LED doctors are overseen by the DME and Deputy DME who hold an ARCP each June / July for these doctors.
Total number of appraisals approved missed	4
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	81
Total number of late recommendations	0
Total number of positive recommendations	77
Total number of deferrals made	4
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	4

2D – Governance

Total number of trained case investigators	9
Total number of trained case managers	10
Total number of new concerns registered	5

Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March	3 months

Median duration of concerns processes closed	3 months
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	136
Number of new employment checks completed before commencement of employment	129 - *7 started pending completed checks. However, the correct process was followed in each case, with the relevant risk assessment being submitted and approved before they started in post.*

This process is outlined in the Safe Recruitment & Selection Policy (published 6 February 2024). The Risk Assessment within the policy states:

> *In exceptional circumstances, it may be necessary for an individual to commence employment with the Trust prior to the completion of all employment checks (e.g. due to immediate service need). If this situation arises, the Lead Service Manager is required to complete this risk assessment, taking account of the role, responsibilities, and risks attached. Please complete the attached and send to your HR Business Partner to obtain approval. Once you have the approval, please send a copy to the Recruitment Team to progress recruitment and retain on file.*

2F – Organisational culture

Total number claims made to employment tribunals by doctors	2
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The majority of the actions that were outlined in last year's report have been successfully completed, whilst others are still in progress.
Actions still outstanding
• Review and publish the Medical Staff Remediation Policy. • Consider Medical Engagement Survey
Current issues
This year we are focusing on QA processes, including appraisal observations, appraiser performance reviews and annual completion of the excellence tool for each appraiser.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Ongoing engagement with RO Network events. • To continue to monitor agreed processes to maintain accurate prescribed connections. • A&R team will continue to work closely with the Trust Medical Education team to ensure all connected doctors are included in their appropriate appraisal system. • Review feedback from the joint delivered education session for our LED's and consider any updates to the programme appropriately. • To maintain delivery of Appraiser Training Workshops twice a year. • To continue to invest in quality CPD opportunities for Medical Appraisers. • Review and publish the Medical Staff Remediation Policy. • Employment checks, maintain compliance with the evolving legal and regulatory landscape: • Regular Policy Reviews: Conduct periodic reviews of the Safe Recruitment and Selection Policy (392) and the Safe Employment Policy (136) to identify areas for improvement and ensure they reflect current best practices and legal requirements. • Legislative Updates: Monitor changes in employment legislation, NHS Employers guidelines,

and other relevant regulatory updates. This proactive approach will ensure that any new legal requirements are promptly incorporated into the Trust's policies and procedures.

- Stakeholder Involvement: Engage with key stakeholders, including HR personnel, legal advisors, and department managers, to gather insights and feedback on the effectiveness of current policies and identify any gaps or areas needing adjustment.

- Training and Development: Provide regular training and updates for HR staff and managers involved in recruitment. This will ensure they are well-informed about any changes in legislation and understand how to implement new requirements effectively.

- Consider Medical Engagement Survey.

- Ongoing attendance at regional meetings, working closely with our neighboring Trusts and sharing best practice.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

WUTH Strategic Priorities for 25/26 encompasses 6 key strategic objectives:

1. **Outstanding Care-** Provide the best care and support.

- Deliver Year Four of the Patient Experience Strategy revised priorities.
- Deliver Year Three of the Quality and Safety Strategy priorities.
- Deliver 25/26 Quality Priorities reducing harm and improving the quality of care to our patients:
  - Deconditioning
  - Behaviours of challenge
  - Infection Prevention
- Deliver national quality standards to improve quality of care to our patients.
- Continue to deliver improvements against the national NHS maternity standards.
- With partners, continue to deliver improvements to special educational needs and disability services (SEND) improving the delivery of care to children and young persons across Wirral.
- With NHS and third sector partners, redevelop clinical pathways for mental health services in an urgent care setting, supporting improvements in access and care.
- Deliver NHS operational objectives for 25/26, focusing on recovery of services and improving productivity.
- Direct and deliver Wirral Urgent and Emergency Care Improvement plan, including establishment of governance and partnership working with Wirral NHS organisations, Council and voluntary sector.

2. **Compassionate Workforce -** Be a great place to work.

- Deliver Year Four of the People Strategy, focussing on:

  - Looking after ourselves and each other
  - Belonging at WUTH
  - Shaping our ways of working
  - Transforming our future

- Deliver and embed the Trust's Equality, Diversity and Inclusion Strategic Commitment and priorities, with a focus on the NHS England High Impact Actions.
- Deliver the 2025/26 Workforce Plan.
- Deliver Mutually Agreed Resignation Scheme.
- Ensure the appropriate and efficient deployment of our workforce, with a focus on:

  - E-Rostering Roll Out and Controls
  - Sickness Absence
  - Bank and Agency Controls

- Continue to develop and enhance our approach to communications across the Trust, aligning to Integration with WCHC.
- Deliver Leadership for All across the Trust, through a range of learning and educational programmes and resource.

3. **Continuous Improvement -** Maximise our potential to improve and deliver best value.

- Develop and deliver Improvement for All, implementing improvement training and education across the Trust.
- Implement national best practice in clinical care across the Trust, improving patient outcomes.
- Deliver Year Three of the Research and Innovation Strategy.
- Drive continued cost improvements and sustained cost reduction across the Trust, supporting improvements in service delivery and outcomes.
- Deliver Year 2 of the Trust's financial strategy.
- Continue to improve the Trust's financial sustainability, in year.
- Continue to embed Well Led principles across all levels of the Trust and implement actions from Well Led Review.
- Implement and respond to NHS Performance and Assessment Framework.
- Review internal governance structures and lines of accountability and align with WCHC.

4. **Our Partners -** Provide seamless care working with our partners.

- Lead the delivery of the Two-Year Integration Plan, in conjunction with WCHC.
- Establish governance arrangements to support the Integration between WUTH and WCHC.
- Deliver the initial stages of the Transaction (Merger Assessment and draft SOC) between WUTH and WCHC.
- Develop and implement the Workforce Sharing Agreement with WCHC to support flexibility of working across organisations.
- Develop and deliver OD, support and engagement packages to support integration.

- Develop joint 5 Year Strategy with WCHC, for approval and commencement in the 26/27 financial year.
- Establish the Wirral Provider Collaborative, developing improvement programmes and priorities, in conjunction with WCHC and CWP.
- Examine approaches and opportunities for accountable care organisation (ACO) on Wirral.
- Develop an approach to working with Primary Care across Wirral, and neighbourhood working.
- Continue to develop our relationships and activities with local and regional universities, supporting research, innovation and education.
- Implement target operating model for health inequalities.
- Drive the continued delivery of mutual aid (elective capacity) to Cheshire and Merseyside and NHSE North West providers, supporting system recovery.

5. **Digital Future -** Be a digital pioneer and centre for excellence.

- Detailed planning and roadmap for the integration of Digital Services with WCHC - with a focus on realisation of efficiencies whilst ensuring continued service levels.
- Tactical enablement & strategic alignment of digital systems and processes to support the integration of clinical and administrative services with WCHC.
- Strengthening of organisational Cyber security posture to proactively defend against evolving threats and ensure resilience through enhanced controls, awareness and response capabilities.
- Upgrade of the Trust Electronic Patient Record system to ensure ongoing vendor support, reduce cybersecurity risks, enhance system performance, and capitalise on opportunities to further improve clinical and administrative workflows.
- Continued enablement of transition to One Patient Record to improve efficiency, data accessibility and patient safety across the organisation.
- Explore and assess opportunities for the appropriate deployment of Artificial Intelligence to enhance clinical decision making, operational efficiency and patient outcomes.
- Compliance through efficiency for FOI and SARs response functions.
- Implementation of Digital Provision for the requirements of the Urgent Emergency Care Upgrade Programme (UECUP). Including transition to the Cheshire & Merseyside shared care record.
- Support activities for the implementation of system wide diagnostic solutions – including Labs Information Management System (LIMS) Picture Archiving & Communication System (PACS) and order comms.

6. **Infrastructure -** Improve our infrastructure and how we use it.

- Deliver Year Four of the Estates and Capital Strategy.
- Deliver year three of the Green and Sustainability Plan.
- Develop model for future clinical service provision across WCHC and WUTH, determining service relocations.
- Continue to delivery the Urgent and Emergency Care Programme.
- Deliver 25/26 capital programme to timetable and budget, along with additional capital projects.

- Continue to work with partners to improve access to hospital campuses for patients and visitors.

We are making excellent progress with the delivery of our strategic priorities, with key priorities for 2025/6 including the following:

- Play the leading role in system work across Wirral Place and ICB footprints, including enhancing the interface and collaboration between primary, community and secondary care.
- Examine and implement partnership and integration opportunities with local NHS providers, to support service delivery and improvements in clinical care provision across Wirral and Cheshire and Merseyside.
- Develop and embed governance to support partnership working and integration of services, with local partners.
- Continue to develop our relationships and activities with local and regional universities, supporting research, innovation and education.
- Drive the continued delivery of the Cheshire and Merseyside Surgical Centre, working with partners to increase use.
- Deliver year three of Estate and Capital Strategy, including year 2 of the Trust's Green and Sustainability Plan.
- Develop model for future clinical service provision across hospital campuses and future service locations.
- Develop options to utilise community space and provision to support access to services and improve space utilisation across Wirral NHS providers and Wirral Council.
- Continue to deliver the Urgent and Emergency Care Programme.
- Deliver capital programme to timetable and budget.
- Continue to work with partners to improve access to hospital campuses for patients and visitors.
- Continue integration with Community Trust.

In relation to appraisal and revalidation, this year we have appointed a new Medical Appraisal Lead (MAL) who works closely with our Medical Appraisal Manager, Senior Appraisers and appraisal office colleagues. The Appraisal and Revalidation team work to continually improve the processes required for Appraisal and Revalidation. The new electronic appraisal system has embedded and that both our appraisal and revalidation rates remain high. Additionally, improved processes for supporting LEDs have been developed, as this group of doctors previously represented our highest deferral rates. We have re-introduced appraisal QA processes including Appraisal observation and Appraiser performance reviews. We have engaged with peers, shared information and processes. We have formalised a peer support process which will continue to be a priority for the year ahead. In addition, we will provide annual completion of excellence tool for each appraiser as part of QA package.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	Wirral University Teaching Hospital NHS Foundation Trust.

Name:	
Role:	
Signed:	
Date:	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 24**

01 October 2025

Title	Antimicrobial Stewardship Annual Report 2024-25
Area Lead	Chris Green - Director of Pharmacy and Medicines Optimisation
Author	Amy Newton - Lead Antimicrobial pharmacist
Report for	Information

Executive Summary and Report Recommendations

This report aims to describe the position against the Trust Antimicrobial Stewardship (AMS) priorities for 2024-5, and significant achievements, which include:

- Surpassed reduction target of usage of IV antibiotics
- Maintaining good ASPIRE audit results and IVOS audit results
- Benchmarking well both locally and nationally
- Widespread proactive AMS ward rounds across the Trust
- Good compliance with quinolone audit standards
- Smaller 5-day antibiotic pre-packs to allow reduction of total and broad-spectrum antibiotic usage have been implemented
- Meetings have started with the Pharmacy informatics team to discuss options/development for the AMS mPage so we can improve our antibiotic reviews and hopefully increase IV to oral switches

The report will also describe Trust AMS priorities for the coming year 2025-26.

The Committee should be aware the AMS mPage requires fixes or an alternative AMS solution, we are scoping out options with the informatics team, however, funding may be required to support any further work required. We understand the competing priorities that the informatics team have but a workable solution would support improvement in the quality of clinical review of antibiotics; reduction of broad-spectrum antibiotics and IV to oral switches (IVOS).

It is recommended that the Board:

- note the contents of this report and the actions being taken to drive improvements in antibiotic prescribing
- note the positive outcomes from the work described
- endorse the AMS priorities

Key Risks

This report relates to these key risks:

- Broad engagement with prescribers of key principles of AMS may be a challenge due to competing priorities at ward level, however, the AMS team approach individuals for input with specific projects as and when required.
- Meeting the local target to reduce usage of broad-spectrum antibiotics by 10% has been challenging, and not meeting it may lead to poor outcomes and increased resistance rates.

- Optimising Cerner AMS tools would, for example, give us the opportunity to improve our antibiotic reviews and increase IV to oral switches which would lead to reduced antibiotic use, reduced inpatient stays, reduced nursing time required (for IVs), and improved reporting capability.
- Additional laboratory IT upgrades/resource are needed to be able to review local resistance rates, as suggested by NICE guideline 15. Risk register entry DRR/0177.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
May 2025	MSOP/IPCG	As above	As above
September 2025	Quality Committee	As above	As above

1	Priorities for 2024/25 and position
1.1	The following AMS priorities were identified based on the 2024-5 Quality Contract, local priorities to support overall delivery of the AMR National Action Plan[1] and based on previous national targets. For 2024/5 the NHS standard contract did not contain antimicrobial prescribing targets. There were no mandatory CQUIN targets for trusts to improve antimicrobial stewardship, however, NHSE published a voluntary CQUIN to build on the work of 2023/4 CQUIN (03) IV to Oral Switch. It was expected that there would be a national target based on a reduction in the proportion of Watch and Reserve antibiotics introduced for 2025/6. The UK-AWaRe classification is based on the World Health Organization (WHO) classification of antibiotics and has 3 main parts. These are: Access, Watch & Reserve; 'Access' describes antibiotics with a narrower spectrum with a lower resistance potential, 'Watch' have a higher resistance potential due to having a broader spectrum of activity and, 'Reserve' antibiotics are "last resort" antibiotics used for severe multi-drug resistant infections. UKHSA reviewed the WHO classification and produced a UK adaption in April 2025, the main change was that first generation cephalosporins e.g. cefalexin, are now classed as Access antibiotics. **Reduction of broad-spectrum antibiotics**

	Target: Reduce consumption of broad-spectrum Watch & Reserve antibiotics by 10% by March 2025 compared with calendar year 2017 (DDDs/1000 admissions) *(NHS Standard contract 2023/24).* **Performance 2024/25: 1.5% decrease** **Reduce consumption of intravenous antibiotics** **Target:** Reduce by 1% compared to previous year (DDDs/1000 admissions reported quarterly) **Performance 2024/25: 3.5% decrease** **Reduce unnecessary IV antibiotics** **Target:** Achieve 10% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria (refer to audit plan). **Performance (Q2 audit): 14%** **Performance (Q4 audit): 10%** **Assurance of compliance with best practice AMS principles outlined by Start Smart Then Focus** **Target:** To achieve >95% compliance with all indicators Antibiotic Safe Prescribing Indicators Report' (ASPIRE) **Performance to date: See Table 1 below** **Assurance of appropriateness of prescribing of restricted antibiotics** **Target:** To achieve >95% compliance **Performance 2024/25: 99%** **Assurance of appropriateness of prescribing of quinolone antibiotics in line with Trust guidance and MHRA restrictions** **Target:** To achieve >80% compliance **Performance (audited during Q1): 92% compliant** **Meeting the requirements of the Quality Contract (located in Appendix 1)**

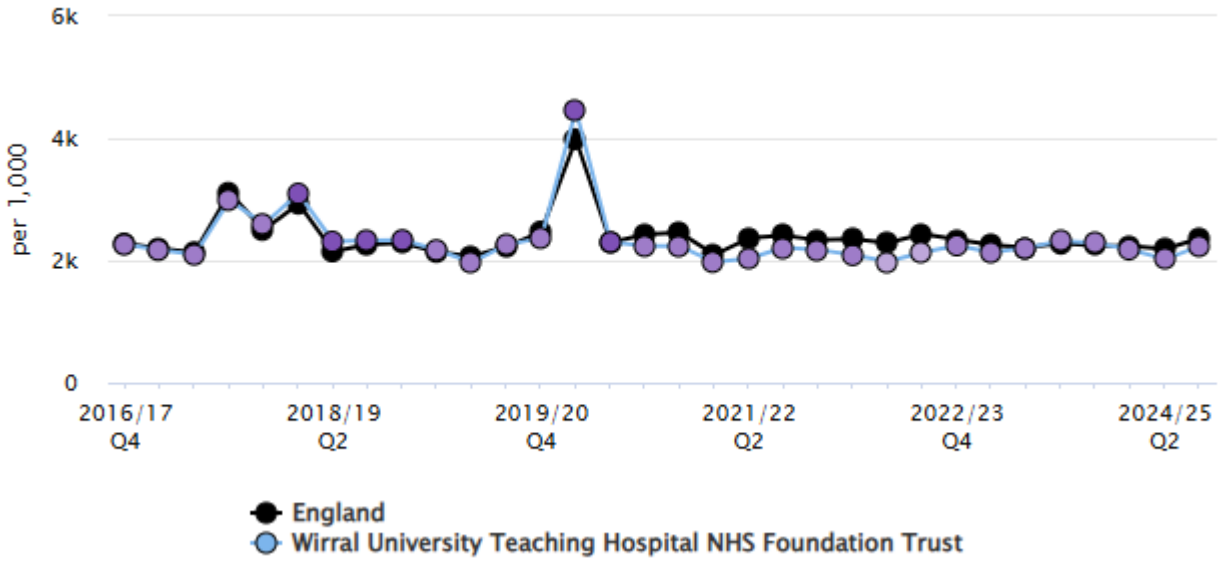
2	**Data sources**
2.1	To provide assurance of good AMS practices, national benchmarking databases (Refine & Define) and data sets published by NHSE (UKHSA Fingertips) are used to track progress against the AMS priorities and benchmark against similar organisations. We also actively participate in regional NW Antibiotic Pharmacist group to share and acquire good practice. Audit plan to provide assurance as outlined below.

3	**2024/25 Position and Benchmarking**
3.1	See section 4 for commentary & actions.

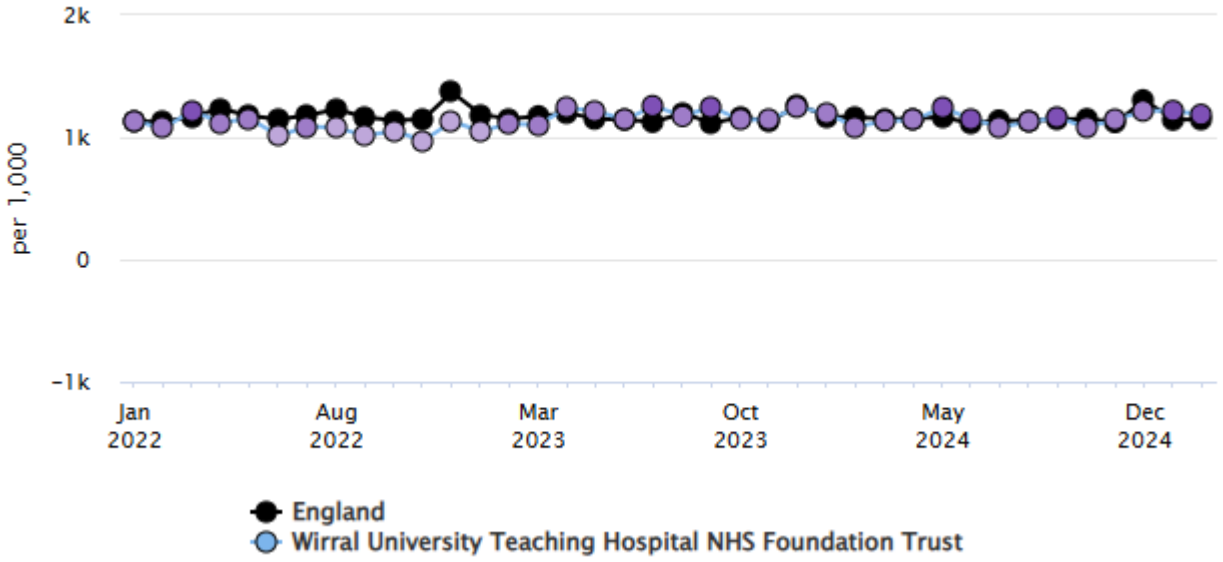
	Table 1. Assurance position	Data source	Target	Q1	Q2	Q3	Q4	Total
1	Reduction of broad-spectrum antibiotics (Watch and Reserve) (DDDs per 1000 admissions reported quarterly) (Baseline: 2164 (2017))	DEFINE	10% reduction	0% change	6.5% decrease	4% increase	4% decrease	1.5% decrease (2129)
2	Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly) (Baseline: 1220 (23/24)	DEFINE	1% reduction	2% decrease	6.25% decrease	4% decrease	2.5% decrease	3.5% decrease (1177)
3	Achieve 10% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria	Local audit	≤10%		14%		10%	
4	Antibiotic Safe Prescribing Indicators Report' (ASPIRE) Quality indicators:	Local audit						
4.1	Compliance with antibiotic formulary		>95%	97%	95%	99%	97%	97%
4.2	Documentation of indication for antibiotics on prescription		>95%	99%	95%	95%	97%	97%
4.3	Stop / review date on antibiotic prescription		>95%	100%	100%	99%	100%	100%
4.4	Antibiotic clinical review undertaken within 72 hours of initiation		>95%	98%	95%	99%	95%	97%
5	Assurance of appropriateness of prescribing of restricted antibiotics	Local audit	95%	98%	99%	99%	97%	98%

Benchmarking compared to England (data from UKHSA Fingertips):

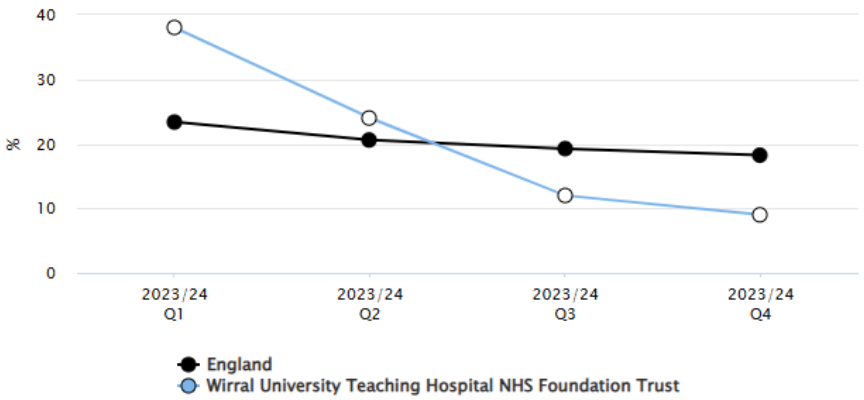
Priority 1. Figure 1. WUTH usage of broad-spectrum, Watch & Reserve antibiotics, DDDs per 1000 admissions by quarter, up to end of Q3 24/25, compared to England.



Priority 2. Figure 2. WUTH prescribing of IV antibiotics, DDDs per 1000 admissions by month, up to end of Feb 2025.



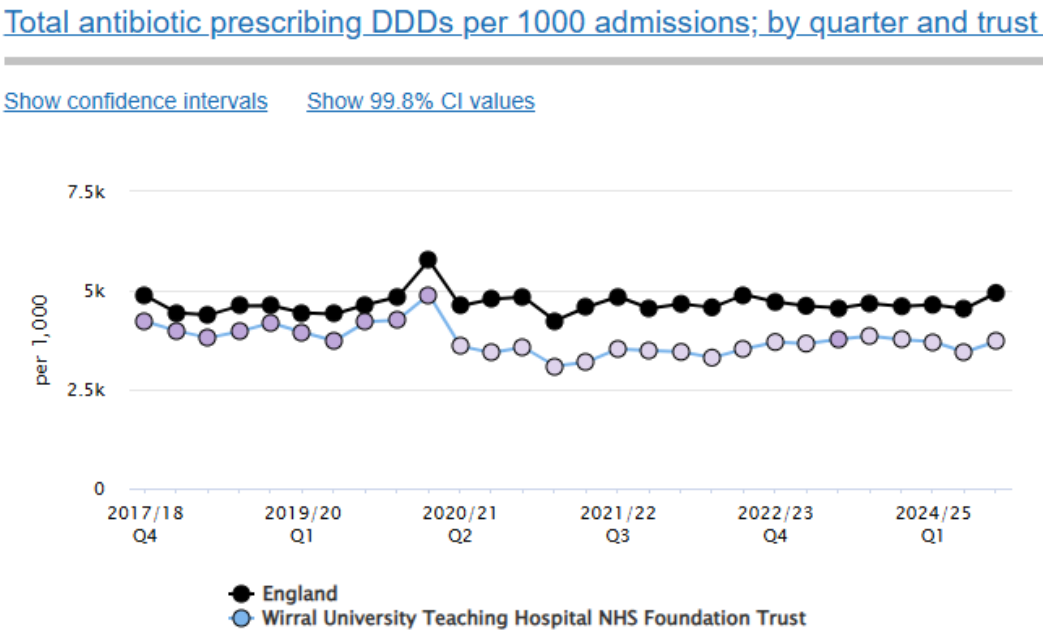
Priority 3. Figure 3. WUTH compliance with CQUIN 23/24: Percentage of patients still receiving IV antibiotics past the point at which they meet switching criteria (no further national data beyond 23/24 as CQUIN is now voluntary, however, in Q4 WUTH remained at 10%).



UKHSA Fingertips does not supply benchmarking data from the remaining priorities.

For purposes of the annual report, total antibiotic consumption has been included below:

Figure 4. WUTH Total antibiotic consumption (DDDs per 1000 admissions) data until the end of Q3 24/25.



WUTH is in the best quintile in England for total antibiotic prescribing, this may be partly due to our usage of co-amoxiclav rather than a combination of antibiotics, such as amoxicillin, metronidazole.

Benchmarking compared to similar NW Trusts (data from DEFINE software):

Priority 1.

Figure 5. WUTH usage of Watch & Reserve antibiotics (DDDs per 1000 admissions), financial year 23/24 and 24/25, compared to similar NW Trusts:

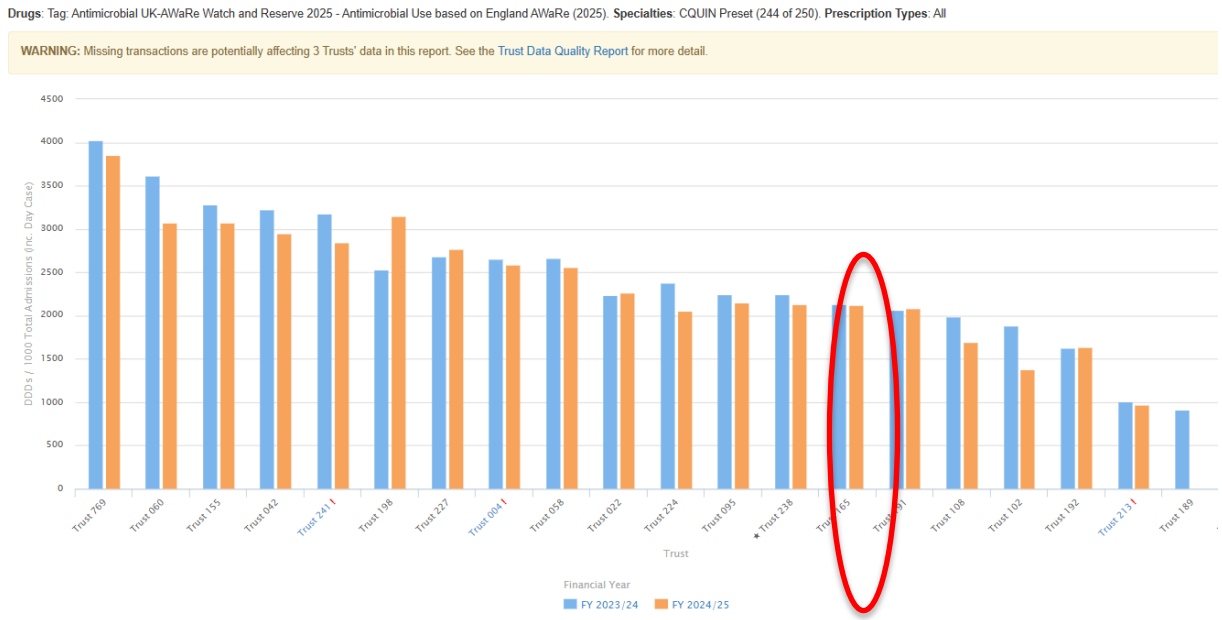
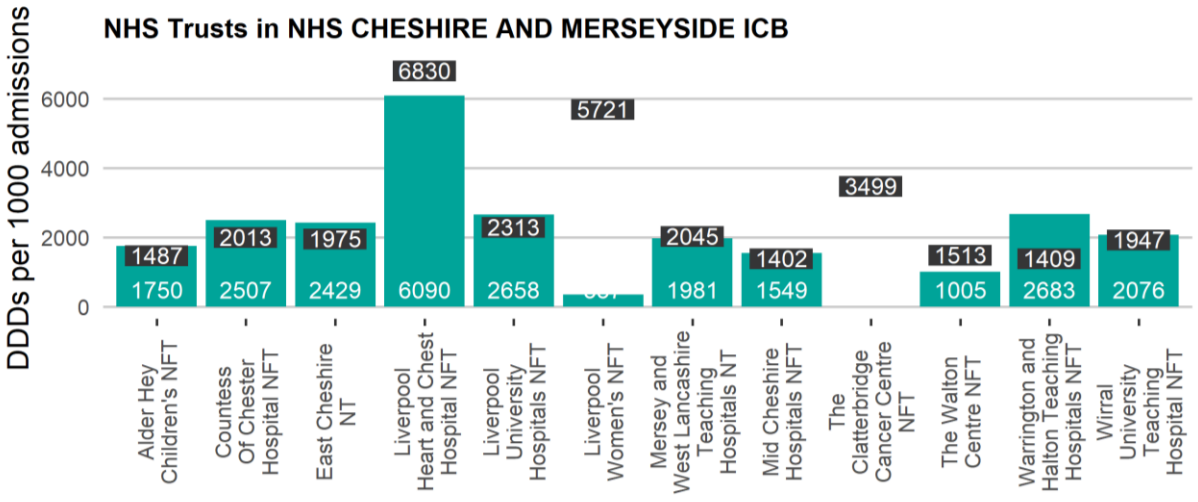
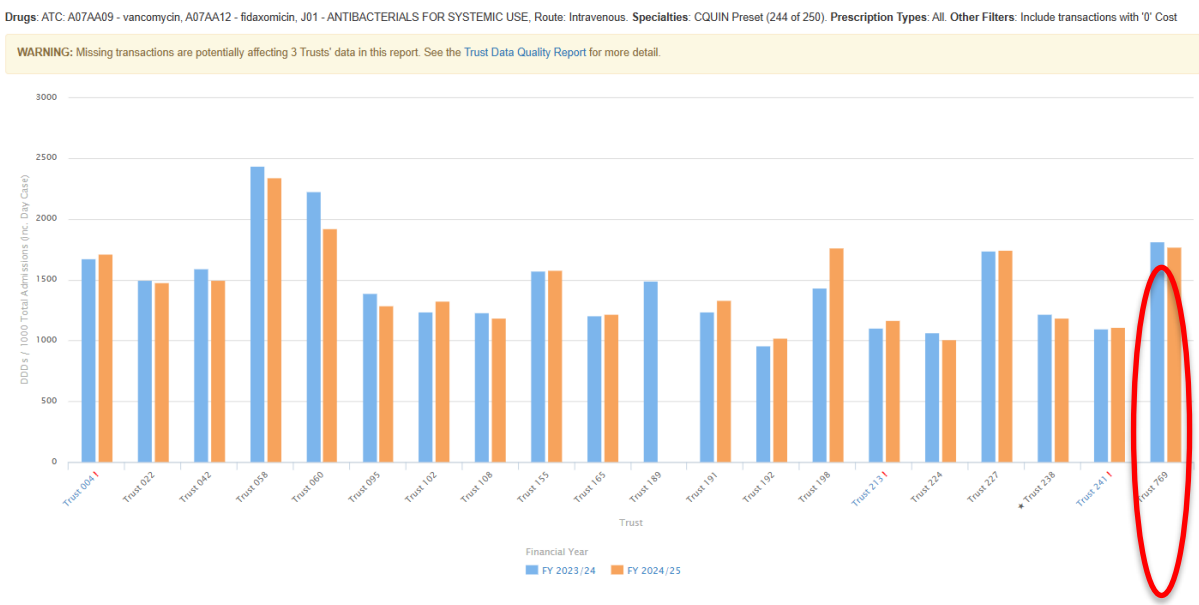


Figure 6. Cheshire & Merseyside Trusts Watch & Reserve DDDs per 1,000 admissions for the four quarters ending Q2 24/25:



Priority 2.

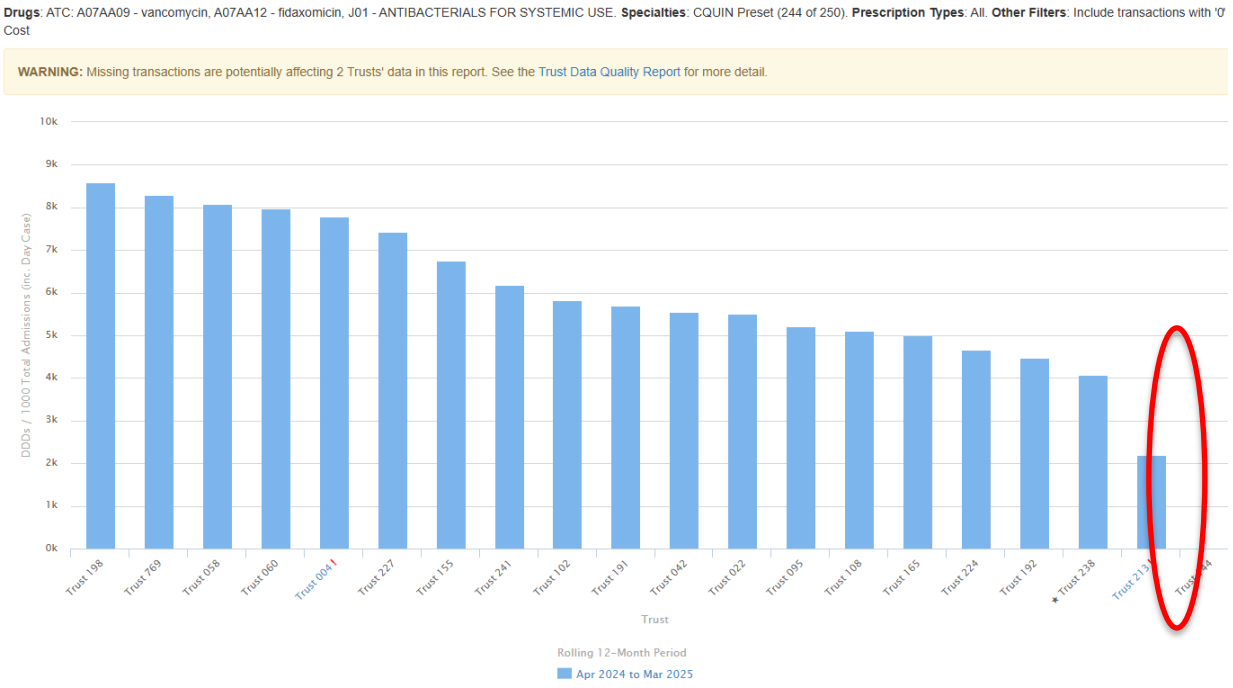
Figure 7. WUTH usage of IV antibiotics (DDDs per 1000 admissions), financial year 23/24 and 24/25, compared to similar NW Trusts:



DEFINE does not have data to compare the remaining priorities.

For purposes of the annual report, total antibiotic consumption has been included below:

Figure 8. WUTH Total antibiotic consumption (DDDs per 1000 admissions), financial year 24/25, compared to similar NW Trusts:



4	Action and Delivery Plans
4.1	**4.1 Audit Plan** The AMS team provide assurance of AMS by delivery of the audit plan (Table 2).

Table 2. 2024/5 AMS Audit Plan

Quarter	Audit	Relevant priority	Progress
Q1	Antibiotic Point Prevalence Audit	Local priority	Data collected in Q2, see below
Q1	Antibiotic Surgical Prophylaxis Audit	Local priority	Delayed until surgical prophylaxis formulary has been updated- in progress, aiming for Q1 25/26
Q1	Quinolone Prescribing Audit	Priority 6	Data collected, see below
Q2	IVOS (50 patients)	Priority 3	Data collected for reduced cohort due to time pressures see below
Q4	IVOS (50 patients)	Priority 3	Data collected, see below
Quarterly audits	ASPIRE Audit	Priority 4	Ongoing
	Restricted Antibiotic Audit	Priority 5	Ongoing

4.1.1 Annual Antibiotic Point Prevalence Audit Summary

Data were collected in Q2 August 2024 for 750 inpatients across the APH and CGH sites. Across both sites, 262 (34.9%) inpatients were prescribed a total of 319 antibiotics. The audit did not include the Emergency department.

Table 3 – Antibiotic Overview by Division and Trust-wide (compared to March 2023 audit figures).

Division	% of patients on antibiotics		% of antibiotics that were IV		% of antibiotics with course length / review date		% of antibiotics with a documented indication in notes		% of antibiotics with correct indication on the prescription		% of antibiotics that were compliant with the formulary / otherwise appropriate	
Comparison	**Aug '24**	Mar '23	**Aug '24**	Mar '23	**Aug '24**	Mar '23	**Aug '24**	Mar '23	**Aug '24**	Mar '23	**Aug '24**	Mar '23
Surgery	***32***	*33*	***63***	*51*	***83***	*93*	***88***	*96*	***89***	*90*	***97***	*94*
Medicine and acute care	***36***	*35*	***55***	*48*	***93***	*96*	***96***	*96*	***76***	*88*	***94***	*90*
Women and Children's (W&C)	***35***	*16*	***69***	*41*	***76***	*76*	***100***	*88*	***100***	*82*	***100***	*94*
Trust wide	***35***	*33*	***58***	*49*	***90***	*94*	***94***	*95*	***81***	*88*	***95***	*91*

Antibiotic review
In total, 250/319 (78%) antibiotics had received a review. For the 69 prescriptions that had not been reviewed, 32 had been prescribed within 72 hours, and so were still eligible for a review. A further 29 prescriptions were for prophylaxis and therefore not reviewed. Therefore, of eligible prescriptions (258) 97% were reviewed.

Conclusion
Overall, compliance with AMS indicators has dropped slightly since the audit last year, with the exception of appropriate prescribing of antibiotics in line with formulary or otherwise appropriate. This rise in compliance for appropriate antimicrobial prescribing was encouraging. The rise in percentage of IV prescribing and incorrect prescription labels could be down to the time the audit was undertaken, given it is a month after new doctors and pharmacists start in the trust, this is likely to influence quality of prescribing and how rapidly interventions are taking place. However, the audit identified some areas for improvement such as co-amoxiclav use for UTIs.

4.1.2 Antibiotic Surgical Prophylaxis Audit
The surgical team will conduct the antibiotic surgical prophylaxis audit within the coming months once the surgical prophylaxis formulary has been updated, aiming for Q1 25/26.

4.2 Reduction of broad-spectrum antibiotics (Priority 1)

We have not met our target to reduce Watch & Reserve antibiotics by 10% compared to 2017 baseline (measured in DDDs per 1000 total admissions), we have reduced by 1.5% (2129 DDDs per 1000 admissions for 24/25).
Regionally, this is similar to other non-specialist trusts, with some reducing but not many have met the 10% target to reduce (regional data as of end Q2, see Figure 6 above).

Actions we undertook to try to meet this target:

- Reduced antibiotic pre-pack sizes to 5 days from 7 days in admissions areas, however, co-amoxiclav packs were delayed due to overlabelling of pre-packs which have only just been re-introduced. This will positively impact our figures for 25/26.
- Used REFINE software to look at areas with high usage of antibiotics
- Commenced new AMS ward round on ward 24
- Discussed with breast surgeons to produce surgical prophylaxis formulary

4.3 Reduction of usage of IV antibiotics (Priority 2)

We have reduced IV antibiotics usage by 3.5% compared to last year, which exceeds our target of a 1% reduction, we expect this figure to improve slightly once March's admissions data are updated. This is likely a result of priority 3, where re-audit of IVOS has shown continued good compliance.

4.4 IVOS (IV to oral switch) audit (Priority 3)

WUTH achieved one of the highest compliance rates within Cheshire & Merseyside with the 23/24 IVOS CQUIN. Performance improved throughout the year and by Q4 23/24, less than 10% of patients audited who were eligible to be switched to oral therapy were not already on oral therapy. There are many benefits of timely IV to oral switch which include reduced inpatient stay, reduced nursing time required, reduced bloodstream

infections, reduced carbon footprint & reduced cost. Due to the importance of this, we continued to audit our compliance for 24/25.

Retrospective review of 22 patients from Q2 showed that 14% of patients were still on IVs past the point at which they met switching criteria. In Q4 we reviewed 50 patients and found that 10% of patients were still on IVs past the point the met criteria, which met our target for 24/25.

To achieve this and ensure continued performance from 23/24, continuous education was provided on our AMS ward rounds & a webpage is available via the antimicrobial formulary. It is included as part of annual F1 & NMP AMS teaching. Further education was provided to nursing staff via IPC link presentations & it was added into IPC WEPP nursing education which is given to new nurses by the IPC team.

4.5 ASPIRE results (Priority 4)

Data is collected for 3-5 patients per ward per quarter, chosen at random from a daily list/report of patients on antibiotics. Each antibiotic is assessed for its compliance with Start Smart Then Focus principles.

Antibiotic Safe Prescribing Indicators Report overall results remained >95% throughout the year. For 2025/26 directorates & divisions will be updated to reflect the changes within the Trust. The Emergency Department is not currently captured within the results apart from CDU, this was previously because patients were not in the Emergency Department (ED) long enough to capture data of antibiotic review etc. This will be reviewed in 25/26 to agree the best way to capture relevant data.

4.6 Restricted antibiotics (Priority 5)

Restricted antibiotic prescriptions from Thursday to Sunday are reviewed on a Monday for formulary compliance, approval by Microbiology or otherwise appropriateness. Prescriptions that are not in line with formulary or as per microbiology are flagged to ward pharmacists or antimicrobial pharmacists for review. 2,331 prescriptions were reviewed during 24/25, results remained >97% throughout the year. The majority of inappropriate restricted antibiotic prescriptions were for Tazocin® (piperacillin/tazobactam) that had not been discussed with Microbiology or as per formulary. This may be because Tazocin®, although restricted at WUTH, it is not at other local hospitals in the area, so prescribers transferring to WUTH may continue using as per local hospitals.

4.7 Quinolone Prescribing Audit (Priority 6)

This audit was conducted to gain local assurance of prescribing practices around quinolones after the MHRA alert came out in January 2024: Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate.

Systemic fluroquinolones can cause long-lasting (up to months or years), disabling and potentially irreversible side effects, sometimes affecting multiple body systems and senses.

The UK indications for systemic fluoroquinolones have been updated so they must only be used in situations when other antibiotics, that are commonly recommended for the infection, are inappropriate.

Situations in which other antibiotics are considered to be inappropriate and where a fluroquinolone may be indicated:

- There is resistance to other first-line antibiotics recommended for the infection.
- Other first-line antibiotics are contraindicated in an individual patient.

- Other first-line antibiotics have caused side effects in the patient requiring treatment to be stopped.
- Treatment with other first-line antibiotics has failed.

All fluoroquinolone prescriptions from 1 week in Q1 (April 2024) were reviewed. A total of 65 prescriptions were identified and reviewed for compliance against the standards listed below:

Table 4. Compliance with quinolone audit standards

Standards	% Compliance
Total prescriptions compliant with Standards 1 and 2	**92%** (60/65)
Prescription in line with formulary for the given indication or microbiology advice (Standard 1)	65% (42/65)
Usage as per MHRA (Standards 2a-d)	72% (47/65)

This would suggest that MHRA advice is being followed, guided mainly by the formulary, but also specific microbiologist advice in some cases and microbiology results in others. It has highlighted several incidences where practice can be improved, and an action plan is currently being implemented.

4.8 Quality Contract (Priority 7)

We have met the requirements of the Quality Contract which stipulated that Trusts should take action to address the issue of antimicrobial stewardship (AMS) and resistance (AMR) with prescribers and non-prescribers. Actions should include evidence of:

- **Prescriber education:**

There is an extensive program of AMS education at WUTH delivered by the AMS pharmacy team, see table below. Microbiology team also provide annual training for F1s, F2s, IMTs and Medical Students.

Staff group	Education topic	Frequency	Mechanism of delivery
F1 doctors	Antimicrobial stewardship	Induction	F2F
F2 doctors	Antimicrobial stewardship	PRN	F2F
Non-medical prescribers	Antimicrobial prescribing and stewardship competencies	Induction and newly qualified	Microsoft Teams
Pharmacists & pharmacy technicians	Antimicrobial stewardship (+ antibiotic pharmacokinetics for pharmacists)	Induction & PRN	F2F
All staff	IPC and AMR awareness	Every 2 years	Mandatory training e-learning

New nurses	Antimicrobial Stewardship	PRN	Delivered by IPC during Wirral Enhanced Preceptorship Programme (WEPP) clinical champion training

- **Non-clinical staff awareness raising & patient awareness raising**

The AMS team led on a campaign to raise awareness of AMR during World Antimicrobial Awareness Week (WAAW) (18th November- 24th November 2024). Actions during the campaign were as follows:

- Social media posts/communications using UKHSA/WHO/Keep Antibiotics Working resources.
- Public staff engagement with a stand in the foyer of the hospital
- Display in patient waiting area in pharmacy
- Quizzes to pharmacy staff for engagement and education
- Presentation around antimicrobial resistance (AMR) to pharmacy staff
- Distribution and communication of AMR campaigns online, via email & Trustwide screensavers e.g. IV to oral switch, not using antibiotics at home, not using antibiotics for viral infections etc.

- **Peer to peer challenge**

The approach to AMS by the AMS team is a collaborative one aiming to achieve the best outcomes for patients. The AMS team provide a comprehensive ward round service each day to most of the hospital to embed a support and advisory approach rather than a culture of challenge (see Appendix 2).

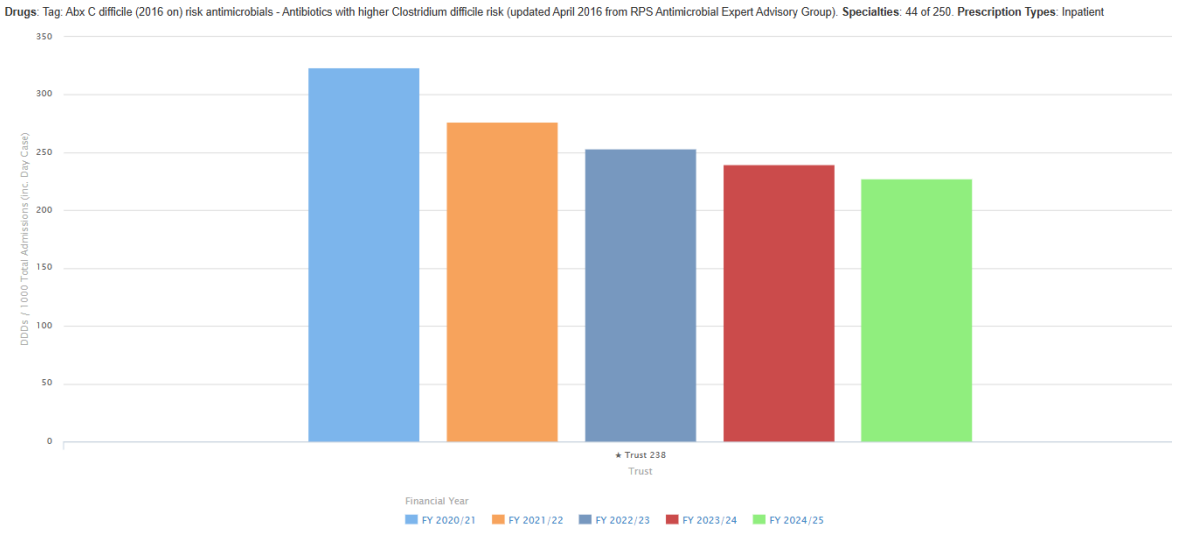
Key areas that the team employ to support AMS and AMR with prescribers are outlined below:

- **Analysis of data at individual prescriber level and at service level.**
- **Challenge appropriateness of prescribing, if an area trend is identified;**
- **Clinical audit**

Multiple audits carried out by the AMS team look at prescriber & service level data, such as the ASPIRE audit, review of restricted antibiotics and the quinolone audit above. If any trends are identified we undertake targeted audits when necessary.

4.9 *Clostridioides difficile*

The Trust made tackling *C.difficile* rates a priority in 24/25 given the awful patient experience and associated high rates of morbidity & mortality.
Our overarching aim was to improve AMS practices within the Trust, which tied in with our other priorities of reducing broad-spectrum antibiotics, reducing usage of IVs and maintaining compliance with Start Smart Then Focus practices. To deliver this, the AMS team have focused on several key areas. This includes review of areas with high antibiotic usage, implementation of targeted audits, review of antimicrobial formularies, implementing a 3-day default on IV antibiotics, commencing a regional pilot using 24 hour antibiotic infusion devices (elastomeric pumps) for outpatients via the OPAT service (this allows more narrow spectrum agents to be used), providing education and commencing additional AMS ward rounds.

	Other recent actions to reduce *C.difficile* rates and align with other Trust priorities (4.2 above) include: - Procuring smaller 5-day pre-packs of antibiotics in ED and other assessment areas to promote optimal course length prescribing for take home medicines. There was a delay due to over labelling of these packs but they are now implemented and the full consumption effect will be seen in 25/26 - Commencing new AMS ward round on ward 24 - Reviewing multiple chapters of the antimicrobial formulary The AMS team plan to sustain the work that we are doing and ask the Trust to engage with recommendations to improve antimicrobial use. Reassuringly the Trust is on a downward trend of use of antibiotics associated with a higher risk of *C.difficile* (e.g. co-amoxiclav, cephalosporins, quinolones, clindamycin, Tazocin® carbapenems) as shown in Figure 9 below. **Figure 9. Graph showing total use of antibiotics with a high association with *C.difficile* (DDDs per 1000 admissions) per financial year back to 20/21, data from DEFINE software.** 

5	Priorities for 2025/26
5.1	There are no antimicrobial CQUIN targets for 2025/26. The NHS Standard Contract is expected to include the following service condition SC21.3 “The Provider (if it is an NHS Trust or an NHS Foundation Trust) must use all reasonable endeavours, consistent with good practice, to minimise its Broad-Spectrum Antibiotic Usage in accordance with the requirements of the National Action Plan for Antimicrobial Resistance”. The UK 5-year National Action Plan (NAP), Confronting Antimicrobial Resistance 2024-2029 includes 2 targets related directly to antibiotic use: - target 4a: by 2029, aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline - target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system The NAP also includes a target to reduce AMR infections:

- target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year (FY) baseline.

There is no specified target to achieve but this will be supported by the above targets, 4 a and b.

Based on the above, the following are our priorities for financial year 25/26.

Priority 1- Reduce total antibiotic consumption by 5% from our 2019 baseline by 2029. Aim to reduce by 1.5% by March 2026 to support overall target (DDDs per 1000 admissions, reported quarterly).

Our 2019 baseline is 3865 DDDs per 1000 admissions (figure from DEFINE software). Our total antibiotic DDDs per 1000 admissions for 24/25 were 4038; target for next year is <3807 DDDs per 1000 admissions (1.5% reduction).

Plan to deliver:

- Promote early cessation of clarithromycin prescriptions.
- Promote 5-day course lengths.
- Continue to monitor areas that are high users of antibiotics.
- Implement 5 day pre-packs of antibiotics in admissions areas- this was approved last financial year but delayed due to over labelling issue of new 5-day packs, should see reduction impact in 25/26.
- Progress 3-day pack sizes for prophylaxis of bites as per formulary in ED

Priority 2- Reduce unnecessary broad spectrum (Watch & Reserve) antibiotic usage by 1% compared to last financial year (reported quarterly, DDDs per 1000 admissions)

Our proportion of total antibiotics from the Access category for 24/25 was 46%. In terms of total Access antibiotics measured in DDDs per 1000 admissions, WUTH benchmarks as one of the lowest users of Access antibiotics across the North West, possibly as a result of being one of the lowest prescribers of total antibiotics (see Figure 8).

Focusing on unnecessary broad spectrum antibiotic usage will increase the proportion of Access antibiotics that are used at WUTH, therefore supporting UK NAP target 4b.

Plan to deliver

- Target unnecessary co-amoxiclav usage:
    - Promote switch of co-amoxiclav to amoxicillin in cases of pneumococcal pneumonia.
    - Promote cefalexin for upper UTIs instead of co-amoxiclav.
    - Re-audit co-amoxiclav usage in ED following implementation of 5-day pre-packs
    - Progress 3-day co-amoxiclav pre-packs in ED for prophylaxis of human/animal bites
- Review the antimicrobial formulary, to include more co-trimoxazole or cefalexin (Access antibiotics) if possible & where appropriate.
- Continue with OPAT elastomeric project which allows patients to go home on IV flucloxacillin- funding is currently under review.
- Target early cessation of clarithromycin for pneumonia where atypical infection is unlikely

Potential barriers to above:

Over the next few years, the Urgent and Emergency Care Upgrade Programme (UECUP) is planning to develop the minors area, which will incorporate the UTC (Urgent Treatment Centre), adapting a side-by-side triage approach to patients requiring urgent care. We anticipate that UTC will be sharing facilities with the ED, including use of a

	shared medicines room. We are expecting this to have some ramifications to our antimicrobial usage figures and spend, currently UTC antimicrobial usage is not included in Trust figures, but at this stage it is difficult to predict what this impact will be and when it will occur. The ED and microbiology pharmacy teams will work closely together to mitigate this impact when this phase of the programme is underway. We do not anticipate this to have any influence on the 2025/2026 financial year. **Priority 3- Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly)** We achieved a 3.5% reduction in 24/25, a further 1% should be manageable. This would reinforce our knowledge that timely IV to oral switches are still occurring.

6	
6.1	• Surpassed reduction target of usage of IV antibiotics • Maintaining good ASPIRE audit results and IVOS audit results • Benchmarking well both locally and nationally • Widespread proactive AMS ward rounds across the Trust • Good compliance with quinolone audit standards • Smaller 5-day antibiotic pre-packs to allow reduction of total and broad-spectrum antibiotic usage have been implemented • Meetings have started with the Pharmacy informatics team to discuss options/development for the AMS mPage so we can improve our antibiotic reviews and hopefully increase IV to oral switches

Appendix 1

Cheshire & Merseyside AMR Priorities Reporting requirements

Contract Section 30.

Requirement
Trusts will submit a report to local Place Quality Team detailing progress against each of the five priorities for reducing AMR and infection outbreaks. These agreed priorities are;
1. Use data to improve reporting on Standard contract for HCAI and GNBSI
2. Implement National Hydration pilot for C&M and scale and spread learning across NW and nationally
3. Optimise use of ant -microbials e.g. Reduce Prescribing course length in C&M
4. Reduce antibiotic prescribing rates for children in C&M
5. Develop Public media campaign for C&M to raise awareness– e.g. importance of Hydration, E bug

It has been agreed that these will be reported at Place / ICB level.

Contract Section 31.

Requirement	Planned evidence / reporting
The organisation will submit 6-monthly summary of actions taken to address the issue of antimicrobial stewardship (AMS) and resistance (AMR) with prescribers and non-prescribers. 6-monthly assurance to be in the form of: Quarter 2 Provider to submit plan of activities, action plan and audit Quarter 4 Provider to submit final report The actions should include evidence of:	
* Prescriber education	
* Non-clinical staff awareness raising	
* Patient awareness	
* Peer to peer challenge	
* Analysis of data at individual prescriber level and at service level and challenge regarding appropriateness of prescribing, if an area trend is identified	
* Clinical audit	

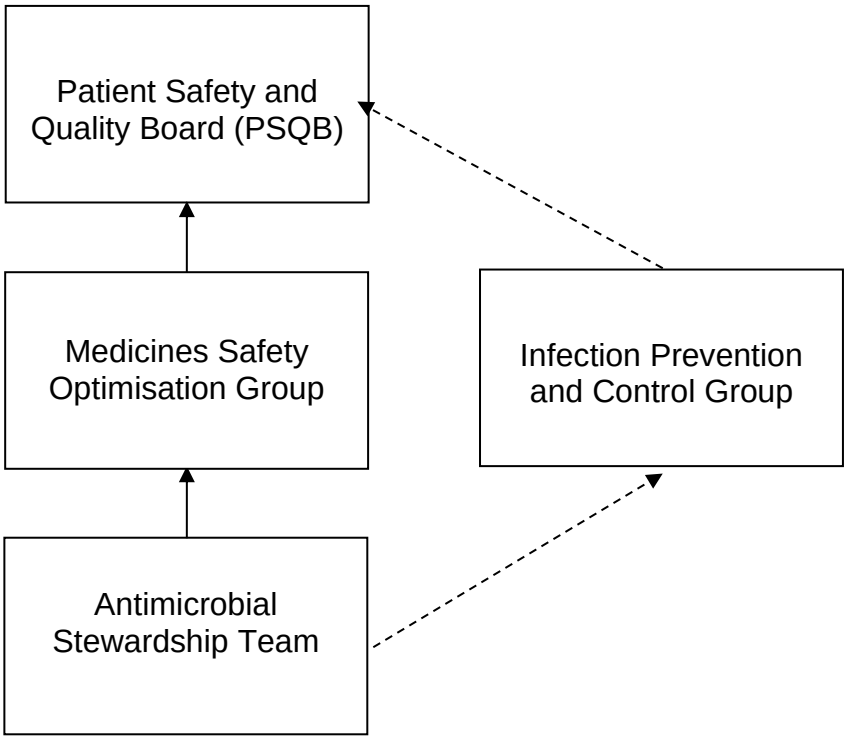
Appendix 2. AMS Governance Framework

The governance framework for AMS at WUTH is based on the recommendations in NICE guideline NG15: *Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use* (2015)

1.1 AMS Team

The Antimicrobial Stewardship Team develops and support the implementation of policies, procedures and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners and junior doctors. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care and Respiratory Consultant. Wider attendance remains a challenge however, the team engages directly with specific teams when required for certain pieces of work.

Chart 1: Antimicrobial Stewardship Team within Trust Organisational Governance Structure.



The AMS Team has the following strategies to improve AMS at WUTH:

- Prescriber education training program
- Maintaining an evidence-based antimicrobial formulary
- Audit program to monitor antimicrobial prescribing and identify areas for improvement (see section 2)
- Ward-based AMS Team
    - The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers.
    - Areas which are high-users of broad-spectrum antibiotics and areas with patients with complex infections requiring long-courses of treatment have been identified

by point prevalence audits and prioritised for visitation by the ward focused AMS Team (see appendix A)

- Service improvements to improve antimicrobial prescribing (new treatments and diagnostic tests, developments to the e-prescribing system, etc).

2.4.1 AMS Team ward rounds

The ward-focused AMS team consists of a CMM and a specialist antimicrobial pharmacist to undertake ward rounds with aim of providing patient specific interventions but also provision of case-based teaching to prescribers. Areas which are high-users of broad-spectrum antibiotics or high incidence of *C.difficile* infections have been identified by point prevalence audits and prioritised for visitation in addition to areas with critical or complex infections requiring long-courses of treatment:

- Critical care (five times weekly)
- Acute Care (five times weekly) – AMU, MSSW, UMAC
- Older Persons Assessment Unit (weekly)
- Gastroenterology ward (weekly) – W33
- Elderly Care wards (weekly) W21, 22, 23 and 27
- Respiratory Unit (weekly) – W37 and 38
- Orthogeriatric wards/T&O – W10,11,12 and WAFFU (weekly)
- SEU (weekly)
- Colorectal unit (weekly)
- General medicine W20 (weekly) & ward 24 (weekly)

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues.

Microbiology +/- AMS Pharmacist also attend the following weekly MDTs:

- Renal
- Haematology
- Endocarditis
- OPAT MDT and “virtual” ward round
- *C,difficile* infection MDT
- Prosthetic Joint MDT

References

1. National Action Plan for Antimicrobial Resistance 2024-2029
Confronting antimicrobial resistance 2024 to 2029 (publishing.service.gov.uk)

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 25**

1 October 2025

Title	Controlled Drug Accountable Officer Report
Area Lead	Chris Green, Director of Pharmacy and Medicines Optimisation
Author	Amy Janvier, Lead Pharmacist Procurement and Medicines Supply
Report for	Information

Executive Summary and Report Recommendations

This report provides the Patient Safety and Quality Board with an overview of Controlled Drug (CD) activity during 2024/25. It is a national requirement for Trusts to employ a Controlled Drugs Accountable Officer (CDAO) and that the CDAO provides assurance around CD management to Trust Boards or their delegated committee. The Trust CDAO is the Director of Pharmacy and Medicines Optimisation.

CD incidents are monitored in the Trust on a daily basis and incidents of note and trends are escalated to the CDAO. In addition, it is a legal requirement that Wirral University Teaching Hospital NHS Foundation Trust (WUTH) report any incidents, concerns or individuals of concern regarding the management of controlled drugs within the organisation to the CD Local Intelligence Network (CDLIN) every quarter or as appropriate. 320 reports of issues involving CDs were submitted in 2024-25.

73 (23%) of the reports were actual incidents where patients received an incorrect medicine, an incorrect dose, a medicine via an incorrect route or an expired medicine; 247 (77%) reports were classed as near misses. 9 incidents caused 'low harm' to patients while all other reports were 'no harm'. The Trust is noted by the regional CDLIN to be a high number, low harm reporter indicative of an open reporting culture.

Audits of controlled drugs were undertaken in all quarters during 2024/25. The standards audited relate to CD legislation reflected in the Trust CD policy. Compliance was very good across all areas.

The recommendations from the report will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion.

It is recommended that the Board:

- Note the report

Key Risks
This report relates to these key Risks: • Controlled drugs are potentially harmful medicines if they are not used in a safe and controlled manner. • Controlled drugs are highly susceptible to the risk of diversion as they are potentially abusable, and because of this they also present an opportunity for illicit sale and distribution.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
August 2025	PSQB	As above	As above
September 2025	Quality Committee	As above	As above

1	Narrative
1.1	**Introduction** In accordance with the Controlled Drugs (CDs) Regulations 2013, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) has an Accountable Officer (AO) for controlled drugs who has responsibility for the safe use and management of controlled drugs. The CDAO is the Director of Pharmacy and Medicines Optimisation. It is the CDAO's responsibility to report CD incidents and near misses, and, individuals of concern to the Regional CD Local Intelligence Network (CDLIN). The CDAO must also produce an annual report for the Board of Directors or its delegated committee to provide assurance around the management of CDs within WUTH.

During 2024/25, WUTH had 3 areas within the Pharmacy Department holding a wide range of CDs: the Pharmacy Dispensary and Aseptic Unit on the Arrowe Park Hospital site and Central Pharmacy Stores at Clatterbridge. In addition, the pharmacy satellite dispensaries stock gabapentin, pregabalin and tramadol which are schedule 3 CDs. These CDs are to be ordered in a CD order book, have additional prescription requirements but are not required to be stored in a CD cupboard. The pharmacy satellites do not stock schedule 2 CDs. CDs are supplied to over 80 wards and departments within WUTH.

The Trust holds two Home Office Controlled Drug Licences which permit the supply of CDs to external organisations such as Wirral Hospice St Johns. There is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs. These standards are applied across all Trust CD activity and their attainment gives additional, external assurance that CD processes are tightly controlled.

1.2 **Monitoring of CD Incidents and Usage Trends**

All incidents are monitored on a daily basis by the Trust Medicines Safety Officer (MSO) and incidents of note and trends including CDs are escalated to the CDAO. In addition, incident numbers are submitted to the CDLIN on a quarterly basis and incidents of note are submitted in real time for review by the CDLIN.

There were 320 incidents involving CDs reported across WUTH between April 2024 and March 2025 compared to 298 reported the previous year. CD incident reports continue to show an upward trend (table 1).

Table 1: CD Incidents Reported April 2015 – March 2025

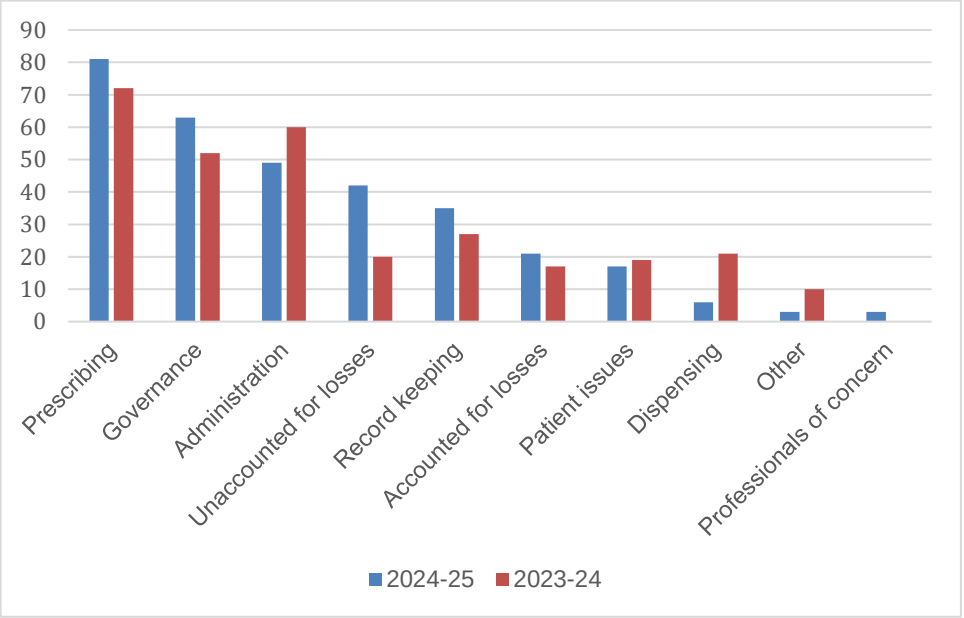
Financial Year	Number of incidents	Percentage increase on previous year
2024-25	320	↑7%
2023-24	298	↑41%
2022-23	211	↑5%
2021-22	201	↑24%
2020-21	161	↓4%
2019-20	169	↑1%
2018-19	167	↑9%
2017-18	153	↑82%
2016-17	84	↑30%
2015-16	65	-

73 of the reports were actual incidents where patients reportedly received an incorrect medicine, incorrect dose or a medicine via an incorrect route; 247 reports were classed as near misses. 9 incidents caused ‘low harm’ to patients while all other reports were ‘no harm’. The number of reports is small in the context of the number of CD transactions carried out across the Trust on an annual basis with an estimate of

over 200,000 doses of CDs administered at WUTH each year. WUTH is noted to be a 'high number, low harm reporter' (in line with National Reporting and Learning System evidence) and it is considered to be good practice to submit all incidents reported rather than simply those of concern.

Figure 1 shows the break down in type of incident reported in CDLIN categories for the year 2024-25 compared to 2023-24.

Figure 1: Categories of CD Incidents Reported



Prescribing and administration errors remain 2 of the top 3 categories. Due to this a thematic review into the prescribing and administration incidents involving opiates was undertaken by the pharmacy medicines safety team. The review looked at incidents reported in the financial year 2023-24 and has been presented at the Medicines Safety and Optimisation group (MSOp). Themes pulled out by the review have continued with incidents reported 2024-25 and the action plan produced as a result of the review is still applicable. As in the review, the majority of the prescribing incidents occurred in the Emergency Department (ED) or admissions due to the number of errors made at the point of medicines reconciliation during a patient's hospital stay, high patient turnover and pressures the units are facing with corridor care.

Prescribing incidents (n=81) was the most common incident type reported. In 49 of the prescribing incidents patients did not receive any incorrect medicines.

30 incidents were related to the prescribing of buprenorphine or methadone for substance misuse. Substance misuse incidents were excluded from the thematic review because a separate review had been completed. The review found that the majority of these incidents are occurring outside of normal working hours when confirming a patient's dose and last collection from their usual community pharmacy is difficult. Work is continuing to review the guideline for management of these patients on admission to ensure patients receive the correct medicine at the correct dose but it is a guideline that is practical to follow in the context of a busy ED.

There were 3 incidents of patients prescribed strong opiates to manage pain when mild opiates or other analgesics would have been more appropriate. In all 3 cases the prescriptions were changed before patients received any doses. The prescriptions originated from the advice of a locum consultant who was not used to following WUTH guidelines and recommended use of opiates in UK.

Governance incidents (n=63) include all incidents that have occurred because Trust policy relating to the safe and secure handling of medicines has not been followed. Policies and procedures relating to the management of CDs from delivery into the Trust until they are used, disposed of or given to patients on discharge are more extensive than those for other medicines. This is because there is additional legislation that covers CDs and CDs are considered high risk medicines both in terms of clinical use and for risk of diversion. Examples of governance incidents include CDs not locked away in a CD cupboard, CD deliveries not dealt with immediately, leaving CDs in the transport bag, patient's own CDs found in bedside lockers, expired CDs not removed from ward / department and CD stock checks not completed correctly. The incidents were all scored as no harm and spread across a range of wards/departments. A spike in governance incidents has been seen in quarter 4 on ward 36. These incidents will be discussed with the ward manager and management monitored moving forward.

Administration incidents (n=49) have seen a reduction from 2023-24. Administration errors included patients being given the wrong drug, wrong formulation, incorrect doses in particular volumes of liquids or injectable controlled drugs and patients receiving doses of expired liquids. CD administration errors are identified more frequently than administration errors with other medicines due to the requirement to record doses given both on Cerner and within controlled drug registers. Discrepancies between quantities recorded in CD registers and the physical quantities in the CD cupboards are often traced to an administration error. As in previous years morphine and oxycodone continue to be the drugs most commonly involved in the administration errors reported.

Nurses involved in administration errors are asked to reflect on any errors made to gain learning for mitigation strategies and were deemed necessary, attend further training.

A contributing factor for administration errors has been identified in the AO report since 2016, which is that Cerner does not always fully display the prescription without needing to 'hover over' the medicine which means that all of the details are not 'face up' and available without this added step. This was a risk register entry at Cerner go live as it conflicts with national guidance requiring electronic prescribing and medicines administration record to have 'face up' medicines description. To date, Cerner have not committed to providing a fix for this direct patient safety issue and therefore this remains as a residual risk.

Unaccounted for losses incidents (n=42) have seen an increase in incidents since 2023-24. Incidents which are originally reported as discrepancies (accounted for or unaccounted for losses) are investigated promptly by pharmacy staff.

12 of the unaccounted for losses were oxycodone liquid discrepancies. The trust is still having to buy the Wrockhardt brand of oxycodone liquid which the trust reported to the MHRA in 2023-24 due to bottles being slightly underfilled. Oxycodone doses

	are often small volumes 1.25 – 2.5ml and every time a dose is given a small amount of liquid can be lost, which across a 250ml bottle can add up to significant discrepancy. Supply problems with medicine bottle bungs has resulted in bungs that are not fitting bottles as well and again this could have lead to liquid discrepancies. Incident reports of individual tablets or ampoules missing are likely to have been dropped or disposed of by mistake, but this cannot be definitively proven. Where losses cannot be accounted for there are no trends or repeat areas and losses tend to be of 1 tablet, capsule or ampoule. As part of an ongoing investigation into a professional of concern, closer scrutiny of controlled drug stocks in a particular department in the trust has resulted in 4 incidents being reported as unaccounted losses. The HR investigation is still on going. The pharmacy procurement office identified repeated discrepancies with midazolam 10mg/2ml injection order being received from a specific wholesaler. This was reported to the Wholesaler and to the Local Intelligence Network. The Wholesaler identified problems in their processes which was resulting in the discrepancies. **Record keeping incidents** (n=35) include entries on incorrect pages of the CD record books, CDs not written out of the record books when given to patients on discharge and doses administered not recorded correctly either in the CD record book or on Wirral Millennium. This is the area of the pharmacy quarterly CD audit most poorly complied with. **Accounted for losses** (n=17). These incidents include breakages or spillages and when the missing controlled drugs have been found and are accounted for following an initial report of a discrepancy. **Patient issues** (n=17) include patients who have not informed staff they have their own supply of controlled drugs and have taken doses resulting in overdoses. There was an incident about a patient who had taken a synthetic opiate and the trust did not have enough naloxone in stock due to a high rate continuous infusion of naloxone being required to reverse the effects. Naloxone stock levels have been increased across Arrowe Park hospital following this. **Dispensing incidents** (n=6) have reduced from 2023-24 (n=21). The dispensary service has seen a reduction in the number of vacancies since 2023-24 which has had a positive impact on the number of dispensing incidents across all categories. In addition, actions identified from the incidents in 2023-24 have been completed and overall incident numbers have reduced. **Monitoring CD Usage Trends** The ‘Abusable Drug Investigational Software’ (ADIoS) is used to monitor usage trends of CDs across the Trust including prescribing on FP10 community dispensed prescriptions. Abnormal usage trends are reviewed, investigated by the Lead Pharmacist Procurement and Medicines Supply and any areas of concern are escalated to the CDAO.

	There have again been numerous movements and re-naming of wards and departments throughout the Trust over the last year. Throughout each move/opening/closure the audit trail and security of CDs and CD stationery has been maintained, however it is noteworthy that the moves and changes in specialty / area location makes the monitoring of usage trends in a given area much more difficult. A project to review ward medicine stocklists involved reviewing medicine stocks issued against doses recorded as administered to patients on Cerner. An unexpected finding was to identify a further 2 areas where there might be concern about the potential diversion of codeine. Investigations are ongoing as mentioned in the section below. **Misappropriation of CDs by Trust Staff** During 2024/25 there have been 5 investigations opened into potential misappropriation or inappropriate management of CDs by staff in the Trust. A HR investigation was completed into the potential misappropriation of codeine from a ward. The investigation included twice daily counting of stock medicines and camera footage from a covert camera installed under RIPA legislation. An individual was identified on camera on one occasion and the decision was made to stop investigating and approach the individual due to previous safeguarding concerns and wanting to ensure the individual was supported. The outcome of the HR investigation was that it could not be proven that the individual was inappropriately taking codeine. Another covert camera was installed on a ward under RIPA legislation but no individual of concern could be identified. The investigation has been stopped and according to the ADIoS system amount of codeine being issued to the ward has significantly reduced in February and March 2025. The area will continue to be monitored. Concerns were raised about patients being inappropriately prescribed zopiclone in theatre recovery at Clatterbridge. An investigation was completed and no concerns were found. Another 2 investigations are currently ongoing.
1.3	**Assurance Audits** **Quarterly Ward/Department CD Stock Checks by Pharmacy Staff** It is a requirement of the Department of Health Safer Management of CDs Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. The quarterly pharmacy CD audits are in addition to the monthly CD audits matrons complete using the Tendable app. As well as a stock check the pharmacy quarterly ward / department CD checks cover the following areas of practice which are also subject to regulation: • Security of CDs e.g., management of keys and controlled stationary, ensuring daily CD counts have been completed. • Correct documentation in terms of entries and corrections

Results of the audits are presented quarterly at MSOP. Across all quarters the audits found:

- The security of controlled drugs, keys and stationery was excellent.
- Compliance with daily checks was very good

Record keeping and governance was on the whole very positive in most areas but attention to detail in recording individual transactions and correcting errors as per policy could be improved on some occasions. In quarter 1 it was identified that there were a couple of areas that did not have rescue medicines (naloxone and flumazenil) available at the time of the audit. Later audits have found naloxone and flumazenil to be available in all areas at the time of the audit.

Quarterly CD Stock Checks in the Pharmacy Department

The WUTH Pharmacy Department is also subject to quarterly CD checks in all stockholding areas by a member of pharmacy staff who work in a different area of the department. These were all completed for 2024/25 without any stock discrepancies being noted. Although not a legal requirement, full CD stock checks are being carried out in Arrowe Park dispensary each month in line with the recommendation made by General Pharmaceutical Council Inspector in 2016. In addition, CD stock levels are checked each time a CD is dispensed, or a delivery is received into the pharmacy department which ensures stock levels are managed in real time.

In addition to the quarterly CD checks other drugs with abuse potential e.g. codeine, zopiclone are counted on a weekly basis and any trends in discrepancies noted and investigated.

Expired stock schedule 2 controlled drugs are destroyed in pharmacy with a member of staff who works elsewhere in the Trust delegated by the Accountable Officer in accordance with CD regulations. Arrowe Park and Clatterbridge Pharmacy Departments both hold an Environment Agency T28 (Sorting and denaturing of controlled drugs for disposal) Waste Exemption which allows the Trust to dispose of these medicines in accordance with Waste Legislation.

CQC Self-Assessment

The CQC self-assessment tool is completed annually and was undertaken in March 2025. A RAG rating is used to highlight any areas of CD management which may need improvement. The assessment results were mostly green and comparable to the 2024/25 assessment. All areas pertaining to process and procedures were green.

The 3 areas which were red were:

- have there been significant CD events in the last year.
- have there been incidents involving CD prescribing in the last year.
- have there been incidents involving a lapse in CD management in the last year.

There have been incidents which fall into the above categories which gives a rating of ‘red’ for these questions. The incidents concerned were reported via the trust incident reporting system and to the LIN.

1.4	**Changes in Legislation / Policy** The Trust's Controlled Drug Policy is currently being updated to mandate that ward/department controlled drug keys are kept on an individual bunch and not with other keys.
1.5	**Controlled Drug Home Office Licence** CD Home Office Licences are required to allow the Pharmacy Aseptic Unit and Pharmacy Stores at Clatterbridge to supply CDs to external customers. The licence renewal applications were submitted in March 2024 and licences were re-issued in January 2025. The Home Office CD Annual Returns were completed and submitted in January 2025.
1.6	**CQC Annual Report** The 2023 report was published in July 2024. There was 1 recommendation included within the report applicable to WUTH: • Share information about concerns in relation to controlled drugs with the right organisations as soon as possible, including with NHS England controlled drugs local intelligence networks This process is already embedded within the Trusts' policies and procedures.
1.7	**LIN Activity** Following the Shipman report the Cheshire and Merseyside LIN was established and is led by the NHS England Area Team Accountable Officer, Dr Devina Halsall. The LIN met virtually four times in 2024/25 and shared information and learning about the prescribing and management of CDs in the local geographical area. The CDAO has a statutory duty to submit quarterly occurrence reports to the LIN with information about any issues identified regarding prescribing or abuse of CDs. Incident occurrence reports were submitted in line with LIN guidance throughout 2024/25.
1.8	**Training** The medicines management induction and mandatory training sessions contain information on opiates as they are a high-risk class of medicines and information on medicine diversion. Induction sessions are attended by all staff starting work at WUTH. Opiate and controlled drug training continues to be provided to F1s and non-medical prescribers. Training is also provided to ward and pharmacy staff.
1.9	**Lessons learned** Actions taken 2024/25 to improve controlled drug management and safety: • Change in the concentration of morphine liquid used in neonatal unit to ensure standardisation with the rest of England and reduce the risk of babies receiving overdoses due to a none standard concentration of liquid being used • Development of a 'Drug seeking behavior' smartzone alert on Cerner. • Powerplan created on Cerner to support prescribers and nurses when midazolam is prescribed for a catastrophic bleeds and to prevent inappropriate stat doses being given when not indicated • Management of bleeding in palliative care patients guideline published which includes information about how midazolam should be stored, prescribed and administered for patients who maybe at risk of a catastrophic bleed. • Attendance and participation in the Wirral Place Community of Practice – Opioid and Drugs of Dependence group.

	• Installation of CCTV in the new ED medicine rooms and in Critical Care with the intention of acting as a deterrent to CD diversion. • Use of electronic Omnicell cabinets for CD storage in ED Resus and the Ambulance Arrival Zone. Actions identified by the thematic review, further incidents and quarterly CD audits: • Bi-monthly opiate safety group to be set up to provide ongoing review of themes and to aim to continue to improve management of opiates. • Review of management and guideline for patients admitted taking methadone or buprenorphine for substance misuse. • Training provided to prescribers and nurses both on induction and ongoing across a variety of opiate topics to be reviewed and provided. • Explore if visiting teams, for example palliative care, can or should be enabled to prescribe own recommendations. • Explore electronic options on Cerner to see if amendments to prescribing screens for opiates could help support correct opiate prescribing. • Review which controlled drugs are routinely stocked on wards and provide resources to be displayed to highlight differences between formulations.

2	**Conclusion**
2.1	The management of CDs continues to be monitored by the Trust AO via incidents reported through the Trust incident reporting system and the ADIoS software. The recommendations will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion: • CD incidents review and trend analysis will continue with actions to prevent further incidents being implemented and any learning from incidents shared • Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of nursing will be held accountable for improved performance via MSOP. • WUTH will work with Wirral Place to support the safe prescribing and management of CDs across all areas of Healthcare on Wirral • Install CCTV cameras across all medicine rooms to discourage diversion of medicines and allow for easier investigation should areas of potential diversion be identified. • Continue to monitor potential discrepancies where the number of doses supplied exceeds the number of doses administered to patients.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 26**

1 October 2025

Title	Safeguarding and Complex Care Annual Report
Area Lead	Sam Westwell – Chief Nurse Executive Director for Midwifery and Allied Health Professionals
Author	Karolyn Shaw, Associate Director of Nursing for Safeguarding and Complex Care
Report for	Information

Executive Summary and Report Recommendations

The Safeguarding and Complex Care Annual Report provides an overview of the national and local context of safeguarding and complex care. The annual report provides the Trust positions across all areas of safeguarding and complex care by providing assurance of how the organsiation is meeting and/or working towards its statutory obligations and national standards. Analysis of the annual safeguarding and complex care activity including progress made against the objectives set out in the Safeguarding Annual Report 2022/23 and an overview of the Trust priorities moving into 2024/25.

The report provides an end of year position of compliance against the following areas:

1. Protecting Vulnerable People (PVP) training against the target of 90%
2. Safeguarding Assurance and Accountability Framework Key Performance Indicators
3. Care Quality Commission updates
4. Trust safeguarding activity
5. Learning Disabilities/Autism and LeDeR (learning form lives and deaths)
6. Oliver McGowan Mandatory Training (OMMT)

Key successes summary during 2024/25:

There have been several key successes to celebrate during 2024/5 which include:

- Strengthening of processes to support DBS referrals 'A safe and confident workforce' following completion of Section 11 audit of Working Together to Safeguarding Children 2023. The disciplinary policy was redrafted to include referrals to both DBS and professional bodies and ratified in Q4.
- Identification of CP-IS champions began in Q2 to support improved and maintain compliance, data collection and overcome any barriers and meet quarterly. CP-IS was further rolled out into Assessment areas in Medicine and Surgery divisions in Q3.
- Through monitoring of trends and themes the increase of Ketamine use was identified amongst children aged 15-17 yrs, to raise awareness of health complications of Ketamine use Wirral youth drug and alcohol service 'RESPONSE' provided a series of 3 educational sessions which were well attended and received.
- Following the planning and development stages of an Initial Health Assessment (IHA) multiagency tracker in 2023/24, the tracker went live (Q3) and has resulted in improvements into Q4 from 19% to 53%.
- Completion of the 2nd phase of the 'HOPE' (Hold On Pain Eases) pilot to develop specific trauma training for professionals following separation of baby at birth for parents. The Named Midwife was invited to develop a short video to showcase the

content of the ‘HOPE’ boxes and capture the experiences of families and professionals to be used as part of a training pool across Cheshire and Merseyside to support implementation across other organisations.

- As part of the International Clinical Trials Day (20 May 2025) the Named Midwife was invited to present the ‘HOPE’ boxes pilot as an example of the breath of research being conducted within the Trust.
- To further improve the Pre Birth Liaison Meeting a tracking system was introduced by the Named Midwife which can monitor cases and actions and went live in Q1. Professionals (multi agency) involved have noted that less babies are being separated at birth and the process provides opportunity for timely formulation of support plans for parents and professionals.
- In keeping with the Patient Safety Incident Framework (PSIRF) the Named Nurse Safeguarding Adults and the Deputy Director of Governance have jointly reviewed the process and template for externally raised safeguarding concerns. This will be presented at the Safeguarding Assurance Group for approval and then circulated to staff during 2025/26.
- Development of a safeguarding incident report through Ulysses in collaboration with the Quality and Safety Analyst to support divisions to have an overview of safeguarding within own areas to monitor divisional themes and trends.
- The embedment of a recording tool within Cerner that monitors ‘Restrictive Practices’ which includes levels of observations and objections, and which legal framework is in place such as Mental Capacity Act, Deprivation of Liberty ort Mental Health Act.
- As a result of monitoring themes and trends for Mental Capacity Act (MCA) the lead for MCA has been involved in a number of developments workstreams including:
    - Deputy Medical Director championing a joint project with pharmacy for the refusal of critical medications and its interaction with the MCA 2005, draft SOP developed and planned to be circulated in 2025/26.
    - Support from the Resuscitation Services Lead to improve DNACPR compliance with MCA 2005 which is included in mandatory training and a specific session for medics.
    - To strengthen audit of MCA 2005 across the Trust and outside of the Safeguarding WISE audit additions have been made to Harms audits to include questions about MCA. These are now included within falls prevention, nutrition and hydration, catheter Insertion and pressure area care. These will be monitored through the newly formed ‘Fundamentals of Care Group moving into 2025/26.
- During 2024/25 the Trust became a core panel member for MAPPA – Multi Agency Public Protection Arrangements (Police, Probation and Prison Services). MAPPA is a process for working together, sharing of information and joint planning for any patients that may pose a risk to staff. They are flagged on the electronic medical record and details of a professional to contact if they attend.
- The Trust supported the ‘Violence Against Women and Girls strategy and actively promoted the 16 days of action with visits to the wards raising awareness. To show the Trusts commitment and support a mosaic mural was donated by a local business to showcase the Trusts permanent pledge and commitment and is displayed in the main corridor of the Trust.
- The final area for implementing the Female Genital Mutilation (FGM) routine enquiry questions were successfully embedded within the Urology Flexible Cystoscopy Clinic. Compliance will be monitored quarterly by the Surgical division moving into 2025/26. The routine enquiry question for FGM is now embedded within all Gynaecological and Maternity areas.
- Complex Care celebrations

- Successful appointment of 2 combined Safeguarding and Complex Care Practitioners during Q1, one Registered Learning Disability Nurse and one Registered Adult Nurse, this incentive provides the trust with a more flexible service for patients within our care.
- The launch of the sensory care bags was also launched as part of the learning disabilities week, a project that was developed in collaboration with Wirral Autism Together, Mencap and Health Watch. The initiative has received positive feedback and was featured in a local newspaper which attracted other organisations to make enquires on how this was implemented.
- Other areas have included development of an awareness video for desensitisation in relation to needle phobia a direct request of Wirral Mencap and meets the AIS as it features 5 experts with lived experience. Inclusion as a key stakeholder in the development of an easy read breast information leaflet as part of the breast awareness campaign to encourage patients with a diagnosis of Learning Disabilities and or Autism to come for breast screening.
- Role out of Oliver McGowan Mandatory Training (OMMT) part A (eLearning) in Q2 ending 2024/25 Trust position of 67.44% equating to 4198 trained staff.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Trust Risk 612 - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate
- Trust Risk - 0221 - FGM screening Cerner – FGM routine enquiry is currently only asked in Maternity and Gynecology service
- Trust Risk 1366 – Oliver McGowan Mandatory Training (OMMT)
- Trust Risk 1872 - The Reasonable Adjustment Digital Flag (RADF) Information Standard

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
08/08/2025	Safeguarding Assurance Group (SAG)	As above	As above
September 2025	Quality Committee	As above	As above

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Glossary

ACE	Adverse Childhood Effects
ADNS	Associate Director of Nursing for Safeguarding
AIS	Accessible Information Standards
AMA	Adoption Medical Advisor
ASC	Adult Social Care
ASD	Autistic Spectrum Disorder
BAAF	British Association for Adoption and Fostering
BI	Best Interests
CDOP	Child Death Overview Panels
CiN	Child in Need
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CLA	Children Looked After
CMICB	Cheshire and Merseyside Integrated Care Board
CP	Child Protection
CP-IS	Child Protection information sharing
CQC	Care Quality Commission
CSC	Children Social Care
DARDR	Domestic Abuse Related Death Review
DBS	Disclosure and Barring Service
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
FGM	Female Genital Mutilation
ICS	Integrated Care System
IFD	Integrated front door
IHA	Initial Health Assessments

IDVA	Independent Domestic Violence Advisor
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
HV	Health visitors
KPI	Key performance indicators
LA	Local Authority
LD	Learning Disability
LeDeR	Learning from lives and deaths – People with a learning disability and autistic people
LPA	Lasting Power of Attorney
LPS	Liberty Protection Safeguards
MAPPA	Multi-Agency Public Protection Arrangements
MAR	Multi Agency Referral
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MND	Motor Neurone Disease
MSP	Making Safeguarding Personal
NOK	Next of Kin
NRLS	National Reporting and Learning System
OMMT	Oliver McGowan Mandatory Training
OPD	Outpatients Department
PBL	Pre-Birth Liaison
PiPoT	People in Positions of Trust
PVP	Protecting Vulnerable People Training
PSIRF	Patient Safety Incident Review Framework
PSQB	Patient Safety Quality Board
RPR	Relevant Persons Representative
RRM	Rapid Response Meeting
SAG	Safeguarding Assurance Group
SAAF	Safeguarding Assurance and Accountability Framework
SARs	Safeguarding Adults Reviews
S42	Section 42 (Statutory Investigation)
SJR	Structured Judgement Review
SOP	Standard Operating Procedure

SUDIC	Sudden Unexpected Deaths of Child
WSAPB	Wirral Safeguarding Adults Partnership Board
WISE	Wirral Individual Safe Care Every Time Accreditation Programme
WRAP	Workshops to Raise Awareness of Prevent
WSCP	The Wirral Safeguarding Children Partnership

1	Background and Statutory Legislation
1.1	**Introduction** Wirral University Teaching Hospital NHS Foundation Trust, thereafter, referred to as the Trust, is committed to ensuring that the safeguarding of our patients, their families, our staff, and our communities is at the foundation of our 'Together we will' Trust values. We strive to improve and build upon the safeguarding practices we offer by promoting the Trust ethos that safeguarding is everyone's business in the drive to continuously make improvements to the service we provide. The term "safeguarding" covers everything that assists unborn, children, young people, and adults at risk to live a life that is free from abuse and neglect, which enables them to retain independence, wellbeing, dignity, and choice. Safeguarding encompasses prevention of harm, exploitation, and abuse through provision of high-quality care, effective responses to allegations of harm and abuse that are in line with multi-agency procedures. Importantly safeguarding embraces the use of learning to improve services for our patients, their families, and carers. In regard to complex care within the Trust this refers to, Learning Disabilities (LD), Autistic Spectrum Disorder (ASD) and Motor Neurone Disease (MND). The Trust strives to achieve equality of health outcomes and that requires identification of barriers, biases, and targeted action to overcome specific inequalities, discrimination and marginalisation experienced by certain groups and individuals. The Trust Safeguarding and Complex Care Team continues to provide a range of activities to support key areas of safeguarding and complex care work, embrace change and respond to emerging themes both local and nationally and strive to ensure all processes are robust and effective. The team structure and further definitions have been elaborated on in appendix 1 and 2. This report provides assurance that the Trust is fulfilling the duties and responsibilities in relation to safeguarding promoting the welfare of children, adults and families who come into contact with our services. For those patients with complex care needs that they feel equality, diversity and inclusion enhancing their sense of belonging and improve their experience. This report reflects the high level of activity across all work streams to improve internal and multi-agency processes and build on existing systems and procedures. We continue to strive to further improve and achieve strong compliance against all our safeguarding standards internally and externally to safeguard the most vulnerable in our society.

1.2	**Statutory Framework and National Policy Drivers (Safeguarding and Complex Care)** Whilst safeguarding shares the same agendas and principals for adults and children, there are significant differences in the laws and policies that shape how we safeguard these groups. The legal framework to protect children is contained in Working Together to Safeguard Children (2023) and the Care Act (2014) for adults. However, the overarching objective for both is to enable children and adults to live a life free from harm, abuse, or neglect. Section 11 of The Children Act (1989, 2004) places a statutory duty on all NHS Trusts to make arrangements to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions. The statutory guidance 'Working Together to Safeguard Children (2023) supports the multi-agency safeguarding arrangements set out in the Children and Social Work Act (2017). The Care Act (2014) set out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The focus is on personalised and outcome focused care with an emphasis on making adult safeguarding 'personal', Adults should therefore be seen as experts in their own lives and safeguarding means working 'with the adult' and not a process that is done to or for an adult. The Equality Act (2010) replaced several pieces of separate legislation covering discrimination, including the Disability Discrimination Act 2005. The Equality Act 2010 makes provisions for nine protected characteristics, including disability. Discrimination on the basis of one of the protected characteristics is unlawful. The act also states that a person discriminates against a disabled person if they treat that person unfavourably because of something arising in consequence of their disability, and they cannot show that the treatment is a proportionate means of achieving a legitimate aim. Section 20 of the act makes provisions regarding the requirement to make reasonable adjustments for disabled people in relation to services and public functions, premises, work, education and associations, which is imposed in various parts of the act. The Health and Care Act (2022) introduced a requirement that providers registered with the CQC must ensure that each person working for the purpose of regulated activities carried on by them receives training on learning disability and autism which is appropriate to the person's role. As set out in the Health and Care Act (2022), the government was required to publish a Code of Practice to provide guidance about how to meet this legal requirement for training on learning disability and autism which is still awaited and expected in June 2025. This training is widely known as the Oliver McGowan Mandatory Training (OMMT).
1.3	**Safeguarding Children** **Wirral Safeguarding Children Partnership (WSCP)** The WSCP is led by three statutory partners Local Authority (LA), Police, and Cheshire and Merseyside Integrated Care Board (CMICB). Structure can be found in appendix 3. The Trust is represented at various WSCP sub groups meetings which are attended by named professionals for Children and Children Looked After and the Unborn.

The Children Act (1989) and Section 11 of the Children Act (2004) in conjunction with Working Together to Safeguard Children (2018) places a statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of children.

Section 11 audit

The WSCP uses a variety of ways to test the strength of safeguarding arrangements across agencies in Wirral but one of the key ways is using an annual safeguarding audit called the Section 11 Audit (Children Act 2004) and has been reinforced in Working Together to Safeguard Children (2023). Section 11 places duties on organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged with regard to the need to safeguard and promote the welfare of children. It is monitored through the WSCP and provides evidence of effective safeguarding arrangements by demonstrating compliance with relevant legislation, provides evidence of reflective practice, identifies areas of good practice, and highlights organisational development and improvement. These audits are completed by the Named Nurse for Safeguarding Children and Children Looked After.

During Q3 topic 4 of the section 11 Audit Safe and confident workforce was completed, areas to strengthen the processes for DBS (Disclosure and Baring Service) referrals were identified, the disciplinary policy has been redrafted and now also includes referrals to professional bodies and was ratified in Q4.

During Q4 The Senior Recruitment Manager and Recruitment Advisor attended the WSCP Safer Recruitment multiagency training as a request of the Associate Director of Nursing (ADN) for Safeguarding to provide assurance of the Trusts safe recruitment processes within the Trust and that they are aligned to the recommendations of the Bichard Report 2004 (Soham Murders Holly and Jessica). Feedback is awaited and expected during Q1 2025/2026.

Multi Agency Reviews

Multi-agency working and information sharing are key to effective safeguarding and child protection. The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children. Rapid reviews conclude with a decision on whether a local child safeguarding practice review (CSPR) should be commissioned, using the criteria set out in Working Together 2023. Information is collated for reviews by the Named Nurse for Safeguarding Children and Children Looked After on behalf of the Trust.

Intra familial sexual abuse has been identified by one of the CSPRs and the WSCP plan to gather a further understanding of professional knowledge and awareness within this identified area (intra-familial abuse occurs within the family environment – key consideration is whether the abuser feels like a family member from the child's point of view). The WSCP are formulating a survey to be shared with professionals to gather this information.

3 learning reviews have been completed and await multi agency action plans, 3 CSPRs remain ongoing into 2024/25 and a further request for a rapid review was made in 2024/25, action plans and findings will be shared once available through the appropriate governance routes.

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Sudden Unexpected Death in Infancy and Childhood refers to the sudden and unexpected death of a child under 18 years old, where the death was not anticipated 24 hours prior. The SUDIC process is a multi-agency approach to investigating these unexpected deaths. The Safeguarding Team have the responsibility to notify partner agencies of unexpected deaths of children in line with the Pan Merseyside SUDIC joint agency Protocol involved and complete the Child Death Overview Panel (CDOP) notification.

In 2024/25 there were 13 child deaths recorded compared to 19 in the previous year. The table highlights yearly comparisons. Only 5 cases in 2024/25 required management via the via the SUDIC process, 8 child deaths were due to poor health outcomes and or existing medical conditions.

	2022/23	**2023/24**	**2024/25**
SUDIC	7	15	5
MEDICAL CAUSE/REASON	5	4	8

To fulfil the statutory child death duty safeguarding partners have a Child Death CDOP for their area. All deaths are reviewed at CDOP, the CDOP lead represents the Trust at this multi-agency panel. Partners have a statutory duty to record and review child deaths to see if there were any preventable and modifiable factors which we can learn from to prevent similar deaths in the future. The CDOP lead for the trust is Dr Thompson (paediatric) and Dr Twain (neonatal).

Child Protection Information Sharing (CP-IS)

The Child Protection - Information Sharing (CP-IS) is part of the National Care Records Service (NCRS), it is a service that allows health and social care professionals to access and update a range of patient and safeguarding information across regional integrated care system (ICS) boundaries

The service helps health and social care workers share information securely to better protect children and young people who are known to social care because they are; looked after or have a child protection plan. CP-IS links IT systems across health and social care in England to help organisations share information securely.

As it covers 100% of local authorities in England, it's the only national register of social care status, and the only system to provide information when a child is out of area.

Trust Position

- CP-IS compliance is monitored by the divisions and shared with the lead for CP-IS and also as part of the divisional assurance reports quarterly presented at the Safeguarding Assurance Group meeting inclusive of any action plans to address areas of non-compliance. Annual compliance can be located in Appendix 4.
- During Q3 CP-IS was rolled out to the medical assessment areas (Acute Medical Unit, Urgent Medical Assessment Centre and Medical Short Stay Ward) and also to the Surgical Assessment Unit. Further training has also been provided to support data collection moving into 2025/26.
- The Paediatric outpatient department correctly raised 139 discrepancies between CP-IS and Safeguarding flags on patient's electronic medical records, 24 cases

were escalated by the lead for CP-IS to Children's Social care (CSC) to request appropriate safeguarding alert to be added onto the NCRS.

- To support further improvement in compliance of the CP-IS process in maternity (both inpatients/outpatients) the lead for CP-IS provided refresher sessions to matrons and CP-IS champions during Q4. Action plans were requested to monitor and track required actions and improvements into 2025/26.
- CP-IS champions have been identified and attend quarterly meetings chaired by the lead for CP-IS, the forum acts as a conduit to share good practice and discuss and overcome any barriers faced to improve compliance and data collection.

Paediatric themes and trends

- 23,351 children attended the emergency department (ED) during 2024/25 a decrease of 1233 compared to 2023/24. 1947 were 16/17yrs and attended adult ED, 99.7% had their status as a child recognised (until 18th birthday) indicating this practice is well embedded within main ED and staff are using the correct child safeguarding frameworks.
- 642 of those children were open to CSC, 175 via a Child in Need (CiN) plan, 153 via a Child Protection (CP) plan and 314 recorded as being a Child Looked After (CLA). All attendances required relevant information to be shared with partner agencies.
- 694 safeguarding incidents were received which highlighted safeguarding concerns for children, young people and adults with caring responsibility for children. This is a reduction however in line with the reduction in attendances.
- 190 child Multi-Agency Referral (MARs) forms were completed and sent to Integrated Front Door (IFD).
- Children attending with complex mental health/behavioural concerns attending ED in crisis has been identified as an increasing theme this year, during Q4 22 children required a multiagency response for safe discharge. For those children who are CLA or have safeguarding concerns the Named Nurse for Children and CLA has provided oversight and information sharing. 2 children (16/17yrs) were considered under the framework of possible deprivation of liberty, however following legal advice the restrictive practices were not sufficient to warrant review by the Court of Protection.
- Information sharing continues as part of the Multiagency Child Exploitation (CE) meeting where both criminal and sexual exploitation is discussed. 346 cases required information, a small increase from 2023/24. Staff receive CE training as part of mandatory training which includes the use of a CE tool to support staff to understand the risk posed for those children where CE is a concern.
- There is an increase in the number of children attending with assault (170), last year 131. Information is shared via the WSCP Quality Assurance Performance Committee and Harm outside the Home Committee (formerly contextual safeguarding) which is used to understand pattern and trends and dictate required multi agency action. A further breakdown of assaults can be located in Appendix 5.

Substance misuse

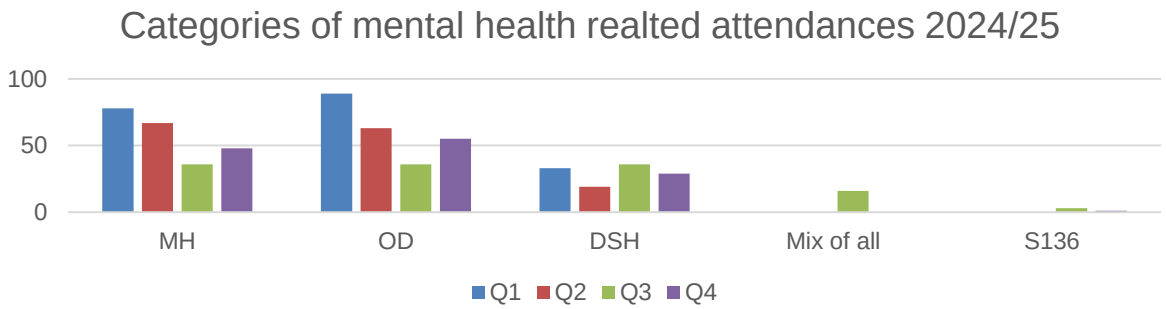
- 129 Children aged 13-17 yrs attended ED with substance misuse identified as the primary cause for admission. This is a 38% (49) increase on 2023/24 data in which 80 children attended, this trend began to increase in the previous 2023/24 (Q4) data 2023/24. Data for 2024/25 can be located in appendix 5.
- Ketamine, alcohol and cannabis continue to raise the most concern and is potentially due to low cost and availability. The mixing of substances continues to cause concern in the 15-17yr age range in which the data suggests this is the

age further experimentation with drugs arise. The health implications of ketamine use remain a concern, to raise awareness with staff Wirral youth drug and alcohol service 'RESPONSE' provided a series of 3 educational sessions for staff, the sessions were a huge success with positive feedback received from all staff who attended.

- There is a process embedded with Cerner Millennium that refers children to 'RESPONSE' when attending with substance misuse. RESPONSE is a confidential service for young people aged 13-19 yrs who offer a wide range of support, covering drugs and alcohol, mental health, homelessness and/or threatened homelessness.

Mental Health

608 children attended ED for mental health, overdose and self-harm related concerns during 2024/25 a similar position to 2023/24. Overdose continues to be the highest theme for mental health attendance. The age range for attendances for overdose is 11 -17 yrs with those aged 15 yrs being the highest attenders for this category.



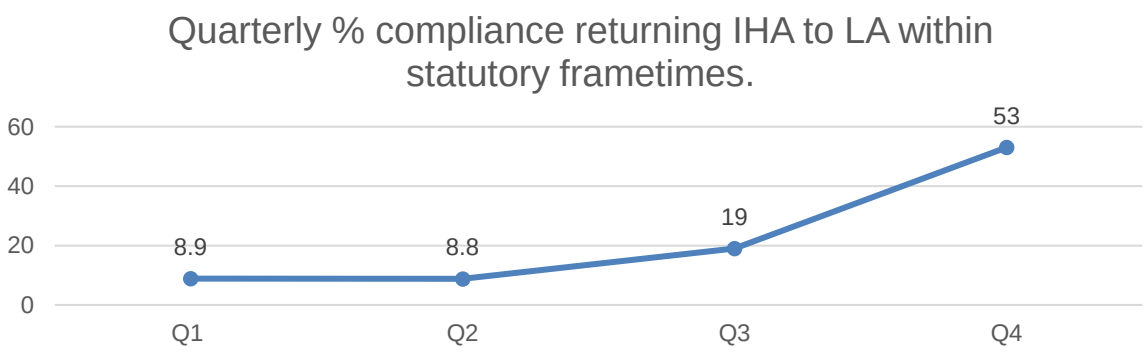
Further mental health workstreams for children are ongoing both internally (Mental Health Transformation Group) and externally including with CSC (Integrated Front Door and Emergency Duty Team), Cheshire and Wirral Partnership (CWP) all with the shared vison to develop standardised processes when a child attends ED on a Section 136 or with mental health concerns.

1.4

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

Children coming into care (known as Children Looked After CLA) must have a statutory Initial Health Assessment (IHA) within 20 working days of becoming a CLA. The Trust are contractually responsible to complete statutory service. Assurance of compliance is monitored via the quarterly Safeguarding Accountability and Assurance Framework (SAAF) data submissions against a set of key performance indicators (KPIs) which cover Adults, Children and CLA.

Trust Position



	• To address the low compliance of statutory completion of IHAs Health and CSC came together and developed a joint IHA tracker, which was rolled out in Q3. Weekly joint meetings are held which promptly address any barriers to completing the IHAs within statutory timeframes. Improvements can be seen following this new collaborative process being initiated in the graph above. • To further support the timely IHA completion a multiagency guidance was developed in Q4, this has been shared with CSC and the Trusts IHA team, this supports all professionals involved to understand what is required including roles and responsibilities of all agencies in regard to IHAs. • Improvements to the quality of IHA completion of coram BAAF forms B (baby) and M (mother) were identified in Q1 through a quality audit completed by the Named Nurse for Children and CLA. Coram BAAF forms B and M are required to provide information on health and behaviors during the neonatal period which inform decisions regarding future placements and positive health outcomes for children. The audit identified no SPOC in health due to a vacancy for completion of these forms which resulted in inconsistent and poor-quality assessments. 2 members of staff have now been identified in the Women and Children division who will complete the forms for Wirral residents who have birthed at the Trust. • Following the implementation of the IHA joint agency tracker as further improvements and timely notifications occur focus will need to consider demand and clinic capacity due to public holidays. The Trust are at risk of losing IHA clinic sessions due to being held on a Monday, this can equate to 7 sessions (each session has 3 slots) which may impact our ability to discharge our statutory responsibilities. • To further streamline this process moving into 2025/26 CSC have been required to provide a generic email address for the sharing of the coram BAAF forms B and M to be shared to once completed. These can then be allocated to the allocated social worker and to the IHA team in preparation of the IHA.
1.5	**Unborn** The Wirral Pre Birth Liaison meeting (PBLM) is a pathway to share information to develop a coordinated plan to safeguard children and unborn babies; this multiagency group is co-chaired by the Trust's Named Midwife. The main purpose is to obtain multiagency information and develop a support plan for the unborn. The threshold and criteria are women who are known to services, for reasons such as safeguarding, mental health issues, substance misuse and those who disclose any form of domestic abuse. **Trust Position** • 141 referrals were submitted for consideration to PBLM by midwives (130 in 2023/24), 116 met the criteria/thresholds to progress (115 in 2022/23). Overall, 161 cases were discussed at the meeting, reflecting that the midwives are highest referrer into PBLM. • The most consistent reasons for referrals into PBLM were previous social care involvement (68) followed by known domestic abuse concerns (21). These reasons remains unchanged from 2023/24 • The Trust completed the 2nd phase of the 'HOPE (Hold on Pain Eases) Boxes' pilot in collaboration with Silver Birch. This focuses on specialised maternal mental health and wellbeing support to support mothers with associated trauma of having their baby removed from their care. The aim of the pilot was developing specific trauma training for professionals regarding parents being separated from their babies at birth. This pilot is in collaboration with midwifery services providing the HOPE boxes and referring the patient to Silver Birch. Feedback from

	Lancaster University Research Team regarding this phase of the HOPE boxes will be shared in 2025/26. • As the Trust had implemented the 'HOPE' project the Named Midwife was invited to develop a short video to showcase the content of the HOPE Boxes and experiences of both families and professionals involved. The video was used as a training tool for organisations across Cheshire and Merseyside to support implementation. • Named Midwife has worked in collaboration with the CSC creating a Pre-Birth tracking system which monitors and provides assurance that all required actions are completed for the unborn. This proactive system supports management of risk and ensures robust plans are in place for when the baby is born. The Pre-Birth Tracker meeting went live in Q1 (April), 104 cases have been discussed during 2024/25. Professionals involved have fedback that they feel this process has resulted in less babies being separated at birth from parents in Wirral and that the process provides the formulation of early robust support plans with parents and professionals alike. • To understand the impact and effectiveness of implementation of the tracker an audit will be completed during 2025/26. • Two requests were received from external agencies (Cheshire East Local Authority and Cumbria Local Authority) to observe Wirral PBLM and share good practice. • As part of the International Clinical Trials Day (20 May 2025) the Named Midwife was invited to share a presentation 'HOPE boxes' as an example demonstrating the breadth of research being conducted within the Trust. • Looking into 2025/26 the Named Midwife begun discussions with external partners to develop a multi-agency pathway to support parents with learning needs who are having a baby. All agencies felt that this was an area which would benefit from such direction and support for parents and professionals alike.
1.6	**Safeguarding Adults** The Care Act (2014) states that adult safeguarding is established as a core function of every LA's care and support system. The Care Act sets out the statutory framework for safeguarding adults. The Care Act (2014) requires each LA to have a Safeguarding Adults Board (SAB) with core membership from the LA, police, NHS, alongside members from other emergency services, probation services and the voluntary sector. One of Safeguarding Adult Partnership Board's key functions is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice. The Wirral Safeguarding Adults Partnership Board (WSAPB) has the primary responsibility to ensure that adults in Wirral, who may be at risk, are able to live fulfilling lives, free from abuse and neglect. The WSAPB has a statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively to safeguard and promote the welfare of adults who live in Wirral (appendix 6. The WSAPB completes much of its work through multi-agency committees who each contribute to completion of the Board's priorities. The Named Nurse for Safeguarding Adults represents the Trust at the 2 permanent subgroups, operational safeguarding group and quality and performance. The subgroups provide partner agencies with the

opportunities to review practice, identify and share good practice and identify improvement areas of weaker practice, to highlight safeguarding priorities and challenge each other to collectively improve arrangements to safeguard adults at risk.

The WSAPB meets quarterly including 2 development days a year with members representatives of agencies across Wirral, including representation from the Trust by the Associate Director of Nursing for Safeguarding.

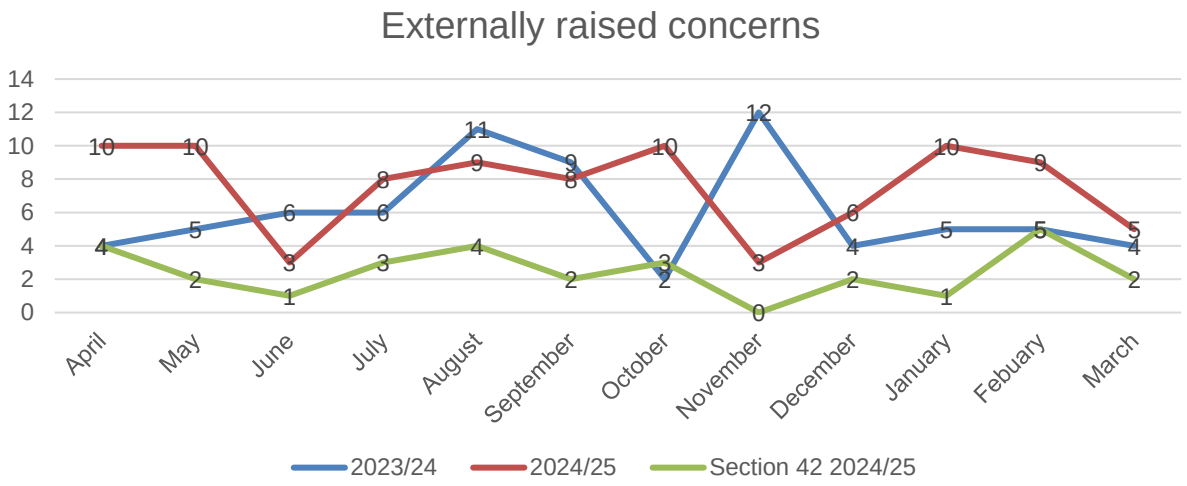
The WSAPB works collaboratively with 3 other adult boards across Merseyside to undertake work in relation to Safeguarding Adult Reviews (SARs). During the annual reporting in the year 2024/25 the Trust were requested to provide information for 7 SAR considerations, 3 of which didn't meet the thresholds for SARS and the remaining 4 cases identified similar themes of self-neglect and discharge related issues and therefore progressed to an overarching SAR of all 4. The Trust continued to support in 3 SARS commissioned in previous years, which have been finalised and the findings have been shared via the Trusts communications bulletin and as part of the Safeguarding Assurance Group (SAG). Findings and learning will be shared across agencies to provide assurance of actions taken to improve practice once finalised during 2025/26, any learning for the Trust will be monitored via the SAG.

Trust Position

- During 2024/25 there has been no legislative changes in policy or guidance in respect of safeguarding adults. The policy is due for review in 2025/26, which will incorporate the revised process for externally raised concerns regarding the hospital aligning with PSIRF (Patient Safety Incident Review Framework).
- The Safeguarding Team received 605 referrals in 2024/25 which remains consistent with previous years. 198 referrals were shared with ASC and 58 were progressed to further statutory section 42 (S42) enquiry.
- The highest cause of concern raised each quarter was consistently neglect. The second highest physical abuse followed by self-neglect and finally financial abuse.
- Professionals were identified as being the highest category of alleged perpetrators of abuse for neglect, family for financial but equal for concerns of physical abuse.
- Compliance of staff following correct policy and procedure when referring an adult at risk into ASC has continued to be monitored throughout the year, there is a requirement to complete both an adult MAR and safeguarding notification form via Ulysses. Quarterly compliance has improved from Q1 (47%) to 60% in Q4. Themes and trends have been identified and divisions are supporting required improvements
- Quality Audits as part of the SAAF audit cycle continue to be completed and is due to be completed Q1 2025/26 with a focus on the quality referrals completed by front line staff into adult social care. Findings will be presented at SAG and also submitted to the CMICB Designated Nurse for Safeguarding Adults, any areas identified as requiring improvements will be monitored through actions plans within identified areas/divisions.
- It is statutory criteria within the Care Act that the adult must always be involved with the enquiry unless exceptional circumstances. An important part of this is 'Making safeguarding personal' (MSP). Gaining consent from the adult, where able, any capacity issues are assessed and if unable to be involved a suitable representative or advocate is appointed. In 2024/25 of the 198 referrals to ASC it was recorded 54% (106) were asked if they consented to be referred to safeguarding however not always recorded their desired outcome. It was not

evident in 14% (28) if consent had been discussed and 32% (64) of referrals involved people who it was reasonable to believe they lacked capacity.

- External concerns raised against the Trust directly from the ASC continue to be managed through the governance divisional leads using the safeguarding rapid review template. Oversight is provided by the Named Nurse for Safeguarding Adults with any learning identified, and subsequent actions monitored by the divisions involved. Themes and trends are reported through the Quality & Patient Safety Intelligence Report feeding into the Patient Safety and Quality Board (PSQB) for wider learning and assurance.
- In 2024/25 91 externally raised concerns against the Trust were received which has increased by 26% (72) from last year. 36 (40%) were closed as initial enquiries following review by the Safeguarding Team with no identified concerns. 26 (29%) were raised as a clinical incident for the appropriate division to review and 28 (31%) progressed to a Statutory S42 enquiry an increase from 14 (19.5%) in 2024/25.



The graph details the number of externally raised concerns in 2024/25 period (Red) compared to the previous 12 months (Blue). The green line is the actual number of concerns which were progressed to a S42 investigation.

- Of the 28 referrals progressed to further statutory S42 investigation, a quarter were found to be unsubstantiated and 11% inconclusive. 36% were substantiated and 21% partially substantiated meaning over half of the reviews completed had some learning identified, actions put in place and monitored by the divisions.
- Themes throughout 2024/25 were aligned to previous years around discharge and/or poor care concerns. Over 50% of S42 concerns were discharge related issues such as package of care provision/arrangements, poor communication and discharge letters which included lack of communication of skin condition and/or wound care advice. 25% were concerns of poor care or acts of omission. Finally, 77% of clinical incidents raised on behalf of ASC were related to discharge issues.
- A review of the process when eternally raised concerns against the Trust has been reviewed jointly by the Named Nurse for Safeguarding Adults and Deputy Director of Governance to align with PSIRF. To be presented and approved at SAG in Q1 2025/26 and a request for the divisional triumvirates to support the rollout of the new process.
- To support the divisions in in improving their awareness of safeguarding incidents, the Named Nurse for Safeguarding Adults the Ulysses - Quality & Safety Analyst to ensure reports can be created through Ulysses. A standard operating

	procedure has also been developed and disseminated to all divisional leads and governance teams. The reports will assist all divisions in providing and monitoring safeguarding performance and addressing areas that require improvement as part of assurance reporting to the SAG.
1.7	**The Mental Capacity Act (2004) and Deprivation of Liberty (2007)** The Mental Capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care, and treatment to people aged 16 and over who live in England and Wales. The five principles of the MCA are: • Assume a person has the capacity to make a decision themselves, unless it's proved otherwise. • Wherever possible, help people to make their own decisions. • Don't treat a person as lacking the capacity to make a decision just because they make an unwise decision. • If you make a decision for someone who doesn't have capacity, it must be in their best interests. • Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms. The MCA allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future. Any individual is deemed to lack capacity to make a decision if they are unable to the following because of an impairment or disturbance of the mind or brain: • Understand the information relevant to the decision • Retain that information • Use or weigh up that information as part of the process of making the decision • Communicate their decision in any means possible The MCA (2005) allows restraint and restrictions to be used – but only if they are in a person's best interests (BI). Extra safeguards are needed if restraint and restrictions are used to deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). In April 2023, the Department of Health and Social Care (DHSC) provided an update that the implementation of Liberty Protection Safeguards would be delayed beyond the life of this Parliament, however feedback will be provided of the consultation by DHSC in due course. In the meantime, DoLS remain an important system for authorising deprivations of liberty, and it is vital that the Trust continues to make applications in line with the MCA 2005 to ensure that the rights of those who may lack the relevant capacity are protected. There continues to be no further updates. The 'Supervisory Body (Adult Social Care) is responsible for assessing and authorising a deprivation of liberty. The Trust as the 'Managing Authority' often need to deprive a person of their liberty before the 'Supervisory Body' can respond to the request, therefore 7-day Urgent authorisations are granted by the frontline staff (Managing Authority) via the Ulysses incident reporting system and can be extended with the agreement of the Supervisory Body.

Trust Position

- There is an identified lead for MCA/DoLS within the Trust who ensures all policies and processes are in place, regularly updating polices in line with legislation and case law ('Role of the Mental Capacity Act 2005 in Acute Healthcare – policy reference 237' and 'Deprivation of Liberty Safeguards – policy reference 217').
- Planned amendments to the electronic MCA/BI templates unfortunately is delayed and expected to be completed during 2025/26. These amendments will ensure that the Trust is aligned to recommendations identified by the supreme court - *A Local Authority v JB* [2021] UKSC 52 which sees a move from the 2-stage assessment to 3 stages introducing 'Causative Nexus' meaning is the person's inability to make the decision because of the identified impairment or disturbance?
- 2739 '7-day Urgent' authorisations and requests for 'Standard Authorisation' were completed by front line staff and were received by the Safeguarding Team during 2024/25 a small increase compared to 2023/24 (2695). 2337 were processed as '7-day urgent' authorisations and requests for 'Standard authorisations' (2248). (see appendix 7 for a breakdown of authorisation and applications that were not processed).
- 282 requests were made to extend the '7-day Urgent' applications for a further 7 days and were granted by the Supervisory Body (Adult Social Care). Only 2 standard authorisation applications were approved and received from the Supervisory Body (both out of area).
- 1610 7-day Urgent authorisations expired during 2024/25 due to the supervisory body not discharging its statutory responsibilities duties authorise the Standard Authorisation in the required timeframes. This results in an unauthorised DoLS with an average of 18.5 days DoLS across 2024/25 and the longest recorded as 167 days. This is a national issue and not specific to the Trust and has been ongoing since 2022/23 which saw an increase of applications to over 300,000, with only 19% of standard applications completed within the statutory 21-day timeframe.
- All DoLS applications submitted to the Safeguarding Team are quality assurance inclusive of MCA and BI. The below chart highlights the compliance percentages for DoLS applications by staff, improvements in compliance are noted.

DoLS application compliance	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**
*RPR details included (NOK details)	61%	61%	66.8%	78.3%	85.3%
*RPR booklet provided	56.4%	57%	59%	68.6%	70.5%
DoLS applications requiring further information	n/a	70%	58%	47.7%	62.7%

*Identification and consent for a Relevant Persons Representative (RPR) and provision of a RPR booklet (statutory obligation) which informs the RPR of their duties/responsibilities.

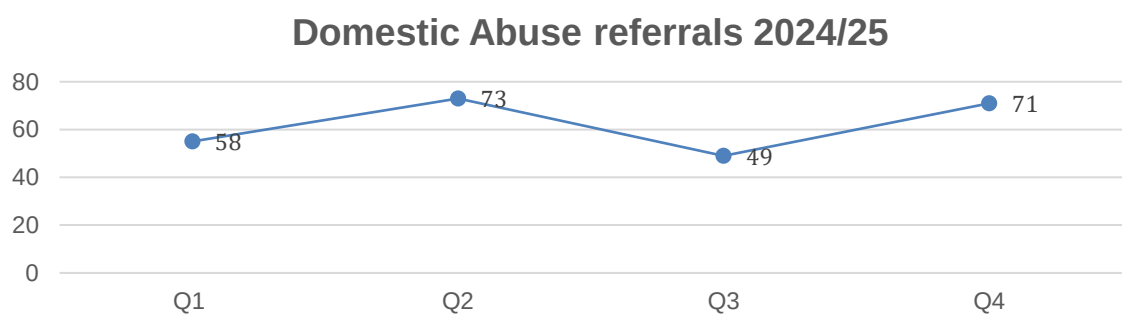
- DoLS applications have been monitored by the Trust since 2023 to understand a position of compliance for timely DoLS applications, there are no known other organisations that monitor this KPI and how that determines the accepted risk as highlighted below:
  - 86.4% (2020) of DoLS were received either within 3 days of admission or when a deprivation of liberty was identified further into the patient's journey in 2023/24, similar to 2023/24 (86.5% - 1946).

- Deep dives are completed for delayed applications and if a valid reason to mitigate the delay is not identified then a clinical incident report is completed for significant delays and learning shared.

- Documentation of restrictive practices was added to Adult Daily Goals to improve monitoring of levels of supervision any restrictions or objections and what legal frameworks are in place. This went live in February 2025 except for Critical Care who await their adjustment to go live in Q1 2025/26.
- Themes and trends continue to be monitored identified during 2024/25 and informs education and training to drive improvements, areas identified can be located in appendix 8. Work streams have already commenced to improve the following areas:
  - Improved compliance with Lasting Power of Attorney (LPA) processes, audit of evidence is part of ward accreditation, LPA question to be added to the electronic BI form as part of required amendments, continued to raise in safeguarding and DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) mandatory training.
  - Raise awareness of requirement to consider MCA assessment completion when patients refuse medications and or interventions. The interim Deputy Medial Director has championed a joint project with pharmacy for refusal of critical medications producing a draft SOP in Q4 that includes medical team expectations for MCA.
    The Lead for MCA has also attended Pharmacy's Learning and Lunch training to present key learning for the administration of critical and covert medications during Q4.
  - The Resuscitation Services Lead is supporting improvements in MCA compliance for DNACPR which is included within DNACPR mandatory training and a specific session designed for medics.
- A wide range of bespoke MCA training sessions and education briefs have been offered and provided throughout the year and various routes highlighting learning from Trust cases, which included - Refusal of medications/treatment and restrictive practices including bed rails, consent, supervision inclusive of documentation requirements.
- Adding to the series of 3 MCA vodcasts commenced in 2023/24 a 2 further vodcasts are in development and are planned to become available early 2025/26. The incentive to use vodcasts are that they not dependent on registration and can be accessed and viewed on phones, computers, or another type of media player at staff convenience which provide staff with a short informative session.
- MCA outside of mandatory training has been included within Impact training (medical division), Core Skills training (newly started CSWs), Wirral Enhanced Preceptorship Programme (new starters RGNs and MWs) and also included within Surgical Training of Positive Practice (surgical division). MCA for discharge training has also been provided to therapists and F1 and 2 medics.
- To strengthen audit outside of the safeguarding team and drive wider improvements across the Trust, questions pertaining MCA have been added to harms audits - Falls Prevention, Nutrition and Hydration, Catheter Insertion Pressure Area Care. Assurances will be provided through the newly formed Fundamentals of Care Group which is due to commence in Q1 2025/26.
- In 2024/25 70 referrals were completed by front line staff to the Advocacy service (N-Compass), 28 of these were appropriate referrals. ASC have the statutory responsibility as the decision maker for decisions regarding change of accommodation, discharge and DoLS related decisions. These referrals are often incorrectly completed by frontline staff and should be completed by ASC.

	Independent Mental Capacity Advocates (IMCA) awareness is audited through WISE accreditation and remains over 90% for knowledge of how to make a referral. To improve the current position for statutory responsibility and appropriate referrals WISE question to be reviewed and updated. • The service level agreement with N-Compass does not include out of area patients therefore, to streamline appropriate Wirral referrals the digital referral form has been amended in Q4 reflecting the criteria. • Policy 'Patients who walk out of Healthcare (previously missing)' was published in Q1 as part of the Right Care Right Person initiative and which also includes the crib sheet and scenarios developed by the lead for MCA and presented at Chief Nurse Check In during Q4.
1.8	**The Counter Terrorism and Security Act (2015)** The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components: • Pursue - to disrupt terrorist activity and stop attacks • Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities • Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack • Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack The NHS and its partners have a role in the 'PREVENT' section of this strategy. The national Prevent data submission moved from the NHS Digital portal to NHS England's Data Collections Framework (DCF) in Q2 of 2024/25. This is to provide a single point of commissioning assurance data between providers, ICBs, regional safeguarding teams and the National Safeguarding Steering Group (NSSG). The submission with continue to be reported quarterly, regarding Prevent training compliance and all submissions have been submitted on time. The Counter Terrorism and Security Act (2015), places a specific duty on statutory bodies including the police, LA's and health organisations to have 'due regard' to help prevent people being drawn into terrorism. The Channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) is a legal requirement for public bodies across the country. **Trust position** • The Trust has a stand-alone policy for PREVENT (reference 305) 'PREVENT Policy and Guidance protecting those who are vulnerable to exploitation and radicalisation through a multi-agency approach' (policy reference 305) which was reviewed and ratified in September 2023. • The police or local authority co-ordinate activity by requesting relevant information from panel partners about a referred person, this information is used to make assessments of the nature and context of the concerns. 32 requests for information were received and returned during the year which has increased from previous years. 11 were regarding children and 21 for adults, 7 of these were for routine 6/12 monthly reviews. • 3 concerns regarding radicalisation were received to the Trust Safeguarding Team by front line practitioners, however after further advice from the PREVENT

	engagement officer 1 did not meet the criteria (extreme ideology) for Channel Panel and 2 were referred to Merseyside police for further consideration. • Quarterly data submissions for Prevent continue, via NHS England's Data Collections Framework (DCF) with oversight from the Chief Nurse. • Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP) training continues as part of all levels of Protecting Vulnerable People (PVP) training. The Department of Health and Social Care has set compliance for Prevent at 85%. Compliance is monitored via PVP through the SAG and PSQB, the Trust finished 2023/24 is a positive position and have achieved compliance for all levels of Prevent training. • In Q1 (May) the Named Nurse for Safeguarding Adults attended the "Combating Extremism in Wirral" conference which gave a deeper understanding of the Extreme Right-Wing, Mixed Unclear and Unstable ideologies, Incel Movement, Islamophobia & Antisemitism. It was confirmed the current threat in Wirral is Right-Wing radicalisation, targeting males aged 15-20. • Following the conference the Named Nurse was invited to join the quarterly Wirral Prevent Strategic Partnership, the purpose of the partnership is to understand local issues and create a Wirral multiagency PREVENT Strategic Partnership Delivery Plan. 3 meetings have been attended during 2024/25.
1.9	**Multi-Agency Public Protection Arrangements (MAPPA)** Multi-Agency Public Protection Arrangements (MAPPA) is a process through which the Police, Probation and Prison Services work together with other agencies to assess and manage the risks posed by individuals convicted of serious violent, sexual and terrorism offences living in the community to protect the public. They were established by the Criminal Justice Act 2003 and are operated locally by 42 Strategic Management Boards across England and Wales. MAPPA are not a statutory body but are a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner by working together, sharing information and joint planning. Agencies at all times retain their full statutory responsibilities and obligations. Professionals assess all MAPPA managed individuals to establish the risk of harm they pose to the public and develop individual risk management plans to minimise those risks. There are four categories of individuals who are managed through MAPPA: **Category 1** - Those subject to notification requirements under Sexual Offences Act 2003. **Category 2** - Those convicted of mainly violent offences who have been sentenced to 12 months or more in custody or to detention in hospital and are now living in the community. **Category 3** - Other dangerous individuals who have committed an offence in the past and are considered to pose a risk of serious harm to the public. **Category 4** - Those subject to notification requirements under the Counter-Terrorism Act 2008 The Trust is classed as a DTC agency (Duty to co-operate) and may have a role to play in protecting the community from the risks presented by individual MAPPA offenders and therefore attend as a core panel member. **Trust Position**

	• During 2023/24 the Trust stopped receiving MAPPA information from Wirral Community Health and Care Trust as a result of ASC reverting back to a single organisation. On discussion with MAPPA Co-ordinator Merseyside its was agreed the Trust would be invited to any cases we have been involved with such as hospital admission. In 2023/24 WUTH were invited to 11 meetings. • Since becoming a core panel member there has been an increase in invitations to MAPPA meetings, during this reporting year members of the safeguarding team have attended 40 MAPPA meetings regarding 17 different individuals. • There has also been an increase in contacts received from probation for those patients attending the Trust who are subject to MAPPA to either share concerns or request confirmation of hospital admission. • Any identified patient subject to MAPPA has a flag applied to their electronic medical record highlighting the level of risk they may pose to staff and/ or the public advising to contact the safeguarding team for further information and if further risk assessments required.
1.10	**The Domestic Abuse Act (2021)** The Domestic Abuse Act (2021) aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. Most of the provisions in the Act will be brought into force by commencement regulations, once the necessary preparatory work has been completed, for example, the making of court rules or the issue of guidance. **Trust Position** • Domestic abuse and harmful practices is included across all levels of PVP training which supports staff in the completion of risk assessing victims of domestic abuse. • The Trust has 2 policies in place; 1 to support staff with patients and 1 for support for staff that may experience domestic abuse: ➢ Domestic Violence and Abuse policy reference 035 ➢ Domestic Abuse Workplace Policy: Support for Staff policy reference 344 • The Trust has an identified lead for Domestic Abuse and Harmful Practices (Named Midwife for Unborn) and supports both patients and staff following any disclosures or concerns. • In 2024/25 the Safeguarding Team received 248 referrals (a slight decrease relating to domestic abuse in comparison to 252 in 2023/24.  • In 2024/25 10 members of staff were supported by the Safeguarding Team following disclosures of domestic abuse which was an increase in comparison to 4 staff members in 2023/24.

- The domestic abuse routine enquiry questions were embedded within Cerner in 2019/20, prompting all patients 16yrs and above to be given the opportunity to disclose concerns to staff. Compliance of this question is monitored through daily IT reports and using the WISE audit programme. Compliance within ED continues to require improvement and is monitored by the division and reported into the SAG. There has been minimal improvement throughout the last two years and a request for an improvement plan has been made to the division to ensure that this action is met and maintained during 2025/26.
- The domestic abuse CAADA-DASH risk assessment is embedded within Cerner supporting practitioners to identify high risk cases of domestic abuse, stalking and honour- based violence. This assessment assists decision making of identifying high risk cases requiring referral to MARAC (Multi Agency Risk Assessment Committee) and enables support mechanisms to be identified. The Trust have referred 25 cases of high-risk domestic abuse victims into MARAC in 2024/25.This is a decrease from 36 cases in 2023/24.
- The Trust has contributed towards 1 new Domestic Abuse Related Death Reviews (DARDR) in Wirral. Reviews are first discussed at a consideration panel to determine if the concerns met threshold for a full review. The reviews await approval from the Home Office and publication, identified learning specific to the Trust will be shared, implemented and monitored through the SAG and mandatory/bespoke training. The domestic abuse lead has attended 2 DARDR review meetings for cases opened in 2023/24 and continued to be reviewed into 2024/25.
- The Trust supported the Domestic Abuse Alliance and Violence Against Women and Girls (VAWG) strategy and actively promoted the 16 Days of Action in 2024/25. This included having a commissioned mural donated by local business to showcase that the Trust supports any persons requiring support relating to domestic abuse and is displayed within the Trust.

Harmful Practices

Harmful traditional practices are forms of violence which have been committed, primarily against women and girls, in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice. They have often been embedded in communities for a long time and are born out of community pressure. The most common forms of Harmful Practices are:

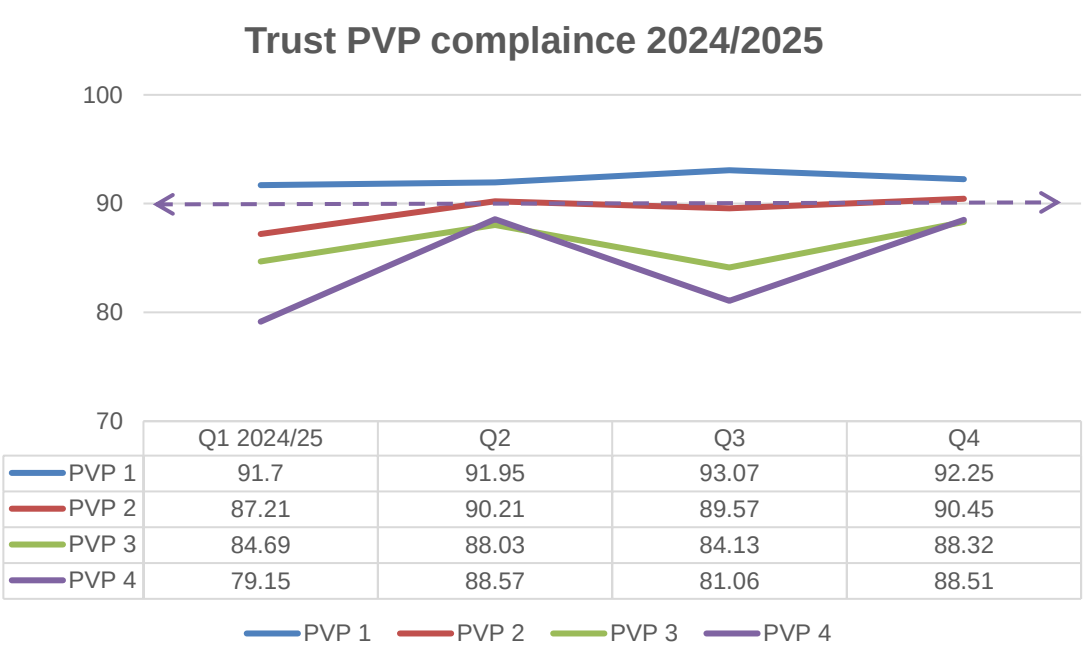
- forced or early marriage
- so called ‘honour’ based violence
- female genital mutilation or cutting (FGM).

Trust Position

- 21 referrals relating to identified cases of FGM were received throughout the year, 13 were identified by midwifery services at the point of women booking into midwifery care and 8 were identified through gynecology services. This is a slight decrease from 2023/24 (25).
- The Urology department have now completed the implementation of the FGM routine enquiry questions within the suggested specific area within Urology. The Urology team will be completing quarterly audits regarding the compliance of staff asking the FGM routine enquiry questions. This will be monitored through SAG.
- No referrals have been received for harmful practices outside of FGM during the year.

1.11	**People in Positions of Trust (PiPOT) (Staff allegations)** All incidents or allegations of abuse are taken seriously by the Trust and are treated in accordance with WSCP and WSAPB procedures. Allegations against staff are raised to the Safeguarding Team following the People in Positions of Trust (PiPOT) policy and process. Allegations that do not require safeguarding involvement are managed via the divisions and Human Resources (HR). Regular bi-weekly meetings are held with HR and Risk Manager monitor progress of any cases to ensure all required actions have been completed. **Trust position** • 88 staff allegations were received during 2024/25, an increase of 20 compared to 2023/24. • Any allegations requiring safeguarding reporting processes to be initiated are also reported to the Designated Nurse/Professional Lead for Adults/Children and to the Local Authority Designated Officer (LADO) for children's concerns. • Staff allegations data and information is reported via the Quality and Patient Safety Intelligence Report into PSQB and SAG for wider learning and assurance. • The divisions are responsible for the Management and coordination of staff allegations whereby Safeguarding are invited to each fact find as part of the membership to determine if the PiPOT criteria is met and initiate any required safeguarding actions. This is audited yearly by the Associate Director of Nursing for Safeguarding for compliance and any areas requiring improvements are shared with the divisions and monitored via the Safeguarding Assurance Group. Audit findings completed in Q1 for 2024/25 identified improvements required to meet time frames of completing fact finds and timely recording of minutes, actions plans were approved by the divisions and monitored at SAG.

2	**Protecting Vulnerable People Mandatory Training (PVP)**
	The Trusts PVP Strategy outlines the pathway for staff to access appropriate safeguarding education relevant to their role and competencies required written within the legislative framework and which reflects the findings and recommendations from the Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document (2014) and the Safeguarding Adults: roles and competencies for health care staff Intercollegiate document (2018). **Trust Position** • PVP training level 1-3 is delivered through an eLearning package and the additional hours aspects of level 3 requirements set out in the safeguarding Intercollegiate documents is delivered as a face-to-face package (including Prevent, MCA and DoLS). • The Trust did not reach the mandatory training compliance target of 90% for PVP by the end of the year 2023/24 for levels 3-4 however finished in an improved position from Q1 and can be seen in the graph below. • Divisionally 13 areas are noted to have achieved compliance at the close of 2024/25, divisional compliance can be seen in the chart below:



Divisional position – Q4 2024/25

Division	PVP 1	PVP 2	PVP 3	PVP 4
Acute	89.29	66.67	100	81.03
Surgery	90.24	90.77	89.57	93.94
Women's & Children	82.83	86.99	88.52	92.39
Medicine	90.97	89.27	87.76	86.15
Diagnostics & Clinical Support	90.98	93.59	90.00	N/a
Corporate	93.98	94.20	75.00	100
Estates & Facilities	94.06	75.86	N/a	N/a

- Throughout the year visibility and bespoke training has continued to multiple departments and wards. Bespoke sessions are implemented for various reasons such as identified learning from incidents, lessons learnt following multi agency reviews, following WISE audit or requests made from managers largely in relation to Mental Capacity Act.
- Assurance of safeguarding knowledge is monitored through WISE. 31 clinical areas have been audited during 2024/25 and the provision of bespoke training is completed in areas identified as requiring improvement. The average score for all audits completed during this period is 88%, it is important to highlight that compliance of PVP has impacted on overall scores.
- Other areas identified as requiring improvement included actions to take following a disclosure of domestic abuse, who to contact both in and out of hours (with out of hours being the biggest lack in knowledge) and awareness of the threshold levels for referrals into Children's Social Care when safeguarding concerns have been identified. The Acute division have good awareness, the areas requiring further improvement are mainly within medicine and surgery.
- In May 2024 NHS England shared a mandate to reform statutory and mandatory training and the requirement to:
  - align to Core Skills Training Framework (CSTF).
  - adopt eLearning for Health Care content as set out in the planning guidance.

	Work throughout the year has included an agreed memorandum of understanding for staff to be signed off as compliant for safeguarding training (Trust PVP) if evidence of national package training and competencies can be provided and completion of a TNA analysis. The Associate Director of Nursing for Safeguarding continues to support this mandate and is engaging with the learning and Development Manager via the Trusts Subject Matter Experts Network Group. This project is not expected to complete until October 2025.

3	Governance Arrangements for Safeguarding
3.1	**Safeguarding Assurance Group (SAG) and Patient Safety and Quality Board (PSQB)** The SAG provides opportunity for challenge and assurance regarding safeguarding arrangements within the Trust, monitor compliance and benchmarking with external standards, clinical effectiveness indicators including CQC outcomes and addresses any areas requiring improvement. The SAG meets quarterly which allows for a defined and joint approach to safeguarding across all divisions within the Trust. The group is chaired by the Deputy Chief Nurse and has divisional representation alongside the named/lead professionals from the Safeguarding Team. SAG agenda includes the compliance with safeguarding standards, including the SAAF and mandatory safeguarding training compliance. The Associate Director of Nursing for Safeguarding provides a quarterly report into the SAG along with assurances from the divisions and then in turn a chairs report the PSQB and yearly annual report. Trust Governance structure arrangements are detailed in appendix 9. **Trust Position** • 4 SAG meetings were held during 2024/25 and subsequent chair's reports shared with PSQB by way of assurance and any required escalation.
3.2	**Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults and NHS England's Data Collections Framework (DCF) for Prevent, Children Looked After and the Safeguarding Commissioning Assurance Toolkit (SCAT).** The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB. The Cheshire and Merseyside SAAF commissioning standards support a consistent approach to quality assurance.

	Compliance of the SAAF is monitored via the SAG and any areas of non-compliance are escalated when required to the PSQB. During Q3 (October) quarterly submissions began to NHS England's Data Collections Framework (DCF) for Prevent, Children Looked After and the Safeguarding Commissioning Assurance Toolkit (SCAT). The Trust is complaint with 26/28 standards, subsequent action plan in place to address identified gaps of training and Patient Engagement was completed and monitored at SAG. Detail for identified gaps can be seen below. A2 Training A2.1 We have a safeguarding training strategy which underpins the safeguarding intercollegiate documents and relevant national guidance, which covers all staff, volunteers and external contractors. Current TNA does not include external contractors, In Q4 the policy was updated with agreed narrative regarding DBS and Safeguarding training for contractors and induction content provided to address this gap. A new TNA and strategy has commenced to include contractors and is being developed in line with the CSTF project. A6 Patient Engagement A6.1 We have appropriate and accessible information about our safeguarding duties and provide this for our population. Accessible information standards (AIS) remain a Trust wide issue, and the Associate Director of Nursing for Safeguarding has requested for this to be discussed at the next Patient Experience Group in Q1. VIP celebrity and representative policy 302 was highlighted by the Associate Director of Nursing for Safeguarding as part of the above SCAT to have areas to be reviewed in terms of strengthening processes and monitoring of visitors on site. Initial discussions held with Head for Communications and Director of Corporate Affairs regarding the inclusion of a visitor event record agreed and policy is also due a review April 2025, safeguarding to have stakeholder input.
3.3	**Safeguarding Incident Reporting** Safeguarding incident notifications are integrated into the Trust's Safeguard database to record all safeguarding incidents both internally and externally. Following receipt of the incident documentation received by the safeguarding team, it is recorded in Cerner to ensure all staff has access to all safeguarding information. The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS). Any alerts required are escalated to CMICB and the CQC as required. The Associate Director Nursing for Safeguarding or a deputy attends the weekly Trust's PSIRF meetings to provide safeguarding and MCA (2005) expertise, advice and overview of incidents presented. Clinical incident forms are completed by the safeguarding team for any concerns that do not meet the thresholds for statutory safeguarding investigations directly to the divisions to investigate and review for any potential gaps in processes outside of safeguarding.
3.4	**Safeguarding Supervision and Support** Safeguarding supervision is a term used to describe a formal practice of professional support and learning which enables individual practitioners to develop knowledge and

competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations.

There are 2 mechanisms for safeguarding supervision:

- Advice on individual case management
- Ensuring that those working with cases with safeguarding issues have sufficient knowledge, skills, and appropriate attitude.

The requirement for Trust employees to have access to safeguarding supervision is explicitly stated in Working Together to Safeguard Children (2018): *"Effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family."*

The Care Act (2014) dictates the requirement for safeguarding supervision: *"Skilled and knowledgeable supervision focused on outcomes for adults is critical in safeguarding work. Managers have a central role in ensuring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available."*

Trust Position

- Safeguarding supervision is provided to all health practitioners who case hold safeguarding cases.
- Safeguarding Supervision Policy – policy reference 247 is in place, review was completed in Q4 and will be next due in December 2027.
- In line with recommendations from The Care Act (2014) safeguarding supervision sessions continue to be delivered via monthly drop-in sessions within the ED. This allows staff opportunity to access supervision for both adults and children. Records of supervision are recorded and kept securely by the safeguarding supervisors on a case-by-case basis.
- The safeguarding team use these opportunities to also educate staff, discuss safeguarding processes and promote training, CP-IS and domestic abuse questions.
- Opportunities for group safeguarding supervision is provided through the ED Paediatrics and Women's and Children's peer review which continue to be delivered on a quarterly basis to share learning and identify how to improve practice. Therse are also attended by the Named Nurse for Safeguarding Children and CLA.
- The Trust Named professionals all access safeguarding supervision from Designated professionals and are 100% compliant with the agreed KPIs of the agreed SAAF.
- Since 2023/24 the Women and Children's division have maintained the management and responsibility in providing assurance regarding the compliance of safeguarding supervision for the division. This is reported at the SAG via divisional assurance report. Safeguarding supervision has been redistributed to now include the newly trained supervisors within the division from April 2025 as an area highlighted as requiring further improvement to meet the required compliance**.** The safeguarding team have a caseload of 30 members of staff within the women's and children's division that they provide supervision for.

4	**Complex Care**
	Following the decision to combine the role of the Safeguarding Adults Practitioner and the Complex Care role vacancies at the end of 2023/24 the posts were successfully advertised (Q1) and successfully appointed 1 Registered Nurse Learning Disabilities and 1 Registered General Nurse who commenced in Q2 and Q3. This incentive provides the Trust with a more flexible service which is hoped to benefit the patients within our care. Complex Care within Wirral University Teaching Hospital includes LD, ASD and MND. The Safeguarding and Complex Care Practitioners form part of the Trusts wider all age Safeguarding Team and their dual role support patients, families, carers and specialist teams during our patients journey through the hospital. They can support links with departments to consider reasonable adjustments, advice on support provision to deliver person centered care and the use of resources such as the Hospital Passports. This may include working closely with multi-agency partners including the Local Authority and Community Learning Disability services. Support for patients and staff also includes: • Mental Capacity Act 2005 advice and support • Liaise with community teams to support patients care requirements for complex cases to overcome barriers such as prolonged discharge. • Support and advice with admission avoidance planning. • Involvement with disputes where local resolution cannot be resolved. • Specialist advice to support complaint responses **Trust position** • As part of the Learning Disability week 17 – 23rd June 'Do you see me?' the newly appointed practitioners complied one-page profiles which were shared internally and externally to raise awareness and celebrate the new appointments to the Trust. The promotion of health and carer passports was also supported in collaboration with Wirral Mencap who engaged with our staff to complete a survey to understand their awareness of a variety of passports and how these can be used to support positive experiences and patient centered care. • The Named Nurse for Safeguarding Adults and lead for Complex Care was proud to launch the sensory care bag initiative and collaborated closely with Wirral Autism Together, Wirral Mencap, and Healthwatch Wirral to develop the idea. The initiative was launched during Learning Disability Week, with the new bags distributed to ED and other admission unit staff, ready to assist patients when needed and enhance patient experience. The initiative has received positive feedback and was featured in a local newspaper which attracted other organisations to enquire into the project. • As part of the Patient Experience Strategy and the promise groups the Trust supported a coproduction with Mencap of an orientation/awareness needle phobia video which can also be used as a desensitisation tool. The production of this video was a direct response to the request from Mencap which meet the AIS and also featured 5 experts with lived experience to make the video more relatable to patients. The video is available on the Trusts patient/visitor's intranet page and has received positive feedback. • As a key stakeholder the safeguarding and complex care team were asked to contribute thoughts into an easy read and desensitisation project as part of the breast awareness campaign led by the Breast Clinic to encourage patients with a LD to come for screening. The easy read breast information is available for patients within the breast clinic at the Clatterbridge site.

- Professional relationships have begun to be reinvigorated with the Cheshire and Wirral Partnership (CWP) Community LD Team and the Trust Safeguarding and Complex Care Team, a local network meeting has been created which focuses on how improvements across both services can be made for our patients to improve patient experience.

Oliver McGowan Mandatory Training (OMMT)

Learning disability (LD) and autism training became a legal requirement for CQC regulated service providers which came into force on 1 July 2022 (Health and Social Care Act 2022).

The OMMT on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff.

The training is named after Oliver McGowan, a young man whose death shone a light on the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability.

OMMT is delivered in 2 tiers 1 and 2, all staff regardless of tier are required to complete a 90-minute eLearning module (part). There is a requirement for staff to then complete part B dependent on roles and responsibilities either Tier 1 – and hour webinar or Tier 2 full day face to face training.

Trust position

- The eLearning aspects (part A) of OMMT for all staff were agreed at the Workforce Steering Board (Q1) and rollout to the wider organisation began in August (Q2).
- The ADN Safeguarding and Chief Nurse have begun to review and consider the next steps required for OMMT (part B) mandatory training in line with the NHSE request to achieve 30% per year trajectory. Costing have been requested from the Trusts finance team and then this will be presented to the Executive Board for a decision once complete in 2025/26.
- Following the roll out of OMMT in August 2024 the Trust position of compliance at the end of Q4 was 67.44% equating to 4198 trained staff.
- There is a Trust risk to monitor and track progress on the OMMT (Trust risk 1366).

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

LeDeR is a service improvement programme for people with a learning disability and more recently autistic people. It was established in 2017 and is funded by NHS England and NHS Improvement.

The Objectives of LeDeR are to: Improve care for people with a learning disability and/or autism. Reduce health inequalities for people with a learning disability and autistic people. Prevent people with a learning disability and autistic people from early deaths.

A LeDeR review looks at key episodes of health and social care provision the person received that may have been relevant to their overall health outcomes. The reviewers look for areas that need improvement and areas of good practice.

LeDeR complete 2 types of reviews:

- Initial Review **-** completed for all deaths notified to the LeDeR programme for people with a learning disability or a diagnosis of autism. It comprises GP records, family and multi-agency consultation and a review of the hospital mortality review

	where applicable. This review identified if there is a need for more in-depth focus review. ➢ Focus Review - focused review builds on the initial review requiring more detailed information about known health and social care involvement. Focus reviews will be undertaken when it is indicated there is learning from the life of the person to inform service improvements. All autism only reported deaths will automatically have a focused review. The Trust is requested by LeDeR to provide a structured review of care during their admission leading to their death usually via a Structured Judgement Review (SJR) form. During 2024/25 the process for completing SJRs was strengthened to include both nursing and medial oversight, previously only review completed from a nursing perspective. In 2024/25 the Named Nurse for Safeguarding Adults reviewed and amended the SJR template aligning to the LeDeR requirements, this has been shared with the Cheshire and Merseyside LeDeR team and approved to be used going forward. In 2024/25 CMICB LeDeR have invited organisations to quarterly forums to share wider learning however 2 have been cancelled by LeDeR. LeDeR remain to be working behind on expected timescales to provide timely learning and feedback despite developing a work plan. **Trust position** • The Trusts Bi-Portal creates a monthly report of any deaths involving patients who have a flag for LD this prompts the completion of LeDeR death notification by the Safeguarding Team. This reported 7 deaths through 2024/25. However, there were 12 reported deaths in hospital of patients with a diagnosis of LD, not all patients with a diagnosis of LD have a flag in place as primary care has not notified the Trust of diagnosis. Further work is required to include diagnosis of Autism within the Bi-Portal reporting system and to improve information sharing from primary care. • The Mortality Review Group (MRG) sent 9 requests for reviews to be completed in 2024/25 however there were 12 mortality reviews completed by Named Nurse some from previous year, all of which have been presented in MRG. 6 graded 0- no care issues or learning, 5 graded 1- care issues where learning identified but would not have affected the outcome and 1 was graded 2 care issues which may have affected outcome, and a request made for further review. Themes included MCA processes not being followed for invasive procedures, delay in DNACPR consideration and poor communication and documentation. All identified learning has been shared with divisions involved and the wider Trust where to support improvements in practice.

5	Looking forwards into 2025/2026
	Safeguarding remains a priority area of work for the Trust and this section defines the priorities and work plan within safeguarding as we move forward into 2025/26. The safeguarding key priorities and aims related to the Trusts workforce are: • Following addition of CP-IS checks to assessment areas to continue to improve and achieve further the Trust position across all divisions with the support for the CP-IS Champions and embed in outstanding areas. • To further strengthen the position for the completion of statutory Initial Health Assessments (IHAs) following the implementation of the joint tracker, areas of focus will be audit to direct improvements and address barriers, review demand for clinic capacity and completion of the coram BAAF form B and M. • In terms of Pre-Birth Liaison complete an audit to understand the impact and effectiveness of the system, to understand if this reflects the feedback provided and how this demonstrates positive outcome for mothers and babies. • Develop the multi-agency pathway for supporting parents with additional learning needs who are accessing midwifery services. • Alignment to PSIRF for safeguarding investigations when raised externally to ensure that reviews are completed consistently inline with the framework and governance processes. • Embed the required amendments to the MCA/BI templates to ensure that the Trust is compliant with most recent case law recommendations in the completion of legislative practices for MCA. (delayed from 2024/25) • Continue to drive the importance of MCA knowledge and how this is embedded in practice, these will be driven through engagement at trust wide learning opportunities and collaboration with areas and leads throughout the trust. • To improve compliance of the domestic abuse routine enquiry question being asked in ED as a direction of the Domestic Abuse Act (2022). (outstanding 2024/25). • Adopt the eLearning for health Core Skills National Framework to replace bespoke Protecting Vulnerable People Mandatory Training due to be completed by October 2025. • Increase the compliance of safeguarding supervision within the Women's and Children's division following newly trained supervisors and redistribution caseloads. • Identify a method of delivery for training for learning disabilities and or autism and develop training plan. • Further development of the complex care team and operational flows to reduce health inequalities and provision of person-centered care i.e., flagging, reasonable adjustments.

6	Conclusion and Recommendations
	The Wirral University Teaching Hospital Safeguarding and Complex Care Team is dedicated to ensuring the Trust fulfils its duties and responsibilities regarding safeguarding and Complex Care. The team adopts a whole-systems approach, working together with our multiagency partners. This annual report reflects safe and effective practices in line with our statutory and regulatory obligations, demonstrating overall strong compliance but also the ability to recognise areas that require further strengthening and improvements.

	Moving forward, the team will continue to build upon existing initiatives and identify key priorities into 2025/26 to ensure that processes remain robust, effective, and aligned with the core values of the Trust. The underpinning message, however, remains the same in that it is everyone's responsibility to safeguard and protect the most vulnerable people in our society at must remain at the center and be the motivation of our actions. It is recommended that PSQB note the assurance provided within the Safeguarding and Complex Care Annual Report and the actions being taken to rectify the areas for improvement. Recognition is given to the hard work and commitment of the safeguarding team and all Trust staff who work tirelessly in ensuring, 'Safeguarding is Everyone Business'.

Appendix 1
Definitions

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

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

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

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

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

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

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

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

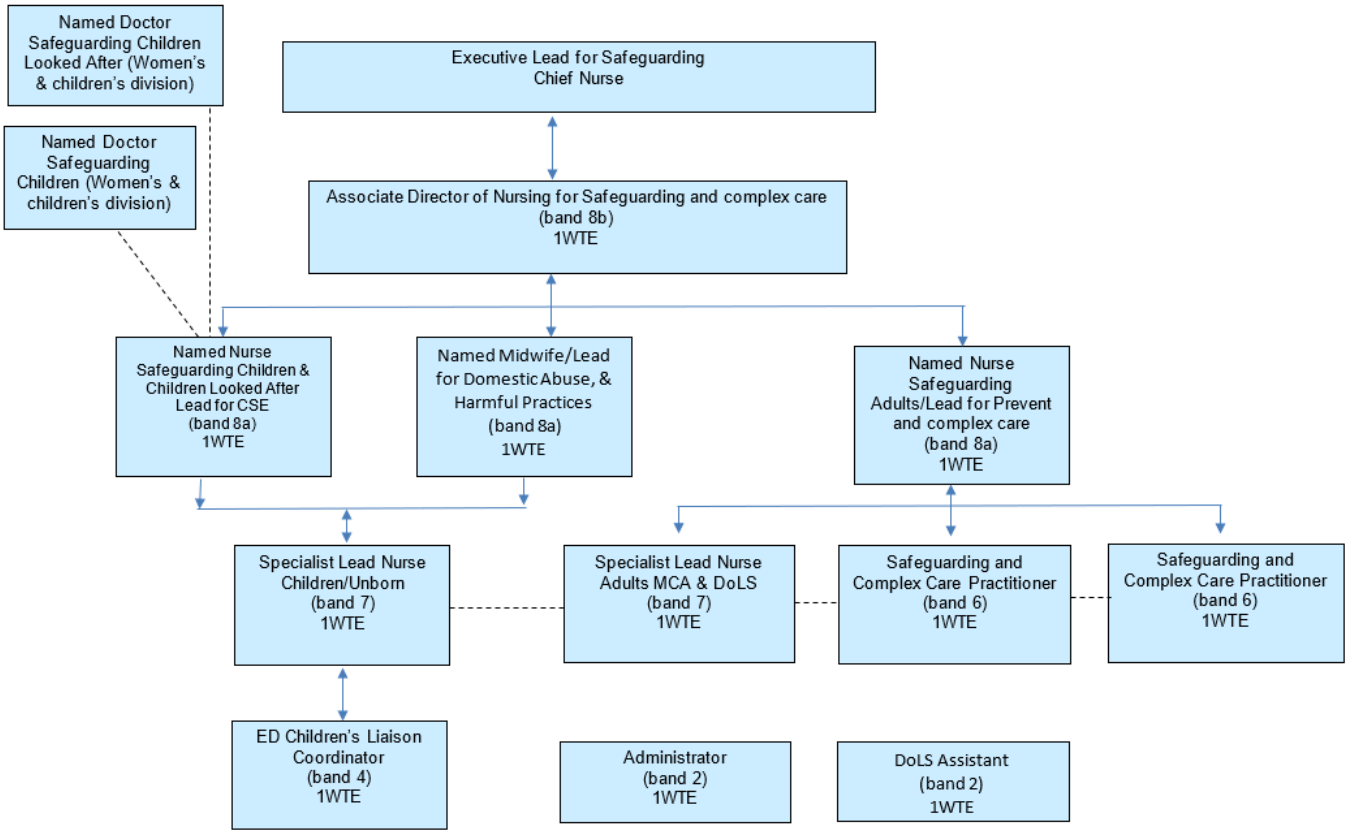
Named Professionals.

Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

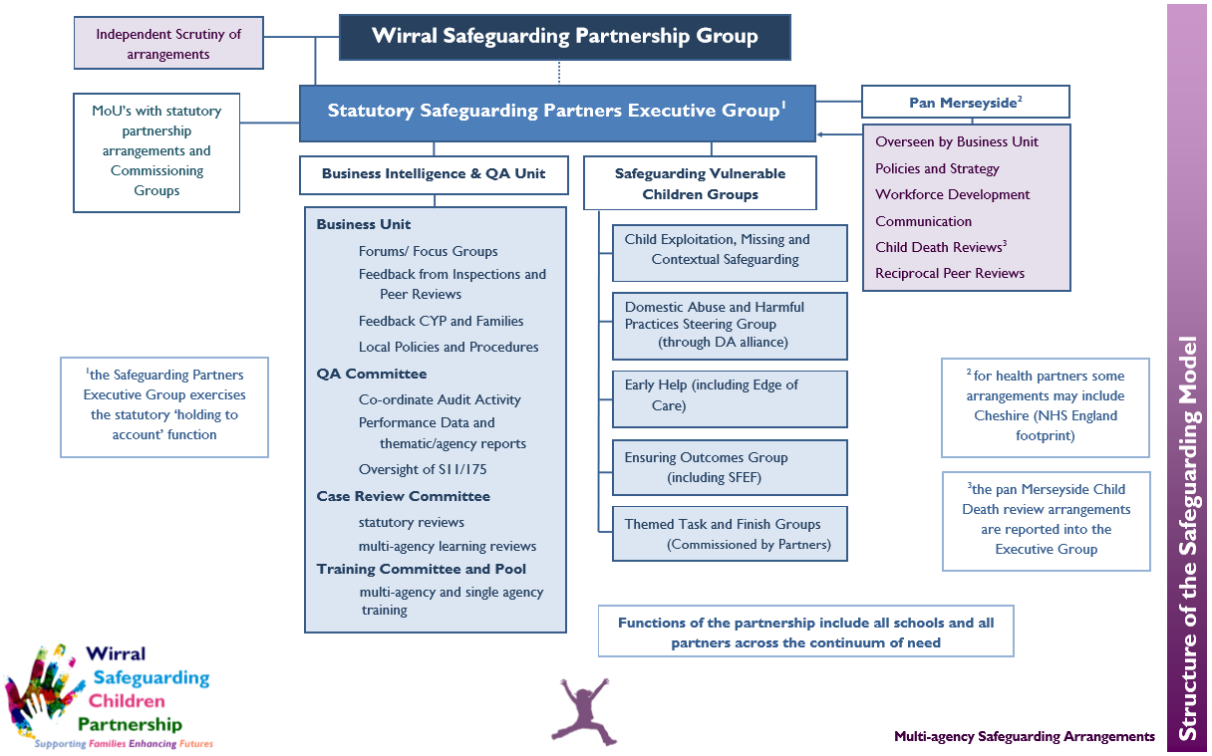
All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their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

From April 2022 - March 2023 the WUTH named professionals were:
- Named Doctor for Children and Young People – Dr Lauren Edwards
- Named Doctor for Children Looked After – Dr Halycon Royden
- Named Nurse for Children and Children Looked After – Nicola Denton
- Named Professional (Nurse) for Adults – Helen Newell
- Named Midwife – Michelle Beales-Shaw

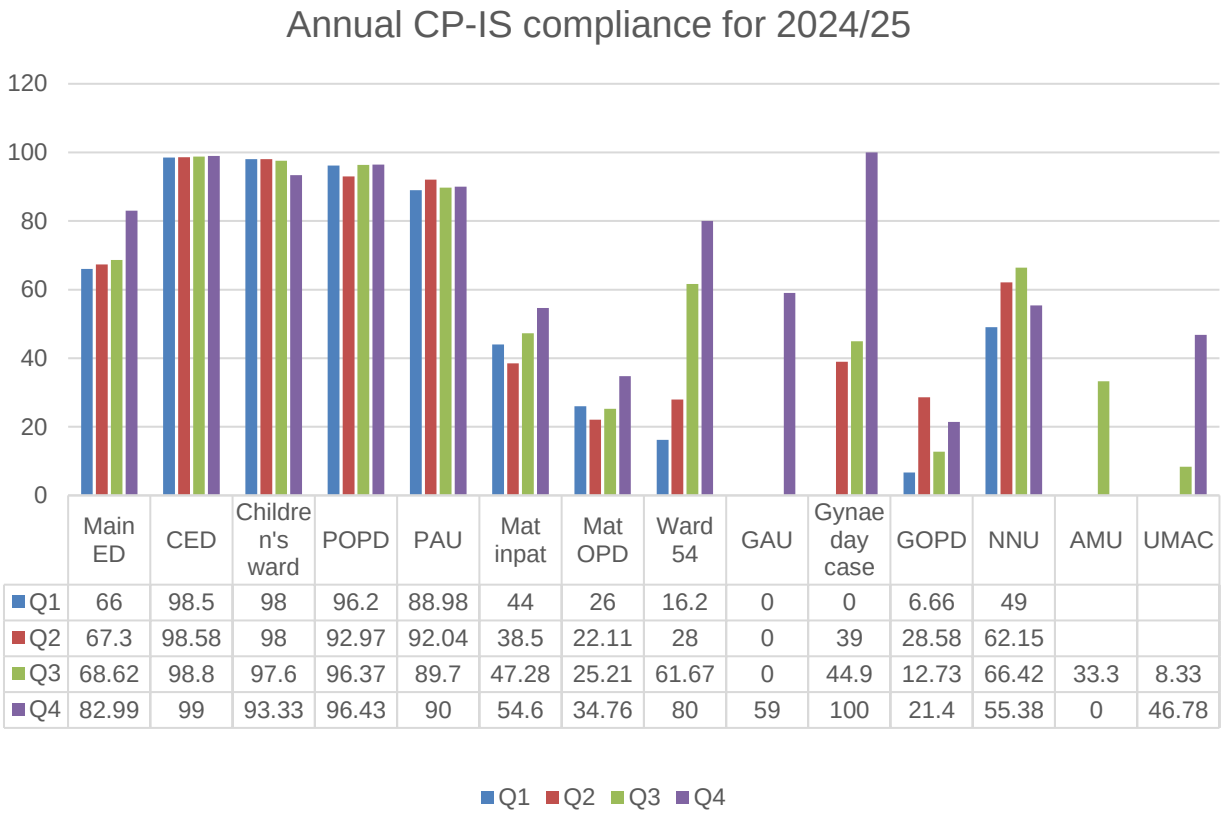
Appendix 2
Safeguarding Structure



Appendix 3
Wirral Safeguarding Children Partnership Structure



Appendix 4
Annual CP-IS data



	Main ED	CED	Children's ward	POPD	PAU	Mat inpat	Mat OPD	Ward 54	GAU	Gynae day case	GOPD	NNU	AMU	UMAC
Q1	66	98.5	98	96.2	88.98	44	26	16.2	0	0	6.66	49		
Q2	67.3	98.58	98	92.97	92.04	38.5	22.11	28	0	39	28.58	62.15		
Q3	68.62	98.8	97.6	96.37	89.7	47.28	25.21	61.67	0	44.9	12.73	66.42	33.3	8.33
Q4	82.99	99	93.33	96.43	90	54.6	34.76	80	59	100	21.4	55.38	0	46.78

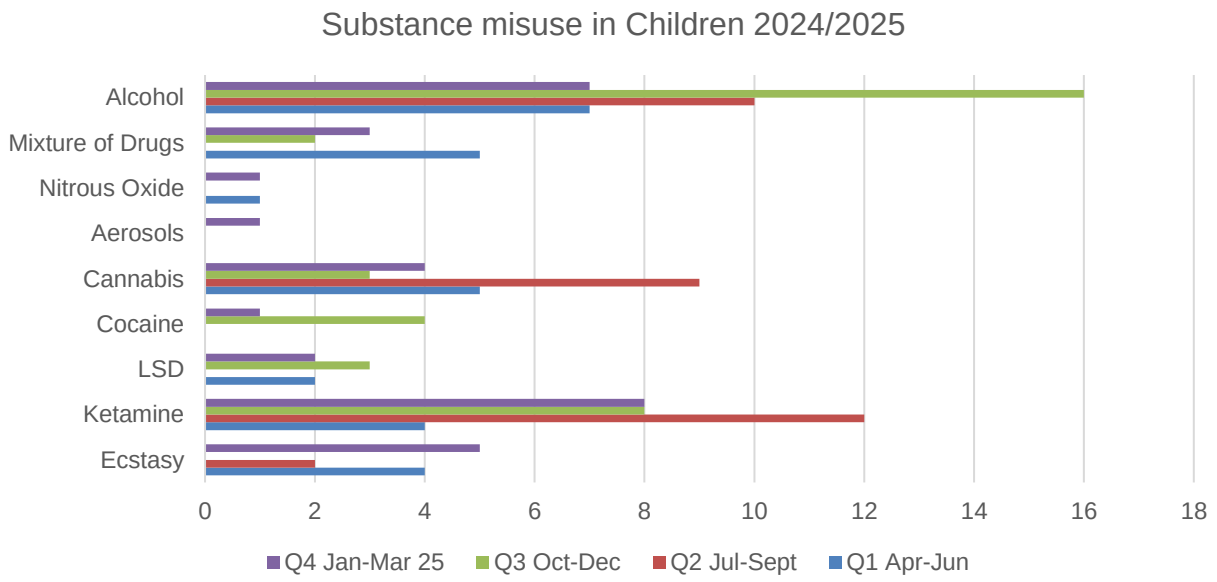
***** AMU - data not recorded for Q4 due no attendances of 16-17yr cohort.
****** GAU – zero returns for Q1-3.

Appendix 5
Children and Young People Themes and Trends

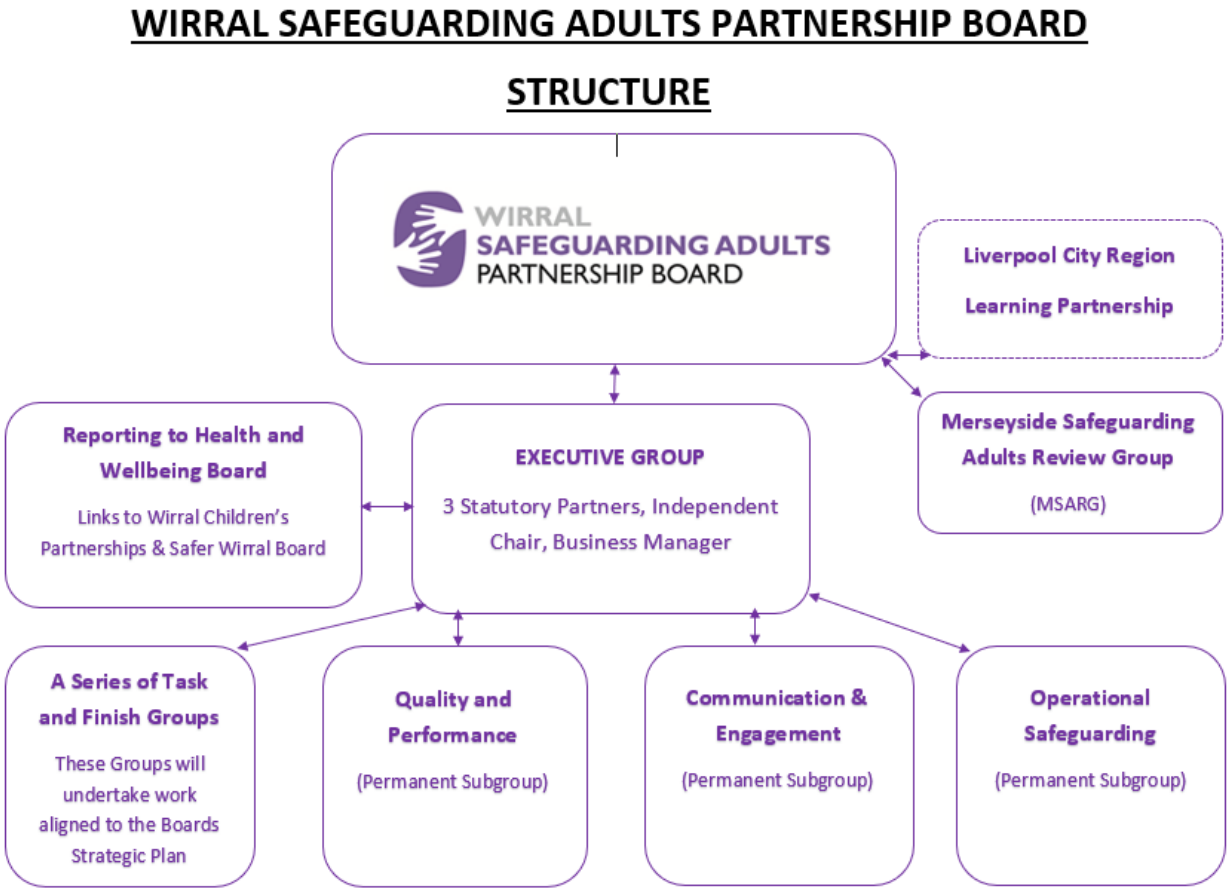
Assault

- 127 were male with 43 attendances being female. This is a 27% (34) increase of attendances by males for assault with a 35% (6) increase in females. As reported in 2023/24 there had been a total 12 cases in which a weapon was used, in which a knife/machete was the most used weapon. In 2024/25 there has also been 14 occasions in which a weapon was used but again the use of a knife/sharp/bladed instrument occurred in 5 occasions.
- A theme noted in Q4 was 5 cases in which children had been "choked/tap out" due to a social media trend on TikTok. The sharing of this data led to a joint notification with health and WSCP in which an alert explaining what was involved and the risks was produced and shared with all agencies and released via social media.
- Of the 170 children who attended for assault 19 open to children's social care 2 open Child in Need, 8 on a child protection plan and 9 children looked after.

Substance misuse



Appendix 6
Wirral Safeguarding Adults Partnership Board – Structure

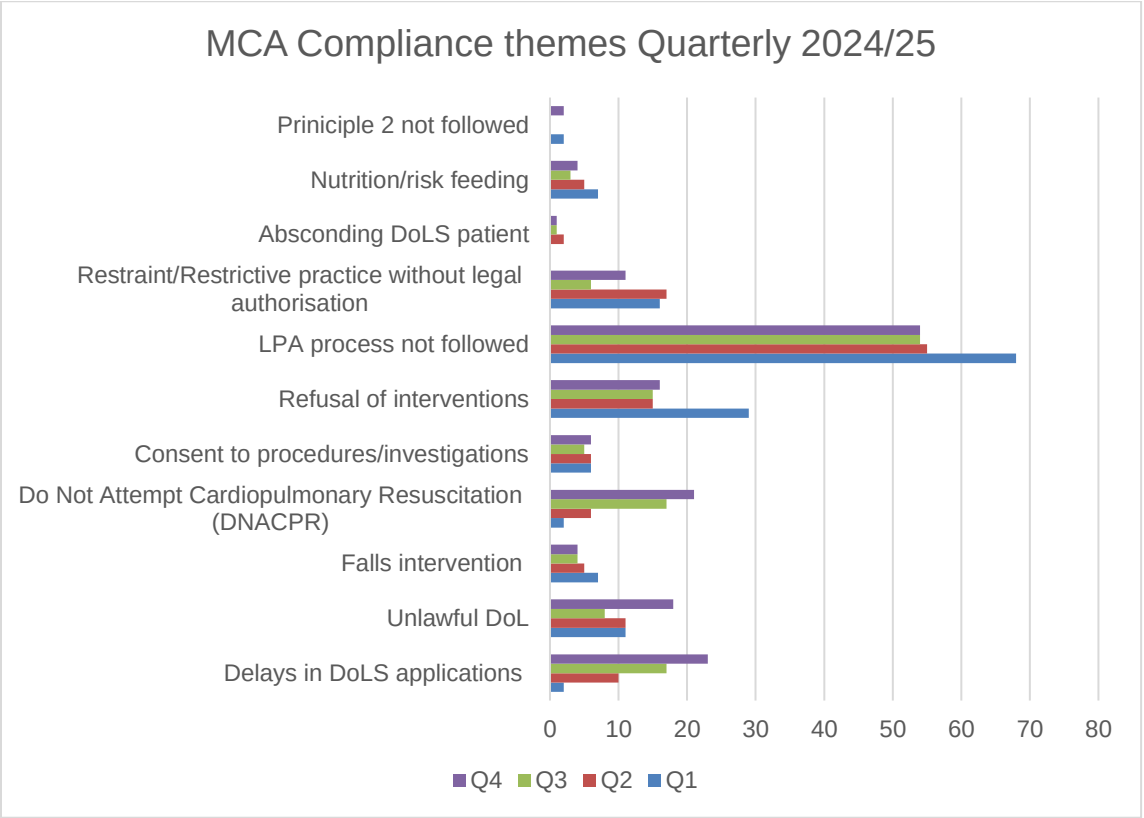


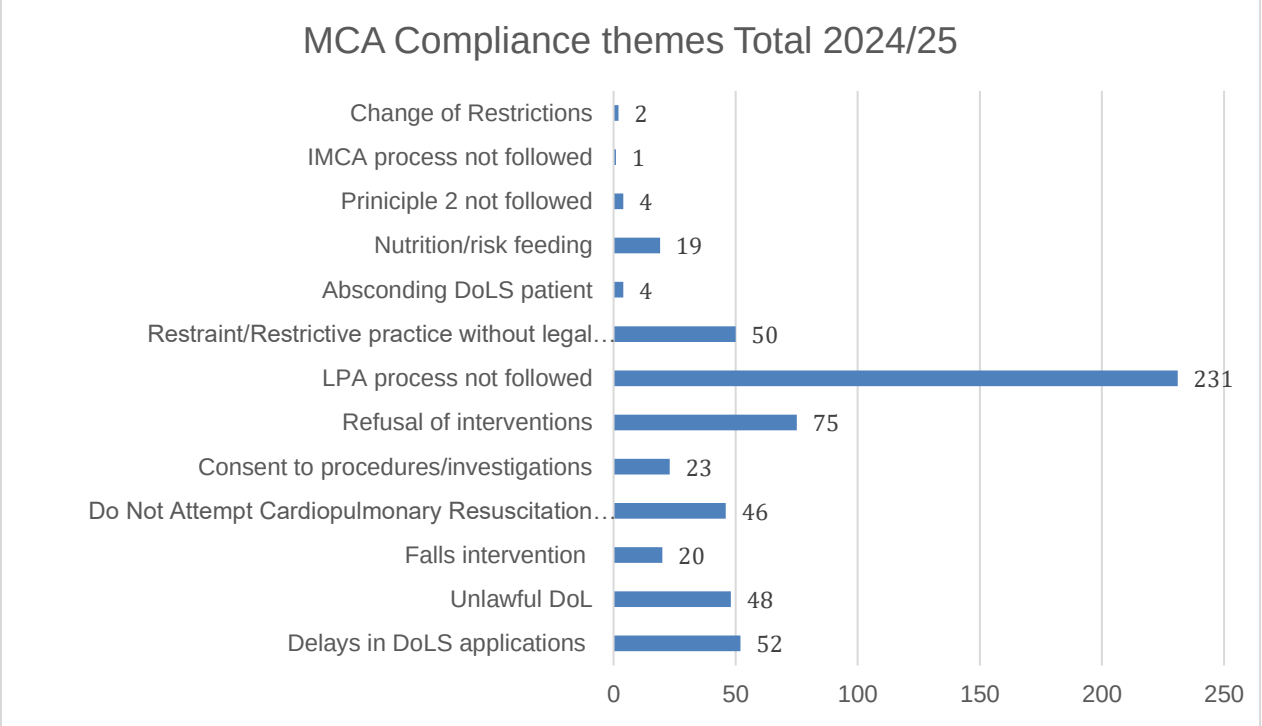
Appendix 7
DoLS applications not progressed

NOT PROCESSED REASON	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	2024/25
Discharged	43 (40.5%)	44 (41.9%)	54 (53.5%)	30 (33.3%)	171 (42.5%)
Duplicate referrals	24 (22.6%)	18 (17.1%)	16 (15.8%)	25 (27.8%)	83 (20.6%)
Have capacity/regained Capacity	18 (17%)	10 (9.5%)	6 (5.9%)	13 (14.4%)	47 (11.6%)
Fluctuating capacity	3 (2.8%)	1 (0.95%)	0	1 (1.1%)	5 (1.24%)
Deceased	5 (4.7%)	9 (8.6%)	8 (7.9%)	4 (4.4%)	26 (6.47%)
DoLS Criteria not met (case law)	9 (8.5%)	22 (21%)	12 (11.9%)	9 (10%)	52 (12.9%)
Use of Mental Health Act	2 (1.8%)	1 (0.95%)	2 (1.9%)	1 (1.1%)	6 (1.5%)
Referral application error (wrong cause/ or saved for later)	4 (3.8%)	0	3 (3.1%)	7 (7.8%)	14 (3.48%)
Total not processed by team	106 (15.6%)	105 (15.5%)	101 (14.6)	90 (13.1%)	402 (14.7%)

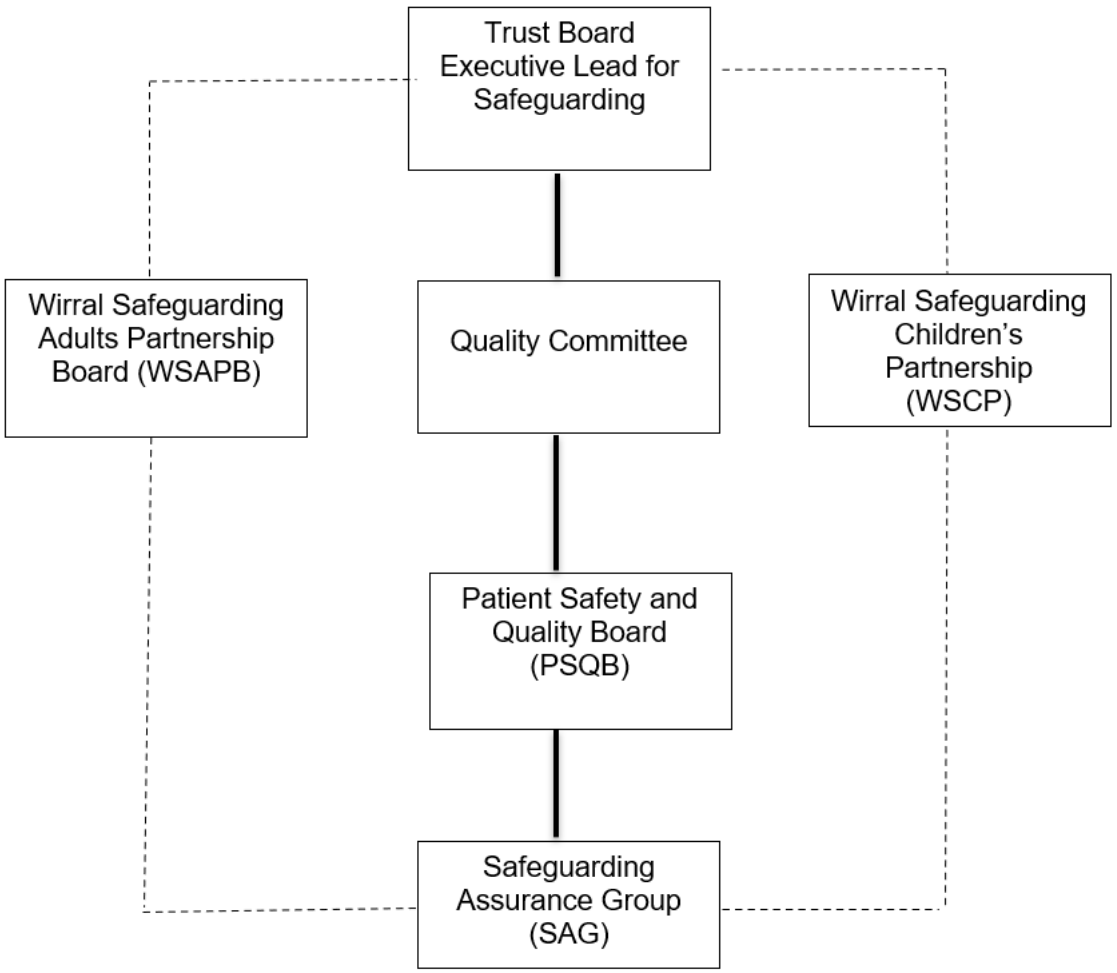
402 (14.7%) applications were not progressed to standard applications due to either duplicate application, discharged or sadly passed away prior to the referral being valid or within 24 hours of receiving it, fluctuating/regained capacity, application of a mental health section used or due to relevant case law. This is a decrease from last year by 45. (447). Duplicate and discharged patients was the most common theme.

Appendix 8
MCA themes and Trends





Appendix 9
Trust Governance Structure (Safeguarding)



Wirral University Teaching Hospital
NHS Foundation Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2024/2025

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1.0 Executive Summary

Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained. The purpose of this report is to provide assurance to the Board of Directors on compliance with the 'Health & Social Care Act 2008: code of practice on the prevention and control of infections and related guidance'.

When the numbers of people attending ED exceed capacity each day risk assessments became the normal occurrence to maintain patient safety on their journey through the Trust. Maintaining the principles of IPC during this time remained a challenge and whilst patient flow continued to be a daily priority for the Trust with competing pressures for beds, the IPC team supported the wards and divisions in managing 33 outbreaks of Norovirus, 15 periods of increased incidences of *Clostridioides difficile*, 23 outbreaks of COVID and 6 Outbreaks of Influenza, this was alongside their daily audit and surveillance activities.

Whilst the Trust exceeded the NHS threshold for *Clostridioides difficile* in 2024/25 during the year there was system wide recognition that both regional and national numbers had increased and following the Quality Improvement work we can evidence that we closed the gap against the regional average in Q4; we now must keep up the hard work to sustain this improvement into 2025/26. Continuing to have support of the Executive team will enable us to continue to implement the fundamentals that have been identified locally as proven reduction strategies for CDI.

A similar result has also been seen when comparing our local objectives for gram negative bacteraemia with many trusts in the Northwest exceeding their thresholds however whilst there are no objectives for MSSA bacteraemia we do remain a significant outlier in the Northwest reporting low annual numbers, this may be a result of our continued investment in antimicrobial body wash for all admissions.

Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 1 MRSA bacteraemia in 2024/25 which is the same as last year.

The Trust continues to report mandatory surveillance of SSI following Orthopaedic surgery for every quarter and has seen a reduction in incidence during the year reporting just 5 infections following 604 surgeries, surveillance of large bowel surgery for every quarter continues which is reported locally..

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and then can progress through to best.

Over the next 12 months the Trust will further review existing work and projects to develop an increased scrutiny in our investigative procedures to further inform practice, working in collaboration with partners across the whole health economy to keep a focus on prevention of infections and compliance with good working practices.

In conclusion, I would like to acknowledge the hard work of the IPC Team and the divisions which they support, working as a team they have shown commitment in the delivery of good infection prevention practices by managing our infection risks together in a caring and competent manner.

Jay Turner-Gardner
Deputy Director / Lead - Infection and Prevention and Control

2.0 Description of Infection Prevention

2.1 Nursing Team

The Chief Nurse, the Director of Infection prevention and control joined the Trust in 2024 and is the senior nurse leader in the organisation responsible for overseeing all nursing and patient care operations to ensure high-quality care, this includes responsibility for leading the organisation's IPC (including cleanliness) strategy, and improvement plan. The Deputy Director/Lead Infection prevention and Control nurse is the Clinical lead for IPC and continues to provide the expert knowledge and advice to the Trust.

The Infection Prevention & Control Matron has managerial responsibility for the Infection Prevention & control team which consists of:

- 3 x band 7 (2.8 WTE) Senior Infection Prevention Specialist Nurses.
- 3 x band 6 (3.0 WTE) Infection Prevention Specialist Nurses
- 1 x band 4 (1.0 WTE) Secretary.
- 1 x band 3 (1.0 WTE) Infection Prevention assistant

Long-term sickness of several members of the team, the reduction in 0.2 WTE hours per week of a band 7 nurse and the resignation of the Infection prevention assistant in November 2024 meant the team was not fully established throughout 2024/25. The lost day and full-time post have not been replaced due to CIP Pressures.

2.2 Infection Prevention on-call

There is no IPC on call service following consultation in 2022/23.

2.3 Medical Staff

The IPC team is supported by a microbiology team consisting of:

- 2 x WTE consultant microbiologists, including the Infection control doctor
- 2 x WTE speciality doctors
- 2 x WTE clinical scientist

Additionally, there has remained one vacancy for a consultant microbiologist, currently being covered by one of the existing specialty Doctors. Locum cover was not approved to cover the gaps in the service during maternity leave of one of the clinical scientists

The out-of-hours consultant microbiologist service is a shared between three Trusts, defined by an SLA. (Chester, Warrington) This support is available on call from 5pm – 9am, and weekends and bank Holidays for Microbiology.
The on-call Consultant Microbiologist service does not provide standalone IPC advice unless related to aspects of care related to Microbiology advice.

2.4 The Infection Prevention and Control Team

The IPC Team and IP Doctor led by the Deputy DIPC provide the Infection Prevention service to the Trust. The Deputy DIPC is responsible for writing the Annual report, delivering the Infection Prevention annual plan and annual audit plan on behalf of the DIPC, who reports to the Trust Board on behalf of the Infection Prevention & Control group.

2.5 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is the Medical Microbiology laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is based in Bromborough, Wirral. It provides most of the lab diagnostics for WUTH including routine cultures, infection screening tests (MRSA, VRE screens) and molecular testing for organisms such as Influenza, *C.difficile*, Norovirus, CPE and SARS-CoV-2. This is a 24/7 service, with the out of hours service being restricted to urgent samples including blood cultures, CSF and COVID-19 tests.

The Point of care testing (POCT) for COVID-19/ Flu continues in the admission areas. Off-site services included tests done in CWMS and some referral work is now sent to Manchester Foundation Trust (MFT) labs rather than to Liverpool clinical laboratories.

2.6 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**

2.7 The Infection Prevention and Control Group

This group continues to meet monthly, and each Division provides representation. The group is chaired by the DIPC; the deputy chair is the Deputy DIPC. Its purpose is to provide a two-way communication channel between the Trust Board via the Patient Safety and Quality Board (PSQB). The IPCG has an assurance/ management role and is authorised to approve Infection Prevention policies and to formulate recommendations for Infection Prevention and Control conveying these to the PSQB via a chairs report.

The Trust Infection Prevention & Control Terms of Reference can be found in **Appendix 2**. These are reviewed bi-annually.

2.8 Departmental/Divisional Infection Prevention and Control groups

The following Divisions/Specialties meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG):

- Medicine
- Orthopaedics
- Specialist Surgery/ Surgery

- Theatres
- Women's and Children's
- Diagnostics

Acute Specialties, who became a stand-alone division during the reporting year have yet to formalise a Monthly Divisional IPC group.

2.9 The Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and replaced the Serious Incident Framework (2015). It represents a significant shift in the way the NHS responds to patient safety incidents.

In terms of IPC, the traditional route cause analysis (RCA) process that was led by the IPC team following incidences of hospital acquired infections were replaced by Rapid Evaluations of Care (REC). The REC took considerably longer to establish these as to promote local ownership they were primarily managed by the Divisions and as a result this has led to a considerable back log.

Lessons learnt following review of the patient journey were no longer timely and in response a weekly meeting was created, chaired by the deputy chief nurse/ IPC lead and medical director. At this meeting the previous weeks incidences of CDT are reviewed and lessons learnt supported to promote future improvements to avoid further occurrence.

The gram-negative blood stream infection reviews are presented to the deputy DIPC on a weekly basis and learning is discussed and shared with the divisions

The Patient Safety Steering Group Chair's Meeting reviews all Rapid Evaluations of Care to assess if they can be closed or escalated to another meeting, such as Patient Safety Learning Panel, one of the Steering groups, or Patient Safety Response Planning Meeting, which takes place every week. At these meetings, escalated Rapid Evaluation of Care reports are assessed by a wider panel, consisting of AMDs, DDONs and key stakeholders for patient safety. The RECs are either closed or escalated for further review as a thematic review, Facilitated Reflective Session (After Action Review or MDT Reflective review) or Patient Safety Incident Investigation (PSII).

Following recruitment to the Deputy Director of patient safety this process is now under review for 2025-2026.

3.0 Reports to the Trust - Summary

Reports written and/or coordinated by the Deputy DIPC include:

- Daily IPC update including outbreak and surveillance summary for the patient flow team, senior management, the nursing teams, and facilities detailing all patients with alert organisms including any areas under increased surveillance due to an increase in prevalence of any specific organism.
- Daily Outbreaks in the community which could have an impact on our service by the WCT.

- Monthly Infection prevention data summary of activities for the IP divisional meetings and the IPCG.
- Monthly IPC chairs reports and updates for the PSQB/ Clinical Advisory Group
- Annual Infection Prevention Report once per year which includes the Annual Infection Prevention plan and Annual Infection Prevention audit plan.
- Ad hoc updates in relation to the Infection prevention board assurance framework
- Weekly Executive Team update for DIPC
- IPC BI portal
- Continence steering group Chairs report to IPCG
- Monthly integrated performance report
- Decontamination group chairs report to IPCG
- Quarterly CDT and Gram negative report to IPCG

4.0 Budget Allocation to Infection Prevention

4.1 Microbiology and Laboratory Services

The medical microbiologists and the Laboratory are funded from the Pathology Division, which is within the Division of Diagnostics and Clinical Support.

4.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

4.3 The Infection Prevention and Control Nursing Team (IPT)

The IPC Team are funded from the Corporate Nursing budget and the Deputy DIPC is the budget holder for the Infection prevention service, the budget funds the nursing team along with any Infection prevention initiatives identified during the year. This includes Infection Prevention signage, posters, study days and campaigns.

4.4 Investments in Infection Prevention at WUTH

In the year 2024/25 the Trust continued in its investment of:

- MRSA screening for all emergency admissions.
- CPE and VRE screening for all Critical Care patients and patients admitted to Ward 30.
- Hydrogen Peroxide Vapor (HPV) ‘fogging’ following incidences of CDI, COVID, VRE, CPE when capacity/patient flow allows.
- Reactive and pro-active HPV programme when bed capacity/essential maintenance works allow.
- EvaluClean – A simple system utilised by the IPC team that uses a UV marker which is invisible to the human eye to mark objects, following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process.

- Adenosine triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) by way of swabbing certain objects to determine if organic matter is detected to measure the effectiveness of cleaning.
- Increased cleaning in addition to the base line clean to support the increase in *C.diff* infection.
- Disposable curtains throughout the trust
- Deployment of Air purifiers in collaboration with Facilities for patients diagnosed with COVID.
- Daily cleanliness monitoring checklists introduced and completed on Tendable by the cleanliness supervisory team.
- Switch from Hibiscrub skin wash to Octenisan

5.0 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Meticillin-resistant *Staphylococcus aureus* (MRSA), *Clostridioides difficile* (*C. difficile*) and in recent times COVID-19.

HCAIs pose a serious risk to patients, staff, and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS.

6.0 Surveillance/ Mandatory reporting

UK Health Security Agency's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections.

The monthly quality check of the mandatory data introduced in 2019 continues. The data is first quality checked by the IPC analyst and the IPC matron and then 'signed off' by the Deputy DIPC on behalf of the Chief Executive on the UKHSA data base.

Each individual alert organism has a senior review (PSIRF) and lessons identified reported to the appropriate steering group, this is to ensure that annual plans include the identified Themes and trends to ensure education and training promote improvement.

Carbapenemase producing *Enterobacteriaceae* (CPE), Vancomycin resistant enterococci (VRE) COVID-19, Influenza, Norovirus and many other organisms are reported locally throughout the year.

6.1 *Staphylococcus aureus*

*Staphylococcus aureus (*Staph) is a type of bacterium (germ) commonly found on the skin and in the nose of about 30% of people. Most of the time staph does not cause us any harm, but it can sometimes cause infections. Staph infections can look like pimples, boils or other skin conditions. In healthcare settings staph infections can be serious or fatal leading to

- Blood stream infections or sepsiswhen bacteria get in the bloodstream
- Pneumonia, which most often effects people with underlying lung disease, including those on mechanical ventilators
- Endocarditis (Infection of the heart valves) which can lead to heart failure or stroke
- Osteomylitis (Bone infection) caused by staph bacteria travelling the blood stream or put there by contact such as trauma (puncture wound of the foot)

In the community, people are at a greater risk of a staph infection if they have chronic conditions (e.g. Diabetes, cancer, vascular disease) or inject drugs.

In healthcare, the risk of staph infection is higher for patients

- In intensive care units
- Who have undergone certain types of surgeries
- With medical devices inserted into their bodies
- With weakened immunity

To reduce the risk patients can avoid sharing items that contact skin, such as Towels, razors, toothbrushes and needles. Healthcare staff can reduce the risk by washing their hands, maintaining good environmental hygiene in and around the patient area and if equipment is shared between patients decontaminating it effectively in between uses.

Most staph infections can be treated with antibiotics, however some staph infections are resistant to certain antibiotics, for example Meticillin Resistant *Staphylococcus aureus* (MRSA)

6.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

Meticillin-resistant *Staphylococcus aureus* (MRSA) infections remain a serious cause of healthcare-associated infection globally. While the incidence is decreasing, this remains an important concern for IPC professionals. Together, the Healthcare Infection Society and the Infection Prevention Society have updated the guidelines for the prevention and control of MRSA in healthcare settings. The Guidelines have been produced by key experts on the front-line of patient care and is freely accessible. The National Institute for Health and Care Excellence (NICE) accredited the Healthcare Infection Society's guideline development process as a mark of quality between 2015 and 2024 before closing its accreditation programme in July 2024.

The WUTH guidelines were reviewed in 2024, and the decision made to continue to complete screening for MRSA as per existing local policy, which was universal screening, and not to adopt targeted screening, this was based on a risk assessment approach.

All patients who require an overnight stay regardless of their MRSA status are given a small bottle of the approved* antiseptic skin wash and asked to wash/shower daily for the first 5 days of their admission, or until the bottle is finished, which must be used in accordance with the manufacturer's instructions. If MRSA screening results are reported as positive, they continue to use the skin wash until discharge, or at least for a minimum of 5 days after diagnosis. This skin wash does not need to be prescribed.

*A decision was made during 2024 to change the skin wash / MRSA decolonisation treatment to Octenisan as the Hibiscrub body wash that had been in use for several years can have a damaging effect on the skin as well as raise concerns regarding Chlorehexidine allergies.

6.3 Reporting and monitoring arrangements for MRSA bacteraemia

All Laboratory reported incidences are entered into the UKHSA data capture system (HCAI DCS) and a Post Infection Review (PIR) is completed by the MDT. There is no longer a mandatory requirement to enter these PIR reports into the DCS reporting system unless requested so by UKHSA as a high outlier.

Completed PIR reports are available to be shared with the Integrated care system* (ICS) and discussed at their quality meetings.

Following a laboratory confirmed MRSA bacteraemia a Multi-disciplinary Team, ideally the patient's clinician, Microbiologist, Deputy DIPC, Matron and Pharmacist meet to complete the investigation to determine the causative factors of the MRSA bacteraemia and identify any learning to support the development of a local action plan, it is the responsibility of the division to achieve the action plan. Causation is determined once the information is gathered.

MRSA Bacteraemia are apportioned according to the DOH guidelines below:

- Day 0 = Day of admission community attributed (pre day 2)
- Day 1 = community attributed (pre day 2)
- Day 2 = Trust attributed (on or post day 2)

* In the context of the UK National Health Service (NHS), Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) are key components of a system-wide approach to healthcare integration. An ICS is a geographic area where health and care organizations collaborate to improve population health and reduce inequalities. An ICB is the NHS organisation within an ICS, responsible for planning and commissioning NHS services for that area.

6.4 The incidence of MRSA bacteraemia since April 2024.

In 2024/25 we have reported 1 MRSA bacteraemia, this is the same as reported in 2023/24.

6.5 Themes from Post Infection review

The MRSA bacteraemia was thought to be related to the patient's parotitis (inflammation of the salivary glands located on the sides of the face between the ear and the jaw) therefore deemed to be unavoidable, however there was some learning identified from the review. The patient had screening

swabs taken from nose and groin on admission that were reported to be negative - the patient had a sacral wound that had not been swabbed - there was lack of clarity as to whether the wound was evident on admission. The patient had a cannula in situ for 277 hours (over 11 days), due to poor access however there was no referral made to the IV access team. Recommended time is 120 hrs (5 days).

SPC Chart 1 below provides a breakdown of **MRSA bacteraemia** by month.

SPC Chart 1

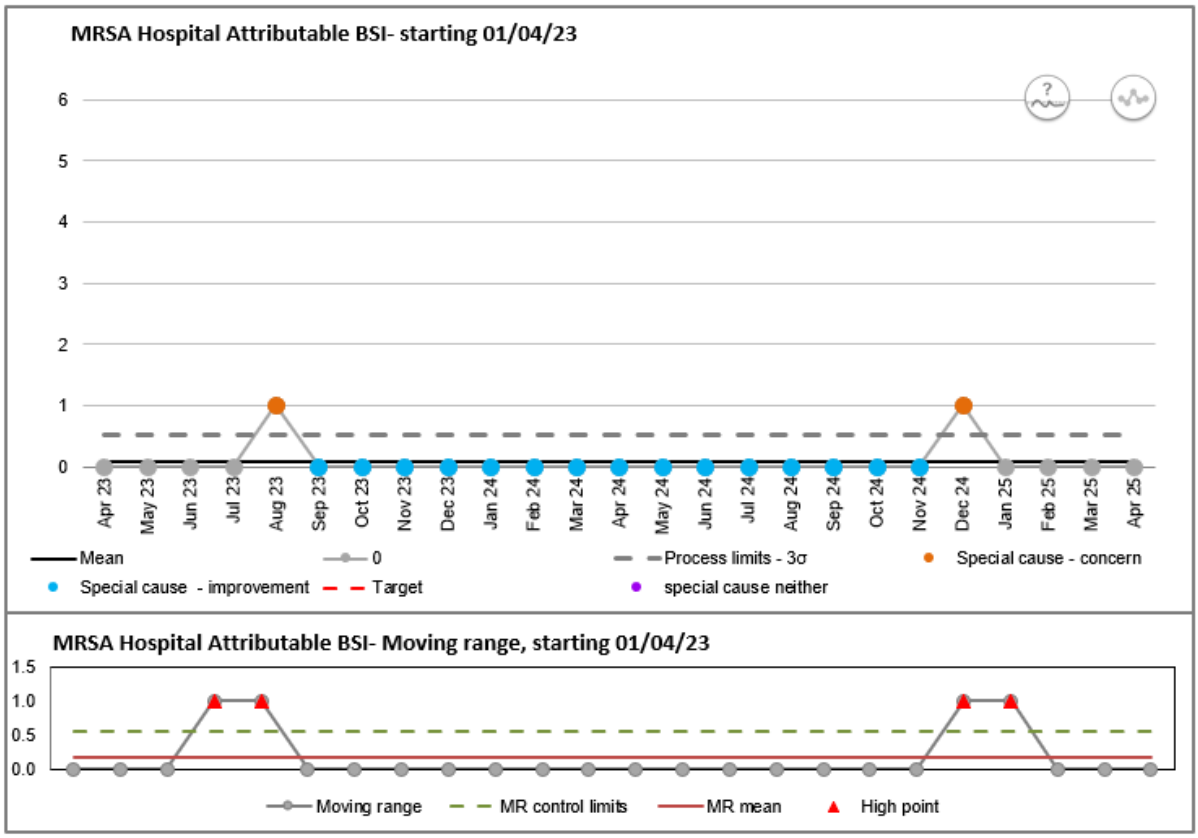


Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15

Table 1

The incidence of MRSA Bacteraemia since 2014/15											
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Pre day 2 for WCT	4	5	3	0	3	2	0	3	1	2	2
Post day 2 for WUTH	3	1	1	2	3	1	2	2	2	1	1
Total for Wirral CCG	7	6	4	2	6	3	2	5	3	3	3

Table 2 below provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated **MRSA bacteraemia** by month.

Table 2

Breakdown of MRSA cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	0	0	0	0	0	0	0	0	1	0	0	0	1
CO-HA	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Associated	0	1	0	0	0	1	0	0	0	0	0	0	2

6.6 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

MSSA affects people of all ages and has been known to cause outbreaks among sports teams, families, prison inmates and people who live and work in close quarters, such as military recruits. Treatment for these infections generally require antibiotics

All Laboratory reported incidences of MSSA bacteraemia are entered into the UKHSA data capture system (HCAI DCS) and a Route cause Analysis (RCA)/ REC is completed by the MDT.

There are no national or local objectives set against these at present and many are related to skin and soft tissue infections. WUTH are a low outlier in the statistics table for 2024/25, this may be because all patients are given the antiseptic body wash on arrival into the trust which will help to eradicate staph on the skin.

In 2024/25 we have reported 24 MSSA bacteraemia, this is a reduction of 8 when compared to 2023/24.

SPC Chart 2

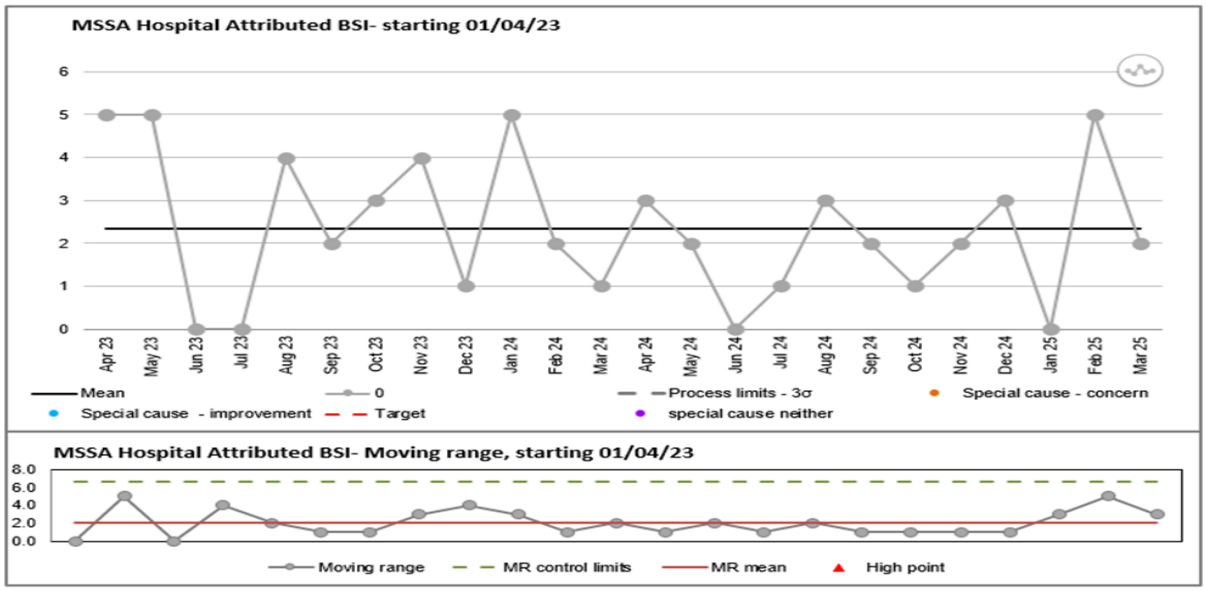


Table 3 below provides a breakdown of **MSSA bacteraemia** by year and month since 2016/17.

Table 3

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18
2021/22	1	2	2	0	0	0	4	0	3	5	4	4	25
2022/23	2	1	4	2	5	2	4	2	1	2	2	5	32
2023/24	5	5	0	0	4	2	3	4	1	5	2	1	32
2024/25	3	2	0	1	3	2	1	2	3	0	5	2	24

SPC Chart 3 below provides a breakdown of **MSSA bacteraemia** by month.

SPC Chart 3

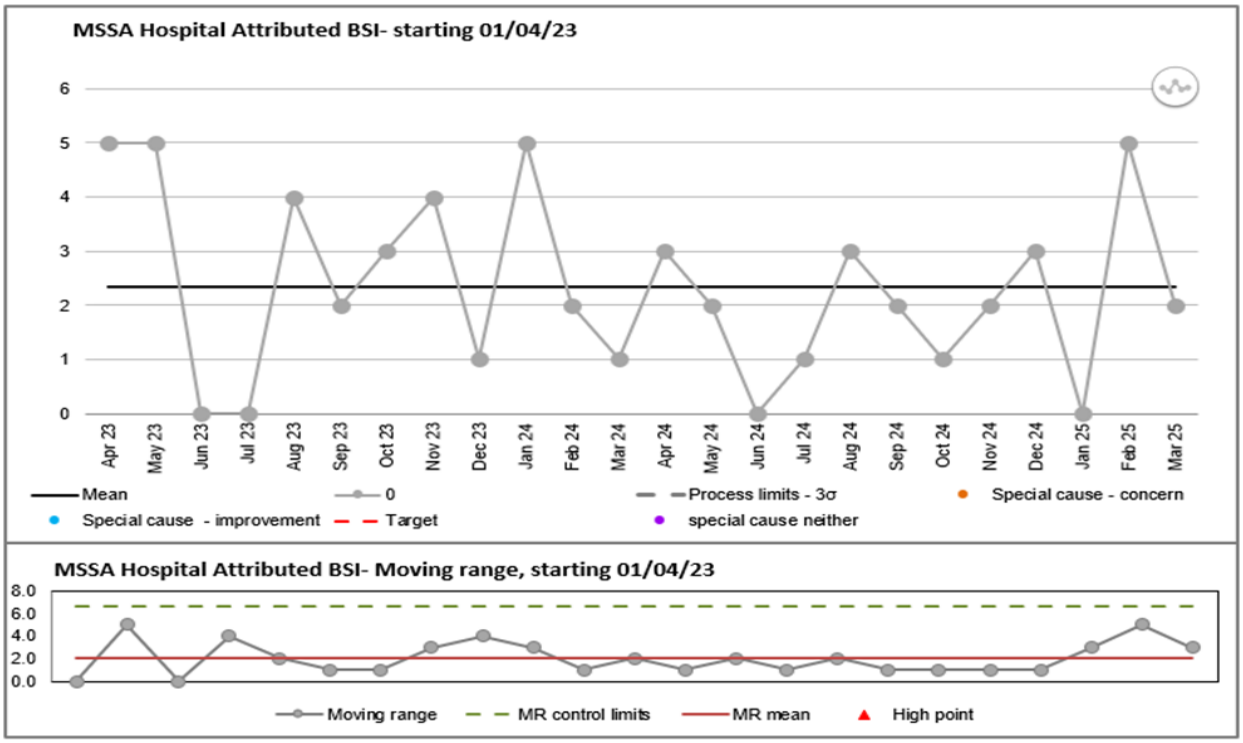


Table 4 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated **MSSA bacteraemia** by month.

Table 4

Breakdown of MSSA cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	1	2	0	0	2	1	1	2	0	0	3	2	14
CO-HA	2	0	0	1	1	1	0	0	3	0	2	0	10
Community Associated	3	7	5	6	5	6	1	2	8	4	2	4	53

The source of the 14 hospital onset MSSA BSIs were identified as:

- 4 – vascular access
- 4 – unknown source
- 1 – infective endocarditis
- 1 – unclear between chest and urinary
- 1 – unclear between chest and deep seated infection
- 1 – deep seated infection
- 1 – skin
- 1 – contaminated portacath from respiratory secretions.

Themes identified from the rapid reviews included:

- Cannula insertion and ongoing care is not always documented in CERNER.
- When lines are thought to be the source of the infection the line tips are not always sent to the lab to confirm line infection.
- Patients required multiple cannulas or had problems with poor access.
- Some patients were none compliant with care, making skin checks difficult to complete.
- It was unknown if patients washed with Octenisan for the first 5 days of admission, as per Trust policy.

6.7 *Clostridioides difficile* Infection (CDI)

Clostridioides difficile (*C.difficile*) is a bacterium found in the intestine. It can be present in healthy people and cause no symptoms, however antibiotics can cause an imbalance of bacteria within the gut resulting in a proliferation of harmful bacteria and *C.diff* infection. *Clostridioides difficile* infection (CDI) is highly infectious and will spread through contact with a contaminated environment or person and is estimated to cause 20 to 30% of antibiotic-associated diarrhoea. As a significant healthcare associated infection, multiple infection control measures and treatment modalities have been explored and this remains an evolving field. Crucially, the management of severe CDI should be considered a medical emergency and urgently assessed and reviewed regularly to ensure that patients receive prompt and optimised care.

All 7 UKHSA regions have seen an increase in counts and rates between FY 2020 to 2021 and calendar year 2024 but to differing extents. The English Surveillance Programme for Antimicrobial

Utilisation and Resistance (ESPAUR) report demonstrates an increase in overall antibiotic consumption in England in 2023. However, consumption remains below pre-pandemic levels, and significantly below the consumption peak seen in 2014. When analysed by NHS commissioning, regional CDI rates varied across England. The highest incidence was observed in the Northwest, at 48.1 cases per 100,000 population.

Use of broad-spectrum antibiotics is a recognised risk factor for CDI. Broad-spectrum antibiotics typically fall under the UK Access, Watch, Reserve, and Other (UK-AWaRe) classification Watch and Reserve categories. Since 2021, use of Access antibiotics as a proportion of total antimicrobial consumption has seen a gradual increase, beyond 2019 levels.

Findings from modelling analyses are in line with the known epidemiology of CDI in England and do not indicate a risk factor causing this increase.

Several data gaps have been identified for further investigation, including use of corridor care (care in unconventional places), waiting lists for hospital treatment, infection prevention control resource and staffing, cleaning procedures within the hospital, sampling and testing practises and so on. This data is planned to be collected by UKHSA using surveys and existing reported data where possible.

Consequences of long waiting times for hospital treatment include antibiotic treatment, perhaps multiple courses of treatment, pending hospital assessment for an underlying condition or a procedure such as an operation. In some cases, antibiotics may be given for a prolonged period. Research showed people waiting for general surgery had an average of 2 more primary care prescriptions and 2 more secondary care contacts per year. This increased to 6 more primary care prescriptions in those waiting for gastroenterology treatment

6.8 Reporting and Surveillance of *Clostridioides difficile*

Trusts are required under the NHS standard contract 2024/25 to minimise *C.difficile* infections so that they are no higher than the threshold levels set by NHS England and Improvement. There were some key changes from the 2023/24 thresholds for 2024/25.

- Due to increasing trends, a more ambitious threshold (for most trusts) of a 5% reduction for *C. difficile* (compared to one case count historically). This also improves the alignment between trust and ICB thresholds.
- Due to increasing trends, a more ambitious threshold for both *C. difficile* and GNBSIs of 1 case less than the count rather than no change to the count where total case count is fewer than or equal to 10 cases.
- In addition to trust thresholds, publication of thresholds at ICB-level (previously published at sub-ICB level, which has then been aggregated to ICB).
- Recalculating the baseline (2023/24) figures for all trusts to reflect definition change - where a patient has been admitted directly after attendance to A&E, the decision to admit is the

admission date rather than the inpatient admission date. As a result of this definition change, case classifications will change from community-onset to hospital-onset

NHS acute providers use the case assignment definitions:

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

6.9 *Local reporting for CDI in 2024/25*

The national objective set for WUTH for healthcare associated *Clostridioides difficile* infections (CDI) this year was 103, which proved to be very challenging, having reported 167 infections, 64 over our objective.

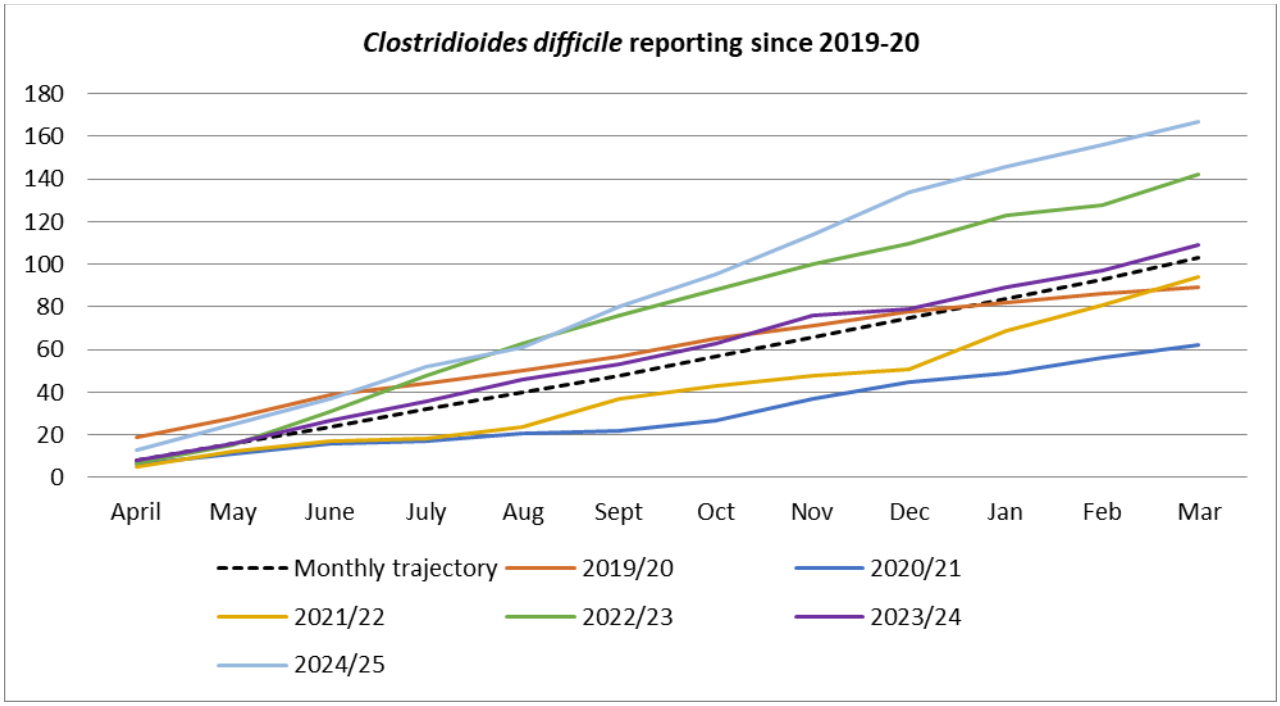
Table 5 below provides a breakdown of ***Clostridioides difficile*** by year and month.

Table 5

Clostridioides difficile cases													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Threshold Awaiting	8	8	8	8	8	8	9	9	9	9	9	10	103
2024/25	13	12	12	15	9	19	15	19	20	12	10	11	167
2023/24	8	8	11	9	10	7	10	13	3	10	8	12	109
2022/23	7	8	16	17	15	13	12	12	10	13	5	14	142
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89

Graph 1 below provides ***Clostridioides difficile*** reported infections since 2019/20 and annual trajectory.

Graph 1



SPC Chart 4 below provides a breakdown of ***Clostridioides difficile*** **infections (CDI)** by month.

Chart 4

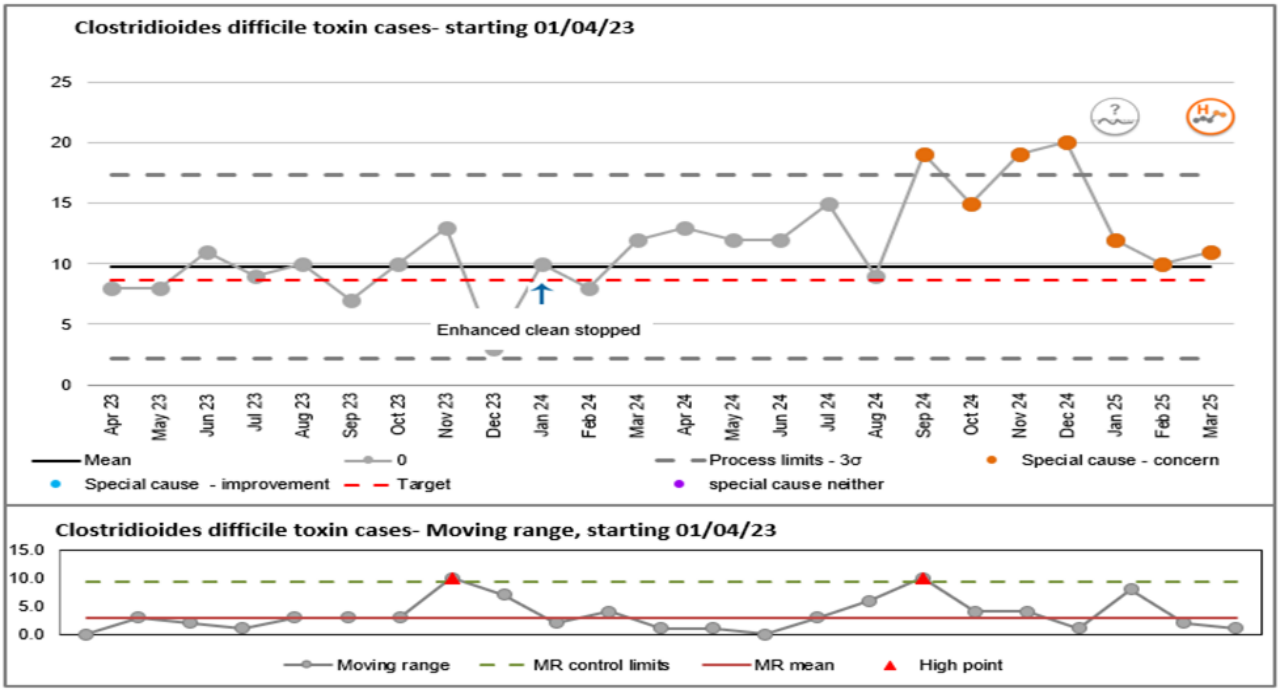


Table 6 below provides a breakdown of Hospital onset Hospital Associated, Community onset Hospital Associated, Community onset Indeterminate Associated, Community onset Community Associated, *Clostridioides difficile* infections (CDI) by month.

Table 6

Breakdown of *Clostridioides difficile* cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	10	9	9	9	5	15	5	14	13	9	10	7	115
CO-HA	3	3	3	6	4	4	10	5	7	3	0	4	52
CO-IA	0	4	3	1	3	0	5	2	4	5	1	1	29
CO-CA	8	13	7	6	3	4	5	2	2	4	0	1	55

Wirral PLACE sits within Cheshire and Merseyside ICB and has a population of 330,000 with recognised challenges and inequalities in parts of the borough. WUTH is the only acute Hospital Trust, there is also a community care trust which delivers services elsewhere and a Mental Health Trust providing services for Wirral. There are over 300 GP's in over 40 GP practices and 120 Care/residential settings.

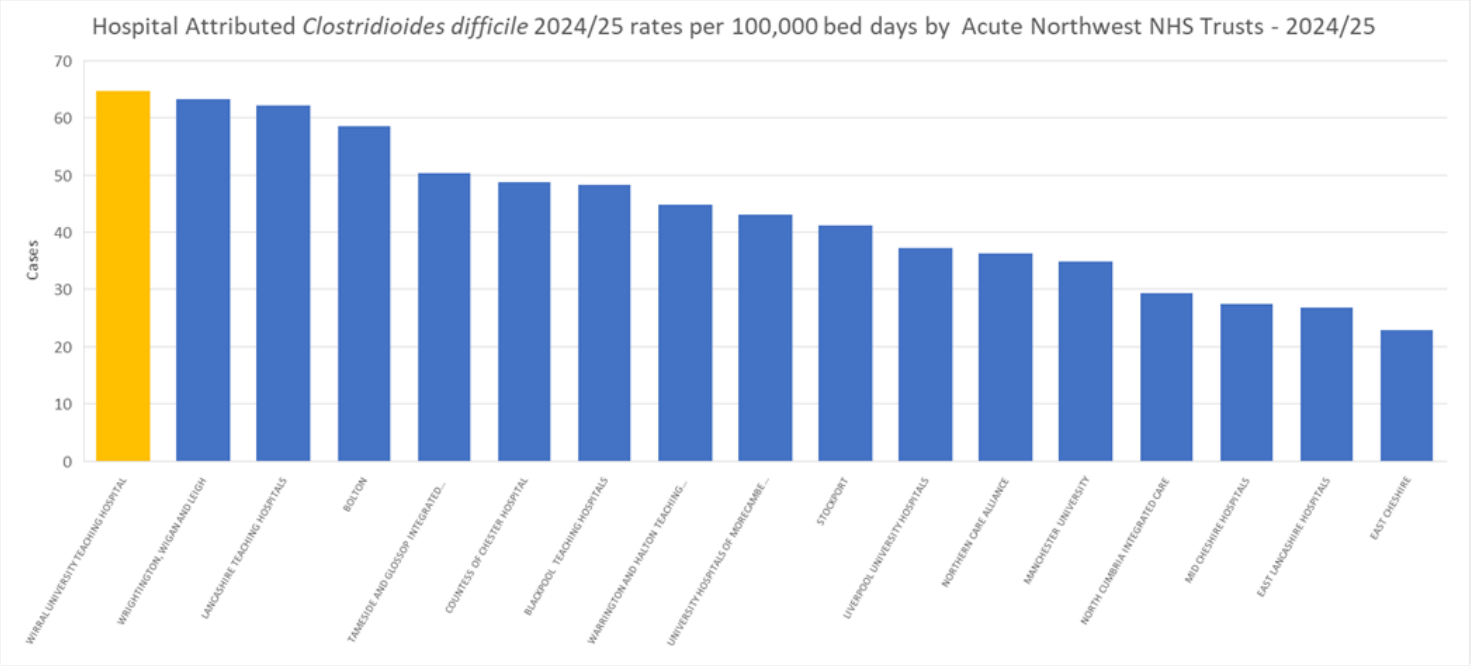
Table below shows *C.difficile* by Trust for Cheshire and Merseyside : Quarterly counts and rates . Healthcare associated cases (Hospital onset and community onset)

Table 7

	Counts				Rate per 100,000 bed days			
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Organisation Name	2024	2024	2024	2025	2024	2024	2024	2025
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	6	2	2	17.8	42.3	13.2	13.2
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	18	27	19	19	43.0	64.1	44.2	44.2
EAST CHESHIRE NHS TRUST	7	5	6	7	25.1	18.5	22.1	25.8
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0	3	1	0.0	0.0	23.8	7.9
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	53	58	56	40	39.1	42.3	39.7	28.3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	1	0	1	0.0	15.1	0.0	15.5
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	20	27	35	32	18.2	24.8	31.3	28.6
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	20	10	6	11	46.6	24.0	13.9	25.5
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	2	5	2	47.3	24.2	62.5	25.0
THE WALTON CENTRE NHS FOUNDATION TRUST	1	4	1	1	8.7	34.0	8.2	8.2
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	29	27	14	20	57.9	54.8	27.7	39.6
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	37	43	54	33	58.2	68.0	82.6	50.4
Cheshire & Merseyside	192	210	201	169	36.3	40.1	37.4	31.4

Graph 2 below shows Hospital attributed ***Clostridioides difficile*** rates per 100,00 bed days by Acute Northwest NHS Trusts

Graph 2



6.10 Incidence of *Clostridioides difficile* Toxin (CDT) and Equivocal Cases

The diagnosis of CDI is based on a combination of laboratory and clinical findings. It is defined by the presence of diarrhoea with the detection of either *C. difficile* toxins or toxigenic *C. difficile* in stool. WUTH follow the recommended 2-step testing system, which is a highly sensitive screening test (GDH EIA, NAAT or PCR) with positive samples proceeding to a highly specific testing with toxin A/B EIA. Table 8 below looks at the numbers of Toxin positive samples against equivocal results per month, equivocal results are those tests that have identified the C.diff bacteria but it isn't producing C.diff toxin.

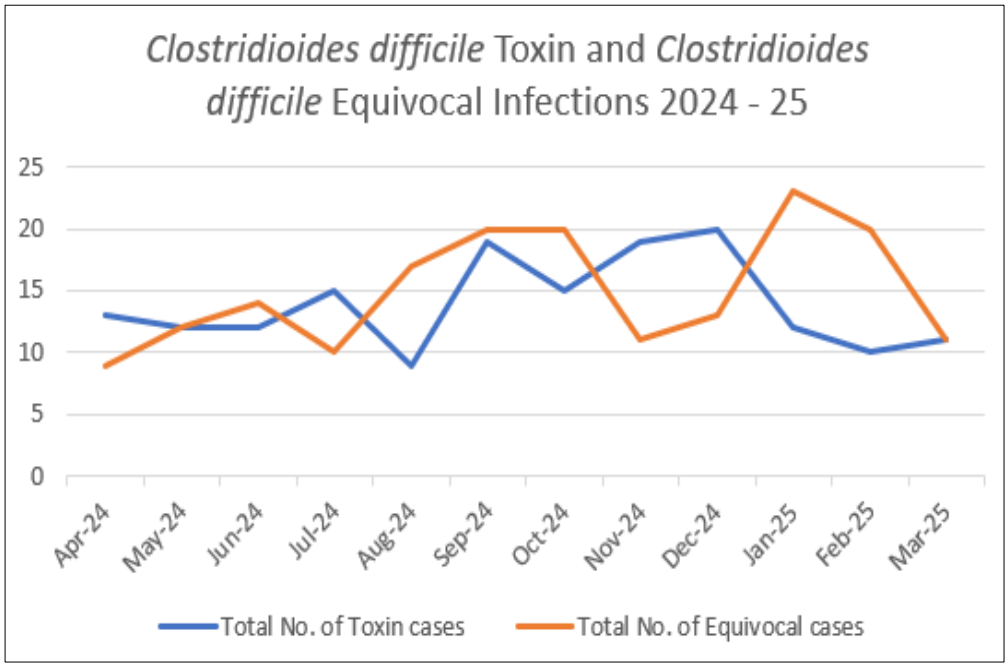
Table 8

Month 2024/25	Total No. of Toxin cases	Total No. of Equivocal cases	Total No. of Toxin and Equivocal
Apr-24	13	9	22
May-24	12	12	24
Jun-24	12	14	26
Jul-24	15	10	25
Aug-24	9	17	26
Sep-24	19	20	39
Oct-24	15	20	35
Nov-24	19	11	30
Dec-24	20	13	33
Jan-25	12	23	35
Feb-25	10	20	30
Mar-25	11	11	22
Total	**167**	**180**	**347**

It is important to understand the burden on the environment as both Toxin and equivocal results add to the bioburden of spores contaminating the environment , patients shared equipment and healthcare workers hands that become a risk to our patients.

Management is the same for those people diagnosed with equivocal results to those identified as toxin positive, in that patients are isolated, antimicrobial treatment commences and enhanced cleaning is introduced. Graph 3 shows Toxin V Equivocal results.

Graph 3



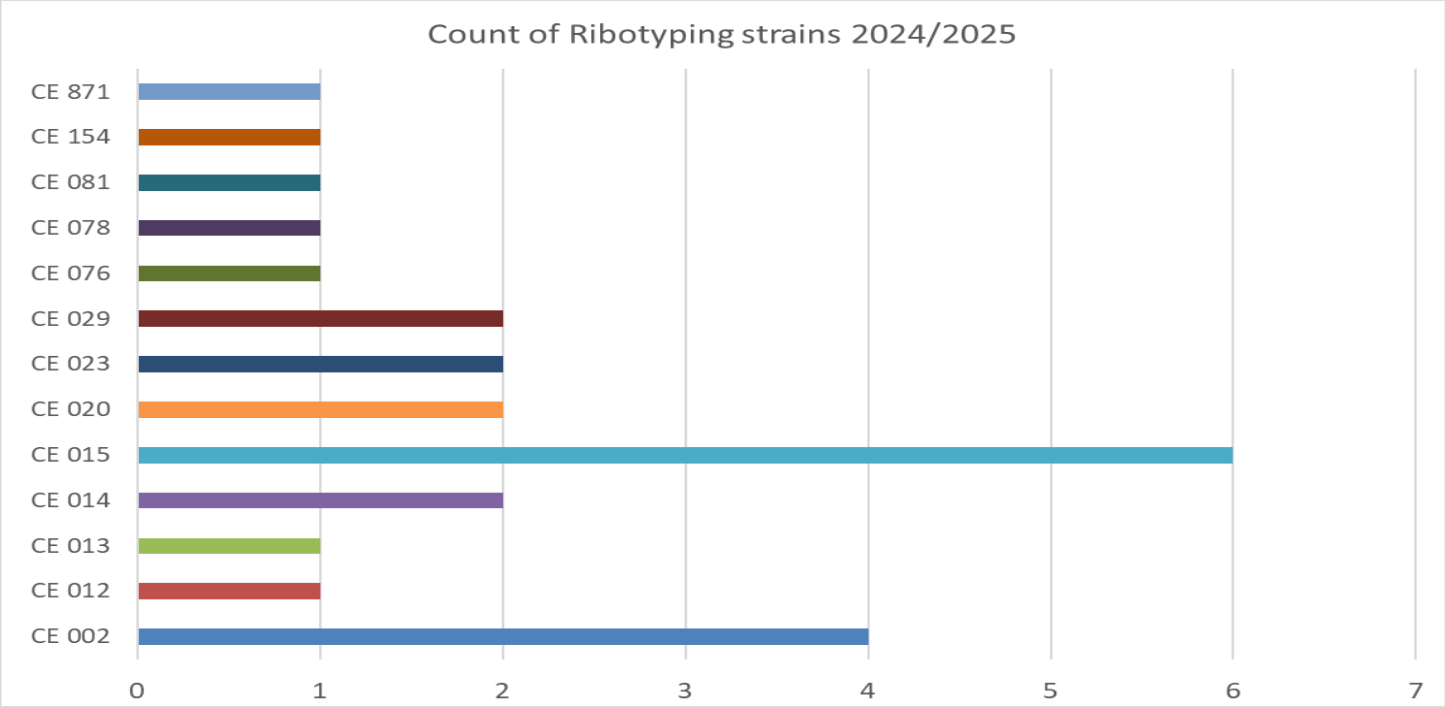
6.11 Molecular typing

Molecular typing is an important infection control tool to monitor the prevalence of certain strains within a healthcare institution or to investigate if a cluster of infections are unrelated or part of an outbreak.

Since April 2024 WUTH have identified increased numbers of patients with CE 015, a change from the previous year when 002, 023 and 020 ribotype were the more common ribotype's seen. Table 20 below shows the ribotype strains of isolates sent for typing since April 2024

Graph 4 below provides a count of ***Clostridioides difficile*** ribotyping results in 2023/24.

Graph 4



6.12 Themes from CDI RCA investigation

Of the completed reviews in 2024/25 whilst no two patients journeys are the same, some common themes continue:

- Missed opportunities to obtain a sample from the patient
- Stool charts not completed daily
- Inappropriate sampling
- Overlap of care with another patient diagnosed with CDT or CDE
- Broad spectrum antimicrobial usage – Co-amoxiclav
- Previous known CDT and prophylaxis not offered when patient was again commenced on Antibiotics (Prophylaxis not part of NICE guidelines, WUTH local policy says consider)
- Delay in isolation
- Delay in prescribing treatment
- Delay in administering treatment
- Re-sampling of a known CDT patient as a care home wanted clearance evidence before they would accept
- Previous known CDT

6.13 Gram-negative bloodstream infections (BSIs)

Since April 2020, reporting trusts were asked to provide information on whether patients with Gram-negative bloodstream infections had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

Since 2021/22, trust-level thresholds comprise of total healthcare-associated cases (i.e., HOHA and COHA).

Objectives for this year are derived from a base line of the 12 months ending November 2022, as this is the most recent available data at the time that NHSE/I was calculating the figures.

For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2022, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count.

All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases (i.e., HOHA and COHA cases).

Gram-negative bacteria - *Escherichia coli (E.coli)*, *Pseudomonas aeruginosa (P.aeruginosa)* and *Klebsiella* species (*Klebsiella* spp.) are the leading causes of healthcare associated bloodstream infections. The national ambition was to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values). Since 2021/2022 Trusts have been given individual objectives for each organism.

E.coli

Escherichia coli (*E.coli*) bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E.coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. *E.coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E.coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

Community-acquired *E.coli* bactereamia are most frequently the result of urinary tract infections in older adults, while hospitalised patients are more likely to develop bactereamia because of lower respiratory tract infection, UTI or surgical site infections.s. *Escherichia coli* causes more than one-third of the bacteraemia cases in England each year, and the incidence of these infections is increasing.

Table 9 below provides a breakdown of Hospital attributed ***E.coli*** **bacteraemia** by month against the trajectory.

Table 9

E.coli bacteraemia													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Threshold 2024/25	7	7	7	8	7	7	7	7	7	7	7	7	85
2024/25	4	12	6	7	10	10	12	7	11	5	3	9	96
2023/24	8	5	6	8	13	7	6	4	5	13	7	8	90
2022/23	8	4	9	12	10	6	5	5	11	5	6	8	89
2021/22	4	4	7	3	3	5	4	4	6	5	6	8	59

In 2024/25 we reported 96 *E.coli* bacteraemia, this is an increase of 6 when compared to 2023/24 and is 11 infections over our threshold for 2024/25.

Graph 5 below provides ***E.coli*** bacteraemia reported infections by month against the trajectory

Graph 5

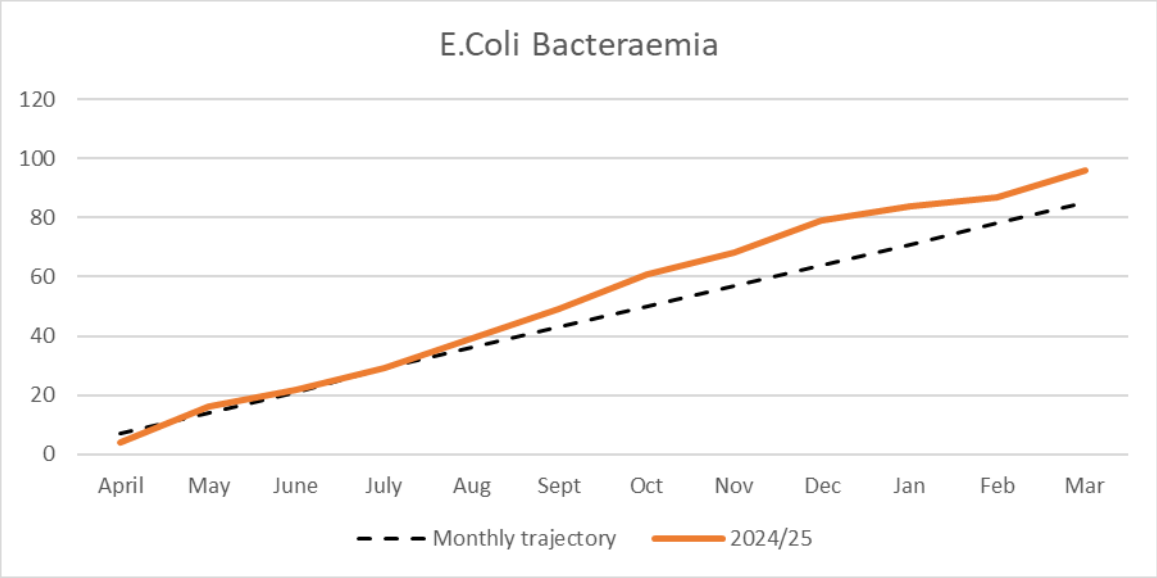


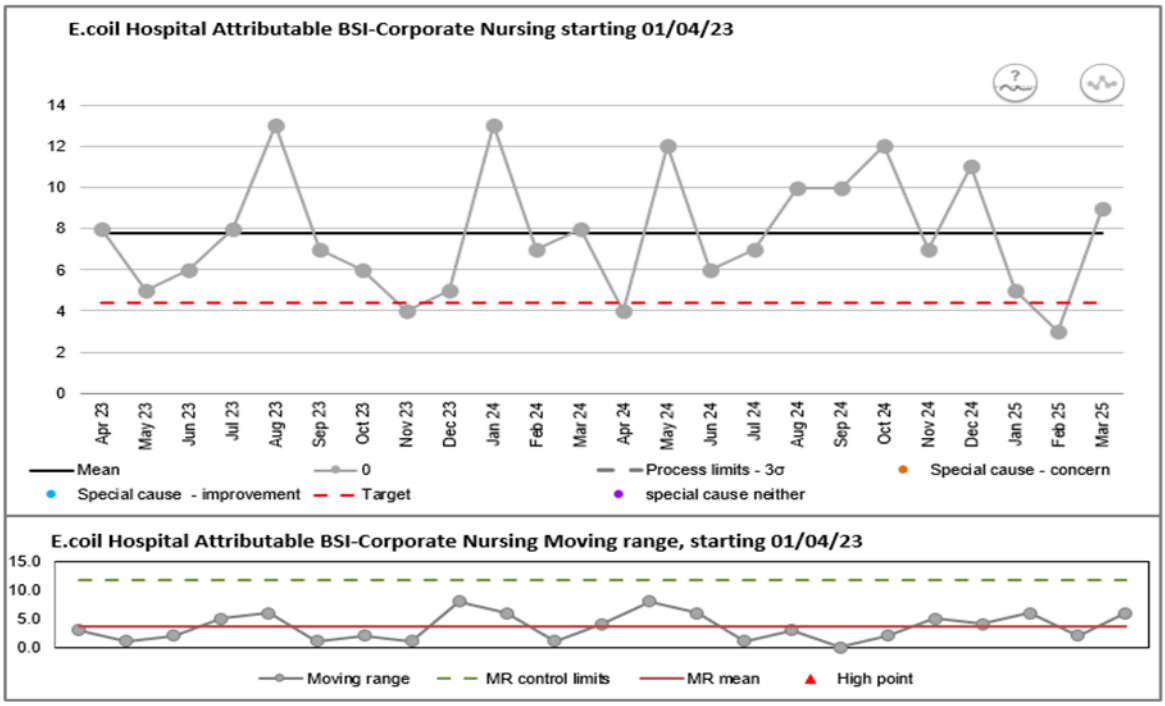
Table 10 below table provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated ***E.coli*** **bacteraemia** by month.

Table 10

Breakdown of E.coli cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	3	7	2	2	5	7	7	5	9	3	1	7	58
CO-HA	1	5	4	5	5	3	5	2	2	2	2	2	38
Community Associated	22	18	15	17	17	12	12	12	18	11	8	19	181

SPC chart 5 below provides a breakdown of *E.coli* bacteraemia by month.

Chart 5



Suspected Source of Hospital onset *E.coli* BSIs:

- 23 – catheter Associated Urinary Tract Infections
- 14 – hepatobiliary / intraabdominal
- 14 – UTI, not catheter related
- 3 – unknown source
- 2 – wounds / abscesses
- 1 – aspiration pneumonia
- 1 – post-op complication

Klebsiella

Klebsiella bacteria are normally found in the human intestines and faeces (where they do not cause disease). In healthcare settings, *Klebsiella* infections commonly occur among sick patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators (breathing machines) or intravenous (vein) catheters, and patients who are taking long courses of certain antibiotics are most at risk for *Klebsiella* infections. Healthy people usually do not get *Klebsiella* infections.

Table 11 below provides a breakdown of Hospital attributed ***Klebsiella* bacteraemia** by month against the trajectory.

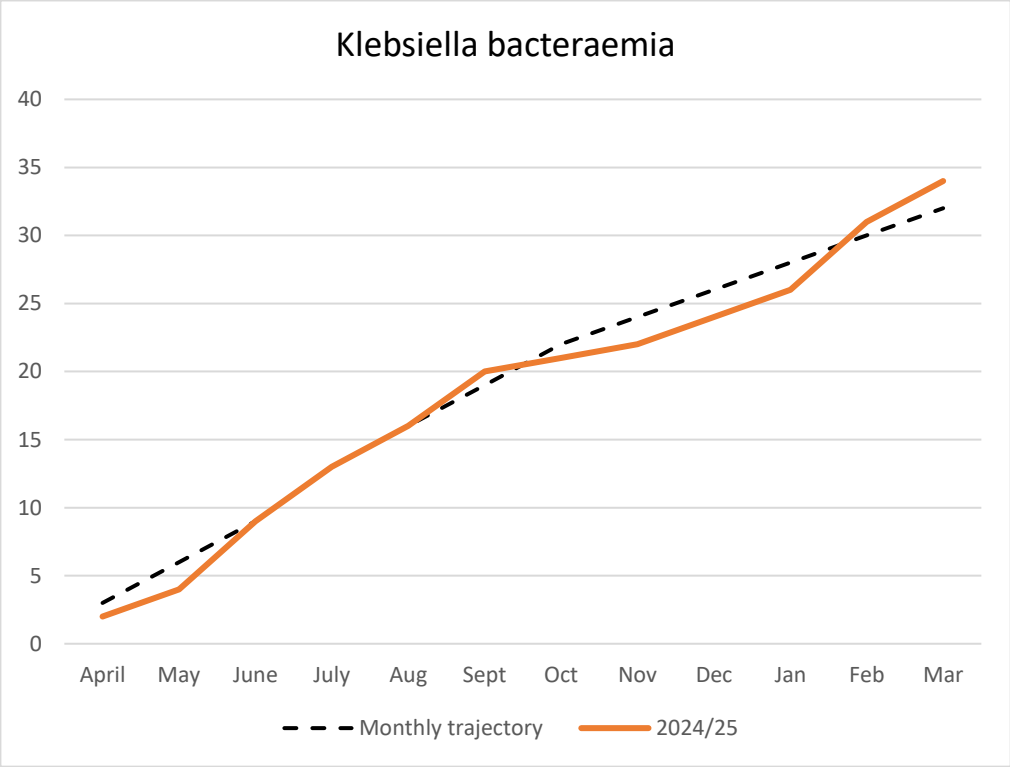
Table 11

Klebsiella bacteraemia													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Threshold 2024/25	3	3	3	4	3	3	3	2	2	2	2	2	32
2024/25	2	2	5	4	3	4	1	1	2	2	5	3	34
2023/24	3	6	2	0	2	4	1	4	2	6	1	3	34
2022/23	0	4	1	3	6	3	2	4	5	2	2	4	36
2021/22	1	3	4	1	3	0	3	2	2	2	1	3	25

In 2024/25 we reported 34 K*lebsiella* bacteraemia, this remains the same during 2023/24 and is 2 infections over our threshold for 2024/25.

Graph 6 below provides ***Klebsiella* bacteraemia** reported infections by month against the trajectory.

Graph 6



SPC chart 6 below provides a breakdown of *Klebsiella* bacteraemia by month.

Chart 6

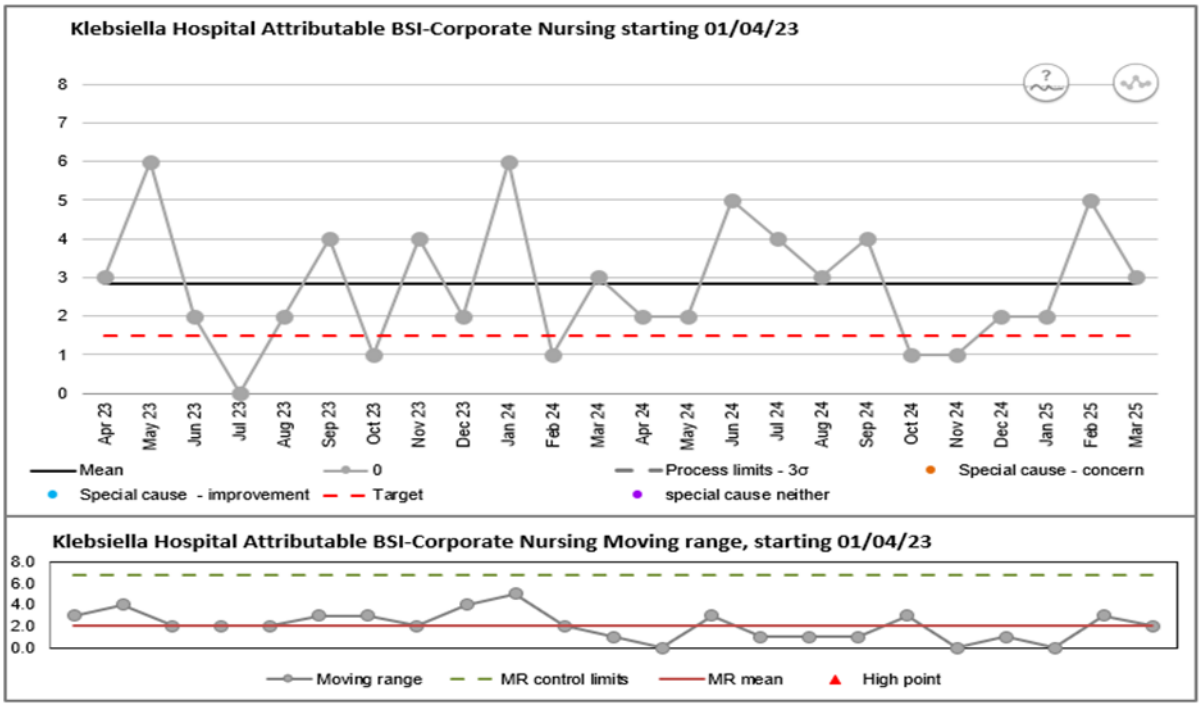


Table 12 below table provides a breakdown of Hospital Onset and Community onset Hospital Associated and Community Associated ***Klebsiella* bacteraemia** by month.

Table 12

Breakdown of Klebsiella cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	2	2	3	1	3	2	0	1	0	1	4	2	21
CO-HA	0	0	2	3	0	2	1	0	2	1	1	1	13
Community Associated	4	2	4	4	4	1	2	1	3	3	2	3	33

Suspected Source of Hospital onset *Klebsiella* BSIs:

- 8 – hepatobiliary / intra-abdominal
- 3 – CAUTI
- 6 – UTI, not catheter related
- 1 – unknown source
- 1 – respiratory
- 1 – pyelonephritis
- 1 – deep-seated infection

Pseudomonas

Pseudomonas aeruginosa is a bacterium commonly found in the environment, particularly in moist areas and water sources. It can also be found in soil and on plants and vegetables. While it is widespread, it rarely causes illness in healthy individuals. However, it is an opportunistic pathogen and can cause infections in people with weakened immune systems such as those in hospital or with conditions like cystic fibrosis. Resistant strains of the germ can also spread in healthcare settings from one person to another through contaminated hands, equipment, or surfaces.

Table 13 below provides a breakdown of Hospital attributed ***Pseudomonas* bacteraemia** by month against the trajectory.

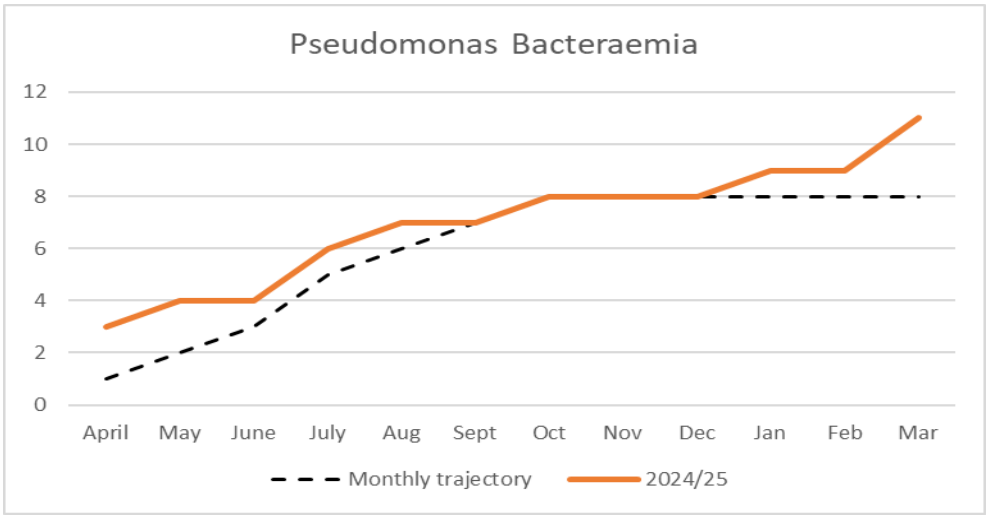
Table 13

Pseudomonas bacteraemia													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Threshold 2024/25	1	1	1	2	1	1	1	0	0	0	0	0	8
2024/25	3	1	0	2	1	0	1	0	0	1	0	2	11
2023/24	1	0	0	0	0	0	3	1	1	1	2	0	9
2022/23	0	0	0	0	1	0	0	1	1	3	1	1	8
2021/22	1	0	0	0	2	3	0	1	0	0	0	1	8

In 2024/25 we reported 11 *Pseudomonas* bacteraemia, this is an increase of 2 when compared to 2023/24 and is 3 infections over our threshold for 2024/25.

Graph 7 below provides Pseudomonas bacteraemia reported infections by month against the trajectory.

Graph 7



SPC chart 7 below provides a breakdown of ***Pseudomonas* bacteraemia** by month.

Chart 7

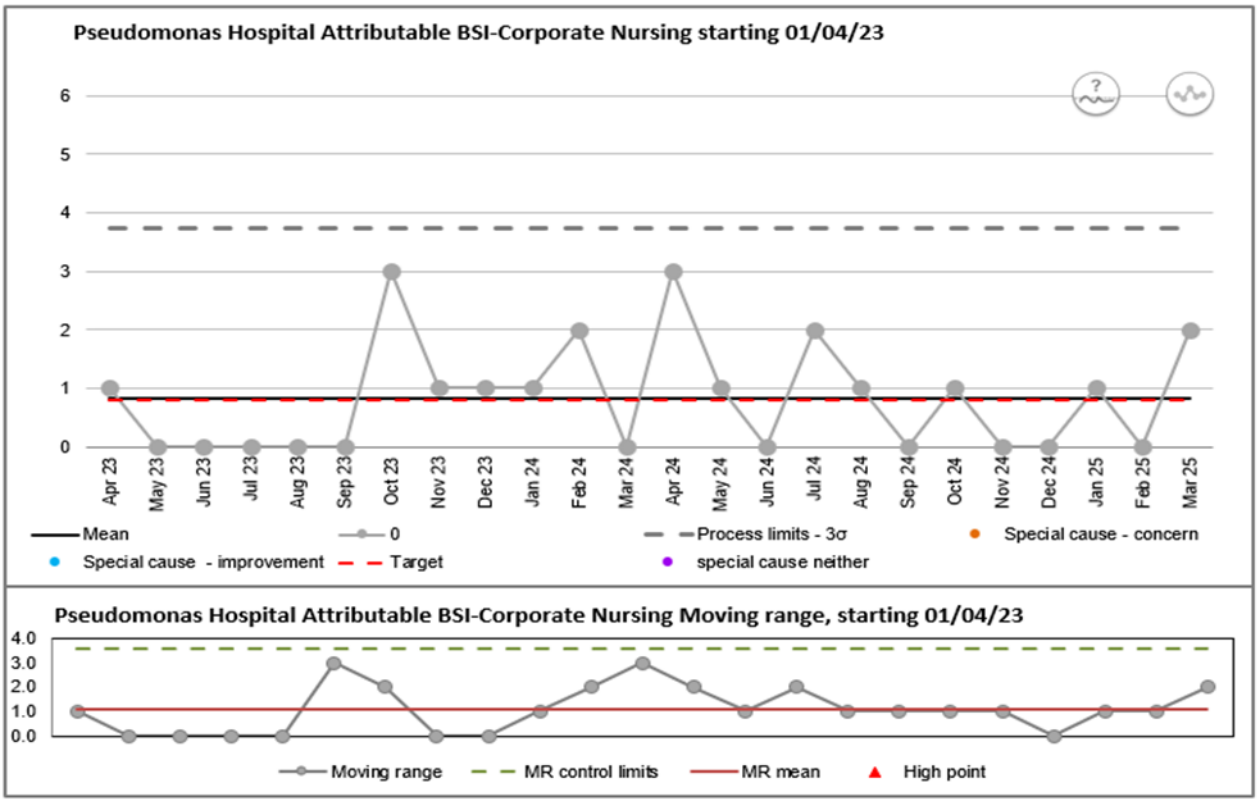


Table 14 below table provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated ***Pseudomonas* bacteraemia** by month.

Table 14

Breakdown of Pseudomonas cases in 2024/25													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	3	1	0	1	0	0	0	0	0	1	0	1	7
CO-HA	0	0	0	1	1	0	1	0	0	0	0	1	4
Community Associated	1	1	0	2	0	3	2	2	5	1	2	1	20

Suspected Source of Hospital onset *Pseudomonas* BSIs:

- 3 – haematology patients with mouth ulceration – on review they all had been using tap water to brush their teeth, they have now reverted to sterile water
- 1 – intra-abdominal
- 1 – CAUTI
- 1 – biliary
- 1 – renal stones

6.14 Themes from gram negative bacteraemia reviews

An initial rapid review of all hospital onset gram negative BSIs is undertaken by IPC and Microbiology to determine an initial source and if it requires further investigation, as often these bacteraemia are unavoidable due to the complexities of the patient. A review is recommended if the source is considered to be linked to either urinary catheter, intravascular device, chronic wounds, surgical or tracheostomy site infection, ventilator associated pneumonia, or if focus of infection is unknown.

A quarterly report is provided to IPCG to provide an update on GNBSI figures, how we compare regionally and what themes have been identified.

Below are the themes that have been identified from the initial reviews.

- Blood culture policy not being followed
- Insertion and ongoing care of invasive devices not clearly documented in CERNER
- National Urinary Catheter Passports nor being given to patients or not being requested when patient admitted
- Appropriate samples not collected when infection suspected
- Urine dipstick has been used to diagnose CAUTI or UTI in people aged over 65 years
- Previous specimen sensitivities not considered when prescribing antimicrobials
- Hydration of patients not being considered, especially in patients who are prone to UTIs

6.15 Carbapenemase-producing *Enterobacteriaceae* (CPE)

The spread of antibiotic resistance in gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are responsible for some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

Table 15 below provides a breakdown of all CPE **bacteraemia** by year and month. There were no reported CPE bactaraemia in 2024-25.

Table 15

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1
2021/22	0	0	0	0	0	0	0	1	0	0	0	0	1
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0
2024/25	0	0	0	0	0	0	0	0	0	0	0	0	0

6.16 Mandatory Glycopeptide resistant *Enterococci* (VRE) bacteraemia

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.

There has been no incidence of VRE bacteraemia reported at WUTH during the period April 2024 - March 2025. Unlike other organisms under mandatory surveillance, UKHSA employs a reporting year which runs from October–September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

Table 16 below provides a breakdown of VRE **bacteremia** by month.

Table 16

The incidence of *VRE bacteraemia since 2019/20*													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	1	0	1	0	1	1	0	0	1	0	5
2020/21	1	0	0	0	0	0	0	0	0	0	0	0	1
2021/22	0	2	0	0	0	1	0	1	0	0	0	0	4
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0

There were no reported VRE bacteraemia in 2024-2025

6.17 Quarterly Mandatory Laboratory Reporting (QMLR)

It is mandatory to submit 'Quarterly Mandatory Laboratory Reporting' data via the UKHSA Health Care Associated Infection (HCAI) Data Capture System. This has been completed throughout the year by the Clinical Scientist in Microbiology.

This data includes:

- Total number of blood culture sets examined.
- Total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- Total number of positive blood culture sets
- Total number of S. aureus positive blood culture sets
- Total number of *Clostridioides difficile* toxin positive reports in people aged 2 - 64 years.
- Total number of *Clostridioides difficile* toxin positive reports results in people aged >=65 years
- Total number of stool specimens tested for diagnosis of C. difficile infection.
- Total number of stool specimens examined.
- Total number of faecal specimens and rectal swabs taken for carbapenemase-producing *Enterobacteriaceae* (CPE) screening

6.18 Coronavirus (COVID-19)

The Government's aim throughout the COVID-19 pandemic was to protect the lives and livelihoods of citizens across the United Kingdom (UK).

The emergence of new variants has been a significant factor in determining the path of the virus as new variants of COVID-19 continue to emerge. Living with and managing the virus like any other respiratory virus will maintain the population's wall of protection, continuing to communicate safer behaviors that the public can follow will also help to manage the risks.

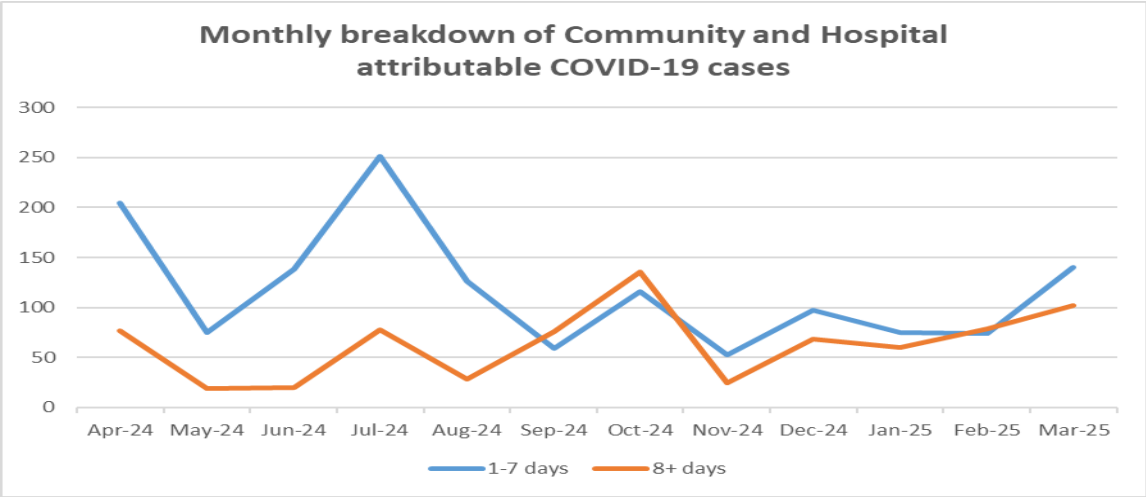
There remained a steady influx of patients identified with COVID-19 throughout the year with most as can be seen in table 17 below being detected shortly after admission which signifies that COVID-19 was still circulating in the community

Table 17

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month	1-2 days	3-7 days	8-14 days	15+ days	
Apr-24	13	2	3	2	20
May-24	52	5	3	4	64
Jun-24	66	5	10	16	97
Jul-24	126	14	8	20	168
Aug-24	54	2	5	8	69
Sep-24	36	4	10	10	60
Oct-24	69	14	26	22	131
Nov-24	17	8	7	8	40
Dec-24	26	5	5	11	47
Jan-25	23	3	1	4	31
Feb-25	11	2	2	4	19
Mar-25	15	1	2	4	22
Total	508	65	82	113	768

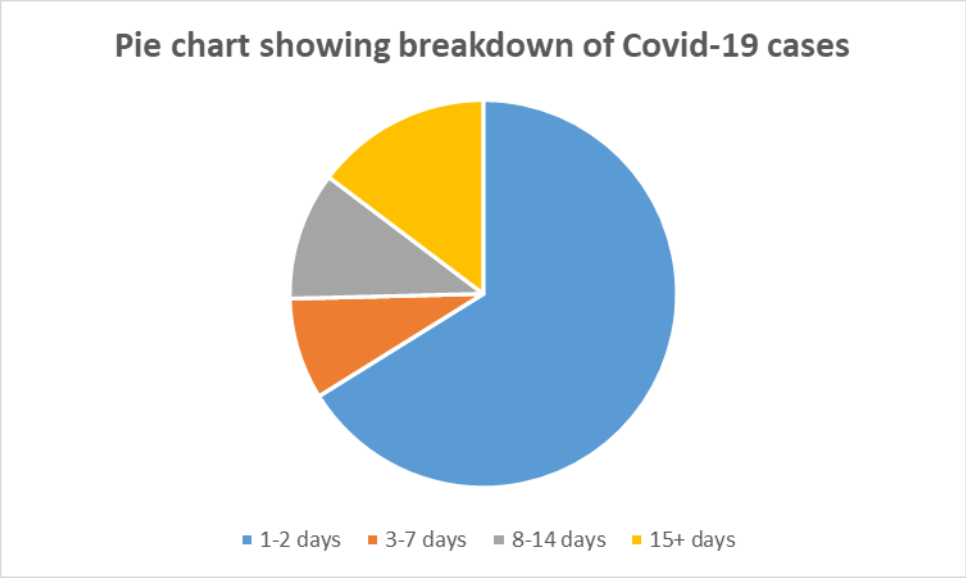
Graph 8 below shows the incidence of patient COVID-19 results in 2024/2025.

Graph 8



The Pie chart 1 below provides a breakdown of COVID-19 in 2024-2025

Pie chart 1



Over time, though hard to predict, it is likely that COVID-19 will become a predominantly winter seasonal illness with some years seeing larger levels of infection than others. This may take several years to occur as waves of infection have occurred throughout the year.

6.19 Seasonal Influenza

WUTH participates in the Unify2 influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU). Table 18 below shows the summary of Influenza Cases in Augmented care areas reported through Unify2 Surveillance Scheme since 2019-2020

Table 18

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
April 2019 - March 2020	3	4	3	0	0
April 2020 - March 2021	0	0	0	0	0
April 2021 - March 2022	0	0	0	0	0
April 2022 - March 2023	2	2	12	0	0
April 2023 - March 2024	1	5	4	0	0
April 2024 - March 20245	3	0	5	1	0

Throughout the rest of the Trust there were 493 positive flu patients admitted in 2024/25, compared with 303 the previous year. There were 441 Flu A positives, 2 Flu A+B and 50 Flu B positives. Some cases were an incidental finding due to the type of test that was performed for COVID-19; as can be seen above 9 patients required level two and level three care settings (ICU and HDU).

Of the reported cases of Influenza, 7 patients died during their inpatient stay, of these all but 2 came into hospital with Influenza. Of the 2 patients who acquired flu whilst an in-patient, neither had flu listed within Part 1 on their death certificate as a direct cause of death.

6.20 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to UKHSA comprising of at least 1 quarter per year for one orthopaedic category as a minimum. Throughout the year the Trust has been completing and submitting results of ongoing mandatory surveillance every quarter for:

Orthopaedic

- *Hip replacement* - Replacement of the hip joint including resurfacing of the joint, acetabulum replacement and revision of previous replacement and conversion from a previous hemiarthroplasty or bone fixation.

Throughout the year the Trust has been completing local surveillance for:

Colorectal

- *Large Bowel* - Incision, excision, or anastomosis of the large bowel, including procedures which involve anastomosis of small to large bowel.

Table 19 below identifies the number of SSI reported

Table 19

Category	Apr-Jun 24		Jul-Sept 24		Oct-Dec 24		Jan-Mar 25	
	Total operations	SSI reported	Total operations	SSI reported	Total operations	SSI reported	Total operations	SSI reported
MANDATORY Hip replacement	145	0	140	1	126	0	193	4
LOCAL Large Bowel	58	11	58	10	50	7	51	6

All suspected SSIs are reviewed by the weekly multidisciplinary team, comprising of IPC, Microbiology, SSI nurse, Clinician and matron to agree if it is a confirmed SSI and identify learning and agree local action plans.

The RCAs and action plans are shared with the ward/Theatre areas and clinicians for comments and learning. Action plans developed with the ward areas are being reviewed regularly to monitor progress. This is fed into divisional IPC for assurance. SSI has also been added to Division clinical governance meetings and any issues are being escalated via divisional quality board (DQB).

Learning identified from the RCA's have been reported at monthly IPCG meetings and action plans developed to address the:

7.0 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of outbreaks which enables control measures to be instigated early to avoid escalation. An outbreak, as defined in the National Infection Prevention manual is

- Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified period

Or

- A higher-than-expected number of cases of HAI in each healthcare area over a specified time.

Once an Outbreak has been identified the IPC Team complete an incident form and arrange an initial outbreak meeting with the divisional teams to give support and advice. A risk assessment is then undertaken to determine if additional meetings are required, however the IPC team visit the outbreak areas daily to provide ongoing support until the outbreak is determined to be closed.

7.1 Norovirus

Between 1st April 2024 and 30th March 2025 there were 33 confirmed Norovirus outbreaks, across 16 wards with 9 wards experiencing more than one Norovirus outbreak. This is an increase of 12 outbreaks when compared to the previous year. Due to significant operational pressures only 11 wards were closed to admissions, although this was not always for the full duration of the outbreak.

The length of outbreaks ranged from 1 day up to 21 days, with an average of 10 to 11 days. 4 of the outbreaks only lasted for 1 to 3 days as all patients were either isolated or discharged from the affected bay. Due to the operational pressures in the Trust, ward restrictions were reviewed daily and following a risk assessment IPC provided robust plans to release empty beds if it deemed to be appropriate. As a result, some new patients admitted to these wards did acquire Norovirus which potentially extended the length of their stay and the length of the outbreaks. There were 375 bed days lost due to closed beds on Norovirus affected wards.

In total, 641 patients experienced diarrhoea and/or vomiting symptoms, of these 175 patients were confirmed to have Norovirus. When Norovirus is confirmed on a ward it is presumed that any further patients on the ward with symptoms are likely to have Norovirus, so not all patients are sampled. There were 87 staff who also reported symptoms during these outbreaks, however 15 outbreaks had no staff affected.

N.B. It is rare to receive samples from staff into the Lab for testing.

7.2 *Clostridioides difficile*

There were 15 wards that were identified as having a period of increased incidence of *C.difficile*, during 2024-25, compared with 6 the previous year:

- Ward 18 – 6 patients were diagnosed in April 2024, 5 with CDT and 1 with an equivocal result. Of the samples sent for typing, 2 patients were identified as having ribotype CE029, which is suggestive of cross infection and one with CE871 and one with CE014.

Due to the introduction of fees for ribotyping, routine typing then ceased.

- Ward 32 – 5 patients were diagnosed in April 2024, 4 with CDT and 1 with an equivocal result.
- Ward 22 – 4 patients were diagnosed in June 2024, 1 with CDT and 4 with equivocal results.
- Ward 36 – 3 patients were diagnosed in July 2024, 2 with CDT and 1 with an equivocal result. The PII was extended for a further 2 weeks as 2 other patients were diagnosed with CDT that were deemed to be linked to the original patients.
- Ward 23 – 4 patients were diagnosed in July 2024, 3 with CDT and 1 with an equivocal result.
- Ward 26 – 3 patients were diagnosed in July 2024, 2 with CDT and 1 with an equivocal result.
- Ward 20 – 5 patients were diagnosed in September 2024, 2 with CDT and 3 with equivocal results.
- Ward 10 – 4 patients were diagnosed in October 2024, 2 with CDT and 2 with equivocal results. A further patient was diagnosed with an equivocal result however they were not deemed to be linked.
- Ward 27 – 6 patients were diagnosed in October 2024, 5 with CDT and 1 with an equivocal result.
- Ward 30 – 6 patients were diagnosed between September and December 2024, 3 with CDT and 3 with equivocal results. The PII was declared in December 2024.
- M1 Rehab – 5 patients were diagnosed in December 2024, 2 with CDT and 3 with equivocal results.
- Ward 22 – 3 patients were diagnosed in January 2025, 2 with CDT and 1 with an equivocal result.
- Ward 31 – 3 patients were diagnosed in February 2025, 2 with CDT and 1 with an equivocal result.
- Ward 24 – 3 patients were diagnosed in February 2025, 1 with CDT and 2 with equivocal results.
- Critical Care – 5 patients were diagnosed in March 2025, 2 with CDT and 1 with an equivocal result.

Once a period of increased incidence (PII) is declared all wards are required to implement the Trust CDI improvement plan, enhanced cleaning is initiated and increased attention to outstanding Estates issues addressed. The PII improvement plan is monitored for a minimum of 4 weeks and may be extended if there are more patients diagnosed with CDI that are deemed to be linked. A plan developed to ensure that all areas of the ward are HPV cleaned. When the PII is over, all documentation is advised to be attached to the incident form which is commenced when the PII is declared.

7.3 COVID-19

Although there was no longer a requirement to report COVID-19 outbreaks to the NHSE/I online reporting system, COVID-19 outbreaks continued to be declared internally with initial outbreak meetings held to review the outbreak situation and monitor mitigating actions, this was supported with regular visits by the IPCT to the outbreak wards.

In October 2024 a review of the length of outbreak monitoring was undertaken by the Clinical Advisory Group and it was agreed that outbreaks would reduce from 14 days to 10 days after the last positive patient, in line with the changes to the UKHSA COVID-19 guidance. In January 2025 this timeframe reduced again to a full 5 days after the last positive patient, this was in line with the community guidance.

Between April 2024 and March 2025 there were 23 COVID-19 outbreaks declared, which is a slight reduction from the previous year when 24 outbreaks were declared.

In total 142 patients tested positive for COVID-19:

- 14 patients tested positive between day 3 and 7.
- 53 patients tested positive between day 8 and 15.
- 75 patients tested positive after day 15 of admission.

Only 9 staff tested positive as part of 6 of the outbreaks, however the true figure of affected staff is unknown as there is no longer a requirement for staff to test for COVID-19.

The number of outbreaks peaked in October, with 6 outbreaks declared followed by September when 5 outbreaks where declared.

7.4 Influenza

There were 6 Flu outbreaks declared in 2024-25, which is an increase of 4 from the previous year:

- Ward 26 in December 2024 – 9 patients tested positive between day 6 and day 51 of admission.
- Ward 31 in January 2025 – 10 patients tested positive between day 3 and day 39 of admission.
- Ward 18 in January 2025 – 3 patients tested positive for Flu A between day 8 and day 26 of admission, however another patient tested positive for Flu B at the same time, 2 staff were also noted to be symptomatic.
- Ward M1 in January 2025 – 2 patients tested positive for flu A between day 32 and day 81 of admission, 2 staff were also noted to be symptomatic.
- Ward 24 in January 2025 – 2 patients tested positive for Flu A between day 7 and day 12 of admission.
- CRC in February 2025 – 4 patients tested positive for Flu A between day 54 and day 122 of admission, 3 staff were also noted to be symptomatic.

Initial outbreak meetings were held to ensure that all mitigating actions were implemented, including mandatory wearing of FRSMs for all staff on the ward and air purifiers in the bays where positive Flu patients had been. The outbreak was monitored until 5 full days after the last positive patient was tested.

7.5 Parainfluenza

A Parainfluenza outbreak was declared on the Neonatal Unit in April 2024. This was identified when four babies tested positive within 2 days of each other, all positive babies were symptomatic and had been nursed in the nursery at the same time. Regular outbreak meetings were held and there was a low threshold for swabbing other babies if it was clinically indicated, however no other babies tested positive. Respiratory PPE was implemented initially across the unit, this was then reviewed and only remained in place whilst the babies remained symptomatic. Visiting was restricted and all mitigating actions were monitored for the duration of the outbreak, which was for 2 weeks.

7.6 Carbapenemase-producing *Enterobacteriaceae* (CPE)

In November 2024, 4 patients were newly identified with CPE OXA-48 colonisation on Ward 30, 3 patients were identified from weekly screens and 1 patient was identified from admission screening, however they were a regular attender on the Haematology Day Ward. At the same time the ward was also identified as having a period of increased incidence of CDT, therefore the increase in CPE was managed in conjunction with the PII of CDT which involved the development of an improvement plan which was monitored over 4 weeks with regular meetings to ensure there was progress with actions. Following this there were no further new CPE acquisitions identified on Ward 30.

8.0 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff have been exposed to a specific infection e.g., scabies, Group A *Streptococcus*, identified by either the IPCT or PHE which results in the need for either staff and patient screening / treatment or both. When these situations have been identified the IPC team support the ward teams to complete contact tracing and screening, if exposed patients / staff are identified immunisation records are checked by the patient's clinician and occupational health for verification of immunity and vaccination offered as required.

8.1 Group A *Streptococcus*

Group A *Streptococcus* (also known as GAS, group A strep, strep A, and *Streptococcus pyogenes*) is a bacterium which can colonise the throat, skin and genital tract. Strep A infections are more common in children, but Adults can also sometimes get them. Most strep A infections are not serious and can be treated with antibiotics. But rarely, the infection can cause serious problems, this is called invasive group A strep (iGAS) It is spread by close contact between individuals, through respiratory particles and direct skin contact. It can also be transmitted environmentally, for example through

contact with contaminated objects, such as towels or bedding, or ingestion of food prepared by someone with the infection.

During 2024-25, 13 patients had an iGAS identified from blood cultures or other samples collected on admission, which is an increase of 3 from the previous year. As this is sometimes only diagnosed post admission, 'warn and inform' letters were regularly issued to staff who may have been exposed, prior to confirmed diagnosis, without wearing a FRSM. There were no cases of healthcare workers who acquired GAS reported by Occupational Health or transmission to other patients identified.

8.2 Mpox

Mpox (previously known as monkeypox) is an infectious disease that is caused by the MPXV virus and was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research. The first human case was recorded in 1970 in the Democratic Republic of Congo (DRC), and since then the infection has been reported in several African countries and, more recently, has spread to multiple countries around the world, including the UK. There are 2 major types of MPXV, called clades, and are known as clade I and clade II, these are also sub-types of each clade.

Since May 2022, cases of human mpox have been reported in multiple countries that do not usually have mpox virus in animal or human populations, this ongoing outbreak is mostly caused by clade IIb and is mostly spread by sexual contact.

Since August 2024, clade I MPXV has also been reported from multiple countries outside of the African region that had not previously reported it, including in the UK. This is mostly caused by clade Ib MPXV and is mostly spread through close physical contact (including both sexual and non-sexual contact).

Mpox was initially considered to be a high consequence infectious disease (HCID), however in January 2023, ACDP advised that clade II no longer met the criteria due to the low case fatality rate, and mild to moderate illness. Later in February 2025, Clade I Mpox , which was previously considered more infectious also had its HCID status revoked.

During the period, 2023 to 2025 (up to 31 March 2025) there have been a total of 483 cases of mpox clade IIb and 11 cases of mpox clade Ib reported in the UK.

Although there have been no confirmed mpox cases admitted to WUTH during 2024-25, there was a patient who was admitted with suspected mpox. Following review of the patient's journey there were several learning points identified, including:

- The importance of screening questions being asked in ED
- Availability of appropriate PPE, including respirator hood batteries being fully charged
- Access to Language Line and having information available in different languages
- Discharge plans for patients who are not well enough to be discharged but who are unable to self-isolate.

8.3 Tuberculosis

Tuberculosis (TB) is an infectious disease caused by the organism *Mycobacterium tuberculosis* (MTB). TB usually presents as a chronic disease of the respiratory tract but may also affect other organ systems. TB is spread by inhalation of infectious droplets, which may be coughed or sneezed by a patient with respiratory TB. People with TB in organs other that the respiratory tract or with latent TB are rarely infectious to others.

During 2024-20245 there were 5 TB 'incidents' that required a multi-disciplinary approach, this included staff from IPC, Microbiology, Occupational Health, and the TB Specialist Team.

- In April 2024, the IPC team were notified by UKHSA of a child who had started being treated for TB in October 2023 and had previously been seen at APH when they may have been infectious. Contact tracing was complex due to the amount of time that had elapsed, however 10 'warn and inform' letters were sent by the TB team.

- In July 2024, a patient was admitted with a complex history and TB was considered as a differential diagnosis. Although the patient was isolated promptly the level of PPE worn by staff was not sufficient, i.e. FRSM instead of FFP3 respirator. 'Warn and inform' letters were sent to appropriate staff by Occupational Health following contact tracing. As a result of this incident the TB Policy was updated to specify the need to wear an FFP3 respirator when caring for patients with suspected or confirmed TB.

- In August 2024, a patient was admitted to ED with a history of haemoptysis and on medical clerking the need to rule TB was highlighted. This information was not communicated, and the patient was transferred into an open bay with other patients for 19 hours, when the patient was subsequently isolated. Following contact tracing, 10 patients were identified as contacts and were followed up by the TB team. 5 staff contacts were required to complete a risk assessment as to level of exposure which were reviewed by Occupational Health.

- At the end of December 2024, the Liverpool TB Team informed WUTH TB team of a patient who was being treated for Pulmonary TB. On review of the patient's records, it was noted that the patient had had 5 visits to APH since October 2024. Contact Tracing was instigated, and an incident meeting arranged. One of the patient's visits to WUTH was during the CERNER downtime and there was no ability to be able to undertake contact tracing for this episode of time, it was therefore agreed to only send letters to patients who had had more than 8 hours contact or those deemed to be 'high-risk' or vulnerable.

- In January 2025, the WUTH TB team were informed of a patient being treated in the Infectious Diseases Unit in Liverpool for Pulmonary TB with cavitating lung lesions. The patient had recently been transferred to Liverpool from WUTH, following a 5-day admission in an open bay with other patients. Contact Tracing was instigated and an incident meeting arranged. Due to the high number of contacts within ED, it was not possible to individually review all patients'

medical histories who had less than 8-hour exposure, therefore it was agreed to send 'Warn and Inform' letters to all contacts. This subsequently generated a lot of concerning phone calls to the TB Team. A holding statement was developed by the Communications team in preparation for any press enquiries however this did not need to be used. The 18 contacts who had more than 8 hours contact were followed up by the TB Team.

The IPC team were also part of the multi-agency team led by the local UKHSA Health Protection team to manage the contact tracing and management of a patient with Multi-drug resistant TB (MDRTB) in December 2024.

The WUTH guidelines for TB contact Tracing were reviewed and updated in March 2025, following the incident in December 2024 and January 2025, to include a more risk-based approach to contact tracing. This updated guidance was subsequently approved at IPCG.

8.4 Measles

Measles is caused by a morbillivirus of the paramyxovirus family. Early symptoms include the onset of fever, malaise (aches and pains), coryza (head cold), conjunctivitis (red eyes) and cough. The most common complications of measles include pneumonia, ear infection, diarrhoea and convulsions. Rarely, measles can and does cause encephalitis and death.

In July 2024 a patient was admitted who had recently been diagnosed with genital herpes and was being treated with Acyclovir. They were admitted into a bay on AMU via ED; however measles was only suspected 5 days into admission when all other investigations where noted to be negative. An incident meeting was held prior to confirmation to ensure that contact tracing was undertaken immediately to identify anyone at risk of developing severe disease. Following confirmation of measles infection 'warn and inform' letters were sent to 50 patients and their GPs, and a holding statement was arranged with Communications. Occupational Health also reviewed health risk assessments from staff and checked immunity status. Following review of this incident it was recognised that diagnosis was difficult due to the patient's presenting features, however when measles was suspected appropriate PPE could not be implemented as staff on duty had not been fit tested for FFP3 respirators, increasing their risk of exposure.

Following the national increase in measles cases at the beginning of 2024, regular Trust Measles Preparedness meetings continued until August 2024.

8.5 Chickenpox

Chickenpox is an acute, infectious disease caused by the varicella-zoster virus (VZV) and is most seen in children under 10 years old. Children with chickenpox are infectious from 24 hours before the rash appears until the vesicles are dry or have crusted over, usually about 5 days after the onset of the rash. Transmission is through close contact, or droplet spread, with an incubation of 1-3 weeks. Pregnant women, neonates and those who are immunosuppressed are at greater risk of complications due to chickenpox and may require post exposure prophylaxis if exposed.
During 2024-25 there were 2 separate occasions when siblings who had visited the neonatal unit developed a chickenpox rash the following day. Contact tracing was undertaken to determine who

may have been exposed and if they had immunity. This included neonates, parents/visitors and staff. To determine immunity of neonates who had been exposed, their mother's booking bloods were checked. Only one neonate required post exposure prophylaxis of intravenous acyclovir. Parents who did not know their immunity status were asked not to visit between day 5 and day 21 of exposure. There was no onward transmission of chickenpox identified from the exposure on the unit.

8.6 Pertussis

Pertussis (whooping cough) is a respiratory disease that is caused by the Bordetella pertussis bacterium and is vaccine preventable. Pertussis can cause serious and life-threatening complications, including pneumonia, difficulty in breathing (apnoea) and seizures. Severe complications and deaths occur mostly in infants under 6 months of age. It is a highly contagious disease that can spread rapidly from person to person through contact with infectious respiratory particles. Patients are most infectious during the early catarrhal phase but can remain infectious for up to 21 days.

In May 2024 a baby was referred to the Paediatric Assessment Unit following a visit by the Hospital at Home Team and was admitted to the Children's Ward and was subsequently confirmed to have Pertussis. Due to the age of the child, they admitted into a cubicle. As this occurred over a weekend the staff alerted IPC to the incident on the Monday, an assessment of staff who had seen the child without appropriate PPE had already been undertaken. There were 4 staff identified who were started on post exposure prophylaxis and required subsequent vaccination.

In July 2024 a baby was confirmed with Pertussis who had been seen in the Paediatric Assessment Unit on 2 occasions in the previous week. Again, due to the age of the child they were admitted to a cubicle, however risk assessments were required to be undertaken by Occupational Health for staff who had cared for the child prior to diagnosis and had not worn appropriate PPE.

Following the re-emergence of pertussis in England, the UKHSA updated their guidance on the management of pertussis cases in August 2024. Communication was circulated across WUTH to increase awareness of symptoms to monitor for.

8.7 Hepatitis A

Hepatitis A virus infection causes a range of illness from mild, like nonspecific nausea and vomiting, through to hepatitis (liver inflammation, jaundice, or icterus) and rarely liver failure. It is normally spread by the faecal-oral route but can also be spread occasionally through blood. Good hygiene along with safe drinking water, safe handling of food and good handwashing practice prevents infection.

In May 2024 a patient was admitted with jaundice, nausea and vomiting and being generally unwell following a flu-like illness for 3 weeks. They were initially seen in UMAC and then transferred to a bay on MSSW prior to being diagnosed with Hepatitis A infection. A review of the patient's journey and contact tracing was undertaken to determine if there was any risk of ongoing transmission or potential serious complications due to exposure. There were 8 patients who identified as contacts however following an incident review meeting no further action was deemed to be necessary.

In January 2025 a patient was admitted with one week history of diarrhoea and vomiting, and new onset jaundice, and was discharged 5 days later. The IPCT were informed a week later by UKHSA that patient was confirmed to have Hepatitis A. On review of the patient's journey, they had not been isolated during their admission, and it was also noted that they were a healthcare worker who had worked whilst symptomatic prior to being admitted to hospital. An incident meeting was held to review the case, and all contacts identified from the beginning of January. Following discussion with UKHSA it was agreed that no further action of contacts was required as the patient was a healthcare worker and was reported to have good standards of cleanliness and hygiene. However, learning was identified in relation to the patient not being isolated despite history of diarrhoea and vomiting, and that IPC were not informed of the result immediately. In response to this Microbiology have updated their protocols and the side room prioritisation list was updated to included suspected/confirmed Hepatitis A.

8.8 Diphtheria

Diphtheria is an acute infectious disease that affects the upper respiratory tract and occasionally the skin. It is caused by bacteria *Corynebacterium diphtheriae* or *Corynebacterium ulcerans*. It is spread through coming into contact with droplets from the respiratory tract of an infected person -particularly spread by coughing and sneezing. It can also spread by touching contaminated objects or skin sores.

In January 2025 there was one suspected case of diphtheria that was identified in UMAC. The clinical area was reviewed and contact tracing was requested and analysed. Although this case was later deemed negative and no further action was required, the IPCT were proactive in collating the information.

9.0 Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable soon and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad-spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

NHS England and regulatory bodies such as the Care Quality Commission (CQC) expect secondary care organisations to be able to demonstrate adherence to guidance such as 'Start Smart Then Focus', a toolkit for antimicrobial stewardship in secondary care. Additionally, they must also be able to demonstrate good performance against other measures of effective antimicrobial stewardship such as consumption as well as the relevant indicators of the Commissioning for Quality and Innovation (CQUIN) framework.

9.1 Antibiotic Stewardship Team (AST)

The Antimicrobial Stewardship Team develops and support the implementation of policies, procedures and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners junior doctors and the Deputy Director of IPC. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care and Respiratory Consultant. Wider attendance remains a challenge however, the team engages directly with specific teams when required for certain pieces of work.

The AMS Team has the following strategies to improve AMS at WUTH:

- Audit program to monitor antimicrobial prescribing, consumption and identify areas for improvement.
- Prescriber education training program
    - Specialist annual training for F1s, F2s, and pharmacists which is delivered by the AMS pharmacy team. Microbiology team also provide annual training for F1s, F2s, IMTs and Medical Students.
    - All newly qualified Non-Medical Prescribers (NMP) attend a training session on AMS.
    - Training also provided on an ad hoc basis when necessary.
- Maintaining an evidence-based antimicrobial formulary and AMS policies & guidelines
- Ward-based AMS Team
    - The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers.
- Service improvements to improve antimicrobial prescribing (new treatments and diagnostic tests, developments to the e-prescribing system, etc).

9.2 Ward – focused Antimicrobial Stewardship Team

The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions but also provision of case-based teaching directly to prescribers. Areas which are high-users of broad-spectrum antibiotics or high incidence of *C.difficile* infections have been identified by point prevalence audits and prioritised for visitation in addition to areas with critical or complex infections requiring long-courses of treatment:

- Critical care (five times weekly)
- Acute Care (five times weekly) – AMU, MSSW, UMAC
- Acute Frailty Unit (weekly)
- Gastroenterology ward (weekly) – W33
- Elderly Care wards (weekly) W21, 22, 23 and 27

- Respiratory Unit (weekly) – W37 and 38
- Orthogeriatric wards/T&O x 3 (weekly) – W10,11,12 and WAFFU
- SEU (weekly)
- Colorectal unit (weekly)
- General medicine (weekly) – W19, W24

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues. Microbiology +/- AMS Pharmacist also attend the following weekly MDTs:

- Renal
- Haematology
- Endocarditis
- OPAT MDT and "virtual" ward round
- *C.difficile* infection MDT
- Prosthetic Joint MDT

9.3 Priorities for 24/25

The following AMS priorities were identified based on the 2024-5 Quality Contract, local priorities to support overall delivery of the AMR National Action Plan and based on previous national targets. For 2024/5 the NHS standard contract did not contain antimicrobial prescribing targets. There were no mandatory CQUIN targets for trusts to improve antimicrobial stewardship, however, NHSE published a voluntary CQUIN to build on the work of 2023/4 CQUIN (03) IV to Oral Switch.

Reduction of broad-spectrum antibiotics
Target: Reduce consumption of broad-spectrum Watch & Reserve antibiotics by 10% by March 2025 compared with calendar year 2017 (DDDs/1000 admissions) *(NHS Standard contract 2023/24).*

Reduce consumption of intravenous antibiotics
Target: Reduce by 1% compared to previous year (DDDs/1000 admissions reported quarterly)

Reduce unnecessary IV antibiotics
Target: Achieve 10% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria (refer to audit plan).

Assurance of compliance with best practice AMS principles outlined by Start Smart Then Focus
Target: To achieve >95% compliance with all indicators Antibiotic Safe Prescribing Indicators Report' (ASPIRE)

Assurance of appropriateness of prescribing of restricted antibiotics
Target: To achieve >95% compliance

Assurance of appropriateness of prescribing of quinolone antibiotics in line with Trust guidance and MHRA restrictions

Target: To achieve >80% compliance

Table below shows the Assurance position at the end of 2024/2025.

Table 19

	Table 20. Assurance position 2024/25	Data source	Target	Q1	Q2	Q3	Q4	Total
1	Reduction of broad-spectrum antibiotics (Watch and Reserve) (DDDs per 1000 admissions reported quarterly) (Baseline: 2164 (2017))	DEFINE	10% reduction (Green = >10% reduction, amber = reduction, red = increase)	0% change	6.5% decrease	4% increase	4% decrease	1.5% decrease (2129)
2	Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly) (Baseline: 1220 (23/24)	DEFINE	1% reduction	2% decrease	6.25% decrease	4% decrease	2.5% decrease	3.5% decrease (1177)
3	Achieve 10% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria	Local audit	≤10% (Green= ≤10%, Amber= <40%, Red= >40%)		14%		10%	
4	Antibiotic Safe Prescribing Indicators Report' (ASPIRE) Quality indicators:	Local audit						
4.1	Compliance with antibiotic formulary		>95%	97%	95%	99%	97%	97%
4.2	Documentation of indication for antibiotics on prescription		>95%	99%	95%	95%	97%	97%
4.3	Stop / review date on antibiotic prescription		>95%	100%	100%	99%	100%	100%
4.4	Antibiotic clinical review undertaken within 72 hours of initiation		>95%	98%	95%	99%	95%	97%
5	Assurance of appropriateness of prescribing of restricted antibiotics	Local audit	>95%	98%	99%	99%	97%	98%

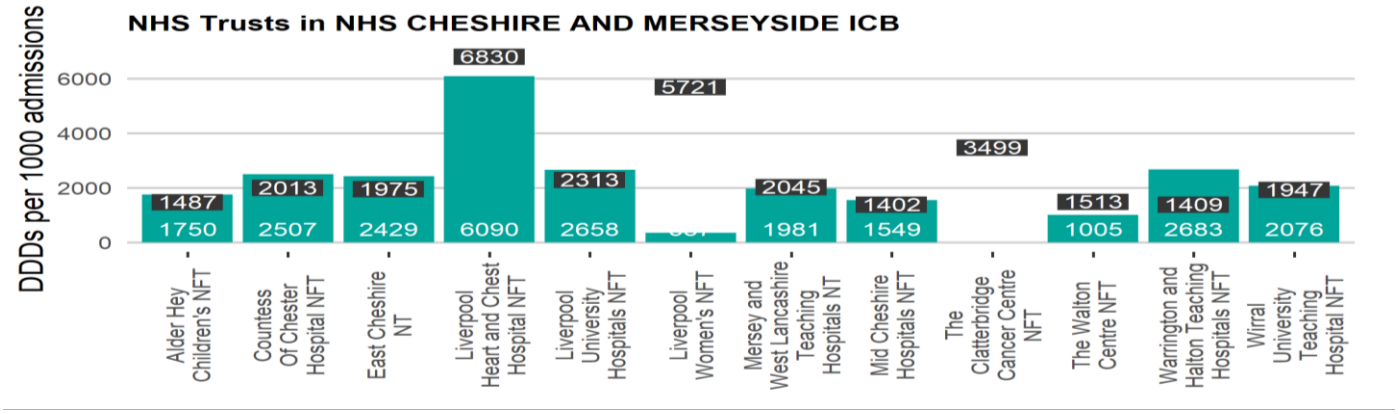
9.4 Antibiotic Consumption

SSTF requires Trusts to understand their antibiotic consumption patterns. Antibiotic consumption is measured as defined daily doses (DDDs) which is the standard dose of that agent for an adult in a single day. Antibiotic consumption data is skewed by hospital occupied bed days and to introduce consistency is often measured by DDDs per 1000 admissions. National data analysis is also available on the RXInfo DEFINE and PHE Fingertips websites.

9.5 Reduction of broad-spectrum antibiotics (Priority 1)

We have not met our target to reduce Watch & Reserve antibiotics by 10% compared to 2017 baseline (measured in DDDs per 1000 total admissions), we have reduced by 1.5% (2129 DDDs per 1000 admissions for 24/25).
Regionally, this is similar to other non-specialist trusts, with some reducing but not many have met the 10% target to reduce (regional data as of end Q2, see Graph 9 below).

Graph 9. Cheshire & Merseyside Trusts Watch & Reserve DDDs per 1,000 admissions for the four quarters ending Q2 24/25

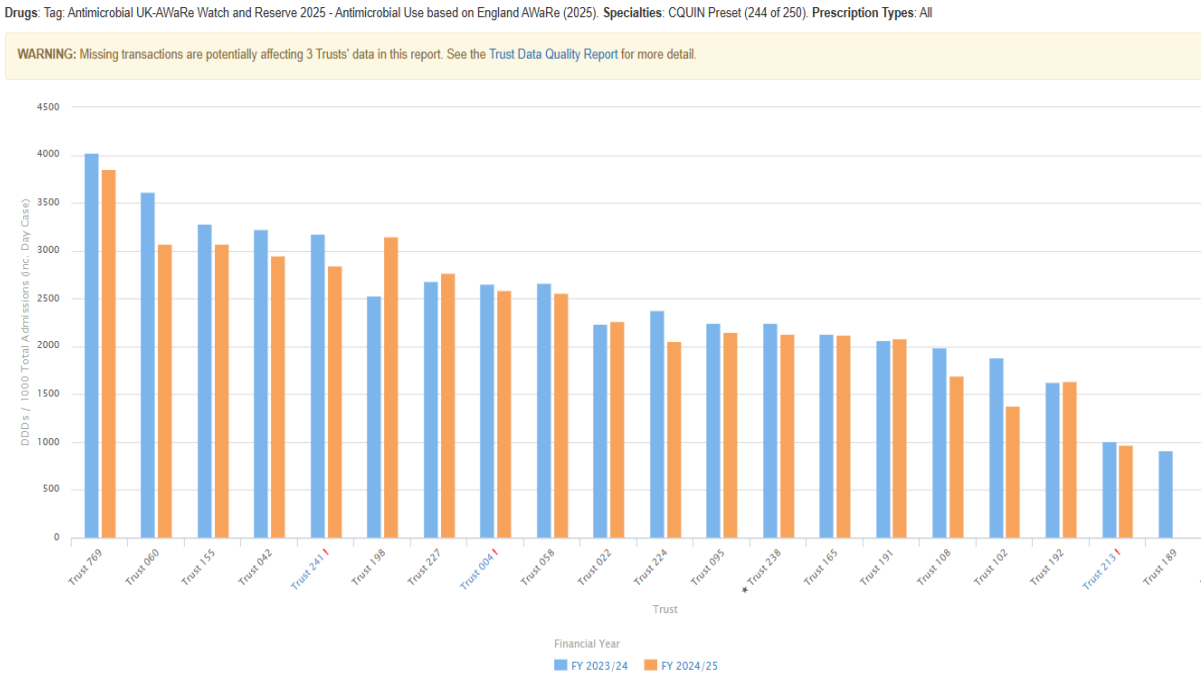


Actions we undertook to try to meet this target:

- Reduced antibiotic pre-pack sizes to 5 days from 7 days in admissions areas, however, co-amoxiclav packs were delayed due to overlabelling of pre-packs which have only just been re-introduced. This will positively impact our figures for 25/26.
- Used REFINE software to look at areas with high usage of antibiotics
- Commenced new AMS ward round on ward 24
- Discussed with breast surgeons to produce surgical prophylaxis formulary

Although the Trust has not met the target to reduce broad-spectrum antibiotics compared to 2017, there is ongoing work within the antimicrobial stewardship team to reduce broad spectrum prescribing via education and improvement projects. Graph 9 below shows prescribing of Watch & Reserve antibiotics for this financial year compared to similar North West NHS Trusts.

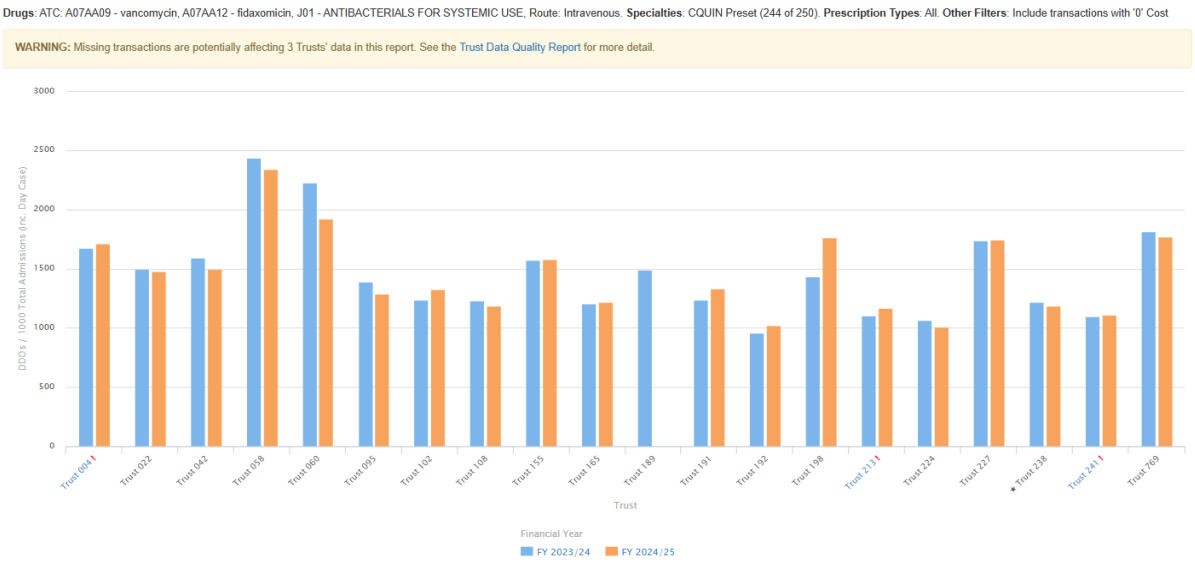
Graph10 . WUTH usage of Watch & Reserve antibiotics (DDDs per 1000 admissions), financial year 23/24 and 24/25, compared to similar NW Trusts:



9.6 Reduction of usage of IV antibiotics (Priority 2)

We have reduced IV antibiotics usage by 3.5% compared to last year, which exceeds our target of a 1% reduction. This is likely a result of priority 3, where re-audit of IVOS has shown continued good compliance.

Graph 11. WUTH usage of IV antibiotics (DDDs per 1000 admissions), financial year 23/24 and 24/25, compared to similar NW Trusts:



9.7 IVOS (IV to oral switch) audit (Priority 3)

WUTH achieved one of the highest compliance rates within Cheshire & Merseyside with the 23/24 IVOS CQUIN. Performance improved throughout the year and by Q4 23/24, less than 10% of patients audited who were eligible to be switched to oral therapy were not already on oral therapy. There are many benefits of timely IV to oral switch which include reduced inpatient stay, reduced nursing time required, reduced bloodstream infections, reduced carbon footprint & reduced cost. Due to the importance of this, we continued to audit our compliance for 24/25.

Retrospective review of 22 patients from Q2 showed that 14% of patients were still on IVs past the point at which they met switching criteria. In Q4 we reviewed 50 patients and found that 10% of patients were still on IVs past the point the met criteria, which met our target for 24/25.

To achieve this and ensure continued performance from 23/24, continuous education was provided on our AMS ward rounds & a webpage is available via the antimicrobial formulary. It is included as part of annual F1 & NMP AMS teaching. Further education was provided to nursing staff via IPC link presentations & it was added into IPC WEPP nursing education which is given to new nurses by the IPC team.

9.8 Antibiotic Safe Prescribing Indicators Report (ASPIRE) (Priority 4)

As part of the audit and feedback program, providers should monitor adherence to SSTF principles regularly in all clinical areas to show:

- Evidence of documenting indication and duration (or review date) on the prescription
- Evidence of antimicrobial stewardship review of antibiotics at 48-72 hours after initiation and documentation of the antimicrobial prescribing decision (stop, change, switch, continue, OPAT) on the prescription or in the notes
- Adherence with local guidance on the choice of antibiotic therapy (or documented reason for non-compliance)

At WUTH these parameters are audited quarterly as part of the Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit which analyses antibiotic prescribing for 3-5 patients selected at random on each ward. The results are displayed as a dashboard demonstrating performance Trust wide as well as at a Divisional and Division level. Results for 24/25 seen above in table 20 demonstrate that average Trust-wide performance across the year was always >95%.
For 2025/26 directorates & divisions will be updated to reflect the changes within the Trust. The Emergency Department is not currently captured within the results apart from CDU, this was previously because patients were not in the Emergency Department (ED) long enough to capture data of antibiotic review etc. This will be reviewed in 25/26 to agree the best way to capture relevant data.

9.9 Restricted Antibiotic Use (Priority 5)

Certain broad-spectrum antibiotics are restricted and should only be prescribed when recommended in the formulary for specific indications or on the advice of a microbiologist. The Pharmacy Department limits where these are stocked and receives a daily automated electronic report to allow

follow up of these prescriptions to ensure this is the case. Restricted antibiotics which are not prescribed as per formulary or on microbiologist advice are referred to the ward pharmacist or antimicrobial pharmacists for review.

During 24/25, 2331 restricted antibiotics were audited, 97% of which were prescribed as per formulary, authorised by Microbiology or otherwise appropriate

9.10 Quinolone Prescribing Audit (Priority 6)

This audit was conducted to gain local assurance of prescribing practices around quinolones after the MHRA alert came out in January 2024: Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate.

Systemic fluroquinolones can cause long-lasting (up to months or years), disabling and potentially irreversible side effects, sometimes affecting multiple body systems and senses.

The UK indications for systemic fluoroquinolones have been updated so they must only be used in situations when other antibiotics, that are commonly recommended for the infection, are inappropriate.

Situations in which other antibiotics are inappropriate and where a fluroquinolone may be indicated:

- There is resistance to other first-line antibiotics recommended for the infection.
- Other first-line antibiotics are contraindicated in an individual patient.
- Other first-line antibiotics have caused side effects in the patient requiring treatment to be stopped.
- Treatment with other first-line antibiotics has failed.

All fluoroquinolone prescriptions from 1 week in Q1 (April 2024) were reviewed. A total of 65 prescriptions were identified and reviewed for compliance against the standards listed below:

table 20. Compliance with quinolone audit standards

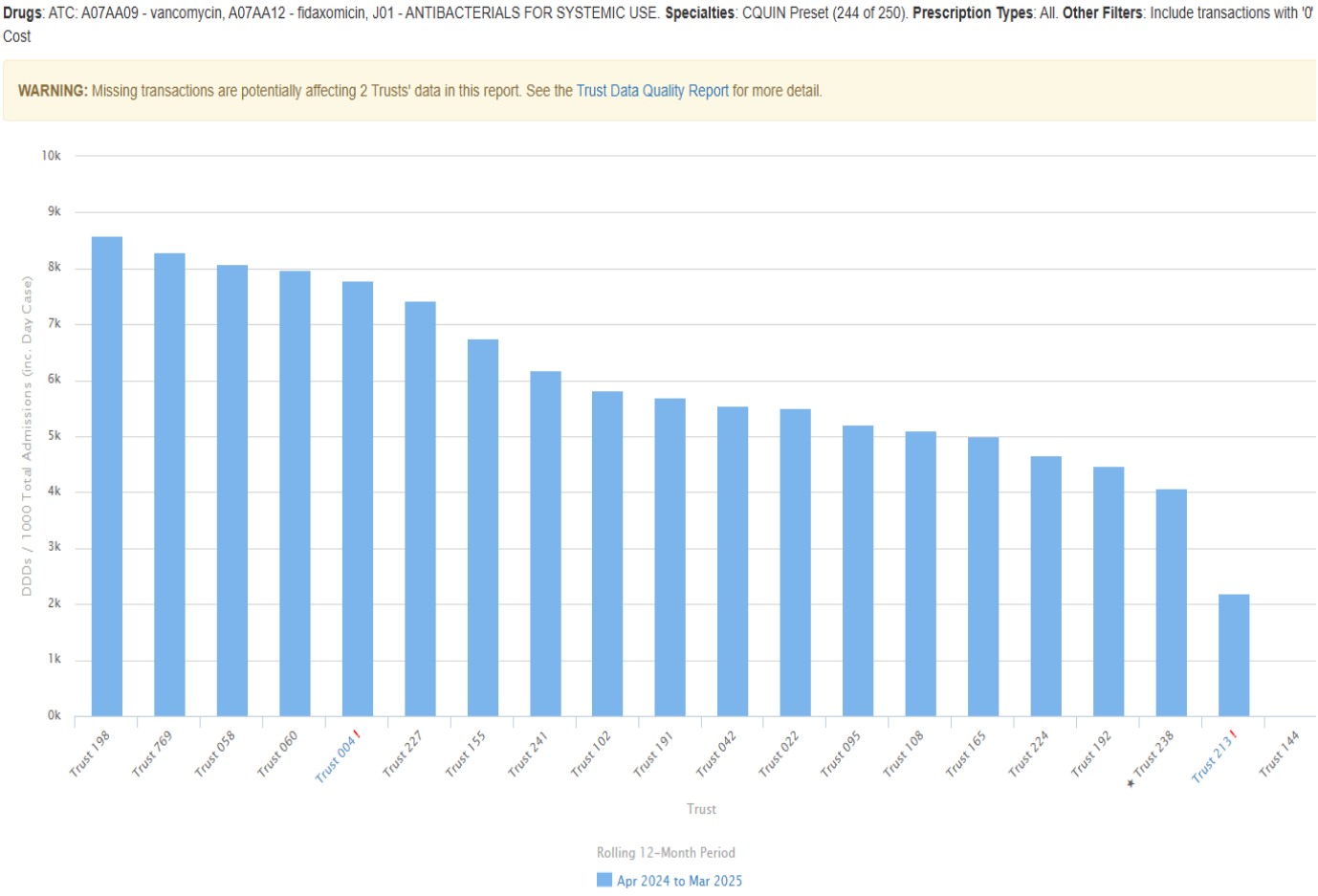
Standards	% Compliance
Total prescriptions compliant with Standards 1 and 2	**92%** (60/65)
Prescription in line with formulary for the given indication or microbiology advice (Standard 1)	65% (42/65)
Usage as per MHRA (Standards 2a-d)	72% (47/65)

This would suggest that MHRA advice is being followed, guided mainly by the formulary, but also specific microbiologist advice in some cases and microbiology results in others. It has highlighted several incidences where practice can be improved, and an action plan is currently being implemented.

9.11 Total Antibiotic Consumption

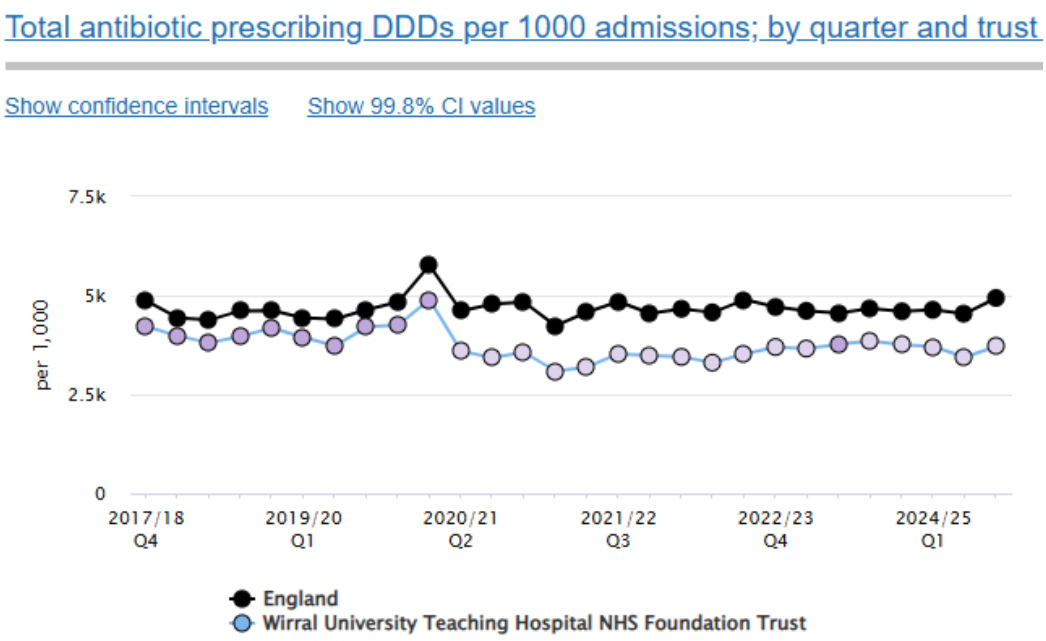
Total antibiotic consumption no longer forms part of the national targets; however, usage is still benchmarked nationally. Data from DEFINE has shown a ~1.5% decrease in total antibiotic consumption (DDDs per 1000 admissions) when compared to 23/24.

Graph 12 WUTH Total antibiotic consumption (DDDs per 1000 admissions), financial year 24/25, compared to similar NW Trusts



Data on PHE Fingertips website shows the Trust remained in the best quintile in England for total antibiotic consumption:

Graph 13. WUTH Total antibiotic consumption (DDDs per 1000 admissions) data compared to England average until the end of Q3 24/25:



9.12 *Clostridioides difficile*

The Trust made tackling *C.difficile* rates a priority in 24/25 given the awful patient experience and associated high rates of morbidity & mortality.
Our overarching aim was to improve AMS practices within the Trust, which tied in with our other priorities of reducing broad-spectrum antibiotics, reducing usage of IVs and maintaining compliance with Start Smart Then Focus practices. To deliver this, the AMS team focused on several key areas. This included review of areas with high antibiotic usage, implementation of targeted audits, review of antimicrobial formularies, implementing a 3-day default on IV antibiotics, commencing a regional pilot using 24 hour antibiotic infusion devices (elastomeric pumps) for outpatients via the OPAT service (this allows more narrow spectrum agents to be used), providing education and commencing additional AMS ward rounds.

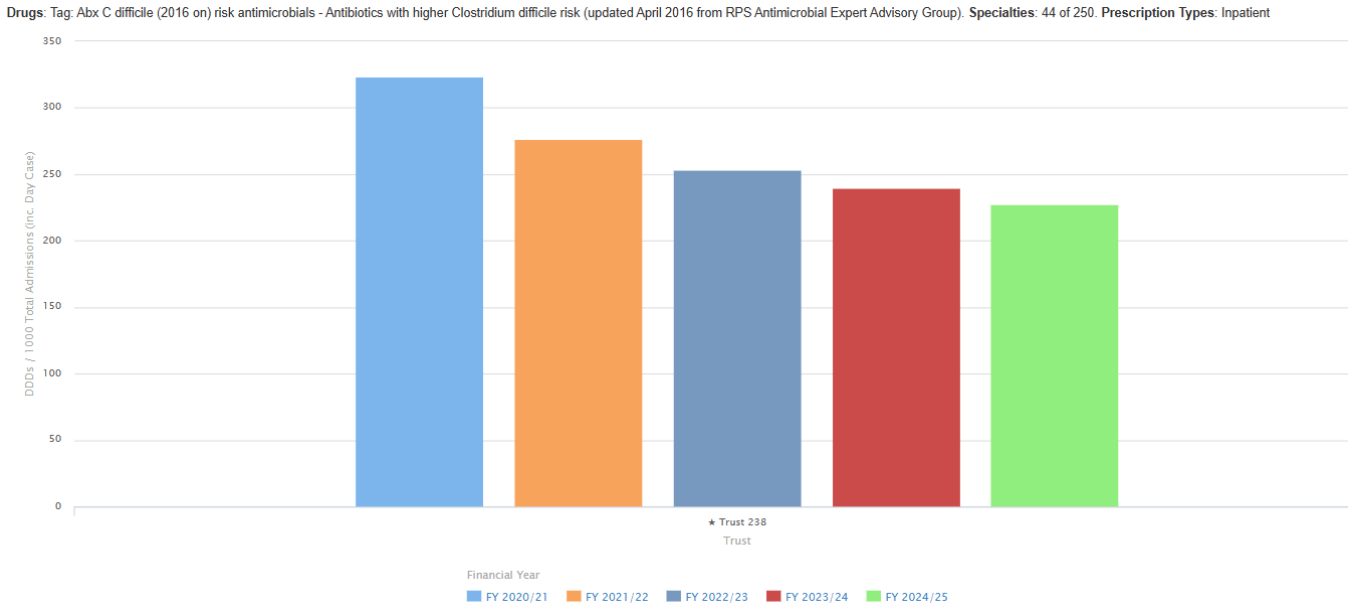
Other recent actions to reduce *C.difficile* rates and align with other Trust priorities (4.2 above) include:

- Procuring smaller 5-day pre-packs of antibiotics in ED and other assessment areas to promote optimal course length prescribing for take home medicines. There was a delay due to over labelling of these packs but they are now implemented and the full consumption effect will be seen in 25/26
- Commencing new AMS ward round on ward 24
- Reviewing multiple chapters of the antimicrobial formulary

The AMS team plan to sustain the work that we are doing and ask the Trust to engage with recommendations to improve antimicrobial use.

Reassuringly the Trust is on a downward trend of use of antibiotics associated with a higher risk of *C.difficile* (e.g. co-amoxiclav, cephalosporins, quinolones, clindamycin, Tazocin® carbapenems) as shown in Graph 13 below.

Graph 14. WUTH total use of antibiotics with a high association with C.difficile (DDDs per 1000 admissions) per financial year back to 20/21, data from DEFINE software.



9.13 New developments/improvement strategies

During the 23/24 financial year, there was the introduction of elastomeric 24-hour infusion devices as a pilot within the Outpatient Antibiotic Treatment (OPAT) service. This has allowed access to narrow spectrum intravenous antibiotics flucloxacillin and benzylpenicillin in an OPAT setting for the first time, thus optimizing therapeutic choice and antimicrobial stewardship.

In addition, piperacillin/tazobactam elastomeric 24hour infusion devices have been introduced giving a treatment option for patients requiring a more broad-spectrum agent. The pilot project is a collaboration between 4 acute trusts in Cheshire and Merseyside. Unfortunately, project funding ran out early at the end of January 2025 and the Trust made the decision not to fund the project itself. Since the start of the project in February 2024, the WUTH team have treated up to 6 patients per week using elastomeric devices. This has saved 572 bed days and released 327 nursing hours for WUTH & WCT.

Separately, the Antimicrobial Stewardship mPage was designed to improve the quality of antimicrobial reviews by highlighting antibiotic prescriptions which are due for review alongside relevant microbiology cultures. Technical fixes are required before its use can be promoted. Potential fixes or new tools to improve the quality of antimicrobial reviews is being explored by the informatics team.

10.0 Decontamination

10.1 Decontamination Arrangements

The Care Quality Commission and the Health and Social Care Act 2008 requires healthcare organisations to keep patients and visitors safe by having procedures and systems in place to ensure that all reusable medical devices are properly decontaminated prior to use, and that all single use devices are not re-used (Criterion 9).

Effective decontamination of reusable medical devices and equipment (including surgical instruments) is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection, and sterilisation) to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.

In March 2024, a standalone Decontamination Lead was recruited and is currently working to improve decontamination processes across the organisation, including both automated systems and manual procedures for instruments that cannot be processed through the decontamination units.

All such devices should follow stringent protocols following Manufacturer's 'Instructions for use' to ensure efficacy, compliance, and the prevention of HCAI's following procedures.

WUTH supports a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment is directed to the Trust Decontamination Lead.

The Decontamination Group meet monthly, chaired by the Decontamination Lead to discuss all areas of decontamination and agree possible actions/resolutions with the support of the Deputy DIPC/Lead – Infection Prevention & Control, the Trust Principle Clinical Scientist, Authorising Engineer for Decontamination (AED), and other key group members. Actions remaining unresolved are escalated to the Infection Prevention and Control Group (IPCG) via the Decontamination chairs report.

Internal audits are now in place and will be conducted at least annually. Action plans will be developed to identify any learning, with progress reported through the Decontamination Group.

10.2 Sterile Services

Sterile Services sits within the Division of perioperative medicine and is situated at the APH site. The unit provides decontamination services to both Wirral University Teaching Hospital NHS Foundation Trust and to other NHS trusts. The services include washing, decontamination, assembly packing

and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items.

In addition, the service operates an Endoscopy Decontamination Unit at the Clatterbridge General Hospital (CGH) site, supporting on-site procedures by providing decontamination of flexible endoscopes through automated high-level disinfection, including cystoscopes and urethroscopes.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external on behalf of the organisation.

The unit operates in compliance with the Quality Management System Standard BS EN ISO 13485:2016 and the relevant provisions of the Medical Devices Regulations 2002, through the effective implementation of the departments procedures.

The unit manager is supported in all activities by the decontamination lead.

The unit regularly updates and reviews their protocols to support continuous improvements in quality and customer service and their effectiveness is monitored through quarterly internal audits, reported incidents and non-conformities. Assurance is provided to the Division of perioperative medicine Infection Control Group, IPCG and other Safety & Quality Boards.

In March 2025, a refurbishment of the department commenced and is scheduled for completion in February 2026. The project will be carried out in two phases to allow the department to remain operational with minimal disruption. As part of the refurbishment, the department will receive new washer/disinfectors and sterilisers, a replacement reverse osmosis (RO) plant, and upgrades to ceilings, walls and doors.

Two of the new washer/disinfectors will be multi-chamber units, and the new sterilisers will be pass-through machines loading straight from the pack room. These enhancements are expected to significantly improve production efficiently and reduce processing times.

11.0 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a ‘Healthcare Cleaning Professional’ Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement, and review of cleanliness services in hospitals and our cleanliness standards are governed by the following legislation:

- National Standards of Healthcare Cleanliness 2021 has replaced the National Specification for Cleanliness in the NHS 2007.

In April 2021, NHS England and NHS Improvement launched the new National Standards of Healthcare Cleanliness 2021 that set out several key changes to how we perform and audit cleanliness to provide assurance of safe cleanliness standards across all our functional areas.

11.1 Management arrangements

The new standards set out to achieve the following ethos:

- Collaboration: A collaborative approach is essential to continuously improve cleanliness. The standards state that organisations should involve a board nominee, clinical colleagues, partner organisations and patients in setting and monitoring cleaning standards for consistently high levels of service.
- Transparency and Assurance: The standards emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met. The transparency of audit and reporting methods, display of audit results and the commitment to cleanliness charter provides assurance that an organisation is serious about cleaning
- Infection Prevention and Control (IPC): Cleaning is a vital part of the overall Infection Prevention and Control process which aims to provide a clinically clean and safe environment for delivering safe patient care. Safe standards of cleanliness minimises risk to patient safety from inadequate cleaning. The new standards will be the measure by which we deliver cleaning services into the future
- Continuous Improvement: To encourage continuous improvement the standards combine mandates, guidance, recommendations, and good practice. The new standards will allow organisations to measure performance in a uniform way and to benchmark it against similar organisations. They seek to drive improvements while being flexible enough to meet the different and complex requirements of all healthcare organisations
- The Facilities Department provides a once daily baseline clean and an additional rapid response infection control cleaning service, which fully conforms and complies to all current legislation and recommendations. This service is audited using a recognised auditing tool to provide assurance of safe cleanliness standards.

11.2 Cleaning Programme

The Healthcare Cleaning Professional Team continues to provide a comprehensive range of cleanliness services to support the Trusts IPC agenda. These services include:

- Rapid Response
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme

Over the past 12 months there has been a significant impact on the continuity and standard of cleanliness achieved due to a more focused scrutiny on the outcomes. Improvements in the overall condition, appearance and maintenance of the environment and improved responsibility and collaboration across the multi-disciplinary groups has resulted in progress that has now started to show results across the hospitals.

During the challenges over the winter period the cleanliness service remained adaptable and high quality. We recognised the requirement for further development of systems and processes to manage the challenges of an aging estate, and the further developments of new estate at both Clatterbridge Hospital and on the Arrowe Park site. Therefore, we put in measures to support the organisation with

the significant challenges ahead and provided assurance of cleanliness outcomes during 2024/25 which was as follows:

- Maximise staffing capacity to provide flexibility to meet the demand and needs of operational service delivery.
- Allocation of Healthcare Cleaning Professionals hours to support additional enhanced cleaning throughout the Trust when patients with infections have been identified.
- Increased cleaning frequency to twice daily cleaning and HPV of sluice areas and patient equipment in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.
- Cleaning frequencies of the Care environment of *C.diff* care areas were enhanced and single rooms, cohort areas and clinical rooms cleaned twice daily.
- Patient Flow continued to allocate the Terminal cleaning required to assist with patient flow.

11.3 Performance Monitoring

To support the assurance of our cleanliness standards the Facilities Department use an industry approved Micad auditing software. It provides our quality control in the form of a visual inspection audit that monitors the quality of cleanliness of all our functional areas across all the responsibility groups of Healthcare Cleaning Professionals, Nursing and Estates. These technical audits involve the scoring of 50 elements within each area assessed and generate a score reflecting the standard of cleanliness achieved.

The mandatory efficacy audits are a management tool to provide assurance that the cleaning standards are met using good practice and that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards by checking the efficacy of the cleaning process at the point of service delivery. Each patient facing functional area should be audited at least once a year and multidisciplinary attendance is key to providing a more rounded view of our cleanliness standards. Efficacy audits were introduced in 2022/23 on a rolling monthly programme with 7-8 functional areas randomly selected each month.

The Trust has adopted a multidisciplinary approach to technical and efficacy auditing periodically, to assess the cleaning from different perspectives and validate the audit score at ward/department level.

During 2024/25, daily cleanliness monitoring checklists were introduced and are now completed by the cleanliness Supervisory team on the Trust recognisable Tendable audit system to provide additional assurance of our cleanliness standards and to support quality improvement.

11.4 Patient-Led Inspection Programme (PLACE)

The Patient-led assessment of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'.

Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

We operated a full PLACE assessment within 2024/25, Arrowe park 16th October 2024 ansd Clatterbridge 23rd October 2024.which was a full review with external and patient assessment. The cleanliness result for Wirral University Teaching Hospital was published as 93.10%, the lowest in the Northwest. An improvement plan was developed by the facilities team and PLACE awareness training is planned for 2025-2026.

11.5 New cleaning standards

The new National Standards of Healthcare Cleanliness 2021 were implemented within 2022-2023 and they primarily encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results.

The new standards are an update on the previously available guidance and provide a new framework within which healthcare establishments set out details for providing cleaning services and assessing 'technical' cleanliness. This will ensure that Wirral University Teaching Hospital has a sustainable, effective healthcare cleaning service that will:

- be patient focused.
- be achieved through collaboration of all responsibility groups.
- provide clarity for all cleanliness responsibility groups to ensure our healthcare environment is clean and safe.
- be consistent with infection prevention and control standards and requirements.
- have clear objectives that will provide a good foundation for service improvements.
- provide a culture of continuous improvement.
- provide an agreed and recognisable auditing and monitoring framework.

Compliance with these standards will enhance quality assurance systems, meet the requirements of CQC outcome standard Regulation 15, provide benchmarks and output indicators and offer a recognisable auditing and monitoring system and more importantly will be future proof. As an Acute Trust we started implementation from April 22 and the new standards are now fully in place across the organization.

11.6 The Decontamination Unit (Central Equipment Library)

The Decontamination Unit at Wirral University Teaching Hospital Foundation is under the Facilities Management Department covering Arrowe Park and Clatterbridge Hospital Sites.

The service is responsible for the cleaning, decontamination, and processing of non-invasive medical devices alternating mattress cells, covers and cushions. Recent Capital Investment involving a structural upgrade and new equipment has increased IPC assurance reducing the risk of cross infection and improved environmental hygiene.

The investment has improved redesign in collaboration with Deputy Director of IPC based on HBN 001 Infection Control in the built Environment, areas of improvement are:

- Flow Design - Separate Entry/ Exit
- Delineated work areas for Decontamination and Clean Processing
- Stainless steel decontamination tables and bespoke shelving for devices
- Improved standard operating procedures for staff to follow within defined work areas
- Improved cleaning guidance of medical devices in line with Medical Devices Policy
- Labelling, processing, and storage of medical devices
- Re-introduction of ATP swabbing following mattress decontamination

11.7 Continued Initiatives

Installation of Otex Decontamination Laundry System was successful in April 2022.This system is HTM 01-04 compliant and provides a validated chemical disinfection process by injecting a continuous flow of ozone into every wash cycle. Ozone disinfection system is effective against micro-organisms such as MRSA *E.Coli* and *C.difficile* spores. The Otex system shows a reduction in water and energy costs by 35% in line with NHS Plan for Carbon Reduction and provides validated assurance of Ozone with each wash cycle.

11.8 Service Improvements

- Education and Training of the Central Equipment Library Team to support the inspection, cleaning of foam mattresses in line with BHTA 2012.
- Identification of criteria for condemning of foam mattress supporting assurance for audit and working collaboratively with all ward staff.
- Purchase of new Trolleys for the safe transportation of foam mattress
- Central Equipment Library deploys Air Purifying Units on request to all areas to assist in the reduction of respiratory viruses.
- All exposed soft foam mattresses identified are processed for decontamination using the Otex Laundry System to support IPC with the reduction in transmission of *C.difficile*.

11.9 Water Safety Group (WSG)

Key elements of water safety in hospitals include regular water quality assessments, advanced filtration systems, robust maintenance protocols, and staff training. Additionally, implementing emergency preparedness plans, using point-of-use filters, and adhering to regulatory standards are

crucial. A Water Safety Plan (WSP) and a Water Safety Group (WSG) are essential for managing and minimizing risks related to waterborne pathogens

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology and Infection Prevention continue to meet monthly. The Legionella risk assessment and Water safety plan (WSP) is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections related to water systems. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The legionella risk assessment and WSP encompasses all areas of potential risk (*Pseudomonas aeruginosa* and Legionella) about water safety; this includes potable water, hot and cold-water systems, endoscopy waters (AER final rinse waters), hydrotherapy pool, birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continue to give advice on remedial action when required where water systems or outlets are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extraordinary meetings to trouble shoot and instigate remedial actions to reduce risks to patients and staff. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.10 Ventilation

Ventilation systems provide thermal comfort to patients and staff, enable the removal of pollutants and odours, provide protection from infection for vulnerable patients and reduce the risk of spread of infection. Patients and staff have a right to expect that it will be designed, installed, operated, and maintained to standards that will enable it to fulfil its desired functions reliably and safely.

Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves to contain, control, and reduce hazards to patients and staff from airborne contaminants. This includes operating departments, intensive care units, isolation suites, pharmacy and sterile supply departments and laboratories.

The sophistication of ventilation systems in healthcare premises is increasing and their importance has been further highlighted at the beginning of the COVID-19 pandemic in 2020.

Good indoor ventilation can reduce the risk airborne transmission of respiratory infections. CO2 air monitoring can be used as a proxy to indicate areas of poor ventilation. It can give an effectiveness of ventilation in a multi-occupancy setting by monitoring levels of CO2 that can build up through exhaled air. It does not provide a direct measure of infection risk, or a direct measurement of ventilation rates. CO2 rates were first measured back in 2021 and to mitigate risk a number of air purifiers were purchased. These air purifiers purchased use HEPA filters which can reduce the number of potentially infectious particles in the air, thereby reducing the risk of transmission of infection. It must be noted that this intervention does not reduce transmission via close range aerosols and droplets or via fomites.

These Air purifiers are now used when a patient who is nursed in a bay is diagnosed with COVID-19, this helps to clean the air within the bay to reduce the risk to others in the bay. When the patient gets isolated, the air purifier remains in the bay as that is where the risk remains. SOPs were developed to support their use.

These Air purifiers are now used when a patient who is nursed in a bay is diagnosed with COVID-19, this helps to clean the air within the bay to reduce the risk to others in the bay. When the patient gets isolated, the air purifier remains in the bay as that is where the risk remains. SOPs were developed to support their use.

Fig 1. Air purifier (AIRVIA AERO 100)



The IPC team acknowledge their use on the daily IPC report and the devices are held and distributed via the Central Equipment Library (CEL).

11.11 The Ventilation safety group

The multidisciplinary Ventilation Safety Group (VSG) comprising of Estates & Facilities in conjunction with Microbiology and Infection Prevention meet monthly to look at the legal and mandatory requirements of ventilation systems in healthcare premises, this includes the design, maintenance, and the operation of ventilation systems. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group. A longer-term trust wide ventilation improvement plan is awaited from the Estates and Facilities Division.

The Water & Ventilation safety groups promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes 1) Systems to manage and monitor the prevention and control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

11.12 Waste disposal

Every year, NHS providers produce approximately 156,000 tonnes of clinical waste that is either sent to high temperature incineration (HTI) or for alternative treatment (AT), which is equivalent to over 400 loaded jumbo jets of waste. This has a significant environmental impact and is associated with high running costs and carbon emissions.

Therefore, as one of the largest producers of waste in the country, it is vital that the NHS disposes it in a safe, efficient and sustainable manner, and we are only creating waste when necessary.

There was an external audit completed in Q4 looking at the management of waste at WUTH, following this concerning report a waste management group was established that now meets monthly to discuss and update the extensive action plan.

12.0 Training Activities

IPC education was delivered across the Trust via a planned programme throughout the year and also add hoc in response to areas with increased infection, none compliance and observations of clinical practice that required further education to promote good practice. The IPCT have delivered education sessions across the two hospital sites in a variety of settings to include clinical and non clinical areas.

The IPCT continue to support specific education programmes coordinated by clinical skills to include; Clinical Champions, Wirral Enhanced Preceptorship Programme (WEPP) and the Care Support Worker Programme.

12.1 Infection Prevention Link Practitioners

The IPC Link Practitioner programme continued during 2024-25. There are two replicated sessions during the day to allow staff to attend either in the morning or afternoon. The primary purpose of the meeting is educational with time set aside for discussion and to share good practice. There were 3 separate IPC Link Practitioner days held that covered:

- July 2024 – Environmental Cleaning
- November 2024 – Antimicrobial Resistance and Stewardship
- March 2025 – Gram negative blood stream infections and catheter associated urinary tract infections

Unfortunately, these sessions were not well attended, however there was positive feedback received by those who did attend.

12.2 Student Nurse Training

Second and third-year student nurses have continued to shadow the IPC team on an ad hoc basis. The IPCT have also supported student inductions arranged by the Practice Educator Facilitators. These sessions provide a basic IPC overview in addition to knowledge gained in the University setting. These sessions are also arranged on an ad hoc basis.

12.3 Mandatory Training for Trust Staff

Infection prevention training is mandatory every 18 months for all WUTH staff based in the hospital and the community. Training is accessed online via the E-learning hub, which includes an e-learning Infection Prevention package for all clinical and non-clinical staff. The e-Learning package covers general principles of infection prevention, hand hygiene, the use of PPE and decontamination. The clinical package identifies more detailed information regarding alert organisms and standard precautions.

Evidence of completion of Infection Prevention and Control mandatory training is confirmed at appraisal and monitored at the Monthly IP performance meetings and reported to the Trust Board. Compliance is also monitored at the Subject Matter Expert meetings chaired by Workforce Development. Plans for 2025-2026 will see changes to the frequencies of level 1 and level 2 training as national CSTF guidance suggests that IPC refresher training is undertaken every 12 months, currently it is completed every 18 months. There is no confirmed date to move to this new frequency however once aligned, there will be a significant increase in non-compliance in the short term. There are plans which will support the impact of this change.

12.4 Trust Induction Training

The IPCT continue to attend and participate in the Trust Induction afternoon, which is twice per month. A member of the IPCT provides a 5-minute talk to new staff on IPC basic principles and being available to answer any specific questions. A newsletter is also provided to new starters on this Induction.

12.5 Wirral Enhanced Preceptorship Programme (WEPP)

WEPP is a 2-day development programme for all newly qualified staff that is held monthly. IPC provide a 2-hour session which covers the chain of infection, standard IPC precautions and alert organisms.

12.6 Care Support Worker Training

This is a 2-day programme to support Clinical Support Workers to undertake the core skills course, which is part of the National Care Certificate, this is held at least monthly. The IPC provide an hour session which covers general IPC, hand hygiene, swab and specimen collection, diarrhoea management and essential mattress checks. The IPCT also support with competency assessment sign off for mattress checking.

12.7 F1 Junior Doctor Induction Training

Twice a year the IPC team join other members of the multidisciplinary teams in an induction program aimed at orientating and familiarising new resident doctors, previously known as FY1doctors.This change, implemented by the British Medical Association (BMA), aims to better reflect the skills and responsibilities of these doctors, who were previously often referred to as "junior doctors". The term

"resident doctor" is intended to be more inclusive and accurate, as it encompasses the full scope of their work, including postgraduate training and gaining experience.

Doctors play a vital role in infection prevention by identifying and managing infectious conditions, implementing and promoting infection control practices, and educating patients and staff on preventative measures. They are also involved in risk assessment, policy development, and outbreak response, working with other healthcare professionals to ensure a safe environment. This session provides an overview of standard IPC precautions, how to access information about IPC alerts in CERNER and a brief overview of alert organisms and what the doctor's role is in preventing transmission.

12.8 Specific Training

The IPCT regularly provide ad hoc training when visiting wards and departments as required. They have also supported regular bespoke training to departments throughout the year including:

- Facilities Supervisor Training – providing underpinning knowledge on the risks associated with certain organisms from the environment and the different types of cleaning required.

- Medical Division Impact Training – held monthly by the Medical Division, IPC facilitate a 1-hour session. This is a practical session for CSWs covering cleaning of commodes / equipment, mattress checks, PPE donning and doffing, use of Chlorclean and importance of stool charts. The RGNs sessions are also provided with detailed information on organisms and routes of transmission.

- Theatre Audit Days – providing an IPC update, with a different topic covered on each audit day. It also provides an opportunity to answer IPC related questions. This also runs alongside a regular 'Basic Principles of IPC' for new theatre staff.

- IPCT have also supported wards providing education as part of the Trust Quality Improvement project for *C.difficile*.

12.9 Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a framework for safe and effective aseptic practice, especially during clinical procedures, focusing on preventing contamination by identifying and protecting "key parts" and "key sites". It's a standardised approach to aseptic technique, internationally recognized and adopted, and helps reduce healthcare-associated infections. ANTT training equips healthcare workers with the knowledge and skills to minimize infection risks during procedures by understanding and applying these principles. Training is provided by Clinical Skills and Divisional Clinical Educators.

The Trust ANTT Policy is currently defined as 3 Tiers:

- Tier 1 – Hand Hygiene
- Tier 2 – Standard ANTT
- Tier 3 – Surgical ANTT

Competency assessments for ANTT are required to be completed annually and compliance is monitored by Divisions at their monthly IPC meetings and reported monthly at the IPCG. However, there is limited availability of ANTT competencies for doctors.

Table 21 below shows the ANTT compliance data up to the end of March 2025 as recorded in the Core Mandatory Compliance Report.

Table 21

Division	Hand Hygiene		Standard ANTT		Surgical ANTT	
	#	%	#	%	#	%
Acute	27	93.10%	172	71.37%	160	69.57%
Clinical Support	839	93.85%	227	63.06%	103	78.03%
Corporate	472	96.92%	40	70.18%	10	43.48%
Estates and facilities	370	42.53%	1	100%	1	100%
Medicine	163	97.02%	940	76.99%	608	68.39%
Surgery	206	98.10%	757	74.14%	550	70.06%
Women and Children's	112	91.80%	343	66.60%	286	69.76%
Overall Trust	**2189**	**78.74%**	**2480**	**72.60%**	**1718**	**69.55%**

In 2025-2026 the tiers that were WUTH interpretation of the standards are going to be replaced by the ANTT national standards as hand hygiene is a pre requisite prior to all ANTT procedure

12.10 IPC Newsletters

During 2024-25 the IPC team published regular newsletters to promote various topics related to IPC



- MRSA
- Hand hygiene
- Urinary Catheter management
- Waste Management
- Continence Management
- Skin Prep
- Water Safety
- Urinary Catheter Management
- Hand Hygiene

12.11 IPC Campaigns

World Hand Hygiene Day on 5th May 2024 was celebrated on Friday 3rd May 2024. The World Health Organisation's campaign theme this year was '*Why is sharing knowledge about hand hygiene still so important? Because it helps stop the spread of harmful germs in healthcare'*.
The IPC Team had a promotional stand in the main entrance at APH, providing useful information for staff, patients and visitors. There were lots of freebies, a hand hygiene quiz for staff and the UV light box was used to assess how well people cleaned their hands.



Clostridioides difficile quality improvement programme

C*lostridioides difficile* Quality Improvement Programme commenced in July 2024, with C.diff improvement having been identified as one of the three key quality priorities for WUTH in 2024/2025.

At the commencement of the improvement work (mid-July 2024) the threshold set out by the 2024/2025 NHS Standard Contract for WUTH (103) was deemed unobtainable within the programme scope, with WUTH at 36.89% to the full year target at the end of Q1. Therefore, the *Clostridioides difficile* Quality Improvement Programme Team devised a stretched target which would form the scope of this improvement programme.

A SMART (Specific, Measurable, Achievable, Realistic and Timely) aim was subsequently defined, with a scope to deliver month-month improvement in hospital attributed (HOHA and COHA) CDI between August 2024 end of March 2025. The Programme Steering Group identified key milestones that would track progress and delivery.

Environmental observations, tracking of positive patients and analysis of themes and contributing factors identified a multitude of causative issues, all of which offered opportunity for improvement, with subject matter expert interviews defining areas of focus.
Improving education and communication was identified as essential in reducing rates of *Clostridioides difficile* infection at WUTH. Awareness campaigns were introduced across several media platforms with key messages tailored to meet different audiences.

A particular focus of the programme was to introduce quick win interventions to reduce rates of CDI on five wards / areas with historically high rates of infection, with the number of incidences attributed to these areas subsequently tracked as a percentage of all Trust incidences. Key interventions include improved awareness with staff, patients and visitors, timely isolation and side room oversight, and increased hand hygiene and IPC compliance.

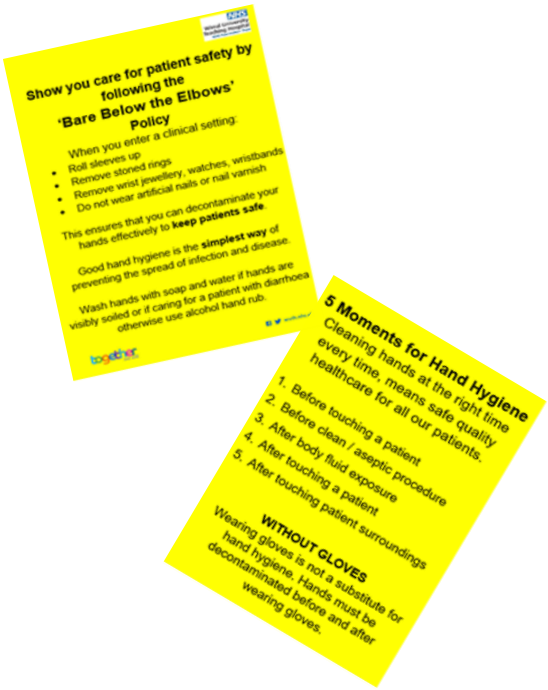
Alternative cleaning equipment (Microfibre mops) started to be used on one of the focus wards (Ward 36) along with a trial of non-alcohol based hand sanitiser (Hypochlorous acid) and an alternative to the current disinfection wipes also using a hypochlorous acid cleaner help re-focus on cleaning and to test the impact on standards of cleanliness and hygiene.

Improved side room oversight and decant processes were developed, with processes in place to support with isolating suspected CDI patients at the earliest stage. The IPC daily report started to identify side room usage and if a patient was appropriate to step out. In support of this the reactive decant SOP was reviewed, with a process put in place for reactive partial ward decant following patient diagnosis with CDI or equivocal result.

A Showcase event was delivered Trust-wide in November 2024, with staff involved sharing proven quick win interventions introduced, with a view to adopting these Trust wide, alongside reaffirmation of best practice as defined by Infection Prevention and Control Policies. These key messages were captured as part of a *Clostridioides difficile* Change Bundle, designed to support teams with introducing these interventions across their areas.







Infection Prevention and Control Week

October saw the National Annual Infection Control week being showcased at WUTH. This year the IPC team promoted the service and undertook a lighthearted scenario approach on when and why to send stool specimens. As well as being light-hearted the approached was also used to engage with clinical staff about the importance of prompt stool sampling, PPE and isolation when dealing with patients with loose stools.

The team visited the wards with a scenario adopted an ancient Greek mythology approach titled ‘Don’t get in a stew about Aphrodite’s poo ‘which saw staff having to identify and address how they would handle and process Aphrodite’s poo. Coupled with this approach IPC also undertook hand hygiene reminders and gave out quiz’s, with prizes.

On the day, the team managed to visit a vast number of wards and departments and engaged with both our chief and deputy chief nurses, along with clinicians, wards staff, therapies team and clerical staff. Everyone appreciated the lighthearted approach, which helped to remind staff of important aspects of their role.

‘Keep Wirral well in winter’

The IPC Team joined the Wirral Community Health and Care IPC Team at the ‘Keep Wirral Well in Winter’ event on Saturday 16th November 2024. This was a community event that was led by the Associate Director of Allied Health Professionals with support from all system partners and local organisations. The aim of the event was to support admission avoidance and empower the community. The IPC teams had a joint stand with lots of information to help people stay safe during the winter, including the importance of hand hygiene and keeping well hydrated, and how to stop the spread of *C.diff*, norovirus and coughs and colds. There was also an activity area for children,

including a ‘Shrek snot gun’ to see how far a sneeze can travel and a competition to guess how many bugs were in the jar; there were 237.



13.0 Audit

13.1 Audit programme for 2024/25

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015).

13.2 IPC Environmental audit

The IPC Environmental Audit programme is aligned the with Wirral Individualised Safe Care Every time (WISE) Accreditation Plan.

During 2024-25, 91 wards and departments had an IPC Environmental Audit undertaken, an increase of 15 from last year. In addition, 9 areas were audited more than once during the year. If a ward scores below 70% (red) a re-audit is undertaken within 3 months, if a ward scores between 70% and 89% (amber) a re-audit is undertaken within 6 months if capacity / workload permits. The Senior Nurses within the Divisions also undertake regular audits to ensure there is improvement, and when a green score is achieved, this is maintained. A monthly report is provided to IPCG with progress to date as well as the audit scores from the Divisional audits. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC Divisional meeting.

Additional IPC Environmental Audit Tools have been developed during 2024-25 for specialised departments including:

- Outpatient Departments
- Theatres
- Microbiology Lab
- Mortuary
- Hydrotherapy
- Sterile Services

Table 22 below is a breakdown of the ward category scores by Division for 2024-25

Table 22

Division	Green	Amber	Red
Medicine	12	13	1
Acute	0	4	1
Surgery	15	4	1
Women's & Children	8	5	0
Clinical Support	3	13	7
Other	0	2	2
Total	**38**	**41**	**12**

13.3 Hand Hygiene Audit

All wards / clinical departments are expected to undertake weekly hand hygiene audits using the Tendable hand Hygiene Audit, which are increased to daily during an outbreak or increased incidence of infection.

In February 2025 the Hand Hygiene audit questions were updated so that if staff do not comply with any aspect of appropriate hand hygiene, including being bare below the elbow the whole observation is deemed to be non-compliant. This will provide a more realistic assurance of compliance.

The IPCT have provided additional support to the auditors to ensure the correct process for auditing is undertaken.

13.4 Commode audit

Quarterly audits of commodes on all the wards have been completed by the IPC team, and ad hoc audits are also completed on specific wards following a patient being diagnosed with *C.difficile* toxin or a CD equivocal result. Audit results are fed back in real time for immediate improvement and reported by the Divisions in their exception report at the monthly IPC meetings.

13.5 Sharps audit

A Sharps Audit was undertaken by WUTH sharps bin supplier 'Daniels' in February 2025. In total 390 sharps containers were audited across 84 areas within the Trust. No bins were found to have protruding sharps, none were more than three quarters full, and all were at the correct height, which is consistent from the previous audits. Overall, the following non-compliance was identified:

- 3 (0.77%) containers were not assembled correctly
- 1 (0.26%) container had mismatched lid and label
- 9 (2.31%) containers were not signed or dated after being assembled
- 3 (0.77%) containers had inappropriate contents
- 18 (4.62%) containers did not have the temporary closure in place when left unattended

Of the 84 areas audited, 68 areas (80%) were fully compliant, 11 areas (13%) scored 95-100%, 4 areas (5%) scored 85-94% and 1 area (1%) scored below 85%.

The audit findings have been shared with the Divisions to action, and with the Health & Safety team.

13.6 Catheter associated urinary tract infection (CAUTI) Audit

A CAUTI audit is a process used to assess and improve practices related to urinary catheter use, with the goal of reducing the incidence of Catheter-Associated Urinary Tract Infections (CAUTIs). These audits involve reviewing catheter insertion and maintenance procedures, identifying potential risk factors, and ensuring adherence to established guidelines and care bundles.

A Trust wide catheter associated urinary tract infection (CAUTI) audit, instigated by the Continence steering group was undertaken in March 2025 by IPC with support from the Divisional Clinical Educators, the Clinical Continence Educator, and Matrons. This year's audit included patients in the Emergency Department which has not been done in previous audits. In total 136 patients throughout the trust were noted to have an indwelling urinary catheter and were included in the audit.

Results of the audit were presented at the IPCG meeting and shared with the divisions for local ownership to share with teams and promote improvement in practice.

13.7 Other Audits via Tendable app

The following audits are undertaken by the staff on the wards and departments via the Tendable App:

- Personal Protective equipment
- Daily First Impression Audit
- High Impact Interventions for:
    - Central Venous Catheter Insertion
    - Central Venous Catheter ongoing care
    - Peripheral Vascular Insertion
    - Peripheral Vascular ongoing care
    - Surgical Site Infection Preoperative / Perioperative
    - Ventilator Associated Pneumonia ongoing a

    - Chronic Wounds
    - *Clostridioides difficile*
    - ANTT
- Care Bundles
    - Urinary Catheter Insertion
    - Urinary Catheter Ongoing Care

14.0 External Assurance Assessments

There have been none related to Infection Prevention & Control during 2024-2025 however there are plans in early 2025-2026 for MIAA to complete an audit to provide assurance of the operational effectiveness of the arrangements in place for the management of Infection Prevention and Control (IPC) at Wirral University Teaching Hospital (WUTH). The review will specifically focus on *Clostridioides difficile* (C.diff).

15.0 Policy Development

WUTH has adopted the National Infection Prevention and Control Manual (NIPCM) for England, which is a comprehensive, evidence-based guide for infection prevention and control (IPC) practices in all health and social care settings. It provides standard infection control precautions (SICPs) and transmission-based precautions (TBPs) to help reduce the risk of healthcare-associated infections (HCAIs). The NIPCM aims to standardize and optimize IPC practices across England, ensuring the safety of patients, staff, and visitors. A link to the National IPC Manual for England is available on the WUTH Intranet which ensures that the most up to date version is available for staff to access.

The following local policies have been reviewed and updated in 2024-25:

- Pol 173 MRSA Infection: Control and Prevention
- Pol 137 *Clostridioides difficile,* Prevention and Management of Infection policy
- Pol 133 Isolation Policy

The very first ‘WUTH CPE guidance: Screening and IPC Measures’ began to be written in February 2025 with a plan to be ratified at IPCG in April 2025

16.0 Infection Prevention & Control Board Assurance Framework

NHSE/I published the first version of the Infection Prevention and Control Board Assurance Framework in 2020. Since this time there have been several published that are updated and refined to reflect the increased learning around COVID-19.This version of the BAF was presented at IPCG for assurance purposes. The framework, structured around the existing 10 criteria set out in the Infection Prevention Control Code of Practice (2008) (Table 23) that was updated in Dec 2022 to reflect changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of infection prevention and control (IPC) (including cleanliness) in optimising antimicrobial use and reducing

antimicrobial resistance. The new document takes account of changes to the IPC landscape that have occurred since the COVID-19 pandemic and link directly to Regulation 12 of the Health and Social Care Act (2008).

Table 23

	IPC BAF Standard
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion.
5	Ensure prompt identification of individuals who are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation precautions and facilities.
8	Provide secure and adequate access to laboratory/diagnostic support as appropriate.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The reporting arrangements for each version have been via the Infection Prevention & Control Group, into PSQB and the Quality Committee, and onto the Board of Directors.

The 2024/5 version was reviewed prior to being submitted on a quarterly basis to the IPCG as assurance against the NHS standard contract for 2024/25.

17.0 Conclusion

The above report details annual infection prevention & control activities in 2024/25 as reported to the monthly IPC. It also details the forward Infection Prevention & Control plan for 2025/26. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

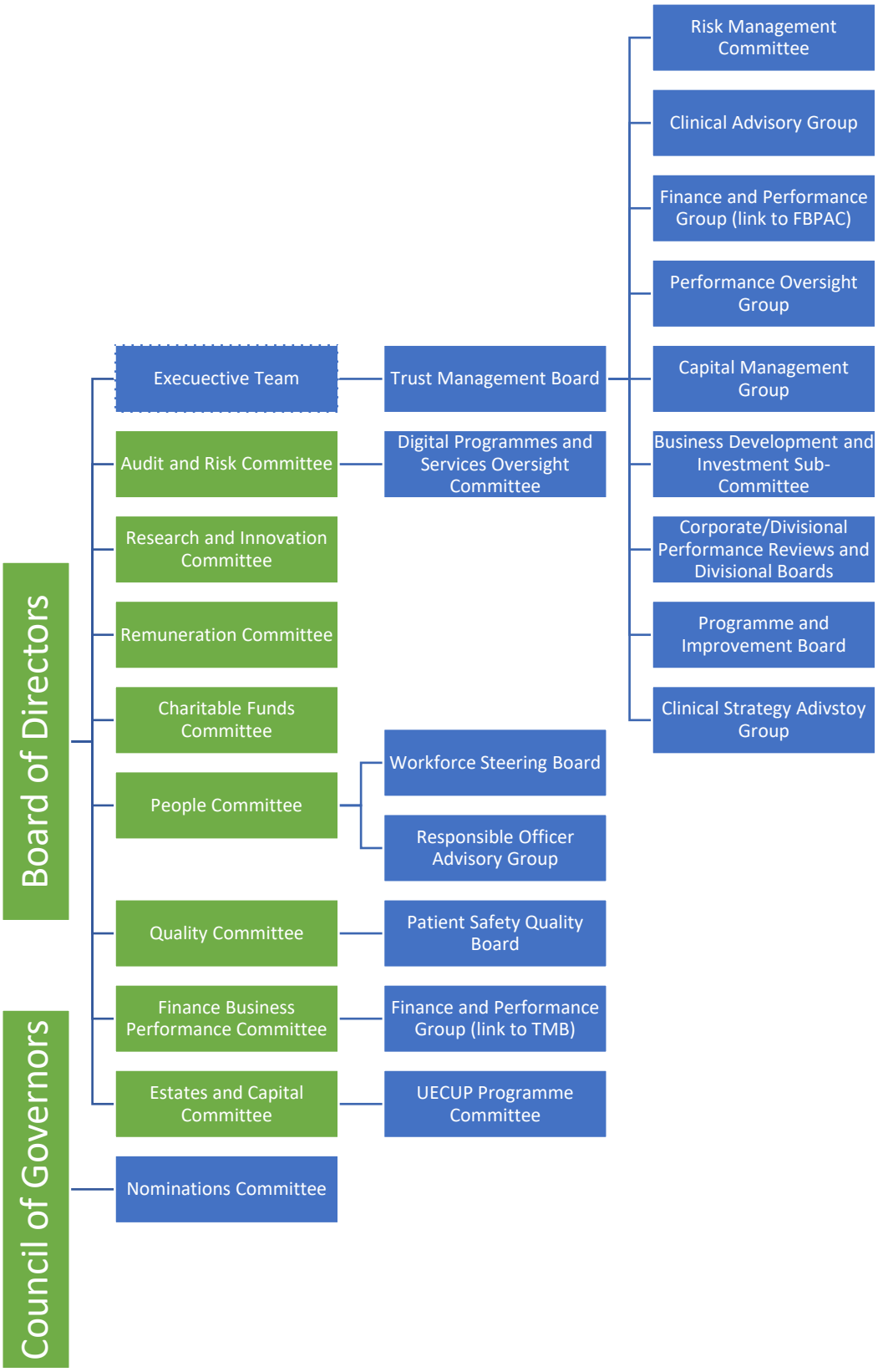
It is essential that there is continued support from Board to ensure that processes are in place to enable staff to make the right choices when caring for our patients and keeping them free from avoidable Infections.

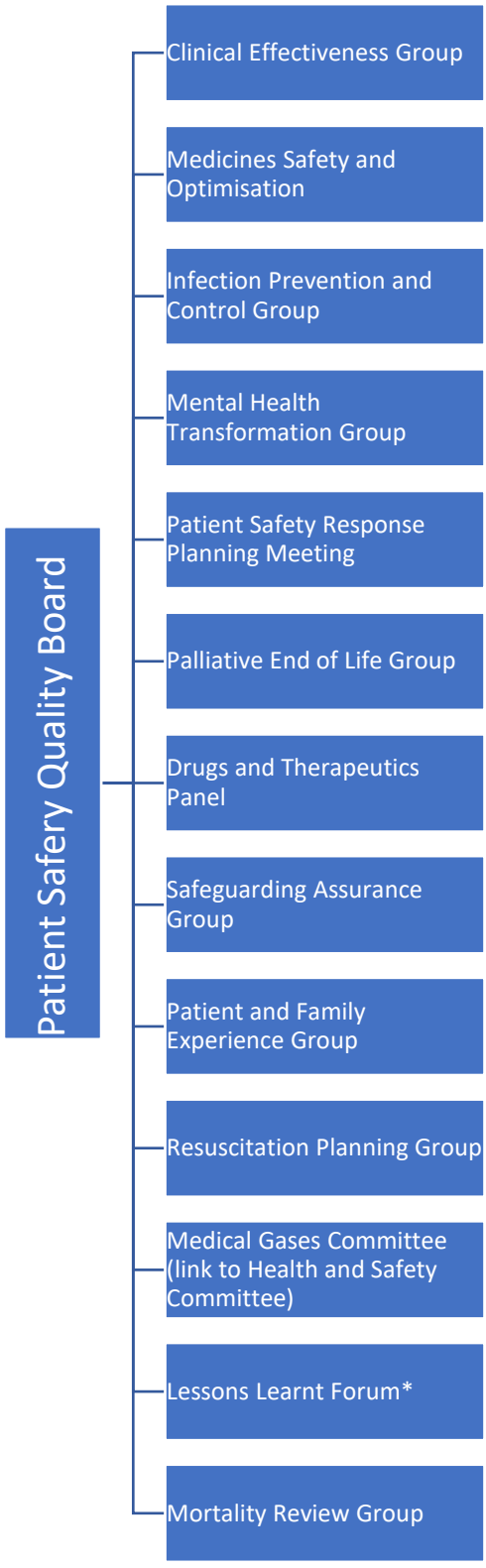
In keeping with our Trust values, we also need to continue to promote and recognise the hard work that the teams deliver daily to help to keep our patients safe to sustain and maintain the improvements.

Jay Turner-Gardner
Deputy Director / Lead - Infection and Prevention and Control

APPENDIX 1

Governance Structure




Patient Safety Quality Board
Clinical Effectiveness Group
Medicines Safety and Optimisation
Infection Prevention and Control Group
Mental Health Transformation Group
Patient Safety Response Planning Meeting
Palliative End of Life Group
Drugs and Therapeutics Panel
Safeguarding Assurance Group
Patient and Family Experience Group
Resuscitation Planning Group
Medical Gases Committee (link to Health and Safety Committee)
Lessons Learnt Forum*
Mortality Review Group

APPENDIX 2

Infection Prevention and Control Group
Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Deputy DIPC and/or the Deputy Chief nurse.

2. MONTHLY CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (DIPC) (Chair)
- Deputy Director of Infection Prevention & Control
- Consultant Microbiologist/Infection Control Doctor
- Principal Clinical Scientist – Microbiology/ Infection Prevention and Control
- Occupational Health representative
- Antimicrobial Pharmacist
- Associate Director of Estates, Engineering and Capital Delivery
- Associate Director of Estates, Facilities and Capital Governance and Sustainability
- Head of Soft FM
- UKSHA Consultant for Cheshire and Merseyside
- Divisional Directors of Nursing
- Divisional Governance Leads

CLINICAL LEADS/MEDICAL REPRESENTATION FROM DIVISIONS ON A QUARTERLY BASIS

- Surgery
- Women & Children
- Medicine
- Acute
- Diagnostics and Clinical support

Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary perspectives and have considered the impact across all the Divisions and departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

3. QUORUM

For decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 8 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor, the Associate Director of Nursing Infection Prevention and Control (or nominated deputy) , and 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month.

6. OVERVIEW

The Infection Control Group is a subcommittee of the Patient Safety and Quality Board (PSQB) and monitors the Infection Prevention and Control strategic objectives. The 3-year IPC Strategy is agreed by the Trust Board and is based on WUTH organisational priorities. The Trust IPCG oversee and monitor the annual IPC plan in meeting the 3-year Strategy.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive and trust board with relevant information and advice.

Approve the Strategic plan and interpret and advise on the National Infection Prevention and Control manual.

Provide assurance that the Code of Practice on the prevention and control of infection NHS core standards and Department of Health recommendations on infection prevention and control are implemented.

Receive assurance and escalations that monthly infection surveillance data and performance, including Outbreaks relating to MRSA Blood-Stream Infections, *Clostridioides difficile* Infections, *Klebsiella* Bacteraemia, *Pseudomonas* bacteraemia and *E.coli* bacteraemia are monitored with learning from a review of these cases with appropriate actions being taken within the divisions to prevent further incidence.

Approve Infection prevention and control policies and guidelines that enable implementation of the National Infection Prevention and Control manual.

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control inclusive of the decontamination of medical and surgical devices equipment, e.g., Health Act 2008 and receive assurance as such from the Divisions.

Receive assurance from the divisions that training and supervision systems regarding Infection Prevention and Control is in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams

Have regard to NICE guideline NG15 (Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use)

Have regard to the Antimicrobial Stewardship Toolkit for English Hospitals.

Support the development of local plans to identify further actions required to meet the requirements of the National IPC Board assurance framework.

Approve the annual infection prevention and control plan and monitor and review progress on a quarterly basis.

8. ORGANISATION

Administration support is provided by the Deputy Director of Infection Prevention and Control's Secretary who organises the meetings and provides minutes.

The Deputy Director of Infection Prevention and Control will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A chairs report will be submitted to the PSQB monthly prepared by the Deputy DIPC

A chairs report will be presented from the Decontamination group, Antimicrobial Stewardship group, the Ventilation safety group, Water safety group, the WIVAT group and Monthly Divisional IP&C meetings be exception.

The Terms of Reference for the group will be reviewed every 2 years.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	

V1.2	November 2022	Reviewed the membership and clarified reporting mechanisms.
V1.3	July 2023	Updated titles of core membership
V1.4	June 2024	To reflect requirements in the NHS standard contract 2024/25

11. DOCUMENT OWNER

Infection Prevention and Control Secretary/Team Administrator

APPENDIX 3

Annual Infection Prevention Audit Programme
2025/2026

Delivery of this audit plan is to support the Trust in meeting its Annual Objectives from the NHS Standard contract 2025-2026. This will be done by

- Reviewing current practices.
- Cross referencing the practices with national guidance i.e., National Infection Prevention and Control manual/National Institute for Clinical Effectiveness
- Supporting the Divisions in identifying areas for improvement to comply with national standards and the patient safety agenda.

	Audit topic	*Frequency*	*Where identified*	*Where reported*	*Responsibility*	*Lead*
1	Hand Hygiene (Compliance & technique)	Wards complete Weekly, inviting IPC at least once per month	IPC Audit plan Division IPC plan Tendable app	Division Governance meetings Monthly Infection Prevention & Control Group meetings Outbreaks PII IPC reviews	Division	Ward/ Departmental Managers
2	Environmental audit	Annual by IPC as determined by scheduled Tendable audit plan	IPC Audit plan Division IPC plan Tendable app	Division Governance meetings Monthly Infection Prevention Control group meetings Outbreaks PII	IPC and Division	Ward/ Departmental Managers
3	Patient shared equipment	Monthly	IP Audit plan Division IPC plan Tendable app PLACE	Division Governance meetings Monthly Infection Prevention & Control Group meetings Incidence of reported alert organism	Division	Ward/ Departmental Managers
4	Food safety	Monthly	IPC Audit plan Tendable app PLACE	Monthly Infection Prevention performance meetings Division Governance meetings	Division	Ward/ Departmental Managers

5	*'Saving Lives'* care bundles Numbers 1-7	Monthly/as and when required	IPC Audit plan Division IPC plan	Monthly Infection Prevention & Control group meeting Division Governance meetings	Division	Ward/ Departmental Managers
6	Antimicrobial reporting	Monthly	IP Audit plan Division IPC plan Antimicrobial audit plan	Quarterly to the Monthly Infection Prevention & Control group meeting Division Governance meetings	Pharmacy	Antimicrobial pharmacist
7	Commode audit	Annual or more frequently	IP Audit plan Division IPC plan	Division Governance meetings Monthly Infection Prevention & Control group meeting On incidence of CDT	Infection Prevention Team	Infection Prevention Team
8	Personal protective equipment	Monthly or more frequently	IP Audit plan Division IPC plan	IP Audit plan Division IPC Plan	Division	Ward/ Departmental Managers
11	Mattress audit	Weekly/after discharge of a patient by the ward. Annual for the whole Trust	Tendable app	Infection Prevention & Control group meeting Division Governance meetings	Division Tissue Viability IPC	Ward/ Departmental Managers
12	MRSA screening compliance for emergency admissions	Monthly	IPC audit plan	IPCG	Division to comply with policy	Corporate information team to produce report

APPENDIX 4 Infection Prevention Annual Plan 2025/2026

The 2025-2026 IPC annual plan describes the methods that will be used to give assurance to the Board that we are meeting the requirements for the annual IPC quality schedule including

- Provider objectives as set out in the NHS Standard Contract 2025/26 (Not published at time of writing this report)
- National Infection Prevention & Control Board assurance framework which provides an assurance structure for boards against which the system can effectively self-assess compliance with the 10 criteria outlined in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

Strategic objective	Action
Objective 1 Training and Education Regulation 12 & 7 (CQC) Criterion 1 (The Hygiene Code)	• Support and contribute to the induction programme and the ongoing learning and development of all levels of Trust staff • Introduce and support Trust wide patient safety initiatives pertinent to IPC i.e., 'Gloves are off' campaign. • Continue with the link nurse programme • Meet with the housekeepers and Domestics on a regular basis to support collaborative learning and share best practice
Objective 2 Audit & Surveillance	• Complete mandatory surveillance of all alert organisms (Infections) • Complete the annual IPC audit plan on Tendable to support W.I.S.E accreditation.

Regulation 9(CQC) Criterion 4 (The Hygiene Code)	• Support further development of the SSI programme, promoting ownership at divisional level of the lessons learnt from the themes identified contributing to infections. • Provide screening data in line with screening policies to promote compliance. • Work in partnership with commissioners/providers across Wirral to reduce the incidents of all alert organisms • Identify Outbreaks / PII's and infection related incidents in a timely manner • Introduce surveillance of multi-resistant organisms
Objective 3 Policies & Procedures Regulation 12 (CQC) Criterion 1 & 9 (The Hygiene Code)	• Develop a Carbapenemase producing *Enterobacteriaceae* (CPE) policy based on national guidance v risk-based benefits to patients. • Ongoing review of the new National IPC manual against WUTH local policies to promote compliance to the manual • Scheduled review of all IPC policies to ensure they reflect national guidance and are current.
Objective 4 Care Environment Regulation 15(CQC) Criterion 2 & 7(The Hygiene Code)	• Appropriate IPC representation at the beginning and throughout all scheme's meetings • Support MDT attendance at facilities efficacy audits. • Develop training tools to support the training needs of the Trusts Healthcare cleaning professionals. • Support the review of current cleaning equipment and solutions to ensure cost effective results
Objective 5 Communication & Information	• Ongoing review of the IPC patient information leaflets • Work with the communications team to ensure IPC updates are communicated to the trust and wider community.

Regulation 17(CQC) Criterion 5 (The Hygiene Code)	• IPC representation at IPC Divisional meetings • Work with information to develop the IPC BI portal. • Work in collaboration with the Community IPC team to support the planned merger. • Support the use of data to identify and deliver quality-based improvements. • Work in collaboration with the Division governance teams to strengthen how the reporting process of HCAI's and the resulting investigations and findings are shared and what impact any changes have made on practice and quality/patient safety. • Support the completion of the IPC Board Assurance Framework which provides a self-assessment of compliance against the measure set out in the national IPC Manual (2023), the Health & Social Care Act 2028, and other disease-specific IPC guidance issued by UK Health Security Agency.
Objective 6 Research & Innovation Criterion 9 (The Hygiene Code)	• To review and investigate any IPC innovations that can be introduced to support the teams with IPC improvements. • Support the introduction of new technologies. • Work in collaboration with procurement to promote cost effective care delivery. • Support ward led quality improvement projects based on lessons learnt from HCAI investigations. • Work with Facilities to look at improvements in cleaning solutions and cleaning equipment to deliver a cost effective service
Objective 7 Antimicrobial Stewardship Regulation 12(CQC)	• Attendance at local and regional antimicrobial groups • Review and document antimicrobial practice as part of the CDI review programme. (PISIRF based)

Criterion 3 & 9(The Hygiene Code)	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 27.1**

01 October 2025

Title	Infection Prevention and Control Board Assurance Framework
Area Lead	Sam Westwell, Chief Nurse DIPC
Author	Jay Turner-Gardner, Deputy Director of Infection Prevention and Control
Report for	Information

Executive Summary and Report Recommendations

The paper provides a summary of the purpose of the infection prevention and control board assurance framework and the full report (appendix 1).

It is recommended that the Board:

- Accept the report as assurance of oversight of the standards required to maintain compliance with the health and social care act and the national IPC manual.

Key Risks

This report relates to these key risks:

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

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

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

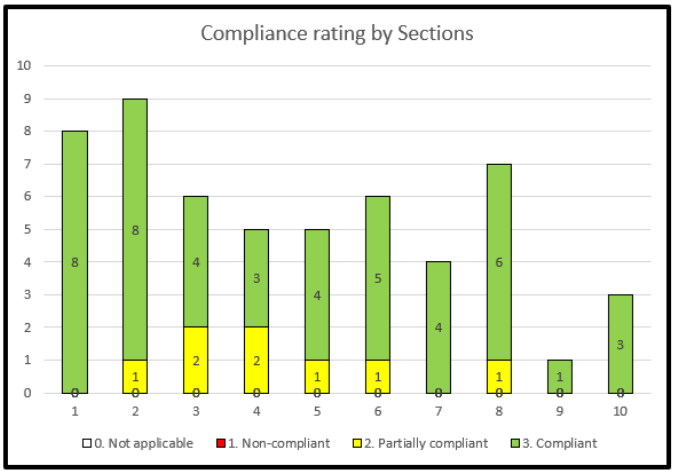
Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**

20th August 2025	Infection prevention and control group	IPC BAF	Information/assurance
17th September 2025	Quality Committee	IPC BAF	Information/assurance

1	Narrative
1.1	**Introduction** The IPC Board Assurance Framework is designed to allow organisations to • Assess their compliance with national guidance on infection prevention and control (IPC) • Provide assurance to the board and stakeholders that effective IPC systems and processes are in place • Identify gaps in current practice and areas requiring improvement • Ensure accountability at board level for infection control practices, The framework is aligned to NHS and UK Health Security Agency (UKHSA) legislation and guidance including: • Health and Social Care Act 2008 (Regulated Activities) Regulations • NICE guidelines • National IPC manuals There are 10 areas of assessment that are RAG rated creating a gap analysis of compliance. 1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections 3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance 4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion 5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others. 6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection 7. Provide or secure adequate isolation precautions and facilities 8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

	9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
1.2	The assurance framework has been completed through the relevant subject matter experts and areas of partial compliance identified with either mitigations or actions to address. Of the 54 standards assessed.

Complaint	46
Partially compliant	8
Non-compliant	0
Not applicable	0



2	**Implications**
2.1	**Patients** • Compliance with infection prevention and control standards is essential to the safety of the patients in our care and members of the community.
2.2	**People** • Our people should be trained in IPC standards to ensure they have the knowledge and skills to care for patients' safety and effectively. They should also be afforded the resources and training to protect themselves from harm.
2.3	**Finance** • There is an impact on finance in the maintenance of buildings and facilities that are fit for purpose and any developments required to maintain safety associated with changes to IPC standards.
2.4	**Compliance** • Support the demonstration of compliance with the health and social care act 2008, IPC manual and CQC quality statement related to infection prevention and control.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Infection Prevention and Control board assurance framework v5.0

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has an Infection Prevention and Control group that meets monthly. This meeting is Chaired by the DIPC, who is the Chief nurse. The lead IPC nurse is the deputy director of IPC. The membership includes Divisional representatives, estates and facilities and key subject matter experts. The group reports to quality committee and to board. The roles and responsibilities are captured in the IPC annual report and the individuals J.D and job specifications.	None identified.	None required	Evidence is the Annual report 2024/25	3. Compliant

1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Infections are reported by the Chester and Wirral Microbiology Service (which is the Medical Microbiology Laboratory) and monitored via the IPC team. Incident forms are completed for all Alert organisms and Reviews are completed within a week and presented in 2 meetings, CDT harm review chaired by the Deputy Chief nurse and blood stream infection chaired by the deputy DIPC/Lead IPC Specialist. Completion is monitored by the governance support unit. All alert organisms are reported into the UKHSA mandatory reporting system and approved monthly by the Deputy DIPC on behalf of the Chief exec. Policies and procedures are in place to promote prevention of infection	None identified	None required	Policies and procedures are followed, and the Trust has adopted the National Infection Prevention and Control manual for England.	3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	The Trust has a proactive approach to reporting incidents and near misses and incident forms are completed when staff are unable to follow local IPC policies. All alert organisms have an incident form completed by the IPC team and the resulting reviews are presented to two senior meetings each week with themes and lessons learnt fed back by the Divisions within their exception reports at the monthly IPCG meeting and themes identified from the basis of improvement schemes.	None present	None required		3. Compliant

1.4	They implement, monitor, and report adherence to the NIPCM.	All WUTH policies have been superseded by the NIPCM which is available on the local intranet, IPC audits are based on the information within the IPC manual	None identified	None required		3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Enhanced surveillance is one of the daily roles of the Team and outbreaks are managed in line with Local policies. The data is fed back at a weekly Wirral Data, Intel and comms meeting chaired by The Wirral Public Health principle. Mandatory reporting is embedded. Daily surveillance reports are generated Trust wide by the IPC team. All reported infections/Outbreaks are discussed at the monthly IPCG meeting and reported via the IPCG chair report to the Monthly Patient safety Quality Board which reports to the Board of Directors via the Quality Committee. There is ongoing surgical site surveillance for every quarter for orthopaedic hip replacement and locally for large bowel. Incidents are reported back to the monthly IPCG meeting	None identified	None required		3. Compliant

1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM. Regular audits undertaken on Tenable for IPC Environmental audit, hand hygiene, PPE, High Impact Interventions etc monitor compliance and IPC support Wards / Departments with developing improvement plans.	None identified	None required		3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Online IPC training is mandatory for all staff. There is also role essential training i.e. Aseptic none touch technique that is delivered locally and recorded in ESR.	Staff with a prolonged period of absence may become noncompliant.	90% threshold allows for this IPC training is completed on return to work Mandatory training monitored via divisional reports to IPCG and workforce steering group.		3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Yes, there is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations as per local policies and the NIPCM. IPC undertake regular reviews and visits to ward and departments, ensuring correct precautions and mitigations are in place, providing ad hoc teaching and ensure staff area aware or protocols in place, i.e. stool rule and side room prioritisation.	None identified	None required		3. Compliant

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Functional Risk site profiles documented and signed off by AD of Facilities and IPC - Annual review process in place. Commitment to Cleanliness Charters present and displayed across Arrowe Park and Clatterbridge. Various auditing processes in place, including, technical and efficacy audits Domestic Service policy in place, reviewed within agreed timeline, consulted on and published. Audit data and updates provided internally within the performance framework for Facilities, and to the IPC monthly assurance group.	Full knowledge of NHS Standards across Domestics Services Teams, Estates Teams, Infection Prevention and Control Teams, Ward based nursing teams, including HCA's, CSW's.	Refresher training plan being developed	Full cleanliness review taking place, and restructuring of Domestic Services being proposed	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Facilities coordinate the national PLACE audits and compliance of any improvements required.	Ownership clinically for outcomes relating to clinical activity	Plan in place and joint clinical and facilities ownership for PLACE and associated improvement plan Process developed for feedback on PLACE outcome, through to Board.		3. Compliant

2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Commitment to Cleanliness Charters outline key role responsibilities. Domestic Services Policy outline key responsibilities	Graduate nurse onboarding, and key skills in cleaning. Refresher awareness for clinical teams requesting different levels of cleaning required.	Under review as part of the CMAST IPC forum.		3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	VSG & WSG scheduled meetings monthly. Divisional governance monthly via EF&C SHE meeting and bi-monthly via Trust HSMC. Annual Authorised Engineer audits completed by Trust appointed AE's. Regular ventilation PPM completed to schedules by local maintenance teams and verification completed by external suppliers. To HTM-03-01. All Water R/A completed annually, and action plans documented.	None identified	None required		3. Compliant

2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Estates Matron coordinates with key stakeholders, including IPC in the event of refurbishment or new build activities. IPC PPMs in place.	Sign off documentation. Environmental audits	Reviewing processes Environmental audits being created		3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen laundered by NHS approved supplier with ISO 9001 and BS EN 14065 certification. Linen delivery schedules located in all delivery areas advising staff on how to handle linen. Trust ratified 146 Linen and Laundry Policy with guidance on how to process soiled and infected linen. pol-146-linen-and-laundry-policy-v5.pdf (wuth.nhs.uk)	None identified	None required		3. Compliant

2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste disposal contracted to NHS approved suppliers. All hazardous waste produced, collected, transported and stored on site in UN approved locked waste carts. WUTH is achieving clinical waste segregation targets of 20:20:60 HTI, AT and OW. All areas subjected to regular auditing of waste management and effective segregation processes. Duty of care notices issued where areas have been identified as breaching compliance. Trust ratified 071 Safe Management of Healthcare Waste Policy with guidance on how to segregate, dispose and manage the risks associated with waste. pol-071-safe-management-of-healthcare-waste-v8.pdf (wuth.nhs.uk)	None identified	None required	ICS review of linen and laundry contract underway.	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	There is a designated Trust decontamination lead who reports to the deputy DIPC. There are monthly decontamination meetings, and all exceptions and non-compliances are reported to the monthly IPCG meeting via a Chairs report.	Not all staff receive decontamination training as part of their role	Annual plan developed		3. Compliant

2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Ward fridge temperature monitoring sheet developed Food hygiene and food safety policies in place and catering teams attend a food hygiene and safety course upon induction into the service.	Ownership for ward fridges. ESR food safety course not mandatory for all staff	Catering developing an awareness poster for ward-based staff in the protocols for the management of ward fridges Housekeeper roles and responsibilities Identify which staff require training		2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	AMS governance structure is included in quarterly and annual AMS assurance reports.	None identified	None required		3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK	Annual AMS report is submitted each year. 24-25 report was submitted to IPCG in May 2025. Highlights reported in IPC annual report	AMS report does not go directly to board	Table for board		3. Compliant

	AMR National Action Plan goals.					
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Medical Director is the executive with responsibility for AMS. Clinical AMS Lead- Dr David Harvey, Consultant Medical Microbiologist AMS Team Chair- Miss Gillian Jackson, Orthopaedic Consultant Lead Pharmacist AMS- Amy Newton	Limited time in job plans for AMS within clinical roles The impact of early, accurate diagnosis and intervention upon outcomes and length of stay is not formally monitored.	AMS pharmacist full time. Service/quality improvement schemes are undertaken to improve outcomes & length of stay, when possible, e.g. IVOS project.		2. Partially compliant

3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	- NG15 Gap analysis available and risk register entries completed where necessary - AMS Policy in place. - Guideline for 'Antimicrobial Stewardship at Ward Level' available. - Audit plan in place to monitor antimicrobial use & provide assurance - Quarterly AMS assurance reports submitted to IPCG & MSOP which feed into PSQB. - Annual objectives set each year to match current NHS standard contract/CQUIN/NAP. - AMS Team in place & meet quarterly - AMS teaching is provided to all F1s, all pharmacy staff, new NMPs, medical students. Ad hoc training is provided to nurses, F2s, IMTs when requested. - AMS overview slides have been added to IPC WEPP Clinical Champions nurse training. - AMS is briefly mentioned in IPC mandatory training & all prescribers receive medicines management training which covers AMS.	None identified	None required		3. Compliant

3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Total, broad-spectrum & IV antimicrobial prescribing information is monitored throughout the year & included in the annual report. Current objectives (broad-spectrum & IV route) are reported via quarterly AMS reports.	Total course length data is not currently monitored as difficult to capture on Cerner.	Ad hoc audits are done which focus on specific areas & may include course length data e.g. antibiotic use in covid patients.	To regularly report on course length data will be difficult as it requires an in-depth review of Cerner, it is not possible to do automatically. A pilot course length audit on focused wards in Q1 25/26 to give us an idea of duration & to see how feasible it would be to do on a regular basis. Results are being analysed.	2. Partially compliant

3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	- Audits in place to measure adherence to AMS principles (ASPIRE, point prevalence). - CQUINs supported as & when appropriate. - Brief overview of AMS included in medicines management training for prescribers. - AMS teaching is provided to all F1s, all pharmacy staff, all new NMPs & medical students. Ad hoc training is provided to nurses, F2s, IMTs when requested. - AMS overview slides have been added to IPC WEPP Clinical Champions nurse training - AMS is briefly mentioned in IPC mandatory training & all prescribers receive medicines management training which covers AMS. - AMS policy, guidelines & formularies are available for all staff including agency staff and external contractors.	None identified	None required		3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						

4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Any IPC related patient information leaflets go through a governance process administered by Clinical Governance Co-ordinators who submit leaflets to the 'Patient Information Review Group' which is a panel of services users/members of the local community who volunteer to review the leaflets to ensure they are fit for purpose, accessible and easy to understand from a patient/service user perspective	The Patient Information Review Group is small and made up of similar demographic of people. We do not have leaflets in other languages	Plans in place to run a promotional campaign to increase membership of the group and use the WUTH patient experience social media platforms to do this to recruit a more diverse demographic of people to review the leaflets including young population (children and age 20 - 30)	A patient information leaflet policy is currently under development which sets out the process of creating and updating PIL's to ensure that they are produced to the high standard set by the Trust.	2. Partially compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	The Trust uses EIDO. Leaflets are reviews every 3 years or if National Guidance changes. Posters are also available across site dependant on what area it is and what health information needs to be delivered	As above	As above		2. Partially compliant

4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All of our leaflets follow national IPC and AMR best practice	None identified	None required		3. Compliant

4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of	Leaflets available for carers and visitors. Newsletters are available for staff. We have annual IPC campaigns based on staff education and engagement. Ongoing IPC comms campaign that involves key information being shared with visitors to the hospital in the form of roll banners, posters, videos in key departments and visitors' newsletters. There are messages regarding not visiting the Hospital to visit if you yourself are unwell	None identified	None required		3. Compliant

	patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.					
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	We use electronic patient records (CERNER) and all patients with Alert organism have an alert on their record to inform all users. Patients have catheter passports	Compliance with the use of urinary catheter passports	Monthly Continence steering group meeting that is a collaboration between community and hospital teams where lessons learnt are shared to inform local action plans going forward		3. Compliant

5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receives timely and appropriate treatment to reduce the risk of infection transmission.	Robust screening in place on admission with regular monitoring of screening results. All patients commenced stool charting on admission. Digital alert system (Cerner) and process reviewed on admission for previous infection risk. Timely diagnostic support and regular review of results for all patients. Vital sign monitored closely of all patients to early identify infection indication.	None compliance with MRSA screening Stool chart completion	Compliance reporting Process embedded and monitored by Ward team. Weekly safety and governance meetings shared learning forums in place with discussion of themes. Focus for senior Nurse Walk round. Education drop-in sessions for Staff Teams in place.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or charted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and	Daily review of stool charting and action taken as needed via Trust policy / Risk assessment of isolation of patients. Daily Ward and assessment area sit rep and discussion and escalation of all patient isolation needs with Divisional senior Nursing team and IPC teams.	Gaps in MRSA screening on admission - Divisional monitoring in place compliance 97% September 2024.	Gaps in stool charting across ward areas. Education and Weekly Audit process in place across division.		3. Compliant

	ongoing isolation decisions.					
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	SBAR and verbal handover for patients on transfer or movement to internal departments Alert organism alert is visible on Cerner.	Infection risk not always handed over on transfer	Alert on Cerner Senior teams daily monitoring of process in place. Safety huddle discussion daily.		2. Partially compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage reviewed weekly as part of IPC audit for all inpatient and outpatient areas. IPC updates actioned. Patient and visitor education / information in place.	Potential no compliance	Re-iterate requirement during senior walk abouts, during IPC walk abouts. During the review process. Reviewed and actioned at divisional IPC meetings monthly.		3. Compliant

5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Robust Governance processes in place on identification of patients with infection. Rapid Evaluation of care process in place with multidisciplinary team involvement. Monthly Divisional and Directorate reviews of individual cases discussed, and lessons learnt forums embedded. Contact tracing process in place and governed by IPC and Ward teams. Outbreak protocol in place.	Timely sharing of rapid evaluation information and MDT meeting availability	Daily ward outbreak meeting structure in place with wards declaring outbreak. Enhanced cleaning schedule process.		3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC include the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Induction and mandatory training are targeted for specific roles, everyone receives hand hygiene training, and the e-learning content is aligned to the national CSTF guidance.	Areas of none compliance	Compliance is part of the Divisional exception reports presented to monthly IPCG		3. Compliant

6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IPC roles and responsibilities features in all Job descriptions	Areas of none compliance	Compliance is part of the Divisional exception reports presented to monthly IPCG		3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Compliance is reported at the monthly IPCG meeting	Areas of none compliance	Compliance is part of the Divisional exception reports presented to monthly IPCG		3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	There are don and doffing competencies for all staff and guidance is available on the intranet in poster form and videos. Add hoc training is also delivered across the hospital when required ,	Areas of none compliance	Divisions responsibility to ensure their staff are updated with training that is available and provided		3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Fit testing is currently the responsibility of the Divisions, there has been 16 new staff trained to be fit testers. There are 5 machines in the organisation and a bi-weekly meeting currently to support the fit testers chaired by the deputy DIPC.	Areas of none compliance	Compliance is part of the Divisional exception reports presented to monthly IPCG Weekly meetings to progress		2. Partially compliant

6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard, and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Staff training is recorded on ESR	Potential for none compliance	Regularly reviewed through education governance		3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Patients are daily assessed for infection risk and need of isolation. Robust timely patient status reports updated and actioned as required.	Availability of side room capacity on ward areas. Limited capacity in speciality ward areas	Daily risk assessment and movement of patients to appropriate base wards Isolation priority protocol Ward 25 now general medicine freeing more side rooms		3. Compliant

7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Daily risk assessment of isolation planning. Patients risk assessed daily and furthermore once results are processed. Clinical decision making on isolation need per individual patient. Cohort clinical decision making in place with clinical teams and IPC teams.	Availability of side room capacity on ward areas due to challenges with competing requirements for side room usage and also patient flow. Limited capacity in speciality ward areas	As above		3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Clear signage in place. Hand hygiene compliance monitored daily with data shared. Mandatory training compliance monitored and continuous education in place to support staff clinical decision making for utilisation of isolation areas.	None compliance	Reminders on walk rounds from IPC and senior leaders Matron audit		3. Compliant

7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Patients transferred on clinical need with senior clinical decision maker involvement at consultant level.	Failure to notify receiving area	SBAR handover completion - all alerts and infections are handed over if patients need to be transferred to appropriate clinical areas Standardised discharge documentation		3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	The laboratory is accredited to deliver Registration and Specialist training by the professional body (IBMS - Institute of Biomedical Science) and is accredited by UKAS (United Kingdom Accreditation Service) to ISO15189:2012, transitioning to 2022.	None identified	None required		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Both conventional and rapid methods for Infectious organisms are carried out and reported and accredited under the laboratories schedule found here: https://www.ukas.com/download-schedule/9595/Medical/	There are a number of configurations for the SGSS UKHSA reporting mechanism which are not met. The Add-on tests and GP tests report to Cerner but do not report to the Infection control system.	Emails are generated to alert IPC colleagues of results, e.g. COVID and C. difficile.	Ongoing work with UKHSA to become compliant with Enteric PCR and RSV changes to SGSS.	3. Compliant

8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	The laboratory produces monthly KPI data feeding into numerous regional and national data collection sets. The laboratory also has Board meetings and Directorate Performance Reviews (DPRs) which in turn are reported through Divisional meetings. Key KPIs are monitored with a narrative for failing items. This information is seen by our accreditation body UKAS.	None identified	None required		3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Screening and testing patients on admission follows local policies based on national guidelines	We currently do not follow guidelines for screening patients for CPE who have had had a healthcare admission in the last 12 months	CPE policy is currently under review. MRSA screening compliant. C.auris screening - partially compliant (High risk unit screening only – e.g. critical care/NNU)		2. Partially compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Patients are tested when symptoms arise to assist in diagnosis, management and treatment to maintain there's and others safety. All samples sent to the laboratory are tested as per national guidelines.	Samples are not always collected in a timely manner.	Review of themes and trends from HCAI reviews and incident reporting.	Stool Rule for detecting CDT. Blood culture policy. Prompt sampling part of Antimicrobial Stewardship.	3. Compliant

8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	The laboratory includes unknown / novel pathogens within the scope of many protocols including for testing, transport and clinical advice. Where applicable the laboratory has Service Level Agreements with UKHSA laboratories for outbreak support.	None identified	None required		3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	The laboratory and service users have a Transport SOP for Hazardous pathogens including Category A, HG4 high risk pathogens. These protocols are overseen by a Dangerous Goods Safety Advisor on retainer as a consultant and are inspected by the Health and Safety Executive and the Department for Transport. Inspections by both governing bodies carried out in Q4 - 2024.	None identified	None required		3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						

9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	The NIPCM for standard transmission-based precautions is used. ANTT training is delivered. Outbreaks of infection are monitored via our daily surveillance activities. UKHSA and public health are invited to all outbreak meetings. We have an isolation policy and a hierarchy for isolation poster. Local Sharps policy and exposure to BBV policy. Decontamination policy that includes locally used disinfectants. Antimicrobial policies, A medical devices group and we report all mandatory infections. We have all policies as advised in the H&S care act	Potential for none compliance with policy	Compliance monitoring		3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Pregnancy risk assessment, return to work interviews post sickness could highlight need for risk assessment, check in and appraisal,	Occupational Health not aware of changing staff health needs unless informed by manager or referred for medical advice	Staff check in and appraisal across the Trust		3. Compliant

10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Exposure SOP, NITS meetings to review exposures, referral pathways to HIV services. Notification of staff exposures by ED are triaged with 24 hours and followed up appropriately according to local SOP. Environmental exposures are notified to OH via IPC and the line managers are then required to send risk ID forms to staff for completion and return to OH to facilitate public health actions or medical interventions.	The reliance is on communications between managers and exposed staff and compliance of staff to complete and return risk OD documents in order to assess.	Manager communications and outbreak meeting.		3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Occupational health records				3. Compliant

Board of Directors in Public **Item 28**

01 October 2025

Title	Biannual Establishment Review
Area Lead	Sam Westwell, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
Author	Julie Roy, Deputy Chief Nurse Johanna Ashworth-Jones, Programme Developer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Trust Board with assurance that WUTH has met its regulatory requirements in accordance with national guidance 'Developing Workforce Safeguards' (NHSI 2018). National guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time National Quality Board (NQB 2016 & 2018).

In addition, the report demonstrates that the Trust has met effective governance requirements aligned to workforce decisions which promote patient safety and comply with the Care Quality Commission (CQC) fundamental standards.

This report comprises of an Executive summary report to support presentation at Trust Board and a comprehensive full report detailing process, assurance evidence, outcomes and next steps which will be published on the Trust website.

Key Risks

This report relates to the following key risks:

- **1091** – Emergency Department - staffing levels and temporary escalation areas
- **2058** – Women's & Childrens Division – Maternity services – Achievement of maternity incentive scheme
- **435** – Critical Care – potential risks related to fulfillment optimal staffing levels
- **809** –There is a risk to the health and wellbeing of both clinical and non-clinical staff within medicine due to high sickness, high number of vacancies and fatigue, may downcore if we continue to be under 5% sickness and we have limited vacancies at present.
- **2176** There is a risk to the staffing stability in the Medicine Division due to the reduction in NHSP bank pay rates, with potential impacts on patient safety, staff retention, and financial sustainability. Mitigating these risks requires a balanced approach that includes fair pay, staff engagement, robust recruitment and retention efforts, and effective governance of temporary staffing. Without such controls, the division risks increased vacancies, reliance on costly agency staff, and compromised care quality.

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

1	Narrative
1.1	**Background** The fundamental purpose of a safe staffing nursing establishment review is to ensure that sufficient nursing capacity and capability is available to provide individualised, person-centered care in a safe and effective way. This is achieved through consideration of a range of decision-making factors which have been clearly articulated in a framework of expectations set out by the National Quality Board (NQB 2016 & 2018) enabling a triangulated approach to staffing decisions. These are;

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Hospital Trusts are required to comply with the NQB 2016 & 2018 guidance which states that providers:

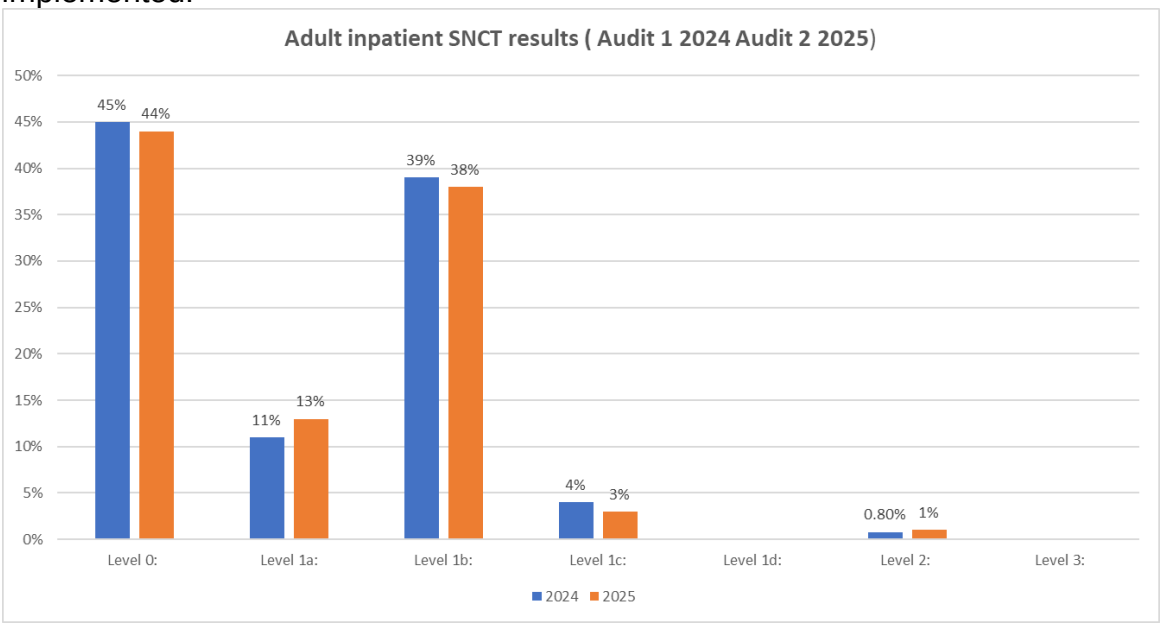
- Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to always keep them safe.
- Must use an approach that reflects current legislation and guidance where it is available.

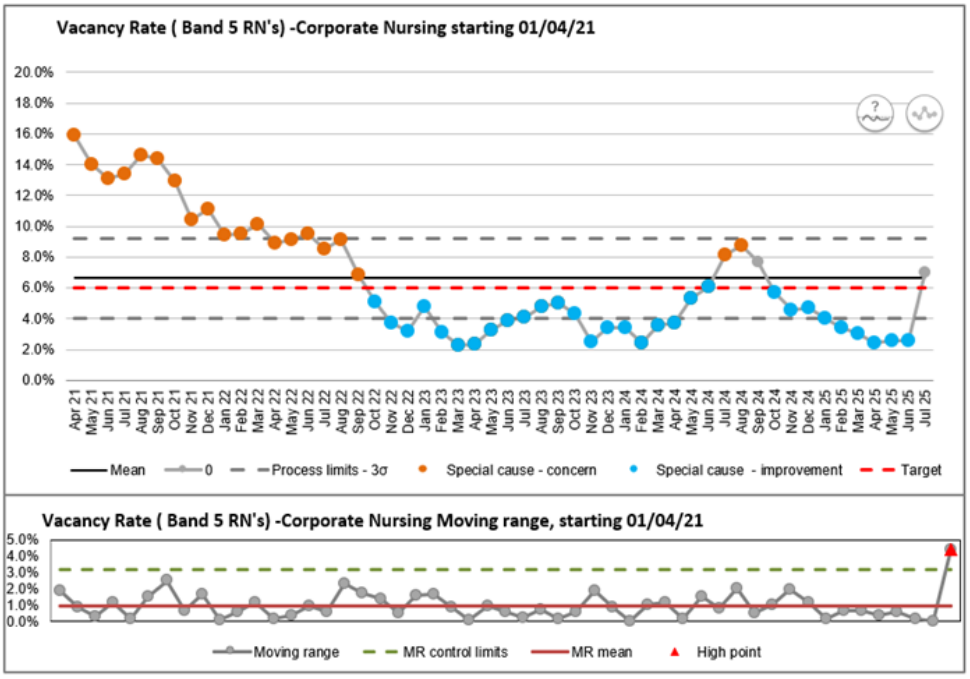
These expectations also form part of 'Developing Workforce Safeguards' (NHSI 2018), along with other recommendations for consideration to provide a triangulated approach for the review of staffing requirements. Trusts must demonstrate that they have used the following three components as part of their safe staffing reviews:

- Evidence-based tools (where they exist).
- Professional judgement.
- Outcomes

1.2	**Governance** Alongside the regulatory requirement to undertake a formal 6 monthly review of nurse staffing establishments, a bi-monthly safe staffing report is presented to People Committee. The bi-monthly report provides an oversight regarding the visibility of safe staffing assurances including any known consequence on patient care, safety, or experience. Included is a comprehensive dashboard providing a month-by-month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD) data, shifts that have experienced any 'red flags', and patient experience metrics. Any known risk is highlighted along with mitigations and plans to enhance staffing assurances moving forward. The bi-monthly report provides narrative and statistical process control (SPC) charts based on the data within a staffing assurance dashboard. A revised integrated performance report is being proposed moving forward and will be reviewed at People Committee in October 2025. In addition, WUTH complies with NHSE Digital requirements to submit monthly staffing data in relation to fill rates and calculation of CHPPD. These monthly returns are available for review on the Trust public website as per national guidance recommendations.

2	**Establishment Review**
2.1	**Process** The Trust has a standardised approach to establishment setting within the adult inpatient wards (SOP Appendix 1). This consists of reviewing an 80 plus indicator establishment template that brings together nurse sensitive indicators, acuity and dependency results, workforce metrics, quality impact measures and finance. These templates are used to consult with each localised leadership model i.e., Ward Manager, Matron, and Associate Director of Nursing. Proposals are then presented by the Divisional Nurse Director at a 'confirm and challenge' meeting with the Chief Nurse and supporting specialist leads. Specialist areas such as Critical Care, Maternity Services, Neonatal Unit and the Emergency Department have speciality specific establishment reviews aligned to the appropriate national guidance which are detailed later in this report. Children's service utilised the Children's and young persons (C&YP) SNCT tool for the first time following training from NHS England in 2025 and details of this can be found under the C&YP section of this report.
2.2	**Expectation 1: Right Staff** **Adult Safer Nursing Care Tool** As detailed in the last 6 monthly establishment paper presented to Board March 2025**.** WUTH are compliant with the licencing agreement of the "New" Adult Inpatient SNCT tool which was launched October 2023. This report provides the results from the second audit undertaken Apr / May 2025 and in line with the licencing red rules, where there have been no changes in ward configuration / speciality results can be used to inform staffing establishment considerations.

	Enhanced Therapeutic Observations and Care (ETOC) referred to as 1c & 1d levels within the SNCT is a significant area of potential efficiency and a quality improvement opportunity for WUTH. WUTH are part of a regional Community of Practice group reviewing a series of improvement initiatives. At a local level this included the appointment of a Dementia Quality Matron. The chart below shows the Adult SNCT levels of care across each of the two audits. The chart shows little variance across the overall Trust results. This would suggest a degree of confidence in a consistent delivery and approach to how the SNCT has been implemented.  *There were some level 1d & level 3 patients during the audit however not enough to create a percentage figure.* Patient care levels: Adult inpatient SNCT • Level 0 – Needs met by provision of normal wards. • Level 1a – Unstable with a greater potential to deteriorate. • Level 1b – Stable condition but are dependent on nursing care to meet most of their needs. • Level 1c – Stable condition but requiring additional intervention to mitigate risk. • Level 1d – Stable condition but requiring intervention by 2 or more people to mitigate risk. • Level 2 – Requires management in designated beds / required staffing expertise or transfer to designated level 2 facility. • Level 3 – Advanced respiratory support / multiple organ failure
2.3	**Expectation 1 – Right Staff** The Chief Nurse will lead the development of a nursing workforce plan for WUTH, This will take into consideration current financial challenges and controls and ensure that the nursing and midwifery workforce is resilient and able to sustain high quality care and patient safety.
2.4	**Expectation 2 – Right Skills** **Mandatory training** Ensuring staff have the right skills to undertake their role safely and confidently is a national NHS requirement. WUTH has robust Ward to Board processes in place to monitor the compliance of staff against mandatory and role essential training including a specific Education Governance Group.

2.5	**Expectation 2 – Right skills** **Development & Education** For 25/26 WUTH has been successful in securing £707,449.41 from NHSE for the upskilling of NMC & AHP registrants. There has been a Trust Training Needs Analysis (TNA) completed with initial plans to support a number of workstreams, focusing on harms prevention. WUTH has a Clinical Skills department which provides clinical education to clinical roles across the Trust, there is currently a risk (ref 2109) on the risk register in relation to capacity and demand. To support education and development at a local level the Trust has a structure incorporating divisional Practice Educators. Education and Development objectives, workstreams and escalation of risks are reported and monitored via the Educational Governance group.
2.6	**Expectations 2 – Right Skills** **Recruitment & Retention** Data from NHS England reports the national registered nurse (RN) vacancy rate as 7.5% (Mar 24) (Latest available data). WUTH reports nurses' vacancy data as part of the bi – monthly safe staffing report to People Committee, this month-on-month data is displayed below as Charts 1,2&3. WUTH's Vacancy rate has consistently been below the national average for over 9months however July 25 figures indicate an increase, this July figure is in real terms a false depiction and is influenced by the realigning of budgets and the impact of a previously approved business case. There are currently no true RN vacancies with the majority of posts having staff recruited against them. This reduced vacancy position is a challenge for the Trust in relation to fulfilling the original forecast of recruitment numbers for graduating registered nurses, a scenario which is being seen nationally. **Chart 1**  Both Trust wide and ward based CSW vacancy data is reported as special cause concern. There has been some vacancy holds for some areas whilst the CSW organisational change has been implemented to ensure the correct placement of staff.

Retention and recruitment campaigns are continuing and are supported by the following actions:

- Successful Introduction of a CSWD scheme which involves collaborative working with NHSP, CSWs who undertake the care certificate program guaranteed an interview for a substantive post.
- Quarterly system-wide recruitment events.
- Exit interviews; review of themes to address key areas.
- Specific placement of CSW apprentices and introductory visits to areas prior to placement.
- A focus on local support to improve retention of CSWs in their first year with the Trust.

Additional focus and recruitment drives will be undertaken once the CSW Organisational change is complete, with a focus on supporting those 'new to care' into the Trust.

Chart 2

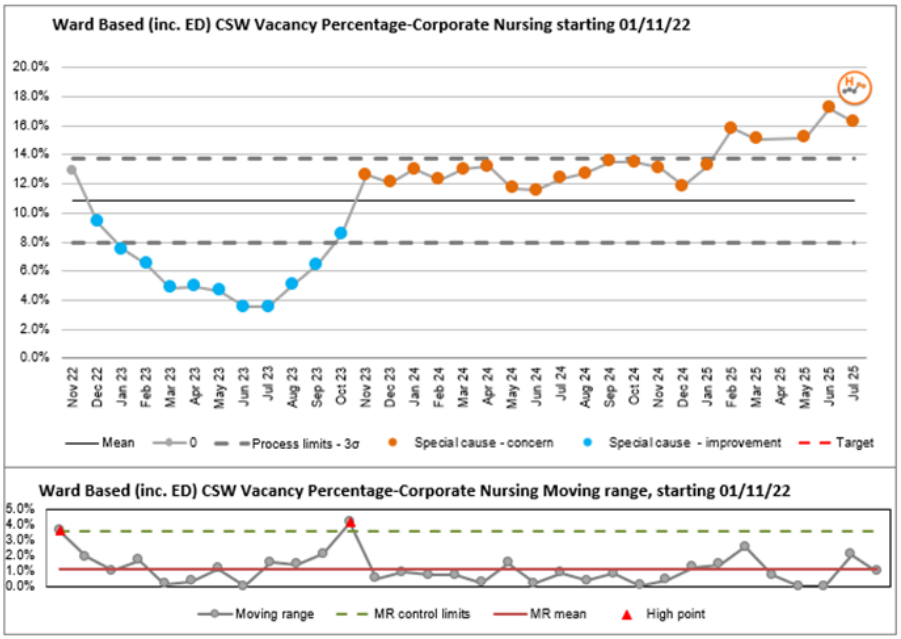
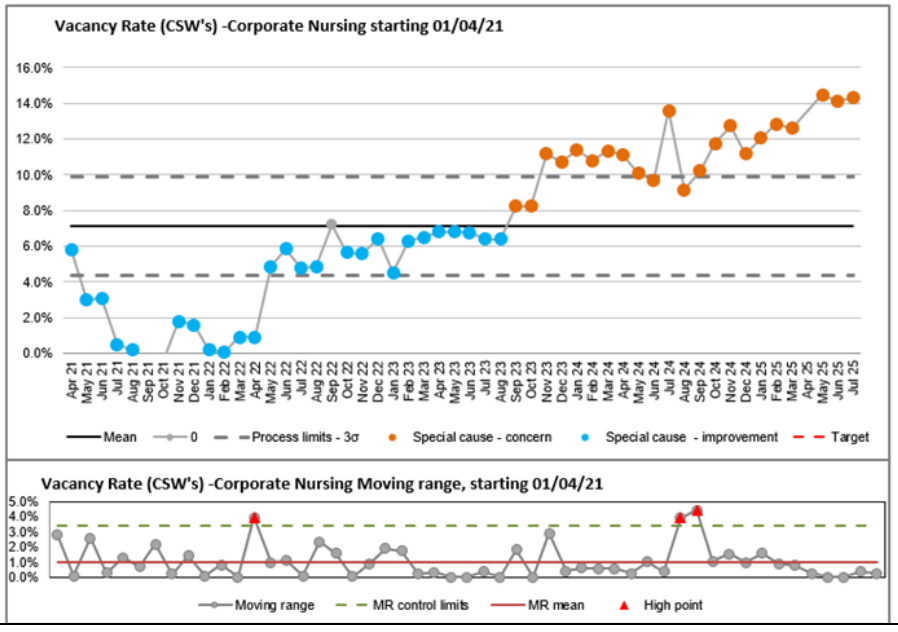


Chart 3



2.7	**CSW Band 2 & Band 3 Organisational Change** Following extensive CSW industrial action in 2023/24 and a subsequent agreement being signed in April 2024 there has been significant work undertaken to clarify the roles and responsibilities of the Trust's care support workers moving forward. A retrospective regrade process has been completed. Two roles have been defined and matched to a new Agenda For Change (AFC) job description and person specification - a band 2 healthcare assistant (HCA) and a band 3 care support worker (CSW). It has been identified that there is a need across the Trust to increase the number of band 3 CSW posts in order to ensure appropriately trained staff are available to deliver care within the remit of their role. As such, a Trust-wide organisational change process has been undertaken with implementation due to be concluded in Q3 25/26. Whilst there has been challenge from staff side colleagues regarding the proportion of band 3 and band 2 roles in the revised ward structures, it should be recognised that this will be reviewed as an element of the bi-annual establishment reviews moving forward.
2.8	**Expectation 2 – Right skills** WUTH has accelerated its position to deliver healthcare in a way that improves patient's clinical outcomes and experience, reduces operational pressures to Emergency Departments and patient flow with the provision of SDEC models and Virtual wards. Ensuring that staff have the correct skill sets to fulfil the service objectives is a key priority and as SDEC speciality areas expand this will need further consideration. Aligned to this is the multi-disciplinary team approach with the specialist input from Allied Healthcare Professionals (AHP's) paramount to the successful delivery of same day emergency care. Given the changing landscape of the NHS, the services that it provides and a wider remit of an MDT approach a full review of AHP staffing provision will be undertaken by Quarter 4 25/26.
2.9	**Expectation 3 – Right place and time** **E – Roster & temporary staffing** It is well recognised following Lord Carter's review of productivity and efficiency of NHS Acute hospitals 2016 that good roster control and management will provide efficiencies such as reducing the requirement for bank and agency staff and ensuring that there are the right staff, in the right place, at the right time by planning staffing against activity and demand aligned to experience and skills. In August 2024, WUTH introduced an E-roster review group consisting of specialist service leads with attendance by invite to senior nurse leaders for each division. These review meetings comprise of the monitoring of key performance indicators aligned to robust roster management and data led discussions of additional control measures, such as 'mis match' reports, retrospective shift allocation and NHSP request rationale and usage. Outputs are reported to an Executive Led Transformation Workforce Meeting which have included the removal of agency staff usage. **Daily staffing meetings** WUTH has a series of robust measures in place to monitor demand and deployment of staff at local and Trust wide level, including daily staffing meetings, nominated senior

lead for Trust wide staffing, divisional staffing leads and a recently revised staffing escalation policy. WUTH has a visible staffing deployment tool the Safer Staffing Oversight Tool SSOT and is on an agreed plan to transfer to Safe Care which directly populates from E roster.

Safe Care E-roster Module

Safe Care within the Allocate E-roster system, provides visibility of staffing levels based on patient numbers and acuity and dependency, enabling day-to-day, operational changes to the roster, in real time which will support any required redeployment of substantive staff across wards and or allocation of any temporary staffing. This Safe Care module however is reliant on correct e-rosters being in place and staff inputting patient acuity and dependency 2 / 3 times a day. WUTH have the Safe Care Module as part of their e-roster package and following the outputs of the E-roster review meetings plan to launch the roll out of Safe Care starting with designated wards within the surgical division with a start date to be confirmed.

2.10 **Establishment review outcomes**

Outcome details of the establishment reviews for each Adult inpatient ward are provided in Table 1. This has been reviewed by the Chief Nurse and Chief Finance officer for overall approval.

For adult inpatients a recommendation of 1 change has been proposed and approved, as detailed below.

There are however a number of other areas which either have undergone or are planned to undergo operational changes within each division.

Table 1: - SNCT results & proposed changes

Division	Ward	Est Status	Funded	SNCT 2024 minus ETOC levels	SNCT 2025 minus ETOC levels
Surgical	10	No Change	28.71*	31.89	29.18
	11	No Change	40.57	35.85	34.95
	12 EOU	No Change	39	10.34	11.86
	WAFFU	No Change		17.56	16.96
	14	**Reduction**	56.86	44.4	46.28
	SEU / 17	**Divisional / Operational Change**	49.07*	33.24	33.69
	18	No Change	45.4	39.12	36.32
	M2 Ortho	Divisional review underway		19.79*	19.76*
	M2 Surg	Divisional review underway		12.86	12.87
Medical	20	No Change	New area		
	21	No Change	40.49	49.76	49.18
	22	No Change	40.26	40.79	49.86
	23	No Change	42.26	40.39	40.88
	24	No Change	30.67	33.83	30.68

25	**Divisional / Operational Change**	47.56	50.95	39.55
26	**Divisional / Operational Change**	48.63	46.61	46.33
27	No Change	40.32	42.22	41.56
30	No Change	36.43	44.56	43.38
32	No Change	42.85	36.24	38.12
CCU	No Change	15.84	9.84	13.18
33	No Change	39.83	35.6	35.7
36	No Change	46.92	48.89	48.64
37	**Divisional / Operational Change**	61.74	66.01	62.85
38	**Divisional / Operational Change**			
CRC	No Change	40.7	39.17	37.33
M1	**Divisional / Operational Change**	39.4	48.79	47.56
AMU	No Change	54.81	45.21	45.57
MSSW	No Change	26.77	26.78	27.44
AFU	No Change	New area		

Women's and Children's Division

Maternity Services

Maternity services use a nationally recognised safe staffing tool Birthrate Plus© which is completed daily and shared across the regional network. Monthly outcome results such as the number of red flags, compliance with the tool and any escalation implementations or diverts are reported in the bimonthly Workforce Assurance Committee report for monitoring and escalation. In addition, staffing for maternity services is also reported to the Executive team in relation to Ockendon report updates, progression against continuity of care model implementation and PSQB reports.

The annual Birthrate Plus© review report undertaken in March 2025 was reported to Board of directors 5th June 2025. The report outlined the findings of the Birthrate Plus© report which identified a minimal shortfall of 4.91wte midwifery staff to deliver care safely and meet the needs of women and families. The report also outlined the Trust compliance against Maternity Incentive Scheme MIS standards, Continuity of Care and details of the the deferred income business case which has been approved and bridged the gap from 14.17wte deficit by 9.26wte.

Following advice from NHS Resolution (NHSR) and the Local Maternity and Neonatal System (LMNS) it has been recommended that the proposed business case relating to maternity workforce arrangements is considered at Board. This will allow appropriate discussion and scrutiny prior to any decision being made. This approach is consistent with national guidance and ensures the Trust's governance processes align with both local systems and our partners' expectations.

Alongside this business case being progressed the Trust has also received targeted funding to support workforce development and retention. This includes:

	• Maternity Support Workers (MSW's). Dedicated funding has been secured to support 2.0wte newly qualified midwives into MSW vacancies of £16,000 until midwifery posts are available for employment. • Newly Qualified Retention: National funding streams have also been acccessed to support the recruitment and retention of newly qualified midwives for 3.9wte posts and £31,520 funding. This investment should be used to provide enhanced preceptorship, pastoral support and tailored development opportunities, ensuring the early-career midwives are well supported and retained within the Trust. These funding streams complement the business case under consideration and demonstrate the Trust's commitment to securing and sustaining a safe and effective workforce, aligned with local and national policies **Gynaecology** As previously reported the Women's and Children's division have completed an activity review which has reduced Ward 54's bed base with the removal of surgical division bed allocation within this area. Ward 54 have been temporarilyy relocated on ward 31 as part of the Neonatal unit upgade. Due to the planned bed base minimum staffing levels will apply which once in place will contiune to be monitored as part of the trust agreed staffing process and professional judgement. **Children's Services** WUTH's Children's ward undertook a review of staffing using the Children's Safer Nursing Care Tool C & YP SNCT. This is the first time WUTH have utilised the tool which is currently under review and awaiting a release of a revised version which will incorporate ETOC provision. As with the Adult SNCT, red rules indicate changes to establishment setting can not be made based on results from just one set of audit results, in addition care provision for patients requiring additional levels of ETOC is an increasing requirement of WUTH children's ward patient case mix, and will be fundamental to capture when considering safe staffing levels. Children's services have specific RCN guidance in relation to staffing levels aligned to required patient to registered nurse ratios, these ratios also incorporate guidance on acuity levels and alignment to children's age. Additional assurances that influence professional judgement include WUTH's attendance at the daily Cheshire and Merseyside network meeting where activity details are recorded and information on acuity shared. WUTH are also members of four children's services networks, Paediatric, Neonatal, Critical Care and Surgical, these networks provide regional support, scrutiny and gather staffing and patient data in relation to activity and workforce indictors. **Neonatal Unit** Due to the acute nature of neonatal medicine it can be difficult to accurately predict required staffing levels and therefore the application of professional judgement using average activity & acuity, aligned to staffing guidance recommendations form the basis of staffing deployment within WUTH's neonatal unit. This approach is in line with the British Association of Perinatal Medicine (BAPM) guidance.

WUTH's neonatal unit is part of a regional neonatal network and is represented at daily meetings to identify any required mutual aid, diverts or escalations. This detail is provided month on month as part of the bimonthly staffing paper. For this report period there is currently no proposed change to the establishment.

Medical Division

During the last 6 months the Medical Division has increased its ward areas to incorporate elements of acute care, AMU, MSSW, AFU including SDEC frailty.

As part of the Trust wide efficiencies and continuous improvement approach, the Medical division have made several changes to ward speciality and bed base allocation, these include wards 25, 37, 38, a change of location and service provision from AFU formally known as OPAU and ward 20 and planned changes to the acute ward footprint. These changes will have staffing establishment changes which have taken place outside of the formal six-monthly nursing establishment review process and therefore are transacted as part of the divisional plan. Professional and clinical judgements have been considered and Equality Quality Impact Assessments (EQIA) completed.

Surgical Division

As highlighted in table 1 there is just one transactional establishment change in line with the establishment review (Ward 14). This reduction in establishment has been utilised to support an additional twilight shift on SEU following a capacity and demand review. As detailed earlier in the report each division has undertaken efficiency reviews and considered continuous improvement opportunities, for the surgical division this includes a review of M2 orthopaedics and surgical services and a divisional review of skill mix for WAFFU and the elective orthopaedic unit.

Emergency Department

WUTH is currently upgrading its Emergency Department (ED) as part of a multimillion-pound capital investment. As the department transitions between the old environment and the new build the department is accommodated across several different areas which has resulted in some unforeseen staffing resource challenges due to temporary space allocation to facilitate the continuation of the new development. In addition, the Trust has experienced unprecedented operational activity pressures which have resulted in ED having to utilise several temporary escalation areas which require additional staff to maintain patient safety. This upgrade is now in Phase 4 and has increased the footprint of the department significantly, as presented in the last report a business case has been approved by Trust Board and has increased the funded establishment by 44.4WTE. All of the ED registered nurse posts have now been recruited to with an anticipated reduction in temporary staffing expected in Q3.

Critical Care

The current staffing establishment for critical care has been mapped according to the Guidelines for the Provision of Intensive Care Services (2022) (GPICS) developed by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This provides a baseline of how the unit is staffed according to the standards. The staffing establishment is based on ensuring that the standards are achieved. For the period of this report there are no proposed changes to the establishment.

2.11	**Headroom** Nursing headroom is the additional percentage of staff added to the baseline roster requirement to cover the time that staff are not available for direct patient care, ensuring that enough nurses are rostered to maintain safe staffing levels even when some are unavailable. WUTH's current headroom is set at 23% across the Trust for all areas of nursing. The safer nursing care tool recommends a minimum headroom of 25% for Emergency Departments in reflection of the additional training requirements for emergency nursing staff. New guidance May 2025 from the Royal College of Nursing RCN for nursing workforce standards has recommended a minimum headroom of 27%. Benchmarking across other regional Trusts has indicated a significant variation in headroom and it must be noted that maternity leave is not covered by headroom at WUTH.

4	**Conclusion**
4.1	The Trust has met the standards and expectations within Developing Workforce Safeguards requirements for adult inpatient wards. In addition, there are evolving processes in place to support professional judgement establishment setting within specialist areas. This report highlights a series of new and proposed workstreams that will ensure standardised approaches to safe staffing. These new initiatives and increased scrutiny and controls will provide a positive impact on patient safety and quality of care whilst also supporting efficiency reviews and increased transparency of staffing metrics. WUTH's current headroom 23% is currently below National recommendations 25% ED SNCT and 27% RCN, this will require further consideration and benchmarking. WUTH faces challenges with accommodating recruitment of future graduate nurses and midwives which is mirrored nationally. WUTH has successfully recommenced the six-monthly staffing cycle and implemented the new adult SNCT in accordance with license requirements. There is confidence that daily staffing monitoring processes are in place with a good system of internal control being applied to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy.

5	**Recommendations / next steps**
	• **SNCT audits:** The next Adult SNCT audit will commence January 2026 to align to the National Adult SNCT programme. The Next EDSNCT audit is planned to commence November 2025 following a period of staff training on the SNCT process. • **Development of a nursing workforce plan** Initial work has commenced on the development of a nursing work plan / strategy to support anticipated gaps in recruitment as detailed under Exception 2 section of this report with a particular focus on CSW and HCA recruitment and developing career pathways to improve retention. This plan will also support the recruitment

	of newly qualified nurses a national priority of the Chief Nursing Officer for England. • **Bimonthly Staffing report** A proposal to change the current format of the bimonthly staffing report is being reviewed which provides a greater holistic view of the triangulation of data bringing together staffing and quality metrics including Model hospital data. • **Safe Care Trust Wide Implementation** As highlighted within the Expectation 3 section of this report the Trust will progress with the implementation of the Safe Care module during 2025/26 with the initial launch of this within the Surgical Division. • **ETOC** WUTH will utilise the learning and quality improvement outcomes from the regional community of practice. The appointment of a Dementia Quality Matron in September 2025 will support the implementation of these outcomes and initiatives with updates reported via Patient Safety Quality Board. • **Development of formalised staffing model standards** Variation in several staffing model considerations such as the application of ward manager supervisory time, and deputy ward manager model have been identified. Agreement of these fundamental standards will be formalised into a Trust wide approach, led by the Chief Nurse. • **Review of staffing establishments within Day case and outpatient areas** Work will commence in 2025/26 to review nurse staffing establishments within the multiple Day Case and outpatient areas across the Trust. There is currently no nationally recognised tool to support this work and therefore a standardised approach based on the NQB guidance focusing on the triangulation of data, clinical specialty guidance and professional judgement will be applied. • **Inclusion of digital efficiency workstreams** Expanding the use of digital solutions and innovations has been identified as one of the main areas of focus within the NHS plan January 2025. It is recommended that progression with these workstreams that have a direct impact on nursing efficiencies are included as part of future reports. This will be supported by the new Chief Nursing information Officer (CNIO) who commenced in post August 2025