Wirral University Teaching Hospital
NHS Foundation Trust

WUTH AND WCHC BOARD OF DIRECTORS IN PUBLIC - 3 SEP

WUTH AND WCHC BOARD OF DIRECTORS IN PUBLIC - 3 SEP

3 September 2025

09:00 GMT+1 Europe/London

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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 3 September 2025
Time	09:00 – 12:30
Location	Hybrid

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	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
7 14	3.	3.1 Minutes of the Previous Meeting – WUTH 3.2 Minutes of the Previous Meeting – WCHC	Sir David Henshaw	
20	4.	Action Logs	Sir David Henshaw	
	Standing Items			
	5.	Staff Story	Hayley Rigby	
	6.	Joint Chair Update – **Verbal**	Sir David Henshaw	
21	7.	Joint Chief Executive Officer Report	Janelle Holmes	
31	8.	WCHC Integrated Performance Report	Executive Directors	
57	9.	WUTH Integrated Performance Report	Executive Directors	
86	10.	WUTH Chief Finance Officer Report	Mark Chidgey	
92	11.	WUTH Chief Operating Officer Report	Hayley Kendall	
101	12.	WUTH Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
127	13.	WCHC Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
	14.	WUTH Lead Governor Report – **Verbal**	Sheila Hillhouse	
168	15.	WCHC Lead Governor Report	Lynn Collins	

	Committee Chairs Reports			
170	16.	WUTH Quality Committee	Dr Steve Ryan	
	17.	WUTH Estates and Capital Committee – **Verbal**	Sir David Henshaw	
	18.	WUTH Charitable Funds Committee – **Verbal**	Sue Lorimer	
	19.	WUTH Finance Business Performance Committee – **Verbal**	Sue Lorimer	
172	20.	WCHC Quality and Safety Committee	Professor Chris Bentley	
175	21.	WCHC Finance and Performance Committee	Steve Igoe	
177	22.	WCHC People and Culture Committee	Meredydd David	
	Regulatory Reports			
179	23.	WUTH Estates Compliance and Sustainability Annual Report	Hayley Kendall	
224	24.	WUTH Green Plan	Hayley Kendall	
265	25.	WUTH Quarterly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
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412	32.	WCHC Infection Prevention and Control Annual Report	Claire Wedge	
	Strategy			
431	33.	NHS 10-Year Health Plan	Matthew Swanborough	

	Governance and Assurance			
442	34.	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common – *to approve*	Ali Hughes	
506	35.	WCHC Annual Declarations of Interests - Board of Directors 2024-25	Ali Hughes	
	Closing Business			
	36.	Questions from Governors and Public	Sir David Henshaw	
	37.	Meeting Review	Sir David Henshaw	
	38.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 1 October, 09:00 – 12:30			

Meeting	WUTH Board of Directors in Public
Date	Wednesday 2 July 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
SR	Dr Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Non-Executive Director (from 10am)
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
RM	Dr Ranj Mehra	Interim Joint Medical Director
MS	Matthew Swanborough	Chief Strategy Officer
SW	Sam Westwell	Chief Nurse
MC	Mark Chidgey	Chief Finance Officer

In attendance:

MD	Meredydd David	WCHC Non-Executive Director & SID
CB	Professor Chris Bentley	WCHC Non-Executive Director
ER	Emma Robinson	WCHC Associate Non-Executive Director
PS	Paula Simpson	WCHC Chief Nurse
TB	Tony Bennett	WCHC Chief Strategy Officer
RC	Robbie Chapman	WCHC Interim Chief Finance Officer
JC	Dr Joanne Chwalko	WCHC Chief Operating Officer & Interim Deputy CEO
AH	Alison Hughes	WCHC Director of Corporate Affairs
DM	Dave Murphy	WCHC Chief Digital Information Officer
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
TC	Tony Cragg	WUTH Public Governor
LC	Lynn Collins	WCHC Lead Public Governor
IC	Irene Cooke	WCHC Public Governor
KS	Kev Sharkey	WCHC Public Governor
HS	Haris Sultan	Observer

Apologies:

NS	Dr Nikki Stevenson	Medical Director & Deputy CEO
HK	Hayley Kendall	Chief Operating Officer & Interim Deputy CEO
DM	David McGovern	Director of Corporate Affairs, WUTH
SI	Steve Igoe	Non-Executive Director & SID

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 4 June were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Joint Chair's Update** DH provided an update on recent matters and highlighted good progress continued to be made to work towards integration. DH added there were regional and national challenges, and it was important that both Trusts lead by example. DH noted this was a shorter agenda and the Chief Operating Officer Reports and Chief Finance Officer Report would be presented as normal in September. The Board **NOTED** the update.	
6	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meeting in June, noting a key discussion on system recovery and financial improvement. JH reported both WUTH and WCHC Annual Report and Accounts were approved by the respective Board of Directors and were submitted on schedule for 30 June 2025. JH advised members that from 1 July 2025, Dr Ranj Mehra, Interim Medical Director at WUTH took up the role of interim Joint Medical Director across both WUTH and WCHC. JH referenced the consultation on the NHS Performance Assessment Framework which closed in May and gave an overview of the Trust's response, indicating that the Trust was supportive of the proposals. JH advised the Secretary of State for Health and Social Care had announced a rapid independent investigation into maternity and	

	neonatal services. JH added the Trust was not one of the 10 Trusts identified however the areas identified for Board assurance in the letter received were being reviewed by the relevant division to provide assurance to the Board. JH reported at WUTH in May there was one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and two Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH explained all staff across both Trusts had received the Better Together - Journey to Integration case for change document which outlined the staff and patient benefits of integrating both Trusts. JH added a Joint Stakeholder Newsletter had also been developed and distributed to Wirral system partners. JH referenced three members of staff across WUTH and WCHC had been selected by NHSE to attend the Royal Garden Party for the NHS in May at Buckingham Place. JH stated both Trusts had participated in celebrating PRIDE and Careers Week during June. JH highlighted the various WUTH and WCHC employee of the month and standout winners for May. The Board **NOTED** the report.	
7	**Integrated Performance Report** JC explained the number of Emergency Department (ED) attendances in month had increased by 5% and identified two risks to the position, noting there were a high number of 12 hour breaches for a decision to admit and patients presenting to the ED in mental health crisis. JC advised work was ongoing to increase the usage of Same Day Emergency Care (SDEC) and options were being explored with system partners to provide a mental health nurse in the ED. JC added in regard to referral to treatment, no patients were waiting 78+ weeks and the number exceeding 52 weeks continued to decrease and this demonstrated a good position for patients. JC highlighted cancer performance had been challenged due to operational pressure and recovery plans were in place. DH queried the fragile services. RM stated ear nose and throat, stroke and cardiology were fragile and would benefit from collaboration at a Cheshire and Merseyside level.	

	JH agreed and added other Trusts were having similar challenges and the outsourcing of these services to treat patients was being explored. Members agreed about the importance of Cheshire and Merseyside strategy for addressing fragile services. RM explained there had been 2 Never Events in May relating to LocSSIPs (Local Safety Standards for Invasive Procedures), no patient had come to lasting harm, and work was underway to identify the relevant learning. RM added members were already aware of the position in relation to the number of patients recruited to NIHR studies and the refreshed key performance indicators. SR commented LocSSIPs had recently been audited with a limited assurance opinion, and welcomed the additional scrutiny on this. SW stated there were 13 incidents of C Diff in May and 3 category 3 hospital acquired pressure ulcers. SW added infection prevention and control was a quality priority for this year. SW highlighted the Friends and Family Test for ED was 73.2%, and Outpatients and Maternity exceeded the 95% of those that responded were either satisfied or very satisfied with the service. SW explained the number of level 1 concerns raised with the Trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff was below the agreed threshold. 100% of complaints were acknowledged within 3 days of receipt. SW reported that, with the exception of CSW day fill rates, RN and CSW staffing fill rates were above the threshold of 90%. Members discussed the importance of sustaining a reduction in the number of C Diff incidents, acknowledging the need to focus on basic infection, prevention and control (IPC) measures and the challenges of high prevalence of community acquired C Diff in Wirral. Members noted work was ongoing between the WUTH and WCHC IPC teams to maximise available resources for quality improvement and that the creation of the Wirral Provider Alliance would enable a Wirral system approach to reduce C Diff. DS highlighted appraisal compliance had increased to 87.75% and explained a review of the documentation had been undertaken to streamline the process based on manger feedback and to focus on impact. Local audits similar to sickness absence audits would be completed later in the year to assess the quality. DS reported sickness absence had further improved but remains above target at 5.47%. Focus continues to be on supporting the	

	health and wellbeing of the workforce and close management of absences in line with the Attendance Management Policy. MC reported at the end of May, month 2, the Trust is reporting a deficit of £1.24m which is in line with the month 2 plan. MC added at month 2 £4.1m (out of £7.0m identified) non-recurrent mitigations have been utilised to support delivery of plan and offset the key risks. MC advised that as previously stated to the Board there were 4 key risks to the plan of which the primary risk was full delivery of CIP, and the risk adjusted annual forecast is below the required target. Other key risks were: - activity/case mix, - aseptic pharmacy income - run rate reductions MC added the deficit continues to place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). The cash balance at the end of month 2 was £4.216m however, this level of cash balance will not be sustained. MC noted the Trust should be able to progress through to Q3 without the need to request additional cash support. MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, agency, capital and cash were green and financial efficiency was amber. MD queried the cash position and the associated risk. MC stated the Trust will be making the ICB and NHSE aware of this and that there were cash mitigations/escalations the Trust could utilise to maintain a cash balance. The Board: • **NOTED** the report and agreed mitigations. • **NOTED** that the Trust's most immediate finance risk remains the cash position. • **NOTED** the risk of delivering the 25/26 plan, including the recurrent £32m CIP target and the ICS schemes of £14.5m. • **ENDORSED** the revised capital budget of £26.071m.	
8	**Chairs Reports – Quality Committee** SR explained he provided a verbal update at the last meeting and that this report summarised that update. The Board **NOTED** the report.	
9	**Chairs Reports – Audit and Risk Committee**	

	MC advised members that Committee had met twice in June to consider the 2024/25 Annual Report and Accounts and 2024/25 Quality Account. MC added the external audit outcome had been positive and the Committee had agreed to recommend the reports along with the Auditors letter of representation for approval by the Board. The Board approved these documents on the 23rd June. The Board **NOTED** the report.	
10	**Chairs Reports – People Committee** LD alerted members that a number of reports raised potential new risks. There was risk related to employee relations cases falling outside the set timeframes due to workforce challenges. A second risk related to the proposed changes in rates of pay for bank staff which may negatively impact bank fill rates. The third risk related to the changes affecting the Resident Doctors exception reporting process which comes into force from September 2025. LD advised work was ongoing by the relevant teams to mitigate these risks. LD summarised the various "Advise" and "Assure" matters from the Committee meeting on 12 June. The Board **NOTED** the report.	
11	**Chairs Reports – Finance Business Performance Committee** SL alerted members to the Trust's financial position, noting at the end of month 2 there was a deficit of £1.2m which was in line with plan, however this included £4.1m non-recurrent mitigations. SL added during the same period the Trust had a positive cash balance of £4.2m and did not anticipate requesting revenue support before quarter 3. SL also alerted members that the full year value of CIP identified to date had increased to £29.5m against a target of £32m. SL added the Committee received a quarterly financial forecast, noting at the time the plan was approved there was £25m risk and this had been mitigated to £7.6m. SL alerted members that there had been a significant increase in head and neck cancer referrals which was further exacerbated by unexpected medical staff capacity gaps. SL advised there was a proposal for discussion and approval in Private Board to address this.	

	SL summarised the various “Advise” and “Assure” matters from the Committee meeting on 18 June. The Board **NOTED** the report	
12	**Chairs Reports – Charitable Funds Committee** SL alerted members that the Committee had agreed to keep the Tiny Stars appeal open until March 2026 due to the continued fundraising by individuals in the community. SL noted the Trust Charity team were not carrying out proactive fundraising. SL also alerted members to the financial position of the Charity, noting the Charity had received a donation of £0.300m from the Incubabies charity for the Neonatal Unit redevelopment. SL alerted members that the Committee considered a proposal regarding future activity and potential income and agreed to the addition of one administrative post to support growth in fundraising activity. SL summarised the various “Advise” and “Assure” matters from the Committee meetings on 23 May and 18 June. The Board **NOTED** the report.	
13	**Fit and Proper Persons Update** AH confirmed good progress had been made regarding the annual Fit and Proper Persons test and Board member appraisals were being conducted in line with the updated guidance. The Board **NOTED** the update.	
14	**Questions from Governors and Public** No questions were raised.	
15	**Meeting Review** Members acknowledged the joint Board structure was still developing and a review of each Trust’s cycle of business was underway. Members agreed they were continuing to learn about each respective Trust.	
16	**Any other Business** DH thanked CC, who was stepping down, for his contributions as a Board member during the past 7 years.	

(The meeting closed at 11:00)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 2 July 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
MD	Meredydd David	Non-Executive Director & SID
CB	Professor Chris Bentley	Non-Executive Director
ER	Emma Robinson	Associate Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
JC	Dr Joanne Chwalko	Chief Operating Officer & Interim Deputy CEO
DS	Debs Smith	Joint Chief People Officer
PS	Paula Simpson	Chief Nurse
TB	Tony Bennett	Chief Strategy Officer
DM	Dave Murphy	Chief Digital Information Officer
RC	Robbie Chapman	Interim Chief Finance Officer
RM	Dr Ranj Mehra	Interim Joint Medical Director
AH	Alison Hughes	Director of Corporate Affairs

In attendance:

MS	Matthew Swanborough	WUTH Chief Strategy Officer
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
CC	Chris Clarkson	WUTH Non-Executive Director
LD	Lesley Davies	WUTH Non-Executive Director
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
LC	Lynn Collins	WCHC Lead Public Governor
IC	Irene Cooke	WCHC Public Governor
KS	Kev Sharkey	WCHC Public Governor
TC	Tony Cragg	WUTH Public Governor
HS	Haris Sultan	Observer

Apologies:

SI	Steve Igoe	Non-Executive Director

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 4 June were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log, the progress reported and the actions still open.	
5	**Joint Chair's Update** DH provided an update on recent matters and highlighted good progress continued to be made to work towards integration. DH added there were regional and national challenges, and it was important that both Trusts lead by example. DH noted this was a shorter agenda and the Chief Operating Officer Reports and Chief Finance Officer Report would be presented as normal in September. The Board **NOTED** the update.	
6	**Joint Chief Executive Officer Report** JH summarised the Cheshire and Merseyside Provider Collaborative meeting in June, noting recent a key discussion took place on system recovery and financial improvement. JH reported both WUTH and WCHC Annual Report and Accounts were approved by the respective Board of Directors and were submitted on schedule for 30 June 2025. JH advised members that from 1 July 2025, Dr Ranj Mehra, Interim Medical Director at WUTH took up the role of interim Joint Medical Director across both WUTH and WCHC. JH referenced the consultation on the NHS Performance Assessment Framework which closed in May and gave an overview of the Trust's response, indicating that the Trust was supportive of the proposals. JH advised the Secretary of State for Health and Social Care had announced a rapid independent investigation into maternity and	

	neonatal services. JH added the Trust was not one of the 10 Trusts identified. JH reported at WUTH in May there was one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and two Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH explained all staff across both Trusts had received the Better Together - Journey to Integration document which outlined the staff and patient benefits of integrating both Trusts. JH added a Joint Stakeholder Newsletter had also been developed and distributed to Wirral system partners. JH referenced three members of staff across WUTH and WCHC had been selected by NHSE to attend the Royal Garden Party for the NHS in May at Buckingham Place. JH stated both Trusts had participated in celebrating PRIDE and Careers Week during June. JH highlighted the various WUTH and WCHC employee of the month and standout winners for May. The Board **NOTED** the report.	
7	**Integrated Performance Report** DS reported turnover was within target at 9.3%, following recent reductions over the last 12 months. Mandatory training also remained within target at 95.2%. DS advised sickness absence improved by 0.5% in May but remained an area of concern at 6.2% against a threshold of 5%, both short term sickness long term sickness had improved in month. DS added mental health conditions continue to be the most commonly occurring reason for absence, accounting for 43% of all sickness absences. JC explained CICC occupancy was at 93.1% and length of stay averaged 16 days. GP out of hours 15 and 30 minute response were also above target. 4 hour performance in UTC and WICs continues on its improvement trajectory. Remedial actions plans in were in place for 4 hour performance and waiting lists. DH queried where Wirral GP performance data was being reported. JC indicated this was not currently reported and the creation of the Wirral Provider Alliance will enable greater visibility and shared accountability of performance.	

	PS reported the patient safety data was incorrect and would be amended for the next report. There had been one fall at CICC resulting in severe harm and this was being reviewed through the governance process to identify learning. PS stated the friends and family test continues to reflect a positive experience for the majority of patients, noting in month 1 the position was 92.6% based on 2,201 responses. PS added there had been errors in the commissioned text messaging service for the friends and family test and this would impact on June data. RC highlighted at the end of May the Trust was reporting a deficit of £0.3m, broadly in line with plan. The Trust was below plan in respect of income, due to delays in agreeing the 0-19 contracts, and in respect of non-pay, with pressures in respect of estates and supplies and services. RC noted this was fully mitigated by under spends on pay driven by vacancies across the Trust. RC stated at the end of May the Trust was slightly ahead of its CIP position having transacted £4.4m against its revised target of £6.6m. RC advised the key risks facing the Trust relate to the negotiations around the 0-19 service and over £1.2m of the CIP plans still categorised as high risk. Members welcomed the inclusion of a report in the pack with graphs and commentary. The Board **NOTED** performance to the end of May 2025.	
8	**Chairs Reports – People and Culture Committee** MD alerted members that sickness absence increased to 6.8% which was driven by long term sickness absence. MD added the pulse survey response rate in April was 17.8% which was a decrease on the previous rate. MD also alerted members that staff had fed back that there is a level of inconsistency of clarity of messaging around integration/merger through the organisation. MD summarised the various “Advise” and “Assure” matters from the Committee meeting on 11 June. The Board **NOTED** the report.	
9	**Chairs Reports – Finance and Performance Committee** RC alerted members that CIP continues to be a high risk to delivery of the financial plan for 2025/26, noting the challenges being faced in regards Estates where substantial pressures still remain.	

	RC also alerted members that there was no recognition of potential cyber security issues in the Board Assurance Framework and Committee requested this be included as a risk in the next iteration. RC summarised the various “Advise” and “Assure” matters from the Committee meeting on 11 June. The Board **NOTED** the report.	
10	**WCHC Staff Voice Forum** AH provided a verbal update on the Staff Voice Forum held on 20 May and explained this focussed on the WCHC and WUTH integration. AH added that staff had the opportunity to ask questions regarding this and were encouraged to keep asking questions. The Board **NOTED** the update.	
11	**Refreshed Green Plan** TB provided an overview of the refreshed Green Plan, recapping the achievements during 2022-25 and the 3 focus areas for 2025-26 which related to energy, waste and adaptation. TB stated this Green Plan would run for 1 year and work would commence to develop a Joint Green Plan with WUTH from 2026 onwards. HS suggested it would be beneficial to also focus on the health inequalities associated with the green agenda. MD noted the gas and electricity usage continued to increase and queried what was driving this. TB stated this was due to the increase in footprint following the opening of Marine Lake Health and Wellbeing Centre and was mitigated by increased use of LED lighting and solar panels. The Board **APPROVED** the refreshed Green Plan for 2025/26.	
12	**Revised Standing Financial Instructions and Delegated Financial Limits** RC sought approval of the revised Standing Financial Instructions, noting this was also a recommendation from the recent Gilburt Review following a review of financial governance related to 0-19 contracts. RC set out the key updates included references to the Procurement Act 2023 and adjustments to delegated financial limits and enhancements to audit and counter fraud measures.	

	The Board **APPROVED** the revised Standing Financial Instructions.	
13	**Fit and Proper Persons Update** AH confirmed good progress had been made regarding the annual Fit and Proper Persons test and Board member appraisals were being conducted in line with the updated guidance. The Board **NOTED** the update.	
14	**Questions from Governors and Public** No questions were raised.	
15	**Meeting Review** Members acknowledged the joint Board structure was still developing and a review of each Trust's cycle of business was underway. Members agreed they were continuing to learn about each respective Trust.	
16	**Any other Business** No other business was raised.	

(The meeting closed at 11:00)

Action Log
Board of Directors in Public
3 September 2025

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1.	5 March 2025	9	To incorporate as part of the integration programme the development of a one Wirral number telephony system for patients to access information by dialling one number	Matthew Swanborough	This will be picked up through the clinical services integration work and raised more widely with the Provider Alliance.	

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	In progress. Due October.	October 2025

Board of Directors in Public **Item 7**
3 September 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 further review will take place following the publication of the National Oversight Framework, due later this month. Urgent & Emergency Care operational performance at WUTH remains challenged with a combination of increased demand and high bed occupancy. and Improvement plans are in place in all relevant areas. 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, notably CICC occupancy has improved, and the length of stay remains below target. Friends and family test continues to reflect a positive experience for service users. WCHC is also reporting a surplus financial position. 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 – July and August** The CMPC Leadership Board met on Friday 4th July and discussed a number of system wide issues currently in focus. A significant portion of the meeting was handed over to a shared discussion with the ICB and NHSE colleagues and Trust Chairs for the Cheshire and Merseyside system to receive a summary of the outputs from the system wide rapid diagnostic review, led by Stephen Hay and supported by a team from PwC. Individual Trust specific reports are expected to follow in month. Discussions are ongoing about how the system will respond to the recommendations arising from the review. Trusts have been notified of further in-depth discussions and exploration of month 3 positions imminently. The Leadership Board received an update on the Efficiency at Scale Programme, specifically with relation to corporate back office and at scale opportunities. Support was provided to the more detailed work up of system wide opportunities covering digital, procurement, occupational health and recruitment. Work will focus on exploring single solutions for C&M where feasible to ensure maximum benefit realisation. CEOs reflected on the system agreement and position in respect of bank rates and next steps. Update papers were also provided on the following areas: • System financial report • System performance update A further CMPC Leadership Board took place on Friday 1st August and discussed a number of system wide issues currently in focus. Trust Chairs were provided with an open invitation given some of the system stretch areas under discussion.

A large part of the meeting was used to explore commercial approaches and opportunities within the system drawing upon experience and lessons from within C&M, the region and progress to date through the CMPC Efficiency at Scale programme. Discussions were led by Bill Gregory, NHSE and James Thomson, UHLG Chief Commercial Officer and sought to provide a framework for response to the system's efficiency requirements but also the recent policy push from NHSE.

Following discussions Trust representatives were asked to confirm their organisation's intention to participate in the next phase of the commercial opportunities programme covering the prioritised system opportunities - Pharmacy, Procurement, Estates & Facilities, and Digital - requirements for additional resource in areas including legal, tax, procurement, and PMO, will be subject to a further proposal for specific resourcing as the work develops.

Next the Leadership Board received an update on the work of the Community Services Programme which has been reviewed and reframed since becoming a CMPC programme. Its focus remains on schemes which reduce hospital admissions or enhance rates of discharge including virtual wards and urgent community response schemes. The programmes in year focus on reducing variation and maximising consistency across C&M.

Consideration was also given to a ICB request for review of virtual ward services with a view to a circa 25% funding reduction £3m of £13m, while it is clear that a commissioning decision is required by the ICB views were put forward and explored on the least disruptive options that could be explored as a result of any such reduced funding envelope.

Finally, the Board were provided with a briefing on the work being progressed at the request of the ICB and the region to collate and prioritise schemes for Regional Transformation Bids. While no decisions had yet been made discussions were taking place on deliverability and in year benefit realisation covering NHS priorities: Analogue to Digital; Hospital to Community; Neighbourhood Healthy and other.

Update papers were also provided on the following areas:

- Update in implementation of Federated Data Platform (FDP) – this included a deployment update, consideration of enhanced governance and to build toward a system decision on use of a single PTL
- System financial report
- System performance update

NHS Oversight Framework (NOF)

The NOF for 2025/26 describes the approach to assessing ICBs and NHS provider Trusts ensuring public accountability for performance. The 1-year framework was published in late June 2025 and sets out how NHS England will assess providers against a range of agreed metrics, promoting improvement. NHSE will use the performance assessment process to measure delivery against each metric, which will determine the segment score for each provider.

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

Each provider will receive an individual organisational score derived from its performance against the relevant metrics together with overall organisational financial performance. This will determine the segment each provider will be placed into from 1 (high performing) to 4 (low performing) and inform the support or intervention needs.

Both WUTH and WCHC are currently engaging with NHSE on a process of data validation in order to determine segmentation.

When finalised and to support transparency, NHSE will publish a dashboard to give the public access to the data the underpins segmentation for each Trust. Each provider's domain scores, organisational delivery score and final segmentation will be shown alongside the individual metric scores used to calculate them.

It is anticipated that the dashboard will also include provider capability ratings – see below.

NHS England approach to assessing provider capability

NHS England has recently set out the requirements under the new NHS Oversight Framework (NOF) which will consistently assess providers alongside an agreed set of metrics.

Whilst we await the publication of the NOF segmentation for each provider Trust, NHSE has confirmed that all Trusts will also be assessed according to their capability based on a self-assessment aligned to 'The Insightful Board' published in late 2024. Together with the NOF segmentation of Trusts and the capability rating, NHSE aims to have a holistic view of providers, not just focused on the delivery of national programmes but also capturing wider information relevant to grip and governance.

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

We expect further information from NHSE including the self-assessment template imminently with a requirement for Boards to complete and submit the self-assessment by October 2025.

We will continue to provide regular updates as further information is available on both the NOF and the capability rating.

Industrial Action

Resident Doctors undertook industrial action form July 25th – July 30th. As with previous periods of industrial action the Trust implemented robust operational planning and oversight to ensure safe services were maintained. All emergency and urgent care services remained fully operational during the period of action, with staffing maintained by permanent medical staff and non-striking resident doctors.

Overall, 584 outpatient appointments were cancelled during the period of actions with all patients booked in to new appointment slots. A total of 141 surgical procedures were cancelled, the majority being day case procedures. There were no cancer procedures cancelled due to industrial action.

Measles

There was an outbreak of measles across Chesshire and Merseyside particularly impacting Alder Hey Children's Hospital.

WUTH established EPRR response to the regional issue and ensured measures were in place to manage any local impact. This included quick reference guides, contact tracing for use regarding a case of suspected/known measles in the hospital setting.

A risk assessment for staff following exposure had been developed and an internal communication campaign was launched. Regional numbers are now reducing.

Better Together - Journey to Integration

WCHC and WUTH continue to work in partnership to maximise the benefits of collaboration across clinical and corporate services.

We continue to see many examples of staff working together to improve service delivery, patient experience and staff experience and we have developed an exciting 2-year programme of integration which will help us achieve our ambition of becoming a single organisation.

In the last month we have made further progress through the appointment of joint Non-Executive Directors across both Trusts and both Executive Teams look forward to working with existing and new NEDs. On behalf of the Executive Teams, I would particularly like to welcome Haris Sultan who is a new appointment to both Trust Boards, and we are looking forward to working with him.

We have also launched an ambitious programme to develop a Joint Strategy with the involvement of staff, our partners across the system and people with lived experience. The Joint Strategy will be a clear and shared plan of action that will help us to make decisions and focus on what matters most to our patients, service users and staff. From September we are inviting staff across both Trusts to get involved in focus groups which will explore our shared vision and strategic priorities and our shared values, and until the end of the calendar year we will be holding some 1:1 conversations with staff and stakeholders to explore their experiences and ideas in more depth. We will continue to provide updates to the Board through this report and through the Integration Management Board which is overseeing the development of the new joint strategy.

In both Trusts we also have monthly briefings, open to all staff, which include updates on our journey to integration and we appreciate the questions being asked by staff both in these forums and direct to myself and the Executive Teams. We remain committed to providing accurate and up to date information to staff in a timely way.

We launched our case for change document earlier in the summer providing an update on our strategic intentions for integration and the benefits we believe it will deliver. This

	is available on both Trust's websites - Better Together - Our Journey to Integration - Wirral Community Health and Care NHS Foundation Trust, Better Together - for people in our care | Wirral University Hospital NHS Foundation Trust **NHS Cheshire and Merseyside Chair Raj Jain to retire in October 2025** Raj Jain will retire from as Chair of NHS Cheshire and Merseyside Integrated Care Board (ICB) in October 2025. Appointed as the inaugural Chair, Raj has played a central role in establishing the ICB and guiding it through its formative years. The Cheshire and Merseyside ICB will confirm succession arrangements in due course.
1.3	**National News and Developments** **Fit for the Future: 10 Year Health Plan for England** The Government's 10 Year Health Plan for England has been launched, setting out a bold, ambitious and necessary new course for the NHS. The plan fundamentally reinvents the approach to healthcare so that we can guarantee the NHS will be there for all who need it for generations to come. It has been shaped by the experiences and expectations of members of the public, patients, our partners and the health and care workforce across the country, reflecting the changes that people wanted to see. Through the 'three shifts' below, we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all. • From hospital to community: transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home. • From analogue to digital: creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide. • From sickness to prevention: shifting to preventative healthcare by making healthy choices easier - banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families. You can read the plan on the Government's website. **David Fuller inquiry: phase 2 report** This is the phase 2 report by the independent inquiry into the issues raised by the David Fuller case. A phase 1 report presenting findings and recommendations of an investigation into how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed, for so long, was published in November 2023. This phase 2 report presents the findings of the inquiry's ongoing investigations, which

	have looked at the broader national picture, and considered if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased. A phase 2 interim report on the funeral care sector was published in October 2024. It is intended that this phase 2 report will assist the government to take essential steps to effectively safeguard the security and dignity of the deceased in all settings where they are cared for, examined or stored across England. This report represents the conclusion of the inquiry. The phase 2 report is available here. **Review of patient safety across the health and care landscape** Dr Penny Dash's review of patient safety across the health and care landscape in England, which was commissioned by the Department of Health and Social Care. This review looked at 6 bodies and how they work within the wider health and care landscape, with a particular focus on patient safety. The 6 bodies were: • the Care Quality Commission • the National Guardian's Office • Healthwatch England and the Local Healthwatch network • the Health Services Safety Investigations Body • the Patient Safety Commissioner • NHS Resolution Dr Dash's 9 recommendations focus on streamlining the patient safety landscape and improving accountability. The review is available here.
1.4	**WUTH Health and Safety** There was two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in July. 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 July 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. • **Healthwatch Wirral: Annual Report 2024/25.** This report showcases the important work Healthwatch Wirral were involved in last year, it demonstrates the impact, achievements and highlights the difference made to Wirral residents as well as Wirral's health and care systems. The report also shares the priorities for the coming year - https://healthwatchwirral.co.uk/report/annual-report-2024-25/

1.6	**Communications and Engagement** **WCHC Shortlisted for 2025 HSJ Award 2025** I'm delighted to share the news that our team from Sexual Health Wirral has been shortlisted for the Innovation and Improvement in reducing Healthcare Inequalities Award at the HSJ Awards 2025. The team has been recognised for their co-production work with young people, *ourPlace, Wirral's Sexual Health Service for young people,* which was shaped through engagement sessions, outreach, and a survey. Insights led to a service designed around young people's priorities: confidentiality, non-judgemental care, and a welcoming, non-clinical environment. A huge congratulations to Sally Barlow, Service Lead, Millie Williams, Service Development Coordinator, and the team at Sexual Health Wirral. The winners will be announced later in the year. **No 10 Mission Delivery Unit Visit to WCHC** **Mission Delivery Unit (MDU) from No.10 visit Wirral** On Tuesday 19 August the Trust was delighted to welcome the Mission Delivery Unit (MDU) from Number 10, who came to see first-hand the fantastic work happening locally to give children the best start in life. Wirral was chosen as one of just 10 areas across the country to host a visit as part of the Government's *Plan for Change.* The MDU team is working towards a goal for 75% of children to achieve a good level of development in the Early Years Foundation Stage Assessment by 2028 (up from 67.7% in 2023/24). To help achieve this goal, visits are taking place across the country and insight gathered which will inform the national approach. The visit focused on the 2 - 2.5 year reviews carried out by the Trust's 0-19+ Service Wirral, which play a key role in spotting early needs and supporting families. The team were keen to understand why Wirral is performing so strongly, despite higher-than-average levels of children living in low-income households. During the first part of the visit the MDU team met with Dave Bradburn, Director for Public Health, Jason Gooding, Acting Chief Executive at Wirral Council and Councillor Julie McManus (Deputy Leader). Following this, the visit focussed on St Catherine's Health Centre where the team met with Bradley Palin, Deputy Chief Operating Officer, Lindsey Costello, Interim Service Director Wirral and Regional 0-19+/25 Services, and members of the 0-19+ Service. It was also an opportunity to engage with colleagues and observe reviews with families in both home and clinic settings. Feedback was really positive, and the insights gathered will help shape the national approach to early years development.

The visit was a great recognition of the dedication and partnership working across services in Wirral and reflects the strong performance of the 0-19+ Service, with the KPI for the 2 - 2.5year review rated green.

WUTH Leadership for All Conference

The 2025 Leadership for All Conference was held on 16 July at the Education Centre.

The day was packed with insight, energy and inspiration which included the launch of the Improvement for All video, thought provoking keynote sessions and hands-on workshops, the conference showcased the very best of leadership at WUTH.

Keynote speakers at the conference included:

- Professor Andy Hardy, who challenged everyone to think differently about creating an organisational quality management system
- Helen Bevan, who not only delivered a motivating talk on “Taking the Power for Change” but also led an engaging workshop on Building Energy for Change

Matthew Swanborough and Jane Hayes-Green shared how they’re building improvement capacity across the Trust.

The afternoon workshops gave everyone the chance to get involved, reflect and learn new skills, from coaching for improvement, to using practical tools, to building the energy for change.

Thanks again to all who attended and helped make the event such a success.

WUTH Nurse Awarded OBE

Katie Kendrick, Team Leader in the Paediatric A&E and Paediatric Assessment department at Arrowe Park Hospital has been awarded an OBE in the King’s Birthday Honours List in recognition of her national campaigning work outside the NHS.

Katie is recognised for her voluntary work co-founding a national campaign group which has helped raise awareness of key issues affecting homeowners.

Katie’s passion for campaigning began in 2017 after a personal experience led her to connect with others through a small online group. What started as a local conversation quickly grew into a national movement, with Katie becoming one of the most well-known voices on the topic.

WCHC Successful Applicants of Magenta Housing Community Fund

Sexual Health Wirral (SHW) submitted a bid to the Magenta Housing - Funding Change in our Community fund and has successfully secured £20,000.

The winning proposal from SHW detailed their plans to support the roll out of a 12-month outreach initiative aimed at reducing health inequalities by embedding sexual health services directly into Magenta Living neighbourhoods across Wirral.

The initiative aims to reduce sexual health inequalities and increase sexual health and wellbeing awareness/education by delivering services directly into Magenta Living

	communities across Wirral, reaching individuals who may not access traditional clinic settings. A huge congratulations to Millie Williams, Service Development Coordinator, Dr Jane Wilkinson, GP Champion, and the team at Sexual Health Wirral. **WUTH Employee of the Month Winners – July 2025** Sandra Manning, Volunteer Services Manager, is the Support Services winner for her boundless energy, kindness, and creativity in supporting colleagues and volunteers across the Trust. Grace Baird-Jones from the Inflammatory Bowel Disease Team is our Patient Care winner – recognised for her dedication to patients and her impact on national-level care. **WCHC Standout Winners – July 2025 – The Central Booking Service Team (CBS)** "CBS show outstanding dedication every day, handling over 8000 calls and 3600 referrals in June alone. Their ability to manage such a high volume of activity with professionalism and care has a direct, positive impact on patient experience. They go above and beyond their core responsibilities by maintaining high standards of service during peak hours, demonstrating compassion, offering empathetic support and clear communication. Known for their reliability and transparency, CBS is a trusted contact for both patients and colleagues" – Submitted by Jayne Naughalty **WCHC Standout Winners – June 2025 – Carmel Coleman and Becky Shaw – Knowsley School Health Team** "Carmel Coleman and Becky Shaw have shown exceptional dedication. Despite being a team of two since January 2025, they've surpassed the 90% target already for the National Child Measurement Programme and maintained strong school relationships. They've shown excellent teamwork and upheld the Trust values while also supporting a new team member and managing Becky's learning commitments and placements" – Submitted by Paula Lawrenson

Board of Directors in Public **Item 8**

03 September 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 July 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 July 2025.

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 service 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.

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

Each provider will receive an individual organisational delivery score derived from its performance against the relevant metrics together with overall organisational financial performance. This will determine the segment each provider will be placed into from 1 (high performing) to 4 (low performing) and inform the support or intervention needs.

It is expected that segmentation information for each Trust against the NOF will be published in September and following publication this report will be reviewed and refreshed to include any additional performance metrics aligned to the NOF.

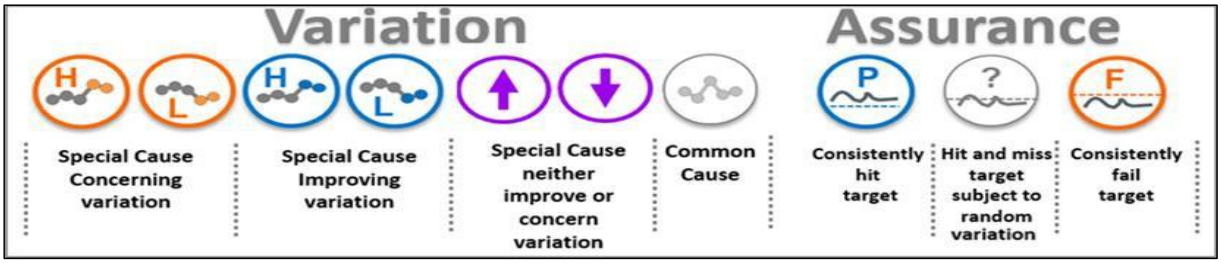
Key Risks
The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the performance of the Trust, to better service our communities and support the work of the Wirral Place, and the Cheshire and Merseyside 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.

Wirral Community Health and Care
NHS Foundation Trust



Integrated Performance Report - July 2025

Together...

we will support you and your community to live well.

Our values:

Compassion

Supportive and caring, listening to others.

Open

Communicating openly, honestly and sharing ideas.

Trust

Trusted to deliver, feeling valued and safe.

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

Turnover showed a minor increase to 9.5% (12-month average) following recent reductions over the last 12 months. For comparison July 24 was 9.4% and this metric remains stable and below target.

Mandatory training dipped slightly to 94.7% for July 25 (94/9% in July 24 for comparison), April 25 was 94.7%, May 25 was 95.2% and June 25 was 95.3%. This remains broadly stable and consistent across the year, a positive metric with all localities over 90%.

Agency expenditure has remained low in July at 0.5% (against Funded WTE) but this has shown a slight increase (May 25 was 0.2%, June 25 was 0.4%) however this remains significantly below target of 3.2% (regional C&M Capped rate reduced to 3.2% of Agency spend as a % of Total Pay Spend for 24/25.) Greatest expenditure in Therapies (Podiatry/SALT), Ophthalmology and CICC.

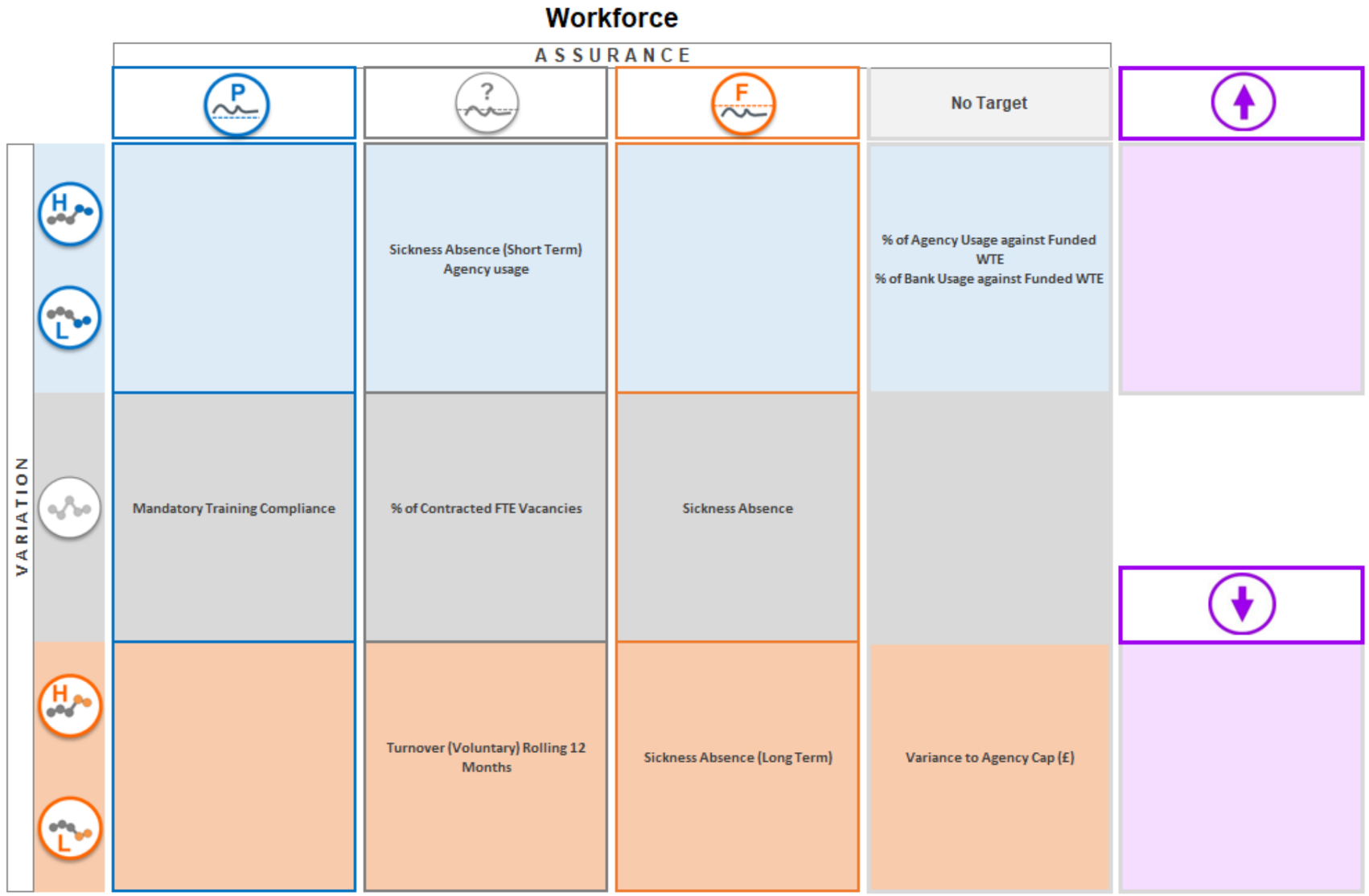
Sickness Absence increased to 7.4% in July 25 which is an urgent area of concern. Short term sickness has shown a slight increase to 1.5% . After a slight dip in long term sickness in May to 4.8%, this has now increased to 5.9% for July 25. Mental health conditions continue to be the biggest reason, accounting for 46.45% of absence overall. Recorded RTW interviews in Roster/ESR sustained significant improvement at 84% (68% in May 25 and 84% in June 25). An urgent review of the approach to proactive wellbeing and absence management has been undertaken, which highlighted 4 themes:

1. Management roles and responsibilities
2. HR support
3. Absence Management
4. Reporting and Recording

Immediate actions have been implemented to address the increasing concern, which include:

- Clarity on expectations of managers in relating to sickness absence.
- Senior HR case management of long term sickness cases.
- Increased HR Advisor capacity.
- WUTH local audit approach to be extended to WCHC.
- Contract review with OH provider.
- Health indicators report to be introduced.

Workforce Domain Matrix

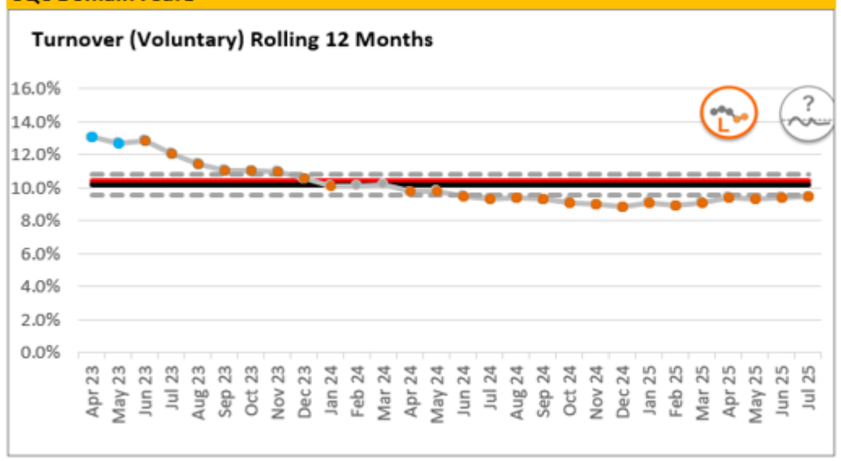


Workforce Summary

Highlights	Areas of Concern	Forward Look (Actions)
Mandatory Training compliance is consistently above the target level and is a stable workforce metric. Turnover has steadily reduced in line with national agenda to retain staff in line with the NHS People Promise and is below target rate.	Sickness absence is a cause for concern as it is above the target level at 7.4%	• Clarity on expectations of managers in relating to sickness absence. • Senior HR case management of long term sickness cases. • Increased HR Advisor capacity. • UTH local audit approach to be extended to WCHC. • Contract review with OH provider. • Health indicators report to be introduced.

Turnover (Voluntary) – Rolling 12 Months

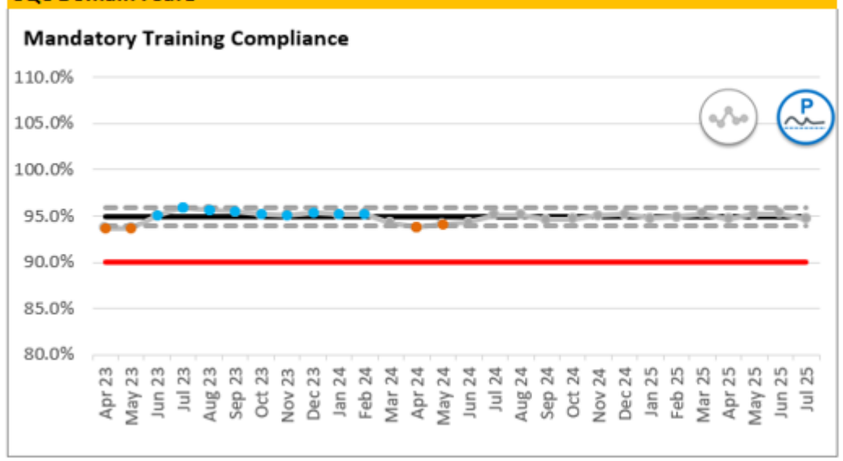
CQC Domain : Safe



Jul-25
9.5%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

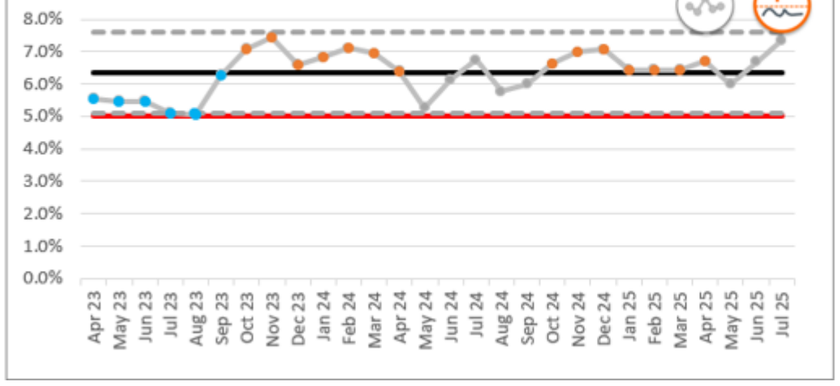
CQC Domain : Safe



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

Sickness Absence

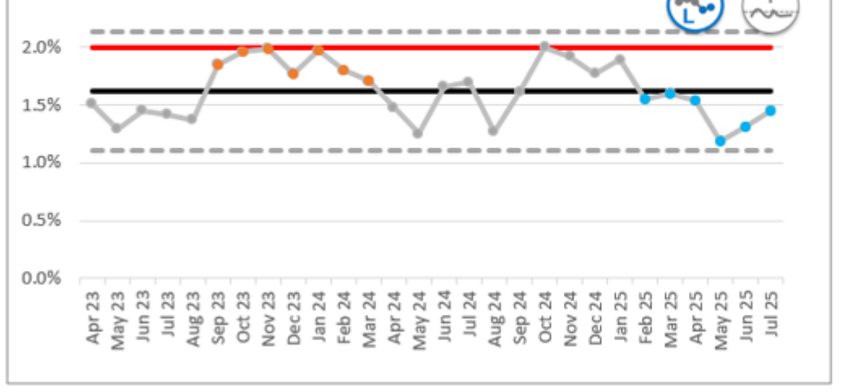
CQC Domain : Safe



Jul-25
7.4%
Variance Type
Common cause variation
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

CQC Domain : Safe



Jul-25
1.5%
Variance Type
Special cause variation - Improving
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Commentary

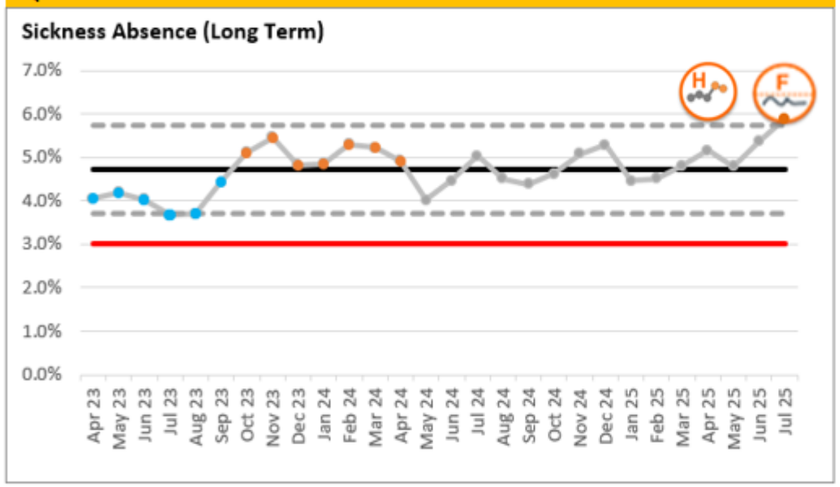
Turnover has gradually been decreasing and is now below target. Training compliance is stable and well managed with consistent compliance with the KPI. Sickness absence is cause for concern and above acceptable levels. Levels are increasing due to an increase in long term sickness absence and a slight increase in short term sickness absence.

Focus on “Return to Work” conversation uptake and recording – monitored at PCOG and has improved significantly and sustained to 84% for both June and July 25 (improved from 40% in July 2024).

Focus on sickness absence in People and Culture Oversight Group has resulted in the development of a High Impact Action plan and sustained focus via Head of HR Projects.

Sickness Absence (Long Term)

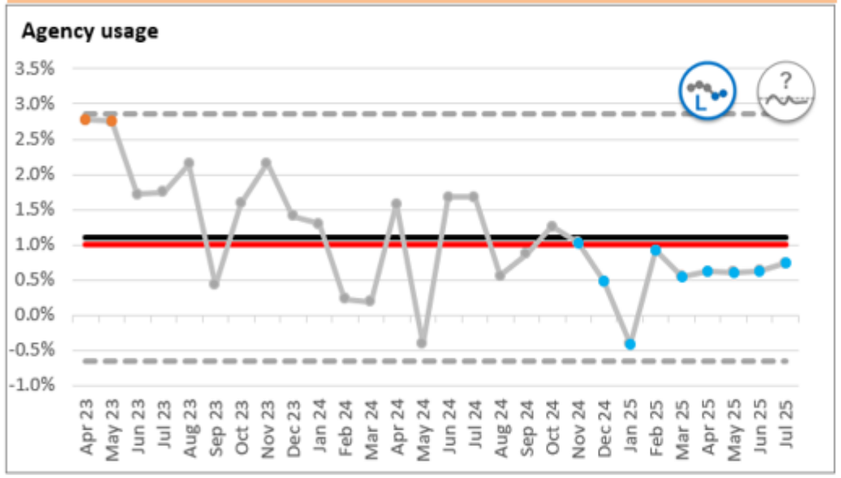
CQC Domain : Safe



Jul-25
5.9%
Variance Type
Special cause variation - Concerning
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

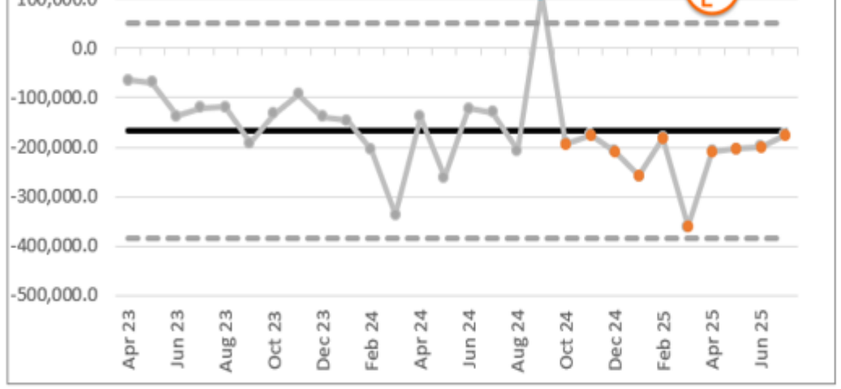
CQC Domain : Well-led



Jul-25
0.7%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

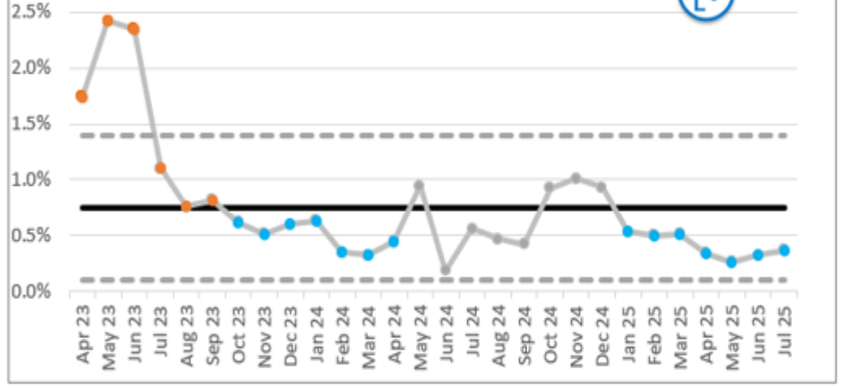
CQC Domain : Well-led



Jul-25
-£175,387.00
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

CQC Domain : Well-led



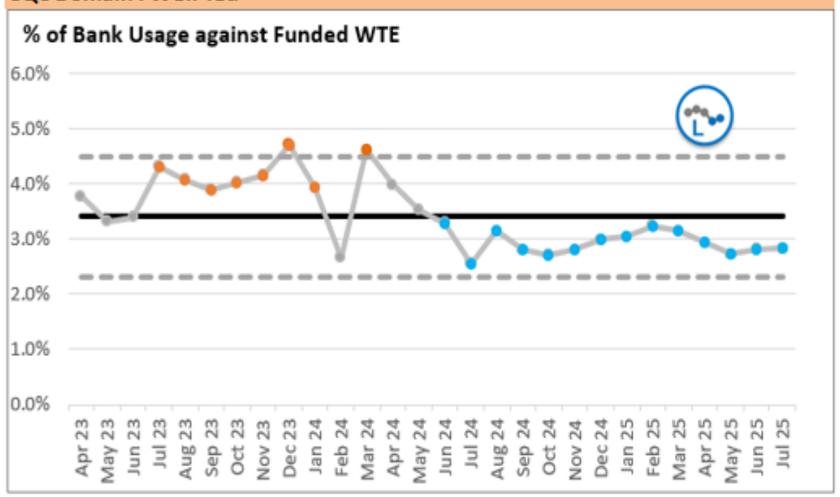
Jul-25
0.37%
Variance Type
Special cause variation - Improving
Threshold
Assurance

Commentary

Minimal organisational use of agency staff, well below target and systems and processes in place to oversee utilisation.
Risk that the minimal use of agency will be driven by shortage occupations or difficult-to-fill posts and reduced Bank staff availability.
Identification of opportunities to undertake substantive recruitment.

% of Bank Usage against Funded WTE

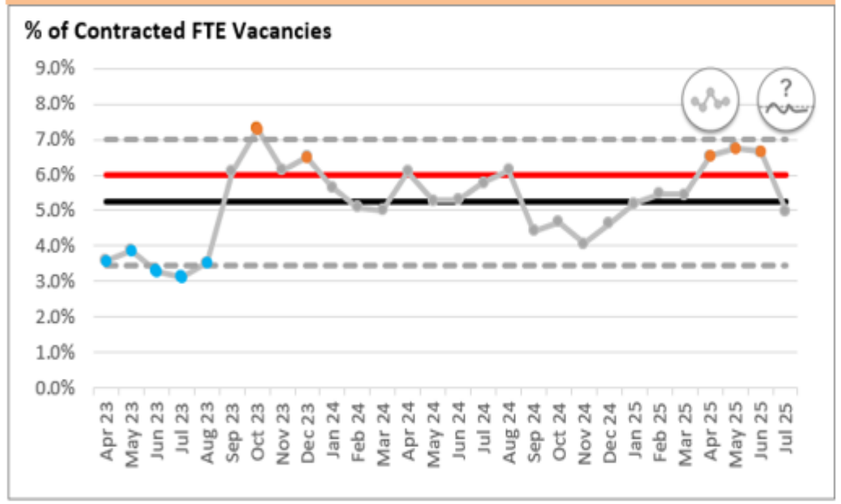
CQC Domain : Well-led



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

% of Contracted FTE Vacancies

CQC Domain : Well-led



Jul-25
5.00%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Commentary

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.

Risks linked to staffing gaps on CICC, Community Nursing, GP Out of Hours and UTC and for covering sickness absence

Close monitoring of variable pay and inclusion in CIP workstream

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 M4 25-26 is:

- 74 Green KPIs
- 6 Amber KPIs
- 11 Red KPIs

Highlights:

- Intermediate care - CICC occupancy has improved further to 96.7% and length of stay remains at 17 days against a 21 day target.
- UCR performance 91.1% against a 70% target.
- GPOOH UCAT 30 min response above target.
- 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
- 0-19/25 services – all key metrics across the four regional teams performing above target

Areas for improvement:

- WIC/UTC/GPOOH – remedial action plans are in place to support performance improvements in 4 hour performance and 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, Cardiology, and Paediatric SALT services.

  Paediatric SALT continues to demonstrate month on month improvements on waiting times and reducing backlogs and is overperforming against the improvement trajectory agreed with local SEND Board. The service is on track for all patients to be below an 18 week wait by September 2025.

  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 with a 33% reduction in the waiting list. Position stable in July compared to previous 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. ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long term solution.

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

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target	↑
H / L	Urgent Community Response - 2 hours RTT - % of Patients Seen Within 18 Weeks	CICC Occupancy Rate (Commissioned Beds) CICC Median LoS (Active Beds Daily Snapshot) GPOOH - CAS Response Times (20 min response)			
	DM01 - % of Patients Waiting with a Wait Under 6 weeks	GPOOH - UCAT Response Times (60 min response) GPOOH - UCAT Response Times (15 min response) GPOOH - UCAT Response Times (30 min response) GPOOH - NHS111 Response Times			↓
H / L		WIC & UTC Attendances seen within 4 hrs GPOOH - CAS Response Times (2hr response)			

Operations Summary

Highlights

- Intermediate care - CICC (96.7%) and length of stay (17 days against a 21 day target).
- UCR performance 91.1% against a 70% target.
- GPOOH UCAT 30 min response above target.
- 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
- 0-19/25 services – all key metrics across the four regional teams performing above target

Areas of Concern

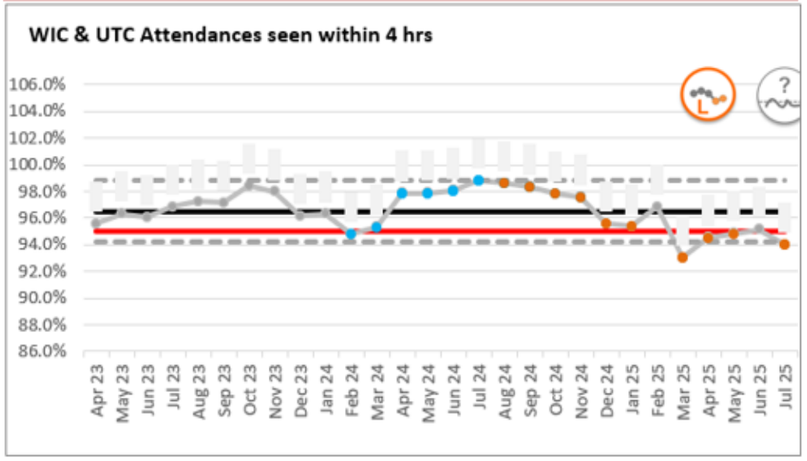
- 4 hour performance
- GPOOH CAS and 111 response times.
- Waiting lists: Dental, Cardiology, Paediatric SALT services
-

Forward Look (Actions)

- Remedial action plans are in place to support performance improvements for 4 hour performance and GPOOH.
- Waiting lists: remedial action plans currently in place for Dental, Cardiology, Paediatric SALT services. SALT on track to hit access target by September 2025.

WIC & UTC Attendances seen within 4 hrs

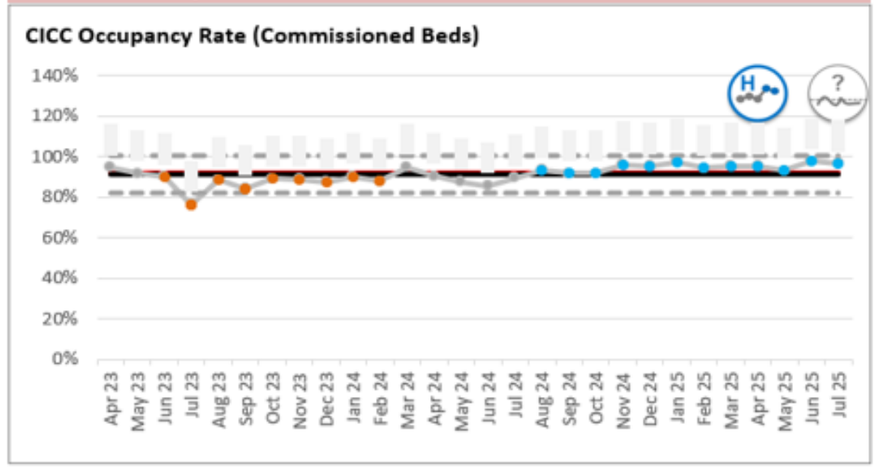
CQC Domain : Responsive



Jul-25
94.0%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CICC Occupancy Rate (Commissioned Beds)

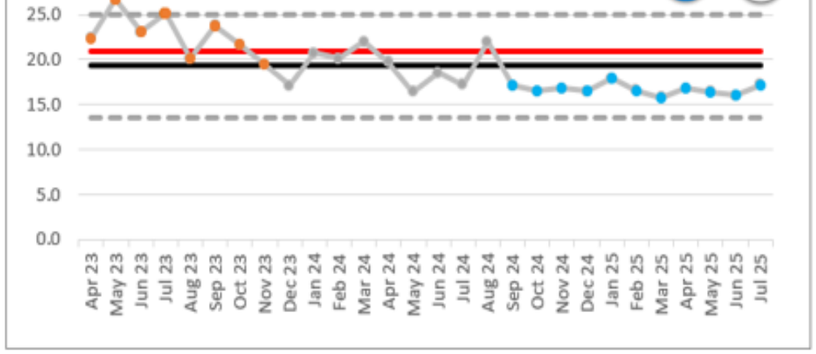
CQC Domain : Responsive



Jul-25
96.7%
Variance Type
Special cause variation - Improving
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

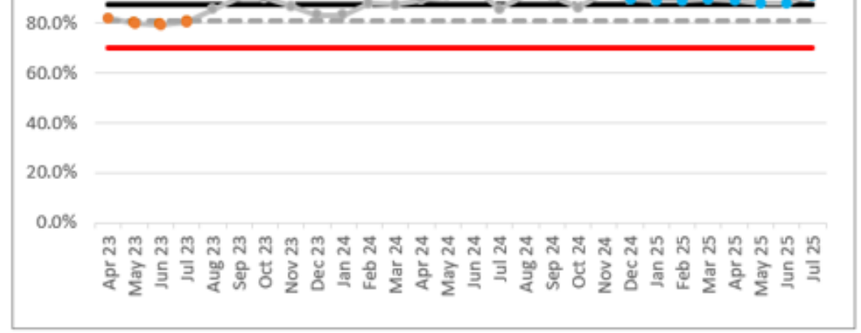
CQC Domain : Responsive



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

Urgent Community Response - 2 hours

CQC Domain : Responsive



Jul-25
91.1%
Variance Type
Special cause variation - Improving
Threshold
≥70%
Assurance
Consistanly hit target

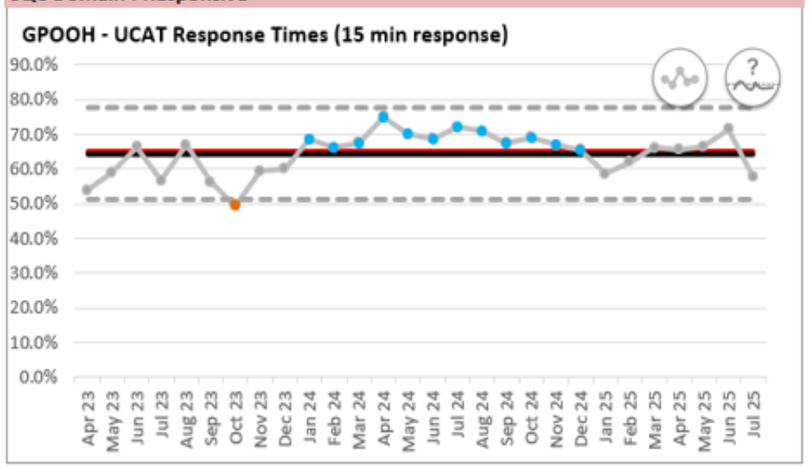
Commentary

4 hour performance under the 95% target. Remedial action plans are in place to support 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

UCR achieving performance against targets, no concerns

GPOOH - UCAT Response Times (15 min response)

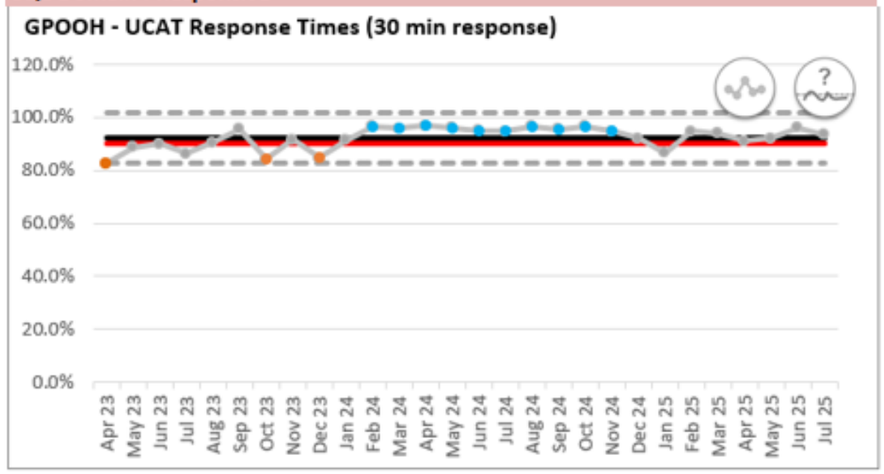
CQC Domain : Responsive



Jul-25
57.9%
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



Jul-25
93.4%
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

Jul-25
98.9%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive

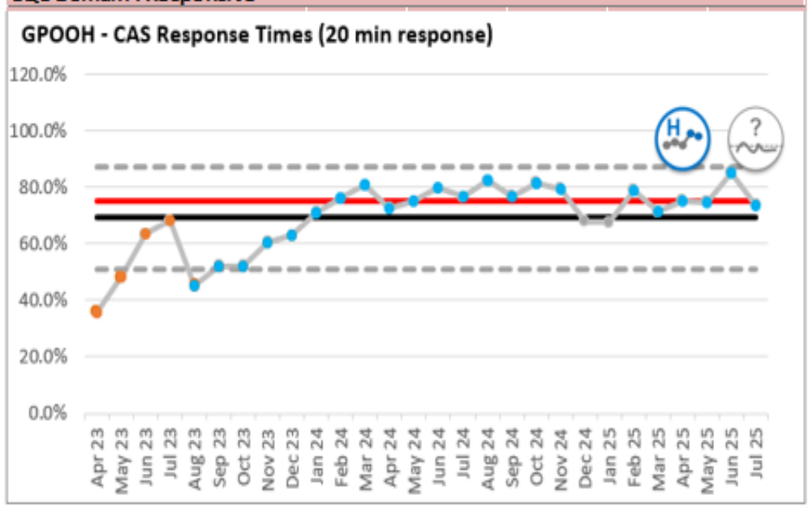
Jul-25
61.3%
Variance Type
Special cause variation - Concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

GPOOH CAS and 111 response times. A range of locally determined response time measures are in place across GPOOH and 111, including 15 ,20, 30 and 60-minute targets, CAS 2-hour standards, and 111 performance metrics. While the 30- and 60-minute measures are currently being met, performance against the 20 min, 15 min, CAS 2-hour and 111 metrics remains below target, albeit with slight improvement this month. Targeted improvement actions are underway, including a review of the operational model (both current and future as part of wider integration plans), recruitment into key vacancies, reduced sickness absence, daily breach reviews to support learning, and L&OD input.

GPOOH - CAS Response Times (20 min response)

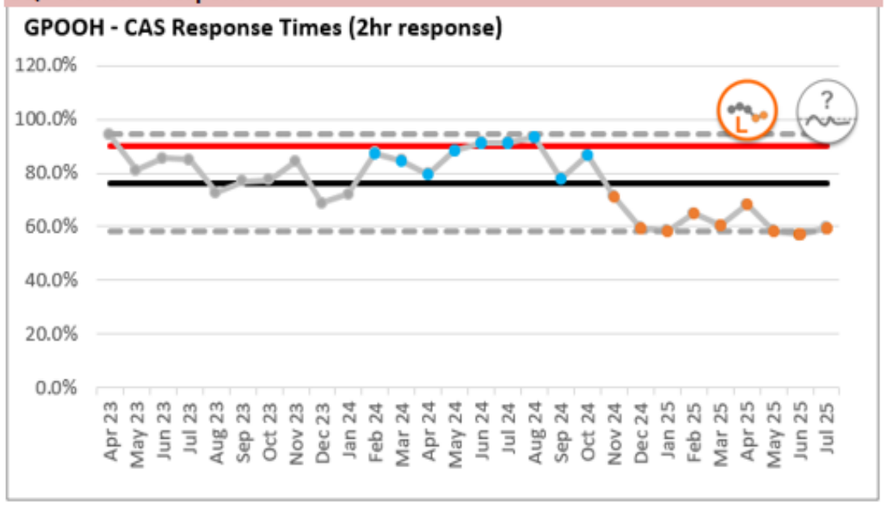
CQC Domain : Responsive



Jul-25
74%
Variance Type
Special Cause variation - Improving
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

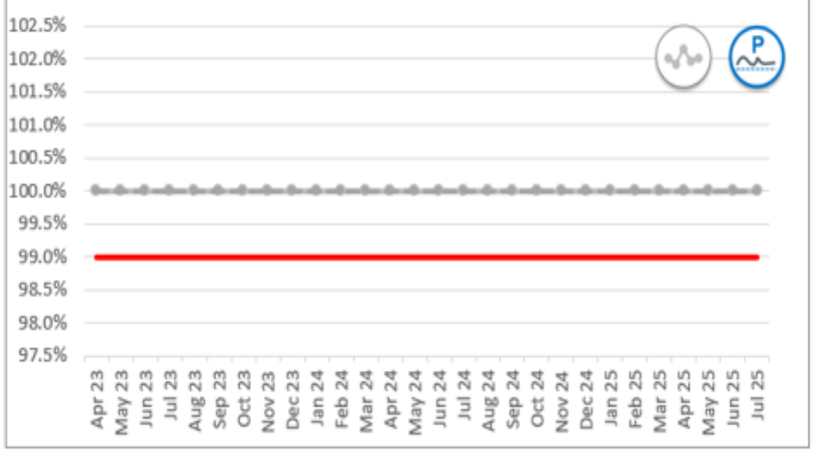
CQC Domain : Responsive



Jul-25
59.6%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

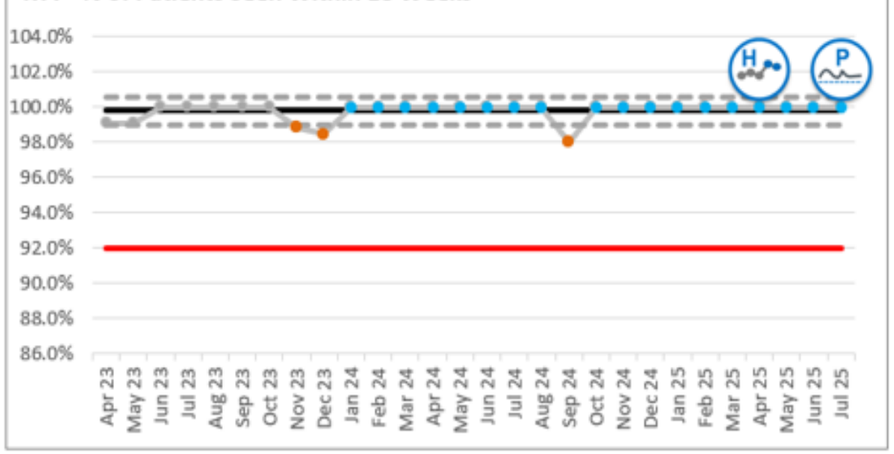
CQC Domain : Responsive



Jul-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



Jul-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 - July 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	82% (-9%)	100% (1%)	100% (0%)	429 (+69)
Specialist Medical	88% (8%)	99% (1%)	100% (0%)	2123 (-681)
Specialist Medical - Dental	33% (1%)	62% (11%)	82% (21%)	233 (-2)
Therapies	58% (7%)	79% (3%)	89% (-1%)	4563 (-874)

0-19/25 Performance

0-19/25 Services - July 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	91.4%	88.7%	87.5%	88.4%	92.3%	94.1%	94.3%	94.6%
12 month reviews	86.8%	89.6%	89.5%	89.8%	96.9%	96.9%	92.5%	91.2%
2.5 year reviews	86.8%	86.8%	88.7%	82.6%	97.3%	94.5%	88.2%	93.7%
Breastfeeding 6-8 weeks	51.2%	55.9%	34.7%	35.7%	33.9%	27.5%	48.5%	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 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 Bladder and Bowel service, however this is within normal variation and is not impacting significantly on access times.

Remedial action plans currently in place for Dental, Cardiology, Paediatric SALT services.
Paediatric SALT continues to demonstrate month on month improvements on waiting times and reducing backlogs and is overperforming against the improvement trajectory agreed with local SEND Board. The service is on track for all patients to be below an 18 week wait by September 2025.

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 with a 33% reduction in the waiting list. Position stable in July compared to previous 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. ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long term solution.

0-19/25 services. No concerns, all key metrics across the four regional teams performing above target

Dashboard	Quality and Governance
Lead	Chief Nurse

Chief Nurse Update

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

During the M4 reporting period, there have been no reported never events, IGO or StEIS reportable incidents.

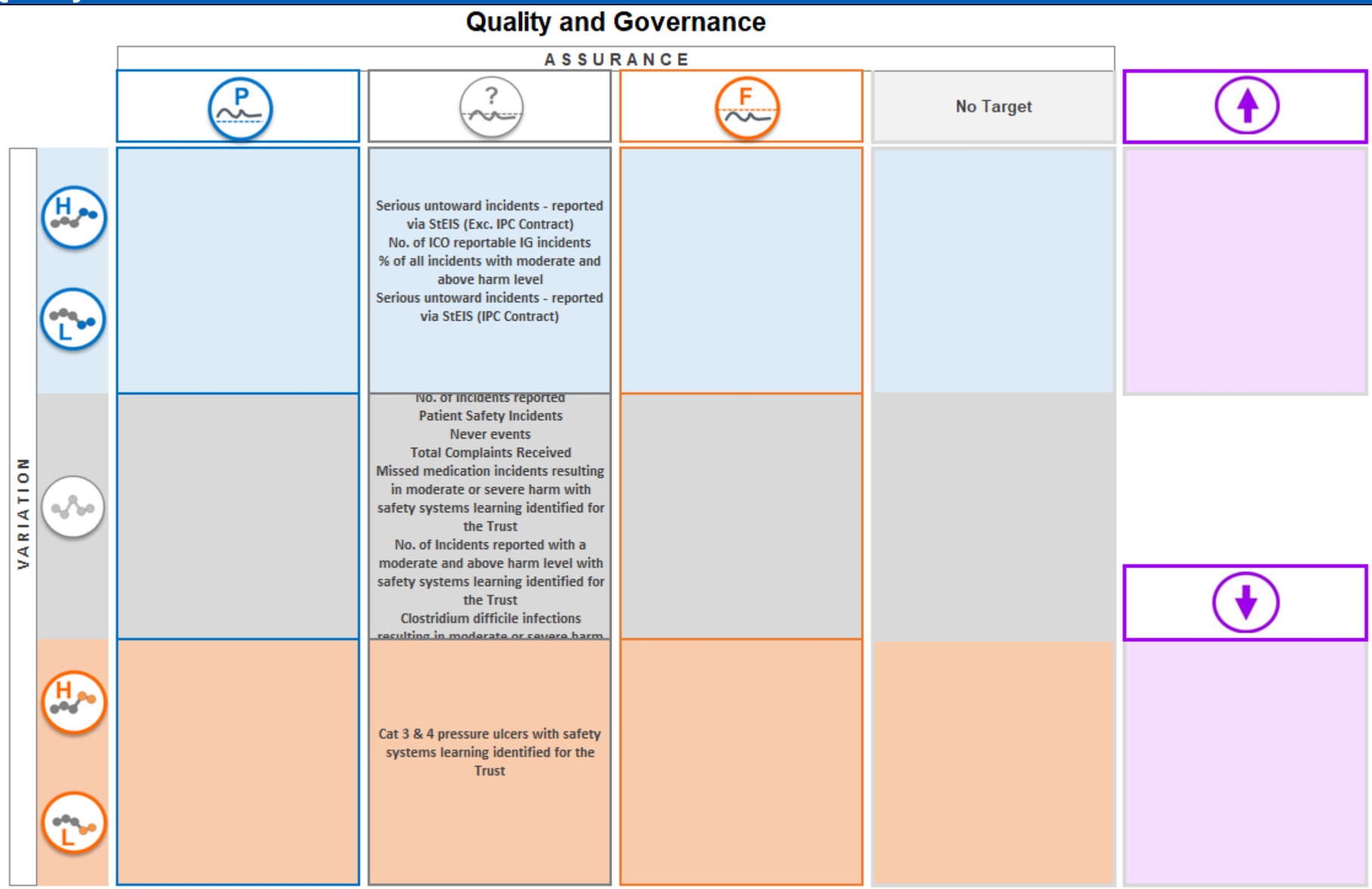
In accordance with the Patient Safety Incident Response Framework (PSIRF) the Trust monitors all patient safety incidents, including those resulting in no or low harm. During M4, 99% of patient safety incidents reported were no or low harm incidents. This reflect a positive reporting culture and high level of thematic learning resulting from these incidents which is aligned to PSIRF principles.

During the M4 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.

Friends and family test continues to reflect a positive experience for the majority of our service users, with a M4 position of 92.9% based on 2,761 responses.

Five complaints have been received by the Trust in M4, which is a reduction from the point of special cause variation noted in June 2025. All complaints are effectively managed via the Trust's governance framework, evidencing responsive action and the identification of learning to continuously improve the quality of care delivered. Whilst the number of complaints received in M3 and M4 is above the Trust's in-month threshold, no themes or trends have been identified from the complaints received. An increase in the number of concerns received by the Trust is also evidence during M4, this cluster of concerns will be closely monitored to identify any emerging themes or trends across services.

Quality and Governance Domain Matrix

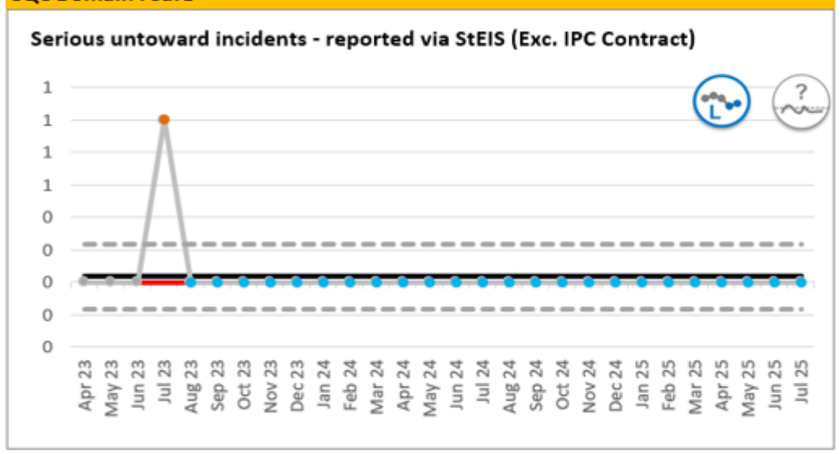


Quality and Governance Summary

The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust governance framework.	No specific areas of concern are identified.	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)

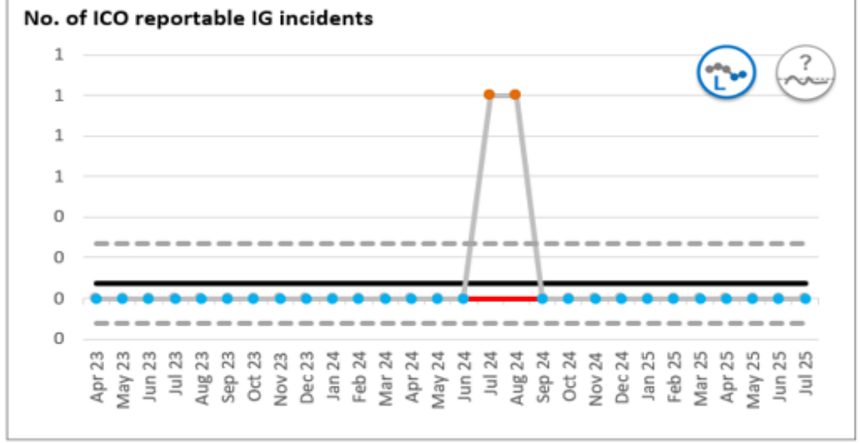
CQC Domain : Safe



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

No. of ICO reportable IG incidents

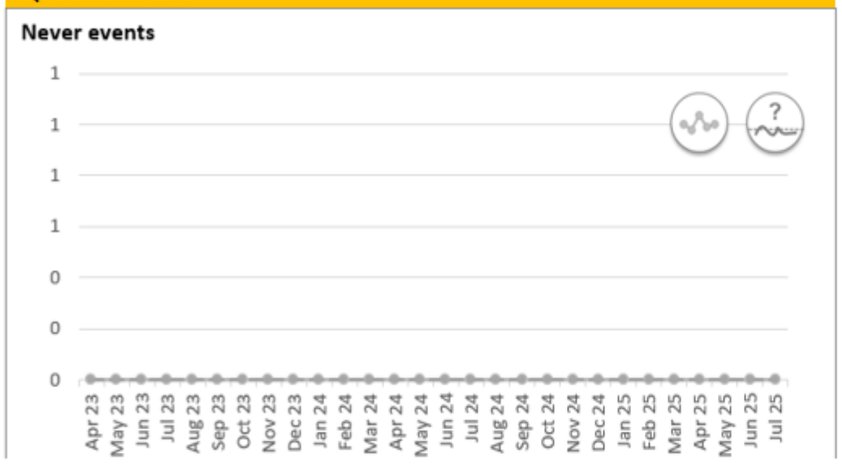
CQC Domain : Safe



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

Never events

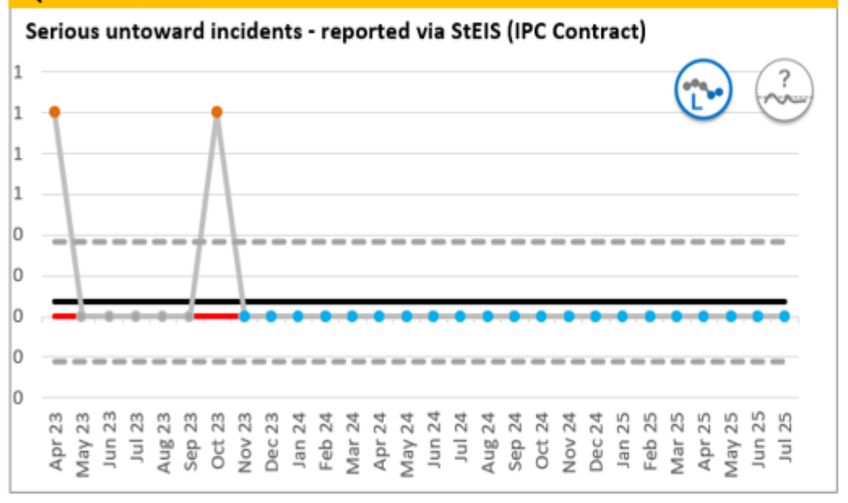
CQC Domain : Safe



Jul-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



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

Commentary

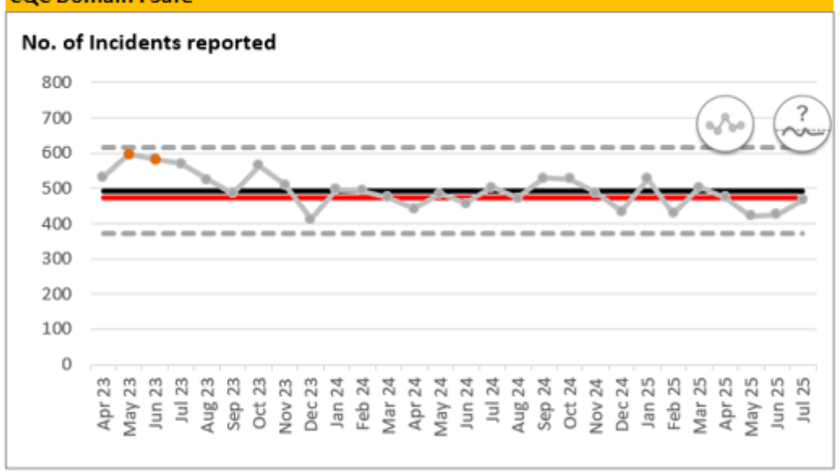
The above indicators all have tolerances of 0.

During the Month 4 reporting period, there have been no reported incidents relating to any of these indicators.

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

Number of Incidents reported

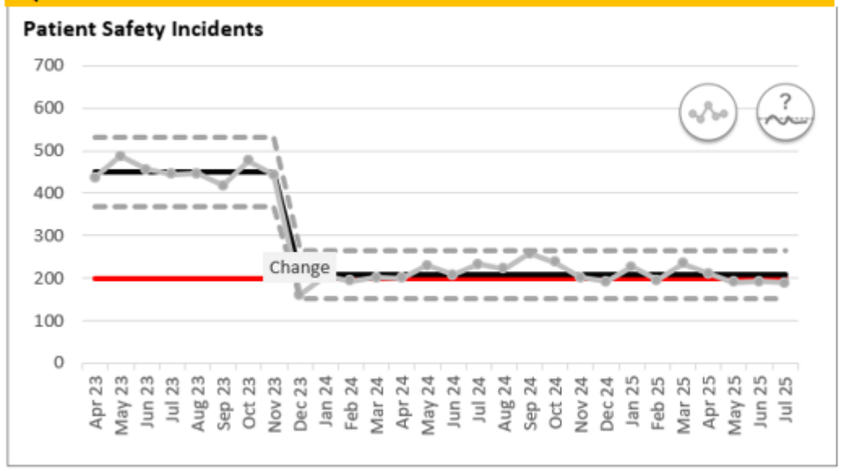
CQC Domain : Safe



Jul-25
466
Variance Type
Common cause variation
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

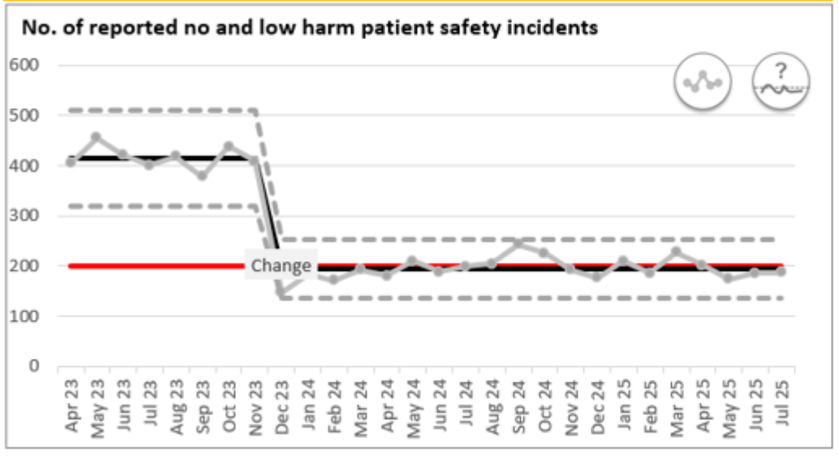
CQC Domain : Safe



Jul-25
189
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

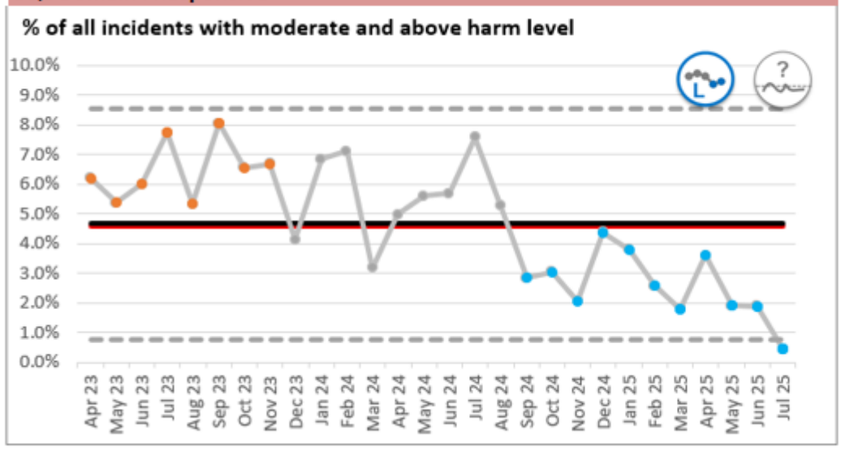
CQC Domain : Safe



Jul-25
187
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



Jul-25
0.4%
Variance Type
Special cause variation - Improving
Threshold
4.6%
Assurance
Hit & miss target subject to random variation

Commentary

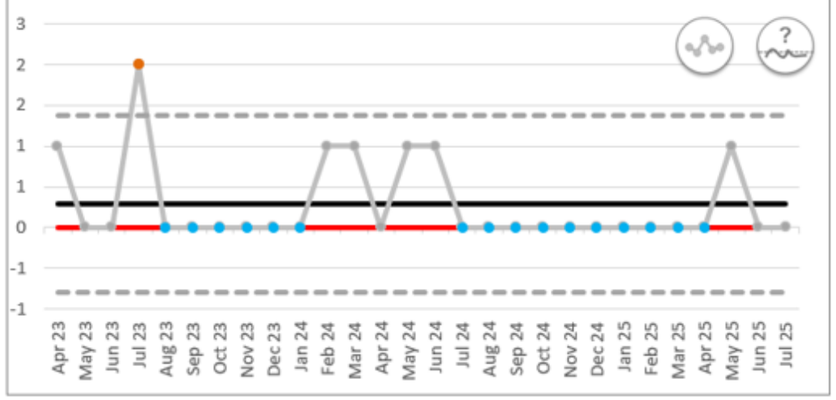
Incident reporting is an effective measure of safety culture across an organisation. The data above indicates that incident reporting has remained within normal variation throughout the reporting period.

The number of low and no harm incidents remains within common cause variation and represents 99% of patient safety incidents reported during M4.

A validated M4 position of 0.4% of all incidents reported reached the threshold of moderate and above harm. These indicators reflect a positive reporting culture and high level of thematic learning resulting from low and no harm incidents which is aligned to PSIRF principles.

Falls resulting in moderate or above harm

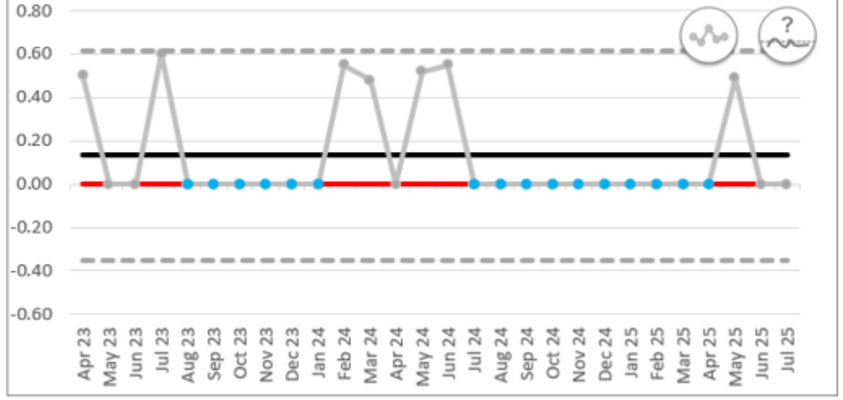
CQC Domain : Safe



Jul-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

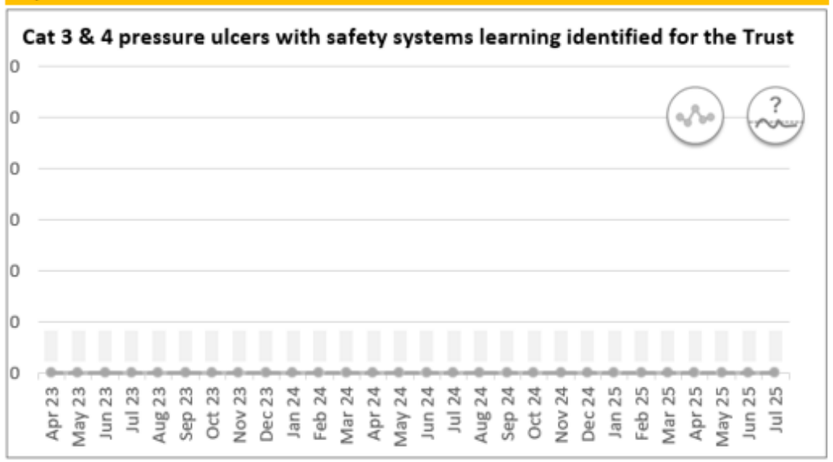
CQC Domain : Safe



Jul-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

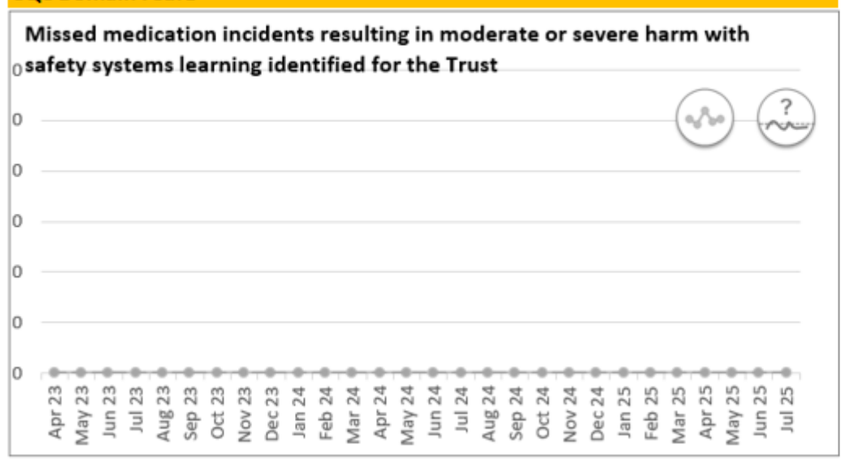
CQC Domain : Safe



Jul-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



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

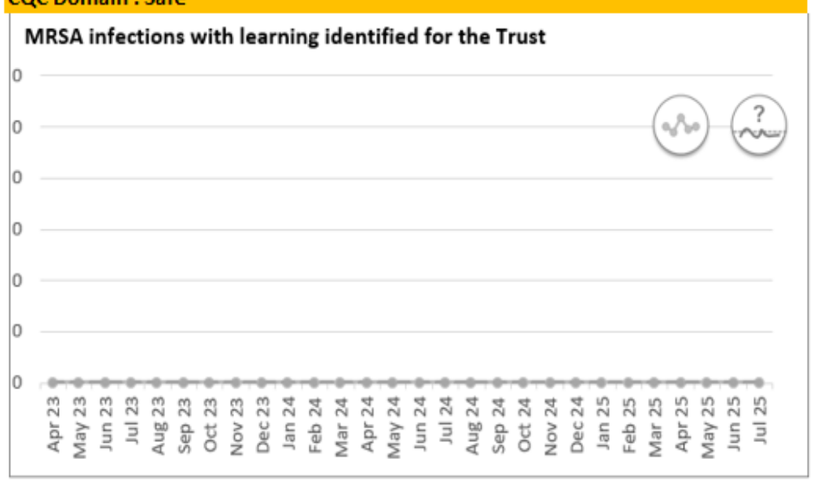
Commentary

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

During the M4 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.

MRSA infections with learning identified for the Trust

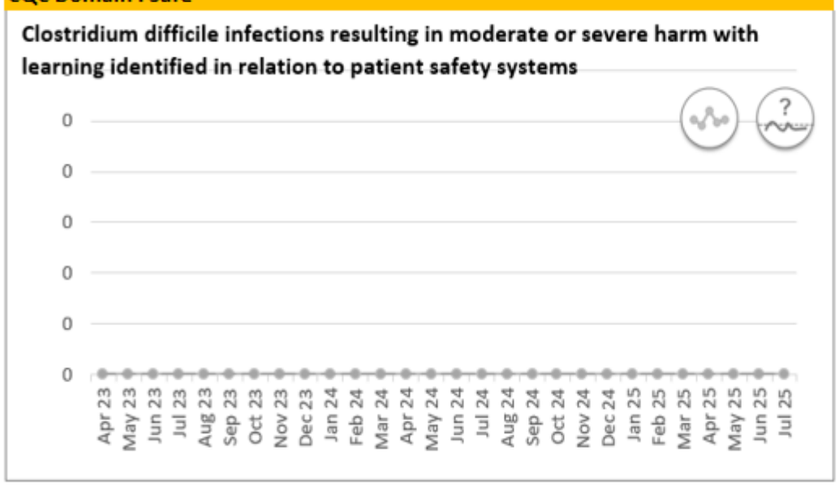
CQC Domain : Safe



Jul-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



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

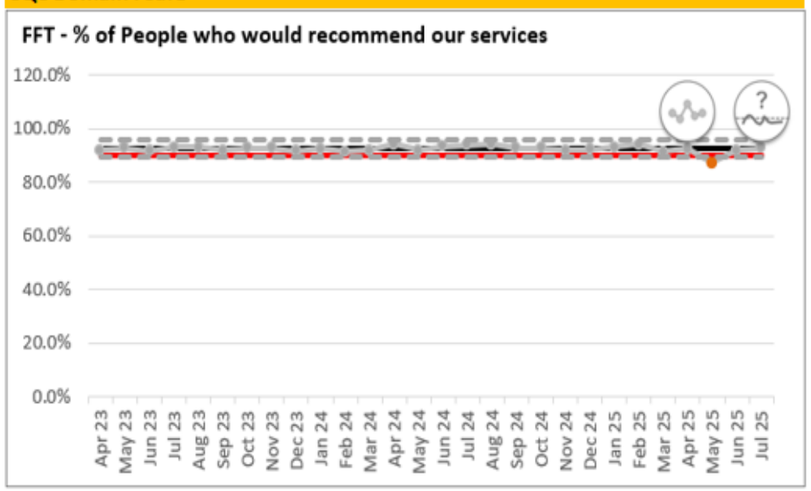
Commentary

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

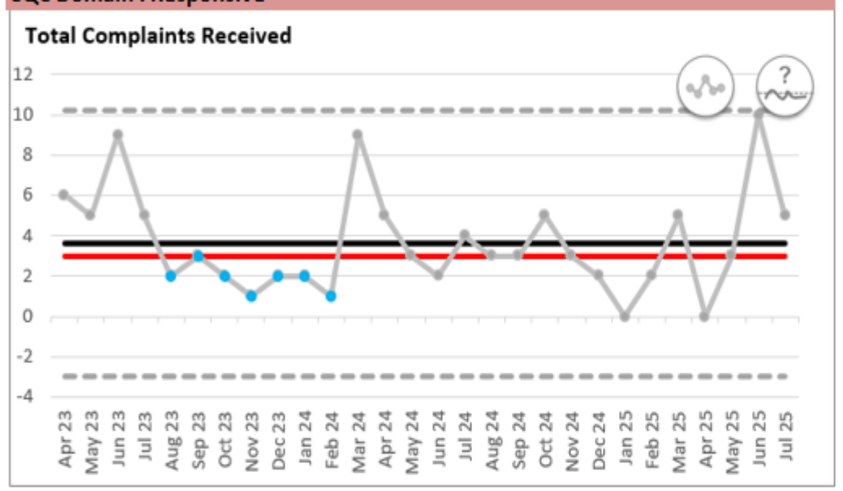
CQC Domain : Safe



Jul-25
92.9%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Total Complaints Received

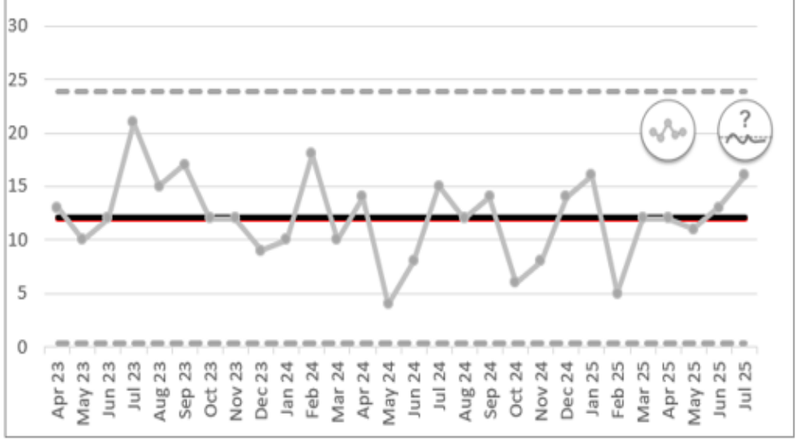
CQC Domain : Responsive



Jul-25
5
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month

CQC Domain : Responsive



Jul-25
16
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

Commentary

Friends and family test continues to reflect a positive experience for the majority of our service users, with a M4 position of 92.9% based on 2,761 responses.

During M4, the technical issue affecting the commissioned text messaging service was fully resolved.

Five complaints have been received by the Trust in M4, which is a reduction from the point of special cause variation noted in June 2025. All complaints are effectively managed via the Trust's governance framework, evidencing responsive action and the identification of learning to continuously improve the quality of care delivered. Whilst the number of complaints received in M3 and M4 is above the Trust's in-month threshold, no themes or trends have been identified from the complaints received. An increase in the number of concerns received by the Trust is also evidence during M4, this cluster of concerns will be closely monitored to identify any emerging themes or trends across services.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of July, the Trust is 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.

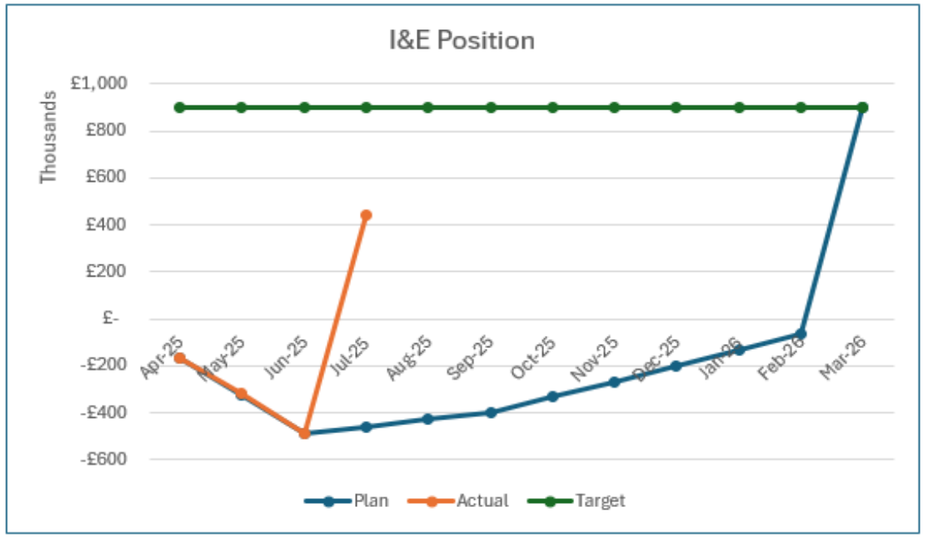
Finance Domain Matrix

Statutory Financial Targets	RAG (M4)	RAG (Forecast)
Financial stability	🟢	🟢
Agency spend	🟢	🟢
Financial sustainability	🟢	🟢
Financial Efficiency	🟡	🟢
Capital	🟡	🟢
Cash	🟢	🟢

Finance Summary

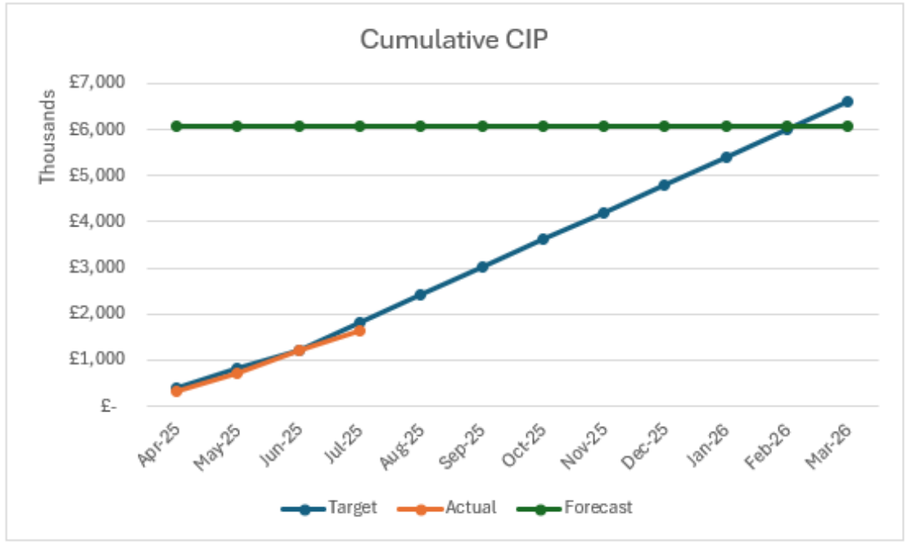
Highlights	Areas of Concern	Forward Look (Actions)
The Trust is ahead of plan at M4. Reductions in income and overspends in non-pay are fully mitigated by underspends on staff costs.	The key risks facing the Trust remain the negotiations around the 0-19 service and the CIP stretch target.	The Trust continues to look at identify additional CIP schemes.

I&E Position



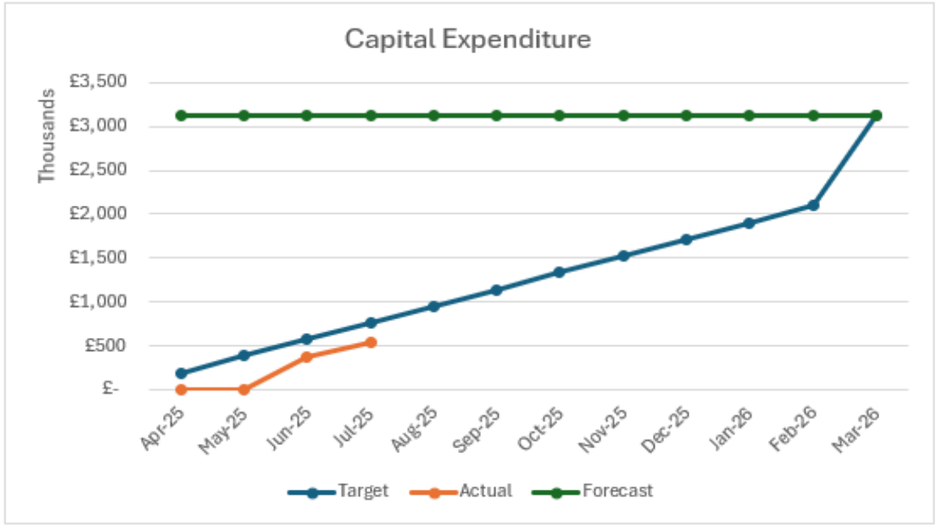
Jul-25
£441k
Variance
Position better plan
Target
£900k

Cumulative CIP



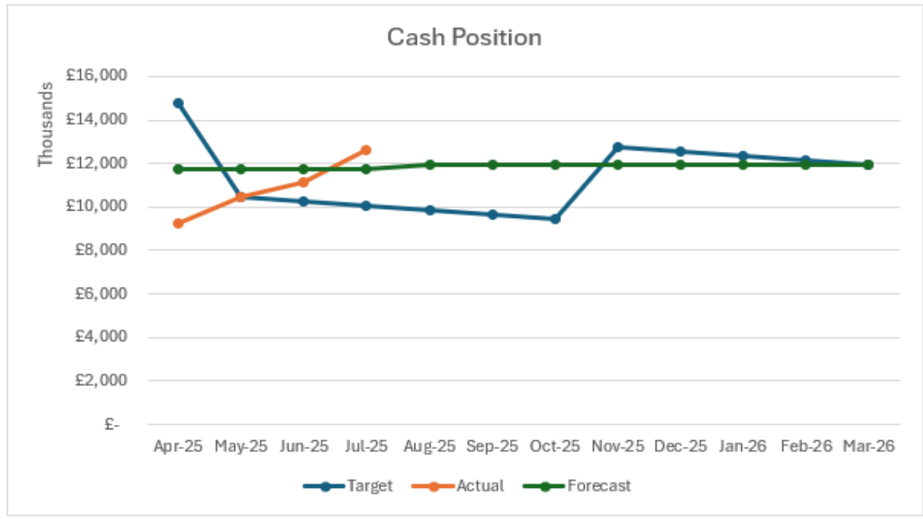
Jul-25
£1,646k
Variance
Position worse than plan
Target
£1,815k

Capital Expenditure



Jul-25
£533k
Variance
Position worse than plan
Target
£761k

Cash Position



Jul-25
£12,602k
Variance
Position better than plan
Target
£10,271k

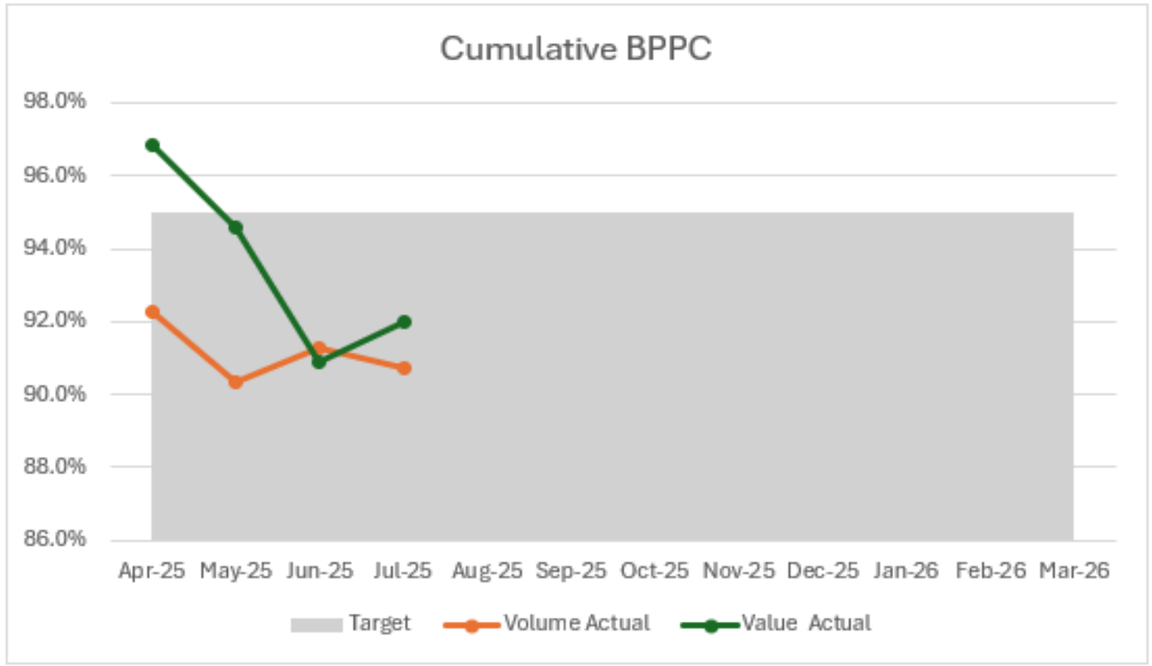
Commentary

The Trust is ahead of plan at M4. However, the Trust is slightly below plan in respect of income, due to delays in agreeing the 0-19 contracts. Non-pay costs are overspent due to pressures in respect of premises costs. However, this is fully mitigated by underspends on pay driven by vacancies across the Trust.

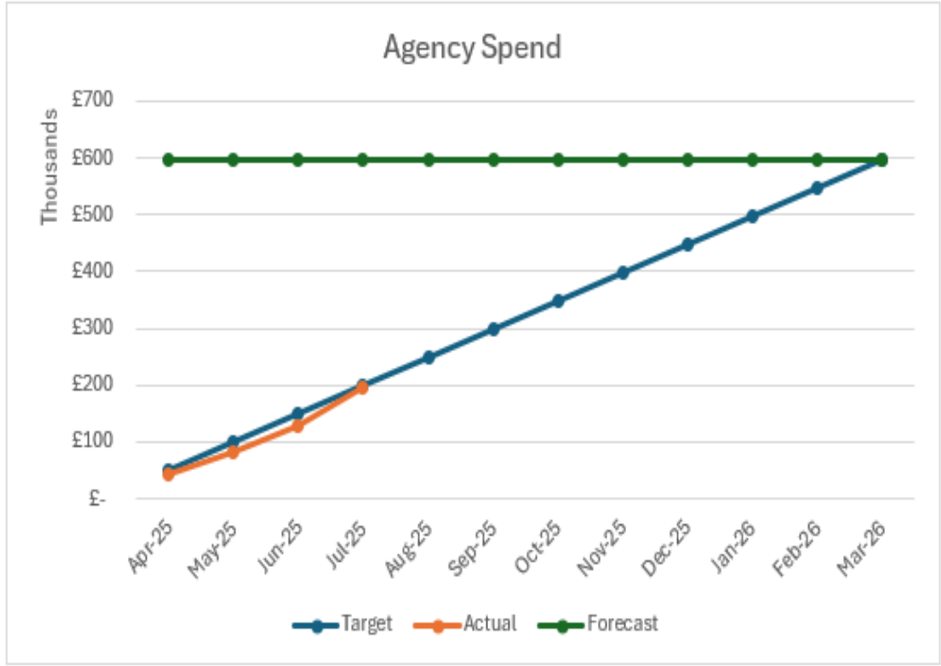
CIP delivered at M4 is £1.646m which is £0.169m behind plan.

The cash balance has increased by of £4.8m since the start of the financial year. This increase is linked to staff vacancies and the increase in creditors and corresponding underperformance on BPPC to date.

Cumulative BPPC



Agency Spend



Jul-25
£197k
Variance
Position better than plan
Target
£200k

Commentary

At Month 4 the Trust is 4.3% (volume) and 3% (value) behind target. The number of invoices on hold continues to increase 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**

03 September 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 July 2025 (or latest data available month). It is recommended that the Board: • Note performance to the end of July 2025.

Key Risks
This report relates to the key risks of: • 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	**2**	**2**	**4**
Operations	**1**	**16**	**18**
Quality and Safety	**9**	**11**	**24**

For latest available data, where agreed targets have been defined, 15 metrics were achieving the agreed target and 35 were not achieving target (there are 10 metrics without target at present).

NHS Oversight Framework (NOF)

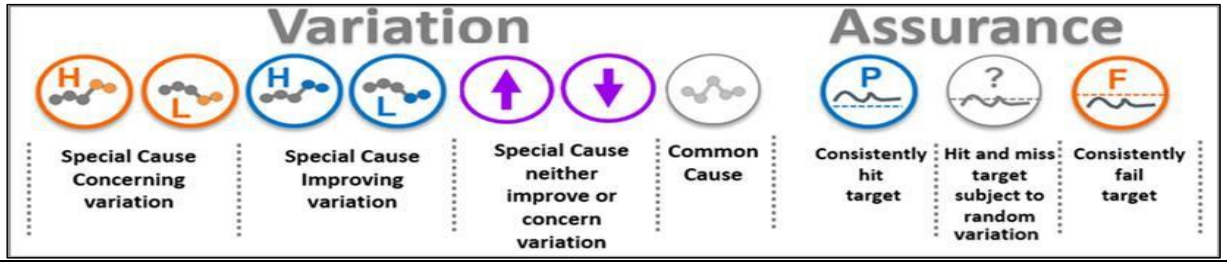
The NOF for 2025/26 has been published and describes the approach to assessing NHS Trusts ensuring public accountability for performance against a range of agreed metrics, promoting improvement. The framework includes six domains for assessment;

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

Each provider will receive an individual organisational delivery score derived from its performance against the relevant metrics together with overall organisational financial performance. This will determine the segment each provider will be placed into from 1 (high performing) to 4 (low performing) and inform the support or intervention needs.

It is expected that segmentation information for each Trust against the NOF will be published in September and following publication this report will be reviewed and refreshed to include any additional performance metrics aligned to the NOF.

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	

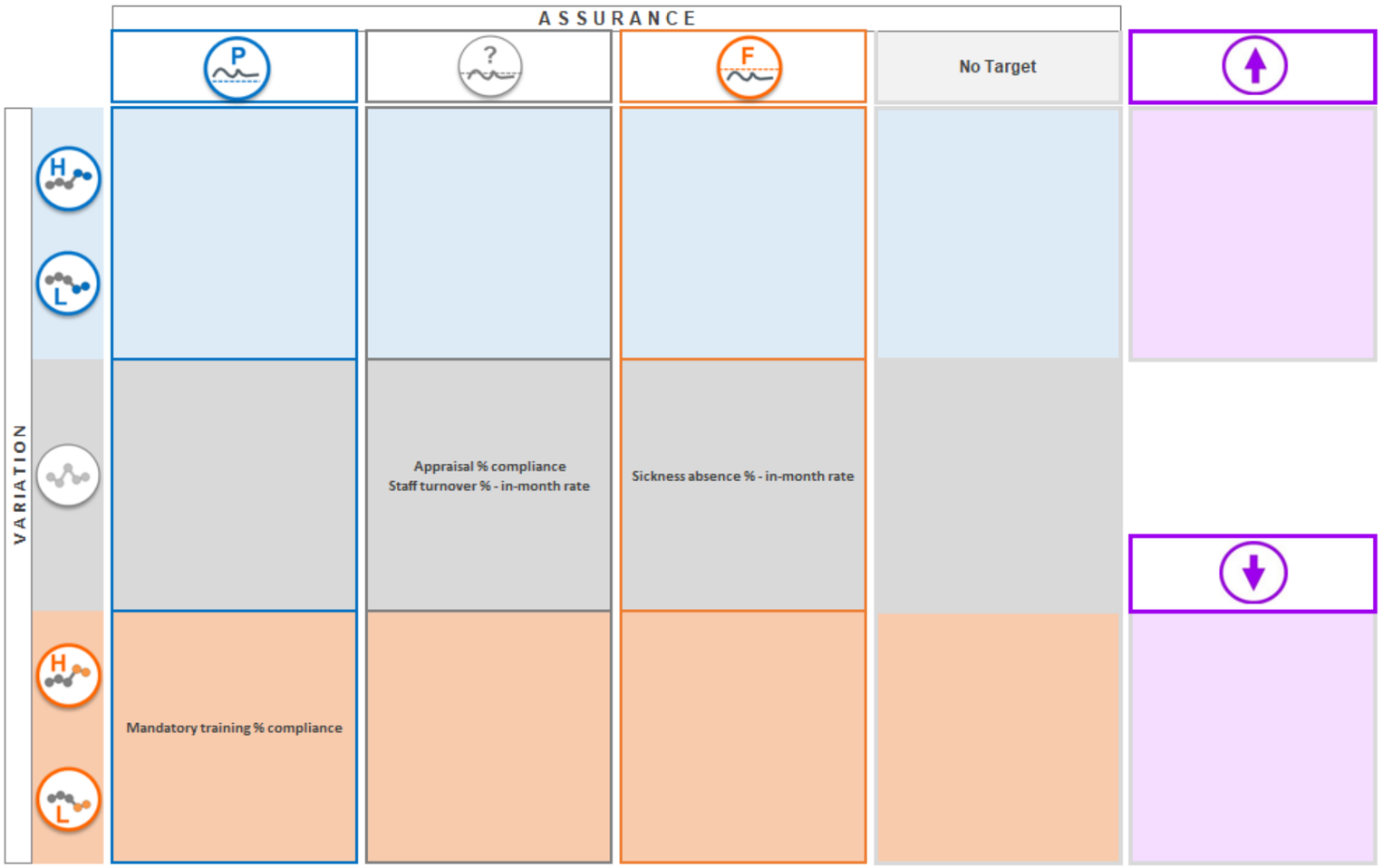
	Orange dots signify a statistical cause for concern. A data point will highlight orange if it: • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance. • Runs for 7 consecutive points below 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	Jul 25	6.16%	≤5%			5.96%
Staff turnover % - in-month rate	Jul 25	0.98%	≤1%			87.91%
Mandatory training % compliance	Jul 25	91.57%	≥90%			92.70%
Appraisal % compliance	Jul 25	85.54%	≥88%			0.91%
4-hour Accident and Emergency Target (including APH UTC)	Jul 25	61.44%	≥95%			61.5%
Number of inpatients not meeting the Criteria to Reside	Jul 25	128	-			162
Patients waiting longer than 12 hours in ED from a decision to admit	Jul 25	710	≤0			613
Proportion of patients more than 12 hours in ED from time of arrival	Jul 25	19.49%	≤0%			17.7%
Ambulance Handovers: % < 30 mins	Jul 25	70.98%	≥95%			51.4%
Ambulance Handovers: % < 45 mins	Jul 25	83.71%	≥100%			70.1%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Jul 25	61.80%	≥92%			58.4%
Referral to Treatment - total open pathway waiting list	Jul 25	47312	≤47171			44772
Referral to Treatment - cases exceeding 52 weeks	Jul 25	1255	≤997			1566
Referral to Treatment - cases waiting 78+ wks	Jul 25	0	≤0			7
Cancer Waits - reduce number waiting 62 days +	Jun 25	120	≤84			135
Cancer - Faster Diagnosis Standard	Jun 25	73.42%	≥77%			74.0%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jun 25	92.71%	≥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)	Jun 25	78.39%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Jun 25	76.82%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Jul 25	90.65%	≥95%			93.2%
Long length of stay - number of patients in hospital for 21 or more days	Jul 25	184	≤79			166
Clostridioides difficile (healthcare associated)	Jul 25	11	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Jul 25	1	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Jul 25	0	≤0			0
Patient Safety Incidents	Jul 25	1252	-			1178
FFT Overall experience of very good & good: ED	Jul 25	71.9%	≥95%			76.4%
FFT Overall experience of very good & good: Inpatients	Jul 25	94.6%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Jul 25	96.1%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Jul 25	95.9%	≥95%			95.6%
Patient Experience: concerns received in month - Level 1 (informal)	Jul 25	327	≤173			219
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Jul 25	4	≤3			3
Falls – Moderate to Severe Harm	Jul 25	0.04	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Jul 25	87.0%	≥90%			88.8%
WUTH Average RN Night Staffing Fill Rates	Jul 25	90.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Jul 25	89.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Jul 25	100.0%	≥90%			99.8%
MRSA Cases	Jul 25	0	≤0			0
MSSA Cases	Jul 25	2	≤0			2
% of adult patients VTE risk-assessed on admission	Jul 25	96.7%	≥95%			97.5%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Jul 25	91.3%	≥90%			89.3%
Mortality (SHMI)	Feb 25	0.979	0.95-1.05			1.023
Number of studies open	Jul 25	42				
% of current studies meeting recruitment target	Jul 25	38.1%				
% of open studies with a commercial sponsor	Jul 25	7.1%				

Dashboard	Workforce
Lead	Chief People Officer

Workforce Domain Matrix



Workforce Summary

Highlights

KPI	Latest month	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Jul 25	6.16%	≤5%		F	5.96%
Staff turnover % - in-month rate	Jul 25	0.98%	≤1%		?	87.91%
Mandatory training % compliance	Jul 25	91.57%	≥90%	L	P	92.70%
Appraisal % compliance	Jul 25	85.54%	≥88%		?	0.91%

Areas of Concern:

Sickness

Sickness absence levels continue to be above the Trust's 5% target. Latest performance is 6.16% an increase of 0.5% since June (5.66%) however, seasonally this is an improvement compared to July'24 which was 6.42%.

The top 3 reasons remain as Gastro, Anxiety/ stress/depression and cold, flu - influenza.

Trustwide the main reason for absence remains as Gastro related and is attributed to 21.60% of all absences but has reduced by 0.54% since June. It has also been the top absence reason for 9 months of the past year.

Estates & Ancillary has the highest monthly rate at 10.62% (a rise of 0.73%). In terms of long-term sickness – Estates, Facilities & Capital have the highest long term % with 3.64% and the highest short-term sickness with 6.44%.

Only Corporate Support (4.01%) were below target, all other Divisions were above the 5% target in-month. Women & Children have the best improvement in-month.

Forward Look (Actions)

Sickness

Proactively supporting physical health and wellbeing:

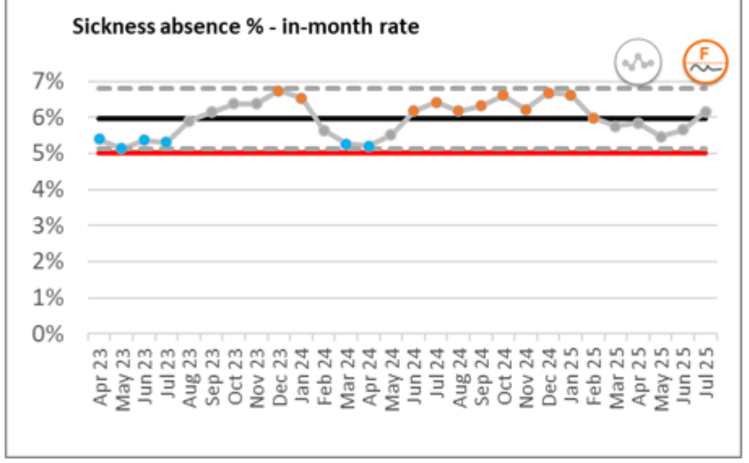
- New burn out sessions led by Trust's psychotherapist began in June with further sessions planned up until October. Sessions are targeted are areas of highest prevalence of stress and anxiety.
- Wirral CiC continue to offer health checks for Trust staff.
- IPC continue to promote infection prevention control – currently IPC Level 2 is below mandatory target. New comms campaign will highlight link between hand washing and spread of infection to both colleagues and patients.
- Administrative resource has been reallocated into clinical capacity following a capacity and demand review in occupational health – additional appointments are becoming available to reduce waiting times and bolster psychological services. These will be fully established by October.
- New sickness communication campaign has been approved to increase awareness of the impact of sickness – 'Every day Counts' launching September.

Managing Absence:

- 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 embedded, and numbers of final stage hearings continue to increase.
- Local Sickness Audits remain on going and are reported into WSB.
- New mini manager essentials training has launched focusing on Reporting Absence and Return to Work Meetings
- Additional attendance management development sessions are being scheduled with revised content and focus on case studies to bring policy to life.
- Sickness remains a key focus of the Workforce Workstream 25/26 programme with a project dedicated to reviewing sickness absence.
- Additional absence data being made available to Departments via DPR's including Bank usage triangulation to sickness and additional proactive HR review touch points with services for those off between 2-4 weeks to review options to RTW.

Sickness absence % in month rate

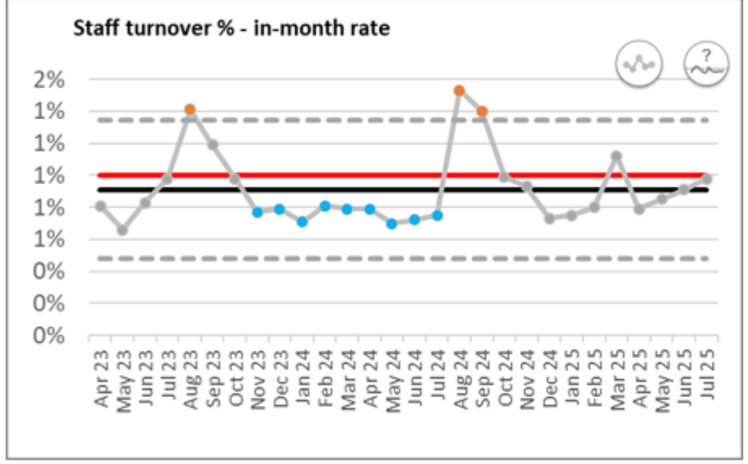
CQC Domain : Safe



Jul-25
6.2%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Consistently fail target

Staff turnover % in month rate

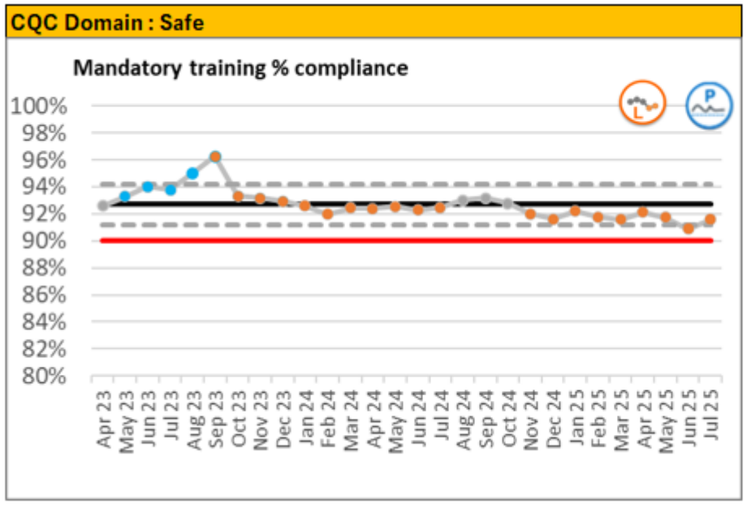
CQC Domain : Safe



Jul-25
1.0%
Variance Type
Common cause variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance

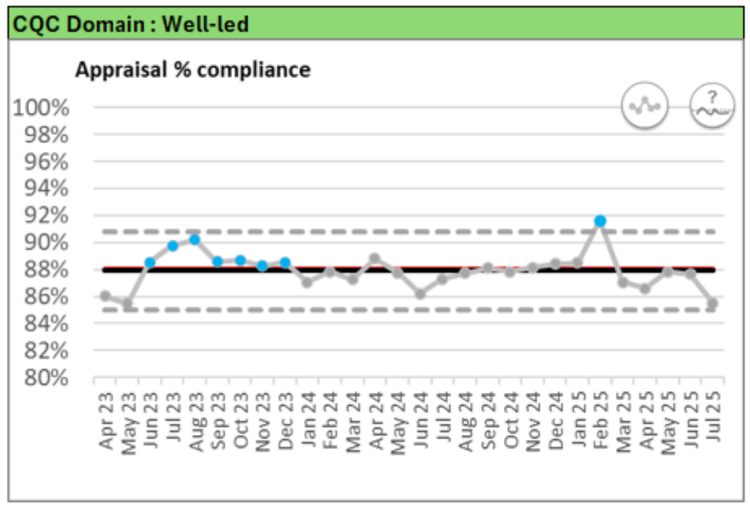
CQC Domain : Safe



Jul-25
91.6%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Consistently hit target

Appraisal % compliance

CQC Domain : Well-led



Jul-25
85.5%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

Appraisal

Areas of Concern

Appraisal compliance has reduced in all areas with the exception of Surgery division, who have seen an increase in appraisal compliance. While overall compliance is below target, both Clinical Support and Surgery Division have achieved the target of 88% whereas Medicine and Women and Children's Divisions have fallen out of compliance this month.

Actions Taken

Considerable work has been completed following feedback from divisions, regarding barriers to appraisal completion:

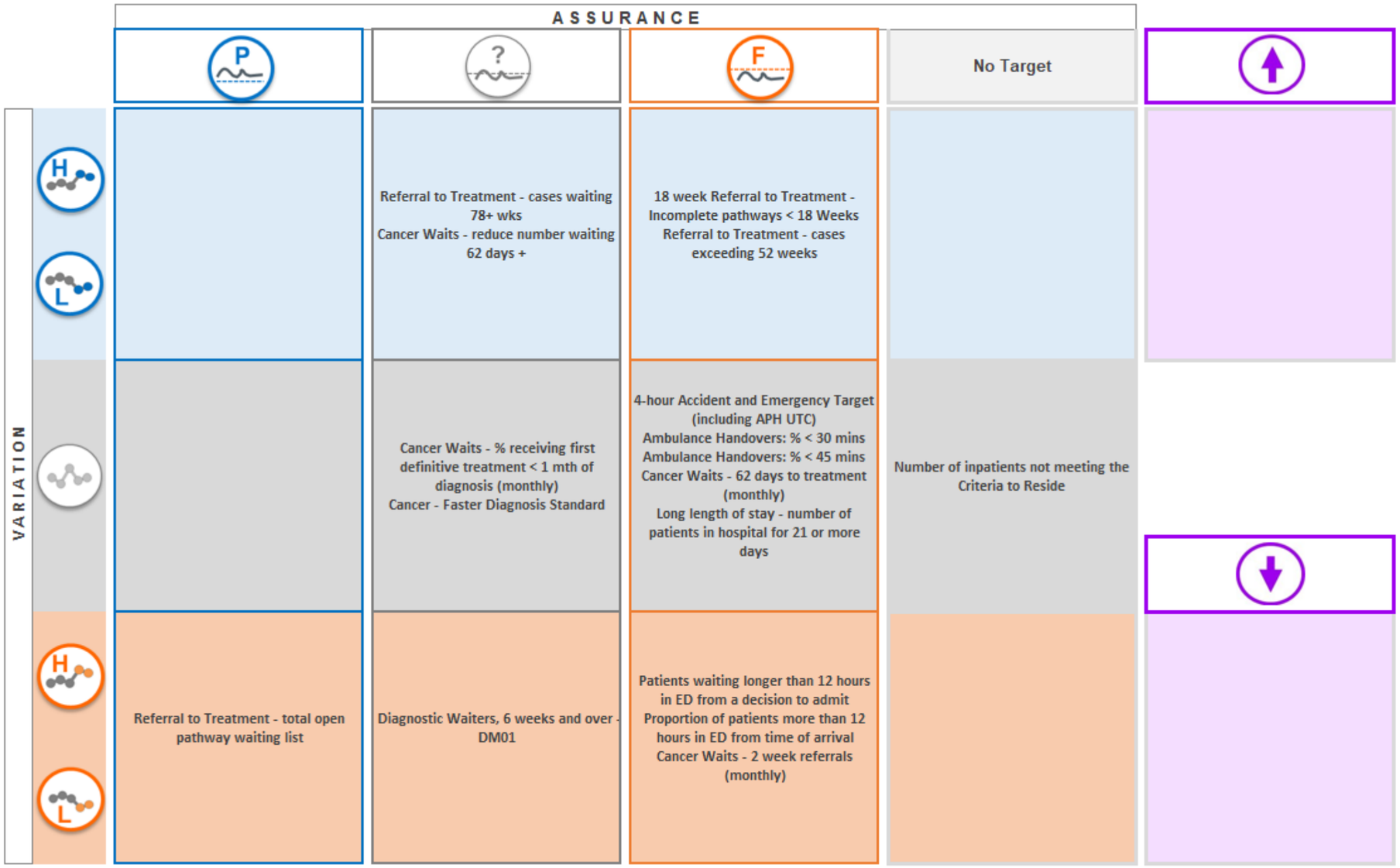
- Feedback from divisional leaders highlighted opportunities for improvement. A staff led review commenced in June as follows:
  - New paperwork established, developed by staff for staff.
  - New feedback mechanism (via QR code on new form), established to monitor quality in real time. HRBPs able to access results more readily.
  - New form launched and communicated in August 2025, along with supporting documentation and video walkthrough of new form.
  - Emails to all divisions and HRBPs with support offer in implementation of new form – work ongoing to promote and support managers to implement quality appraisals
- Feedback suggested that ESR reporting mechanisms could be improved, these have been explored with both local and national team and unfortunately functionality is limited to ESR system; more guidance provided to managers to support recording.

Additional actions taken include:

- Design of Appraisal and Check-in e-learning module (currently in testing phase)
- Ongoing offer of bespoke support for divisions (offered directly and via HRBPs)
- Appraisal and Check-in education sessions
- Building assurance and KLOE into Divisional and Directorate 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.

Dashboard	Operations
Lead	Chief Operating Officer

Operations Domain Matrix



Operations Summary

Highlights

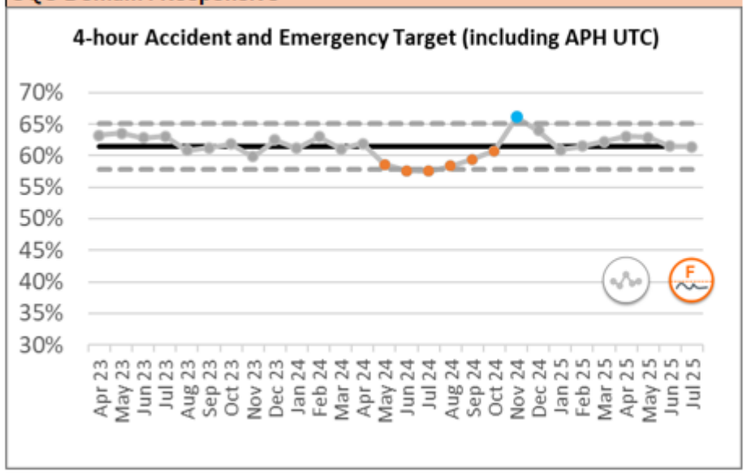
KPI	Latest month	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Jul 25	61.44%	≥95%			61.5%
Number of inpatients not meeting the Criteria to Reside	Jul 25	128	-			162
Patients waiting longer than 12 hours in ED from a decision to admit	Jul 25	710	≤0			613
Proportion of patients more than 12 hours in ED from time of arrival	Jul 25	19.49%	≤0%			17.7%
Ambulance Handovers: % < 30 mins	Jul 25	70.98%	≥95%			51.4%
Ambulance Handovers: % < 45 mins	Jul 25	83.71%	≥100%			70.1%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Jul 25	61.80%	≥92%			58.4%
Referral to Treatment - total open pathway waiting list	Jul 25	47312	≤47171			44772
Referral to Treatment - cases exceeding 52 weeks	Jul 25	1255	≤997			1566
Referral to Treatment - cases waiting 78+ wks	Jul 25	0	≤0			7
Cancer Waits - reduce number waiting 62 days +	Jun 25	120	≤84			135
Cancer - Faster Diagnosis Standard	Jun 25	73.42%	≥77%			74.0%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Jun 25	92.71%	≥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)	Jun 25	78.39%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Jun 25	76.82%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Jul 25	90.65%	≥95%			93.2%
Long length of stay - number of patients in hospital for 21 or more days	Jul 25	184	≤79			166

Areas of Concern

Forward Look (Actions)

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

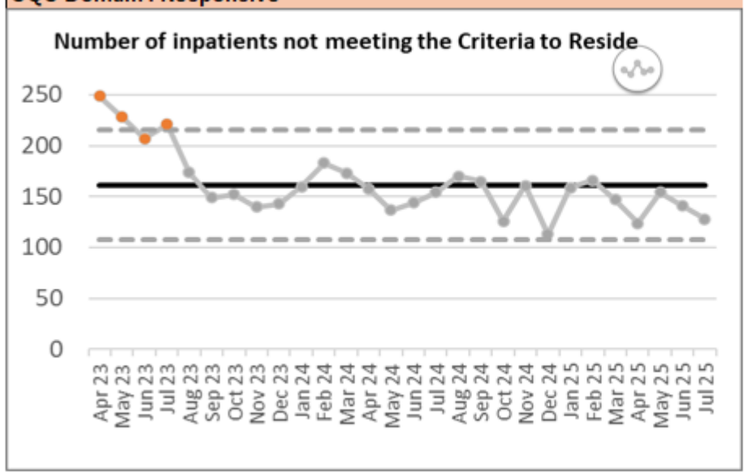
CQC Domain : Responsive



Jul-25
61.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

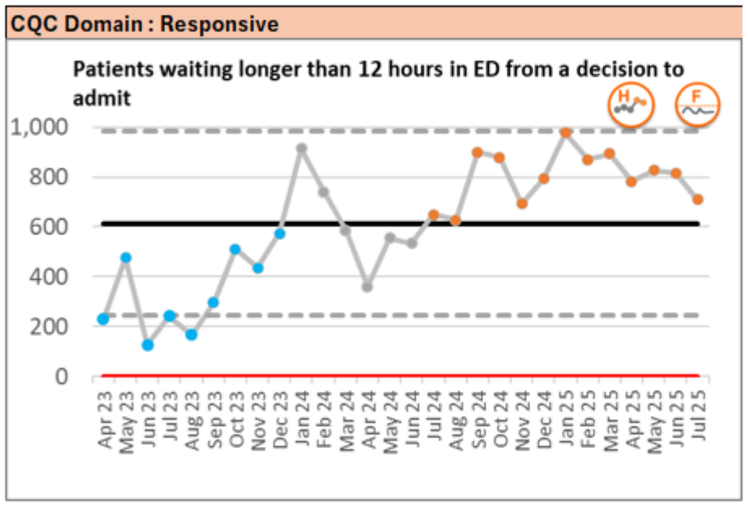
CQC Domain : Responsive



Jul-25
128
Variance Type
Common cause variation
Threshold
-
Assurance
Not applicable

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

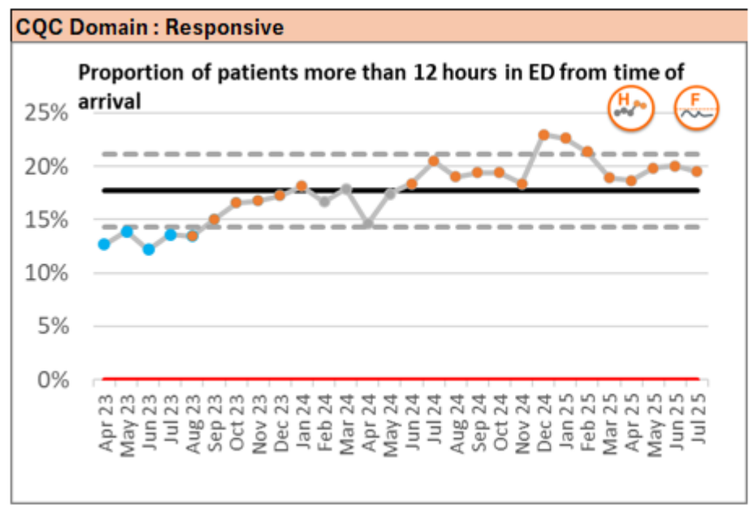
CQC Domain : Responsive



Jul-25
710
Variance Type
Special cause concerning variation
Threshold
≤0
Assurance
Consistently fail target

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

CQC Domain : Responsive



Jul-25
19.5%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

Commentary

4-hour - In July 2025, performance against the 4-hour Accident and Emergency standard (including APH UTC) was 61.4%. This remains significantly below the national target of 95%. Performance has been stable in recent months but continues to fall short of the required standard, reflecting the ongoing pressures in the department. Improvement actions are focused on reducing 12-hour waits, expanding same day emergency care pathways, and strengthening discharge processes to increase capacity. During August and September there are a number of PDSA's to test change and new escalation action cards implemented.

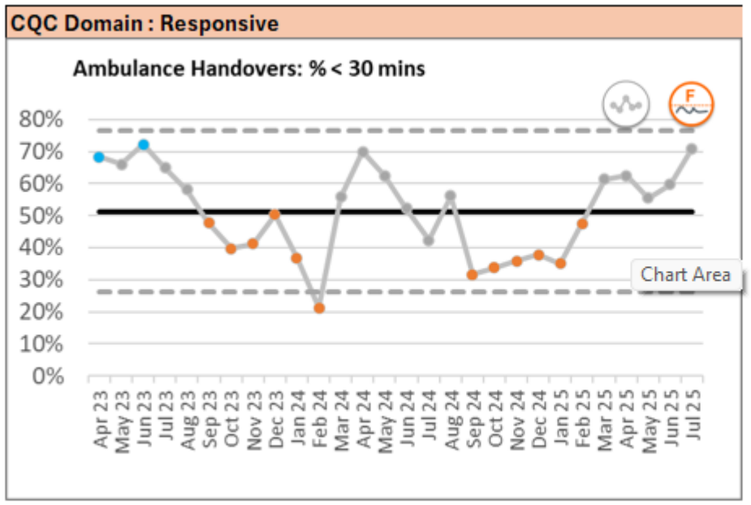
NCTR - The number of inpatients not meeting the Criteria to Reside was 128, showing a further reduction from June and continuing the downward trend seen since April. This reflects a sustained improvement compared to the higher levels from earlier in the year. The position indicates greater stability in discharge processes, although continued focus is required to maintain this improvement and reduce variation further.

12 hours DTA - 710 patients in month waited longer than 12 hours in ED following a decision to admit. This is a slight improvement from June but remains significantly above the required standard, with performance categorised as special cause variation. Actions being taken to reduce the number of patients waiting over 12 hours following a decision to admit align to the indictor of overall wait in the department of over 12 hours.

12 hours in ED - In July 2025, 19.5% of patients remained in ED for more than 12 hours from time of arrival. This remains significantly above the national standard. The position has been broadly consistent in recent months, with levels averaging around 18–20%, reflecting ongoing challenges in patient flow and timely access to beds. Reducing 12-hour breaches continues to be the greatest risk to UEC performance. The Trust is focused on improvement, with rapid progress expected through strengthened escalation processes, increased use of SDEC pathways, and improved discharge planning. New escalation action cards have been implemented and an internal improvement trajectory set for 15%.

Ambulance handover % < 30 minutes

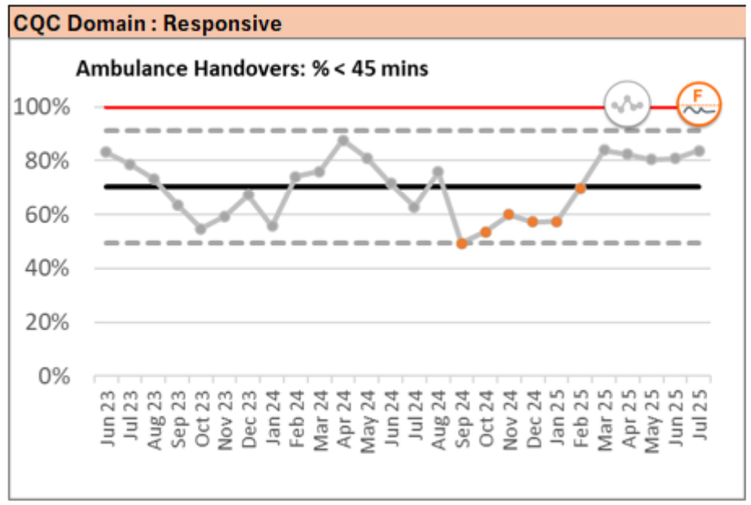
CQC Domain : Responsive



Jul-25
71.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

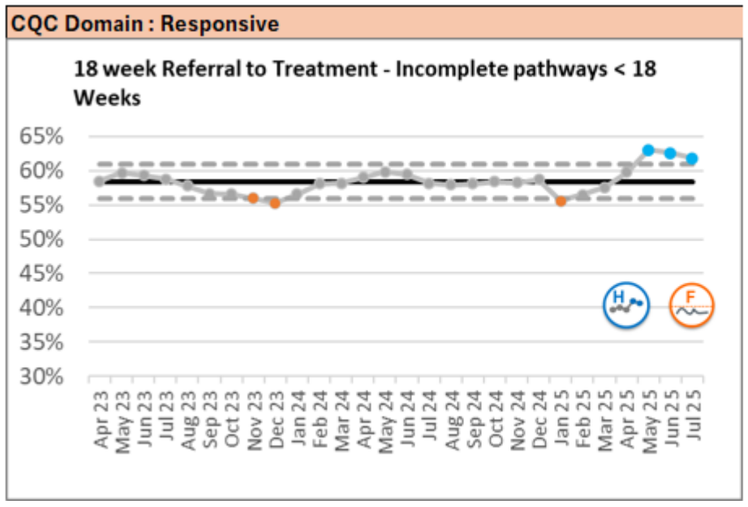
CQC Domain : Responsive



Jul-25
83.7%
Variance Type
Common cause variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

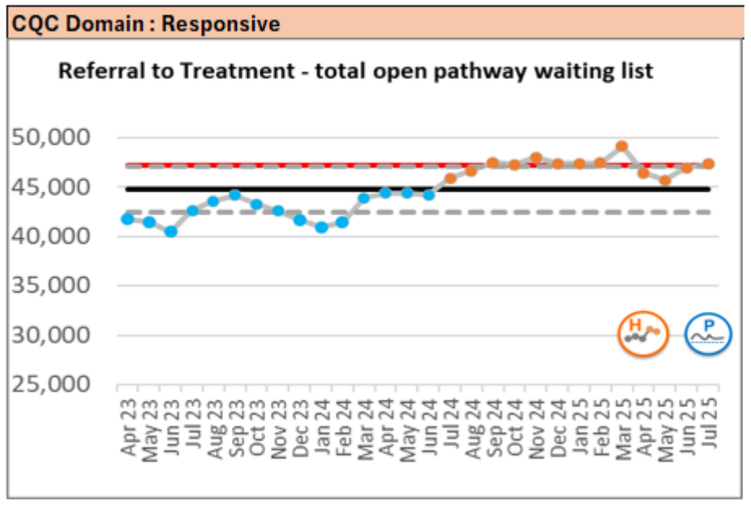
CQC Domain : Responsive



Jul-25
61.8%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



Jul-25
47312
Variance Type
Special cause concerning variation
Threshold
≤47171
Assurance
Consistently hit target

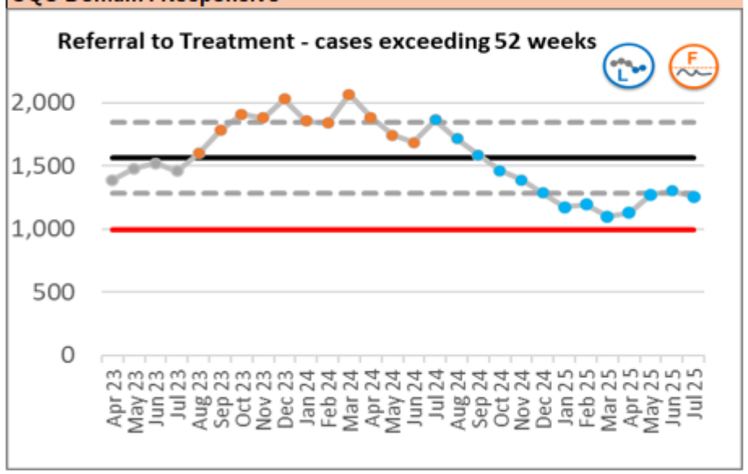
Commentary

Ambulance Handover – The Trust continues to see a significant improvement in handover performance with a high percentage of patients now handed over with less than 45 minutes. Following the launch of 45 minute release and rescue approach, number of crews held at 45 minutes has minimised with strong local performance against the standard.

RTT - The Trust achieved trajectory for RTT caseload and percentage of patient waiting 18 weeks or under. Whilst remaining below trajectory, the overall RTT waiting list increased in size in July 2025, following reductions seen from the national validation sprint. Increases in caseload from the May 2025 position are attributed to Physiotherapy, where there has been a change in location of the service from Arrowe Park site into the community, Dermatology due an significant increase in referrals due to ceasing of ICB funding for advice and guidance alongside introduction of a new AI pathway, and ENT where there are wider capacity constraints and routine capacity has been converted to support the management of cancer waiting times. Plans are being developed with Divisions to address these issues, alongside progression of the second national validation sprint.

Referral to Treatment – cases exceeding 52 weeks

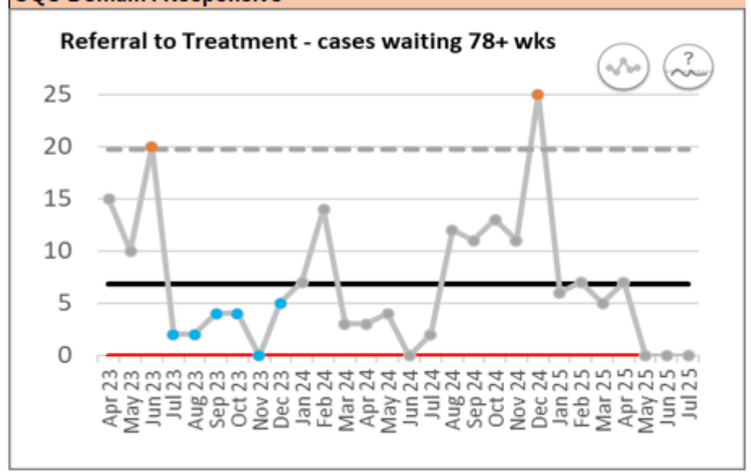
CQC Domain : Responsive



Jul-25
1255
Variance Type
Special cause improving variation
Threshold
≤997
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

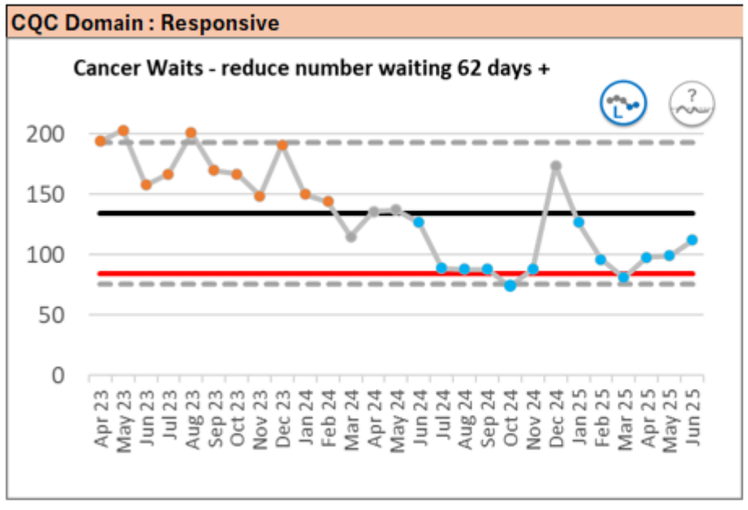
CQC Domain : Responsive



Jul-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 +

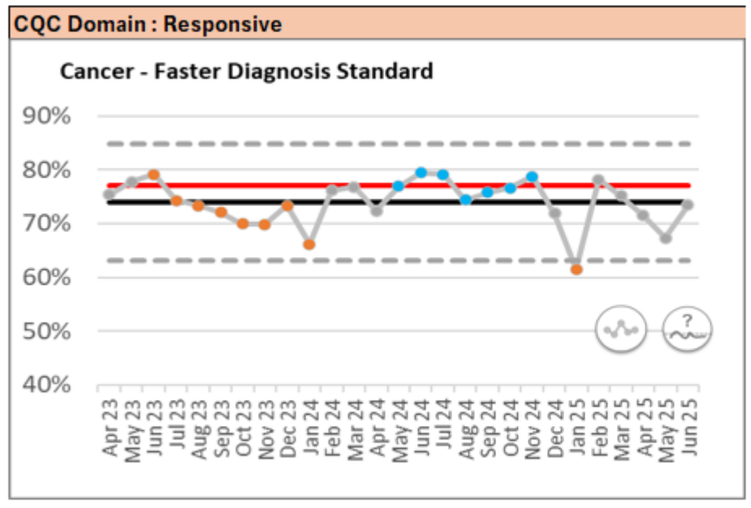
CQC Domain : Responsive



Jun-25
120
Variance Type
Special cause improving variation
Threshold
≤84
Assurance
Hit and miss target subject to random variation

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



Jun-25
73.4%
Variance Type
Common cause variation
Threshold
≥77%
Assurance
Hit and miss target subject to random variation

Commentary

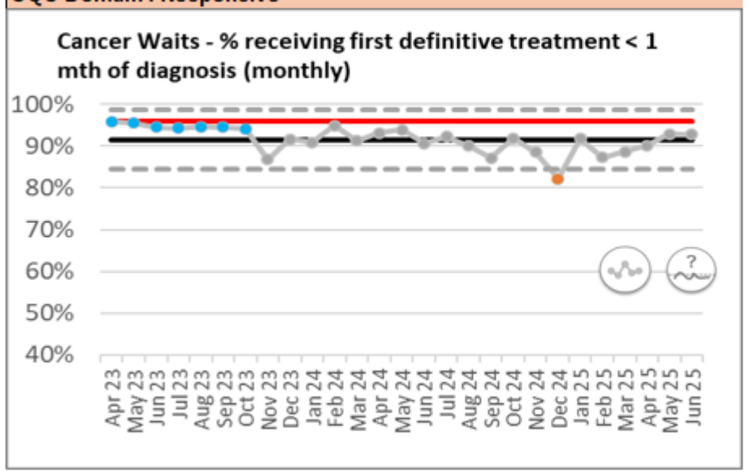
RTT - The Trust achieved 0 x 78-week waiters in July. The number of 65-week waiters has reduce to 16 in July. The largest number are within ENT where outsourcing is due to commence in September to provide additional capacity. The Trust was over trajectory for number and percentage of 52-week waiters in July 2025 although the number has decreased steadily. Whilst focus remains on the reduction of 65-week waiters to zero, weekly trajectories are being developed at specialty level to support management of 52-week waiters.

Cancer – The Trust has failed to meet the local trajectory for the Faster Diagnosis Standard with June performance at 73.42% versus trajectory of 77.92%. Performance is challenged in a number of tumour sites, including Dermatology, Breast and Gynaecology. Dermatology cancer performance has deteriorated following regional ceasing of funding for tele-dermatology, alongside regional implementation of an AI pathway. This deterioration in Dermatology cancer performance is reflected across the region. Plans are being developed to rapidly implement an alternative advice and guidance service and provide

additional capacity. Gynaecology faster diagnosis performance is forecast to improve from September with the implementation of a redesigned pathway. Positive progress has been made on clearing backlogs ahead of the pathway implementation. The Trust has bid for additional regional funding to support an improvement in the Breast position in order to provide additional capacity.

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

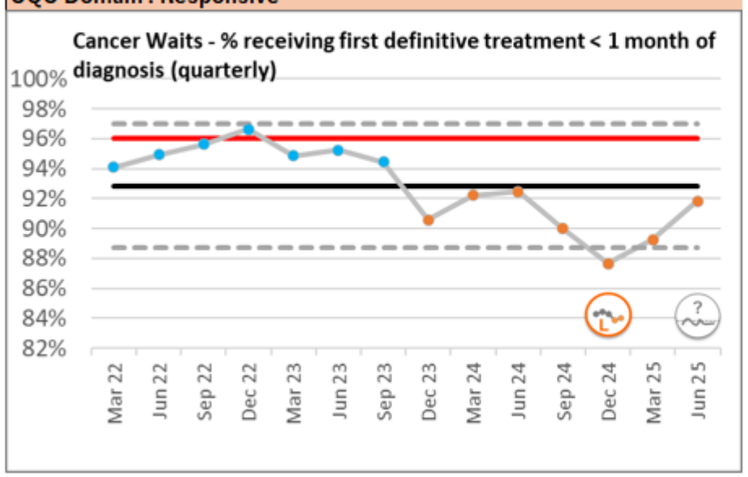
CQC Domain : Responsive



Jun-25
92.7%
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)

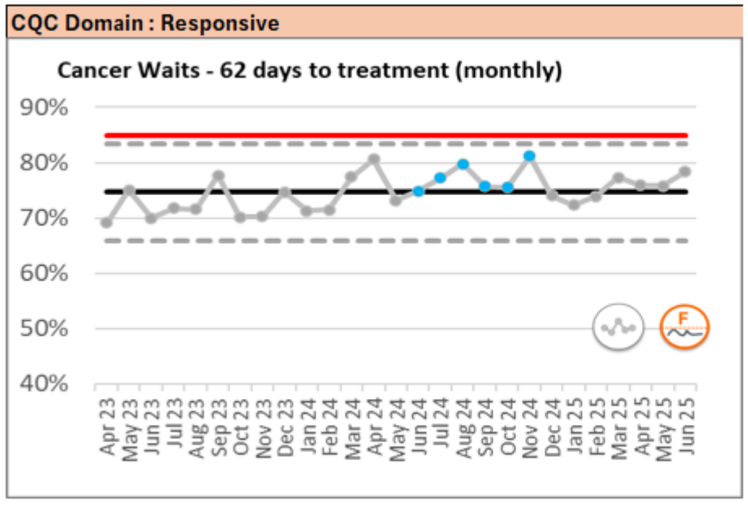
CQC Domain : Responsive



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)

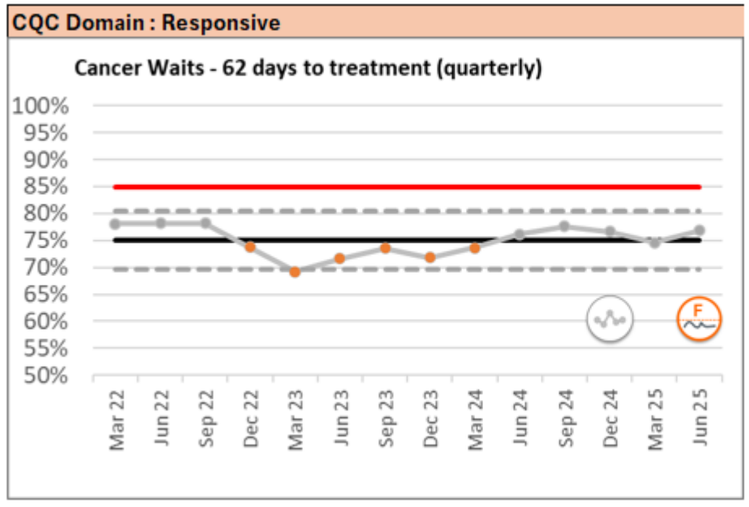
CQC Domain : Responsive



Jun-25
78.4%
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

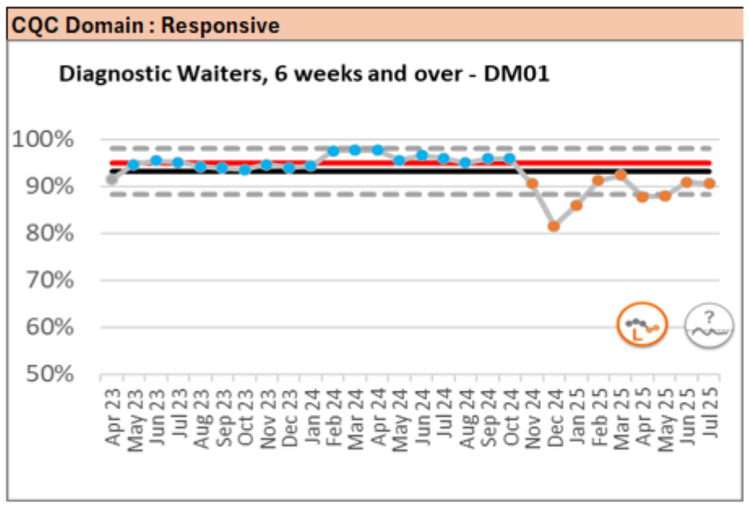
Commentary

31 Day Treatment Standard - The Trust achieved local trajectory in June 2025 at 92.71% versus trajectory of 90.46%.

62 Day Treatment Standard - The Trust achieved local trajectory in June 2025 at 78.39% versus trajectory of 75.73%. Pressure on 62-day performance is noted from an increase in 28-day waits for diagnosis and will impact on future months' performance.

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



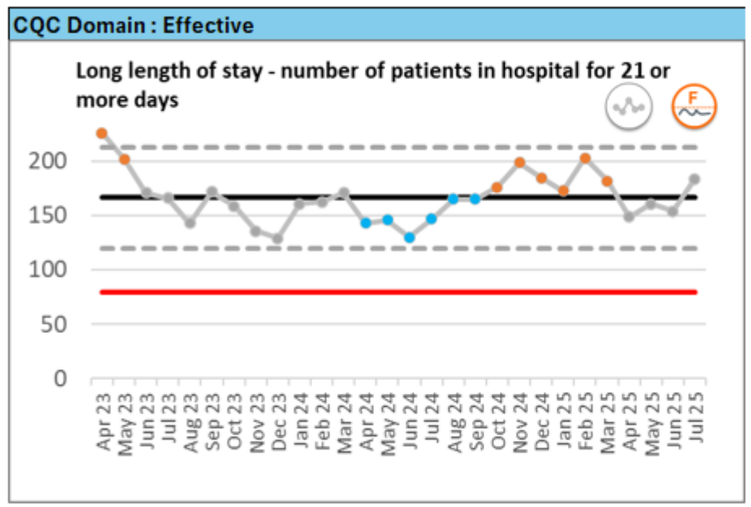
Jul-25
90.7%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

The Trust achieved above 90% of patients waiting 6 weeks or less of a diagnostic test. Non-obstetric ultrasound remains the area of greatest pressure despite increased capacity and ongoing use of mutual aid with a recovery plan in place to reduce waiting times by the end of September.

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

CQC Domain : Effective



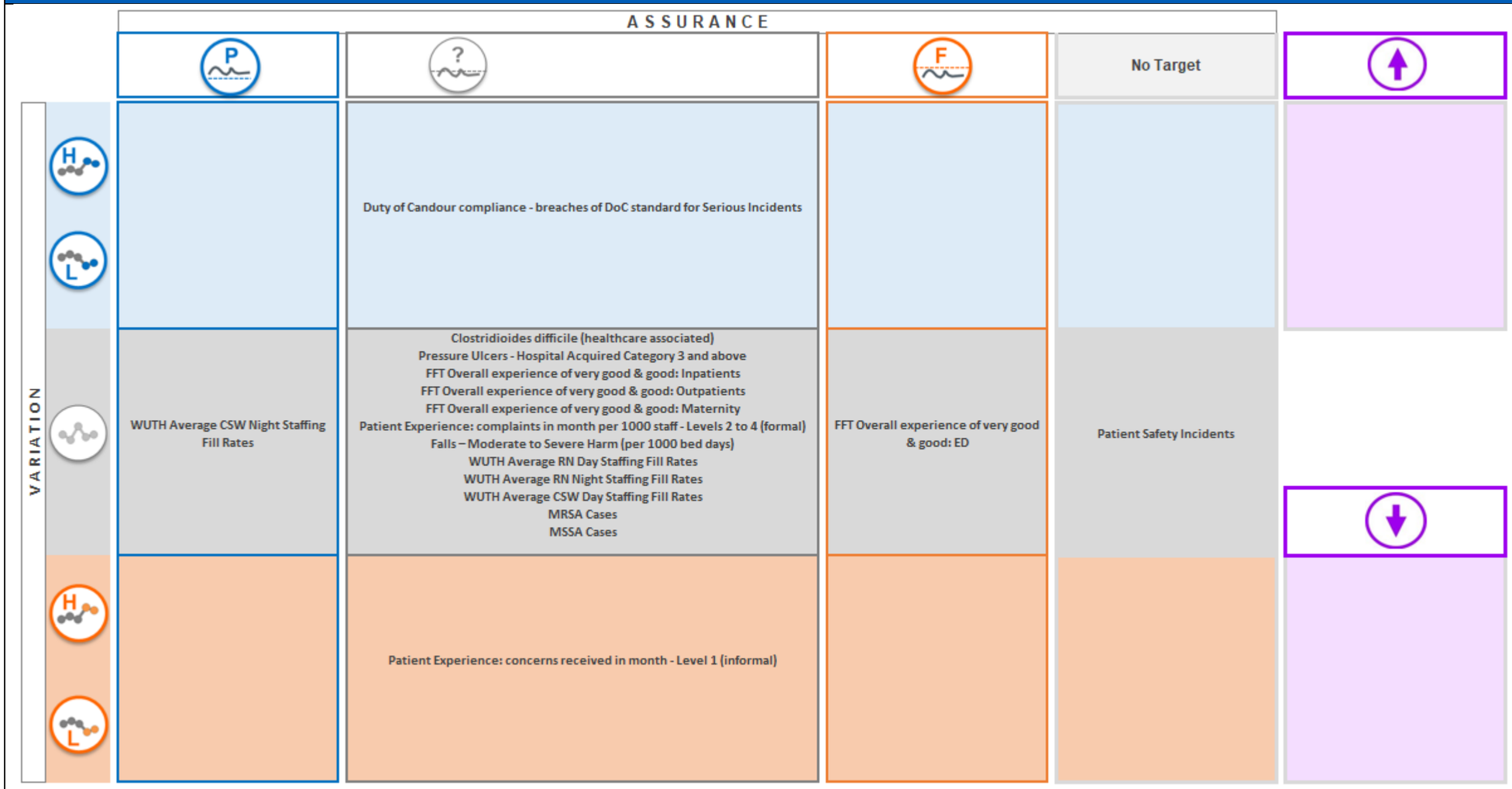
Jul-25
184
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

Commentary

Deep dives being undertaken by divisions to understand the drivers of long length of stay given the relatively low number of patients with no criteria to reside.

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)	Jul 25	11	≤6			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Jul 25	1	≤0			1
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Jul 25	0	≤0			0
Patient Safety Incidents	Jul 25	1252	-			1178
FFT Overall experience of very good & good: ED	Jul 25	71.9%	≥95%			76.4%
FFT Overall experience of very good & good: Inpatients	Jul 25	94.6%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Jul 25	96.1%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Jul 25	95.9%	≥95%			95.6%
Patient Experience: concerns received in month - Level 1 (informal)	Jul 25	327	≤173			219
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Jul 25	4	≤3			3
Falls – Moderate to Severe Harm	Jul 25	0.04	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Jul 25	87.0%	≥90%			88.8%
WUTH Average RN Night Staffing Fill Rates	Jul 25	90.0%	≥90%			90.0%
WUTH Average CSW Day Staffing Fill Rates	Jul 25	89.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Jul 25	100.0%	≥90%			99.8%
MRSA Cases	Jul 25	0	≤0			0
MSSA Cases	Jul 25	2	≤0			2

Areas of Concern

CDIF numbers. 8 x HOHA, 3 x COHA.

Healthcare associated pressure ulcers, grade 3 and above.

There has been a 22% increase in the number of level 1 concerns received.

Forward Look (Actions)

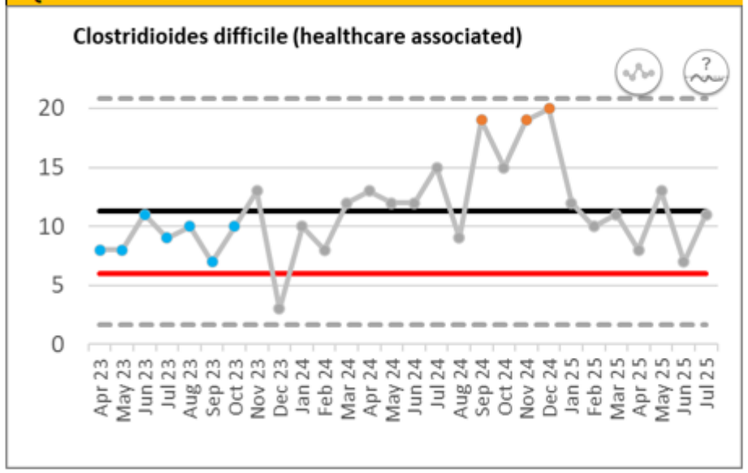
Refreshed improvement plan for infection prevention and control

1 in month, demonstrating a reduction on previous Months, new fleet of 350 dynamic mattresses received and deployed to the clinical areas. Acute and community teams working closely to support an integrated approach. C+M have agreed a dressing formulary, which will be reduced to a Wirral dressing formulary.

Thematic analysis undertaken, increase in concerns seen in services that are operationally challenged, i.e.; Children's, ophthalmology and ED. Each area has actions underway to improve the Situation.

Clostridioides difficile (healthcare associated)

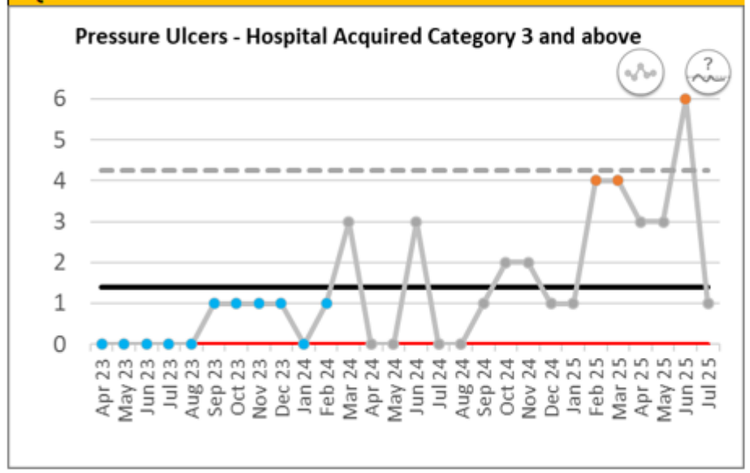
CQC Domain : Safe



Jul-25
11
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit and miss target subject to random variation

Pressure Ulcers – Hospital Acquired Category 3 and above

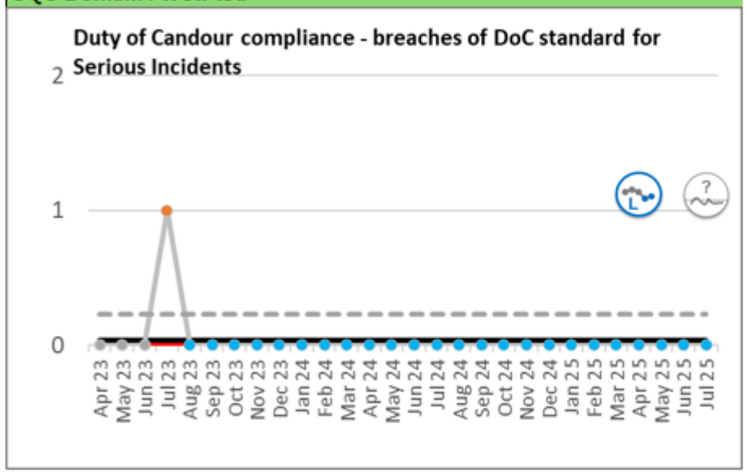
CQC Domain : Safe



Jul-25
1
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Duty of Candour Compliance

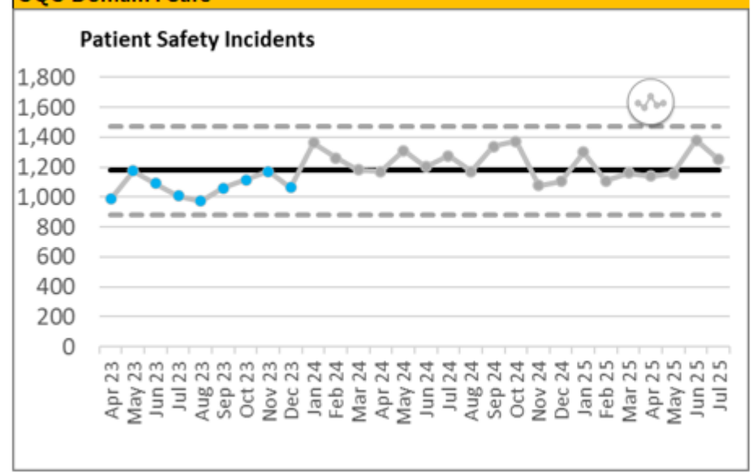
CQC Domain : Well-led



Jul-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



Jul-25
1252
Variance Type
Common cause variation
Threshold
-
Assurance
Not applicable

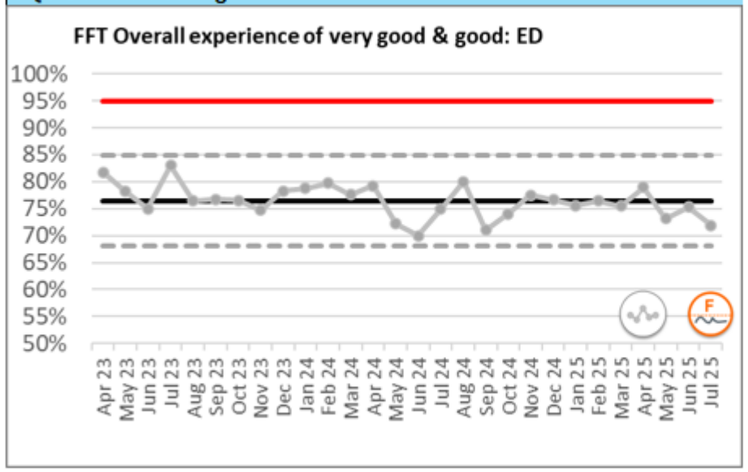
Commentary

Incidences of CDIF below the mean since January 2024, remains an area of concern. The National threshold has now been received, and we are expected to have 103 or less in 25/26, this would mean no more than 8 per month. The improvement plan has been refreshed, taking learning from last year and focusing on the environment and staff awareness and compliance with basic standards.

1 grade 3 HAPU device related to a CPAP mask, on ward 25. New fleet of 350 dynamic mattresses received and deployed to the clinical areas. Acute and community tissue viability teams working closely to su agreed a dressing formulary, which will be reduced to a Wirral dressing formulary.

FFT Overall experience of very good & good – ED

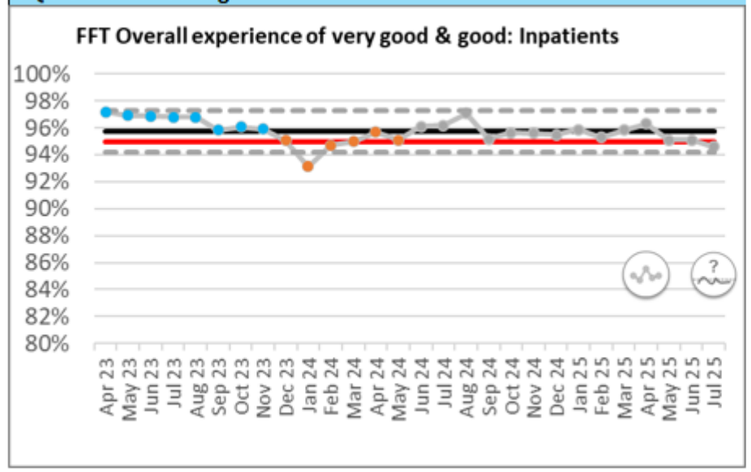
CQC Domain : Caring



Jul-25
71.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

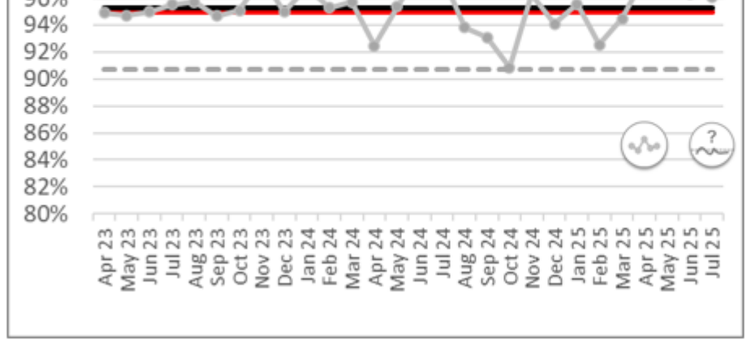
CQC Domain : Caring



Jul-25
94.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

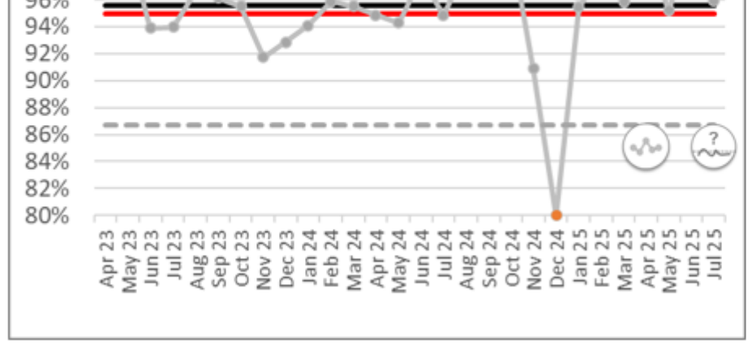
CQC Domain : Caring



Jul-25
96.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring



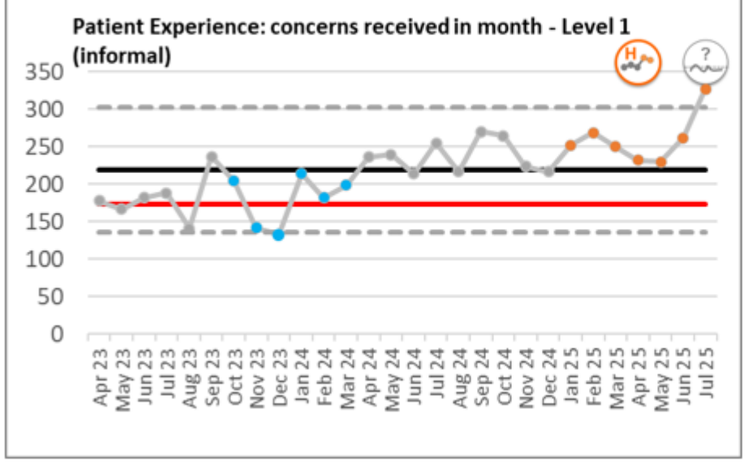
Jul-25
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

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)

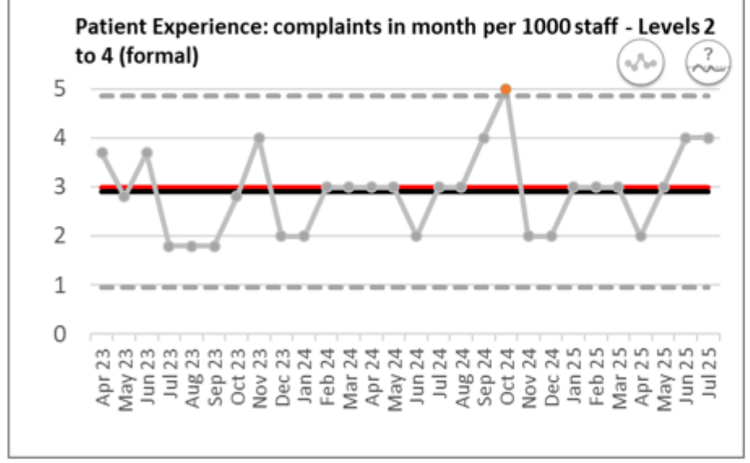
CQC Domain : Responsive



Jul-25
327
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)

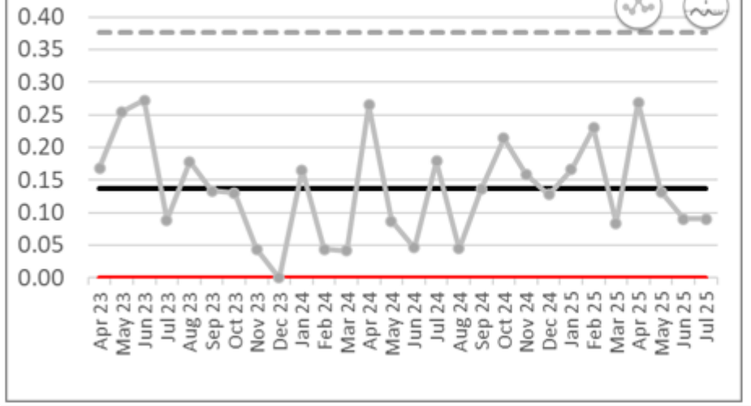
CQC Domain : Responsive



Jul-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



Jul-25
0.04
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

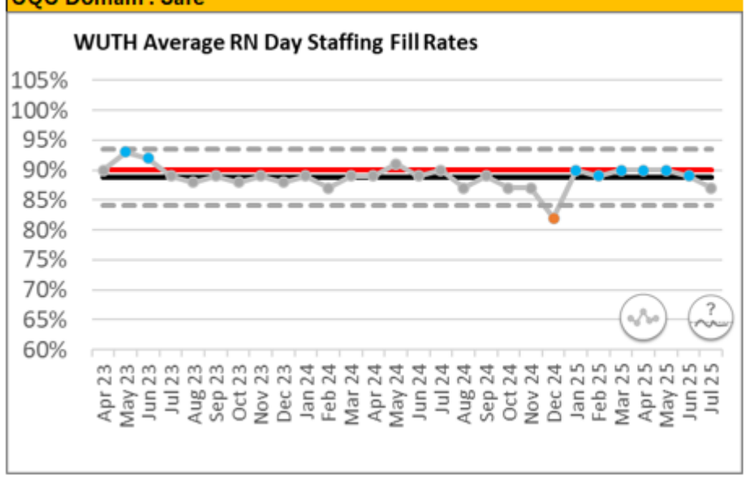
Commentary

There has been a 22% increase in level 1 concerns received, thematic analysis has identified increased in operationally challenged areas, including community pediatrics, ophthalmology and ED.

Falls resulting in moderate and above harm 0.04 per 100 beds days, third month of reduced incidence. The Trust has recently appointed a matron lead for falls prevention/safer mobility and a new medical lead has been appointed. The trust has recently rolled out yellow wrist band for falls risk identification. Deconditioning reduction improvement work has commended on wards M1, 10, 11, 24, 27 and 36, an increase in falls was anticipated in these areas, however this risk has not materialized.

Average Registered Nurse Day Staffing Fill Rates

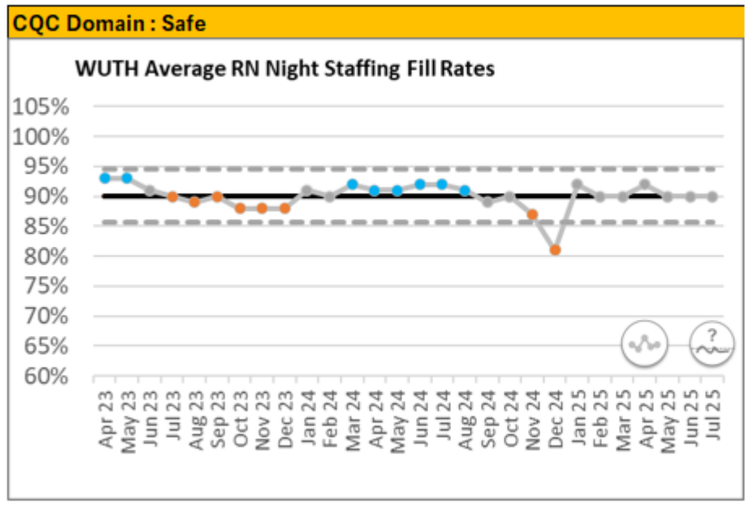
CQC Domain : Safe



Jul-25
87.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse

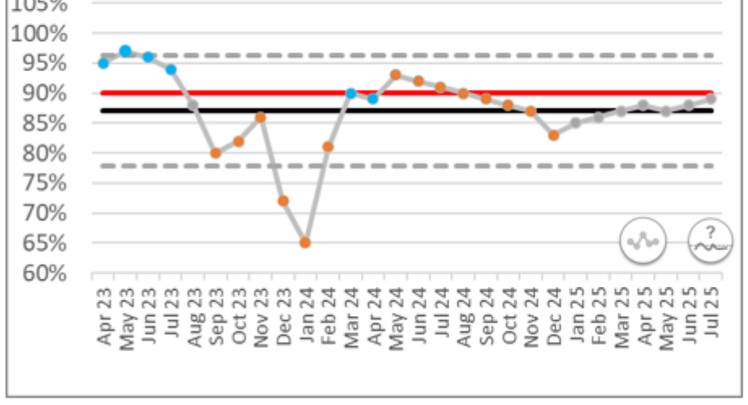
CQC Domain : Safe



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

Average Clinical Support Worker Day Staffing Fill Rates

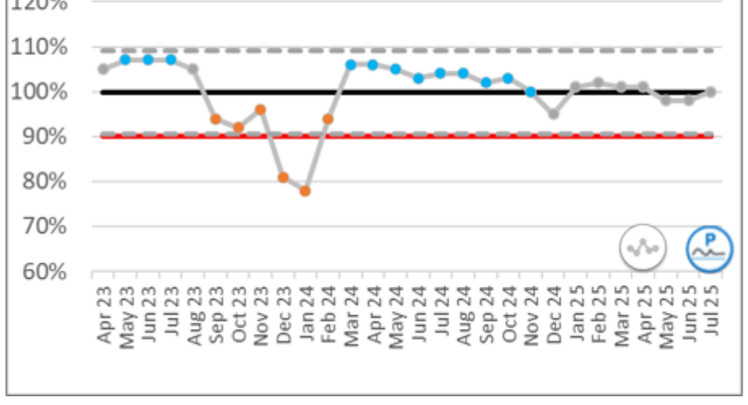
CQC Domain : Safe



Jul-25
89.0%
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



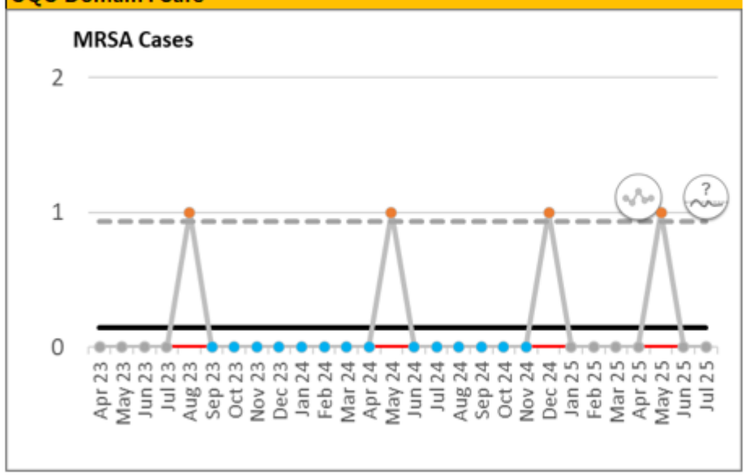
Jul-25
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Commentary

Normal variation experienced in staffing fill rates, as yet no significant impact as a result in the reduction of rates of pay to mid-point of grade required.

MRSA Cases

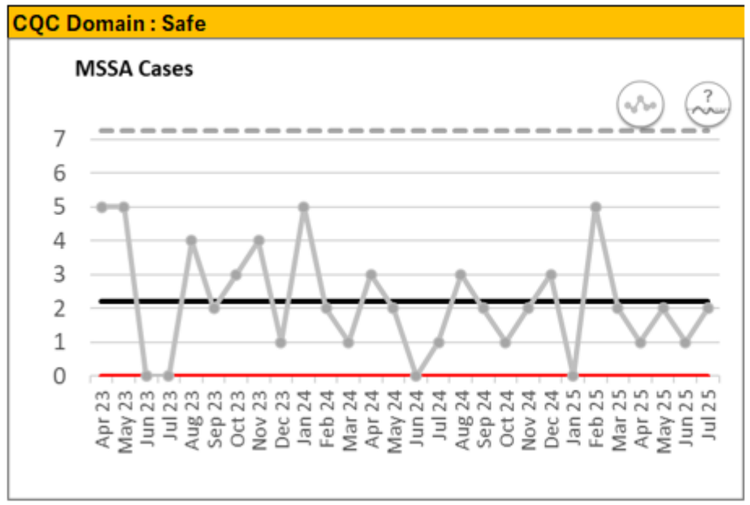
CQC Domain : Safe



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

MSSA Cases

CQC Domain : Safe



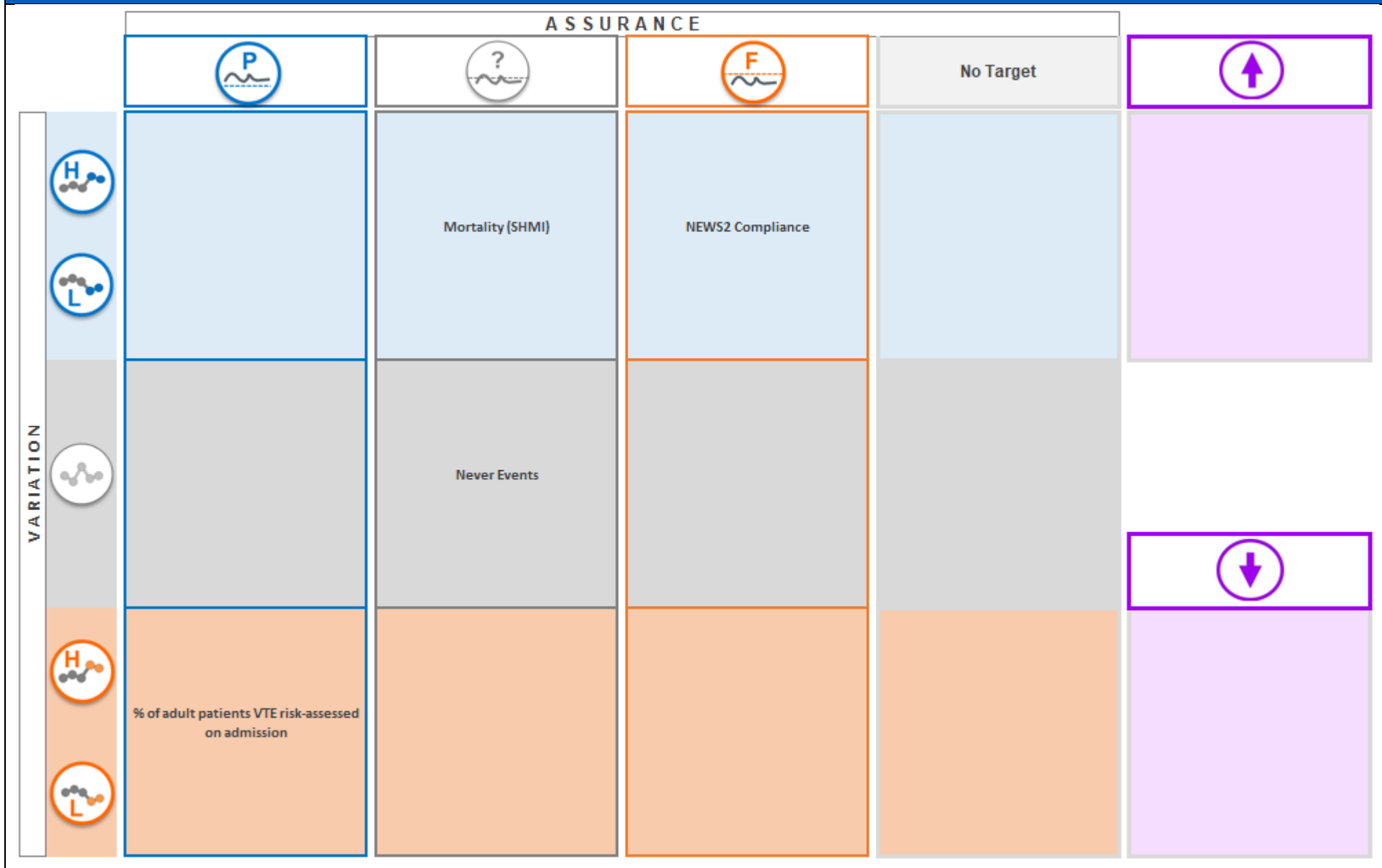
Jul-25
2
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Commentary

2 x MSSA bacteremia reported in July 25, 1 was as a result of patient admitted with cellulitis and 1 healthcare associated related to cannula care. Learning has been actioned, by IPC and local team.

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	Jul 25	**96.7%**	≥95%			97.5%
Never Events	2025/26	**4**	≤0			
NEWS2 Compliance	Jul 25	**91.3%**	≥90%			89.3%
Mortality (SHMI)	Feb 25	**0.979**	0.95-1.05			1.023
Number of studies open	Jul 25	42				
% of current studies meeting recruitment target	Jul 25	38.1%				
% of open studies with a commercial sponsor	Jul 25	7.1%				

Areas of Concern

Overall VTE compliance above target, but Compliance is variable across clinical areas.

Zero Never events for July but 4 during this financial year

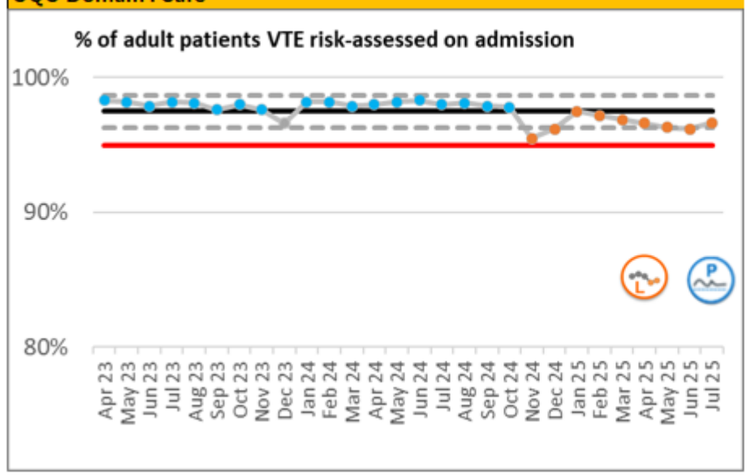
Forward Look (Actions)

Monitor through DPR. Focus on areas of low Performance

Focus on LocSSIPs with regular audits underway

% of adult patients VTE risk assessed on admission

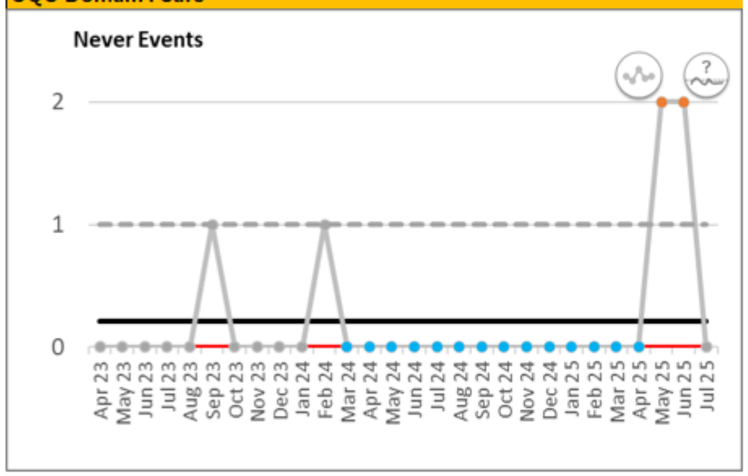
CQC Domain : Safe



Jul-25
96.7%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

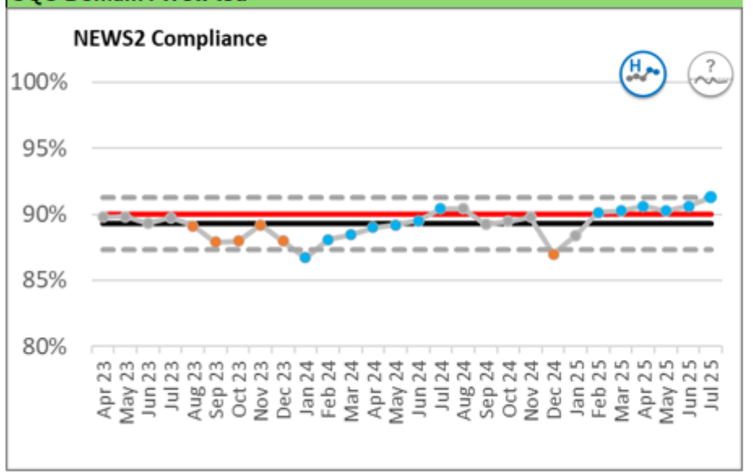
CQC Domain : Safe



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

NEWS 2 Compliance

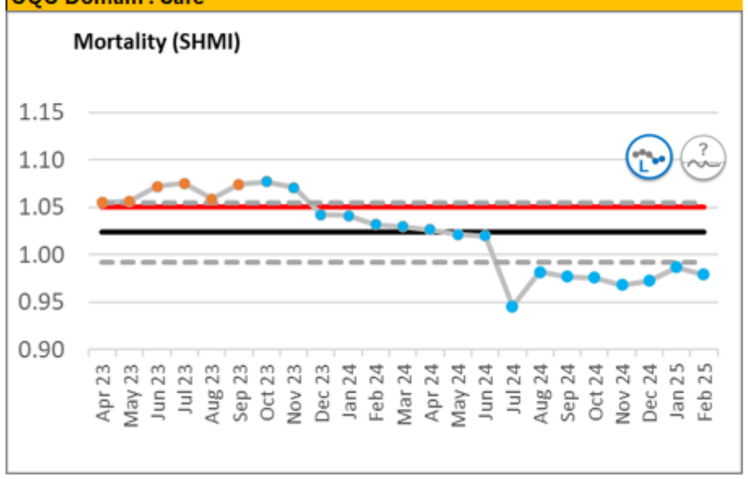
CQC Domain : Well-led



Jul-25
91.3%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Feb-25
0.9791
Variance Type
Special cause improving variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

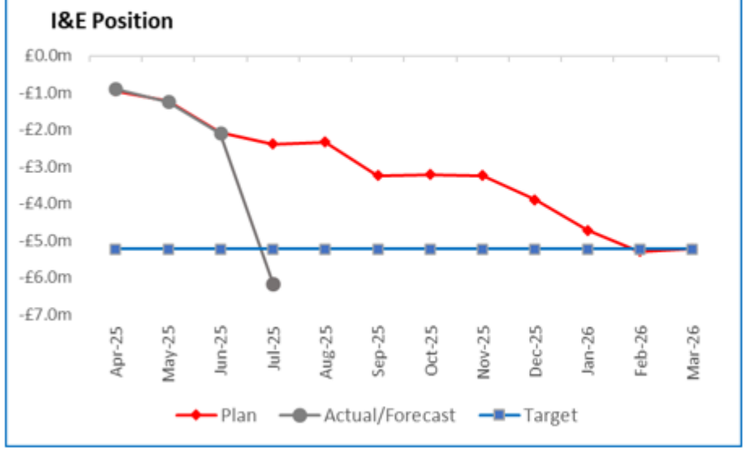
Commentary

Current Open Studies snapshot

42	38.1%	7.1%
Open studies	Open studies meeting recruitment target	Open studies with commercial sponsor

I&E Position

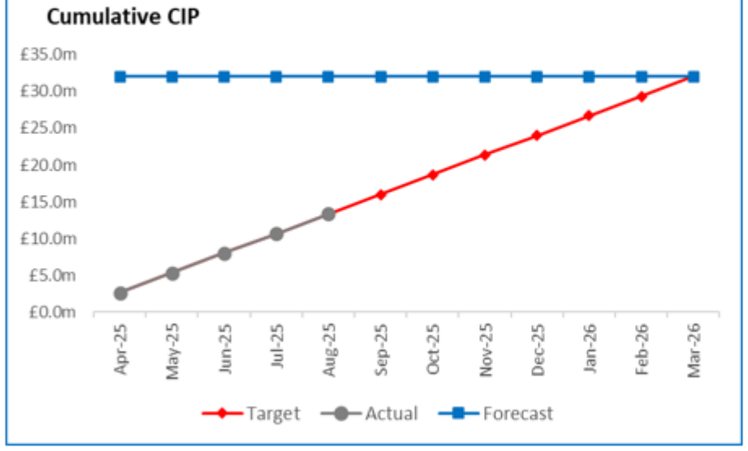
CQC Domain : Use of Resources



Jun-25
-£6.2m
Variance Type
Position doesn't meet the plan
Target
-£5.2m

Cumulative CIP

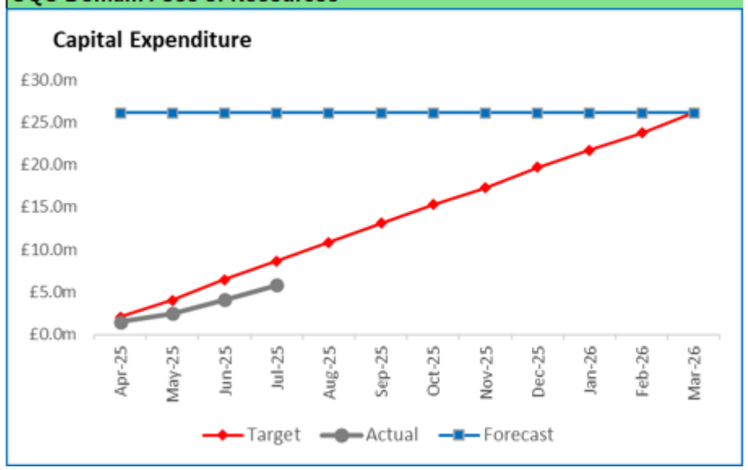
CQC Domain : Use of Resources



Aug-25
£13.3m
Variance Type
Position meets the plan
Target
£13.3m

Capital Position

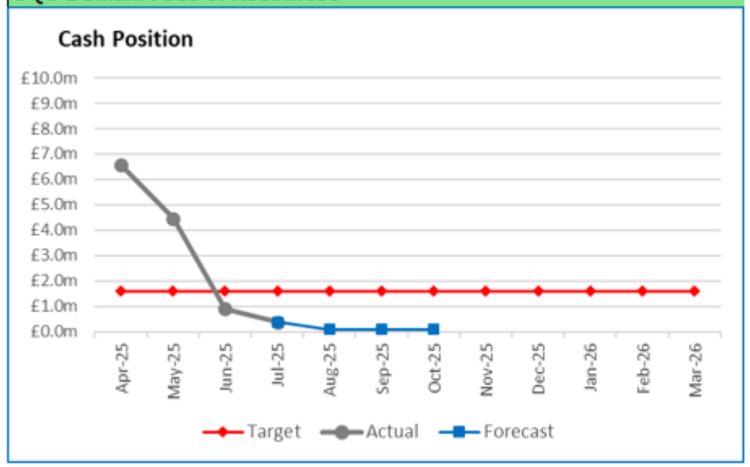
CQC Domain : Use of Resources



Jul-25
£5.8m
Variance Type
Position meets the plan
Target
£8.7m

Cash position

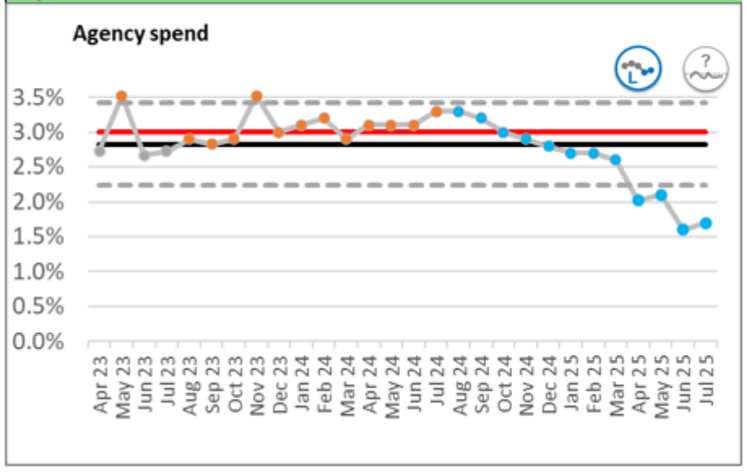
CQC Domain : Use of Resources



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

Agency spend %

CQC Domain : Use of Resources



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

Chief Finance Officer

Executive Summary

At the end of July 2025 (M4) the Trust is reporting a deficit of £6.2m which is a £3.8m adverse variance to plan. As part of the C&M ICS finance review process the Trust has submitted a mid-case forecast which is an adverse variance to plan. 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)).

M4 included two additional and material factors relating to the financial position:

- NHSE has withheld DSF across C&M for M4-M6. This negatively impacts the Trust's I&E and cash positions by £1.4m per month.
- Industrial Action in M4 has negatively impacted expenditure and elective income by an estimated £1.2m.

These factors are now added 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 (£14.5m).
- Activity / Casemix – Adjusting for the impact of IA, elective income remains below plan at M4.
- Aseptic Pharmacy – This risk is materialising with a 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 pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). The cash balance at the end of M4 was £0.38m. The Trust will maintain a positive cash balance in August but has submitted a request for provider revenue support in September of £16.5m.

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 is now being developed.

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

Statutory Financial Targets	RAG (M4)	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 the risk to delivery of the annual plan is £13.0m and to approve processes for identification and implementation of additional mitigations.
- Note that the Trust's most immediate finance risk remains the cash position and that a request for provider revenue support has been submitted.

I&E Position

Narrative:

The table below summarises the M4 position:

	Year to Date		
Cost Type	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£161.7m	£158.8m	-£2.9m
Other Operating Income	£11.7m	£11.1m	-£0.6m
Total Income	**£173.3m**	**£169.8m**	**-£3.5m**
Employee Expenses	-£127.9m	-£129.7m	-£1.8m
Operating Expenses	-£51.3m	-£51.6m	-£0.3m
Non Operating Expenses	-£1.6m	-£1.7m	-£0.1m
CIP	£5.1m	£0.0m	-£5.1m
Total Expenditure	**-£175.7m**	**-£183.0m**	**-£7.3m**
Unmitigated Forecast Risk 25-26	**-£2.4m**	**-£13.2m**	**-£10.8m**
Non Recurrent Mitigations		**£7.0m**	
Mitigated Forecast Risk 25-26	**-£2.4m**	**-£6.2m**	**-£3.8m**

Key variances within the YTD position are:

Clinical Income – £2.9m adverse variance relates to elective underperformance including industrial action, HC drugs and loss of DSF.
Employee Expenses - £1.8m adverse variance relates to use of bank, agency, industrial action and vacancy factors.
Operating expenses – £0.3m adverse variance relates to HC drugs (offset by income above) and a reduction in the CNST incentive credit.
Cost Improvement Programme – £5.1m underdelivered at month 4 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 £27.5m at M4 of which £7.0m is non-recurrent mitigations. A further £5.9m of CIP has been identified for delivery in 25/26. Full delivery will mean that the Trust meets its in year CIP target.
The Trust has identified recurrent CIP with a full year effect of £31.2m, a shortfall against target of £0.8m however, this identified figure reduces to £25.3m once risk adjusted and therefore the risk adjusted shortfall is £6.7m recurrent.

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 £36.1m at M4, reflecting an adverse variance of £1.5m ytd. This underperformance is driven within the Surgical Division, primarily 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 M4:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M3	Revision to budget M4	Revised Budget
CDEL					
Internally Generated	**£9.765m**	**£0.000m**	**£0.000m**	**£0.000m**	**£9.765m**
ICB/PDC/WCHC	**£14.550m**	**£0.656m**	**£0.000m**	**£0.000m**	**£15.206m**
Charity	**£1.100m**	**£0.000m**	**£0.000m**	**£0.000m**	**£1.100m**
Confirmed CDEL	**£25.415m**	**£0.656m**	**£0.000m**	**£0.000m**	**£26.071m**
Total Funding for Capital	**£25.415m**	**£0.656m**	**£0.000m**	**£0.000m**	**£26.071m**
Capital Programme					
Estates, facilities and EBME	**£3.100m**	£0.656m	£0.000m	£0.000m	**£3.756m**
Operational delivery	**£8.440m**	£0.000m	£0.000m	£0.000m	**£8.440m**
Medical Education	**£0.080m**	£0.000m	£0.000m	£0.000m	**£0.080m**
Transformation	**£0.250m**	£0.000m	£0.000m	£0.000m	**£0.250m**
Digital	**£0.750m**	£0.000m	£0.000m	£0.000m	**£0.750m**
UECUP	**£7.800m**	£0.000m	£0.000m	£0.000m	**£7.800m**
PDC commitments	**£0.304m**	£0.000m	£0.000m	£0.000m	**£0.304m**
ICB hosted	**£3.591m**	£0.000m	£0.000m	£0.000m	**£3.591m**
Charity	**£1.100m**	£0.000m	£0.000m	£0.000m	**£1.100m**
Approved Capital Expenditure Budget	**£25.415m**	**£0.656m**	**£0.000m**	**£0.000m**	**£26.071m**
Total Anticipated Expenditure on Capital	**£25.415m**	**£0.656m**	**£0.000m**	**£0.000m**	**£26.071m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

There have been no revisions to the capital budget at M4.

Spend at M4 totals £5.812m which is £2.846m below plan mainly across backlog and operational schemes.

Cash Position

Narrative:

The cash balance at the end of M4 was £0.38m. This includes the impact of a £1.4m reduction in planned Deficit Support Funding; the impact of which will continue at least until Month 6 (September). The Trust follows a structured and robust approach to cash management. Once all available mitigations have been deployed the Trust will require £16.5m of cash support in September. A request has been submitted with a response due early in September. 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**
3 September 2025

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

Executive Summary and Report Recommendations

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

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

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

The 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

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**
This is a standing report to Board			

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

2	Planned Care
2.1	**Elective Activity** In July 2025, the Trust attained an overall performance of 100% against plan for outpatients (100% for new outpatient attendances), and an overall performance 92% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for July	Actual for July	Performance
Out pt New	13,032	13,088	100.4%
Out pt Follow up	28,031	27,909	99.6%
Out pt procedures	4,182	4,378	104.7%
Total Out pts	45,245	45,375	100.3%
Day case	4,980	4,530	91.0%
Inpatients	613	603	98.4%
Total	5,593	5,133	91.8%

The Trust achieved plan for outpatient new appointments and outpatient procedures but underachieved for elective / daycase.

Underachievement for elective/daycase was seen in Medicine and Surgery with Women's and Children's exceeding plan. Surgery underachievement was seen largely in Trauma and Orthopaedics, Oral Surgery and Ophthalmology whilst Medicine, Dermatology and Cardiology saw the largest underachievement against plan. The

	operational team are developing an activity recovery plan that plays into the Trust financial forecast.
2.2	**Referral to Treatment (RTT)** The Trust's performance at end of July 2025 against RTT metrics was as follows *(RAG rated versus monthly trajectories from Trust planning submission)*:

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

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.

The overall RTT waiting list increased in size in July 2025, following reductions seen as a result of the national validation sprint. Increases in caseload are attributed to Physiotherapy, where there has been a change in location from Arrowe Park site into the community, Dermatology due to ceasing of ICB funding for advice and guidance alongside introduction of a new AI pathway seeing referrals increase significantly, and ENT where there are wider capacity constraints and routine capacity has been converted to support management of the cancer waiting times. Plans are being developed with Divisions to address these issues, alongside progression of the second national validation sprint.

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

The number of patients waiting 65+ weeks has reduced to 16. Of the 16 patients waiting, 4 x were complex, 1 x was a graft and 11 were due to capacity. ENT remains the biggest challenge to achievement of 0 x 65-week waiters. Outsourcing in ENT is due to commence in September.

2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 1:

Quarter	1
Period	01/04/2025 - 30/06/2025

National Standards:

Standard	Indicator	Threshold	April-25	May-25	June-25	Quarter 1
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	77.00%	71.47%	67.34%	73.42%	70.80%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	90.08%	92.82%	92.71%	91.83%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.96%	75.81%	78.39%	76.82%

Operational Planning Trajectories:

Standard	Indicator	Threshold	April-25	May-25	June-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	71.47%	67.34%	73.42%
28 Day Wait	Breast >=90%	90.00%	87.98%	82.56%	90.05%
28 Day Wait	Skin >=90%	90.00%	90.58%	86.64%	88.19%
31 Day Wait	Individual Trust Provider Trajectory	Per Month	90.08%	92.82%	92.71%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.96%	75.81%	78.39%

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	April-25	May-25	June-25
14 Day Wait	GP USC Referral to First Appointment	93.00%	55.90%	58.69%	57.34%

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for June 2025. Areas of pressure include Dermatology as a result of the changes to advice and guidance and the introduction of artificial intelligence. Breast and Gynaecology have seen challenges in achieving the standard with new waiting times being a pressure. Both areas have recovery options that are being considered.
- *62-day treatment* - The Trust achieved local trajectory in April - June 2025.
- *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
Actual 25/26	81	64	106	98	105	102	94	99	110	126	124	128	112	120	119	121	124
Trajectory 25/26	105	105	105	105	98	98	98	98	91	91	91	91	91	84	84	84	84
Pre-COVID Average	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
Actual 25/26	26	23	22	19	21	23	22	22	26	26	23	26	24	28	26	31	28
Trajectory 25/26	22	22	22	22	21	21	21	21	19	19	19	19	19	17	17	17	17
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

The Gynaecology position is forecast to improve with the implementation of a straight to test pathway to reduce demand from September, positive progress has been made on clearing backlogs ahead of implementation. The Trust has been successful in securing regional funding to support recovery in Breast.

2.4 DM01 Performance – 95% Standard

The Trust achieved 90% of patients waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 for July.

Non-obstetric ultrasound remains the area of greatest pressure despite increased capacity and onging use of mutual aid. The position is forecast to improve by the end of September.

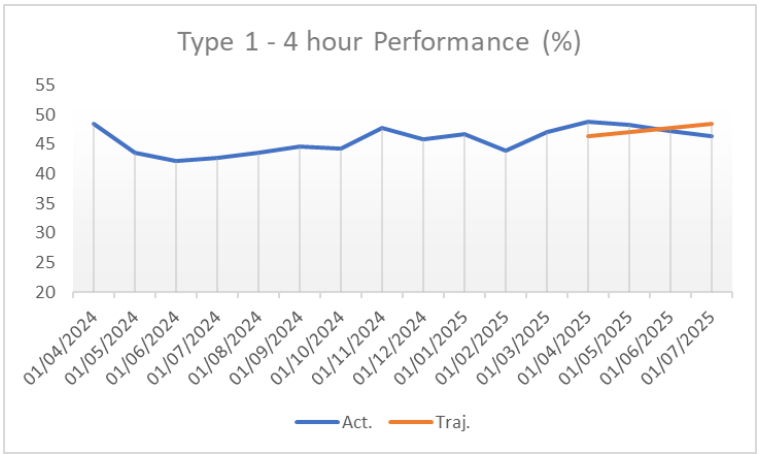
2.5 Risks to recovery and mitigations

	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 and consistently delivering 0 x 65 weeks. 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. Since June there have been two theatres out of commission due to infrastructure challenges. One theatre remains out of use until the middle of September following building works to rectify the issue. This has proven a challenge in accommodating all operating lists across both sites.

3.0	**Unscheduled Care**
3.1	**Performance** In July, Type 1 performance was reported at 46.38%, with a combined performance across all Wirral sites reaching 72.60%.

Type 1 ED attendances: • 7,932 in June (avg. 264/day) • 7,987 in July (avg. 258/day) • 0.7% increase from previous month	Type 3 ED attendances: • 3,078 in June (avg. 103/day) • 3,413 in July (avg. 110/day) 10% increase from previous month

In July, urgent and emergency care demand increased, with a slight rise in Type 1 attendances and a more noticeable growth in Type 3 (UTC) presentations. While performance against the Type 1 4-hour standard was marginally below trajectory, this highlights the continued importance of maximising flow and utilisation of alternative urgent care pathways.

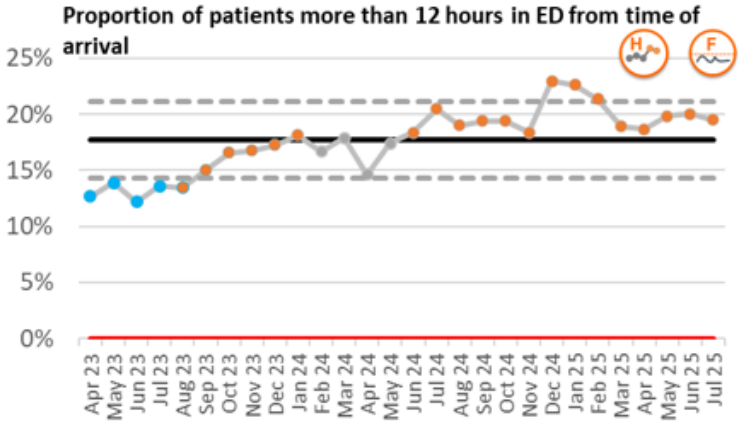


The most significant risk to UEC performance remains achieving a sustained reduction in patients waiting over 12 hours in the Emergency Department. Both the Trust and the

wider Cheshire and Merseyside system are national outliers, with an average of 21% of patients experiencing a stay beyond 12 hours. A system-wide focus led by NHSE and the ICB, is now in place with active collaboration across all acute providers and the two mental health providers for the region.

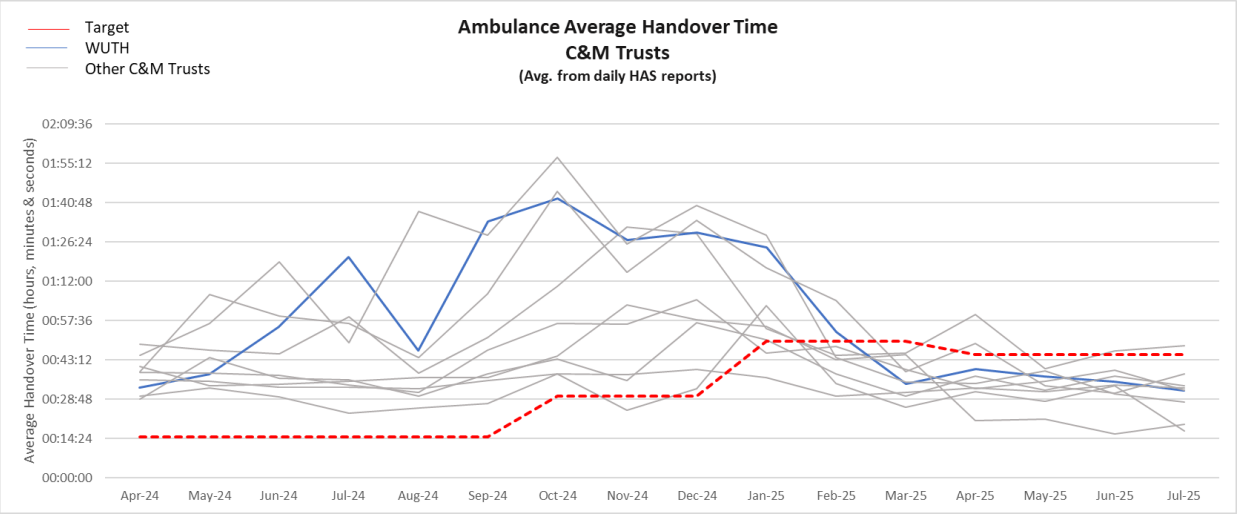
Recent actions within the Trust include the introduction of escalation cards, changes to referral pathways into SDEC services, and strengthened oversight through the development of a new business intelligence portal.

The next phase of work will focus on embedding these changes, ensuring consistency in escalation processes, and maximising use of alternative pathways. Further system actions are planned for Q3 and Q4 to support measurable improvement and provide assurance to the Board on progress against national standards. This will include engagement with regional and national colleagues on both 4 and 12 hour performance.

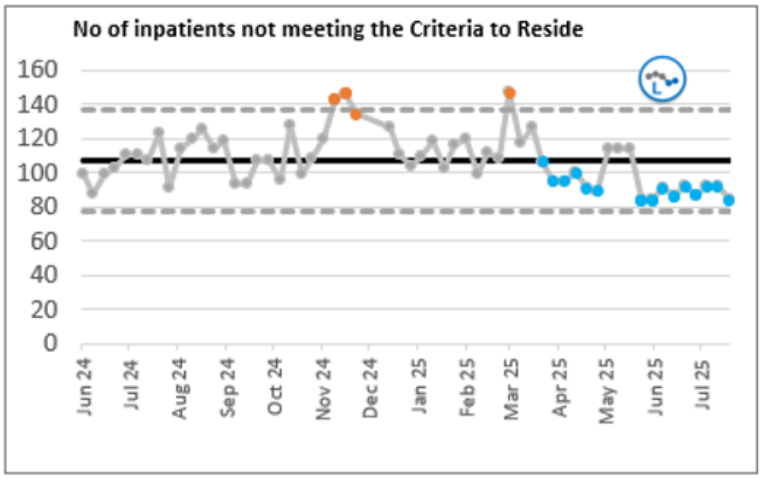


Ambulance handover performance remains in a strong position, with the Trust overall meeting the expected trajectory. Focus and coordination remains on working to avoid delays and maintain effective patient flow from ambulance arrival to clinical handover.

The ED department has recently moved to the final phase of works which has provided the opportunity to implement the ‘rapid assessment triage’ model within the ambulance arrivals area which has improved the position further.



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

	In July 2025, the position has remained stable, showing only minor variation from May and June levels. The reduction since April has been sustained over a three-month period, providing assurance that the changes implemented are embedding into practice. The continued stability demonstrates the impact of strengthened discharge processes, closer system collaboration and the increased use of community and home-first pathways. Work now centres on maintaining this level of performance, reducing variation further, and ensuring resilience going into winter. To support this, an ECIST capacity and demand model is in development and will be completed by September 2025, providing a system-wide view of requirements and supporting the sustainability of discharge improvements  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 14.2%. **Provider** ▲ | **Current** Countess | 22.0% East Cheshire | 18.8% LUHFT | 20.9% Mid Cheshire | 15.7% MWL | 19.3% W&H | 20.7% Wirral | 14.2% **Total** | **19.1%**
3.3	**Mental Health** In July, the Trust opened a new mental health area within the Emergency Department as part of the final phase of UECUP. This purpose-designed space is located away from the busier areas of the department and includes an additional assessment room, increasing capacity from three to four rooms. The development is intended to provide a calmer environment, improve patient experience, and support the delivery of care plans within a stay of less than 12 hours. The focus on reducing 12-hour waits applies equally to mental health patients. The local mental health provider is working alongside the Trust and NHSE to prioritise

	improvements in this area, and rapid progress is expected as joint pathways are strengthened and new processes are embedded. Mental health demand, however, remains consistently high, with July seeing a further increase in patients conveyed under Section 136 (s136). This continues to place significant pressure on the Emergency Department, particularly given the limited availability of timely and appropriate crisis care. The Trust is also awaiting the outcome of a capital funding bid to support the development of a dedicated Mental Health Crisis Hub for the Wirral. If approved, this investment would expand local capacity and provide an alternative to the Emergency Department for s136 patients without acute medical needs, thereby helping to relieve pressure on the department and improve patient outcomes.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to make steady progress in delivering the actions set out within the urgent care improvement plans, with a focus on achieving key quality standards. Performance is being closely monitored through the Urgent and Emergency Care (UEC) Improvement Group, with oversight of sentinel metrics provided by Place leads and the System Control Centre (SCC). Despite this progress, several risks remain. Increased patient acuity, sustained demand for beds, and long waits to be see continue to place significant pressure on patient flow and the delivery of planned improvements. The requirement to strengthen nursing capacity within the Emergency Department particularly to support timely ambulance handovers remains a key operational challenge, alongside rising vacancy levels among junior medical staff. In addition, ongoing demand for mental health support continues to impact ED capacity and staffing and presents a continued risk to overall system flow.

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 particular due to the challenges in making improvements across the urgent and emergency pathways.

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.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 3 2025/26

Item 12

Contents

No.	Item
1.	Introduction
2.	Our Vision, Strategy and Objectives
3.	Our Risk Appetite
4.	Operational Risk Management
5.	Creating and Monitoring the BAF
6.	Monthly Update Report

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

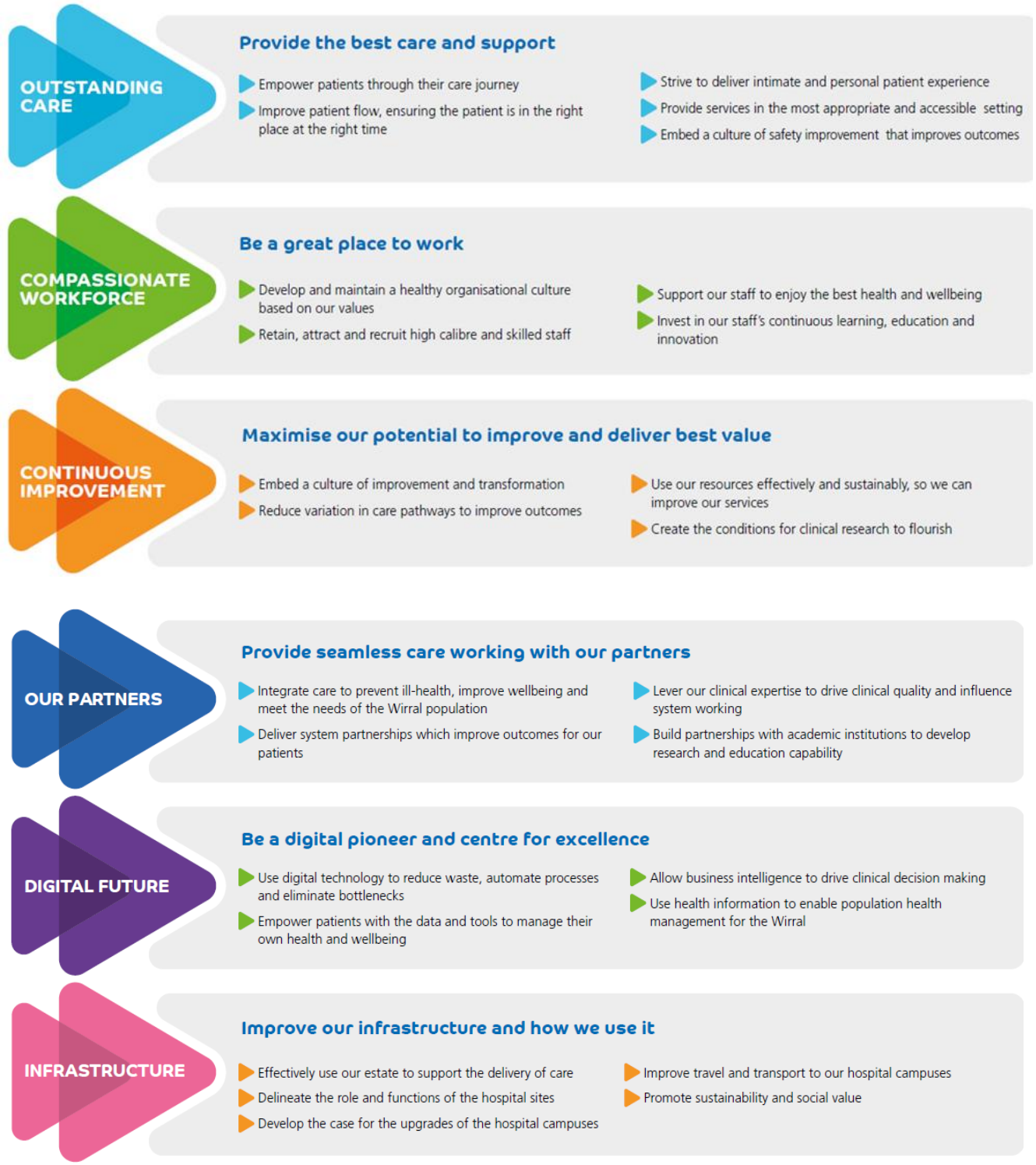
2.1 Our Vision

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:

- Approve 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	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 • **Management of head and neck wait list**	• 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				
Review Date	Q3 2025/26	Initial Score	Last Quarter	Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • Trust safety huddle. • Patient safety Learning Partners. • R and I Strategy. • **PSQB divisional reporting.**	• Executive Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance. • GIRFT. • AXA accreditation. • National SNAPP Audits. • Nursing and Maternity Champions. • Monthly Maternity report. • CEO Complaints sign-off. • Digital – Incident dashboard. • Programme Board. • **ACCA Accreditation.** • **NCIP Data.**

Gaps in Control or Assurance
• **Fully complete and embedded patient safety and quality strategies.** • **Current operational impacts and organisational pressure.** • **Capital availability for medical equipment.** • **Medical workforce gaps.** • **Impact of unscheduled care demand.** • **Significant financial controls in place.** • **Update required to WISE accreditation programme.** • **Lack of BI capacity impacting on patient outcome data** • **Delays in incident investigation** • **Inconsistent learning from complaints and incidents** • **Lack of effective patient safety surveillance system**

Action	Responsible	Deadline
Complete implementation, monitoring and delivery of the patient safety and quality strategies.	Chief Nurse	Q3, 25-26
Monitoring Mental Health key priorities	Chief Nurse	Q3, 25-26
Complete delivery of the Maternity Safety action plan	Chief Nurse	
Ongoing review of IPC arrangements – SIT Review.	Chief Nurse	
CQC preparedness programme and mock inspections.	Chief Nurse	Q2, 25-26
Delivery of Mental Health key priorities.	Chief Nurse	
Unscheduled Care Board action plan.		
Trust and C and M elective recovery programme.		
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	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.

• 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.		
Wellbeing Surgeries across sites		
OH Capacity and Demand Review		
Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing		
Talent mapping exercise for senior leaders		
Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months.		
The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.		

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

Strategic Priority	Compassionate Workforce				
Review Date	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

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

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

Strategic Priority	Continuous Improvement				
Review Date	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. • Finance Gold Command implemented. • **25/26 Planning process in place.**	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • FBPAC meeting more frequently. • **24/25 risk Mitigated from 21m to 3m.** • **Board briefed on 25/26 plan and drivers of the gap to control total.** • **PWC programme in final stages and completion of handover.** • **Board considered additional actions in relation to finance and associated risk.**

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

Action	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 (4x3)	12 (4 x 3)	12 (4 x 3)	8 (4x2)

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

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

Action	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 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.

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

Controls	Assurance
•	•

Gaps in Control or Assurance
•

Action	Responsible	Deadline

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 (4x4)	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**

03 September 2025

Title	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 detailed review through July and August 2025.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks
- Approves the proposal to change the risk appetite for ID06 from Cautious to Moderate, as recommended by the Finance & Performance Committee

Key Risks

This report relates to the following key risks:

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

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

Contribution to WCHC strategic objectives:	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
16/10/24	Board of Directors	BAF	The Board of Directors was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board and noted the current risk ratings and ID04 as the highest scoring risk.
11/12/24	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the recommendation from the Finance & Performance Committee that ID06 had achieved its target risk rating and would be kept under review for the remainder of the financial year.
19/02/25	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the MIAA Assurance Framework Report 2024/25.
19/03/25	Informal Board	BAF	The members of the Board supported an informal discussion to review current and emerging risks for 2025-26 and to inform the position presented to the committees and the Board in April and May 2025.
23/04/25	Board of Directors	BAF	The Board of Directors approved the recommendation for new risks for 2025-26.
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.

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 June 2025 an update was provided on each of the strategic risks for the start of the new financial year.
1.3	The summary table at **appendix 1** confirms the current position of strategic risks as reviewed by committees of the Board during July and August 2025. This includes a new risk (ID05) associated with cyber security and EPRR which is monitored via the Finance & Performance Committee.
1.4	A revised risk description for ID11 is being developed to reflect the Partnership Agreement established between both WCHC and WUTH and the risk of failing to develop a Joint Strategy and deliver the 2-year plan to realise the benefits of integration. This will be considered by the Integration Management Board in September 2025 and reported as appropriate to the Board of Directors.
1.5	The BAF now includes 8 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	Through each of the committees of the Board a review of the risk appetite for strategic risks also has been completed. This also included a review of equivalent strategic risks on the WUTH BAF recognising alignment and variance where appropriate. The Finance & Performance Committee supported an amendment to the risk appetite for 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* from Cautious to Moderate - *Tending always towards exposure to only modest levels of risk*, recognising the opportunity to deliver and transform services differently to effect efficiency gains and improved patient experience, which ensuring a robust EQIA/QIA process. The People & Culture Committee completed a review of workforce strategic risks in each Trust including risk appetite and target risk scores, which demonstrated a level of alignment and resulted in no current changes to WCHC strategic workforce risks.
1.7	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.
1.8	**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

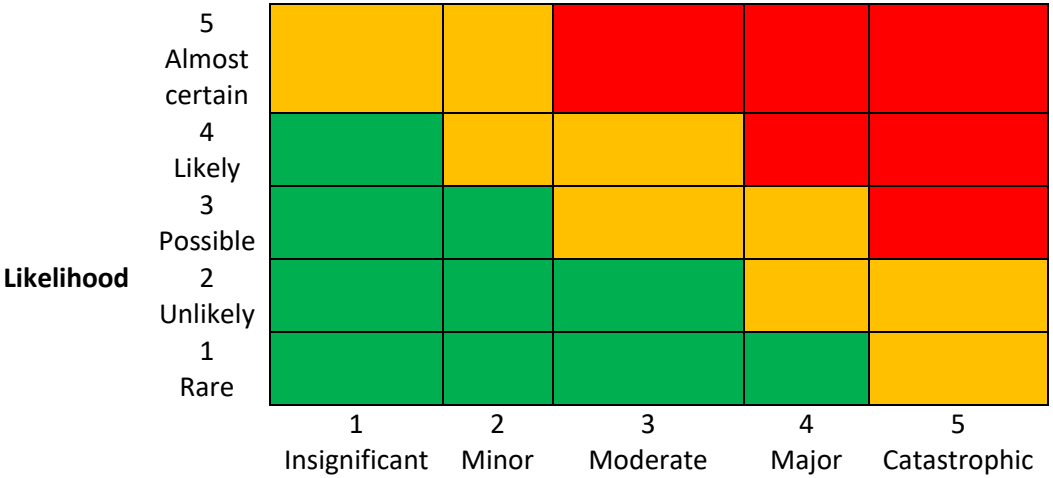
2	Implications
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF is 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) (August 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
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	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 Better employee experience to attract and retain talent	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) (August 2025)	Target risk rating (LxC)	Risk Appetite
ID08 - Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12) ⟷	1 x 4 (4)	Moderate
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee	Grow, develop and realise employee potential. Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8) ⟷	1 x 4 (4)	Open
~~ID11 - Failure to achieve the Trust's 5-year strategy due to the absence of effective partnership working resulting in damaged external relations, failure to deliver the financial plan 24-25 and the recommendations from the Wirral Review, with poorer outcomes for patients and a threat to service sustainability.~~	Board of Directors	Make most efficient use of resources and ensure value for money	New risk to be developed between WCHC and WUTH to have oversight via the Integration Management Board.			



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 Lead in post and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation reported to the committee
- PSIRF policies and procedures developed and implemented to promote sustainability.
- PSIRF stakeholder group established.
- Robust gantt chart aligned to the national PSIRF implementation timeframes, reporting to POG monthly by exception.
- High-level of compliance with patient safety training.
- 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) - CICC non-registered staffing and ID2830 (RR15 - 5 x 3) - resource to meet demand for EHCPs
Patient safety incident / emerging issue reported to private Board - 02.07.25</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></td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Actions to ensure safe care and support every time to prevent variation of standards across localities and teams.
Headline measures in-month (M02)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 1 fall (moderate & above harm) - QUAL17
- 91.7% FFT - QUAL22 YTD
- 3 complaints received (3 YTD) - QUAL08</td><td colspan="2">- 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</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</td><td>- 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</td></tr>
</table>

- 421 incidents reported - QUAL02 *(2.1% moderate and above harm - QUAL18)*
- 190 patient safety incidents (M9) - QUAL03
- Mandatory training compliance trust-wide achieved target - 95.2% (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.
- Enhanced PSIRF training delivered (over 425 staff trained exceeding target of 250) (Quality Goal 2)
- PSIRF champions identified and communicated on Staff Zone (Quality Goal 2)
	- QI programme to address waiting lists in specialist speech and language and ND assessments *(aligned to Ofsted/CQC Wirral SEND inspection report established) (Quality Goal 4)* - **Deputy Chief Nurse**	mitigated position agreed with committee
		~~- 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~~
			priority clinical risks - **March 2026**
			- 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**
			~~- PSIRF actions to further embed in the process and culture *(quality goal 2)* - **Q1, 2025-26**~~

- '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 RCA'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. - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme	- 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	

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

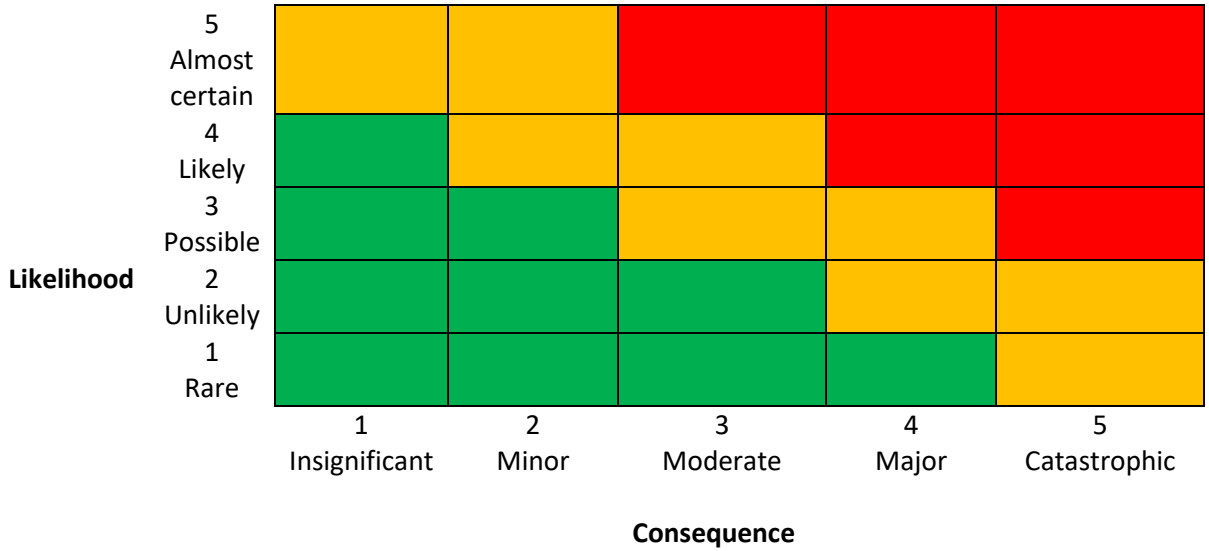
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">Actions to ensure collaboration and co-design with community partners.
- EDI training compliance - 96.8%
- Quality Strategy Delivery Plan including 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</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

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 oversight

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.*

Consequence;

- Financial sustainability impact
- Negative reputational impact for the Trust and system
- Enhanced financial control from ICB and NHSE

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Cautious**	2 x 4 (8)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)					

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• 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 • Full participation in C&M ICS reviews - ICS Director Turnaround, NHSE review	• 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	• 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**

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	• 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**		

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

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

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

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="6">Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board
CIP workstreams established with SRO Leads at Executive level</td><td>CIP delivery to support delivery of improved position - Interim Chief Finance Officer
Community Nursing Development Programme to</td><td>Delivery of the benefits of integration as described for each service
Staff experience and staff morale</td><td colspan="2">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 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">• 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 colspan="2">• Achievement of substantial compliance against the EPRR core standards self-assessment - Chief Operating Officer
• Alignment of EPRR functions with WUTH - Chief Operating Officer
• Implementation of recommendations from DSPT/CAF</td><td>• EPRR core standards self-assessment - substantial compliance</td><td>• EPRR core standards self-assessment - substantial compliance - March 2026
• Implementation of all recommendations from DSPT/CAF audit review - Q1, 26-27</td></tr>
</table>

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

Board Assurance Framework 2025-26

Strategic risks with oversight at People & Culture Committee

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

Corporate Governance

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

Workforce Governance

- 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>
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(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 $\leq$ 28.0% v's 2024 result 33.23% • Improve staff retention Year 4 target $\leq$12% v's 8.9% in 2024-25 • We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63% • Positive FFT results at 'very good' or 'good' Year 4 target 93% • 'Morale' sub-score in NSS Year 4 target $\geq$6.1 v's 2024 result 5.84% • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target $\geq$7.30 v's 2024 result 7.30 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target $\geq$7.20 v's 2024 result 7.28 • Targeted culture interventions *'We are safe and healthy'* Year 4 target $\geq$6.3 v's 2024 result 6.20	**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="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 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>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>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	

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item 15**
3 September 2025

Lead Governor Report

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

I have highlighted below some key areas of note in relation to the governor duties and activity.

Joint Non-Executive Directors

Haris Sultan

We are delighted that Haris has now joined the Trust Board as our first jointly appointed NED with Wirral University Teaching Hospital NHS Foundation Trust.

Haris brings valuable insight and experience to the role having previously worked with Leeds Community Healthcare NHS Trust, was appointed as the NExT Director for Citizens and Future Generations on West Yorkshire Integrated Care Board and has sat on NHS England's Children and Young People's Programme Board.

Alongside his professional contributions, Haris is also a medical student at the University of Liverpool and is undertaking an MBA at UCL's Global Business School for Health.

We warmly welcome Haris to WCHC and look forward to the energy, insight, and compassion he will bring.

Steve Igoe

We are pleased that Steve has now also been appointed as Non-Executive Director to the WCHC Board of Directors for the remainder of his current Term of Office. Steve has been in an interim role since April 2025.

Meredydd David, Chris Bentley and Lesley Davies

We welcome the appointment of both Meredydd and Chris also to the WUTH Board of Directors and most recently we welcome Lesley Davies, Non-Executive Director on the WUTH Board to the WCHC Board.

Lesley has worked in the education and training sector for the majority of her career and is an Executive Director for the Chartered Institution for Further Education (CIFE) and Honorary Vice President of the Council of British International Schools. Lesley is also a National Leader of Governance for the Department for Education, and Chair of Cheshire College South and West.

On behalf of the Council of Governors, we would like to extend our thanks to the Joint Chair and Joint CEO and members of the Executive Team who have supported us in considering these important appointments.

I would also like to extend my thanks to all governor colleagues who have been responsive to the requests and actively supported the process to make these appointments.

WCHC and WUTH Councils of Governor Development - 9 July 2025

We enjoyed a very interesting and engaging development session, together with governor colleagues from WUTH in early July 2025.

The session included updates on the statutory transaction to integrate both Trusts and the process to develop a Joint Strategy including both staff and stakeholder engagement. It was a very helpful update, appreciated by all with an opportunity for lots of debate and discussion.

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

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

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

Your Voice

The members of the Your Voice group came together on 15 July 2025 with a varied and engaging agenda. The members of the group received an update on the NHS Sexual Safety Chartered provided by a HR Business Partner. An update on the Rehab at Home service patient information leaflet was provided by the Team Leader and members were invited to feedback on the leaflet by 25 July 2025.

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

The Your Voice group will meet again on 17 September 2025 at 2.00pm.

Lynn Collins
Lead Governor (public governor, Wirral West)

15 August 2025

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
3 September 2025

Item 16

Report Title	Committee Chairs Reports – Quality Committee
Date of Meeting	4 August 2025
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It received an update on healthcare associated Clostridioides difficile infections at the Trust. It was noted that this is a national issue but the Wirral and the Trust have seen rates of infection at a higher level than most peers and above improvement trajectories. The Committee noted a second phase of improvement work had recently commenced which was planned to address issues & themes identified by executive-overseen reviews of all cases. The Committee asked for an update at its next meeting to clearly understand the progress being made with control measures, as framed by the Infection Prevention and Control Board Assurance Framework. The Committee interrogated the modified arrangements for decant of bays where a patient presented with C difficile, and were assured that arrangements were suitable and subject to ongoing oversight. ○ Following the announcement by the Secretary of State of an independent review of maternity and neonatal services, the Divisional Director of Nursing and Midwifery has undertaken a gap analysis and action plan for each of the Statements (action areas) identified. The Committee welcomed this paper and recognised that even though maternity and neonatal service have had positive external assessments, there are always opportunities to improve. The Committee discussed how the risks of midwifery, obstetric and Allied Health Professional staffing could be mitigated. This report will come directly to the Trust Board. ○ It received the Complaints Annual Report. Although there has been some significant progress in addressing backlogs in the handling of complaints, there are still delays in meeting our agreed response times in the majority of cases with further work required to address this. Excess waiting times, particularly in the emergency department, are leading to significant increase in complaints and informal concerns which include complaints about the communication of delays to those waiting. The redesign of the Emergency Department and improvement work in unscheduled care

	aim to address the root cause of the issue. In the emergency department, a waiting room nurse role has been introduced to improve communication and clinical oversight with regular intentional rounding in that area. ○ The Committee noted 2 never events in the Patient Safety Incident Response Chair's Report and were made aware of a further 2 events. The Committee asked how, given such a cluster has arisen, actions would address this. Firstly the new on-line Local Procedures guidance is to be implemented forthwith, and this will enable ongoing audit to ensure compliance. We will also make sure that safety huddles ensure that known control measures are considered. A communication plan is also being implemented with not only staff but also patients & families being involved in making their care safer. The Trust is also sharing the learning regionally.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee received a report on the action plan to address feedback received from the CQC following their unannounced inspection of Urgent and Emergency Care and Medicine Assessment in May 2025. An action plan has been developed containing 21 actions. Actions and timescales have been submitted to the CQC to evidence the Trust's responsiveness. Actions are either completed, in progress or have an agreed commencement date and hence are all on-track.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The four remaining complex actions outstanding from the 2019 CQC inspection have been addressed, including addressing the redevelopment of the neonatal unit. ○ The Learning from Deaths report provides ongoing assurance of the scrutiny of all deaths of patients at the Trust, relevant learning from independent clinical mortality review and medical examiner input. Standardised mortality rates remain within accepted limits. It is interesting to note that Wirral has one of the highest rates of its residents dying in hospital rather than other settings
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 really clear and helpful reports that enabled it to conduct its business.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 20**
3 September 2025

Report Title	Committee Chairs Reports – WCHC Quality and Safety Committee
Date of Meeting	9th July 2025
Author	Chris Bentley - Committee Chair

Alert	QSC wish to alert members of the Board that the committee:
	• **Chief Nurse reports on System meetings attended, by exception**:
	  ○ Local Area SEND Partnership Board. SEND inspection report response priority action plan now approved by Ofsted and CQC
	  ○ Regional update. Work ongoing at ICB level with Mandy Nagra leading on system recovery. Nursing agency and overtime controls significantly tightened, and bank pay rates standardised
	• **Policy adherence**. The Committee has referred an issue to People and Culture Committee. It concerns whether there is appropriate induction in relation to policy adherence when staff are working under the Workforce Sharing Agreement.
	• **Board Assurance Framework**. Assured by updates on mitigations to the 2 risks (ID01 andID02) with QSC oversight. Useful discussion in relation to future coming together with WUTH BAF risks. Example of NHS Outcomes Framework, where e.g. MRSA, C Diff and E Coli measures for acute trusts, not community. But one system pathway would be preferable to support people treated in different settings.

Advise	QSC wish to advise members of the Board that the committee: • **Policy review.** Several policy reviews have requested extensions recently, increasingly in anticipation of alignment with WUTH. Director of Corporate Affairs has been requested to review process through the Policy for Policy Management looking to some rationalisation and ways of reducing the review workload. • **Reporting of Strategic Transformational Programmes.** Having identified that some key strategic operational programmes have not been reporting progress through Committees of the Board for governance purposes, a number of these are now being tabled to report through QSC. The first of these on Integrated Frailty Teams was presented with an introductory overview for information. Subsequently, periodic updates will be brought to Committee, which will report appropriately to the Board. The presentation described the development of teams across the Wirral. It incorporates Population Health Management elements and is consistent with integrated neighbourhood team development and is sensitive to addressing health inequalities. Some good outcomes are emerging from early adopter PCNs and their populations.
Assure	QSC wish to assure members of the Board that it signed off: • **Quality Strategy Delivery Plan 2025/26.** 6 Quality Goals agreed, and delivery plan outlined and under development. Now extended to Q3 and Q4. Some reworking requested in relation to Quality

	Improvement and research. Advised that good work on joint scoping underway with WUTH. RM confirmed that a Research Manager post will work across the Trusts. Confirmed that other activity continues from the Quality and the Inclusion Strategies and will be reported next time. • **Quality and Patient Experience Report.** Reported through TIG by exception. Assured by delivery of safe, effective quality of services. • **Infection, Prevention and Control Annual Report 2024/25.** Noted significant achievements to assure trust standards in relation to IPC practice and associated regulatory compliance. Helen Wilcox, Head of IPC was congratulated on the excellent performance, and Deputy Chief Nurse thanked for her ongoing support. Approved for onward reporting to Board • **PSIRF Assurance Report Q4.** Assured by progress embedding PSIRF throughout the organisation, with robust monitoring mechanisms and evidence of impact and outcomes. • **Safeguarding Annual Report 2024/25.** After detailed discussion of this complex report, it was approved for onward reporting to the Board for approval. It will be accompanied by the refreshed Strategic Plan for 2025/25 for Board information. Thanks to the Head of Safeguarding for her excellent leadership across the geographies. • **Complaints Annual Report 2024/25.** Assured by the content and detail and emphasis on dissemination of lessons learned. Approved for onward reporting to Board. • **Medicines Optimisation Annual Report 2024/25.** Committee members commended the very thorough report, and the effective actions detailed and were assured by the content. • **Audit reviews.** Nil outstanding • **Standard Operational Procedures (SOP).** Assured by the process to maintain these up to date. Approved 5 extensions to review date.
Review of Risks	High-level operational risks which had been discussed at the (operational) IPB were brought to QSC for information and discussion in accordance with the Risk Policy: • Risk ID 3125. (L4XC4). Teams now working on a robust QI transformation plan to mitigate risks across the whole ND diagnostic pathway. With £180k non-recurrently from WUTH, a joint risk assessment is being developed. • Risk ID 2830. (L5XC3) Commission resource unable to meet demand. Risk now mitigated by a successful business case resulting in £750k recurrent and £330k non-recurrent funding from Schools Forum. • Risk ID 3147 (L5XC3). SAFE system problem mitigated; risk reduced to RR9 • Risk ID 3137 (L4XC4) Call bell system on Bluebell ward of CICC. Still outstanding. Chief Nurse reviewing consistency of application of clinical mitigations. Exploring use of portable system as used at WUTH. • Risk ID 3201 (L4XC4). Concerns about persistent low levels of non-registered staffing resource at CICC. Suggested rolling

	recruitment process for this cohort of staff. Oversight and review now referred to PCC.
Other comments from the Chair	No further comments.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 21**
3 September 2025

Report Title	Committee Chairs Report – Finance and Performance Committee
Date of Meeting	7th August 2025
Author	Steve Igoe – Committee Chair

Alert	• The Committee wish to alert members of the Board of Directors that: ○ Failure to deliver CIP continues to be a high risk to delivery of the financial plan for 2025/26.Mitigations are in place and may be required if the Trust is to support the Acute Trust in relation to the £3.5m savings mitigation transacted last year. ○ The Committee discussed the BAF risks in detail. It noted that there was now a risk related to Cyber issues and EPRR. It noted that despite extensive mitigations should the Trust be subject to any such attack it is likely that there would be an impact on the quality of patient care. A review by MIAA of Cyber readiness and DSPT compliance confirmed the same and made a number of recommendations to mitigate the risk which the Trust is working to deliver. These recommendations and their resolution will be monitored closely by Audit Committee. ○ A number of operational risks were reported to the Committee, specifically: ▪ Challenges with the pre diagnostic element of the ND pathway. Funding for this is proving difficult and WUTH/WCHC senior colleagues are revieing mitigations to manage capacity and delivery ▪ Staffing levels in the maintenance team are challenging although WUTH colleagues are supporting in the current position. ▪ Management of Health and Safety remains a challenge due to staffing issues however short-term support has been identified and it is likely this risk will be downgraded in the next Risk iteration.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ A recent MIAA report identified the system regarding the management of contracts as adequate. Whilst some of these issues were historic, nonetheless a number of recommendations were made in the report, and the Trust remains committed to addressing these as a matter of urgency. The response to these issues will be monitored through Audit Committee and it is expected that they will have been addressed by the time the Committee next meets.
Assure	• The Committee wish to assure members of the Board of Directors that:

	○ At the end of M3 the Trust is reporting a favourable variance to plan of £3k v's a deficit of £489k. It was intending to continue to report a year end position of £900k in line with plan. ○ Revised CIP to M3 was £1.2m exactly on plan and on a fully recurrent basis. ○ Early indications for M4 was a financial outcome with a surplus of £400k . ○ Total CIP for the year, including the ICB stretch target, was £6.6m with £5m transacted to date. ○ Operationally in terms of KPI's , 79 were green , 3 amber and 9 red. Of those red KPI's Trust staff were monitoring them closely and were possible developing mitigations to address issues. ○ The Committee received a positive Information Governance Annual Report for 2024/25.
Review of Risks	N/A
Other comments from the Chair	• All covered in the above.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 22**
3 September 2025

Report Title	Committee Chairs Report – WCHC People & Culture Committee
Date of Meeting	13 September 2025
Author	Meredydd David Chair

Alert	• The PPC wish to alert members of the Board to: ○ Sickness absence rates at 6.7% during this period are still too high, mainly in long term sickness and absence linked to stress with this accounting for 43% of absences. ○ Appraisal compliance is lower than expected at just over 40% and the appraisal window has been extended to the end of September. ○ Nationally in dispute with BMA regarding Resident Doctors. Tense industrial relations Nationally and with Unions although good relationships at the Trust. ○ Nursing and Midwifery job matching profiles updated Nationally and published beginning of June. This adds to risk levels due to capacity to undertake reviews; financial implications; possible industrial action; impact on staff motivation. ○ Noted a need to reduce use of Agency staff at CICC although recognised control of Agency across the Trust is good.
Advise	• The PPC wish to advise members of the Board that: ○ Staff turnover rates are relatively stable at 9.4% which was anticipated due to the workforce plan and also training compliance remains good. ○ There is now a new joint Learning and Organisational Development Manager in role shared across the two Trusts. ○ The 2025/26 People Strategy progress report which has been aligned with WUTH's where possible was received and good progress was recognised. Impact measures and KPI's have been included and embedded. Recognised progress made in a number of areas although not always recorded on the plan. Progress on delivering three actions was deferred for a period. ○ Workforce sharing agreement working well with 36 employees engaged with this approach. ○ One policy HRP3 relating to management of redundancies had an extension request for 3 months approved. It was confirmed it is still current and compliant. ○ Agreed to review the level of detail and duplication in PCC Safe Staffing Report submitted to P&CC and QSC with the responsibility transferred from Carla Burns to Paula Simpson and Claire Wedge. The Safe Staffing report will be reviewed in detail at PPC for this period
Assure	• The PPC wish to assure members that:

	○ Mandatory, essential and role related training all compliant against targets and remain strong. Management supervision is at 79% and reminders have been circulated as necessary. ○ Comprehensive Trust wide and local engagement plans are in place with training and materials provided to managers and teams in response to surveys and in preparation for the next NHS Staff survey. ○ Workforce Disability Equality Standard report and action plan was received and approved for publication. It was disappointing to see staff with a disability experienced great discrimination and bullying from members of the public and colleagues. This is sadly in line with National findings but not acceptable. ○ Workforce Race Equality Standard report and action plan was received and approved for publication. Both of the above plans contain significant data sets and the WRES data set also shows our colleagues from diverse ethic backgrounds experience greater discrimination from members of the public and colleagues.
Review of Risks	• Two high-level risks were escalated to the committee (ID3214 - UTC/WIC sickness absence rates and ID3201 - CICC non-registered staffing resources); both remain under review • The risk health score at the middle of July had decreased to 96%. Due to the slight decrease, there would be a focus on targeting corporate areas during this period. • All strategic risks in the BAF have been reviewed with current mitigation, identified gaps, outcomes and trajectories to mitigate. • There are no proposed changes to risk ratings though it is recognised that support and communication with the workforce is vital as the Trust continues to integrate with WUTH to ensure staff feel looked after and have a good experience. It is noted that this has also been recognised by the Integration Management Board
Other comments from the Chair	• With the merger and integration work coupled with the challenges associated with National industrial action and the Nursing and Midwifery Job matching profiles now released, the People team are fully stretched, and the workload is intense which can add to risk levels.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 23**

03 September 2025

Title	Estates Compliance and Sustainability Annual Report
Area Lead	Hayley Kendall, Chief Operating Officer
Author	Matthew Williams, Head of Sustainability, Energy and Compliance
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide assurance to the Estates and Capital Committee by the Estates, Facilities and Capital (EF&C) division on Estates, Facilities and Sustainability service provision performance metrics, aligned to the strategic objectives of the Trust.

Key updates within this report are performance by exception, highlighting key risks and issues arising, and identifying actions and next steps for the following areas:

- Estates and Facilities High Level Compliance
- Sustainability Report and Task Force on Climate Related Financial Disclosures (TCFD)

It is recommended that the Board:

- Note the report
- Approve the PAM Self-Assessment scoring for submission to NHS England (see Appendix 1)

Key Risks

This report relates to these key risks:

- Adherence to Statutory Legislation and Mandatory NHS Guidance related to Estates and Facilities Compliance (Acts, Regulations, and Best Practice/Mandatory Guidance)
- Adherence to requirements Health and Care Act relating to Green Plan and Greener NHS 'Delivering a Net Zero NHS Report'
- Compliance with Task Force on Climate Related Financial Disclosure (TCFD) Reporting

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**
7th August 2025	Estates and Capital Committee	Estates and Facilities Annual Report	Review and approve for onward submission to Board of Directors

1	Annual Estates Compliance and Sustainability Report
1.1	**Introduction** At Wirral University Teaching Hospitals NHS Foundation Trust (WUTH), we recognise our responsibility as a healthcare organisation to comply with statutory obligations relating to Estates and Facilities. We also recognise our commitment to reduce our environmental impact and support the NHS's ambition to become the world's first net-zero national health service. This report provides an update on the Trust's Estates and Facilities Compliance and Green Plan strategy, detailing ongoing progress towards our targets and highlighting key accomplishments achieved over the past year. It also serves as a marker for the planned refresh of the WUTH Green Plan 2025 - 2028. Included in this report is information pertaining to the Trust's compliance with the Task Force on Climate-related Financial Disclosure (TCFD), providing a high-level overview of the organisation's governance around climate change.

2	Estates and Facilities Compliance
2.1	**Introduction** Estates, Facilities, and Capital (EF&C) hold frequent operational, tactical, and strategic meetings pertaining to Statutory Compliance and Performance. EF&C completed a formal review of safety group meetings to ensure appropriate items are covered from Statutory Legislation and Health Technical Memoranda (HTM), ensuring prompt multi-divisional oversight of critical infrastructure and risk management, with formal attendance, cycle of business, and chair's reporting. EF&C also hold a monthly 'Division Compliance Board' meeting (DCB) which will be responsible for providing assurance in relation to the Statutory elements and HTMs to the Trust Health and Safety Management Committee (reporting into the Executive Assurance and Risk Committee) on a quarterly basis, and Infection Prevention and Control Group (reporting into the Patient Safety and Quality Board) on a monthly basis. Estates have made measurable progress to improve statutory and HTM compliance by increasing the range of in-date periodic inspections across statutory maintained assets.

	There have been vast improvements with the involvement of Authorised Engineers, audit management, but improvements should be made to the logging of and completion of findings from Authorised Engineer audits, which will support further improvements in compliance to legislation and HTM guidance.
2.2	**Adherence to Legislation and Guidance** HTM's are a suite of best practice guidance documents published by the department of health specifically for healthcare engineering. Their primary purpose is to provide Estates and Facilities teams with comprehensive advice and guidance for the management, design and procurement of business-critical engineering components within a healthcare facility to ensure optimum safety, reliability and resilience. There are eight specialist subject areas, as detailed below. There are many benefits for following this guidance, this includes most importantly ensuring critical engineering components within our portfolio of buildings are safe and fit for purpose. That they are being maintained and appropriately managed to maximise efficiency and to sustain asset life. Lastly, that we are adhering to a structured set of published guidance principles, which subsequently helps to ensure compliance with standards and further associated legislation. Furthermore, by ensuring this guidance is adhered to as far as reasonably practicable and by embedding systems to monitor, track and escalate any associated non-conformities, this provides the Trust with the necessary confidence that effective HTM management is in place. **HTM-01 Decontamination Services** There are Authorised Persons (AP's) appointed across the two sites carrying out decontamination and there is a Trust-wide Decontamination Group which meets routinely, led by colleagues within Infection Prevention and Control (IPC). Competent Persons (CP's) for decontamination services undergo training, however there are recognised gaps in the skill set of some individuals, and this will need to be reviewed and a decision made to link with equipment manufacturers where such services cannot be serviced and maintained in the correct manner (resource issues). Decontamination equipment is at various stages of life across sites, but a rolling programme is in place and equipment changed when at end of life or when there are continuing service problems. **HTM-02 Medical Gas Pipeline Services** WUTH has a very well-established Medical Gas Committee, chaired by the Director of Pharmacy. The group meets monthly to discuss a wide range of medical gas compliance issues and topics covering policy development, site-based risks, Authorising Engineer (AE) audits, recommendations and capital improvements linked to Medical Gas infrastructure. The recent AE Audit was categorised as both reasonably and limited assurance for compliance and resilience. The AE issued the Trust with recommendations, all of which are being carefully managed and will be tracked by the compliance team to ensure they are all addressed in a timely manner. The group also addresses critical issues related to medical gas cylinders, in particular oxygen risks, medical gas alerts, cylinder management, appropriate use of medical gases and staff training. The expected outcomes of this group are to ensure patient safety through the implementation of standardised procedures and protocols for the management of medical gas cylinders. Reduce incidents related to medical gases, and

finally, improve efficiency in medical gas cylinder utilisation and inventory management, leading to cost savings and resource optimisation.

HTM-03 Ventilation Services

WUTH has a well-established Ventilation Safety Group (VSG), chaired by the Senior Capital Projects Manager, SME for Ventilation, and meetings are taking place monthly and are well attended by the multi-disciplinary team of staff across the whole of WUTH. The most recent AE audit was issued with a reasonable level of assurance for ventilation compliance. The AE clearly stated that significant improvements have been made within the previous review period, which should be noted. The AE has identified further individual recommendations to enhance our compliance on this discipline. All of which are being carefully managed and will be tracked by the compliance team to ensure they are all addressed in a timely manner.

A chairs report is written outlining the discussion and escalation points as per the triple-A format: Alert, Advise, Assure. Escalations are then discussed at Infection Prevention and Control Group, and Health and Safety Management Committee for onward escalation.

HTM-04 Water Safety

Similar to Ventilation Safety, WUTH has a very well-established Water Safety Group (WSG) meeting monthly, which is chaired by the Associate Director of Estates and Capital Planning, and is attended by Estates and Facilities, IPC, consultant microbiologists and external Water Safety contractors. The most recent AE Audit undertaken in Autumn 2024 indicated that WUTH are currently achieving a reasonable level of assurance for water safety compliance across the organisation. The AE has acknowledged that many HTM aspects are in place, such as a well-represented WSG, policy documentation and key staff appointments (Responsible Persons Water and Deputy Responsible Persons Water).

HTM-05 Fire Safety

WUTH has established systems in place to manage fire safety across the organisation, however there are still improvements to be made in key areas, such as passive Fire compartmentation. WUTH has recently appointed a replacement fire safety advisor from Q1 25/26.

Attendance and engagement from multiple internal and external stakeholders at the monthly Fire Safety Group (FSG) has improved throughout 2024/25. The agenda focuses on compliance, planned maintenance, training and risk and as a result, several risks have been entered onto the Trust's risk register relating to non-conformity with HTM 05-01 Fire Code and British Standards, regarding breaches to compartmentation incl. Fire Dampers, and Fire detection systems.

HTM-06 Electrical Safety (High and Low Voltage Systems)

WUTH has recently established an Electrical Safety Group (ESG) which is chaired by the site's Maintenance Manager. The group meets monthly and consists of a multi-disciplinary membership to discuss both Low Voltage (LV) and High Voltage (HV) systems, Maintenance and Risks. The most recent AE Audit LV report received in February 2024 has indicated that, 'Whilst there were some omissions and areas of

concern noted within this report the general condition of the High and Low Voltage substations inspected were found to be very good'. The concerns and risks are being addressed by the Estates teams through an action plan, and the corresponding AE Audits are due to take place within Q1 and Q2 of 2025/26.

HTM-07 Environmental and Sustainability

HTM-07 predominately focuses on safe and sustainable management of healthcare waste. To support our compliance against this HTM, the Trust have appointed a dedicated Waste Manager and enabled a Waste Management Safety Group (WMSG) which meets monthly and is chaired by the Head of Soft FM. Whilst this HTM does not specify the requirement of an AE, the Trust did instruct the completion of an external audit by a competent auditor and developed an action plan from the resulting audit. Recommendations contained in this audit are centrally held and tracked by the Trust's dedicated Waste Manager.

Other Environmental topics, as outlined in HTM-07 are discussed at Trust's internal Sustainability Board, including Net Zero compliance, and the Green Plan strategy.

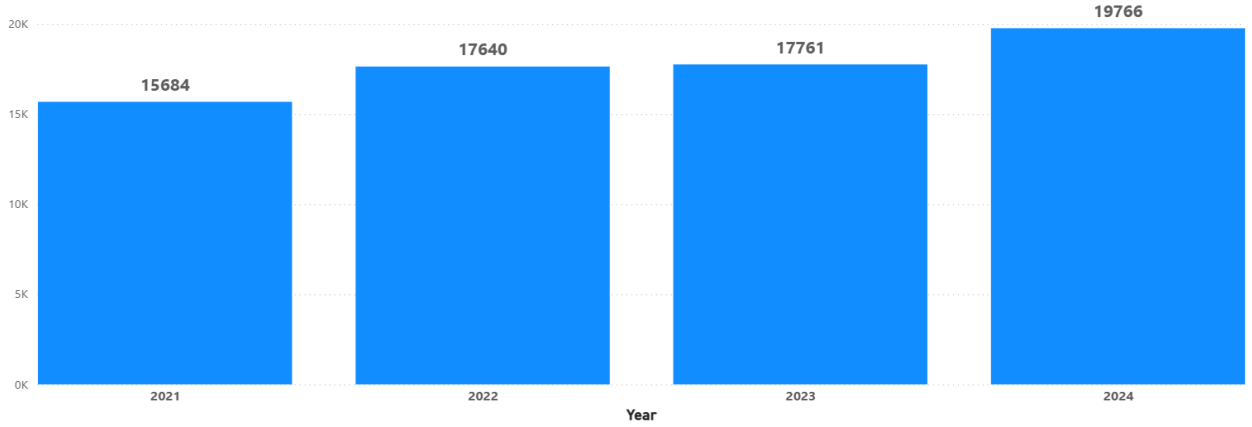
HTM-08 Specialist Services

HTM-08 documentation covers specialist areas of health care, such as Acoustics (08-01), Lifts (02), Bedhead Services (03) and Pathology Laboratory Gas Systems (06). At present WUTH does not have a specific HTM governance group established to cover all aspects of this HTM in totality so that we can formally measure our level of compliance. The Trust does however include Lifts (08-02) within the HTM-06 Electrical Safety Group.

Reactive Maintenance

Reactive Maintenance remains at 100% attend and fix SLA for Priority 1 work orders. Performance fix SLA has fluctuated across 2024/2025 for Priority 2, Priority 3, and Priority 4 work orders however all three priorities are currently below their target of 95%, 90%, and 85%, fix/complete respectively.

Estates have seen a high demand for reactive work order requests year on year to support Trust service delivery, patient care, and building safety. Estates reactive work orders have increased by 26.5% between 2021/22 and 2024/25, from 15,684 per annum to 19,766. Factors contributing to this increase are requests for resource to support the phases of UECUP and Estates support of other capital projects, the ageing Trust estate and backlog maintenance, and improvements in reporting through the Helpdesk.



Volume of reactive work orders year-on-year

	Delays relating to the internal approval and processing of purchase orders and supply chain relating to critical parts and spares, owing to enhanced controls implemented by the Trust, have also impacted completion rates. The enhanced financial controls are also impacting overtime provision, which is presenting delays to jobs where out of hours access is required, such as theatre, however, alternatives solutions are being explored. Estates will continue to monitor all spend and action only essential repairs and maintain all critical assets as per legislative and compliance requirements.
2.3	**Summary** WUTH has a full maintenance programme in place across both Hospital sites with contractors Concept Lifts and Allied Lifts, statutory inspections are completed by Allianz plc. and the Trust have a formally appointed AE with Cundall. As part of the contractors' commitments, The Trust has developed a life cycle condition report across all of our lifts. This information supports securing necessary funding to ensure our lifts are being maintained in the most appropriate way based on risk and resilience. Some of the actions listed by the AE's require significant investment and therefore they are being appropriately risk assessed for capital prioritisation. Estates and Facilities have implemented a High-Level Tracker to provide a summary on how HTM audit actions are progressing. In addition to the High-Level Tracker, a detailed AE individual audit tracker has also been developed. The purpose of this system is to directly extract the recommendations received from each of the AE reports into a tracker spreadsheet system. Each recommendation is provided with a risk score. This exercise is conducted with the direct support from the appointed AP for that HTM. The recommendations are also all given an anticipated timeline for completing, which are regularly tracked and monitored by the compliance team and the risk/recommendation owner. The information is also presented in the form of a dashboard where we can clearly see what audits have been received, the dates of the audits, the levels of assurance obtained, and the appointment of AEs, Aps, and CPs. Estates and Facilities are confident that our compliance arrangements are steadily improving, and we can now use these systems to measure our progress. However, we appreciate that change does take time to translate into tangible results, especially when we have to consider an ever-ageing estate and infrastructure, along with capital availability. Furthermore, it is becoming more challenging environment with financial pressures. The EF&C Division continue to work towards strategies to maintain run rate whilst delivering efficiency targets, but more importantly delivering a safe environment for staff and patients. This will significantly help deliver a more improved Statutory and HTM compliance standard across all sites in the very near future once embedded fully.

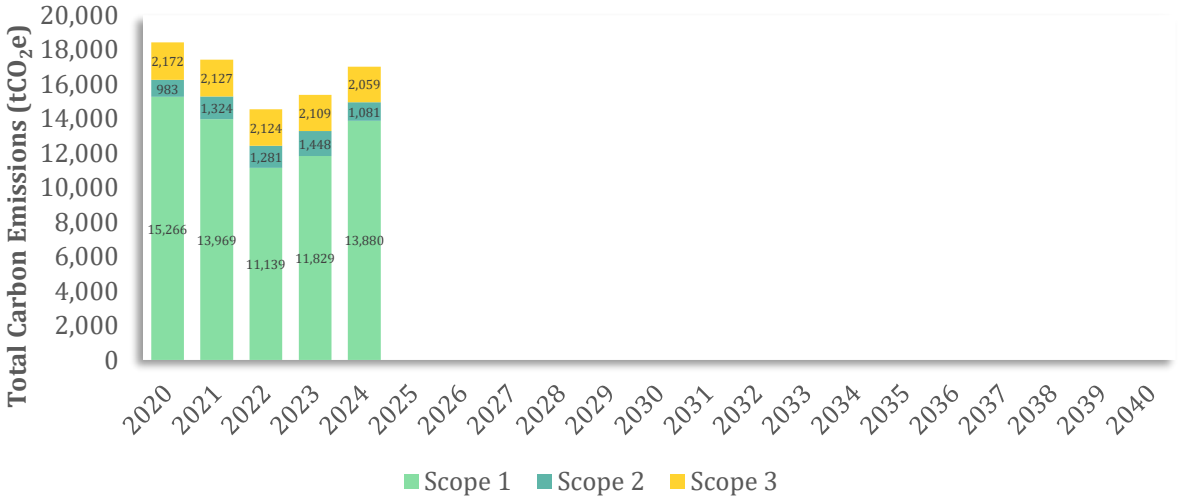
3	Sustainability Reporting
3.1	**Introduction** Recognising the essential role the NHS plays in achieving the net-zero targets established under the Climate Change Act [2008] (2050 Target Amendment) Order 2019, the NHS has set two clear targets outlined in the Delivering a 'Net Zero' National Health Service ([published October 2020, Updated July 2022]): to achieve net zero by 2040 for the NHS Carbon Footprint and net zero by 2045 for the NHS Carbon Footprint Plus. The Trust has adopted these targets and aligned the Green Plan to these net-zero ambitions. **Green Plan** The Green Plan serves as the central document for WUTH's sustainability agenda and strategy, detailing the Trusts vision for sustainable development and establishing actions and targets across various focus areas. The Plan aims to integrate sustainability, low-carbon practices, and promote social value throughout the Trust. The Green Plan has been refreshed to detail the strategy for the next 3-years, from 2025 to 2028, and will be published following Board approval. The structure follows the NHS Guidance (Green Plan Guidance [2025], and How to produce a Green Plan: A three-year strategy towards net zero [2021]) and will continue to be reviewed annually and updated where necessary to ensure continuous improvement and progress toward our net-zero target. The refreshed Green Plan outlines nine Areas of Focus which are aligned to the Delivering a Net Zero NHS guidance: • Workforce and Leadership • Net Zero Clinical Transformation (previously Sustainable Models of Care) • Digital Transformation • Medicines • Travel and Transport • Estates and Facilities • Supply Chain and Procurement • Food and Nutrition • Climate Adaptation **Progress** The Green Plan is supported by the Green Plan Action Tracker, a comprehensive list of actions aligned to each area of focus. Since the launch of the Green Plan in 2021/22, significant progress has been made across the identified actions. Notable achievements include appointing an Executive Net Zero Lead, working with anaesthetists and pharmacists to completely phase out the use of desflurane, and installing Automatic Meter Readers on the water network to monitor usage and aid leak detection. Delivery of the Green Plan will continue to be co-ordinated by the Sustainability Team and will be overseen by the Executive Net Zero Lead. The Green Plan aligns to the current Trust strategies and will inform and be embedded into the new strategies which are being developed for 2026–2031. To monitor progress of the actions, Green Plan delivery groups have been established to bring together stakeholders aligned to workstreams tackling actions across the breadth of the Areas of Focus. The Green Plan Delivery Groups are as follows: • Digital Healthcare • Medicines

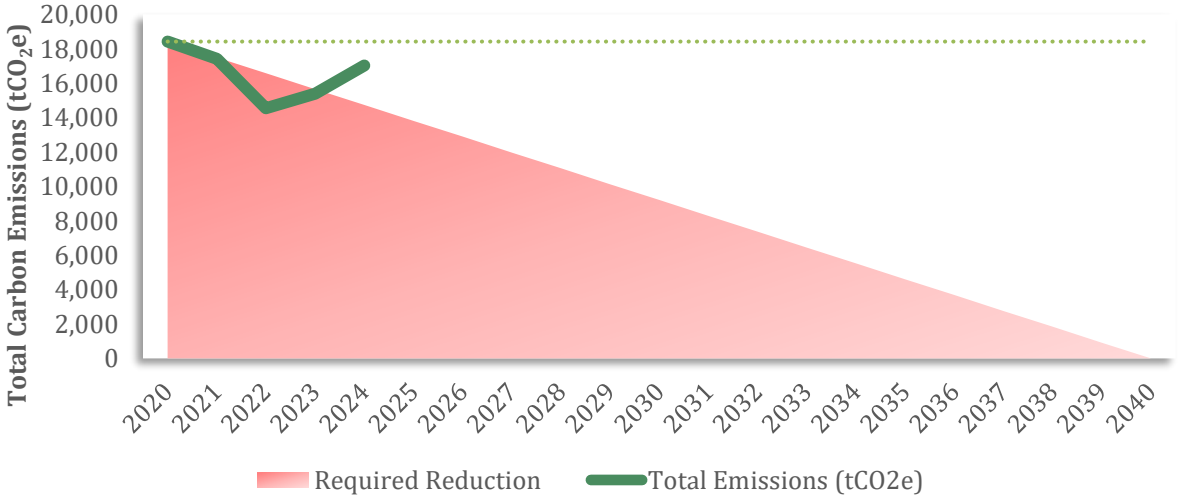
	• Travel and Transport • Estates and Capital Projects • Waste • Supply Chain and Procurement • Catering The delivery groups are chaired by the Trust's Sustainability Team, who report progress to the Estates and Capital Committee.
3.2	**Annual Governance Statement** The Trust has undertaken risk assessments and has plans in place which take account of the Delivering a Net Zero Health Service [2020] report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with. The Sustainability Team continues to progress the Green Plan through Green Plan delivery groups and Green Champions Network and has delivered against the Estates Energy Plan (2023-2026), which aligns to our Estates Strategy, through the installation of LED lighting across both sites following successful National Energy Efficiency and renewable energy Funding (NEEF) award. The Trust has also been successful in securing grant funding to install solar photovoltaic (solar PV) panels across the site, in a bid to increase on-site renewable generation, reduce electrical consumption from Grid supply, and re-invest energy costs into frontline patient services. The Sustainability Team have also focused on Food Waste and Theatre Waste Segregation pilots, Medical Gas Nitrous Oxide reduction, Greenspace and Biodiversity (installation of Trees provided by NHS Forest), and external engagement with Cheshire and Merseyside Sustainability Board, Cool Wirral Partnership, and Liverpool City Region (LCR) Combined Authority. The Trust is continuing to move its position to Net Zero, in line with NHS England's Delivering a Net Zero NHS (October 2020). Carbon emissions have reduced since the publication of the Green Plan in 2022, following a substantial reduction in emissions from anaesthetic gases and improve energy efficiency initiatives which has seen a reduction in our energy consumption despite increasing the Trust sites' footprint with Modular Theatres and UECUP. **How do we plan to get to carbon net-zero?** The Trust is committed to advancing the sustainability agenda across the organisation, implementing goals and objectives outlined in previous strategies as well as those specified in the Green Plan. Progress against the targets is regularly monitored and reported, encouraging continuous improvement in sustainability practices. The Trust actively engages with stakeholders both internally and externally, to align efforts and share best practices. As a healthcare facility providing critical services 24 hours a day, our energy and resource consumption significantly contribute to our carbon footprint emissions. Our estate consists of a mixture of buildings varying in type, age, and usage, presenting challenges in implementing resource efficiency measures and heating improvements.

	We will be following the four-step approach within the NHS 'Estates 'Net Zero' Carbon Delivery Plan' to address our estate by: 1. **Making every kWh count**: Investing in energy saving measures via implementing technologies and practices that provide immediate and long-term benefits, are cost-effective and reduce energy consumption. Some of the key technologies that maximise energy efficiency include modern Building Monitoring Systems (BMS), advanced metering and improved insulation. 2. **Preparing buildings for electricity-led heating**: Ensuring that our estate is energy-efficient and capable of supporting electric heating systems. A crucial step in this transition is upgrading the building fabric (walls, roofs, windows, and floors) to minimise heat loss, reduce energy demand and enhance the efficiency of electric heating systems. This should be outlined within a mandated Heat Decarbonisation Plan, which sets out the strategy on transitioning to electricity-led heating systems and reduced reliance on fossil fuels. 3. **Switching to non-fossil fuel heating**: Investing in innovative new energy sources and replacing fossil fuel reliant heating systems with low carbon alternatives such as heat pumps. 4. **Increasing on-site renewables**: Investing in on-site generation and upgrading end of life equipment with renewable energy systems, such as solar panels, wind energy and geothermal. To achieve our carbon emissions reduction objectives and meet the contractual requirement for Net Zero operations, the Trust must seize all possible emission reduction opportunities. After maximising emission reductions, we will depend on innovation and the ongoing development and availability of new technologies to reduce the remaining emissions. All initiatives require capital investment to implement, but they represent an invest-to-save strategy by minimising reliance on grid electricity, safeguarding against external power disruptions, and protecting against future energy price fluctuations.
3.3	**Carbon Emissions and Reporting** To assess and manage climate risks and opportunities, the Trust reports on carbon emissions and footprints annually according to the Green Plan. We have set specific metrics and targets to manage the risk and opportunities related to the climate change. Below is a summary of our past four years' performance metrics for carbon dioxide emissions based on our 2020/21 baseline data. These greenhouse Gas emissions fall into three main categories: Scope 1, Scope 2, and Scope 3. 1. Scope 1 covers direct emissions from owned or directly controlled sources on our sites 2. Scope 2 includes indirect emissions from the mains electricity we purchase 3. Scope 3 includes all other indirect emissions that occur in producing and transporting goods and services, including the full supply chain. The Trust considers all the areas we control and where we can influence energy procurement.

	Tonnes CO2 emitted (tCO2e)			
	Scope 1	**Scope 2**	**Scope 3**	**Total**
2020/21 (Baseline)	15,266	983	2,172	18,420
2021/22 (2021)	13,969	1,324	2,127	17,420
2022/23 (2022)	11,139	1,281	2,124	14,544
2023/24 (2023)	11,829	1,448	2,109	15,385
2024/25 (2024)	13,880	1,081	2,059	17,020

	% Change Y-o-Y	% Change v Baseline
2020/21 (Baseline)	-	-
2021/22 (2021)	**5.4%**	**5.4%**
2022/23 (2022)	**16.5%**	**21.0%**
2023/24 (2023)	**-5.8%**	**16.5%**
2024/25 (2024)	**-10.6%**	**7.6%**





The chart above highlights the total carbon emissions in tonnes of Carbon Dioxide, emitted by the Trust for scope 1, 2, and 3 categories since the 2020 baseline. The trajectory of emissions is in-line with NHS targets for scope 1 and 2, but there was a slight deviation in 2023/24 and 2024/25 due to an increased consumption of natural gas across both Hospital site, which supports our Electrical demand. Scope 1 emissions have increased, but scope 2 and scope 3 emissions have decreased.

	CO2 emissions increased over the past two years as a result of increased reliability of the Combined Heat and Power engine (CHP), which provides the majority of electricity and heat across both Hospital sites. Approximately 65% of the electricity consumed was generated by the CHP, and 35% supplied by the grid. The CHP converts natural gas into electricity and heat through combustion, that is consumed within both hospitals. This process is a more cost-effective way of supporting our Trust's electrical demand compared with grid electricity supply, because the unit cost of natural gas is significantly less than the unit cost of electricity (natural gas is approximately five times cheaper per unit than grid electricity). However, the combustion of natural gas by the CHP emits carbon dioxide, along with other Greenhouse gases (GHG), which contributes towards the Trust's Scope 1 emissions, hence why Scope 1 emissions have increased within 2024/25. WUTH, along with many other NHS organisations entered into a long-term contract (15 years), supported by the Carbon Energy Fund (CEF), to consume electricity generated by the CHP, which started in February 2015. There are contractual targets that the Trust has to adhere to in relation to electrical generation by the CHP, otherwise there are financial penalties payable by the Trust. The contract was agreed prior to the Delivering a Net Zero NHS Report (2020) and Health and Care Act (2022) requirements regarding carbon emissions and 2040 targets. However, The Trust is on a zero-carbon tariff for grid electricity, so any consumption of grid electricity theoretically does not contribute to our carbon emissions, although there are indirect emissions such as transportation of waste and infrastructure, however these are negligible. The Trust is also looking to introduce renewables, such as Solar Photovoltaic arrays, highly efficient heating and ventilation assets such as Air Source Heat Pumps within the new UECUP area, and Trust wide implementation of LED lighting to reduce our electricity consumption and hence carbon emissions. The opportunities of climate change include generating renewable energy on our estate. In the future, we will investigate installing renewable electricity systems on site to reduce costs, enhance price stability, and reduce carbon intensity, according to the Targets within our Green Plan.

4	**Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC)**
4.1	**Premises Assurance Model (PAM)** The Premises Assurance Model (PAM) is an annual audit that is mandated by NHS England. The aim of PAM is to provide a nationally consistent basis of assurance for Trust Boards on regulatory and statutory requirements relating to their estate and related services. The NHS PAM bridges the space between NHS boards and the operational detail of its day-to-day estates and facilities operations. The PAM self-assessment requires the collaboration of a large number of individuals not only within Estates and Facilities, but throughout the Trust. Scores must be justified through the gathering of physical evidence, that if requested can be provided to NHSE.

	NHSE review the PAM audit template each year and introduce any required changes they feel are necessary for the next submission. For 2024/25, two further sections were added to the audit, these were: • SH20 – Mortuaries • SS1- Terrorism Act 2025 (Martyn's Law) The presentation, Appendix 1, provides a summary of the Trust results for our 2024/25 PAM submission. Since last year's submission (2023/24), further improvements have been made which are reflected in this year's PAM scores with 9 prompt questions rated as "Outstanding" a further 8 prompt questions rated as "Good", and 1 less prompt question rated as 'Requires Moderate Improvement'.
4.2	**Estates Return Information Collection (ERIC)** ERIC collects information relating to the costs of providing and maintaining the NHS Estate including such things as building, maintaining and equipping hospitals, the provision of services such as cleaning, laundry, food and portering and the consumption and associated costs of utilities. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and supports work to improve efficiency. It is therefore critical that the data provided is of the highest quality in terms of its accuracy as well as being consistent with other trusts. ERIC collects data relating to: • Costs of providing for and maintaining NHS estates • Costs of maintaining and equipping hospitals • Consumption and Costs of utilities (Elec, Gas, Water) • Water and Sewage • Cleaning • Portering services • Food/Catering • Laundry & Linen • Operational costs of Estates and Facilities • Sustainability • Building Safety • Waste volume and disposal The return is coordinated and managed by the Estates and Facilities Governance and Sustainability Team and key stakeholders and owners of data across the Trust are asked to submit provisionally into their relevant sections, such as Energy, Finance, Services, Areas and Portfolio etc. Data is then peer-reviewed and submitted through NHS Digital's Estates and Facilities Management (EFM) Portal. Data that is submitted is then normalised by area or other applicable units, so that it can be directly compared against other Trusts within a certain group or category, using units such as £/m² or £/kWh.

5	Implications
5.1	**Patients** The commitment by the organisation to monitor and improve statutory and mandatory compliance ensures that there is a greater likelihood that patients will remain safe during their period of care within the Trust. The Annual report provides assurance of steps taken to monitor and improve statutory and mandatory compliance in line with relevant statutory legislation.
5.2	**People** The Annual report demonstrates the commitment from the organisation to ensure staff are able to undertake their duties in a safe environment with adequate and satisfactory building level service provision. The PAM audit summarises the areas that require improvement and assesses what is needed in order to achieve this, i.e. capital funding, resource, further policies and procedures etc.
5.3	**Finance** There are significant financial direct costs incurred to support statutory and mandatory compliance provision by Estates and Facilities teams. This involves the inspection and maintenance aspect as well as any remedial actions required to repair or make safe the asset. Failure to comply with statutory requirements or legislation could prove significant in terms of fines from the Health and Safety Executive and place responsibilities on staff and management.
5.4	**Compliance** Relevant legislation and guidance sets out roles and responsibilities of all individuals working in providers of NHS funded care settings. The responsibilities for compliance form part of the core functions for each organisation and therefore assurance regarding compliance should be provided to Board level on a periodic basis. This includes compliance of the overarching Health and Safety at Work Act (1974), and asset specific legislation such as: Regulatory Reform (Fire Safety) Order (2005), Lifting Operations and Lifting Equipment Regulations (1998), Electricity at Work Regulations (1989) and Pressure Systems and Safety Regulations (2000) – non exhaustive. There must also be demonstration of compliance and adherence to the NHS England Health Technical Memoranda governing the guidance of building level disciplines such as Fire code, Water Safety, Medical Gases, Electricity, and Environmental.

NHS Premise Assurance Model (PAM)

WUTH 2024/25 PAM Self-Assessment

August 2025 V1.0

NHS Premise Assurance Model (PAM)
Overview

Wirral University Teaching Hospital
NHS Foundation Trust

- The NHS Premise Assurance Model (PAM) has been developed to provide a nationally consistent basis of Assurance for Trust Boards, on regulatory and statutory requirements relating to their estate and related services.

- The NHS PAM bridges the space between NHS boards and the operational detail of its day-to-day estates and facilities operations.

- The NHS PAM is held and maintained by the NHS England. A user group made up of NHS Trusts, regional colleagues, the Care Quality Commission (CQC) and other users oversee changes to the NHS PAM.

- This is a huge collaborative effort across the Trust that relies on a large number of individuals not only within E,F&C, but from other areas of the Trust supplying information and physical evidence to justify our ratings. Some of these include Complaints & PALS, Learning & Development, Sterile Services, Medical Devices, Workforce Engagement and Inclusion, Emergency Preparedness, Resilience & Response (EPRR), Mortuary, Decontamination and Patient Experience.

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PAM Self-Assessment Domains

Wirral University Teaching Hospital NHS Foundation Trust

The NHS PAM Self-Assessment is defined by six main 'domains', with a further 4 added sections; these are then broken down into individual SAQs (50), and into further questions known as 'prompt' questions (386), excluding the FM Maturity Framework 001 section (22 questions), FM Maturity Framework 002 section (30 questions) and Helipad (N/A to our Trust). There has therefore been a total of **438 questions** reviewed this year.

The model is completed by rating the prompt questions under each SAQ based on the supporting physical pieces of evidence that we can supply to justify the ratings we give ourselves. **500+** individual pieces of evidence have been collated for this year's submission.

The six domains are:

- Safety Hard (SH)
- Safety Soft (SS)
- Patient Experience (P)
- Efficiency (F)
- Effectiveness (E)
- Governance (G)

The additional sections are:

- Helipad (H)
- Contacts
- FM Maturity Framework 001
- FM Maturity Framework 002

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PAM Self-Assessment Questions (SAQs)
Response options for prompt questions

Wirral University Teaching Hospital NHS Foundation Trust

There are six possible responses for a prompt question within the six main domains:

Not applicable: this prompt question does not apply to our organisation/site.

Outstanding: compliant with no action plus evidence of high-quality services and innovation.

Good: compliant no action required.

Requires minimal improvement: the impact on people who use services, visitors or staff is low.

Requires moderate improvement: the impact on people who use services, visitors or staff is medium.

Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.

PAM Self-Assessment Questions (SAQs)
New SAQ's for 2024/25

Wirral University Teaching Hospital NHS Foundation Trust

SAQ SH20 – Mortuaries

- Consists of 14 questions
- All questions are scored using the usual PAM scoring system
- Feedback received was that a lot of this was duplicated as this is regulated by the Human Tissue Authority
- Feedback has been passed on to NHSE on a number of occasions

SAQ SS10 – Terrorism Act 2025 (Martyn's Law)

- Martyn's Law received Royal Assent in April 2025, this has not yet fully come into effect due to the Government deciding on an implementation period of at least 24 months before the Act comes into force. Despite this, NHSE have insisted that this section be scored this year for our 24/25 submission
- Consists of 5 questions which are not all scored using the current PAM system:
  - 1 scored using current system (included in our general results)
  - 2 are not being scored but still require a response (not included in general results)
  - 2 are simply scored as either 'Good' or 'Requires improvement' which sits outside of the current PAM scoring system (not included in general results)

PAM Self-Assessment Questions (SAQs)
New SAQ's for 2024/25

Wirral University Teaching Hospital
NHS Foundation Trust

SAQ SS10 – Terrorism Act 2025 (Martyn's Law)

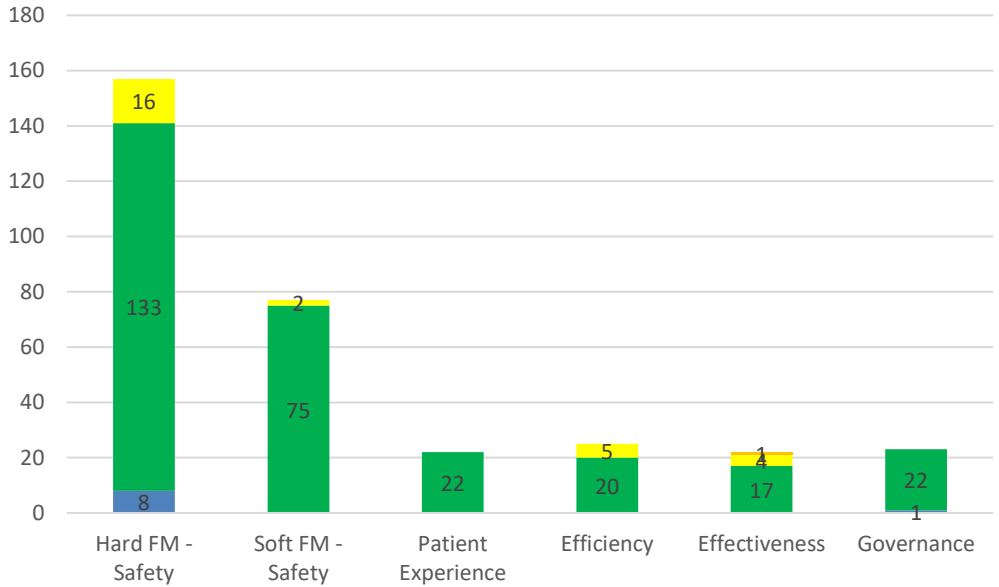
SS10: With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following?	Applicable	This SAQ relates only to the requirements of the legislation related to the premise and does not cover event planning.
1: Policy The organisation should have undertaken an assessment of 'qualifying premises' as per Part 1 of the Act.	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.
1.2 Policy Please state how many sites the organisation has at Enhanced Tier	2	This question will not be scored
1.3 Policy Please state how many sites the organisation has at Standard Tier only	N/A	This question will not be scored
2: Roles and Responsibilities The organisation's Board or governing body, as the person responsible for the premises, should have appointed an accountable officer with lead responsibility for the implementation of the legislative requirements. Confirm your organisation has an appointed an Accountable Officers?	requires improvement	Schedule 1 of the Act outlines that the responsible person for premises that are a hospital operated by an NHS trust, NHS foundation trust or a Health & Social Care Trust , that Trust or in any other case, the governing body of the hospital. Please mark yourself as good if you have this in place or requires improvement if not. Please provide name, organisation role and email address within the contact section of PAM
3. Roles and Responsibilities The organisation's Board has appointed a Designated Individual(s) for relevant premises?	requires improvement	Part 1 Section 10 of the Act Please mark yourself as good if you have this in place or requires improvement if not. Please provide name, organisation role and email address within the contact section of PAM

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PAM Self-Assessment
Summary Chart

Wirral University Teaching Hospital
NHS Foundation Trust



Of the 386 'prompt' questions, 56 were deemed 'Not Applicable'*, 2 are not being scored, along with 2 scored as 'requires improvement' for 24/25 which do not sit within the usual confines of the PAM scoring system (Martyn's Law), therefore out of the 326 remaining:

- **2.76 % (9 items) were rated as "Outstanding"**
- **88.65% (289 items) were rated as "Good"**
- **8.28% (27 items) were rated as "Requires Minimal Improvement"**
- **0.3% (1 items) were rated as "Requires Moderate Improvement"**

None were rated as Inadequate

*Based on advice from NHSE, the prompt questions for the costed action plan (CAP) for each SAQ have been rated in the same manner as other years and have been scored as "Not Applicable" as this requirement is captured within the Capital and Backlog annual budgets on a project by project or on a risk adjusted itemised basis or requires staff resource and therefore is not practical to breakdown individual risk allocated budgets to each of the PAM questions.

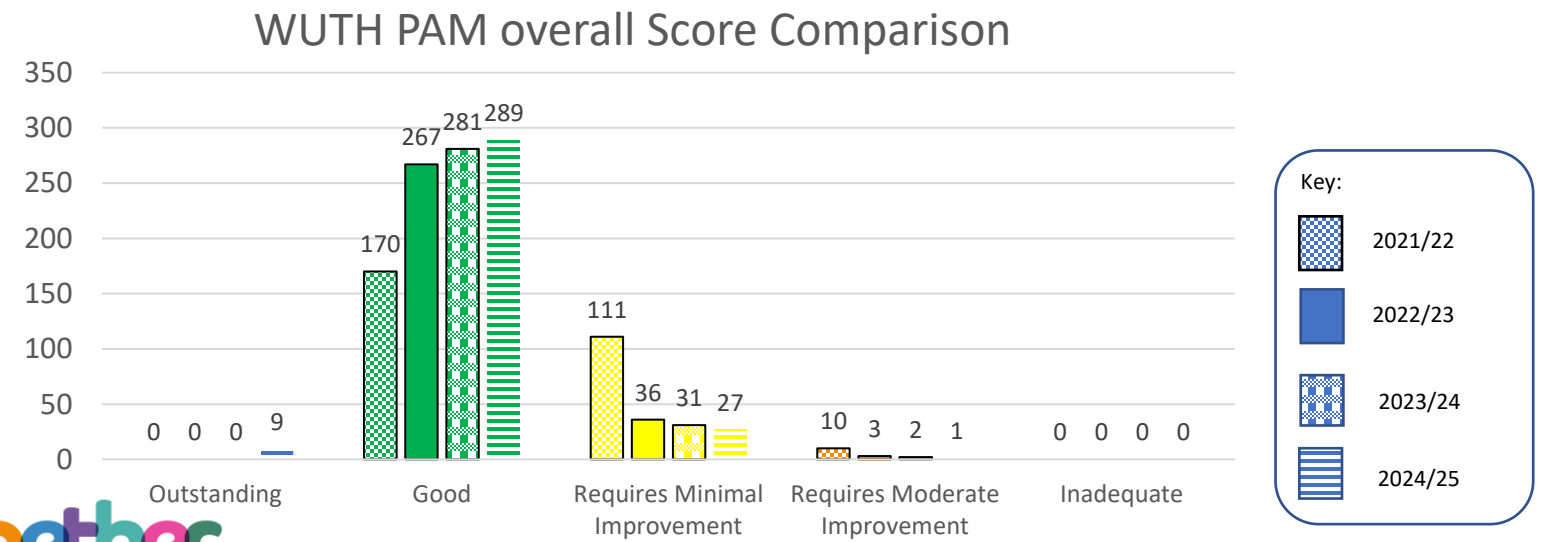
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PAM Self-Assessment 2024/25
Comparison

Wirral University Teaching Hospital NHS Foundation Trust

- It can be demonstrated that generally there is a “Good” standard of procedural practice and compliance across the main Domains at WUTH.
- Improvements have yet again been made across the Domains for 2024/25 assessment compared with 2023/24 with 9 prompt questions rated as “Outstanding” a further 8 prompt questions rated as “Good” this year, and 1 less prompt question rated as ‘Requires Moderate Improvement’.



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FM Maturity Framework
Overview

Wirral University Teaching Hospital
NHS Foundation Trust

The FM Maturity Framework has been developed by the Office of Government Property to assist departments in self assessing against the FM asset data standards, FMS 001 - Management and Services and FMS 002 - Asset Data. The framework is designed around five maturity stages (Developing – Basic, Developing – Improving, Good, Better, Best) and six assessment dimensions (Structure, Assurance and Quality, Ownership and Access, Systems, Usage, Team). **It should be noted that the target set by the Office of Government Property is for all questions to be at a rating of 'Good (3>)' by 2030.**

The stages in this maturity framework are aligned to the "Government Functional Standards - Handbook for assessing performance against functional standards, version 1.1", issued 25th November 2020.

1	2	3/3+	4/4+	5
Developing – Basic	Developing – Improving	Good	Better	Best
Non existential or very basic stage (Default value)	Meets some of the mandatory and important elements	Meets all the mandatory and most important elements (Minimum expected stage)	Exceeds expectations beyond the mandatory and most important elements	Industry leading / Best in the market covering wide range of elements

Note: For some questions in the assessment there are only three scores available 1 to 3+, therefore the 'Best' or 'Better' level are not relevant.

FM Maturity Framework
Results

Wirral University Teaching Hospital
NHS Foundation Trust

The FM Maturity Framework 001 and 002 sections consist of 52 questions in total in line with the FM asset data standards FMS 001 - Management and Services, and FMS 002 – Asset Data . These questions fall within various dimensions:

FM Maturity Framework 001 dimensions:
- Integrated
- Collaborative
- Delivery excellence
- Strategic
- Intelligent

FM Maturity Framework 002 dimensions:
- Data Structure
- Data Assurance & Quality
- Data Ownership & Access
- Data Systems
- Data Usage
- Team Capacity & Capability

A summary of our scores for the 2024/25 submission is as follows, improvements have been made this year:

FM 001

Year	1 Developing - Basic	2 Developing - Improving	3/3+ Good	4/4+ Better	5 Best
2023/24	1	9	10	2	0
2024/25	0	9	11	2	0

FM 002

Year	1 Developing - Basic	2 Developing - Improving	3/3+ Good	4/4+ Better	5 Best
2023/24	1	9	15	3	2
2024/25	0	6	18	4	2

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PAM Self-Assessment 2024/25
Points of note and Next Steps

Wirral University Teaching Hospital NHS Foundation Trust

- For the one ‘prompt’ question that was rated as “Requires Moderate Improvement” an Improvement Plan 25/26 has been developed outlining the evidence required to move the criteria to “Good” (Appendix 1).

- For the 27 ‘prompt’ questions that were rated as “Requires Minimal Improvement” Improvement Plans 25/26 have been developed (Appendix 2). *To note, of the 27 rated as “Requires Minimal Improvement”, **6** of these could be changed to “Good" upon the completion of a full asset survey.*

- FM Maturity Framework - for any scores below 3, actions for how to increase these scores to 3 or better by the target year 2030 have been agreed (Appendix 3).

- This Presentation will be taken by the COO to the Exec meeting on the 19th August. It will then be taken to Board on the 3rd September, with the aim of our results being entered and submitted in the national system on the 4th and 5th of September 2025.

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Appendix 1
Requires Moderate Improvement (Effectiveness)

Wirral University Teaching Hospital NHS Foundation Trust

The below table highlights the prompt question rated as “Requires Moderate Improvement” and the improvements that need to be made to upgrade our rating based on the evidence requirements suggested by NHSE within PAM:

Effectiveness (1)

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
E4: With regard to having a suitable Sustainability approach in place and being actioned.	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	**Requires moderate improvement**	• Complete Clean Air Hospitals Framework Tool • Develop Sustainability & Efficiency Policy incorporating air pollution procedures as part of its development. • Develop long term action plan to meet air pollution targets (Please note: Air Pollution has been identified within the Trusts Green Plan 25 -28. Further work to develop a separate action plan and complete some of the other work listed above forms part of the work plan for the Sustainability Team for 25/26)

Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital NHS Foundation Trust

The tables on slides 13 - 25 include all of the prompt questions (27) rated as "Requires Minimal Improvement" and the improvements that need to be made to upgrade our rating based on the evidence requirements suggested by NHSE within PAM:

Safety Hard (16)

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	**Requires minimal improvement**	• Complete a full **Asset Survey** so we have a complete picture of all of the assets within our Trust and the maintenance requirements for these
SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	**Requires minimal improvement**	• Further evidence that would be required to change this to good would be the completion of a Six Facet Survey on both sites, which would provide evidence of accessibility audits. • Complete and approve Travel Plan

Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	**Requires minimal improvement**	• Complete a full **Asset Survey** so we have a complete picture of all of the assets within our Trust and the maintenance requirements for these.
SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	**Requires minimal improvement**	• Further evidence that would be required to change this to good would be the completion of a Six Facet Survey on both sites, which would provide evidence of accessibility audits.
SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	**Requires minimal improvement**	• Divisional SOPs developed and Trust Wide Policy in place. However, Investment in an electronic Document Management System and the introduction of a computerised document management system would allow oversight and access to all documents and provide further required control measures.

Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	**Requires minimal improvement**	• Investment in an electronic Document Management System. The introduction of a computerised document management system would allow oversight and access to all documents.
SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	**Requires minimal improvement**	• Divisional SOPs developed and Trust Wide Policy in place. However, Investment in an electronic Document Management System and the introduction of a computerised document management system would allow oversight and access to all documents and provide further required control measures.
SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	**Requires minimal improvement**	• Divisional SOPs developed and Trust Wide Policy in place. However, Investment in an electronic Document Management System and the introduction of a computerised document management system would allow oversight and access to all documents and provide further required control measure.

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Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH6: With regard to Medical Gas Systems can the organisation evidence the following?	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	**Requires minimal improvement**	• Further work and updates to be made to BCPs to consider current position of VIE etc. This has been added as an action for the Medical Gas Committee.
SH10: With regard to Mechanical Systems and Equipment can the organisation evidence the following?	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	**Requires minimal improvement**	• Complete a full **Asset Survey** so we have a complete picture of all of the assets within our Trust and the maintenance requirements for these.
SH13: With regard to Pressure Systems can the organisation evidence the following?	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	**Requires minimal improvement**	• Develop pressure systems BCP

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Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?H10: With regard to Mechanical Systems and Equipment can the organisation evidence the following?	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	**Requires minimal improvement**	• Complete a full **Asset Survey** so we have a complete picture of all of the assets within our Trust and the maintenance requirements for these.
SSH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?H11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?	**4: Maintenance** Are assets, equipment and plant adequately maintained?	**Requires minimal improvement**	• Complete a full **Asset Survey** so we have a complete picture of all of the assets within our Trust and the maintenance requirements for these.

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Appendix 2
Requires Minimal Improvement (Safety Hard)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SH20: With regard to Mortuaries can the organisation evidence the following? **Is your organisation responsible for the running or maintenance of one or more mortuaries? This includes Mortuaries in PFI or other out-sourced regimes.**	**6. Future demand** Does the organisations long-term permanent storage meet their forecasts for predictable peaks in a resilient manner?	**Requires minimal improvement**	• Invest in more Bariatric Freezer (Capital funding) The mortuary currently has 8 long-term bariatric freezers. It has been assessed as the department requires increasing this type of storage and this has been added to the trust risk register and to the trust capital plan awaiting any allocation of funds. The trust also has a memorandum of understanding with another trust to use their freezers in the event of long-term storage capacity issues.
SH21:The built environment: Reducing harm by ligature in practice. **With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:**	**1: Policy** The Trust has a policy in place which specifically relates to ligature and can evidence it is being followed in line with the CQC guidance?	**Requires minimal improvement**	• Requirement for Clinical Leads to develop a dedicated Ligature Policy.
SH22: Estates IT and Building Information Management (BIM) systems This SAQ relates to the **Public Switch Telephone Network services**.	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	**Requires minimal improvement**	• Review the potential for the monitoring of calls throughout the Trust for quality purposes Suggested evidence for this Prompt question : ➢ Process for monitoring operators handling of calls for quality purposes

Appendix 2
Requires Minimal Improvement (Safety Soft)

Wirral University Teaching Hospital NHS Foundation Trust

Safety Soft (2)

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SS6: With regard to Security Management can the organisation evidence the following?	**4: Maintenance** Are assets, equipment and plant adequately maintained?	**Requires minimal improvement**	• CCTV upgrade required (Capital funding) • Discuss ownership of system and develop ToR for future use of Access control systems
SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	**Requires minimal improvement**	• Approve the Carparking Policy for staff, patient and visitors parking. • Review Policies and Procedures aligned to the variety of Transport Services within the Trust

Appendix 2
Requires Improvement (Martyn's Law n/a*)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SS10: With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following?	**2: Roles and Responsibilities** **The organisation's Board or governing body, as the person responsible for the premises, should have appointed an accountable officer with lead responsibility for the implementation of the legislative requirements.** ***Please mark yourself as good if you have this in place or requires improvement if not.*** ***Please provide name, organisation role and email address within the contact section of PAM*** ***Confirm your organisation has an appointed an Accountable Officers?***	**Requires improvement**	• A briefing paper has been submitted to exec team to give and understanding of Martyns law and the legal requirements both accountable officer and designated individual are yet to be identified ***Please note: This question has not be scored within the usual confines of the PAM scoring system for 24/25. Once the accountable officer for the Trust has been agreed, this prompt question will move to "Good".**

Appendix 2
Requires Improvement (Martyn's Law n/a*)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
SS10: With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following?	**3. Roles and Responsibilities** **The organisation's Board has appointed a Designated Individual(s) for relevant premises?** ***Please mark yourself as good if you have this in place or requires improvement if not.*** ***Please provide name, organisation role and email address within the contact section of PAM*** ***Confirm your organisation has an appointed an Accountable Officers?***	**Requires improvement**	• A briefing paper has been submitted to exec team to give and understanding of Martyns law and the legal requirements both accountable officer and designated individual are yet to be identified ***Please note: This question has not be scored within the usual confines of the PAM scoring system for 24/25. Once the Designated Individual for the Trust has been agreed, this prompt question will move to "Good".**

Appendix 2
Requires Minimal Improvement (Efficiency)

Wirral University Teaching Hospital NHS Foundation Trust

Efficiency (5)

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	**Requires minimal improvement**	• Additional work is required to further improve our SLA management
F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?	**6.Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?	**Requires minimal improvement**	• Develop Heat Decarbonisation & delivery Plan
F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?	**3. Board reporting and contracting** Is there comprehensive and regular reporting relating to estates and facilities services to the trust board highlighting performance, risks and issues. Are contracts in place for all estates and facilities services, documenting requirements with appropriate ability to terminate or manage poor performance and defined change control arrangements.	**Requires minimal improvement**	• Improve Contracts Management within EFC over next 12 months

Appendix 2
Requires Minimal Improvement (Efficiency)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	**Requires minimal improvement**	• NZC & Sustainability risks to be added to the register & reviewed via the correct governance route
F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?	**6. Use of Information** Is information used proactively to improve estates and facilities services?	**Requires minimal improvement**	• Complete full **asset survey** to understand maintainable assets. • Update information on the Staff intranet pages

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Appendix 2
Requires Minimal Improvement (Effectiveness)

Wirral University Teaching Hospital
NHS Foundation Trust

Effectiveness (4)

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
E4: With regard to having a suitable Sustainability approach in place and being actioned.	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	**Requires minimal improvement**	• Seek funding opportunities and capital investment in line with Energy plan to reach sustainability targets. • Develop site level Heat Decarbonisation plans
E4: With regard to having a suitable Sustainability approach in place and being actioned.	**5: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	**Requires minimal improvement**	• Approve Car Parking Policy. • Complete and approve Green Travel Plan • Look to integrate Zero emissions vehicles in line with NHSE Net Zero Travel & Transport strategy

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Appendix 2
Requires Minimal Improvement (Effectiveness)

Wirral University Teaching Hospital
NHS Foundation Trust

Self-Assessment Question	Prompt Question	Score	Improvement for 25/26
E4: With regard to having a suitable Sustainability approach in place and being actioned.	**6: Water** Are water services efficiently and effectively delivered?	**Requires minimal improvement**	• Develop Sustainability Policy and include water efficiency • Develop Net Zero Carbon Plan
E4: With regard to having a suitable Sustainability approach in place and being actioned.	**7: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	**Requires minimal improvement**	• Develop Climate Change Adaptation risk assessment and add to risk register. • Develop and approve a Climate Adaptation plan.

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Appendix 3
FM Maturity Framework <3

Wirral University Teaching Hospital
NHS Foundation Trust

The below table includes all of the FM Maturity Framework Questions that have been scored below 3 (FM001 = 9 and FM002 = 6). Actions have been agreed for how to increase these scores to 3/3+ or better by 2030, as per the Office of Government Property Target. **Please note, as it was felt that some of the below questions were not necessarily relevant to our Trust, feedback was given on this to NHSE last year, however, no changes have been made to these sections.**

FM Maturity Framework 001 (9)

Dimension	Sub-Dimension	Question	Our Score	Target Score
Integrated	Integrated Leadership	Q3. How integrated is Property Leadership?	2 FM links in some what with construction, design and asset management teams, but gaps remain.	3 Leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.
Integrated	CAFM	Q4. How integrated are your FM Management IT Systems?	2 Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.	3 A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital
NHS Foundation Trust

Dimension	Sub-Dimension	Question	Our Score	Target Score
Collaborative	Partnership & Transparency	Q6 - How strategic and effective are supplier relationships?	2 'A supplier relationship model (SRM) is in place (See CCS) **Please note: this is due to the fact that the vast majority of our services are in house. And therefore do not require a supplier relationship.**	3 'Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.
Delivery Excellence	Standards and Best Practice	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	2 Use of some industry standards, but less maturity on other aspects	3 'Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital
NHS Foundation Trust

Dimension	Sub-Dimension	Question	Our Score	Target Score
Delivery Excellence	Standards and Best Practice	Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	2 'Use of some industry standards, such as SFG20 but less maturity on other aspects.	3 'Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met
Strategic	FM Strategy	Q16 - How strategic is FM?	2 Basic FM strategy and service plan in place, but not fully integrated with wider business priorities.	3 FM Strategy in place, considering 5 year + horizon, service plan refreshed annually.
Strategic	Governance	Q17 - Do you have effective FM governance in place?	2 'Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.	3 Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital
NHS Foundation Trust

Dimension	Sub-Dimension	Question	Our Score	Target Score
Intelligent	Management structure	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	2 A defined, central FM team undertaking most FM duties, but with some aspects still devolved.	3 Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.
Intelligent	Forward Planning	Q22 - How proactive is FM service delivery in your organisation?	2 Short term planning - next financial year only.	3 Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital
NHS Foundation Trust

FM Maturity Framework 002 (6)

Dimension	Sub-Dimension	Question	Our Score	Target Score
Data Assurance & Quality	Coverage and Completeness	Q4 - What is the level of coverage of assets in the asset register data?	2 The asset data covers all assets in some estates but only some assets in other estates.	3 The asset data covers all assets in all estates.
Data Assurance & Quality	Audit	Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	2 Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.	3 Data is up to date and complete. An asset verification exercise is not currently required.
Data Assurance & Quality	Data Quality Control	Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	2 Inconsistent processes exist covering some parts of the estate.	3 Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital NHS Foundation Trust

Dimension	Sub-Dimension	Question	Our Score	Target Score
Data Assurance & Quality	Governance	Q11 - What governance is in place to support data assurance and quality (5.6)?	2 A dedicated asset data-quality governance group/board exists but meets on an irregular basis or without the required attendees.	3 A dedicated asset data-quality governance group/board exists, which meets regularly with all the relevant attendees.
Data Assurance & Quality	Governance	Q12 - What level of documentation exists for the these data quality processes and governance (5.6)?	2 Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.	3 Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis

Appendix 3
FM Maturity Framework <3/3+ cont.

Wirral University Teaching Hospital NHS Foundation Trust

Dimension	Sub-Dimension	Question	Our Score	Target Score
Team Capacity and Capability	Training	Q28 - What training is provided for teams working with asset data (9.4)?	2 Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.	3 Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 24**

03 September 2025

Title	Trust Green Plan (2025-2028)
Area Lead	Hayley Kendall – Chief Operating Officer
Author	Matthew Williams – Head of Sustainability, Energy, and Compliance (EFC)
Report for	Approval

Executive Summary and Report Recommendations

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition. The Health and Care Act 2022 reinforced this commitment, placing new duties on integrated care boards (ICBs), NHS trusts and foundation trusts to consider statutory emissions and environmental targets in their decisions.

Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans, which must be refreshed in line with statutory guidance by 31 July 2025.

The proposed refreshed Green Plan (2025-2028) has been updated using NHS England Guidance How to produce a Green Plan: A three-year strategy towards net zero. The proposed Green Plan has been attached to Appendix 1

It is recommended that the Board:

- Approve the Trust's refreshed Green Plan

Key Risks

This report relates to these key risks:

- Non-compliance with the Health and Care Act placing new duties on NHS trusts and foundation trusts to consider statutory emissions and environmental targets in their decisions. Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans.

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

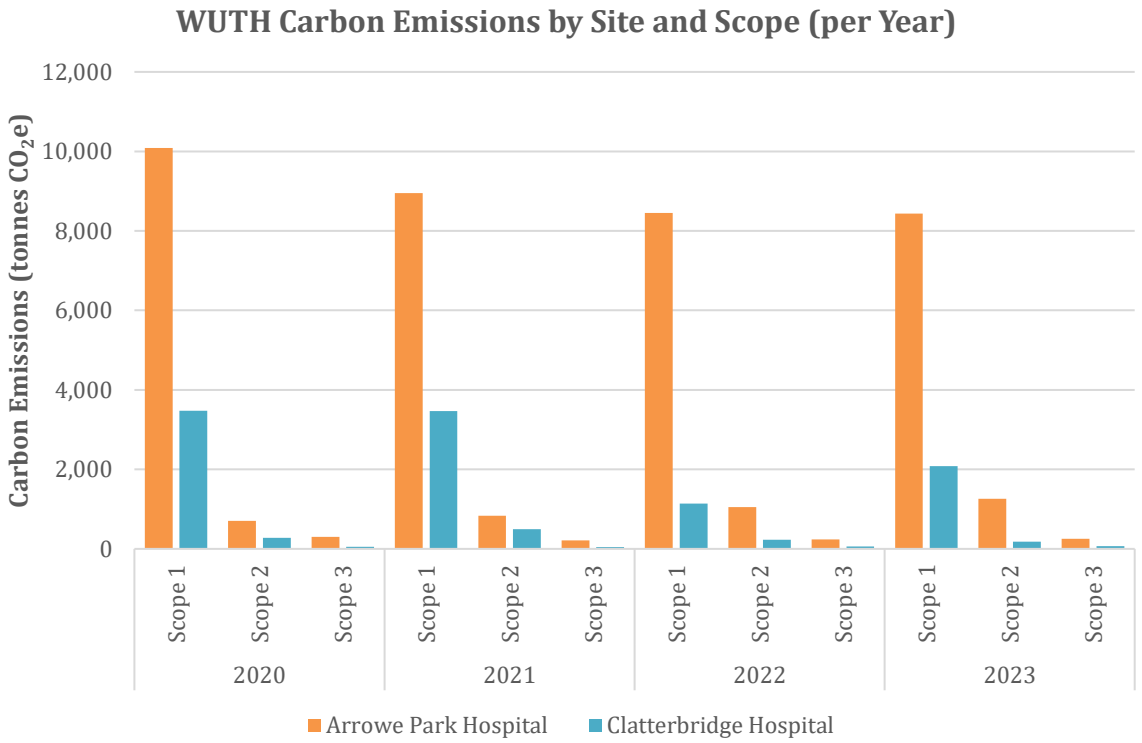
Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes

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**
August 2025	Estates and Capital Committee	As above	As above
July 2025	EF&C Senior Management Team	As above	As above

1	**Narrative**
1.1	**Green Plan Refresh (2025-2028)** In 2022, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) published its first Green Plan which covered 2022 – 2025. It was developed by Inspired Energy who were commissioned by the Trust to support meeting the ICS deadline of 31st January 2022, in which all Trusts had to submit a Board approved Green Plan. In the document, we considered our impact on the environment as a consequence of our activity to deliver care to our communities, ensuring that the Green Plan aligned to the Trust's "2021-2026 Our Strategy" document. Although we recognise that there is still much work to be done, we have achieved some key milestones in that time, thanks to the contribution from our teams and individuals within the Organisation. The structure of the refreshed Green Plan continues to follow the NHS Guidance which defines the following nine Areas of Focus; Workforce & Leadership, Net Zero Clinical Transformation (previously Sustainable Models of Care), Digital Transformation, Medicines, Travel and Transport (including Air Quality), Estates and Facilities, Supply Chain and Procurement, Food and Nutrition, and Climate Adaptation. This proposed refreshed Green Plan covers our objectives for the next three-year cycle (2025 – 2028), and we remain absolutely committed to ensuring the Trust is on track to reach Net Zero by 2040 for emissions we control directly (Scope 1), and Net Zero by 2045 for emissions we can influence, in accordance with the Delivering a Net Zero NHS Report. The three-year cycle allows the next update to encompass the integration of Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health and Care NHS Foundation Trusts into a single form organisation. Once formal arrangements have taken place, the opportunity to combine each organisation's Green Plan will be undertaken to support an integrated NHS Wirral wide Green Plan across the Acute and Community portfolio.
1.2	**A Net Zero NHS** On 1 July 2022, the NHS became the first health system to embed Net Zero into legislation, through the Health and Care Act 2022. This places duties on NHS England,

	Trusts, Foundation Trusts and ICBs to consider statutory emissions and environmental targets in their decisions. WUTH is expected to meet these duties and contribute to the NHS's net zero ambition through the delivery of a board-approved Green Plan, as outlined in statutory green plan guidance. This will bring direct benefits for public health, health equity and taxpayers, including through reducing air pollution, reducing energy costs and minimising waste. As part of the Care Quality Commission (CQC) assessment framework, organisations are expected to have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, energy efficient, and use renewable energy sources where possible. The WUTH Green Plan serves as the central document for the Trust's sustainability agenda and outlines our commitment to deliver sustainable and high-quality services, and how we work with colleagues and partners to positively impact the wider determinants of health to address health inequalities, embed social value, and deliver a number of actions to reduce emissions.
1.3	**Carbon Footprinting and Emissions Tracking** WUTH have developed a Carbon Footprinting tool to identify the gap between the Trust's current performance and the pathway required to meet the NHS's 2040 and 2045 Net Zero targets. This footprint adheres to the NHS Carbon Footprint requirements specified in the Delivering a Net Zero NHS Report and provides a quantification of the annual carbon emissions of the organisation for which data has been collected. The carbon footprint tool provides a visual demonstration of WUTH's current performance and desired trajectories. This provides the basis for the Trust to develop a narrative on the need and urgency for action, and the ability to show the negative impact of 'do-nothing' and/or 'business as usual' scenarios. It also provides the capacity to identify key carbon 'hot spots' within WUTH's operations, which will in turn support the Trust in the identification of key areas for intervention that bridge the gap between the current performance and the trajectory towards target delivery.



1.4 **WUTH Trust and Estates Strategy**

At Wirral University Teaching Hospital, it is important that the 2021-26 Trust Strategy is put into practice across the Trust. The strategy sets out what the trust intends to achieve between 2021-26 and how to improve to deliver the best care for our patients. The strategy introduces the vision, values and six strategic objectives. Our Enabling Strategies provide the link between our Trust strategy and its delivery in practice, and in particular, the Estates Strategy.

The proposed Green Plan has been aligned to the six strategic priorities which have been incorporated as part of the Sustainability Areas of Focus, aligned as follows:

Strategic Priority	Sustainability Area of Focus
OUTSTANDING CARE Provide the best care and support	Net Zero Clinical Transformation Medicines Food and Nutrition
COMPASSIONATE WORKFORCE Be a great place to work	Workforce and Leadership

	Travel and Transport Adaptation
	Supply Chain and Procurement
	Digital Future
	Estates and Facilities

The Green Plan development has considered sub-priorities of the six strategic priorities intends to support the provision of outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. The Green Plan recognises that as the Wirral system develops, the Trust and its partners may need to adapt our Green Plan to ensure opportunities to improve patient experience and outcomes, staff experience and value for money do not get delayed.

Consideration has also been given to the Estates Strategy. The Trust's Estates Strategy is a key enabler to the delivery of our Clinical Strategy. Our Estates Strategy describes how we need to respond to planned and anticipated changes in activity, efficiency, models of care, ways of working and demographics. Objectives from the four campaigns of the Estates Strategy have been implemented into the Green Plan



	• Technical Management Review
	  ○ Undertake a robust technical assessment to understand the key components that support and drive improvements across property management, including environmental impacts to inform integrated capital planning and investment programmes.
	• People
	  ○ Improve our staff facilities, including: indoor break areas and outdoor space, enhance changing areas, shower facilities and bicycle storage, across our campuses to support staff wellbeing.
	  ○ Develop and implement a WUTH transport plan in collaboration with Wirral Place partners to enable patients and staff to utilise eco-friendly sustainable methods of transport to reach our hospital campuses.
	• Support Delivery of Clinical & Non-Clinical Service Strategies
	  ○ Make effective use of our estates through delineating the roles and functions of the sites, whilst promoting sustainability and social value.
	  ○ Improve travel and transport to our hospital campuses and undertake a review of our signage to support navigation around our hospital campuses.
	• Portfolio Development & Future Planning
	  ○ Optimise the use of our estates through enhancements that are directed by population health needs and our understanding of capacity and demand of our clinical services, whilst preserving the synergies created through co-location of specialist services.
	  ○ Introduce sustainability and social value as a standard consideration in our procurement processes, in order to enhance recycling, reduce waste and minimise the use of single-use equipment where appropriate.
	
	This Green Plan has been developed in line with Greener NHS and NHS England and Improvement guidance, and reflects national priorities established within the Delivering a Net Zero Carbon National Health Service report. The strategy aims to ensure that the Trust is aligned to the NHS's wider ambition to become the first healthcare system in the world to reach net zero carbon emissions. This Plan will aim to prioritise interventions that will enable the Trust to continue improving patient care quality whilst delivering carbon reductions and improving our wider sustainability performance. The strategy will also support increasing efficiency throughout the organisation.

1.5	**Methodology and Delivery** Incomplete actions form the current version of the Green Plan (2022-25) were cross-referenced with other Green Plans, Strategies and Guidance across Wirral Place including Cheshire & Merseyside's newly published Green Plan and a draft version of Cool Wirral's Strategy refresh. The actions were also cross-referenced with relevant NHSE/Greener NHS guidance/strategies such as: Delivering a Net Zero NHS Report, NHS Net Zero Travel & Transport Strategy, NHS Clinical Waste Strategy, Simpler Recycling guidance, NHS Net Zero Supplier Roadmap etc., This was to ensure that the proposed Green Plan would cover all requirements that we are expected to achieve within the next three years. Each Green Plan Area of Focus action was assessed to ensure that they were SMART: specific, measurable, achievable, relevant, and time-bound within the three-

	year timeframe. It was decided that any actions that were completed, duplicated, not applicable or not achievable within the three-year timeframe would not be included in the refreshed Green Plan (2025-2028), however the team ensured that these actions remained within the tracker with justifications for their exclusion for record. Actions taken forward to the refreshed Green Plan (2025-2028) have either remained the same or have been amended slightly to make them more relevant to the Trust and assigned a deliverable that could be monitored against. Green Plan delivery group meetings have been set up with the relevant departments/stakeholders and the first meetings assessed the actions agreed with stakeholders and accountable action owners. The formal Areas of Focus as referenced in the Green Plan are supported by multiple departments from across the organisation, and therefore to support departments in delivering their actions, which may span across multiple Areas of Focus, the Sustainability Team set up the following Green Plan delivery groups: • Travel & Transport *(Bi-monthly)* • Waste *(Monthly)* • Catering *(Bi-monthly)* • Estates & Capital *(Monthly)* • Digital Healthcare Team *(Bi-monthly)* • Supply Chain & Procurement *(Bi-monthly)* • WUTH Sustainability Team *(Monthly)* • Medicines *(Bi-monthly)* The Sustainability Team decided to hold separate meetings for each department (listed above), rather than one meeting that involved all department leads as it was found previously that staff did not engage well with this. Depending on the number and timeframe on the actions, some meetings were set to be held monthly and some bi-monthly (as indicated above), the frequency can be amended to suit as we progress.
1.6	**WUTH and WCHC Trusts** Both WUTH and WCHC has developed separate Green Plans that will be published individually to Cheshire and Merseyside ICS but understand that these will likely be combined into one Integrated Green Plan across both Trusts once formal integration between Trusts takes place. Once formal arrangements have taken place, the opportunity to combine each organisation's Green Plan will be undertaken to support an integrated NHS Wirral wide Green Plan across the Acute and Community portfolio. The submission deadline of 31st July 2025 for refreshed Green Plans and the current stage of integration did not support the production of a collaborative Green Plan at this stage.
1.7	**Conclusion** The proposed Green Plan will be a living document and will be regularly reviewed for progress against the action plans. As such, actions and targets may be revised where necessary to support delivery where there is a risk due to a financial or resource shortfall. Adequate budgets and resources should be allocated to achieve our goals and deliver sustainable care. We will look to achieve the low cost 'quick wins' first, though anticipate significant investment requirements in future years, especially in making our buildings

	‘climate-ready’. Any investment opportunities will be communicated with the Trust in advance of any proposal put forward. There have been lengthy discussions between stakeholders to ensure the actions within the Green Plan are SMART and that delivery is achievable and measurable. Stakeholders have agreed to take accountability and responsibility for the delivery of actions relating to their areas to ensure the Green Plan progresses and delivers what it intends to achieve. Our dedicated workforce is core to our care provision and delivery of this Green Plan. With the necessary structures in place, it will be our people and service users who will drive the changes to make us a more sustainable organisation. We will continue an open dialogue with all stakeholders to improve our Green Plans and the care we deliver.

Wirral University Teaching Hospital
NHS Foundation Trust

Greener wuth



Green Plan 2025 – 2028

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Foreword

In 2022, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) published its first Green Plan which covered 2022 – 2025. In the document, we considered our impact on the environment as a consequence of our activity to deliver care to our communities, ensuring that the Green Plan aligned to the Trust's "2021-2026 Our Strategy" document. Although we recognise that there is still much work to be done, we have achieved some key milestones in that time, thanks to the contribution from our teams and individuals within the Organisation.

This refreshed Green Plan covers our objectives for the next three-year cycle (2025 – 2028), we remain absolutely committed to ensuring the Trust is on track to reach Net Zero by 2040 for emissions we control directly, and Net Zero by 2045 for emissions we can influence, in accordance with the Delivering a Net Zero NHS Report [2020, Updated 2022]. Reaching these targets will only be possible with the continued contribution from stakeholders within the Trust covering many departments, and our partnership work with NHS organisations across Cheshire & Merseyside and the wider NHS portfolio.

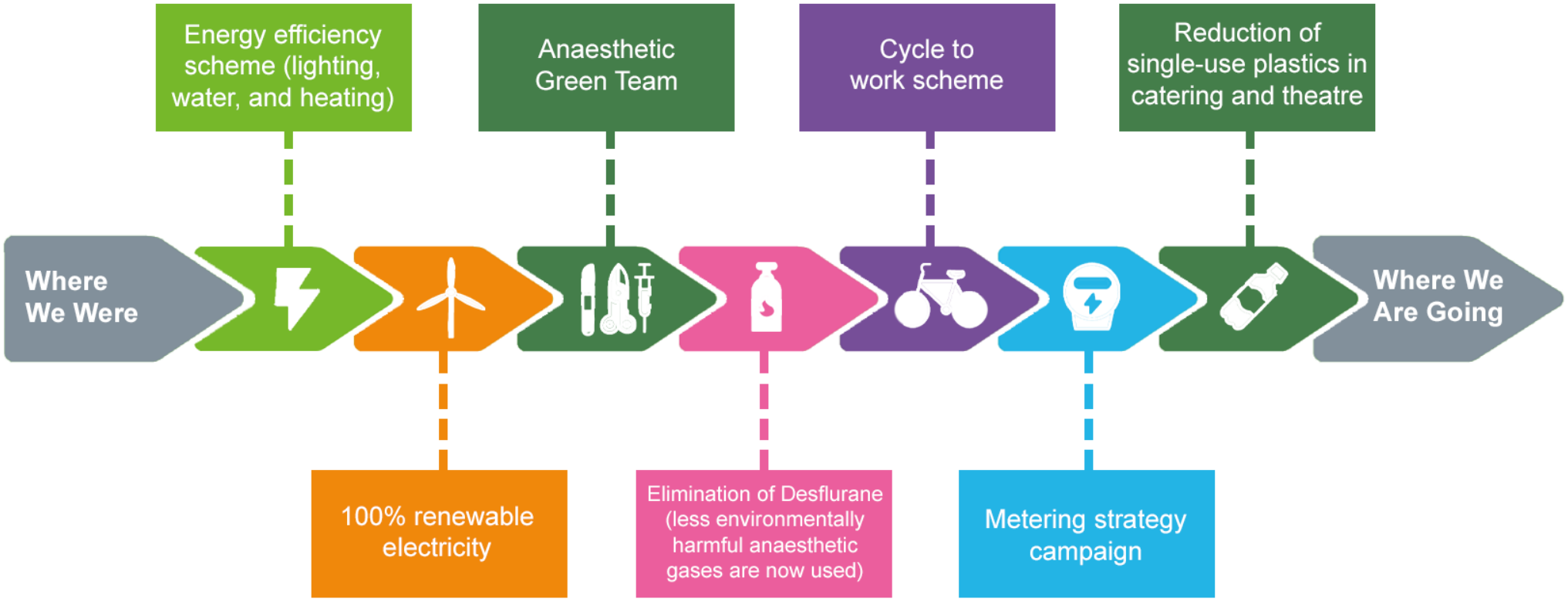
The structure of the refreshed Green Plan continues to follow the NHS Guidance which defines the following nine Areas of Focus; Workforce & Leadership, Net Zero Clinical Transformation (previously Sustainable Models of Care), Digital Transformation, Medicines, Travel and Transport (including Air Quality), Estates and Facilities, Supply Chain and Procurement, Food and Nutrition, and Climate Adaptation.

However, it must be emphasised that Net Zero Carbon is not the only objective this plan sets out to achieve. We are already seeing the effects of climate change. We must adapt to these changes to enable us to continue to deliver the best quality and safest care to the communities we serve. In doing so, the Trust must strive to improve local air quality, reduce waste, deliver social value and provide health benefits to our staff and patients.

Hayley Kendall, Chief Operating Officer and Executive Net Zero Lead

Highlights

Looking back at the road we've travelled



Green Plan Achievements (2022-2025)

Workforce and Leadership

Communication of Greener NHS campaigns to improve staff engagement and implementation of “Building a Net Zero NHS” training onto ESR

Net Zero Clinical Transformation

Launch of “Without Gloves” campaign, aimed at all staff across our organisation that might usually reach for a pair of gloves as part of their work. The campaign aims to improve hand hygiene, reduce gloves use (and therefore carbon footprint) and reduce spend on non-sterile gloves.

Digital Transformation

Adoption of staff and patient portals, reduction in paper payslips and appointment letters

Medicines

Switched off a Nitrous Oxide Manifold at our Clatterbridge site which will reduce the amount of Nitrous Oxide that is wasted, it is estimated to reduce our carbon footprint by 100 tonnes CO2e per year.

Awarded funding as part of the NHSE Nitrous Oxide Waste Mitigation Scheme. The funding will be used to supply Arrowe Park Hospital with cylinder trollies so that the Nitrous oxide manifold can then be switched off.

Travel and Transport

Provision of Dr Bike sessions for staff and partners to promote cycling to work schemes and low carbon transport

Provision of discounted staff public transport through local partners

Green Plan Achievements (2022-2025)

Estates and Facilities

Supported Endoscopy Team with improving waste segregation processes. The aim of this project was to reduce the amount of waste that was being disposed of as Offensive waste and re-directed to Recyclable waste streams as a result of correct segregation.

Successful in securing approximately £1m to support LED lighting improvements at both Arrowe Park and Clatterbridge Hospital sites, improving carbon savings and reducing energy costs for the Trust and wider NHS which can be reinvested in patient care

WUTH Charity received an award-winning show garden from the Tatton Flower Show which has been installed on the Clatterbridge site. “Constructing Minds” is based on the hidden issues of mental health for construction workers and has been designed as a calming space to help those struggling with their mental health.

Supply Chain and Procurement

All procurement tender evaluations now include a minimum of 10% net zero and social value weighting

Food and Nutrition

Explored feasibility of food dryer at Arrowe Park Hospital to reduce volume of food waste

Climate Adaptation

The Trust have been successful on two applications for fully funded trees from NHS Forest which have been planted on the Clatterbridge Hospital site and will help to alleviate flood risks in the long term and improve staff wellbeing and green spaces.

Introduction

What is climate change?

Climate change refers to long-term shifts in temperatures and weather patterns. Such shifts can be natural, due to changes in the sun's activity or large volcanic eruptions. But since the 1800s, human activities have been the main driver of climate change, primarily due to the burning of fossil fuels like coal, oil and gas. Burning fossil fuels generates greenhouse gas (GHG) emissions that act like a blanket wrapped around the Earth, trapping the sun's heat and raising temperatures.

The main GHGs that are causing climate change are carbon dioxide and methane. These are produced when driving a petrol/diesel car or burning coal for heating a building, for example. Clearing land and cutting down forests can also release carbon dioxide. Energy, industry, transport, buildings, agriculture and land use are among the main sectors causing greenhouse gases. What Is Climate Change? | United Nations

A growing coalition of countries, cities, businesses and other institutions are pledging to get to net-zero emissions. Net Zero refers to the balance between the amount of GHG that's produced and the amount that's removed from the atmosphere.



Image courtesy of Pixabay

A Net Zero NHS

On 1 July 2022, the NHS became the first health system to embed Net Zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, Trusts, Foundation Trusts and ICBs to consider statutory emissions and environmental targets in their decisions.

WUTH is expected to meet these duties and contribute to the NHS's net zero ambition through the delivery of a board-approved Green Plan, as outlined in statutory green plan guidance. This will bring direct benefits for public health, health equity and taxpayers, including through reducing air pollution, reducing energy costs and minimising waste.

As part of the Care Quality Commission (CQC) assessment framework, organisations are expected to have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, energy efficient, and use renewable energy sources where possible.

The WUTH Green Plan serves as the central document for the Trust's sustainability agenda and strategy and outlines our commitment to deliver sustainable and high-quality services, and how we work with colleagues and partners to positively impact the wider determinants of health to address health inequalities, embed social value, and deliver a number of actions to reduce emissions.



Image courtesy of Delivering a Net Zero NHS Report 2022

Pathway to Net Zero Carbon

(by 2040 and 2045)

The UK is committed to becoming carbon-neutral by 2050, as per the Climate Change Act 2008. The national NHS targets are based on the Climate Change Act 2008. In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the profound and growing threat to health posed by climate change.

The 'Delivering a Net Zero Health Service' report sets out a clear ambition and two evidence-based targets:

- by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032.
- by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.

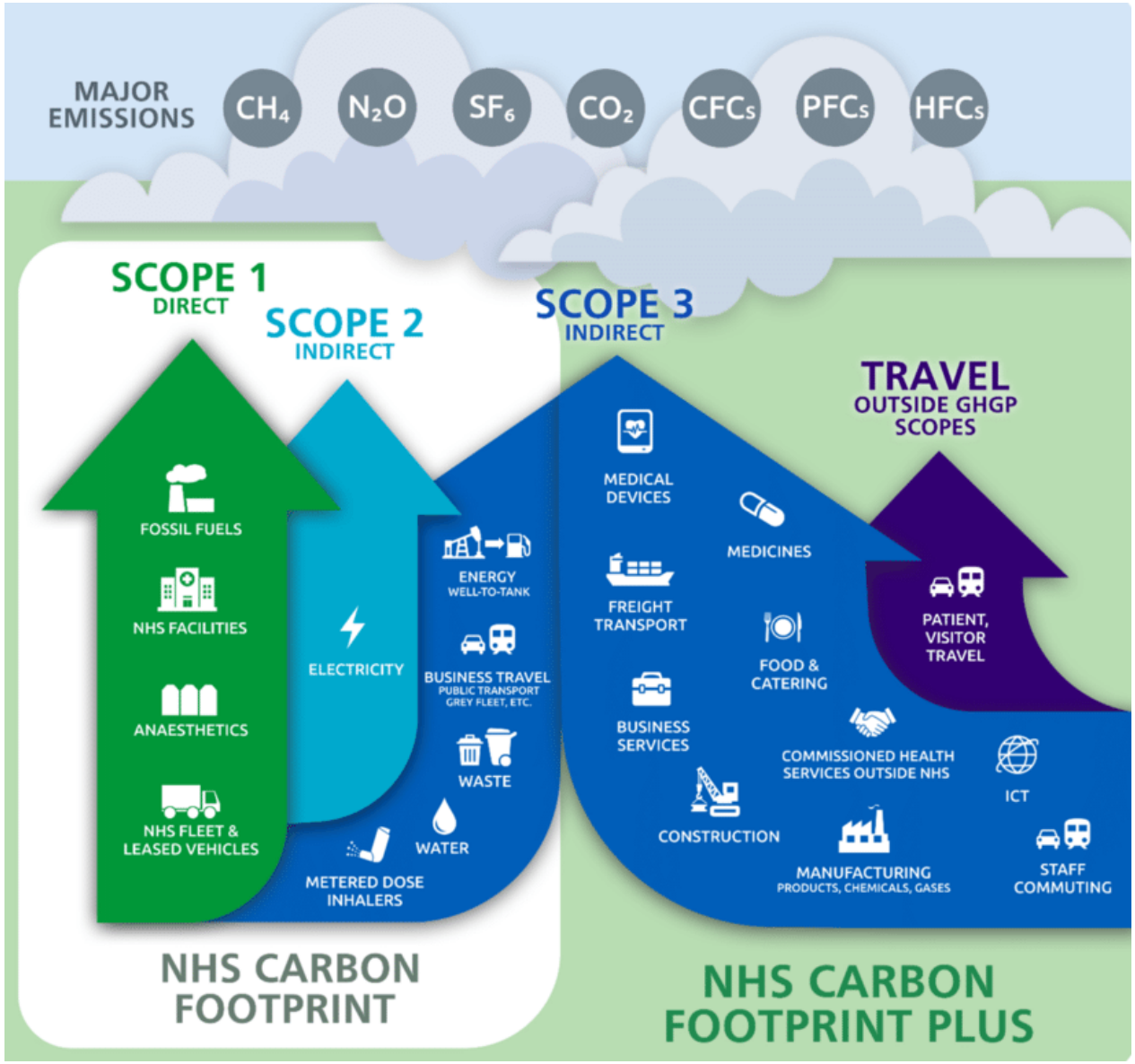


Image courtesy of Delivering a Net Zero NHS Report 2022

Carbon Footprinting and Emissions Tracking

WUTH have developed a Carbon Footprinting tool to identify the gap between the Trust's current performance and the pathway required to meet the NHS's 2040 and 2045 Net Zero targets. This footprint adheres to the NHS Carbon Footprint requirements specified in the Delivering a Net Zero NHS Report and provides a quantification of the annual carbon emissions of the organisation for which data has been collected.

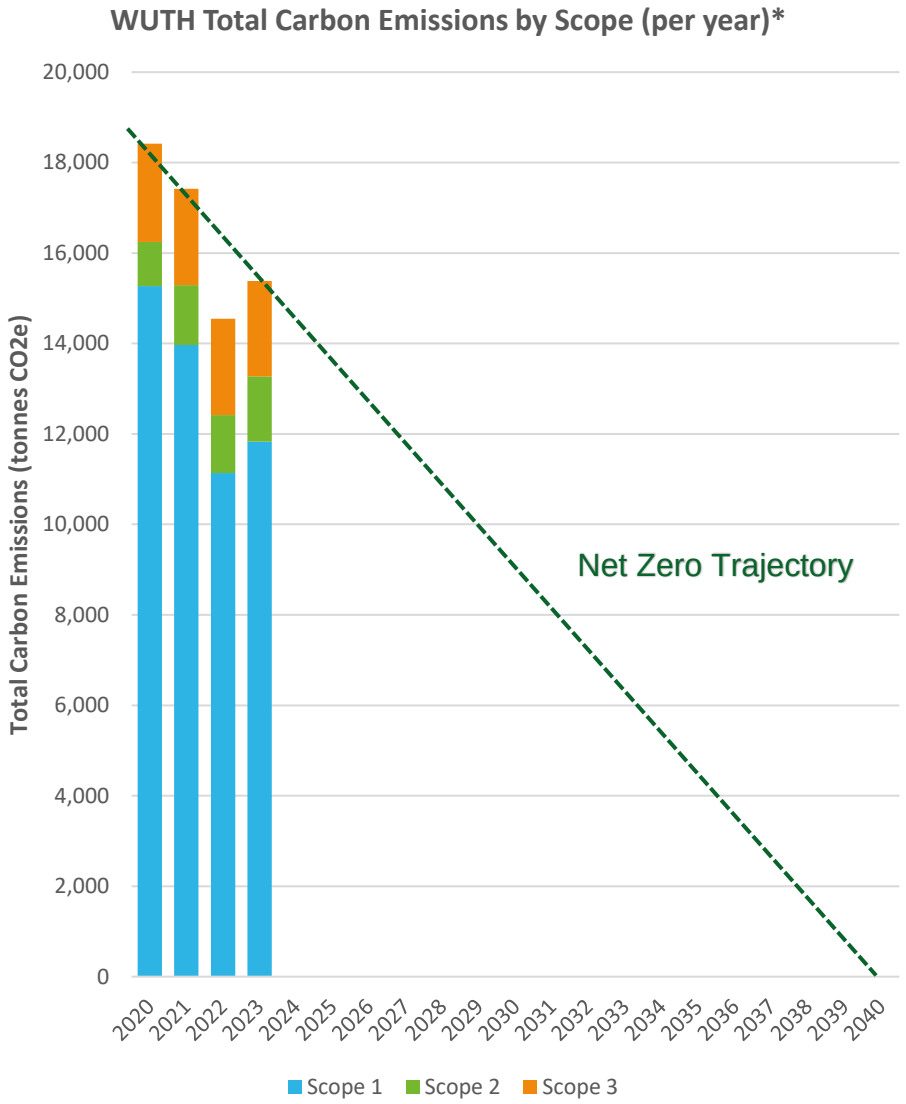
The carbon footprint tool provides a visual demonstration of WUTH's current performance and desired trajectories. This provides the basis for the Trust to develop a narrative on the need and urgency for action, and the ability to show the negative impact of 'do-nothing' and/or 'business as usual' scenarios. It also provides the capacity to identify key carbon 'hot spots' within WUTH's operations, which will in turn support the Trust in the identification of key areas for intervention that bridge the gap between the current performance and the trajectory towards target delivery.

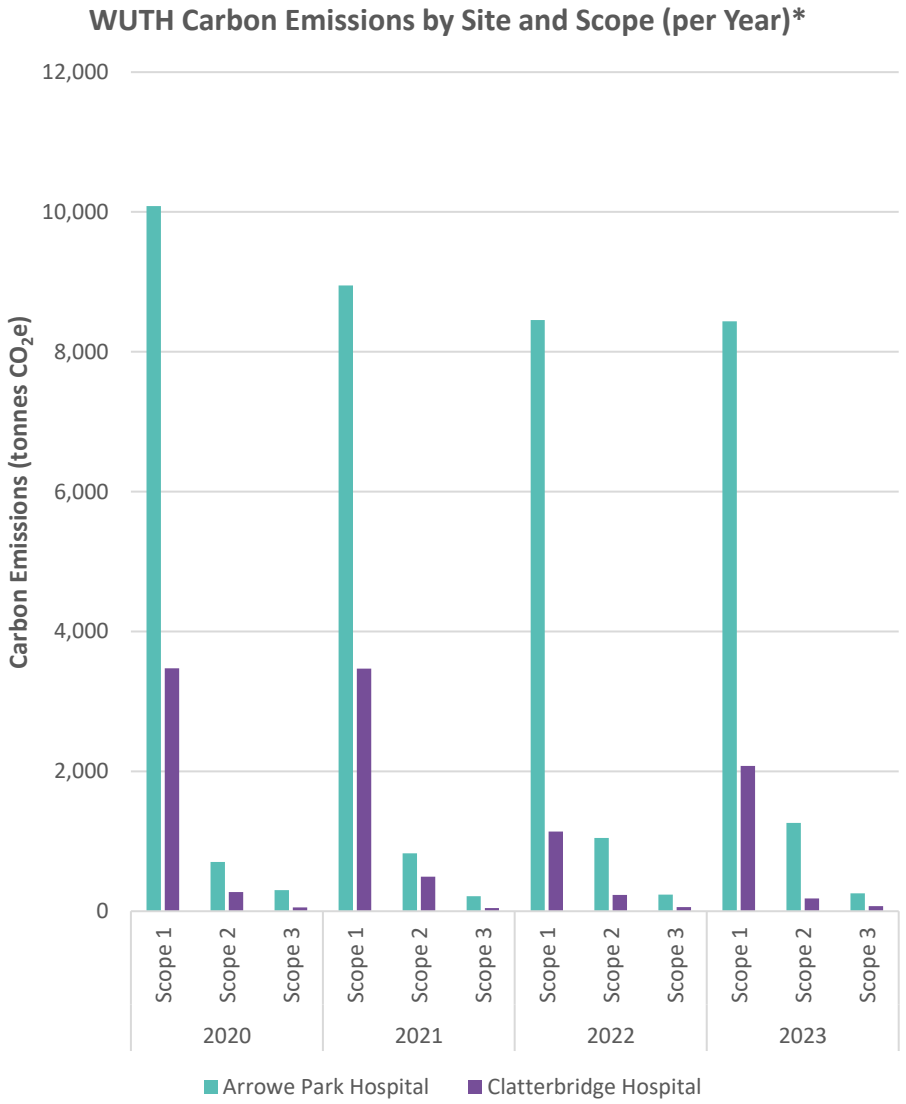
WUTH Carbon Emissions have followed a consistent trajectory towards Net Zero by 2040, with the exception of the FY 2023/24, which saw greater output of the Combined Heat and Power (CHP) System which provides the majority of the Trust's Electrical Demand.

The CHP System produces electricity and heat which is used by the Trust, by produces carbon dioxide and other GHG as a waste product of the combustion of natural Gas. The Trust are looking at alternative power systems to supply buildings with sufficient electrical and heat capacity, which include solar PV, Air Source and Ground Heat Pumps, and are monitoring research being conducted into larger capacity systems such as Geothermal extraction and Hydrogen Fuels.



Image courtesy of WUTH Library





FY 2023/24 saw greater output of the Combined Heat and Power (CHP) System which provides the majority of the Trust's Electrical Demand. The Trust has contractual agreement for displacement and savings targets relating to the generation of CHP usable Electricity and Heat

The UN Sustainable Development Goals

Our Trust is working meaningfully towards the United Nations (UN) Sustainable Development Goals (SDGs) through our Green Plan, which we have aligned to relevant SDG targets.

The SDGs underpin a global action framework to 2030, adopted by every UN member country to address the biggest challenges humanity faces.

Each goal has targets and indicators to help nations and organisations prioritise and manage responses to key social, economic and environmental issues.

"The NHS belongs to all of us" *

The NHS and its people contribute to multiple SDGs through the delivery of its core functions, for example, target 3.8, to achieve universal health coverage.

Established on 5th July 1948, the UK's National Health Service is the world's first modern fully universal healthcare system, free at the point of use, and celebrating its 75th year in 2023.

** Constitution of NHS England*



Organisational Vision

Delivery of the WUTH Green Plan will continue to be co-ordinated by the WUTH Sustainability Team and will be overseen by the Executive Net Zero Lead.

The refreshed WUTH Green Plan structure continues to follow the NHS Guidance (Green Plan Guidance [2025], and How to produce a Green Plan: A three-year strategy towards net zero [2021]), which defines the following nine **Areas of Focus**:

- **Workforce and Leadership**
- **Net Zero Clinical Transformation *(previously Sustainable Models of Care)***
- **Digital Transformation**
- **Medicines**
- **Travel and Transport (including Air Quality)**
- **Estates and Facilities**
- **Supply Chain and Procurement**
- **Food and Nutrition**
- **Climate Adaptation**

The Green Plan aligns to the current Trust Strategy (2021-2026) and will inform and be embedded into the new strategies which are being developed for 2026-2031.

To monitor progress of the actions, Green Plan Delivery Groups have been established to bring together stakeholders aligned to workstreams tackling actions across the breadth of the Areas of Focus. The Green Plan Delivery Groups are as follows:

- Digital Healthcare
- Medicines
- Travel and Transport
- Estates and Capital Projects
- Waste
- Supply Chain and Procurement
- Catering

They are supported and chaired by the Trust's Sustainability Team, who report progress to the Estates and Capital Committee chaired by the Trust Chairman and attended by members of the Trust Board.

WUTH Strategy (2021-2026) and Stakeholder Engagement



Our strategic priorities have been derived by reviewing national, regional and local context and can be found in our '2021-2026 Our Strategy' document. Six strategic objectives will be incorporated throughout this Green Plan as part of the Sustainability Areas of Focus.

It is important that the 2021-26 Trust Strategy is put into practice across the Trust through appropriate sub-plans. The Trust Strategy sets out what the trust intends to achieve between 2021 and 2026 and how to improve to deliver the best care for our patients. The strategy introduces the vision, values and six strategic objectives. Our Enabling Strategies provide the link between our Trust strategy and its delivery in practice, and in particular, the Estates Strategy.

The Green Plan development has considered sub-priorities of the six strategic priorities intending to support the provision of outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. The Green Plan recognises that as the Wirral system develops, the Trust and its partners may need to adapt our Green Plan to ensure opportunities to improve patient experience and outcomes, staff experience and value for money do not get delayed and are progressed forward.

Each Trust Strategic Priority has been aligned with one or more Sustainability Areas of Focus to ensure both plans align.

There have been lengthy discussions between stakeholders to ensure the actions within the Green Plan are SMART and that delivery is achievable and measurable. Stakeholders have agreed to take accountability and responsibility for the delivery of actions relating to their areas to ensure the Green Plan progresses and delivers what it intends to achieve.

Strategic Priority	Sustainability Area of Focus
	Net Zero Clinical Transformation Medicines Food and Nutrition
	Workforce and Leadership
	Travel and Transport Climate Adaptation
	Supply Chain and Procurement
	Digital Transformation
	Estates and Facilities

Estates Enabling Strategy

Consideration has also been given to the Trust's Estates Strategy. The Estates Strategy is a key enabler to the delivery of our Clinical Strategy. Our Estates Strategy describes how we need to respond to planned and anticipated changes in activity, efficiency, models of care, ways of working and demographics. Objectives from the four campaigns of the Estates Strategy have been implemented into the Green Plan.



Portfolio Development & Future Planning

Optimise the use of our estates through enhancements that are directed by population health needs and our understanding of capacity and demand of our clinical services.

Introduce sustainability and social value as a standard consideration in our procurement processes, in order to enhance recycling, reduce waste and minimise the use of single-use equipment where appropriate.

Technical Management Review

Undertake a robust technical assessment to understand the key components that support and drive improvements across property management, including environmental impacts to inform integrated capital planning and investment programmes.

Support Delivery of Clinical & Non-Clinical Service Strategies

Make effective use of our estates through delineating the roles and functions of the sites, whilst promoting sustainability and social value.

Improve travel and transport to our hospital campuses

People

Improve our staff facilities, including indoor break areas and outdoor space, enhance changing areas, shower facilities and bicycle storage, across our campuses to support staff wellbeing.

Develop and implement a WUTH transport plan in collaboration with Wirral Place partners to enable patients and staff to utilise eco-friendly sustainable methods of transport to reach our hospital campuses.

NHS and External Partners

Cheshire and Merseyside (C&M)

At WUTH we are committed to working individually as well as at Place and System level. Since the adoption of the first iteration of our Green Plan we have actively engaged with partner organisations to establish system priorities and have been working towards delivering them. This exemplifies the collaborative efforts of Cheshire and Merseyside ICS in mitigating our carbon footprint, reducing health inequalities, and enhancing social value.

Our refreshed Green Plan is aligned to the Cheshire & Merseyside ICB Green Plan 2025–2028 and regular updates on WUTH's progress are provided at the Cheshire & Merseyside Sustainability Board.

The Cheshire & Merseyside Sustainability Board has five sub-groups which WUTH also attends: Air Quality (AQ), Waste, Energy, Travel and Transport, and Biodiversity. Some examples of how we are working together to maximise outcomes in these sub-groups are:

Air Quality

- Agreeing a local NHS position statement on AQ and health to use our voice as health professionals to influence wider action
- Actions on AQ as part of Green Plans
- Engaging our board level leads on AQ
- Joining up campaigns on indoor and outdoor air pollution including around clinical, managerial, and patient engagement
- Sharing experiences, best practice, and value of AQ monitoring
- Exploring how to improve indoor air pollution
- Joining together to explore sources of funding

Waste

- Baselining waste stream supplier and waste disposal activity to identify and optimise operations
- Identifying opportunities to eliminate or reduce single-use plastics
- Maximising the potential of recycling and generating rebates from items such as scrap metals and batteries
- Embedding the waste hierarchy throughout our organisations
- Donating surplus furniture to community organisations and developing countries

Energy

- Working together on sources of funding and funding bid submissions
- Support with Heat Decarbonisation Plans (HDP)
- Collaborating with ICB Estates Team regarding estates strategy
- Maximising opportunities to act collectively in establishing efficient service standard expectations from suppliers and energy brokers
- Sharing ideas, best practice, and ‘quick wins’ to reduce emissions and make financial savings, i.e. LEDs; CHP performance; building occupancy
- Piloting renewable energy technology to generate learning and advancement opportunities
- Monitoring the transition from fossil fuels to renewable energy sources

Travel & Transport

- Supporting each other to meet the national targets set out in NHS England’s Net Zero travel and transport strategy
- Collaborating on ideas to encourage modal shift to active travel and public transport
- Strengthening relationships with Local Authorities and aligning strategy/ campaigns where appropriate
- Developing a list of events (Dr Bike/ cycling buddy sessions, etc) to share with wider partners, staff and communities

Biodiversity & Nature Recovery

- Defining what nature recovery looks like for C&M
- Explore the ‘doing’, starting with biodiversity baseline assessments on sites
- Linking to Biodiversity Net Gain targets and establishing collective goals
- Mapping nature based social prescribing opportunities and addressing barriers to setting activity up
- Improving biodiversity through large-scale, multi-landowner/landscape nature recovery projects in urban areas
- Sharing best practice and resources across Trusts

Moving forwards, C&M have identified some key priorities that we aim to achieve, as a system:

- LED Lighting across our entire estate – Approximately 80% of all Lighting at WUTH is high efficiency LED
- Increased use of solar panels across the estate – WUTH has been successful in a funding application to introduce roof mounted solar on our sites which is planned for installation within 2025/26.
- Have one agreed measurement approach for Carbon Footprinting across the system – WUTH currently report Carbon footprint aligned to Scope 1, 2, and 3 emissions described in section: Carbon Footprinting and Emissions Tracking
- Have all organisations signed up to the anchor framework and TOMs – WUTH became an Anchor Institution on 31st March 2023

Social Value and Anchors

Cheshire and Merseyside ICS has been a social value accelerator site since 2018 and has co-produced a Social Value Charter as well as developed a Social Value Award. Working closely with the Health and Wellbeing Board as well as the All Together Fairer Marmot team, they have also co-produced an anchor framework.

Public, private and voluntary sector organisations, including WUTH have signed up to these initiatives, delivering one approach. In addition, they have developed a systemwide set of themes, outcomes and measures (TOMs) to measure social value and demonstrate delivery.

Cool Wirral Partnership

WUTH is part of the Cool Wirral Partnership (formerly the Wirral Climate Change Group) which co-ordinates local action on climate change. The partnership is supported by the Wirral Council and meets three times a year. A variety of organisations participate, including: Cheshire and Wirral Partnership, Energy Projects Plus, Faiths4Change, Forum Housing, Magenta Living, Merseyside Police, Merseyside Fire and Rescue, Merseytravel, and Merseyside Recycling and Waste Authority.

WUTH has supported the development of the third iteration of the Cool Wirral Strategy 2025–2030.

Integration of Single Organisation Form with Wirral Community Health and Care Trust

Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health and Care NHS Foundation Trust (WCHC) are commencing an integration into a single form organisation. Once formal arrangements have taken place, the opportunity to combine each organisation's Green Plan will be undertaken to support an integrated NHS Wirral wide Green Plan across the Acute and Community portfolio.

Areas of Focus Contents

The following Areas of Focus give an overview of what WUTH has achieved currently, what the Green Plan aims to deliver over the next three years, and what the success measures will be for these aims

Area of Focus	*Page*
Workforce and Leadership	*21*
Net Zero Clinical Transformation	*22*
Digital Transformation	*23*
Medicines	*24*
Travel and Transport	*25*
Estates and Facilities	*26*
Supply Chain and Procurement	*28*
Food and Nutrition	*30*
Climate Adaptation	*31*

Workforce and Leadership

The transition to a Net Zero NHS will be driven by its people, our workforce will be vital to delivering our ambitions. We will build our Green Plan into our strategic planning and governance, and support our staff and leaders to learn, innovate and embed sustainability into everyday actions.

What have we achieved?

- ✓ Appointment of Board-level Net Zero Lead
- ✓ Green Champions Network
- ✓ Communication of Greener NHS campaigns to improve staff engagement and implementation of “Building a Net Zero NHS” training onto ESR

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Nominate and empower a Health Inequalities Lead and a Climate Change Adaptation Lead
- ➢ Ensure staff are resourced to undertake Green Plan duties
- ➢ Implement mandatory training related to Environmental Sustainability to build capability in all staff, including the link between climate change and health, including practical actions that staff can take to help achieve Net Zero
- ➢ Create Green Plan intranet pages for staff access and external webpages for other stakeholders; upload Green Plan content and progress updates accordingly

Success measures:

- ❖ Appointment of Health Inequalities Lead and a Climate Change Adaptation Lead
- ❖ Delivery of Green Plan actions
- ❖ Provision of additional Net Zero/Sustainability training for all staff
- ❖ Development of Green Plan intranet and webpages for staff/external stakeholders



Image courtesy of WUTH Library

Net Zero Clinical Transformation

To achieve our Net Zero ambitions, we must deliver care in a way that incorporates reducing carbon emissions. This includes principles such as optimising location of care, earlier and quicker detection, diagnosis and treatment, embedding the best clinical practice, treating for the long-term and digital technology. Carbon savings will predominantly be achieved by reduced presentations in A&E and outpatients, reduced staff and patient mileage, reduced bed days, fewer pharmaceuticals being prescribed, and less carbon intensive procedures

What have we achieved?

- ✓ Initiated integration with the Community Trust which has opened up conversations and opportunity to move care closer to people's homes
- ✓ In 2022, WUTH launched a "Without Gloves" campaign. This was aimed at all staff across our organisation that might usually reach for a pair of gloves as part of their work, the campaign aims to improve hand hygiene, reduce gloves use (and therefore carbon footprint) and reduce spend on non-sterile gloves.

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Develop care pathways and systems such that patients can receive treatments in the community rather than attending the acute site
- ➢ Build on current efforts to reduce health inequalities and improve early intervention, linking this work to potential emissions reductions
- ➢ Health Inequalities Lead to coordinate delivery of an updated Health Inequalities Action Plan
- ➢ Continue to collaborate with other Trusts and public authorities on the population's health

Success measures:

- ❖ Reduced traffic and congestion on the acute site improving carbon footprint
- ❖ Delivery of Health Inequalities Action Plan

Digital Transformation

DIGITAL FUTURE

Be a digital pioneer and centre for excellence

Strong digital foundations are essential for transforming care by improving access, quality, productivity and reducing emissions. NHS organisations achieved remarkable digital transformation during the coronavirus pandemic. WUTH intends to build on this progress by focussing on ways that further harness digital infrastructure, systems and data to streamline service delivery and supporting functions, improve use of resources and reduce carbon emissions. WUTH is well-placed to support the development of digital care as a tool to promote inclusion and increase access to quality care in the Cheshire and Merseyside region.

What have we achieved?

- ✓ Provided appropriate hardware and software to staff delivering work remotely, reduction in staff travel to and from site
- ✓ Adoption of staff and patient portals, reduction in paper i.e. payslips and appointment letters
- ✓ Continued cyclical replacement programme of IT hardware with more energy efficient solutions

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Build on our current practice and current online patient guidance, participate in delivery of the Long-Term Plan commitments for digital first primary care and an NHS digital front door, linking this to potential emissions reductions.
- ➢ Use relevant guidance to ensure the Trust has robust ICT systems in place to deliver on digital transformation.
- ➢ Build on current practice of engaging staff and care groups in digital care channels, meaning fewer patient journeys.
- ➢ Transfer paper-based systems such as prescribing, bed state, observations, ward state, referrals, expense claims forms to a digital alternative. Reduce use of paper across all back-office functions.

Success measures:

- ❖ To complete phase 2 & 3 of Trust's One Patient Record Programme
- ❖ Measurable progress with digital transformation
- ❖ Reduce paper use and postage



Image courtesy of WUTH Library

Medicines

A small number of medicines account for a substantial proportion of all emissions within the NHS in England, particularly anaesthetic gases, nitrous oxide and inhalers which account for around 5% of NHS emissions.

The production and use of medications, inhalers, and anaesthetic drugs contribute significantly to environmental damage due to the waste generated from packaging, the manufacturing processes, pollution of water bodies during production, the disposal of unused drugs into public water sources and landfills, and the release of pollutants into the air. This Green Plan will set out how WUTH intends to address these issues and reduce our impact on the environment whilst continuing to prioritise patient care.

What have we achieved?

- ✓ Worked with our anaesthetists and pharmacy teams to phase out the use of Desflurane completely
- ✓ Switched off a Nitrous Oxide Manifold at our Clatterbridge site which will reduce the amount of Nitrous Oxide that is wasted, it is estimated to reduce our carbon footprint by 100 tonnes CO2e per year.
- ✓ The Trust was awarded funding as part of the NHSE Nitrous Oxide Waste Mitigation Scheme. The funding will be used to supply Arrowe Park Hospital with cylinder trollies so that the Nitrous oxide manifold can then be switched off.

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Establish a nitrous oxide project to reduce nitrous oxide waste from Medical Gas Pipeline Systems (MGPS) by progressing actions outlined in the Nitrous Oxide Waste Mitigations Toolkit
- ➢ Educate patients to promote correct medication technique, self-management and adherence to support reduction in waste
- ➢ Trust to undertake Entonox Waste Audits supported by the Nitrous Oxide Toolkit.

Success measures:

- ❖ Completion of actions outlined in the Nitrous Oxide Waste Mitigations Toolkit
- ❖ Production of educational materials relating to medication technique
- ❖ Completion of Entonox Waste Audits and corresponding action plans

Travel and Transport

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14% of the system's total emissions. The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution. The aim at WUTH is to promote low-carbon travel for patients, visitors and staff, and work with our partner organisations across Cheshire and Merseyside to reduce our contribution to air pollution.

What have we achieved?

- ✓ Supported flexible working and increased staff's home-working arrangement where possible
- ✓ Reviewed existing staff lease scheme to encourage the uptake of Ultra Low Emission Vehicles and Zero Emission Vehicles
- ✓ Provision of Dr Bike sessions for WUTH staff and partners at both sites
- ✓ Provision of discounted staff public transport

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Develop a Sustainable Travel Plan which incorporates a variety of strategies for travel to and from the hospital sites for patients, visitors and staff
- ➢ Explore campaigns on outdoor air pollution with local authorities and explore how to improve indoor air quality
- ➢ Install Electric Vehicle (EV) charging points to support transition to an EV fleet
- ➢ Investigate NHS Salary Sacrifice Scheme to ensure delivery of NHS Net Zero Travel and Transport Strategy guidance, which states that by 2026, all vehicles offered through NHS salary sacrifice must be Electric
- ➢ All new vehicles owned and leased by the NHS will be zero emission vehicles from 2027

Success measures:

- ❖ Development of a Sustainable Travel Plan
- ❖ Installation of Electric Vehicle (EV) chargepoints
- ❖ Electric Vehicles (EV) only to be offered through NHS Salary Sacrifice Scheme
- ❖ Purchase or lease of Zero Emission Fleet Vehicles



Image courtesy of Jacek S

Estates and Facilities



As we provide critical services 24 hours a day 365 days a year, our energy and resource consumptions are significant. Therefore, we need to optimise energy use in our buildings and move away from using fossil fuels to meet NHS Net Zero goals. Our estate comprises a mixture of buildings of different types, ages and usage, which presents challenges to retrofitting resource efficiency measures and heating improvements.

Estates & Facilities comprises of the following areas:



Capital Projects

The Built Environment of the NHS influences both the quality of our care and our environmental impact. How we design and construct our buildings in the future will play a decisive role in our collective ability to achieve net zero.



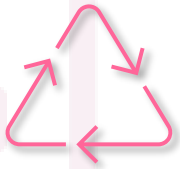
Water Efficiency

The supply of fresh water and treatment of wastewater produces indirect harmful emissions. Although these emissions are low compared to those produced by energy consumption, water efficiency is important to prevent and alleviate water stress.



Biodiversity & Greenspace

WUTH wants to protect biodiversity within our estate and reduce our negative impact, both locally and globally. Greenspace and nature are important for the health and wellbeing of patients, visitors and staff alike. WUTH will promote access to greenspace and consider opportunities and risks for biodiversity in the areas we operate.



Waste

The NHS is one of the largest producers of waste in the country, therefore it is vital that waste is disposed of in a safe, efficient and sustainable manner. To achieve sustainable practices WUTH will work to ensure that waste is segregated correctly and that we are reducing, reusing and recycling our waste where possible.

What have we achieved?

- ✓ WUTH has been successful in securing approximately £1m to support LED lighting improvements at both Arrowe Park and Clatterbridge Hospital sites. Funding was awarded by NHS England as part of the National Energy Efficiency Funding (NEEF) Scheme Phase 3. This will improve carbon savings and reduce energy costs for the Trust and wider NHS which can be reinvested in patient care.

- ✓ In July 2024, WUTH Sustainability Team and Facilities & Support Services supported the Endoscopy Team with improving their waste segregation processes within the department. The aim of this project was to reduce the amount of waste that was being disposed of as Offensive waste and re-directed to Recyclable waste streams as a result of correct segregation.

- ✓ In October 2023 WUTH Charity received an award-winning show garden from the 2023 Tatton Flower Show which has been installed on the Clatterbridge site, the garden's theme "Constructing Minds" is based on the hidden issues of mental health for construction workers and has been designed as a calming space to help those struggling with their mental health.

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Optimise energy use across the Trust through infrastructure improvements and culture change
- ➢ Develop a Heat Decarbonisation Plan (HDP) which identifies the phasing out of all existing fossil fuels and submit business cases to support measures outlined in the HDP
- ➢ Ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard

Success measures:

- ❖ Measurable reduction in energy consumption and associated carbon emissions
- ❖ Development and publication of a Heat Decarbonisation Plan with associated strategy
- ❖ Assurance from Capital Team that all newbuilding and major refurbishment projects are compliant with the NHS Net Zero Building Standard



Image courtesy of Pixabay

Supply Chain and Procurement



NHS England procures around £30 billion of goods and services annually across 80,000 suppliers. Procurement has major potential social, economic, and environmental impacts both locally and globally. This includes using local suppliers to reduce carbon emissions and tackling modern slavery in supply chains.

WUTH is committed to engage our suppliers and support the sustainable procurement objectives of NHS England wherever practicable.

What have we achieved?

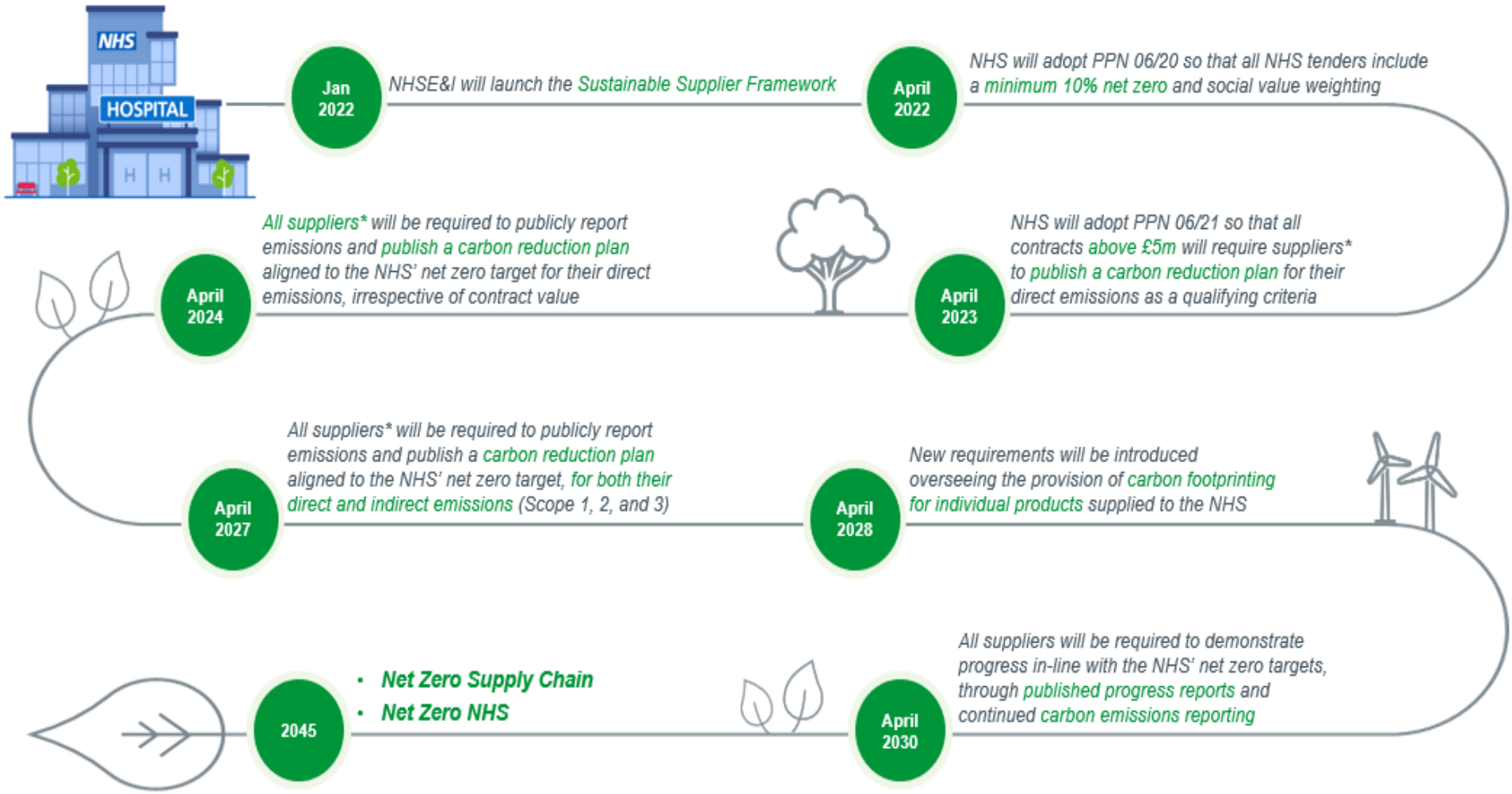
- ✓ Tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts from April 2022 and 2023 respectively
- ✓ All paper purchased is now closed-loop recycled paper
- ✓ All procurement tender evaluations now include a minimum of 10% net zero and social value weighting

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Embed NHS Net Zero Supplier Roadmap requirements into all relevant procurements and
- ➢ All suppliers intending to tender for a contract or framework will require, at the point of submission, a valid Evergreen sustainable supplier assessment as well as a compliant Carbon Reduction Plan for contracts over £5,000,000.00 per annum (excluding VAT).
- ➢ Support work to reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects and patient pathways

Success measures:

- ❖ Monitor NHS Net Zero Supplier Roadmap requirements and update SOP accordingly
- ❖ Record of Evergreen sustainable supplier assessment and compliant Carbon Reduction Plan (when appropriate)
- ❖ Implement reusable products into clinical improvement projects and measure carbon and cost effectiveness



Building net zero into NHS Procurement – shows how NHS England will require all suppliers to provide carbon and social value reporting

Food and Nutrition

Food illustrates the links between climate change and public health. The NHS Long Term Plan commits us to promote plant-forward diets and reduce unhealthy options like sugary drinks on NHS premises. Not only will these actions help prevent obesity and non-communicable disease, but they will also play a role in reducing our greenhouse gas emissions and environmental impact.

What have we achieved?

- ✓ Limited sugary drinks sales at our facilities across both sites
- ✓ Switched to plastic-free cutlery and food containers in our restaurants across both sites
- ✓ Explored feasibility of food dryer at Arrowe Park Hospital to reduce volume of food waste

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Phase in more Plant-forward diets and explore greater seasonal menu changes high in fruit and vegetables and low in heavily processed foods
- ➢ Measure food waste in line with the Estates Return Information Collection (ERIC) and set reduction targets
- ➢ Introduce electronic meal ordering system for patients

Success measures:

- ❖ Provision of more Plant-forward foods and evidence frequent seasonal menu changes
- ❖ Measurable reduction in food waste in line with ERIC benchmarking
- ❖ Implementation of electronic meal ordering system for patients



Image courtesy of WUTH Library

Climate Adaptation



As well as working to reduce our emissions to reach the NHS Net Zero targets, we must also adapt to the changing climate which brings along many risks such as; extreme weather events, shifts in disease patterns, sea-level rise and their impact on vulnerable populations in our community. These risks will impact demand for services, staffing, supply chain, travel and transport, digital systems, and physical infrastructure. In order to ensure continuity of our services to our community, WUTH will analyse these risks and develop a strategy and action plan across our estate and service areas.

What have we achieved?

- ✓ Completed trial of Cheshire & Merseyside Climate Change Adaptation Toolkit
- ✓ The Trust have been successful on two applications for fully-funded trees from NHS Forest which have been planted on the Clatterbridge Hospital site and will help to alleviate flood risks in the long term
- ✓ Collaborated with partners across Cheshire and Merseyside to understand Climate Adaptation risks

What the refreshed Green Plan aims to deliver (2025-2028):

- ➢ Develop Climate Adaptation Plan
- ➢ Add Climate Adaptation risks onto the Trust risk register
- ➢ Comply with the adaptation provisions within the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and the NHS Standard Contract to support business continuity during adverse weather events
- ➢ Factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions
- ➢ Ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government's Adverse Weather and Health Plan

Success measures:

- ❖ Development and publication of Trust Climate Adaptation Plan
- ❖ Inclusion of Climate Change risks and mitigation on Trust risk register
- ❖ Compliance with NHS Core Standards for EPRR and the NHS Standard Contract
- ❖ Assurance from Capital Team to factor in effects of climate change when making infrastructure decisions and designing new facilities
- ❖ Assurance from Trust EPRR Lead of adherence to Adverse Weather and Health Plan at Trust level

Conclusion

This Green Plan is a living document and will be regularly reviewed for progress against the action plans. As such, actions and targets may be revised where necessary.

Adequate budgets and resources should be allocated to achieve our goals and deliver sustainable care. We will look to achieve the low cost ‘quick wins’ first, though anticipate significant investment requirements in future years, especially in making our buildings ‘climate-ready’.

This Green Plan will enable us to become an adaptable and resilient organisation. It will help steer our direction of travel with other local anchor institutions, bolstering our ability to provide a continued critical service.

Our dedicated workforce is core to our care provision and delivery of this Green Plan. With the necessary structures in place, it will be our people and service users who will drive the changes to make us a more sustainable organisation. We will continue an open dialogue with all stakeholders to improve our Green Plans and the care we deliver.



Arrowe Park Site - Image courtesy of Google Earth

Contact Details

All of the information contained in this report is, to the best of our knowledge, accurate at the time of publishing.

If you wish to contact the Wirral Sustainability Team, please email **wuth.sustainability@nhs.net**

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Birkenhead,
Wirral
CH49 5PE

You can follow us on Twitter: **@GreenerWUTH**

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Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 25**

03 September 2025

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

Report Purpose and Recommendations

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

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

This paper provides a specific update regarding MIS Year 6 and 7, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Midwifery staffing update, Maternity Continuity of Carer (MCoC) together with a progress update on MPOP, Neonatal Unit Expansion, MNVP and other items supporting the Maternity Incentive Scheme requirements to evidence Board oversight and submission. The report also includes an update on the forthcoming Maternity and Neonatal Inquiry.

It is recommended: -

- Note the report and associated appendices.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of the Maternity and Newborn Safety Investigations (MNSI) and declaration of one PSII for Neonatal Unit.
- Note the position with the Maternity Incentive Scheme Year 6 and launch of Year 7 requirements.
- Note the PMRT reports for Q4 24/25 and Q1 25/26.
- Note the progress of the Trust's position with Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Support the recommendations and action plan within the Maternity and neonatal inquiry report and appendices.
- Support the recommendation in the midwifery staffing workforce paper.
- Note the Neonatal Unit medical and nursing staffing position in accordance with BAPM.
- Note the progress with the Maternity Portal Online Programme.
- Note the continued outstanding practices with the Maternity and Neonatal Voices Partnership (MNVP),
- Support the recommendations within the Maternity and Neonatal Annual report.

- Note the compliance with consultant presence on the labour ward in line with the RCOG guidance.

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**
September 2025	Divisional Quality Board	Quarterly Maternity and Neonatal Services Report	For information
September 2025	Maternity and Neonatal Assurance Meeting	Quarterly Maternity and Neonatal Services Report	For information
September 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 (June and July 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. **Appendix 2** includes the recommendations from the publication of the revised Perinatal Quality Oversight Model which has been significantly delayed due to the current transition in NHS structures and has been agreed as the interim measure

	model. As providers and systems, it has been highlighted as providers we should be working towards this model with the understanding that review of roles and responsibilities, particularly between systems and regions, which will be required once a fuller picture of the new operating model. The PQQM has been reviewed and updated accordingly. In addition to the tool the Board of Directors will receive a detailed annual summary report.

2	**Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in May, June and July 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, one received in draft for factual accuracy and one new referral. There was one Patient Safety Investigation Incidents (PSII's) declared in May 2025 for Neonatal services. The incident has also been declared as a Never Event as it related to the displacement of a Nasogastric tube. The incident has been correctly classified as a never event according to NHS England criteria and a PSII is being commissioned in, line with the PSIRF Policy. The Maternity and Neonatal Assurance Board will track progress by reviewing the investigation, root causes and identified contributing factors identified along with corrective measures and learning. An update will be provided at the next quarterly Board of Directors There have been no further Patient Safety Investigation Incidents (PSII's) declared in June and July 2025.

3	**Maternity Incentive Scheme (MIS) Year 6/7**
	The declaration for MIS Year 6 was submitted as approved by the Board of Directors in January 2025 to NHSR. As advised by MBBRACE and NHS Resolution Safety Action 1 was declared as non-compliant in the first instant, with a view to a review of the position when the external verification is undertaken. Whilst reassurance was provided by NHS Resolution and MBRRACE and an appeal process WUTH have been declared non complaint with Safety Action 1 of the CNST Maternity Incentive Scheme (MIS) Year 6. As a result, the Trust has received a one-off payment £296k discretionary funding to invest in maternity services. All identified posts to meet Safety Action 1 are being recruited and will also support the workforce gaps identified in the Birth Rate plus report and works towards achieving Safety Action 5 of the Maternity Incentive Scheme. 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 3.** 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 October and November 2025 reports utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB.

4	**PMRT Reports**
	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 4 and 5**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 1 and Quarter 2 25/26 period. .

5	**Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS Year 7 Scheme**
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 30th June 2025 the Trust achieved 94% compliance against the 6 elements included at **Appendix 6**. This was an increase from the previous quarter and the Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper. Quarter 2 25/26 evidence has been submitted and under review by the LMNS for compliance of a updated version and changes to the required interventions and evidence requirements.

6	**Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations**
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly.

	A full review has been undertaken, and the gap analysis is included at **Appendix 7** and remains in the same RAG rated position as fully compliant.

7	Three Year Delivery Plan – Maternity and Neonatal
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 8** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

8	Maternity and Neonatal Rapid National Investigation
	A rapid national investigation into NHS maternity and neonatal services has been ordered by Health and Social Care Secretary, Wes Streeting. This is to provide truth and accountability for impacted families and drive urgent improvements to care and safety, addressing systemic problems dating back over 15 years. This government inherited a situation where issues in maternity and neonatal care had been ongoing for some time and a series of independent reviews into local trusts had found similar failings in compassionate care - including the failure to listen to women, concerns over safety and issues with leadership and culture. The investigation will urgently look at worst-performing services in the country but also across the entire maternity system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care. Crucially, it will be co-produced with clinicians, experts and parents all feeding in, following a series of private meetings last week between the Secretary of State and families who have been harmed or bereaved by failures in their care. It will begin its work this summer and report back by December 2025. The investigation comes alongside a package of immediate actions to improve care, including greater intervention by the Secretary of State and NHS Chief Executive to hold failing trusts to account - a key step in delivering the government's mission to build an NHS fit for the future through the Plan for Change.

	The details of the inquiry are included within the letter at **Appendix 9** and an additional paper for the Board of Directors to inform the Trusts readiness for the Maternity and Neonatal Inquiry **(Appendix 10).** NHS providers are expected to demonstrate transparency, learning and measurable action. Included at **Appendix 11** is WUTH's current position against each of the statements. Included at **Appendix 12** is a high-level analysis table identifying gaps against the key themes and actions to work towards prior to the publication of the inquiry expected in December 2025.

9	Midwifery Workforce and update on Birth Rate
	As previously presented to Board of Directors a full workforce review is required to be undertaken every 3 years in line with Ockenden utilising the Birth Rate + workforce tool. The report was received in March 2025 and the maternity workforce report with recommendations for consideration is included at **Appendix 13** with an action plan of the requirements at **Appendix 14**. There is a requirement to meet required staffing levels in line with Safety Action 5 of the Maternity Incentive Scheme (MIS).

10	NNU Medical and Nursing Workforce
	Included at **Appendix 15** is the neonatal medical and nursing workforce paper reported in line with British Association of Perinatal Medicine (BAPM) providing an update on the Trusts position.

11	MPOP
	There is a requirement by the LMNS to report the progress of the Maternity Portal Online Programme (MPOP) to the Board of Directors and it is included at **Appendix 16.**

12	Maternity and Neonatal Voices Partnership (MNVP)
	In line with Safety Action 7 WUTH has a well embedded Maternity and Neonatal Voices Partnership collaboration and infrastructure in place aligned with the national standards and funding received. The Board of Directors can have assurance the Board Safety Champions meet with the perinatal leadership team at a minimum of bi-monthly and any support required by the Trust Board if identified will be escalated and implemented. The evidence for Safety Action 7 has been uploaded to the Future Platform for review by the LMNS to include the co-produced self-assessment tool developed to support providers in adopting the guidance. The Board of Directors is provided assurance the Maternity and Neonatal Assurance Board and Safety Champions monitor progress of the governance and oversight of MNVP).

13	NNU Expansion
	From 2018/19 to present, the Trust Charity, along with Incubabies Charity, have fundraised approximately £1m for the redevelopment of the Neonatal Unit at Arrowe Park Hospital. Across 2023 and 2024, the Estates Team, with the support of Day Architectural examined a range of design options to support the redevelopment of the unit. The expansion of the Neonatal Unit footprint to comply with the British Association of Perinatal Medicine (BAPM) commenced in June 2025 and completion is expected in November 2025. The NNU is temporary relocated to an alternative ward area within the Women's and Children's division and building.

14	Maternity and Neonatal Culture
	Creating and sustaining a positive culture in maternity and neonatal services was a key recommendation from the national reviews and culture improvement is also central to the Maternity Incentive Scheme Safety Actions and Local Maternity and Neonatal Systems (LMNS) priorities. Included at **Appendix 17** is the Annual Maternity and Neonatal Culture report.

14	Consultant Presence on Labour Ward
	Included at **Appendix 18** is a report to demonstrate full compliance through a three-month audit consultant attendance to the listed clinical situations outlined in the RCOG workforce document.

15	Conclusion
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The Board are requested to note the declared PSII for Neonatal unit and support the Maternity and Neonatal Assurance Board to track progress. The Board is asked to note the assurance on Safety Action 7 compliance and endorse the continued resourcing and involvement of the Maternity and Neonatal Partnership (MNVP) and service users in governance processes. The Board is asked to support the recommendations in the following reports:- • Gap analysis and Trust readiness to the Maternity and neonatal inquiry. • Midwifery staffing paper and action plan to meet the midwifery workforce establishment. • Maternity and Neonatal Culture Annual report. • Board Assurance MIS Year 7, Action 4 and compliance with the RCOG guidance. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

16	Implications
16.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
16.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 9 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. Safety Action 1 noncompliance has no impact on quality and safety of maternity services and is a data transcription error. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Progress with sustainability of Ockenden. • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
16.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity workforce is required and funding options continue to be explored. A paper will be submitted to BDISC for approval to increase establishment and maintain compliance with Safety Action 5. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels.
16.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 26**

03 September 2025

Title	Guardian of Safe Working Annual Report (including Q4 2024/25)
Area Lead	Dr Ranj Mehra, Executive Medical Director
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to give assurance that doctors and dentists in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS).

This is an annual report including data for 1st January to 31st March 2025 (Q4 2024-25) and outlines the following:

- Actual number of doctors in training.
- Exception reports submitted for the reporting period by specialty and grade.
- Breaches of safe working hours and fines incurred.

There are a small number of exception reports outstanding which will be closed with the support of the newly appointed Guardian of Safe Working. The Trust continues to support junior doctors to complete exception reports as it gives a greater understanding of workforce and training issues.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
12 June 2025	People Committee	As above	As aboce

1 Narrative

To monitor compliance with the working hours directive, Doctors/Dentists in Training (DIT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service.

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 299 (282.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 299 (282.6 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the guardian (if any): Access to 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Quarterly Exception reports (regarding working hours)

Exception reports by department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident & Emergency	0	3	3	0
General Medicine	0	38	38	0
General Surgery	0	4	4	0
Geriatric Medicine	0	8	8	0
Neonates	0	1	1	0
OMFS	0	2	2	0
Otolaryngology (ENT)	0	3	3	0
Psychiatry	0	1	1	0
Trauma & Orthopaedics	0	1	1	0
Total	0	61	61	0

Exception reports by Grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	33	33	0
SHOs	0	23	21	2
SpRs	0	5	5	0
Total	0	61	59	2

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E SHO	0	1	1	0
A&E 20%	0	1	1	0
A&E SpR	0	1	1	0
Basic Hours	0	1	1	0
DCT Rota	0	2	0	2
ENT General Full Timers Slot Share	0	3	3	0
Ger Med GPST 2024	0	8	8	0
Medicine Extra F1	0	6	6	0
Medicine F1 2024	0	22	22	0
Medicine IMY2 2024	0	2	2	0
Medicine SHO LTFT 0.8 Flexi	0	4	4	0
Medicine SHO LTFT 0.8 MTWT	0	2	2	0
Medicine SHO 9-5	0	2	2	0
Neonates T1	0	1	1	0
Psych F1 LIFT WF	0	1	1	0
Surgical F1	0	4	4	0
Total	0			

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	11	12	6	3	1	0
SHO	14	3	3	1	0	2
SpR	2	0	0	1	2	0
Total	27	15	9	5	3	2

Quarterly Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Basic Hours	0	1	1	0
Medicine Extra F1	0	1	1	0
Medicine F1	0	5	5	0
Medicine IMY2	0	2	2	0
Medicine SHO 2024 LTFT 0.8 Flexi	0	1	1	0
Neonates T1	0	1	1	0
Total	0	10	10	0

Annual Exception reports (regarding working hours)

Exception reports by department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident & Emergency	2	25	27	0
General Medicine	5	94	99	0
General Practice	1	5	6	0
General Surgery	1	30	31	0
Geriatric Medicine	0	9	9	0
Obstetrics & Gynaecology	0	6	6	0
OMFS	0	2	2	0
Otolaryngology (ENT)	0	3	3	0
Paediatrics	2	1	3	0
Psychiatry	0	1	1	0
Total	11	176	187	0

Exception reports by Grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	5	87	92	0
F2	1	6	7	0
CT/ST 1-2	5	56	61	0
ST 3-8	0	25	25	0
Total	11	174	185	0

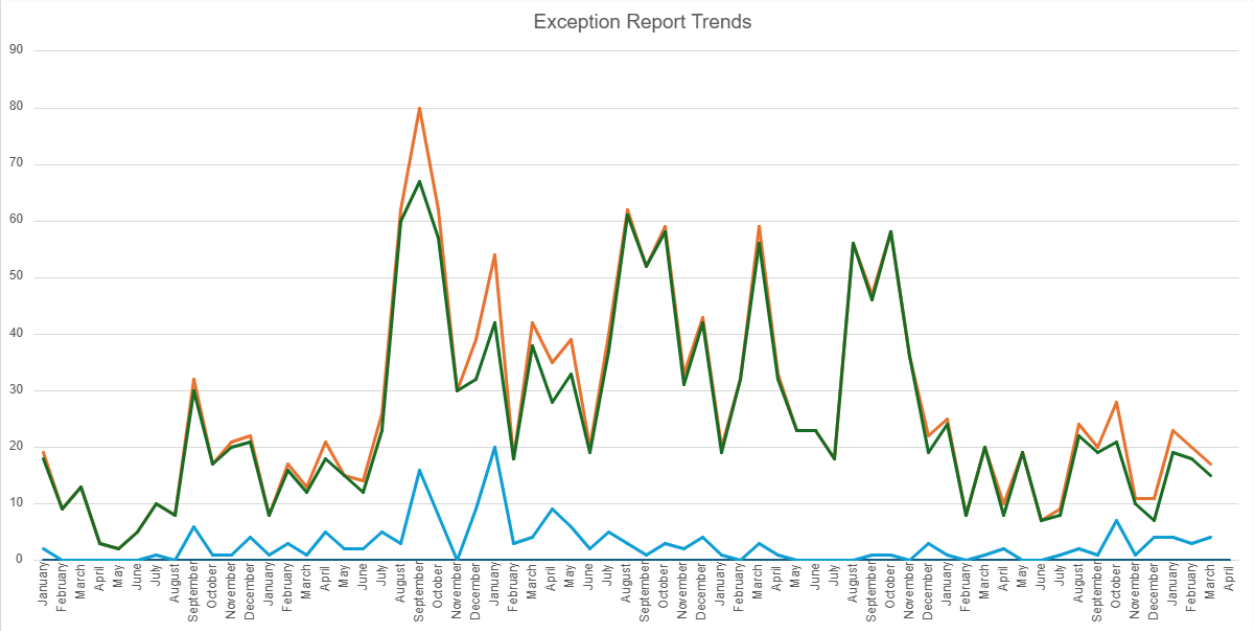
Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	31	29	9	13	5	0
SHO	0	1	5	0	0	0
SpR	16	7	10	16	7	0
Total	2	1	8	12	2	0

Annual Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Basic Hours	0	1	1	0
ENT FT Slot share	0	1	1	0
GP F2 2023	0	2	2	0
Medicine Extra F1	0	1	1	0
Medicine F1	0	7	7	0
Medicine F1 2024 LIFT WF	0	1	1	0
Medicine IMY2	0	9	9	0

Medicine IMY2 LTFT 0.8 Flexi	0	1	1	0
Medicine SHO 2024 LTFT 0.8 Flexi	0	1	1	0
Neonates T1	0	1	1	0
Surgical F1 2022	0	2	2	0
O and G T1 2024 0.8 Flexi	0	2	2	0
Total	0	29	29	0

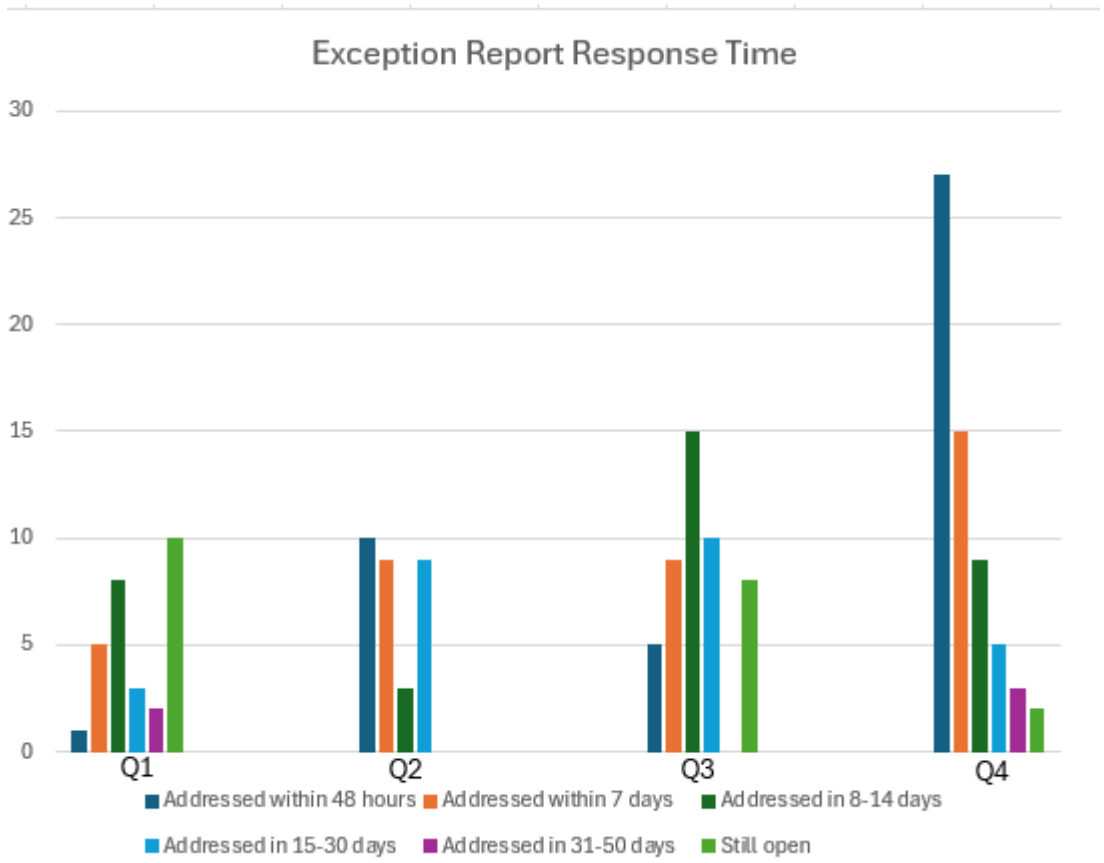
Exception report trends (by calendar month from 2016)



Blue represents educational exception reports, green hours & rest exception reports and orange the total number of reports.

Variations across the training year can be seen to mirror the same pattern across the years of exception reporting although the absolute number of exception reports in each year differs.

Response times for exception reports



Whilst this graph has been produced with data from the beginning of April rather than current data is demonstrates a trend towards more efficient processing of exception reports through the quarters of the year.

Rates from Exception Reports (pay and penalty)

Nodal point	Pay (PT)	Penalty (PT)	Dr (PT)	GOSW (PT)	Pay (ET)	Penalty (ET)	Dr (ET)	GOSW (ET)
1	15.89	63.56	23.83	39.73	21.77	87.08	32.64	54.44
2	18.39	73.56	27.59	45.97	25.20	100.78	37.79	62.99
3	21.76	87.04	32.64	54.4	29.81	119.25	44.72	74.53
4	27.58	110.32	41.38	68.94	37.79	151.14	56.68	94.46
5	31.63	126.52	47.45	79.07	43.34	173.34	65.01	108.33

Nodal point relates to the seniority of the doctor on their pay scale. PT plain time, ET Enhanced time. The penalty is 4 times the hourly rate with this being divided between the doctor and the GOSW fines monies. These are nationally prescribed levels.

Exception Reports

The annual data for Hours and Rest exception reports demonstrates that the main department for reporting exceptions is General Medicine with General Surgery and Accident & Emergency being the other 2 main reporting areas. Other specialties have fewer or no exception reports submitted.

Foundation 1 doctors are the most frequently reporting group. There also high numbers in the CT/ST1-2 and ST 3-8 levels which may reflect more support from DiTs higher up training to support the F1 doctors and also a shift in reporting culture.

As GOSW I have been working to foster an open culture where Exception Reports are welcome and the DiTs know that they are used as a means of assessing and improving working conditions rather than solely as a means of remuneration for the individual.

There are no outstanding Exceptions at the time of producing this report. Where there has been very slow, or no, response from the Educational or Clinical Supervisors the Exceptions have been managed directly by the GOSW. This has also been the case where there is an obvious error with submitting the report – for example a time entered instead of the number of hours the time entered in minutes instead of hours.

There is additional information about patterns of reporting and time taken to manage Exceptions which is included in this report above.

Work schedule reviews

There have been no work schedule reviews this quarter although there are currently 2 queries open, one with the Lead Employer, around 80% LTFT working patterns. These are being addressed with HR and the Director for Medical Education with support from myself.

Vacancies

There continue to be a number of vacancies which affect the rotas. Some departments are working at, or close to, minimum staffing levels and this may reflect in the numbers of exception reports from their doctors.

Fines

There have been a small number of fines raised in the last year. The current value of GOSW fines pot is calculated as £168.44. Where this money is spent will be determined by the Resident Doctors Forum.

Resident Doctors Forum

This forum is jointly chaired by the Director for Medical Education and the GOSW. Attendance by the Doctors in Training has been very poor through the last year. We are working, with input from the BMA representative, to trial different ideas to improve attendance and also have a survey open for the doctors in training to try to improve attendance.

Changes to Exception Reporting process

It is of note that, as part of the Doctors in Training contract negotiations there has been an agreed change to the Exception Reporting process from September 2025. Whilst there is still some dissemination of information as to how this process will work in practice the GOSW team and HR are working together to put this in place. One of the main changes is a move from Supervisors signing off Exception Reports to this being

	primarily a process being led by HR. There will not be involvement of Educational Supervisors unless in specific circumstances. There are also planned to be several more situations in which fines are issued. These will include not having access to Exception Reporting before completion of induction, information sharing and a reduced time for reports to be processed.

2	Implications
2.1	**Patients** • The role of the safe working hours is designed to reassure junior doctors and the Trust that rotas and working conditions are safe for doctors and patients.
2.2	**People** • The Guardian ensures that issues of compliance with safe working hours are addressed by the doctor and the Trust as appropriate. It provides assurance to the board of the employing organization that doctors' hours are safe. • The guardian works in collaboration with the Director of Medical Education and Local Negotiating Committee to ensure that the identified issues within exception reports, concerning both working hours and training hours, are properly addressed by the Trust.
2.3	**Finance** • The Guardian distributes monies received as a consequence of financial penalties to improve the training and working experience of all doctors. There have been no financial penalties this quarter.
2.4	**Compliance** • This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
3 September 2025

Item 27

Title	Learning from Deaths Report (Q4 2024-2025)
Area Lead	Dr Ranjeev Mehra, Interim Joint Medical Director
Author	Dr Ranjeev Mehra, Interim Joint Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q4 2024-2025.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to Jan 2024 is 0.99 (within expected range)
- HSMR on the latest available data is 101.3 (within expected range)
- Telstra Health have flagged a CUSUM Alert for deaths due to pneumonia
- The Mortality review group (MRG) is a multidisciplinary group that meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstra Health data to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and via the Divisional Quality Boards. Specific learning points are also fed back to relevant Trust wide steering groups.

It is recommended that the Board:

- Note the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.

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

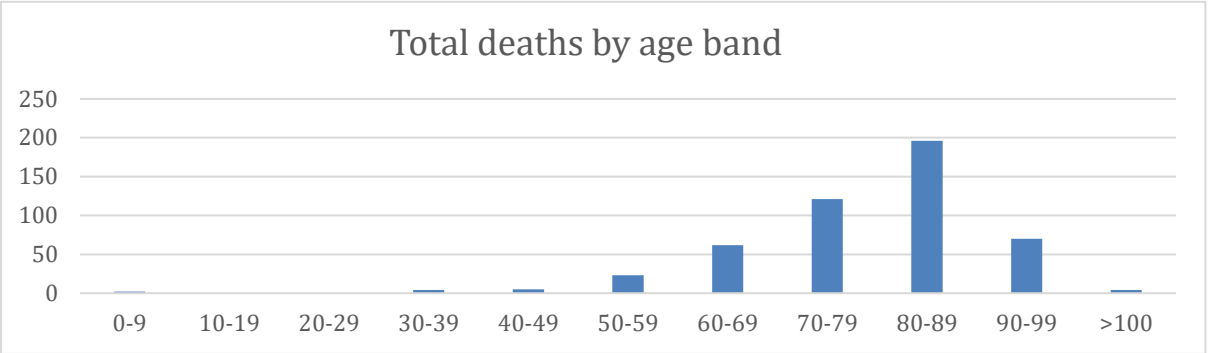
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No

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**
4 August 2025	Quality Committee	As above	As above
17 July 2025	Patient Safety Quality Board	Complaints Annual Report 2024/25	For information

1	**Narrative**
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospitals NHS Foundation Trust over Quarter 4 (Jan- Apr 25). It aims to identify key learning points, trends, and areas for improvement to enhance patient safety and care quality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare and benchmark against mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide an indication of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random sample of non-escalated deaths (approx. 5% per quarter) are selected for a “quality assurance” mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group, and by the circulation of this report through Divisional Quality Boards. **<u>Patient demographics</u>** There was a total of 487 deaths in Q4 24-25.

Most recorded deaths are in the over 70 age group and the vast majority fall into the "White British" Ethnic band. This is in keeping with previous quarters.



Ethnicity	Number of deaths
White - British	437
White - Irish	3
White - Any other White background	6
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	3
Other Ethnic Groups -	0
Black/ Black British	1
Not stated/ Not known	37
Total	487

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to January 2025) is 99.9 which is within the "as expected" range. SHIMI for WUTH has been relatively stable in the "expected" range for several quarters now.

Factors impacting SHIMI.

- Specific diagnostic groups

There were no individual diagnostic groups that had a statistically high SHIMI on the latest data

- Deprivation

The Trusts continues to have a higher-than-average percentage of provider spells from the most deprived areas. Potential additional risks/complexities associated with these

patients, is not factored into the SHMI calculation unlike HSMR, and can lead to a higher SHIMI.

- Palliative care coding

As discussed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will impact on SHIMI as the SHIMI model does not exclude these patients.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR on the latest 12 months rolling trend is at 101.3 This is in the expected range.



Summary of all Adult in patient deaths and case reviews					
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q1 (24-25)	420	100%	9	12	21
Q2 (24-25)	436	100%	16	32	48
Q3 (24-25)	471	100%	14	27	41
Q4 (24-25)	487	100%	15	26	41

Mortality Dashboard

The medical examiners (MEs) continue to maintain scrutiny of all WUTH deaths and escalate cases where potential concerns are identified.

15 cases escalated by the ME service during Q4 have been allocated for review using our Mortality Review form. 4 of these cases were in deaths in patients with a recorded Learning Disability.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 26 deaths were allocated for review in Q4 (5%) using the PMR template.

Grading of Adult Care and avoidability following review in Q4 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Number of cases	29	13	2	0

During Q4 44 reviews were discussed at MRG and graded as above.

During Q4 there was 1 death reported for patients with a recognised learning disability

Learning Disability Mortality Reviews			
	Total No. of LD Deaths	No. reviewed	Referred to National LeDeR Programme
Q1 (24-25)	0	0	0
Q2 (24-25)	5	5	5
Q3 (24-25)	1	1	1
Q4 (24-25)	4	4	4

Perinatal and Neonatal deaths

All Neonatal deaths are discussed in a monthly neonatal mortality review meeting attended by Consultants, Nurse Managers, Advanced Neonatal Nurse Practitioners, trainee doctors and senior neonatal nurses. A standardised review template is used to collate information relating to the inpatient care. The deaths are then further reviewed using the PMRT which is a review that supports external attendance from Obstetricians, Neonatologists and Midwives.

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q1 (24-25)	1	2	1	3
Q2 (24-25)	0	3	3	3
Q3 (24-25)	4	5	4	9
Q4 (24-25)	2	2	0	4

All neonatal deaths and stillbirths will be reviewed using the PMRT process

Outcome of PMRT reviews reported in Q4 (each PMRT is graded for 3 elements)				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	3	8	4	1

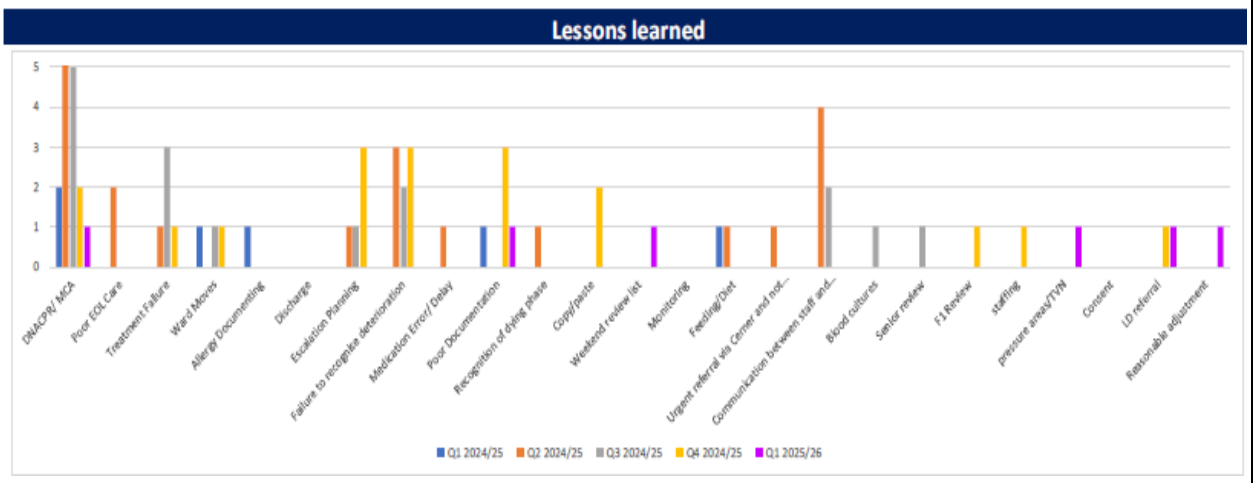
Learning from PMRT reports is fed back to clinical teams. One element of care was graded as “D”. This related the lack of a bereavement suite rather than concerns about clinical care. The issue has been addressed by the Division.

Learning identified through review of mortality reviews during Q4.

Learning for mortality is derived from 3 main sources.

- Mortality reviews (collated into a learning log)
- Themes and trends escalated from the Medical Examiner
- Learning identified through the PSIRF process.

General learning themes from mortality reviews are collated on a learning tracker and shared across Divisions for learning



External Benchmarking Data

Telstra Health Data

The Telstar Health (formerly Dr Foster) dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality.

During Q4 a CUSUM alert was generated for deaths due to pneumonia. Further analysis deaths in this group showed that

- A higher proportion of patients at WUTH had palliative care input than peers
- Frailty was not being accurately recorded (frailty is part of the HSMR risk adjustment)
- The review identified issues with coding of deprivation (a higher proportion of patients in the “ unknown” band.
- It was noted that the SHIMI for the corresponding period was not statistically raised for deaths due to pneumonia.

	Conclusion • Mortality Indicators remain in the “as expected” category • MRG continues to meet every 2 weeks to scrutinise and review mortality across the Trust • The Medical examiner service continues to provide 100% scrutiny of all inpatient and Emergency Department deaths • A CUSUM alert was identified for deaths due to pneumonia which has been reviewed and learning identified. This will continue to be monitored through MRG

Board of Directors in Public **Item 28**

03 September 2025

Title	Complaints Annual Report 2024/25
Area Lead	Sam Westwell, Chief Nurse
Author	John Molyneux, Head of Complaints
Report for	Information

Executive Summary and Report Recommendations

This report summarises concerns and complaints activity and performance at Wirral University Teaching Hospital NHS Trust (WUTH) for the fiscal year April 2024 to March 2025.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Board Assurance Framework 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	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**

4 August 2025	Quality Committee	As above	As above
17 July 2025	Patient Safety Quality Board	Complaints Annual Report 2024/25	For information

1	Narrative
1.1	**Comparative Performance (Formal Complaints)**

	2023/24	2024/25	% Change Over Previous Year
Formal Complaints Logged[1]	202	221	9%
Active Caseload (at Year End)	65	40	-38%
Ongoing Breaches (at Year End)	25	11	-56%
% Acknowledged in 3 Working Days[2]	98%	98%	0%
% Responded to Within Original Timescale Agreed	35% (65/185 responses)	30% (74/247 responses)	-5%
Avg. Response Time (Working Days)	60	60	0%
Re-opened Cases[3]	45	22	-51%
PHSO Cases Opened	8	6	-25%
PHSO Completed Investigations Upheld or Partially Upheld	3 (23% of closed cases and 75% of detailed investigations)	1 (17% of closed cases and 25% of detailed investigations)	-67%

The Trust logged 221 formal complaints, averaging 18 cases per month, and 3 per 1000 staff (below the trust metric of 3.1).

The most frequently cited theme in formal complaints remained 'Communication', featuring in 63% of cases and aligning with national trends. Other prominent themes included 'Treatment & Procedure' (50%), 'Access & Admission' (20%), 'Medication' (17%), and 'Diagnosis' (14%), with most complaints involving multiple overlapping issues. These patterns are broadly consistent with previous years, although some areas (such as access, medication, and tests) show signs of rising concern.

[1] Trust performance metric is set at </= 3.1 per 1000 staff per calendar month.
[2] Trust performance metric is set at 90% per calendar month.
[3] Trust performance metric is set at </= 5 per calendar month.

The Medicine Division received the highest number of complaints (76), followed by Emergency Care (71), Surgery (64), and Women & Children's Services (53), which saw a marked rise from the previous year.

At department level, the Emergency Department recorded the highest number of complaints, mainly around communication, treatment, diagnosis, and test delays. Community Child Health complaints focused on access. Urology, Colorectal & Upper GI, and Gynaecology Outpatients raised recurring issues around communication, treatment, and access.

Of the 247 complaints responded to, 70% were either upheld or partially upheld – a 10% rise from last year and slightly above the national average of 66%. Most upheld issues related to communication (with WUTH perhaps more frequently recognising partial service failings than peers) and delays.

Comparative Performance (Level 1 Concerns)

	2023/24	2024/25	% Change Over Previous Year
Level 1 Concerns Logged[4]	2191	2885	32%

The Trust recorded 2885 level 1 concerns in 2024/25 – a 32% increase and the highest volume in five years. Although this may reflect improved visibility and early resolution, it may also indicate growing dissatisfaction, especially given that formal complaint numbers have not declined.

Concerns focused heavily on access and operational delays, with 'Access and Admission' the leading theme (32%). 'Communication' remained significant (22%), although less dominant than in formal complaints. Compared to complaints, informal concerns less often involved treatment or diagnosis.

The Medicine Division recorded the highest number of informal concerns (859), a 54% rise from the previous year, overtaking Surgery. Significant increases were also seen in Surgery (752), Women and Children's Services (607), and Diagnostics & Clinical Support (348), highlighting growing pressures in high-demand clinical areas. Corporate Services concerns more than doubled, while Estates & Facilities remained stable.

Numbers rose sharply across most of the top 20 departments in 2024/25, with the Emergency Department leading at 312 cases (up 34% on last year). Community Child Health also saw a 35% increase, with notable rises in Urology, Gynae OPD, Gastroenterology, ENT, and Cardiorespiratory. The Access to Information Office saw the steepest rise (up 272%), due to delays in the timeliness of processing of subject access requests. The dominant themes in the top five departments were delays in treatment and access, poor communication, lost property, and test/result issues.

[4] Trust performance metric is set at </= 173 per calendar month.

	Positives • 98% of complaints were acknowledged and forwarded to divisions within three working days (and on average within one working day). • There was a 34% increase in productivity in terms of completed complaint investigations, with 247 cases closed in 2024/25, compared to 185 in 2023/24. • Formal complaints comprised just 0.02% of WUTH patient contacts. • 54% of level 1 concerns were resolved within three days; 75% within ten days. • Only 2.8% of level 1 concerns escalated to formal complaints. • There was a 51% reduction in re-opened complaints. • Fewer complaints progressed this year to PHSO detailed investigation, and were upheld or partially upheld, with PHSO final report findings largely mirroring the previous Trust investigation. **Areas for enhancement** • The 60-working-day average response time still exceeds the Trust's 40-working-day target, which was only achieved in 30% of cases – 5% down on 2023/24. • There was a 9% increase in formal complaints and a 32% increase in level 1 concerns. • Divisional investigation delays remain the primary cause of level 2 breaches. • Multi-divisional coordination continues to pose a challenge, often requiring the Complaints and PALS Team to consolidate fragmented divisional inputs. • Further strengthening of the central mechanism to collate comprehensive evidence aligned to action plans for assurance, with sustained monitoring mechanisms.

2	Implications
2.1	**Patients** • Analysis of complaints themes and trends, and improvement action taken as a result of complaints, feeds into and supports the Trust's patient safety and patient experience agendas. It also may highlight potential inequalities of service and lack of reasonable adjustments. • This annual report therefore provides assurance of such themes and trends, as well as highlighting any specific and substantive actions or learning resulting from service user (patients and relatives) complaints and feedback.
2.2	**People** • An effective complaint process should ensure that staff are enabled to give a fair and balanced account of what happened and what conclusions they reached on every complaint. The wellbeing of staff involved in a

	complaint should be supported via a culture of fairness, openness, and learning, with staff feeling confident to acknowledge when things go wrong, promoting a culture of psychological safety. • Equally, where complaints are not upheld, staff should feel supported during the complaints process, the outcome of which should be both timely and fairly explained.
2.3	**Finance** • Although there are no direct financial implications arising from most complaints, where there has been a finding by the PHSO of maladministration or service failure, financial remedy may be recommended. Poor and untimely complaints handling may also be followed by litigation, with associated costs incurred in defense or compensation. • Conversely, service and process improvements made because of learning from complaints may have a positive fiscal impact.
2.4	**Compliance** • As per The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, healthcare bodies are required to prepare an annual report that must: a) specify the number of complaints received; b) specify the number of complaints that were decided to be well-founded; c) specify the number of complaints referred to the Health Service Commissioner (PHSO) or Local Commissioner (LGSCO); and d) summarise (i) the subject matter of the complaints received; (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled; (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints. • This annual report is therefore in line with those regulations and provides assurance of compliance.

Complaints Annual Report, 2024/25

Purpose

This report summarises the concerns and complaints activity and performance at Wirral University Teaching Hospital NHS Trust (WUTH) for the financial year April 2024 to March 2025.

Introduction / Background

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 outline a two-stage complaints process: local resolution by the NHS body, followed by referral to the Parliamentary and Health Service Ombudsman (PHSO) if the complainant remains dissatisfied.

The Trust's Concerns and Complaints Policy emphasises early resolution by frontline staff to prevent unnecessary escalation to formal complaints. Where a formal complaint is raised, a complaints specialist in the central Complaints and PALS Team manages the process end to end, serving as the point of contact for both the complainant and divisional investigation leads.

As part of the registration process, the Complaints and PALS Team confirms each issue the complainant wishes to raise and agrees a likely timescale for completion of the investigation.

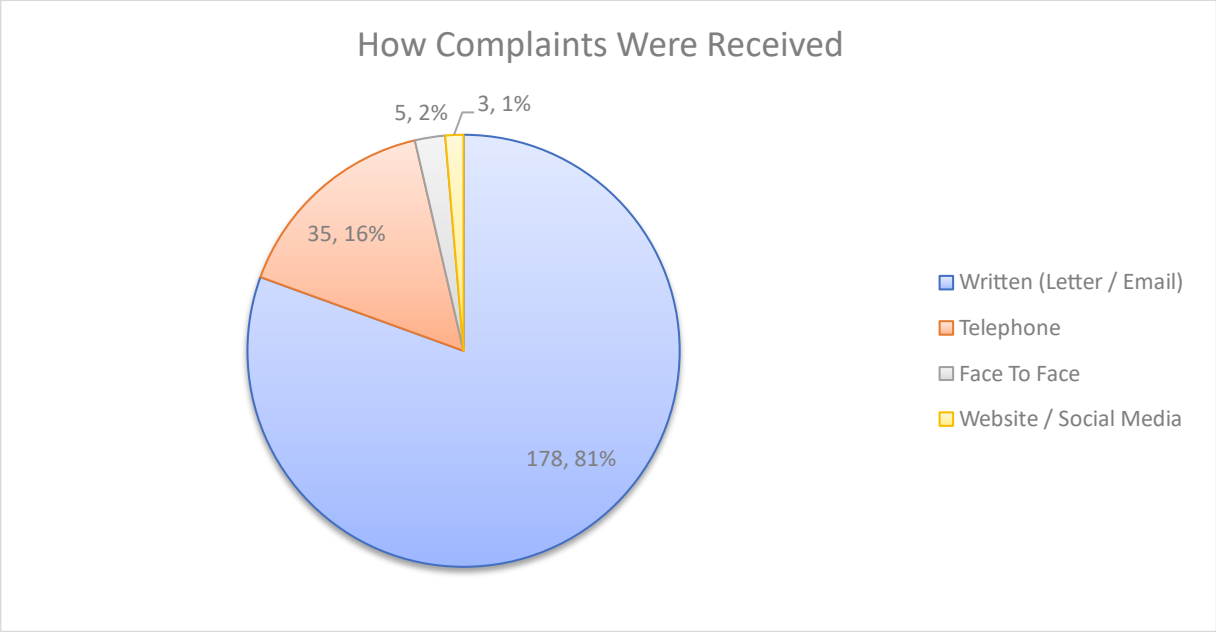
While the 2009 Regulations removed national response timescales in favour of individually agreed deadlines, WUTH's policy supports timely resolution by grading concerns and complaints on a scale of 1 to 2, with associated timescales.

Level 1	Level 2
This will be investigated as an informal concern that has the potential to be resolved quickly by front line staff within three working days. Level 1 concerns may be resolved verbally and do not require a written response unless requested by the enquirer. Any such written response may be signed off at departmental / divisional level.	This is a formal complaint that should be acknowledged within three working days of receipt and responded to within 40 working days via a written response signed off by the Trust's CEO. In the absence of the CEO, level 2 complaint responses may be signed off by the CEO's deputy.

Complaint Activity

A total of 221 formal complaints were registered in 2024/25, averaging 18 per month.

Most complaints were submitted in writing (81%), with a further 16% made by telephone.



This represents a 9% increase compared to the 202 complaints received in 2023/24, but an 8% decrease from the 240 complaints recorded in 2022/23. (For context, formal complaints account for just 0.02% of WUTH's patient contacts.)[5]

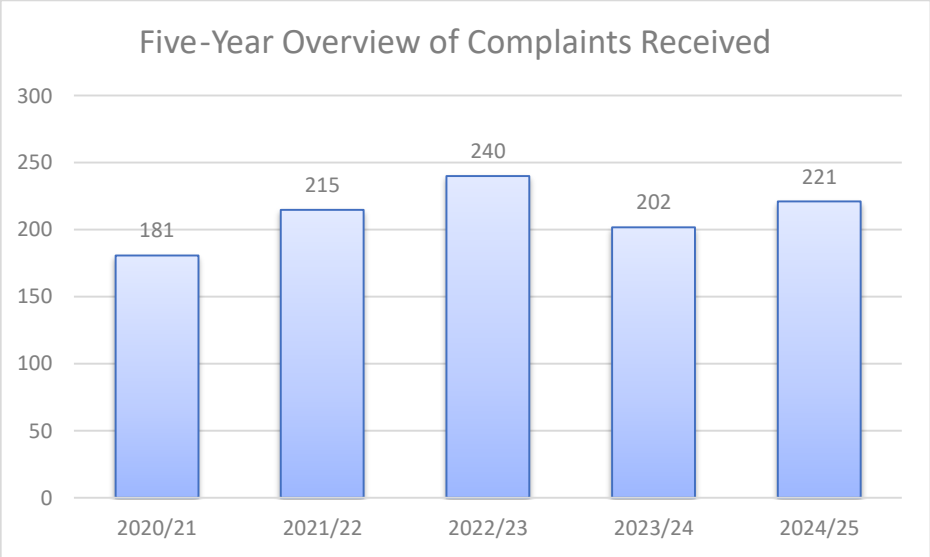
At the time of writing, NHS Digital's K041 performance data for 2024/25 had not yet been published. However, the most recent available data for 2023/24 indicated a 4% year-on-year increase in formal complaints received by hospital and community health services in England.

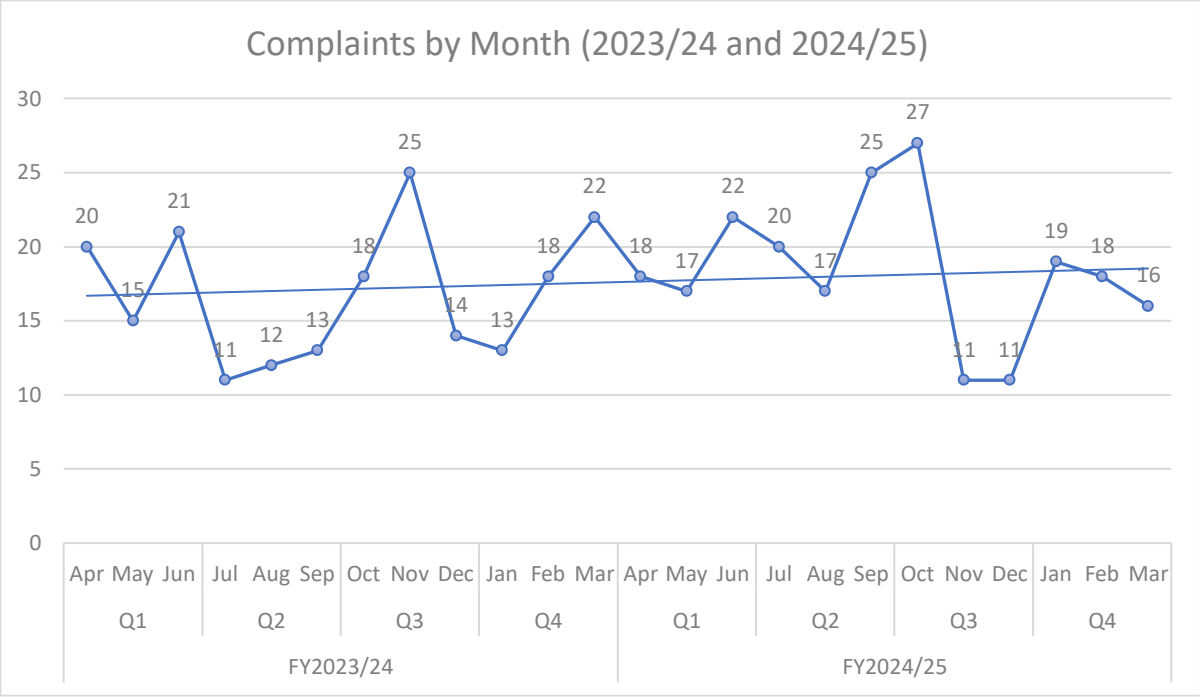
[5] The patient contact / activity data for 2024/25, excluding total births and diagnostic orders, were as follows.

New Outpatient attendances	**149,174**
F/Up Outpatient attendances	**377,685**
Diagnostic examinations performed	**342,807**
ED Attendances	**89,380**
Emergency admissions*	**53,162**
Elective day case admissions**	**52,366**
Elective planned admissions	**7,619**
Total	**1,072,193**

* Including maternity emergencies but excluding births.

** Excluding Nephrology.





‘Communication’ remained the most frequently cited theme in formal complaints, featuring in 63% of cases, consistent with the previous year. (This also aligns with national KO41 data as the biggest complaint theme). The majority of concerns related to communication failure with patients, visitors, or carers (42%), followed by staff attitude issues – nursing (10%), medical (6%), and other staff (4%). Lesser but notable subthemes included confidentiality breaches (3%) and failures within or outside the immediate team (6% combined).

‘Treatment and Procedure’ continued to be a prominent category, recorded in 50% of cases (down by 2%). The dominant subtheme was delays or failures in treatment (24%), with additional issues around post-operative complications (7%), failure to assist with personal care (5%) or nutrition (4%), and failures to monitor (4%). Several complaints also highlighted lapses in privacy and dignity (3%) and end-of-life care (3%).

‘Medication’ accounted for 17% of complaints, down by 2%. Most were centred around delays or failures in prescribing (7%) and administering medication (5%), with prescribing errors (5%) and lack of follow-up/monitoring (1%) also reported.

‘Access and Admission’ featured in 20% of complaints, a 1% increase from last year. These focused on delays or failures in accessing care (11%), outpatient cancellations or delays (6%), and inpatient appointment issues (2%), reflecting sustained pressure across referral and appointment pathways.

‘Diagnosis’ concerns were raised in 14% of complaints (down by 1%), primarily around delays or failures to diagnose (9%) and incorrect diagnoses (4%), with occasional issues relating to clinical or risk assessment.

‘Transfer and Discharge’ also accounted for 14% (down by 1%), most commonly citing inappropriate discharge (6%), discharge planning failures (4%), and delays in transfer (2%).

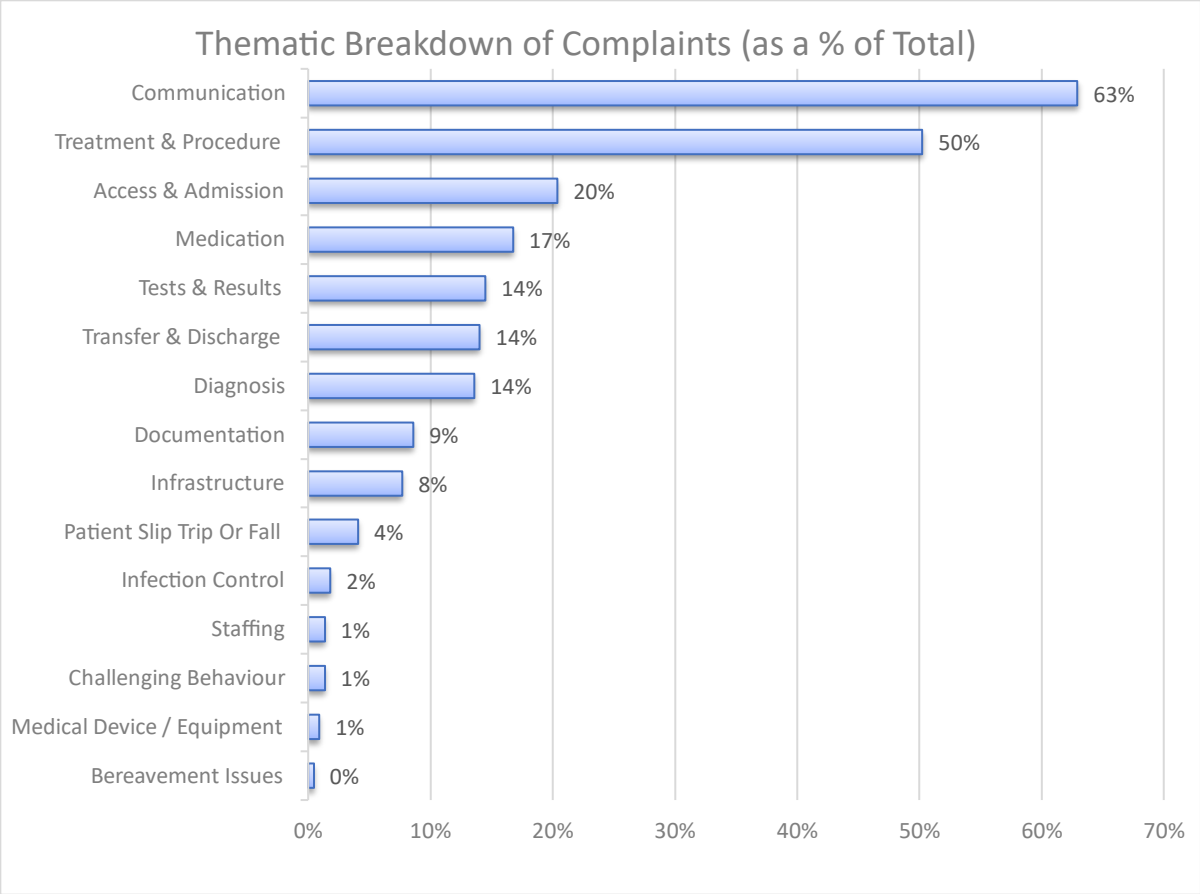
‘Tests and Results’ made up 14% (consistent with last year), with complaints including failures to undertake tests (7%), incorrect or delayed interpretation (2%), and missing or inaccurate results (4%).

Other notable themes included:

- ‘Documentation’ (9%, no change), especially around poor record-keeping and delays in receiving or accessing notes.
- ‘Infrastructure’ (8%, down by 1%), particularly patient property issues (2%) and unsafe environments (3%).
- Categories such as ‘Staffing’, ‘Infection Control’, and ‘Equipment Failure’ each remained under 2% but featured in specific individual complaints.

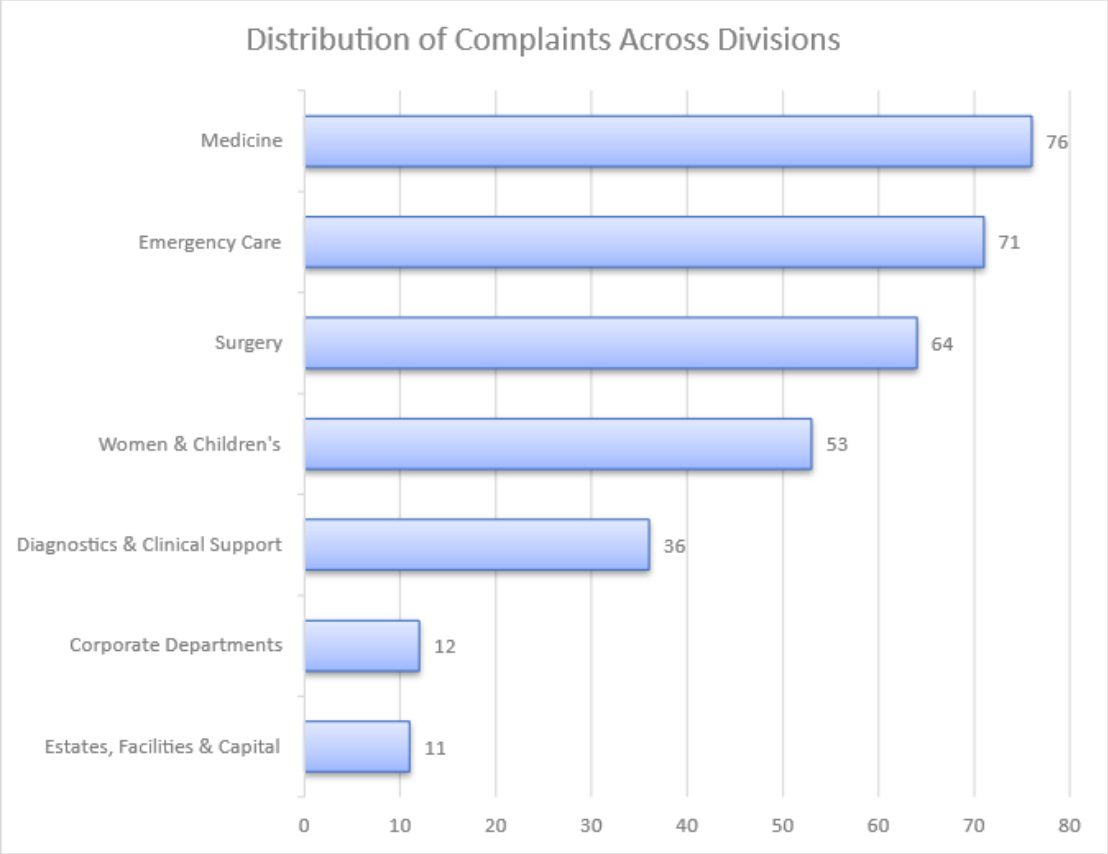
These figures show consistent thematic concerns from previous years, with some upward trends in access, test/result complaints, and medication-related issues. They also demonstrate a detailed pattern of concerns that are frequently multifaceted, requiring both clinical and organisational responses.

All thematic categories have been recorded and are presented in the following charts, along with comparative data from the previous four years. (Please note that a single complaint may comprise – and often does comprise – multiple issues, which may span several categories.)



Safeguard Category	2020/21	2021/22	2022/23	2023/24	2024/25
Communication	54%	68%	62%	63%	63%
Treatment & Procedure	46%	47%	49%	52%	50%
Access & Admission	7%	6%	11%	19%	20%
Medication	7%	6%	14%	17%	17%
Tests & Results	6%	6%	12%	14%	14%
Transfer & Discharge	23%	13%	14%	15%	14%
Diagnosis	19%	18%	11%	15%	14%
Documentation	5%	4%	6%	9%	9%
Infrastructure	6%	7%	7%	7%	8%
Patient Slip Trip Or Fall	3%	2%	4%	4%	4%
Infection Control	5%	1%	1%	1%	2%
Challenging Behaviour	2%	3%	3%	4%	1%
Staffing	2%	2%	2%	1%	1%
Medical Device / Equipment	1%	1%	3%	1%	1%
Bereavement Issues	1%	1%	1%	1%	0%
Unexpected Events	0%	0%	1%	0%	0%
Patient Accident	1%	0%	0%	0%	0%

During 2024/25, the highest number of complaints was received by the Medicine Division, which was involved in 76 cases, a modest increase from 73 in the previous year. This was followed closely by Emergency Care, with 71 cases, which reflects a slight reduction compared to last year's combined figure of 74 for the broader Acute Care grouping.

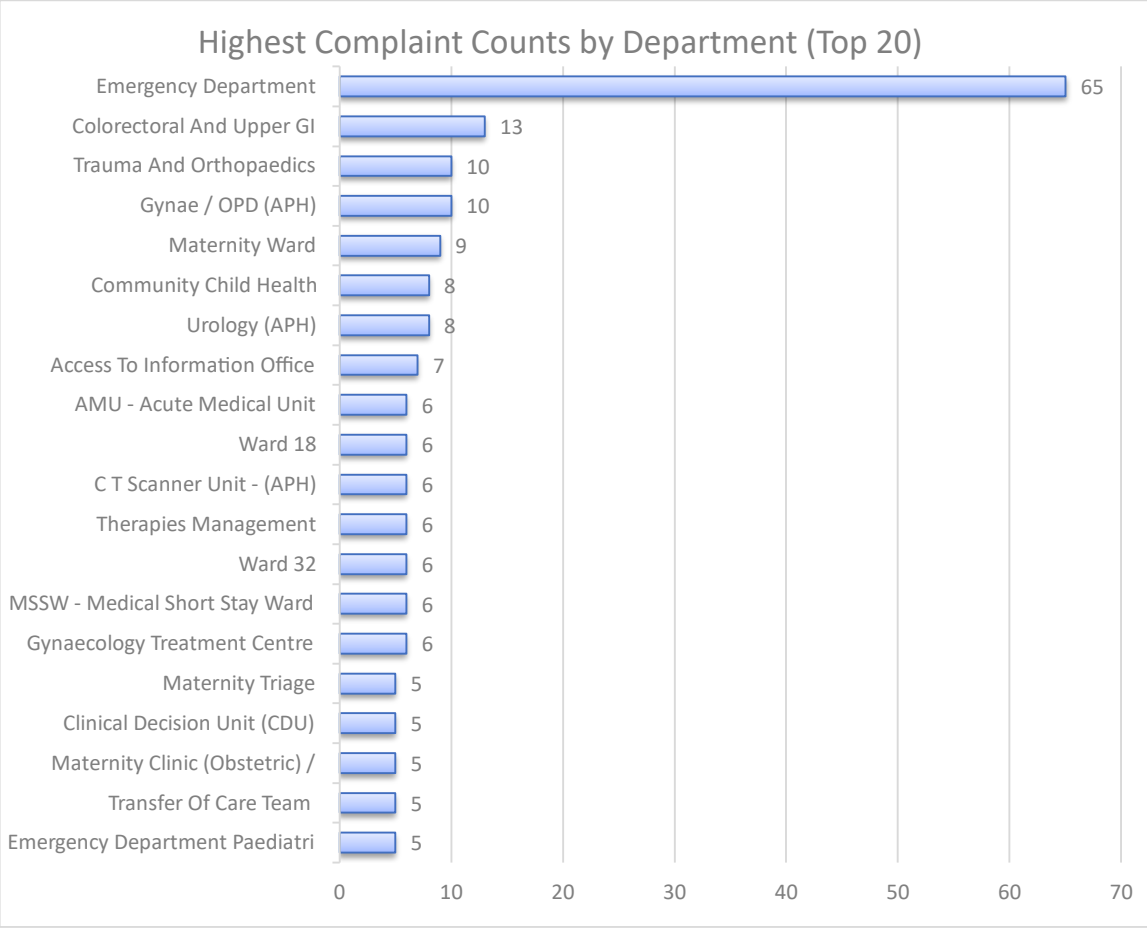


The Surgery Division received 64 complaints, up from 59 the previous year, and Women & Children's Services were involved in 53 complaints, a notable rise from 38.

Diagnostics & Clinical Support was involved in 36 complaints, slightly down from 42 in 2023/24, while Corporate Departments and Estates, Facilities & Capital received 12 and 11 complaints respectively – both slightly reduced from 13 in the previous year.

Overall, while the distribution of complaints remains broadly consistent with prior years, the increases seen in Women & Children's and Surgery suggest areas of ongoing challenge. The rise in Emergency Care complaints also reflects continued capacity and service pressures.

The top 20 individual areas and departments to receive a complaint are shown in the following chart.



This year's complaint data reveals key thematic patterns across the Trust's five most frequently cited departments.

1. Emergency Department

The Emergency Department generated the highest number of complaint themes overall; the most frequently raised themes were:

- 'Communication' (30 cases) – including concerns around explanation of treatment decisions, updates during waiting times, and staff attitude.
- 'Treatment & Procedure' (22 cases) – covering delays, perceived failings in urgent clinical care, or lack of appropriate intervention.
- 'Diagnosis' (13 cases)
- 'Access & Admission (12 cases)
- 'Tests & Results' (9 cases)
- 'Medication' (8 cases) – highlighting issues with administration of pain relief or prescriptions.

2. **Community Child Health**

- ‘Access & Admission’ (5 cases)

3. **Urology (APH)**

- ‘Communication’
- ‘Treatment & Procedure’
- ‘Access & Admission’ and ‘Diagnosis’

4. **Colorectal and Upper GI**

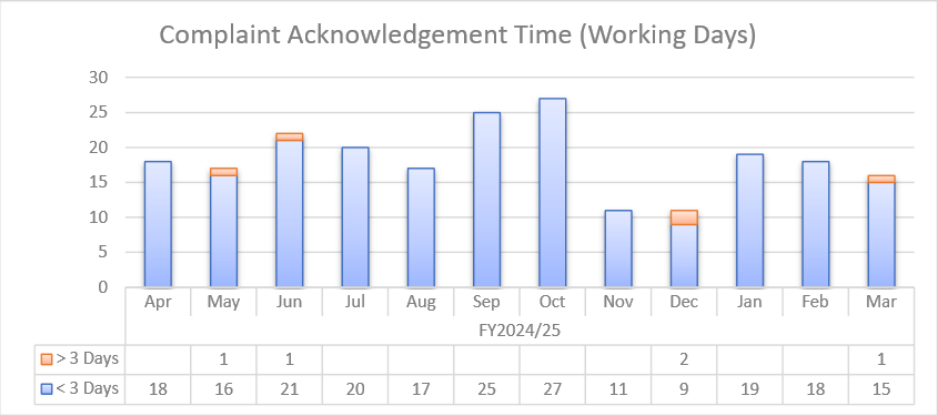
- ‘Communication’ (4 cases)
- ‘Treatment & Procedure’ (4 cases)
- ‘Access & Admission’ (3 cases)

5. **Gynaecology Outpatients (APH)**

- ‘Treatment & Procedure’ (7 cases)
- ‘Communication’ (5 cases)
- ‘Access & Admission’ (3 cases)

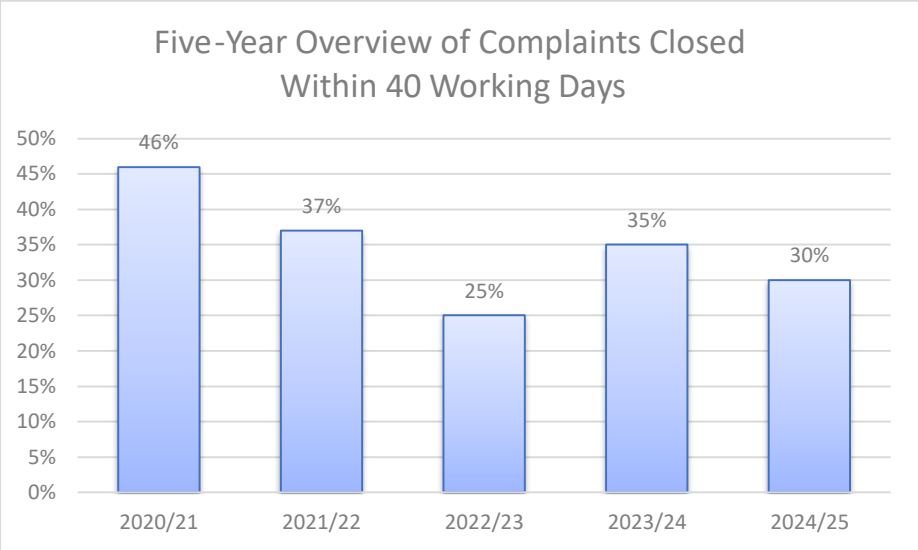
Complaint Response Timeliness

From October 2020, the Trust’s Concerns and Complaints Policy established a standard timescale of 40 working days for responding to complainants. Internal divisional response times are currently set at 23 working days, running concurrently with an initial acknowledgement target of three working days. The remaining time is allocated to finalising the response letter by the Complaints and PALS Team after receipt of the divisional investigation, followed by executive quality assurance and sign-off by the Chief Executive Officer or deputy.

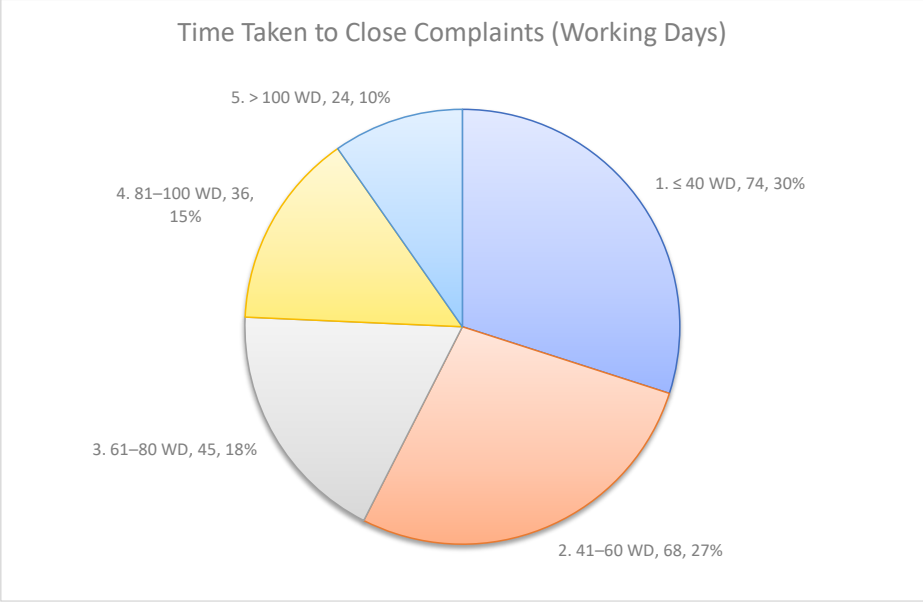


During 2024/25, 98% of formal complaints were registered and acknowledged within the national target of three working days, with an average acknowledgement time of just one working day. However, only 30% of complaints received a response within

the local target of 40 working days, representing a 5% decrease compared to the previous year.



The average response time remained unchanged at 60 working days.



Notably, there was a 34% increase in productivity in terms of completed investigations, with 247 cases closed in 2024/25, compared to 185 in 2023/24.

Analysis of the end-to-end complaints process highlights the complexity of clinical divisional investigations, resulting in protracted timescales that frequently exceed the internal deadline of 23 working days. The process of further revision and quality assurance impacts the overall response timeframes and will be subject to further review and improvement during 2025/26.

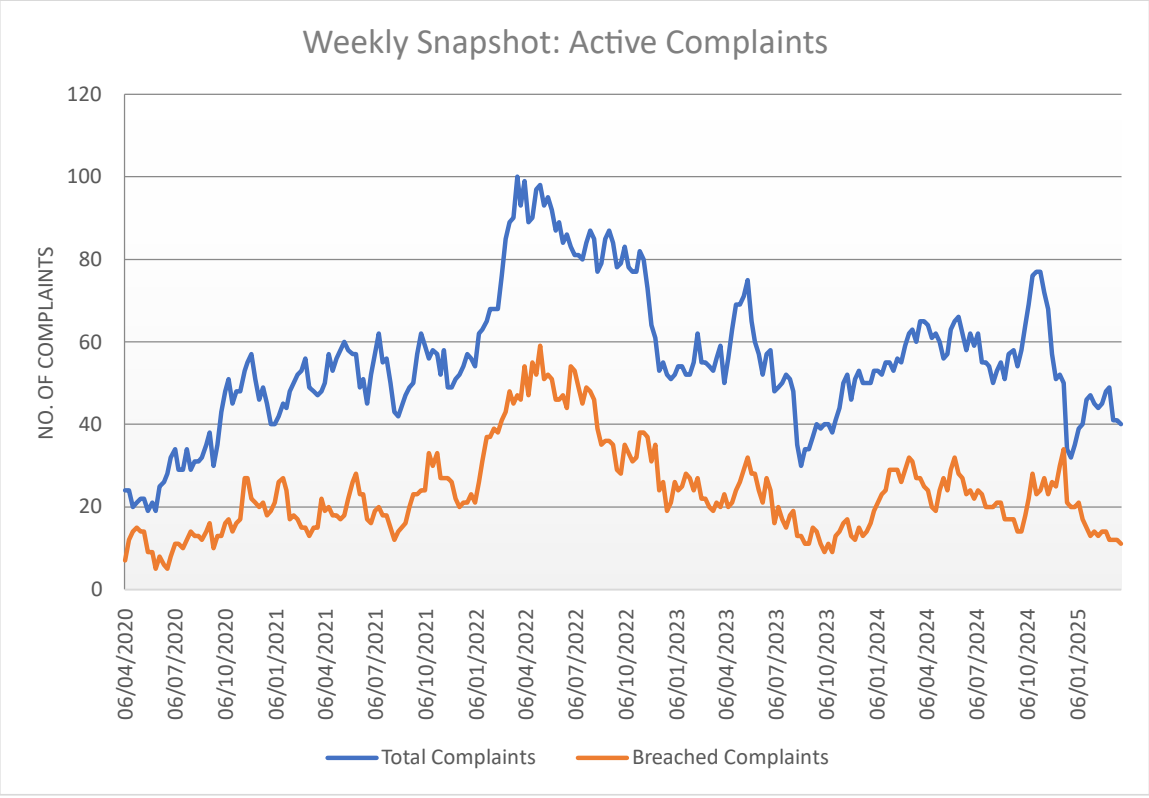
The multi-divisional nature of many complaints, combined with the iterative drafting and quality assurance process, makes it challenging to quantify these delays with

precision. However, the following chart offers a comparative snapshot of the 40 open cases as of the end of Quarter 4, 2024/25.

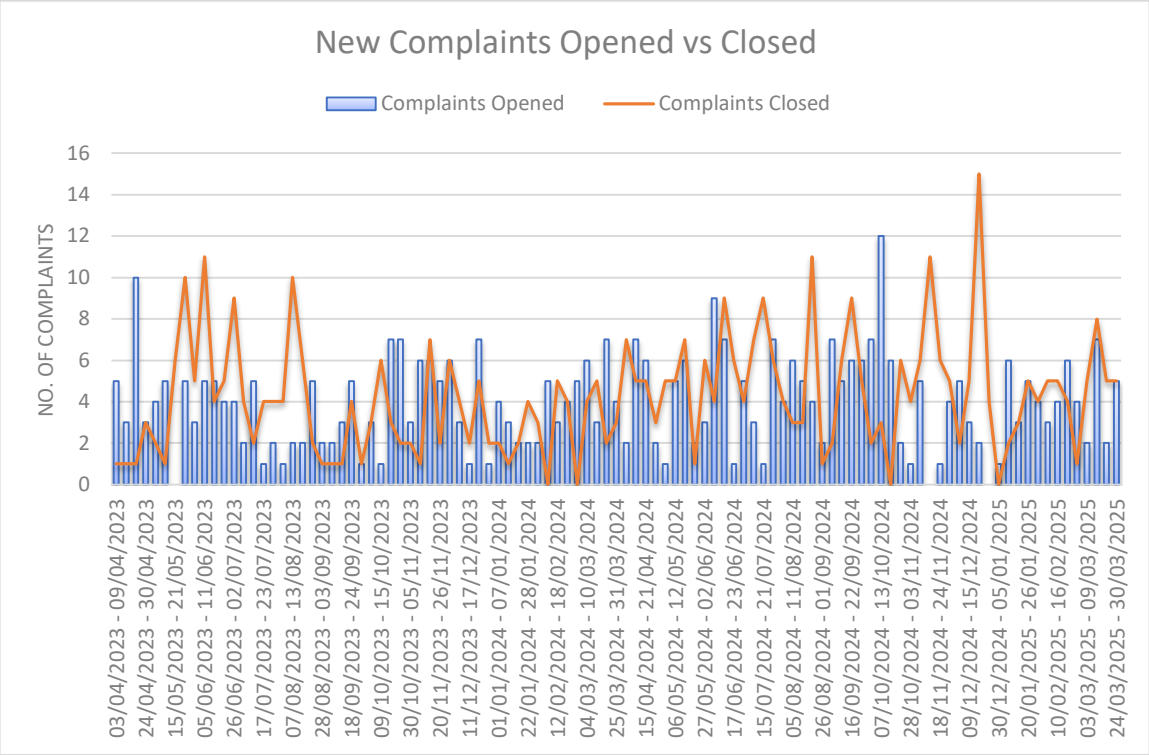
Division	All Cases	Cases Breached Internal 23 Working Days Deadline	Cases Breached External 40 Working Days Deadline
Corporate Departments	1	1	1
Diagnostics & Clinical Support	7	3	3
Emergency Care	17	4	7
Estates, Facilities & Capital	1	0	0
Medicine	13	3	4
Surgery	9	2	4
Women & Children's	12	5	2

WUTH began 2024/25 with an active caseload of 65 complaints, 25 of which had exceeded the 40-working-day timescale. By the end of the year, this had improved to 40 active complaints, with only 11 breaching the timescale – representing a 38% reduction in overall caseload and a 56% reduction in overdue cases.

The following chart shows the weekly fluctuations in active caseload over the past five years.

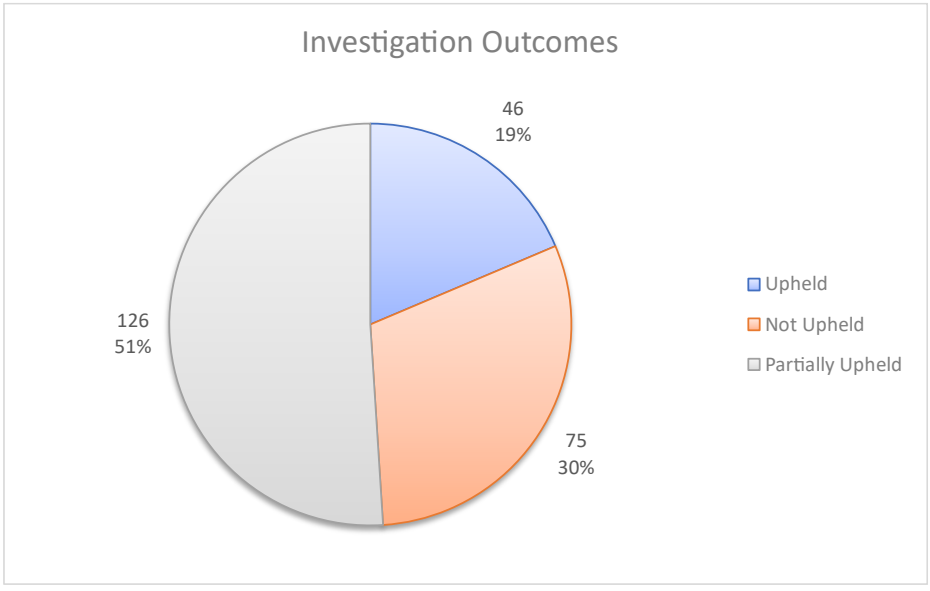


A comparison of the complaint numbers opened and closed each week over the past two years is shown in the chart below.



Complaint Outcomes

During 2024/25, a total of 247 complainants received a first response to their concerns – representing a 34% increase compared to the 185 responses issued in 2023/24. Of these responses, 19% of complaints were upheld, 51% were partially upheld, and 30% were not upheld.



This reflects a 10% increase in the proportion of upheld and partially upheld complaints compared to the previous year.

For comparison, NHS Digital K041 data for 2023/24 (covering all hospital and community health services in England) reported the following outcomes:

- 26% upheld
- 40% partially upheld
- 34% not upheld

Compared to the national figures, WUTH recorded a lower proportion of fully upheld complaints, but a notably higher proportion of partially upheld outcomes. The combined total of upheld and partially upheld complaints at WUTH was 70%, compared to 66% nationally.

This variance may indicate a greater number of areas for improvement within our organisation, or alternatively, it may reflect a more reflective and patient-centred approach to complaint review – one in which we recognise and respond to partial service failings more readily than some peers.

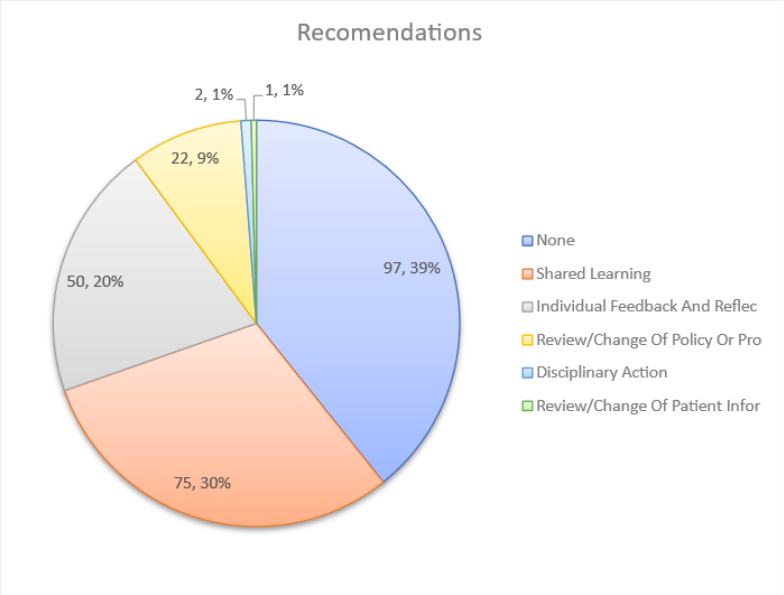
The majority of upheld or partially upheld complaints related to issues around communication and appointment or treatment delays. In many cases, where concerns involved communication, the complaint aspect was upheld on the basis that communication is inherently subjective, and complainants are generally afforded the benefit of the doubt in such circumstances.

Learning from Complaints

Since October 2020, all divisions have been required to submit an action plan alongside each complaint response, detailing identified leads and timescales for completion. These are intended to support the tracking of actions via the Ulysses Safeguard system.

A review of the governance mechanisms to evidence learning and improvement will be conducted throughout 2025/26 to further strengthen systems and processes.

Of the 247 complaint responses issued in 2024/25, 97 cases were judged not to require any formal actions. The following chart summarises the broad themes of actions and recommendations described in the responses.



The following are examples of specific learning actions and process changes described within complaint responses as having been implemented during the year.

Emergency Care	
Ref: 19363	• All triage nurses have been reminded that patients meeting criteria for direct streaming to another speciality should be referred promptly to avoid delays. • The Emergency Department's operational team will liaise with the Endoscopy Team to develop improved pathways. Patients seeking advice after recent endoscopic interventions may, where appropriate, be directed to the Surgical Evaluation Unit (SEU) rather than the Emergency Department.
Corporate Services	
Refs: 21071, 21887, 22735, 22779	In response to delays in processing Subject Access Requests (SARs): • Monthly monitoring of SAR performance by the Trust's Information Assurance Group, with escalation to the Executive Assurance and Risk Committee and Trust Board. • Implementation of new SAR software to improve logging and processing. • Commissioning of a Service Improvement Team review of SAR processes to identify efficiencies and ensure adequate support. • Exploration of the safe and appropriate use of Artificial Intelligence technologies to support SAR handling.
Diagnostics and Clinical Support	

Ref: 22552	Following a transcription error in a coronary angiogram report (misinterpretation of 'RIMA' as 'LIMA'): • All cardiac radiology reporters have been advised to avoid using the acronym 'RIMA'. • Reporters have been instructed to fully verbalise 'left' and 'right' to reduce the risk of misinterpretation by voice recognition software.
Estates, Facilities, and Capital	
Ref: 19451	• Updates are being made to the Trust's public website to improve visibility and accessibility of information on car parking charges.
Medicine	
Refs: 18621, 22645	In response to the unavailability of a hoist during a Dermatology outpatient appointment: • Staff are exploring the use of appointment system alerts to flag equipment needs at booking stage. • A review is underway into creating a central equipment storage area at Clatterbridge Hospital for use across departments. • A hoist compatible with community slings has been ordered and will be stored at Clatterbridge Hospital for Dermatology use.
Surgery	
Ref: 17807	• A new Standard Operating Procedure (SOP) has been introduced to ensure that scans requested by GPs are re-ordered appropriately for inpatients. Clinical teams have been reminded to reassess urgency and indications to ensure accurate referrals and correct routing of results.
Ref: 18137	• Future urology investigations (e.g. flexible cystoscopy) will take place in a dedicated SEU treatment room. • Equipment modifications include the use of a light source plugged directly into the mains to avoid battery failures.
Ref: 19841	• Patient confidentiality has been improved by asking patients to verbally state their address (or write it down) rather than having it read aloud by clerks.
Ref: 20884	• New pre-procedure briefings now include agreed methods (e.g. safe word or hand gesture) for patients to pause or stop procedures like cystoscopy.
Ref: 21397	In response to injecting a steroid to the wrong part of the patient's foot:

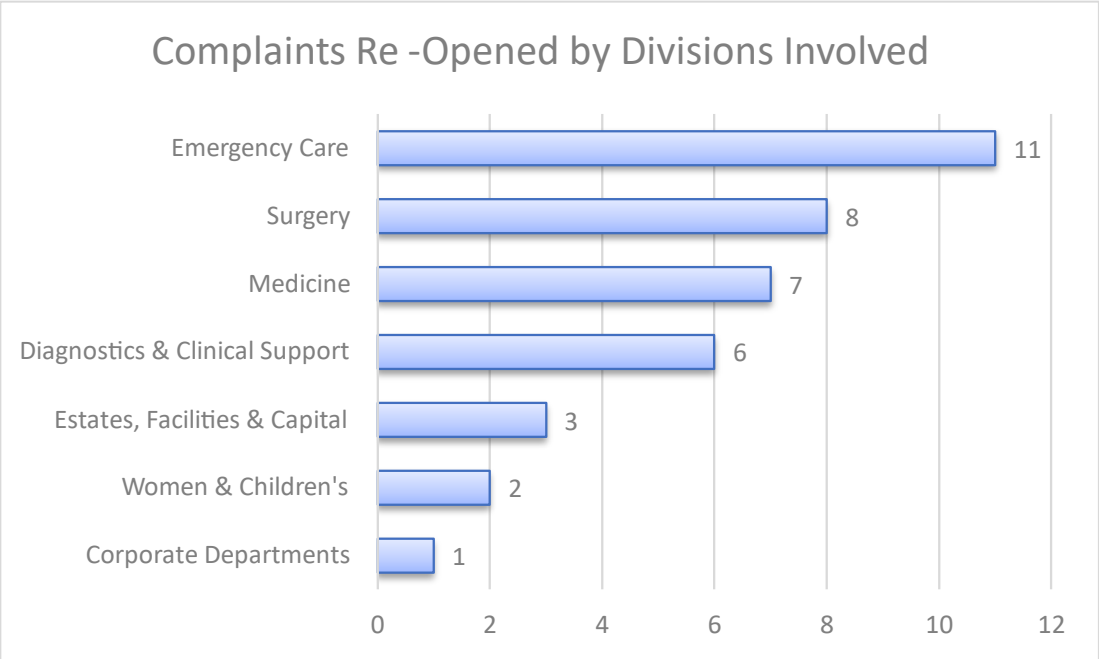
	• Theatre equipment layout has been adjusted to improve visibility of imaging. • Fewer injections are now scheduled per theatre list to allow time for thorough setup and checks.
Ref: 19885	To address record keeping standards relating to the maintenance of fluid balance in a surgical patient in the ED: • A 24-hour fluid care plan will now begin on ED attendance for surgical patients. • New documentation and handover processes are being implemented to ensure continuity of fluid management and escalation where plans are not documented.
Women's and Children's	
Ref: 22108	In response to communication issues between surgeons and the Children's Ward: • Parents will be given an admission note to present to triage nurses following ED attendance. • The Children's Services matron will provide the Surgical Team with information on available post-operative and community support. • A new SOP will be developed to clarify listing, admission, and post-operative planning processes.
Ref: 18976	• A review is underway into pain medication prescribing practices for patients undergoing treatment for pregnancy loss. • A digital prescription template is being developed to ensure timely access to all relevant medications without delays during the procedure.
Ref: 19587	• The TCI (To Come In) time for medical management of miscarriage is being brought forward to 09:00 hours to ensure a doctor is present at the start of the shift. • All relevant documentation and prescriptions are now double-checked by two nurses prior to treatment commencement.
Ref: 20257	• Ongoing recruitment and service improvement work is underway to reduce waiting times in the Community Paediatrics Service.

Ref: 20975	• Following a failed IVF referral, a new referral contact has been established with Liverpool Women's Hospital after identifying issues with the previous provider's email system.

Re-opened Complaints and PHSO Cases

In 2024/25, 22 complaints were re-opened for further local resolution or clarification – a 51% reduction from the 45 re-opened cases in 2023/24.

Complaints were re-opened primarily because complainants either disagreed with the original investigation findings or proposed actions (including in 13 cases where the complaint had already been upheld or partially upheld) or because they were seeking further explanation or clarification regarding the response.



During 2024/25, seven complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) for consideration of independent investigation, compared with eight in 2023/24. At the time of writing, no outcomes had yet been confirmed for these new referrals.

Six complaints opened in previous financial years were closed by the PHSO:

- Two were closed without investigation.
- Three were not upheld.
- One was partially upheld.

These relatively low numbers suggest that, despite WUTH's lengthy response times, its final response letters are generally providing comprehensive and fair outcomes to formal complaints.

The partially upheld PHSO case related to a complaint from a patient who, in 2021, had alleged that WUTH had failed to diagnose an arteriovenous malformation and had incorrectly advised her that she had a brain tumour. She stated there were delays in arranging an MRI scan and that she had not been properly informed about it.

As a result, the complainant reported experiencing unnecessary pain, distress, and long-term anxiety requiring therapy. She described a lasting fear of hospitals and a loss of trust in medical staff. She sought an apology, service improvements, and financial compensation.

The complaint had been partially upheld by WUTH (in respect of communication) and was not clinically upheld by the PHSO. The PHSO agreed that there were failings in communication with the patient, particularly regarding the explanation of a possible diagnosis and the scheduling of the MRI scan. Further failings were identified in the interpretation and communication of the MRI report. However, the PHSO did not find that these failings led to a significant impact, and therefore did not recommend any additional learning actions beyond those already taken by the Trust.

Complaint Demographics

In 2024/25, 57% of complaints were raised on behalf of the patient, consistent with previous years, while the remaining 43% were raised by the patient themself.

A higher proportion of patients were recorded as female (57%) compared to male patients (43%).

Sex of patient	**57%**	Female
	43%	Male

Most complaints (86%) related to patients identifying as White British, with very small proportions from other ethnic groups. A combined 9% of complainants either did not state their ethnicity or selected 'Other – Not Stated'

Ethnic group of patient	**86%**	White British
	5%	Other - Not Stated
	4%	Not Stated
	1%	White - Any Other White Background
	1%	Mixed - Any Other Mixed
	1%	Background
	0%	Asian or Asian British - Bangladeshi
	0%	Mixed - White and Asian
	0%	Chinese - Other Ethnic
	0%	Asian or Asian British - Indian
		Asian or Asian British - Pakistani

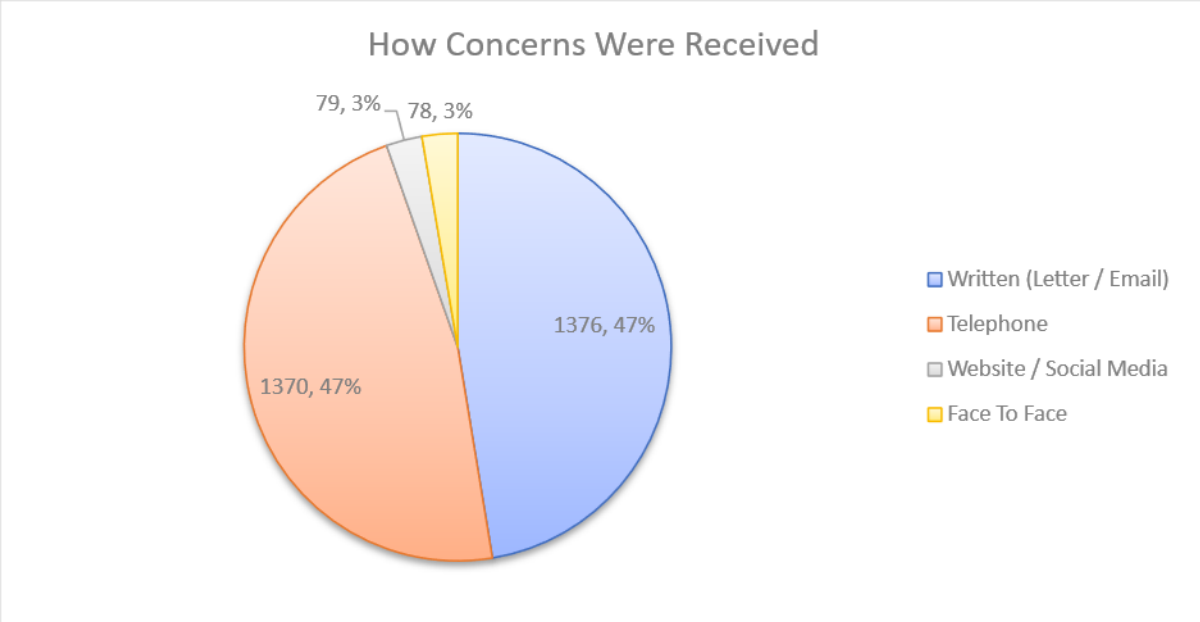
Most patients were aged 36–89, accounting for over 70% of cases. Younger age groups (1–35) made up 25%, while those aged 90 and over represented 2%.

Age range of patient	**0–17**	10%
	18–35	15%
	36–53	23%
	54–71	23%
	72–89	26%
	90+	2%
	N/A	1%

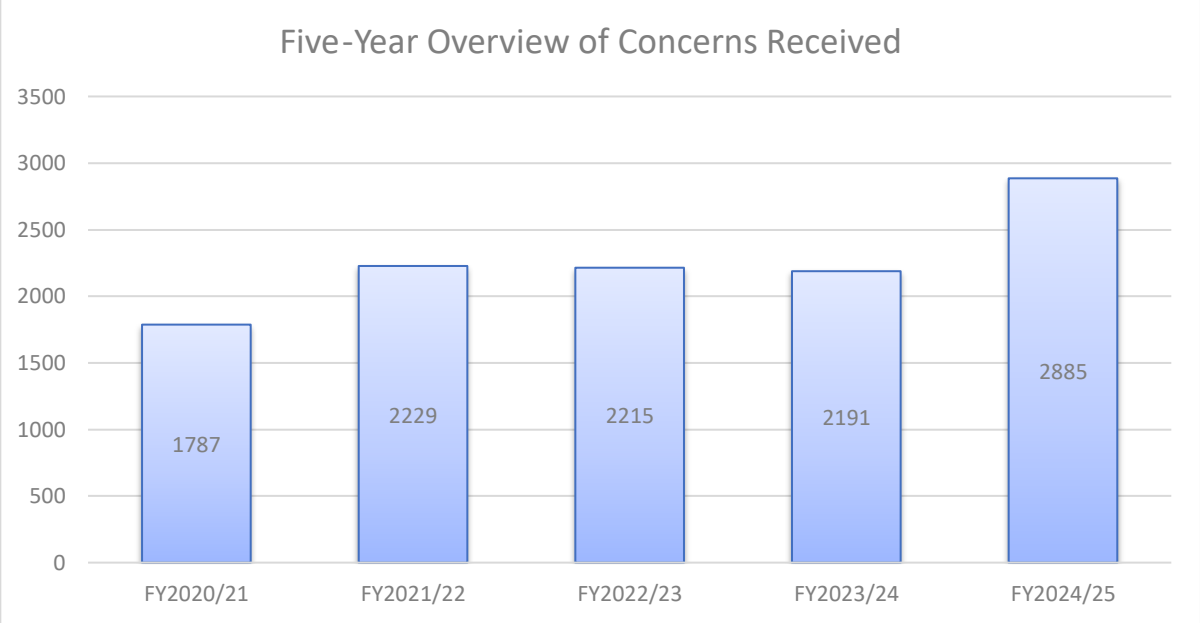
Overall, the data indicates that most complaints related to patients aged between 36 and 89, with a White British ethnicity, and with a slightly higher representation of females (57%) compared to males (43%). Younger patients (0–35) accounted for a quarter of cases, while those aged 90 and over were a small minority.

Level 1 (Informal Concerns)

In 2024/25, WUTH received a total of 2,885 informal concerns, averaging 240 cases per month, the overwhelming majority by email and telephone.

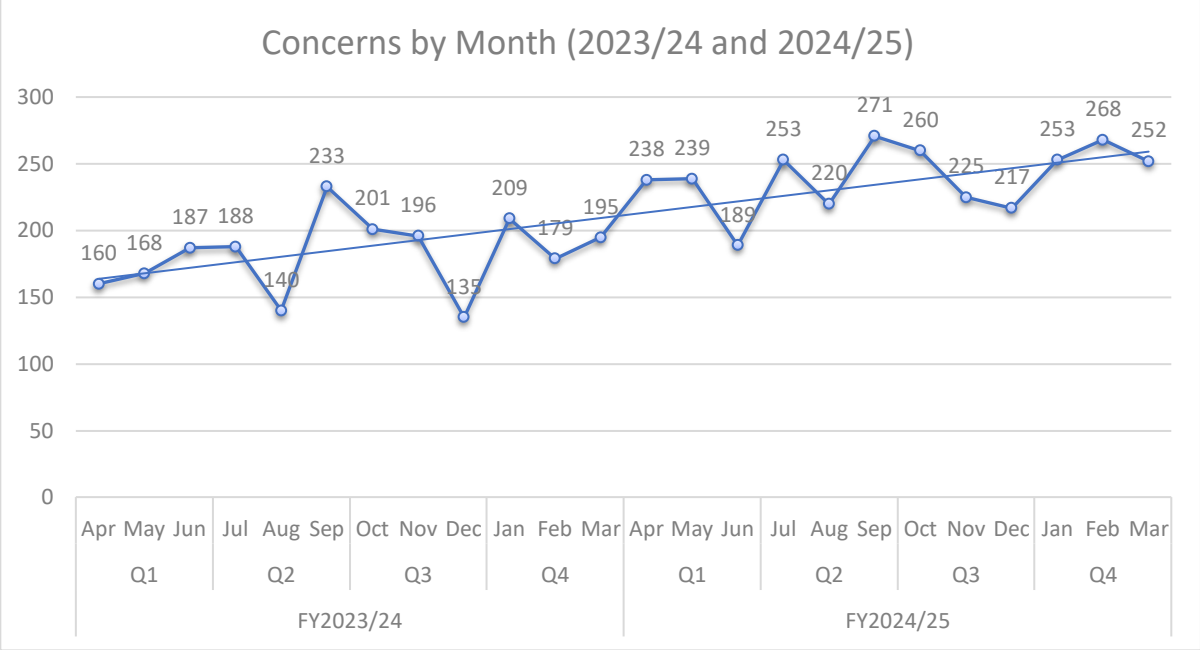


This was a 32% increase compared to the 2191 concerns received in 2023/24. This represents the highest volume of informal concerns recorded in the past five years and a marked upward shift compared to the relatively stable figures from 2021/22 to 2023/24.



A month-by-month comparison between the two most recent years further illustrates this growth. Each quarter in 2024/25 recorded significantly higher volumes than the corresponding quarter in the previous year.

Quarter	2023/24	2024/25
Q1	515	666
Q2	561	744
Q3	532	702
Q4	583	773



This upward trend may reflect a combination of both positive and negative factors.

Positive drivers could include greater visibility of how to raise concerns, and a deliberate emphasis on resolving concerns informally, where appropriate.

Conversely, the increase could also suggest a rise in dissatisfaction with elements of care or service, particularly as the trend has not been accompanied by a reduction in formal complaints.

Informal concerns recorded through the year showed a distinct thematic profile compared to formal complaints, with a strong emphasis on service access, responsiveness, and operational issues.

'Access and Admission' represented the highest thematic category at 32% (up by 8% from last year), reflecting concerns with delays in accessing care (12%), outpatient appointment delays/cancellations (10%), and follow-up issues (7%). These figures are notably higher than the equivalent themes in formal complaints and likely reflect growing frustration with capacity and scheduling challenges.

'Communication' featured in 22% of informal concerns (down by 6% from last year), notably around failures in communication with patients or carers (15%). Compared to the 63% in formal complaints, this suggests that many communication concerns are initially managed at an informal level. However, staff attitude still featured (6% total),

showing that issues around interpersonal conduct are not confined to escalated complaints.

‘Treatment and Procedure’ accounted for 15% (down by 4%), largely relating to treatment delays (8%) and complication recognition (2%). The lower proportion compared to formal complaints (50%) suggests these issues are more likely to be escalated if not resolved early.

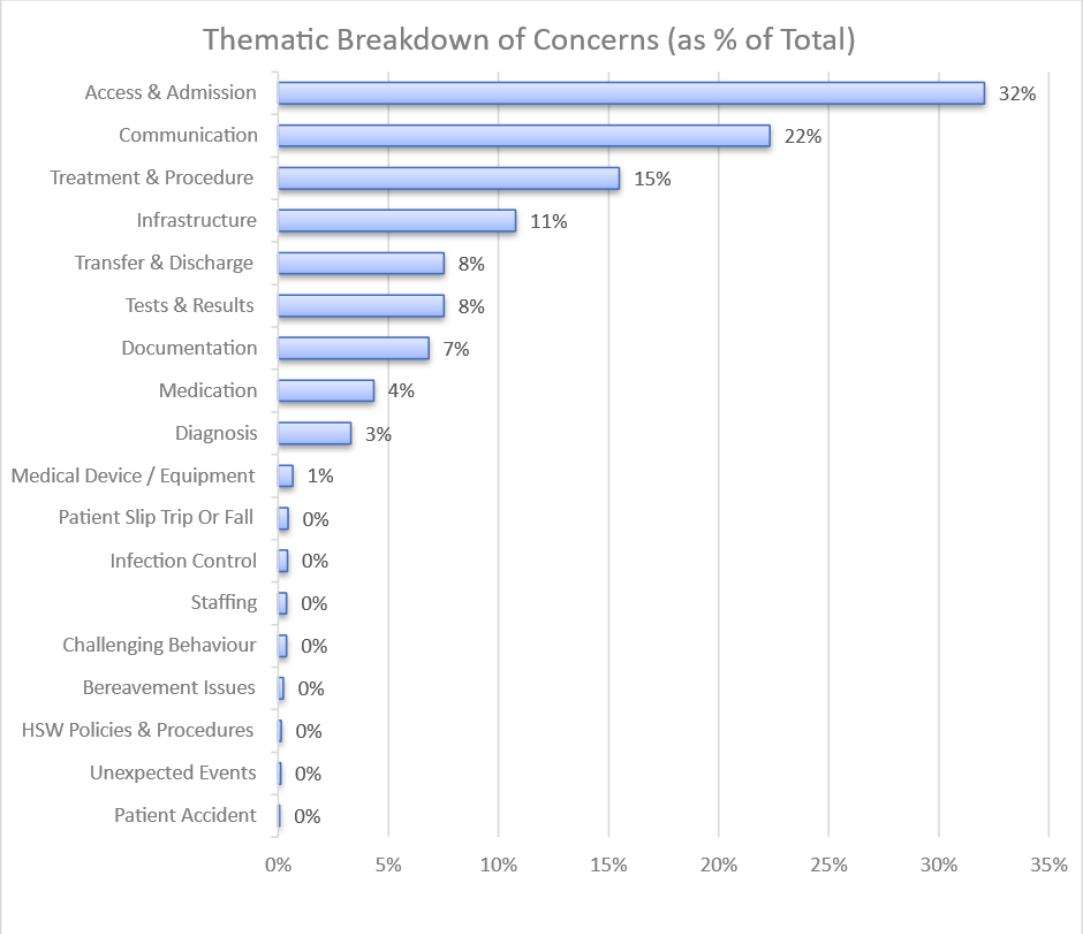
‘Infrastructure’ (11%, down by 1%) concerns mostly focused on property and expenses (4%), IT/telecom issues (3%), and general ward environment or service provision.

‘Tests and Results’ (8%, up by 2%) and ‘Transfer & Discharge’ (8%, no change) reflected concerns about delays in testing, referral processes, or planning discharges, again highlighting areas where timeliness and clarity are essential to the patient experience.

Smaller but notable themes included:

- ‘Documentation’ (7%, up by 3%), especially around access to records and summary accuracy.
- ‘Medication’ (4%, up by 1%), typically involving delays in issuing or advice.
- ‘Diagnosis’ (3%, no change), showing a smaller footprint than in formal complaints, suggesting patients raise these more seriously when unresolved.

Overall, this year’s data shows that informal concerns tend to focus on immediate operational or communication issues. Although some of these may be resolved effectively without escalation, others – particularly those involving treatment or diagnosis – may convert into formal complaints if not addressed to the satisfaction of the individual.



Safeguard Category	2020/21	2021/22	2022/23	2023/24	2024/25
Access & Admission	20%	13%	17%	24%	32%
Communication	40%	56%	50%	32%	22%
Treatment & Procedure	13%	12%	11%	19%	15%
Infrastructure	12%	8%	12%	14%	11%
Transfer & Discharge	8%	4%	5%	8%	8%
Tests & Results	6%	5%	6%	6%	8%
Documentation	3%	2%	2%	4%	7%
Medication	3%	2%	3%	3%	4%
Diagnosis	1%	1%	2%	3%	3%
Medical Device / Equipment	1%	1%	1%	1%	1%
Patient Slip Trip Or Fall	1%	0%	0%	1%	0%
Infection Control	2%	1%	0%	0%	0%
Challenging Behaviour	1%	0%	1%	1%	0%
Staffing	0%	0%	0%	0%	0%
Bereavement Issues	0%	0%	0%	0%	0%
HSW Policies & Procedures	1%	0%	0%	0%	0%
Unexpected Events	0%	0%	0%	0%	0%
Patient Accident	0%	0%	0%	0%	0%

During 2024/25, the Medicine Division received the highest number of informal concerns, with 859 cases, overtaking Surgery, which had been the most reported

division in the previous year. This represents a 54% increase from the 557 concerns recorded for Medicine in 2023/24 and may reflect either rising patient dissatisfaction or improved accessibility for raising early-stage concerns.

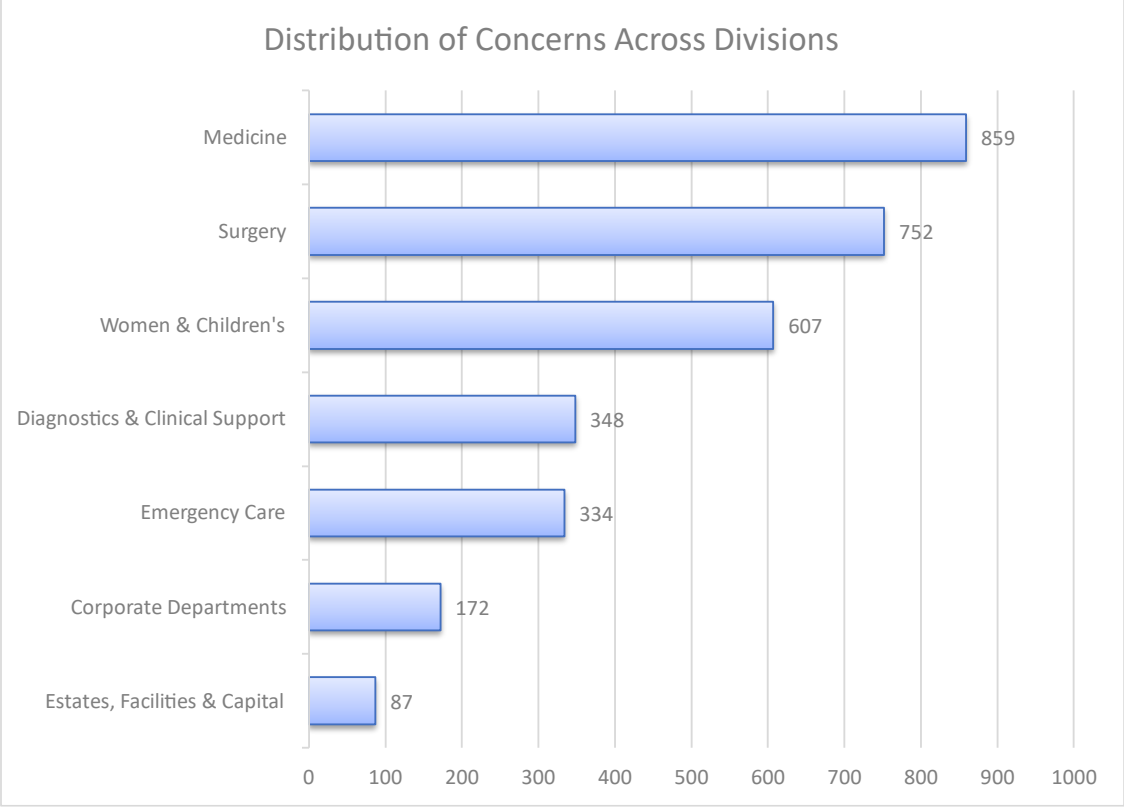
Surgery followed closely with 752 concerns, an increase from 597 last year, while Women and Children's Services also saw a significant rise to 607 cases compared to 485 in 2023/24. These increases across high-volume clinical divisions suggest persistent pressures on service delivery and patient experience, particularly in elective and outpatient settings.

The Diagnostics and Clinical Support Division received 348 concerns, a notable increase from 195 in the previous year.

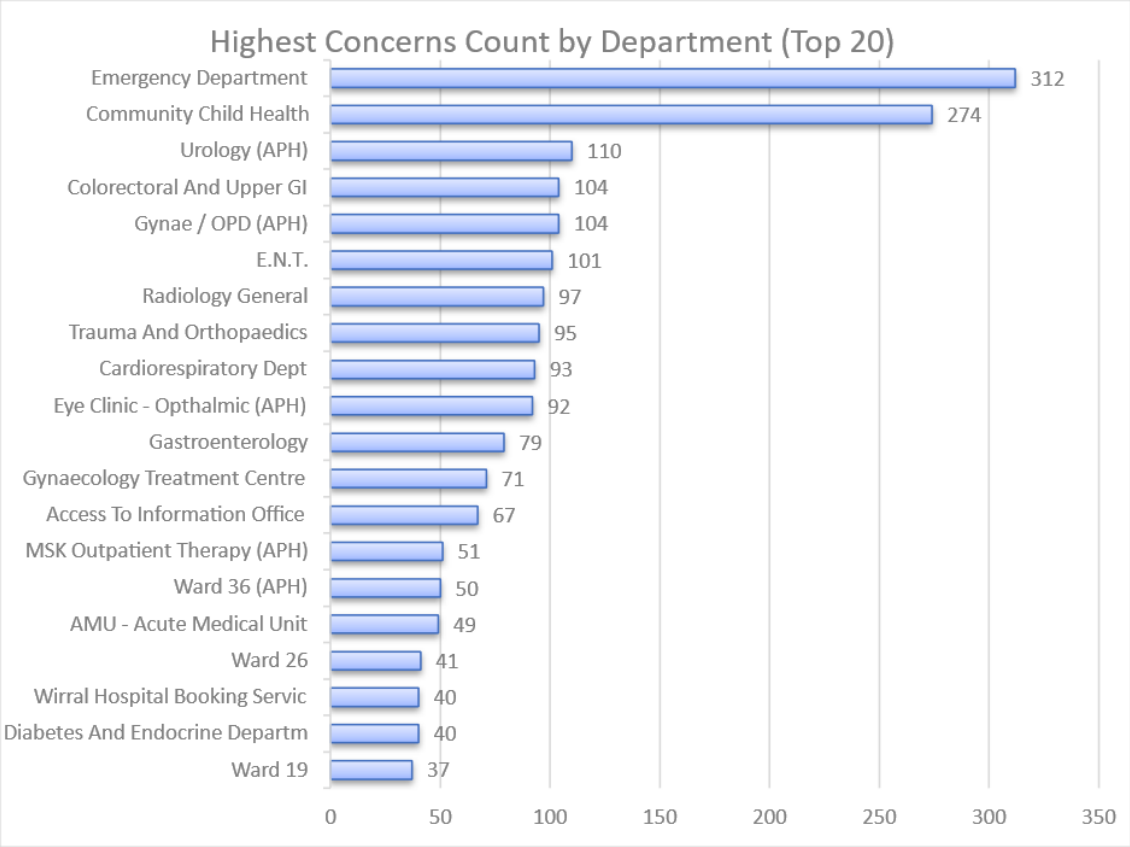
Emergency Care saw 334 concerns (mostly involving the Emergeny Department), up from 301 last year (N.B. the increase is likely proportionately greater, as the divison now comprised fewer areas than its predecessor, Acute Care – see departmental figures, later).

Corporate Departments received 172 concerns, more than doubling the 82 recorded in 2023/24.

Estates, Facilities & Capital recorded 87 concerns, comparable to the 89 recorded last year, suggesting a relatively stable pattern in non-clinical operational feedback.



The top 20 department and areas to receive a concern are shown in the following chart.



An examination of the figures highlights significant increases across the majority of the top 20 departments compared with the previous year, and growing pressures and patient dissatisfaction in several key areas.

Foremost among these is the Emergency Department, which continues to attract the highest volume of informal concerns. This year, concerns have risen sharply from 232 to 312, representing an increase of over 34%. Such a marked rise is indicative of increasing demand and potential strain on emergency services.

Similarly, Community Child Health has seen a considerable increase, with concerns rising by 35%, from 203 last year to 274 this year.

Within other specialty departments, several have recorded notable rises. Urology increased from 102 to 110, Gynae OPD rose from 96 to 104, Colorectal and Upper GI increased from 91 to 104, and Trauma and Orthopaedics rose from 70 to 95.

The ENT Department experienced a steep rise in concerns, jumping from 60 to 101, while Gastroenterology rose by nearly 50%, from 54 to 79. The Eye Clinic almost doubled its informal concerns (from 51 to 92), as did the Cardiorespiratory Department (47 to 93).

Other clinical services, such as MSK Outpatient Therapy and Ward 36, have seen steady rises. The Acute Medical Unit (AMU) almost doubled its informal concerns from 27 to 49.

Of particular note is the Access to Information Office, which saw an extraordinary increase from 18 to 67 – a rise of nearly 272% – related to acknowledged issues around the timeliness of processing subject access requests.

While concerns rose in many departments, some previously high-volume areas such as Dermatology Clinic, Children's Services General, and Gynaecology Ward have seen reductions, indicating possible improvements in those areas.

The top themes in the top five departments receiving the highest volumes of concerns were as follows.

1. **Emergency Department**

   The Emergency Department continued to face high-volume and wide-ranging concerns. The predominance of concerns about 'Treatment & Procedure' and 'Communication' reflects both clinical delivery pressures and dissatisfaction with how care is explained or coordinated. 'Infrastructure' largely related to missing patient property, while 'Access & Admission' and 'Transfer & Discharge' reflect systemic pressures in managing capacity and patient flow.

   - 'Treatment & Procedure' (85 cases)
   - 'Communication' (69 cases)
   - 'Infrastructure' (67 cases, mainly lost property)
   - 'Access & Admission' (43 cases)
   - 'Transfer & Discharge' (22 cases)
   - 'Medication' (19 cases)
   - 'Documentation' (18 cases)
   - 'Tests & Results' (12 cases)

2. Community Child Health

A sharp rise in concerns within Community Child Health from 203 to 274) is largely driven by difficulties in 'Access & Admission' – i.e. waiting times, referral routes, and appointment systems. High numbers of concerns about 'Diagnosis' reflect anxiety around the ADHD pathway.

- 'Access & Admission' (169 cases)
- 'Diagnosis' (40 cases)
- 'Communication' (23 cases)
- 'Medication' (19 cases)
- 'Documentation' (15 cases)
- 'Tests & Results' (7 cases)
- 'Infrastructure' (6 cases)

3. Cardiorespiratory Department

This department shows almost double the concern volume compared to last year (from 47 to 93).

- 'Access & Admission' (28 cases)
- 'Tests & Results' (28 cases)
- 'Communication' (17 cases)
- 'Medication' (7 cases)
- 'Documentation' (5 cases)
- 'Diagnosis' (3 cases)
- 'Infrastructure' (3 cases)

4. Colorectal and Upper GI

As with other outpatient-heavy specialties, Colorectal and Upper GI services are experiencing significant concern volumes around access.

- 'Access & Admission' (47 cases)
- 'Communication' (21 cases)
- 'Treatment & Procedure' (20 cases)
- 'Tests & Results' (10 cases)
- 'Transfer & Discharge' (5 cases)
- 'Documentation' (3 cases)
- 'Medication' (3 cases)

5. Eye Clinic – Ophthalmic

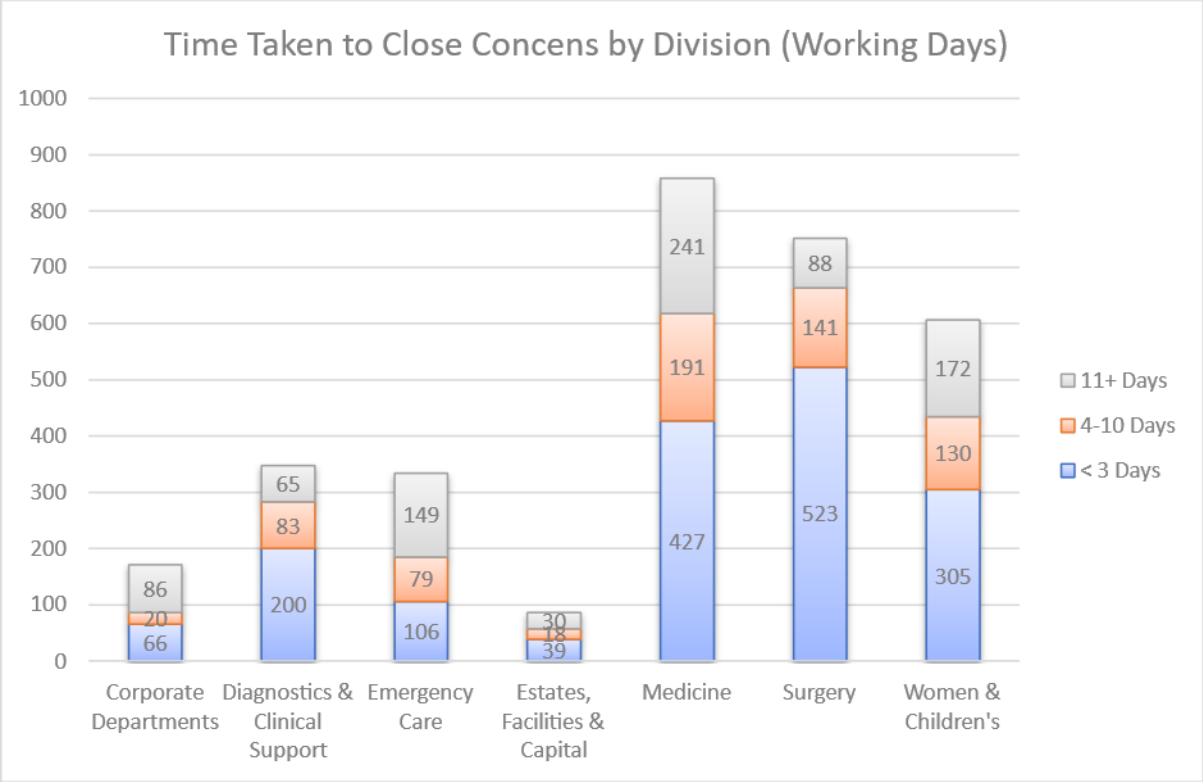
The Eye Clinic saw an 80% increase in concerns (from 51 to92), driven overwhelmingly by access issues.

- 'Access & Admission' (58 cases)
- 'Communication' (12 cases)
- 'Treatment & Procedure' (12 cases)

- ‘Transfer & Discharge’ (5 cases)
- ‘Documentation’ (3 cases)

Level 1 Concerns Timeliness and Performance

The following chart illustrates the varying resolution timescales across divisions, categorised into three brackets: resolved in fewer than 3 working days, within 4 to 10 working days, and in more than 10 working days.



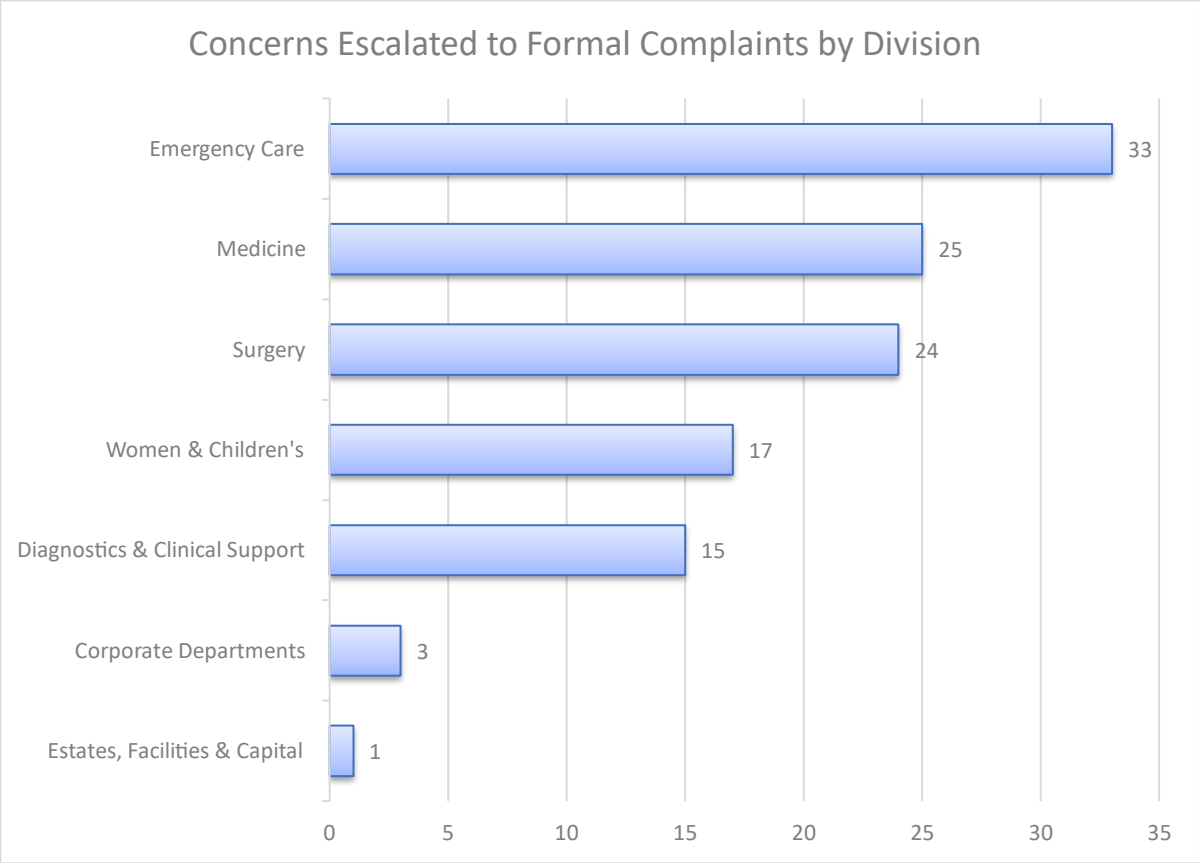
Of all concerns, 54% (1560 cases) were resolved within three working days, demonstrating a continued focus on early, timely resolution. However, this marks a slight decline compared to 2023/24, when 58% of concerns met this timescale.

Importantly, this reduction must be viewed in the context of a significant rise in caseload – an increase of 32% in the number of concerns received year-on-year. Against this backdrop, maintaining over half of all resolutions within three days suggests that frontline teams have managed to absorb much of the increased demand while continuing to prioritise responsiveness.

A further 21% (603 cases) were resolved within 4 to 10 working days.

This overall profile suggests a generally responsive complaints-handling process, although the remaining 25% (722 cases) took more than 10 working days, suggesting more complex issues requiring extended resolution or operational delays in some areas.

Encouragingly, the rate at which informal concerns escalated to formal complaints has decreased, with only 2.8% of Level 1 concerns progressing in 2024/25, compared to 3.5% in the previous year.



Conclusion

In 2024/25, the complaints process at WUTH has continued to perform well in areas under the direct responsibility of the Complaints and PALS and Executive teams – namely timely acknowledgement and registration of complaints, and the quality assurance of final responses. There has also been a reduction in the proportion of informal concerns escalating to formal complaints (2.8% this year versus 3.5% last year).

However, the Trust recognises that further work is required to improve the overall performance of complaints managed within 40 working days.

For complex, multi-divisional complaints, the intended model (where one division takes lead responsibility and coordinates input from other stakeholders) requires further embedding within divisions to ensure it is consistently applied.

Improvements in final complaint responses have been noted throughout the reporting year. The impact of this improvement in quality is evidenced by fewer re-opened complaints and fewer cases progressing to the PHSO, whose findings then frequently align with those of the Trust. This reflects the strength of the quality assurance and governance process applied to complaint responses.

Next Steps for 2025/26

Targeted intervention is needed in high-volume areas such as Medicine, Surgery, Emergency Care, and Women & Children's, which again accounted for most complaints and concerns. These divisions must prioritise timeliness, coordination, and quality of investigations.

'Communication' remains the most frequently cited theme in both complaints and concerns, often linked to staff attitude and interpersonal interactions. A renewed focus on communication training and relational care is necessary, particularly in front-line and high-pressure settings.

'Access & Admission' and 'Treatment & Procedure' delays also remain prominent themes, with increasing concern in areas such as Community Child Health and the Emergency Department. These patterns highlight wider systemic pressures requiring operational attention and pathway improvement.

Divisions must ensure that learning from complaints is captured, shared, and actioned, with formal tracking mechanisms in place to demonstrate change and improvement over time.

Appointment of a single, named lead investigator per complaint must become standard practice, with responsibility for coordinating all relevant clinical and managerial input.

Divisions should be asked to review staff support processes during complaint investigations and ensure staff are properly debriefed, supported, and informed of learning.

The Complaints and PALS Team will continue to deliver monthly investigation and response writing training to divisional managers, following the successful roll-out of these sessions in 2024. Further uptake and integration into leadership development programmes is encouraged.

Finally, while resolution delays persist, the Complaints and PALS Team will maintain its emphasis on proactive communication with complainants, particularly where delays are unavoidable. Setting realistic expectations and ensuring regular updates remains central to maintaining trust in the process.

Board of Directors in Public **Item 29**

03 September 2025

Title	WCHC Information Governance Annual Report 2024-25
Lead Director	Dave Murphy, Chief Digital Information Officer
Author	Dave Murphy, Chief Digital Information Officer and Karen Clearkin, Risk & Governance Manager
Report for	Information

Executive Summary and Report Recommendations

The Information Governance Annual Report is presented to the Board to provide assurance in relation to activity undertaken across the organisation for the reporting period 01 April 2024 - 31 March 2025, in relation to the Trust's organisational compliance with legislative and regulatory requirements relating to the handling of information.

This includes compliance with the Data Protection Act (DPA) 2018, UK General Data Protection Regulation (GDPR) and the Freedom of Information Act (FOIA) 2000.
The Trust is a recognised and registered Data Controller within the Information Commissioner's Data Protection Register. The Trust's Data Protection Registration number is Z2567487. There are no current or historical conditions or cautions against the Trust's data protection registration.

The Annual Report also details compliance with the Data Security and Protection Toolkit (DSPT) aligned to the Cyber Assurance Framework (CAF) introduced this year and provides assurance of on-going improvement in relation to managing risks to information

It is recommended that the Board:

- receive the Information Governance Annual Report for 2024-25 and be assured of the IG arrangements in place through the Trust and the organisational compliance with legislative and regulatory requirements relating to the handling of information

Key Risks

The IG Annual Report provides assurance on the Trust's compliance with relevant regulatory requirements and therefore provides mitigation in relation to ID01 and the safe delivery of services

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7 August 2025	Finance & Performance Committee	Information Governance Annual Report 2024/25	The IG Annual Report was approved for onward reporting to the Board of Directors.

1	Implications
1.1	**Quality/Inclusion** Individualised care and Trust governance is delivered to ensure compliance with equality and diversity standards for staff and people who use Trust services.
1.2	**Finance** No implications identified.
1.3	**Compliance** The report relates to the Trust's organisational compliance with legislative and regulatory requirements relating to the handling of information. This includes compliance with the Data Protection Act (DPA) 2018, UK General Data Protection Regulation (GDPR) and the Freedom of Information Act (FOIA) 2000.

2	The Trust Social Value Intentions
2.1	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 ☐ Reducing environmental impact ☐

Compassion Open Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust



Information Governance Annual Report

2024/25

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Background

1. The purpose of this annual report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust (WCHC) Board of Directors on activity undertaken across the organisation for the reporting period 01 April 2024 - 31 March 2025, in relation to the Trust's organisational compliance with legislative and regulatory requirements relating to the handling of information. This includes compliance with the Data Protection Act (DPA) 2018, UK General Data Protection Regulation (GDPR) and the Freedom of Information Act (FOIA) 2000.

2. The Trust is a recognised and registered Data Controller within the Information Commissioner's Data Protection Register. The Trust's Data Protection Registration number is Z2567487. There are no current or historical conditions or cautions against the Trust's data protection registration.

3. This annual report will also detail compliance with NHS Digital's Data Security and Protection Toolkit and provide assurance of on-going improvement in relation to managing risks to information.

Key Roles and Responsibilities

Senior Information Risk Owner Key Roles and Responsibilities:

4. It is recommended that the Senior Information Risk Owner (SIRO) is an Executive Director, who is part of the organisation's management hierarchy rather than being in an advisory role and is someone who understands how strategic business goals may be impacted by information risk.

5. The Chief Digital Information Officer is the Trust's Senior Information Risk Owner (SIRO) and has executive responsibility for the management and mitigation of all information risk. The SIRO is a core member of the Information Governance and Data Security Group and reports directly to the Chief Executive Officer.

   The key roles of the SIRO are:

   - reviewing and agreeing action in respect of identified information risks
   - briefing the Board on identified information risk issues.
   - ensuring that all information assets have assigned information asset owners.
   - annually signing off the information asset register
   - ensuring that the organisations approach to information risk is effective in terms of resource, commitment, and execution and that it is communicated to staff.
   - taking ownership of the risk assessment processes for information and cyber risk.
   - overseeing the development and implementation of an incident risk policy*
     (NHS Digital, 2018)

   *The Trust has in place the Policy for Risk Identification and Management and the Incident Management Policy, both available on Staff Zone.

6. During 2024-25 the SIRO has successfully completed Templar Executives SIRO Training and Templar Executives Cyber Security Board Training. Refresher training is scheduled for August 2025 to include SIRO, Cyber Security Officer and Risk and Governance Manager.

Caldicott Guardian

7. Recommendation three of The Caldicott Committee's Report on the *Review of patient-identifiable information* (Department of Health, 1997) stated that a senior person, preferably a health professional, should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information.

8. The Chief Nurse is the Trust's Caldicott Guardian. The Caldicott Guardian has a strategic role with regard to representing and championing information governance and confidentiality at Board and, where appropriate throughout the Trust. The Caldicott Guardian is a core member of the Information Governance and Data Security Group and reports directly to the Chief Executive Officer.

   The key roles of the Caldicott Guardian are:

   - ensuring that personal information collected about patients / service users is used legally, ethically, and appropriately, and that confidentiality is maintained.
   - applying the eight Caldicott Principles wisely, using common sense and an understanding of the law
   - actively supporting work to enable information sharing where it is appropriate to share and advising on options for lawful and ethical processing
     (UK Caldicott Guardian Office, 2017)

9. During 2024/25 the Caldicott Guardian completed the required Caldicott Guardian Training.

Data Protection Officer

10. The Trust is legally required to employ a Data Protection Officer (DPO), the requirement is set out in Article 37 of the UK GDPR. The DPO should be designated based on professional qualities and expert knowledge of data protection law and practices and the ability to fulfil the tasks referred to in Article 39 of the UK GDPR.

11. The Trust's Information Governance Lead held the role of DPO until December 2024. The DPO function was held by Head of Data Protection & Information Governance, MIAA, from December 2024.

12. The Data Protection Officer is a core member of the Information Governance and Data Security Group and reports directly to the Deputy Chief Nurse / Chief Nursing Information Officer. The DPO reports indirectly to the Board of Directors through the SIRO and Caldicott Guardian.

    The key roles of the DPO are:

    - monitoring organisational compliance with data protection legislation
    - informing and advising on data protection obligations
    - reviewing Data Protection Impact Assessments (DPIAs)
    - cooperating with the Information Commissioner's Office (ICO)
    - being the first point of contact for the ICO and individuals whose data is processed by the Trust (patients, service users, staff, volunteers etc.)
      (NHS Digital 2018).

Assurance Framework

13. The objective of the Information Governance and Data Security Group is to support and drive the information governance agenda, ensure effective management of information risk, providing the Finance and Performance Committee (FPC) with assurance that best practice mechanisms are aligned with national standards, and local contract requirements are in place for information governance and information security within the Trust. The group has overall responsibility for the Trust's Cyber Assessment Framework (CAF) - aligned DSPT.

14. The key duties of the Information Governance and Data Security Group are:

- overseeing and supporting Trust compliance with NHS England's (formerly NHS Digital) Cyber Assessment Framework (CAF) - aligned DSPT and consequently measuring performance against the National Data Guardian's ten data security standards.
- ensuring compliance with legislative and regulatory requirements of information governance
- receiving Cyber Security Assurance through monthly Cyber Security/IT Security Group report
- reviewing information governance and data security guidance relevant to the Trust and escalating them when appropriate to FPC.
- monitoring information assets and data flows captured within the Information Asset Register
- monitoring Information Governance / Record Keeping incidents and trends, system access audits outcomes, SAFE IG checklist compliance and data quality metrics and reports.
- monitoring mitigations, controls and progress of Information Governance and Data Security risks and escalating in line with the Policy for Risk Identification and Management.
- reviewing and monitoring Freedom of Information, Environmental Information Regulation and Subject Access Requests.
- monitoring, reviewing and approving information governance and data security policies, procedures, and guidance in a timely way to support compliance with legislative and regulatory requirements prior to endorsement by FPC.
- identifying organisations with which personal data is routinely and regularly shared and developing suitable information sharing arrangements.
- reviewing and approving requests for the destruction of records in line with Records Management Code of Practice 2021.
- reviewing and approving Data Protection Impact Assessments produced as part of a privacy by design approach to new projects and ways of processing.
- overseeing action plans that are developed as a result of information governance and data security incident investigations and escalating them to the appropriate group or committee.
- monitoring outcomes of annual record keeping and information quality audits and identifying learning.
- monitoring incidents and trends of inappropriate access to confidential information.
- monitoring staff compliance with e-Learning for healthcare Data Security Awareness Level 1 and specialist staff compliance with training identified from the annual Training Needs Analysis.

Cyber Security/Information Technology Security Group

15. The objective of the Cyber Security/Information Technology Security Group is to advise and provide assurance on the Trust's information technology security as it relates to delivering effective healthcare and enabling the Trust to complete its function as an employer.

16. Cyber security is the application of technologies, processes, and controls to protect systems, networks, programs, devices, and data from cyber-attacks. It aims to reduce the risk of cyber-attacks and protect against the unauthorised exploitation of systems, networks, and technologies. Information technology security is defined as, the protection of computer systems from the theft or damage to the hardware, software, or the information on them, as well as disruption or misdirection of the services they provide.

17. The Cyber Security/Information Technology Security Group makes decisions in relation to Cyber and IT Security, providing a summary report to the IGDS group monthly for assurance.

Information Governance Policies & Standard Operation Procedures

18. The Trust's Information Governance assurance framework is underpinned by a robust infrastructure of Trust Policies & Standard Operating Procedures (SOPs). All Information Governance Policies & SOPs are currently in date, see Table 1 below. Staff can access via Staff Zone, and any updates are highlighted within the Communications Update.

Table 1: Table of Information Governance Policies & Standard Operating Procedures review dates

Policy / SOP name	Review by
Email Policy GP020	March 2026
Password Policy IG20	May 2026
Remote Working SOP IG0003	August 2026
Data Protection and Confidentiality Policy IG10	March 2027
General Security Policy IG23	March 2027
Mobile Computing Policy IG13	June 2027
Information Governance Policy IG01	August 2027
Permanent Removal SOP IG004	October 2027
Data Protection by Design and Default Standard Operating Procedure IG22	December 2027
Records Management Policy GP6	January 2028
Standard Operating Procedure for managing Information Assets and Dataflows on the Information Asset Register SOP IG002	January 2028
Individual Rights and Accessing Records Policy IG06	February 2028
FOI Policy IG09	April 2028
Personal Data Breach Reporting SOP IG 003	April 2028
Data Quality Policy IG24	April 2028
Data Protection Impact Assessment (DPIA) Policy IG21	May 2028
Information Requests and Redaction SOP IG001	May 2028
Accessing Visit Information Using Digital Solutions IG0004	May 2028
Protocol for Accessible Information Standards IG05	May 2028

Compliance with the Data Security and Protection Toolkit

19. In September 2024, the Data Security and Protection Toolkit (DSPT) changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. This led to NHS Trusts, CSUs, ALBs and ICBs seeing a different interface, which sets out CAF-aligned requirements in terms of objectives, principles and outcomes. The scope of the 24-25 DSPT includes additional cyber and information governance requirements compared to the 23-24 DSPT. The new CAF-aligned DSPT is split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

20. The DSPT requires evidence of compliance with mandatory assertions. Key members of staff with specific roles in Information Governance and Information Security are required to annually update assertion areas with relevant evidence.

21. The Trust commissioned MIAA to conduct a DSPT assurance readiness report to support final submission of the toolkit by the national deadline of 30 June 2025. In accordance with the guidance mandated by NHS England, MIAA reviewed 12 outcomes across the 5 objectives in the Cyber Assessment Framework. Following both Phase 1 and 2 of the audit, MIAA provided the Trust with a final report and overall assurance rating as follows:

    The Overall Assurance rating – Moderate Risk.

    The Overall Confidence rating – High Confidence (no deviation from the Trust's self-assessment).



22. The Trust's CAF-aligned DSPT was submitted on 30 June 2025 with 11 out of the 12 outcomes meeting the minimum achievement level. Outcome A4.a (Supply Chain) did not meet the minimum requirement.

Information Sharing

23. WCHC recognises that there is a responsibility to work with partners to minimise the burden of data collection and ensure that data is used effectively to support the overall aims of Public Sector and voluntary organisations, ensuring the delivery of safe, high quality clinical care.

24. Under the UK GDPR, the legal basis for most information shared by the Trust is covered by:
Article 6 (e) *'processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller'*

Article 9 (h) *'processing is necessary for the purposes of preventative or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3'*

25. Consequently, Information Sharing Agreements are only produced for secondary purposes or when sharing with non-NHS organisations. Additionally, legally binding contracts have been put in place with suppliers processing Trust personal data and information flows are recorded within the Trust's Information Asset Register.

Complaints to the Information Commissioner's Office

26. During the 2024/25 period, there were no complaints made to the Information Commissioner's Office about the Trust.

Freedom of Information Requests (FOI)

27. During the period from 01 April 2024 to 31 March 2025, the Trust received a total of 358 requests under the Freedom of Information Act (FOIA) 2000; this is an increase of 24 FOIs when compared to the previous reporting year.

28. 305 were managed within the 20-day timescale and 53 responses were not managed within FOI timescales. This equates to 85% of FOI requests being responded to within the required timescale.

Any delayed FOI responses related to complex requests which often required a coordinated response from multiple Trust departments resulting in a protracted timescale.

Table 2: Table to show number of FOI requests received by the Trust and % managed within time frame in 2022/23, 2023/24, and 2024/2025

Freedom of Information	2022/23	2023/24	2024/25
Number of FOI requests	291	334	358
% Managed within 20 working days	87%	88%	85%

Subject Access Requests (SARS)

29. The UK General Data Protection Regulation (GDPR) 2018 provides the following rights for individuals:

    1. The right to be informed
    2. The right of access
    3. The right to rectification
    4. The right to erasure
    5. The right to restrict processing
    6. The right to data portability
    7. The right to object
    8. Rights in relation to automated decision making and profiling

30. Article 15 states that individuals have the right to obtain from the controller information that is held on them. Such requests are termed Subject Access Requests (SARs) and have a response time of one calendar month. Under GDPR, SARs are free of charge. Correct and prompt management of SARs increase levels of trust and confidence in the organisation by being open with individuals about the personal information held about them.

31. SARs are monitored monthly by the Information Governance and Data Security Group. During 01 April 2024 to 31 March 2025, the Trust received a total of 494 subject access requests (444 in 2023/24). Of these 494 requests, 75 were identified as relating to another organisation.

32. Of the remaining 419 Trust relevant requests received, 95.5% were responded to within the timescale, compared with 100% recorded during 2023/24. See Table 3.

33. Article 16 describes how data subjects have the right to have inaccurate personal data rectified by the data controller.

34. The Trust received 0 right to rectification requests during 2024/25.

Table 3: Table to show number of Trust relevant Subject Access Requests received and % managed within time frame in 2022/23, 2023/24 and 2024/25.

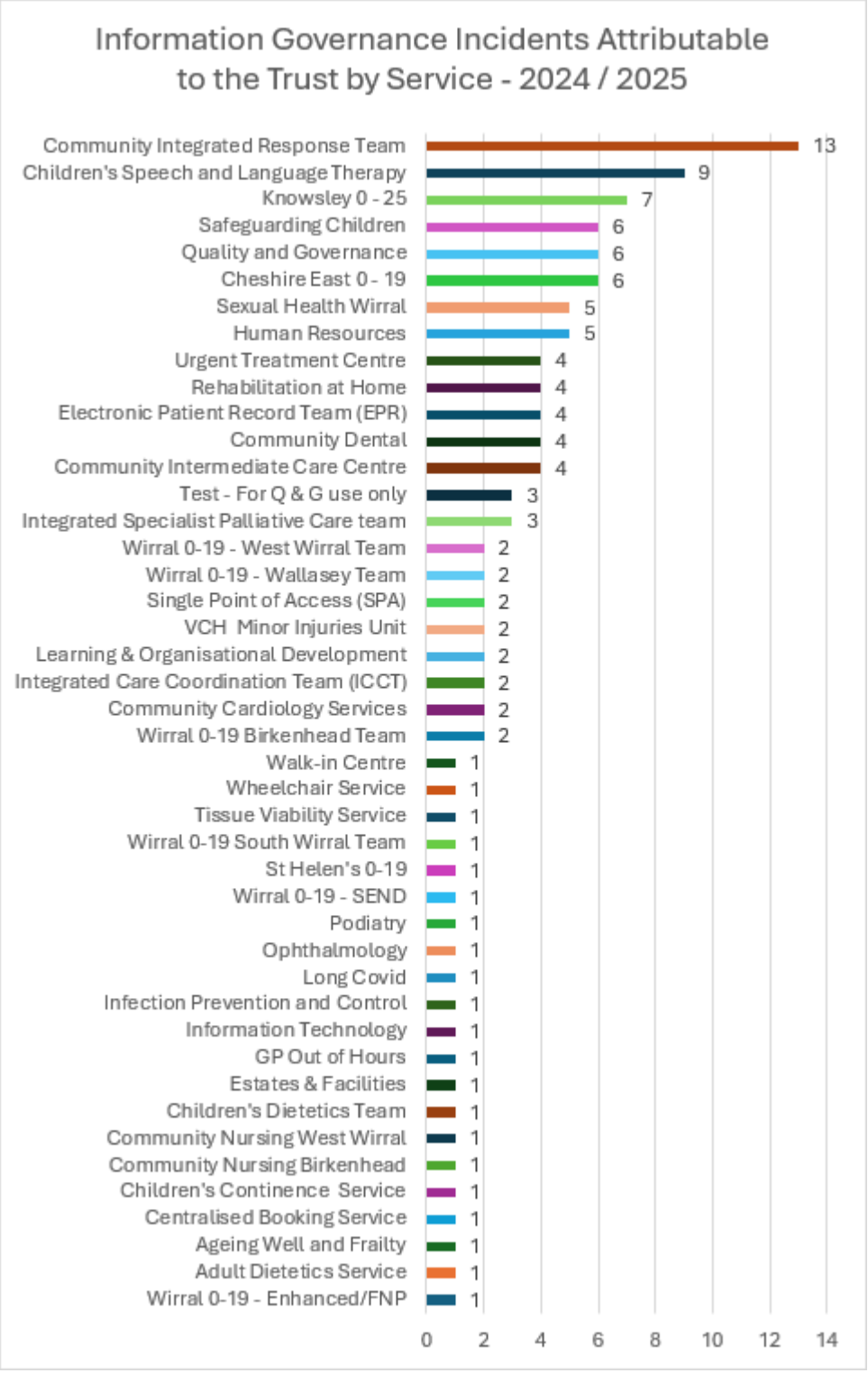
Subject Access Requests	2022/23	2023/24	2024/25
Number of SAR requests	420	444	419
% Managed within one calendar month	97%	100%	95.5%

Information Governance Incidents

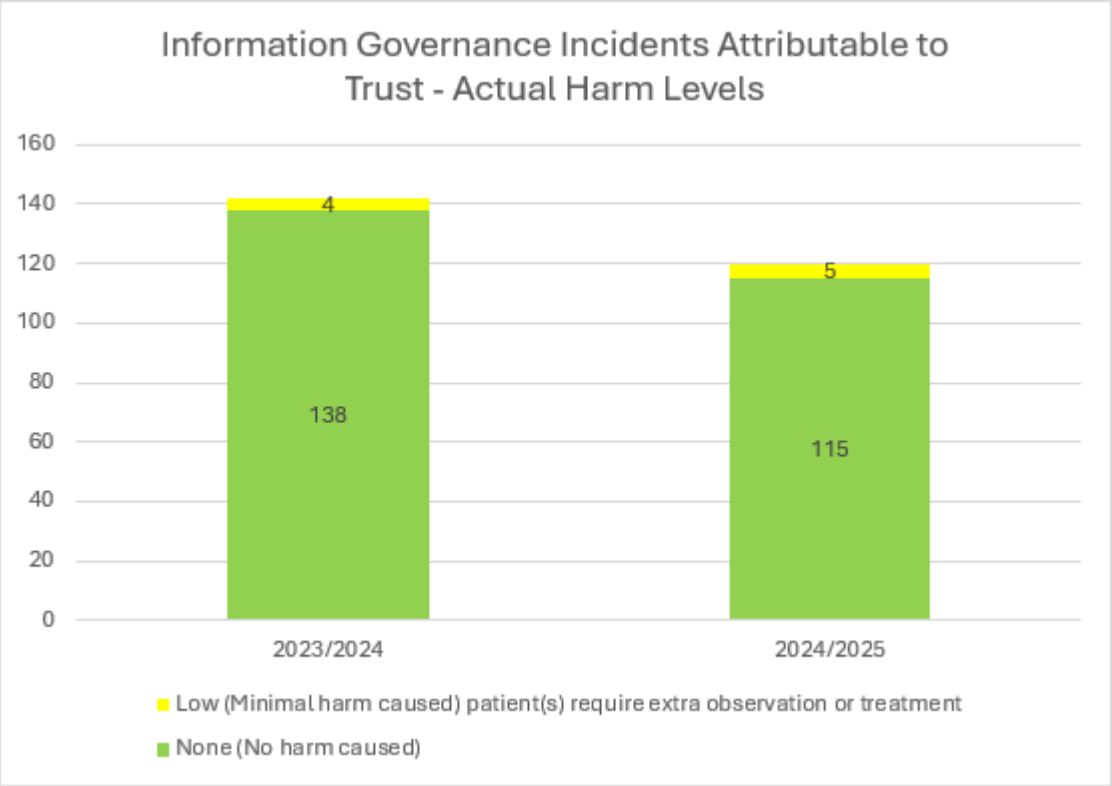
35. During the period 01 April 2024 to 31 March 2025, 150 Information Governance incidents were reported by Wirral Community Health and Care Foundation Trust staff. Of these,120 were deemed attributable to the Trust. This is compared to 142 reported during the 2023/24 period.

    Of the 120 incidents, 115 (96%) were classified as resulting in no harm with the remaining incidents classified as low harm. This is indicative of a strong culture of reporting and learning, supported by the Trust's approach to disseminating learning from incident reporting.

Graph 1: Graph to show Information Governance incidents relating directly to Trust Services between April 2024 and March 2025.



Graph 2: Shows the different harm levels for IG incidents between April 2023 and March 2025



36. As illustrated in Graph 1 Community Integrated Response Team (13), Children's Speech and Language Therapy (9) and Knowsley 0-25 (7) reported the most Information Governance incidents between 01 April 2024 and 31 March 2025.

    The Trust's Information Governance Team is incorporated in the Quality and Governance Service which shares incidents that are applicable to services Trust-wide to enhance visibility whilst maximising learning opportunities.

    Trust wide themes from reported Information Governance incidents include:

    - Information being emailed to the wrong recipients.
    - Paper notes containing identifiable information being misplaced.
    - Recording keeping.

37. Learning from incident investigations is disseminated Trust-wide via the twice weekly 'The Update', 'Special Editions', screensavers and posts via the staff Facebook group.

    Total number of articles in The Update: 9

    Total number of Special Editions of The Update: 2

    Total number of screensavers: 9 including reruns

    Today number of posts via the staff Facebook group: 5





Information Governance and cyber awareness... drop-in session

Help keep our data safe…

Come along to the Information Governance and cyber awareness drop-in session for top tips and information from the Trust's Cyber Security Expert and Information Governance Lead

Date: Wednesday 18 September, 10.00am - 1.00pm





Lawful and unlawful access to records

The Trust has seen a sharp increase in incidents of staff accessing clinical records without a purpose and outside the scope of their roles. Unlawful access of records is not tolerated.

Lawful access to records:

- Clinician is providing direct care to the patient or service user.
- Operational or management purpose eg reviewing records to respond to a concern/complaint, writing a chronology or auditing.

Unlawful access to records:

- Accessing the records of family members, friends, neighbours, colleagues, or people known to the member of staff.
- Using a clinical system to search for information about individuals eg VIPs, people in the press, or those known to the staff member.
- Accessing individual records - if staff want access to health information held about themselves then they must complete a Subject Access Request (SAR) and submit it to the relevant organisation as outlined in both UK General Data Protection Regulation and Data Protection Act 2018.

38. The Information Governance Team are automatically notified of all Information Governance incidents reported on Datix. The IG Team provide bespoke advice and guidance to incident reviewers. Where service specific trends have been identified, an action plan will be developed to support both mitigation and reduction of incident type.

39. The following actions have been taken to ensure learning from identified Trust wide themes:
    - Communication and guidance for staff through Staff Zone, The Update (staff bulletin), screensavers, and the Information Governance area on Staff Zone. In November 2024 and January 2025 there were specials edition on Information Governance and Data Protection.
    - Communications Bulletins have been disseminated following identified areas of improvement.
    - Environmental Information Governance audits have been conducted to identify any breaches and improve staff awareness. Where required, action plans have been put in place to improve IG compliance and to support service specific learning.
    - Information Governance policies have been reviewed and updated where required to outline the Trust's position clearly and consistently on information governance. This ensures the confidentiality, integrity, and appropriate availability of information.
    - The SAFE IG Checklist questions are reviewed every 3 months, based on IG incidents that have been reported in Datix. This ensures that learning from individual incidents is disseminated to all services within the Trust.

Information Governance Incidents Reported to the Information Commissioner's Office

40. WCHC reported 2 incidents to the Information Commissioner's Office between 01 April 2024 to 31 March 2025. Both incidents were closed by the ICO with no further action.

Information Governance Risks

41. During the period 1 April 2024 - 31 March 2025, 2 Information Governance risks were added to the Trust's risk register. Control measures were effectively implemented to mitigate risk to Trust services and both risks have now been archived.

Table 5: Information Governance risks added to the Trust's risk register in 2024/25

Number	Risk ID	Initial Risk Rating	Description	Closed/Active
1.	3057	9	An increase in the number of permanent deletion from the records requests by staff across all 0-19/25 services not just Cheshire East. This is either staff entering the wrong information into the systmone templates or by attaching documents to the record that pertain to someone else. Risk added by Cheshire East 0–19 Service. Risk added 22/07/24 and closed 18/02/25.	**Closed**
2.	3106	9	File Live, a solution by Oasis, was procured to store legacy records. A redaction feature was identified as a necessity during the procurement process as staff were redacting on Word (black highlighter) and converting to PDF, if shared electronically this can be reversed. This function is not working on File Live and this is creating a risk as we are still receiving access to record requests. Risk added by IG Manager. Risk added 30/10/2024 and closed 01/04/25.	**Closed**

Annual Data Security Awareness E Learning

42. All employees of the Trust, including Non-Executive Directors bank staff and volunteers, individuals on secondment, trainees, those on a training placement as well as locum or temporary staff employed through an agency are required to complete annual Data Security Awareness Training. This is mandated against annual training requirements.

43. In 2024/25 Mandatory Data Security Awareness e-Learning was successfully completed by 96.48% of staff across the Trust.

Summary of Key Achievements in 2024/25

44. During the reporting period 01 April 2024 - 31 March 2025 the following were all achieved in relation to Information Governance:

- Mandatory Data Security Awareness e-Learning was successfully completed by 96.48% of staff.
- Board Cyber Security Training, SIRO and Caldicott Guardian Training completed.
- Cyber Assessment Framework (CAF) - aligned DSPT submitted in June 2025, with 11 out of 12 outcomes achieved and action plan developed for the outcome not achieved.
- 95.5% of Subject Access Requests responded to within the required timescale.
- All reported Information Governance Incidents attributable to the Trust have been reported and presented to the Information Governance and Data Security Group.
- All Information Governance Policies reflect national standards and remain in-date.

Priorities for 2025/26

45. The Information Governance priorities for the reporting period 01 April 2025 - 31 March 2026 are:

- Continue to maintain compliance for 11 out of the 12 outcomes achieved for the Cyber Assessment Framework (CAF) - aligned DSPT.
- Implement recommendations and complete the action plan for outcome A4.a for the Cyber Assessment Framework (CAF) - aligned DSPT.
- Creation and implementation of an annual Information Governance and Cyber Security Communications Plan.
- Joint Information Governance and Cyber Security drop-in sessions across different Trust localities.
- Reviewing and updating Information Governance Policies and SOPs due for renewal.
- Continue to maintain compliance with relevant Data Protection/Information Governance legislation.
- Implementation of an improvement plan to increase the percentage of Freedom of Information responses managed within national timescales to 90%.
- Maintain >95% of staff compliance with Data Security Awareness E Learning.
- Specific training for all staff with identified key roles within the Information Governance structure.
- Transfer of all Trust Information Assets and data flows to the Information Asset Register app developed by NHSE on behalf of WCHC and establish an Information Asset Owner network.

Dave Murphy
Chief Digital Information Officer and Senior Information Risk Owner (SIRO)

31 July 2025

Board of Directors in Private **Item 30**

03 September 2025

Title	Complaints and Concerns Annual Report 2024/2025
Lead Director	Paula Simpson, Chief Nurse
Author	Ian Salisbury Senior Complaints Officer Ben Bowsley, Datix and Compliance Manager Claire Wedge Deputy Chief Nurse
Report for	Information

Executive Summary and Report Recommendations
The purpose of this report is to share the 2024/2025 Annual complaints and concerns report to the Board of Directors for information.

Key Risks
This report provides evidence and monitoring in relation to Strategic Risk ID01, within the Trust's Board Assurance Framework: Failure to deliver services safely and responsively to inclusively meet the needs of the population: Current Risk Rating 12 (L3xC4) with an 'Averse' Risk Appetite. There are no new BAF escalations identified, based on the content of this report.

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

Contribution to WCHC strategic objectives	
Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	No
People	Choose an item.
Improve the wellbeing of our employees	No
Better employee experience to attract and retain talent	No
Grow, develop and realise employee potential	No
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
9 July 2025	Quality and Safety Committee	Complaints and Concerns Annual Report 2024/2025	Approval

1	Narrative
1.1	The annual report provides an overview of complaints and concerns activity during the 2024/2025 period, supporting the delivery of safe, effective and quality services. Wirral Community Health and Care NHS Foundation Trust received 35 formal complaints during the reporting period 01 April 2024 – 31 March 2025 compared with 47 for the previous year. There were 39 complaints closed during 01 April 2024 – 31 March 2025 of these 24 (62%) were upheld and 4 (10%) were partially upheld by the trust. The remaining 11 (28%) were not upheld. The report details the learning identified following receipt of complaints and concerns, as part of the Trust's commitment to a culture of continuous quality improvement. Equality and diversity monitoring data has been included within the report, ensuring that a review of experience can be analysed from an equality perspective; evaluating if the needs of those with protected characteristics are being met by Trust services.

	Priorities for 2025/2026 have been identified and are detailed within the report.

2	Implications
2.1	**Quality/Inclusion** Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services.
2.2	**Finance** Effective complaints management will support organisational learning and the delivery of high-quality care, whilst reducing the potential for litigation and regulatory action.
2.3	**Compliance** Complaints are required to be handled according to the Statutory Regulations set out by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

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

Compassion Open Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust



Complaints and Concerns Annual Report 2024/25

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Introduction

1. The purpose of this annual report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust Board of formal complaints and concerns activity undertaken across the organisation for the reporting period 01 April 2024 – 31 March 2025, in relation to the Trust's requirements to demonstrate compliance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Principles

2. The NHS Complaint Regulations state that arrangements for dealing with complaints must ensure that:
   - Complaints are dealt with efficiently
   - Complaints are thoroughly investigated
   - Complainants are treated with respect and courtesy
   - Complainants receive as far as is practical:
     (i) Assistance to enable them to understand the complaints procedure
     (ii) Advice on where they may obtain such assistance
   - Complainants receive a timely and appropriate response
   - Complainants are told the outcome of the investigation and actions taken, if appropriate

3. Complaints should be managed in the spirit of the Parliamentary and Health Service Ombudsman's (PHSO) principles – Principles of Good Administration, Principles of Good Complaints Handling and Principles for Remedy. The PHSO recommends NHS organisations follow these principles to ensure effective complaints handling:

   - Getting it Right
   - Being Customer Focused
   - Being Open and Accountable
   - Acting Fairly and Proportionately
   - Putting Things Right
   - Seeking Continuous Improvement

Overview of Trust Services

4. Trust services are local and community-based, provided from around 50 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

5. We also provide integrated 0-19 services in Cheshire East, Knowsley and St Helens comprising health visiting, school nursing, enhanced and family nurse partnership (FNP) and breastfeeding support services from 17 bases.

6. The Trust is commissioned to provide care across three in-patient wards at the Community Intermediate Care Centre: Bluebell, Iris and Aster wards.

7. The wards operate a multi-disciplinary and integrated approach to care, with teams consisting of physiotherapists, occupational therapists, social workers, nurses, health care assistants, administrative staff as well as an extended workforce consisting of students and volunteers.

8. The Trust actively encourages feedback regarding all services to ensure that these experiences shape and inform future service design, support organisation learning and the Trusts' quality improvement infrastructure; this includes complaints and concerns.

9. Experience is a standard agenda item throughout all team meetings and all managers are actively encouraged to share and learn, looking for continuous opportunities to identify quality improvements.

10. The Trust is committed to the principles as outlined in a user-led vision for raising concerns and complaints (PHSO and Healthwatch). This ensures that people:

    1. Feel confident to speak up
    2. Feel that making a complaint was simple
    3. Feel listened to and understood
    4. Feel that their complaint made a difference
    5. Would feel confident making a complaint in the future



Organisational Analysis of Complaints and Concerns

11. The Trust currently have two types of investigation, which are discussed and agreed with the person intending to raise a concern or complaint with the Trust. These are as follows:

Concerns Process (Local Resolution)	Complaints (Full Investigation)
Concerns are a way of handling complaints by resolving or clarifying the matter directly with the complainant through discussion in a meeting arranged for the purpose, service responding direct by phone call or in writing. This can be a more proportionate, flexible and responsive way to resolve concerns that do not require a full review/investigation. The complaints process is fully explained and made accessible to all individuals raising a concern with the Trust.	Complaints are subject to full investigation in accordance with Trust policy and national guidelines. This includes, but is not limited to, a review of written records and procedures, interview with the staff involved and where applicable, witnesses to the event. Services are asked to complete a After Action Complaint Review (AACR) and return this for the Chief Nurse and Complaints Team to review. At the conclusion of the review/investigation, the complainant receives a response from the Chief Executive or nominated Executive Director. For complex complaints, meetings are also offered with a Senior Manager within the Trust, to provide feedback directly to the complainant.

	There is also a monthly review at Safety Risk and Learning Review Panel (SRLaRP), who look to triangulate information from complaints and concerns and develop improvement and learning opportunities across the trust.

12. Wirral Community Health and Care NHS Foundation Trust (WCHC) received 35 formal complaints during the reporting period 01 April 2024 – 31 March 2025 compared with 47 received for the previous year (this included 9 complaints in relation to Adult Social Care which transferred from the Trust to the Local Authority on 01 July 2023).

13. There were 39 complaints closed during 01 April 2024 – 31 March 2025 of these 24 (62%) were upheld and 4 (10%) were partially upheld by the trust. The remaining 11 (28%) were not upheld.

14. Analysis of patient and service user contacts received and recorded on Datix are as follows:

    - 35 formal complaints, of which 35 were NHS complaints
    - 127 informal NHS concerns.

15. The Trust received experience feedback from 33,145 people who accessed services, with an average of 93% of those people reporting a very good or good experience.

16. Analysis of the annual complaints data from 2020 - 2025 evidences a decrease in the number of complaints received by the Trust compared to 2023/2024 (in 2023/2024 this included 9 complaints in relation to Adult Social Care which transferred from the Trust to the Local Authority on 01 July 2023).

01 April – 31 March	Total number of complaints received
2020/2021	69
2021/2022	74
2022/2023	79
2023/2024	47
2024/2025	35

Complaint responses and number of patient contacts recieved

17. There were 35 Health Complaints received during the period of 1 April 2024 – 31 March 2025.

18. Of the 35 complaints received during this reporting period, 7 remained open into 2025/26 and have been closed during quarter one 2025/26.

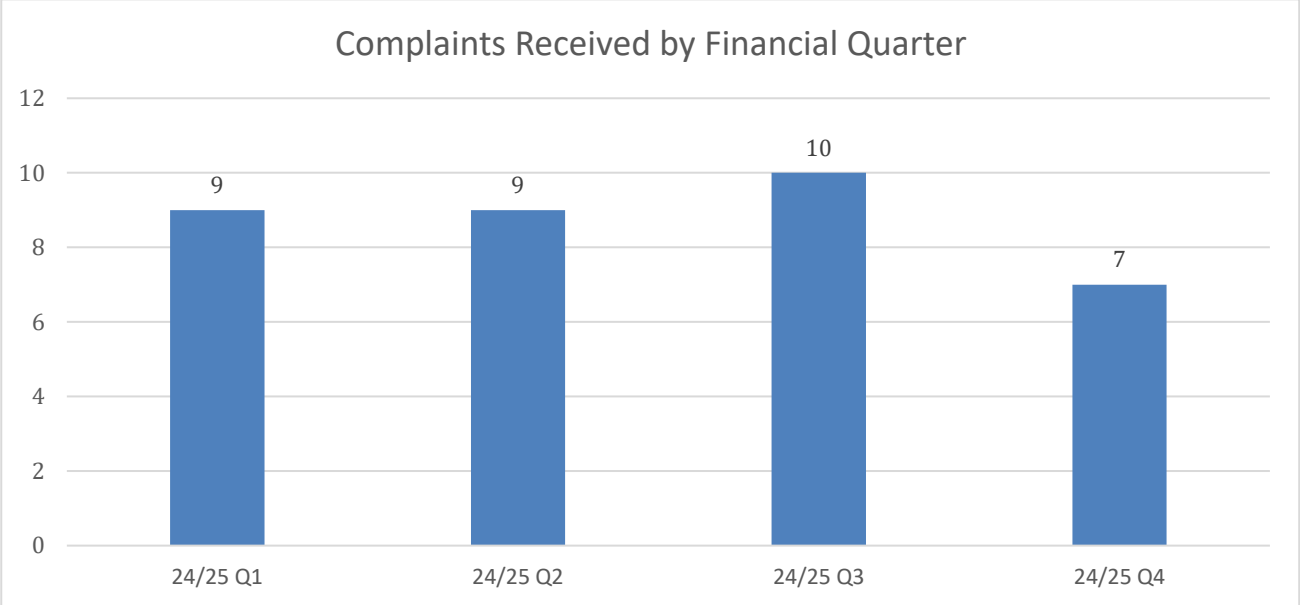
19. Of the 35 Health complaints received, 32 (91%) were acknowledged within 3 working days. The reason for 3 (9%) complaints not being acknowledged within 3 working days, was due to capacity within the complaints team. A rapid review of systems, processes and service continuity plans have been implemented during Quarter 1 of 2025/26; during this quarter period, 100% of complaints have been acknowledged within 3 working days.

20. For NHS complaints, national guidance states timescales for responding as 40 working days. An extended timescale may be required to ensure a comprehensive response due to the complexity of the complaint. Complainants are kept fully informed of any extended timescales required. Of the 35 complaints received, 20 (57%) were responded to within timescales agreed with the complainant, and 15 (43%) were responded to outside of agreed timescales. The rationale is that complaints can become complex and delays occur from both Trust services and external partners. Patients and complainants are kept up to date when delays occur to ensure effective governance and communication. No concerns or complaints regarding response times have been raised with the Trust or external bodies during the annual reporting period.

21. It is important to contextualise the number of complaints and concerns received in relation to patient contacts. In 2024/2025 there were a total of 1,222,426 contacts delivered across Trust services.

22. Chart 1 demonstrates the total number of complaints received by quarter during 2024/25:

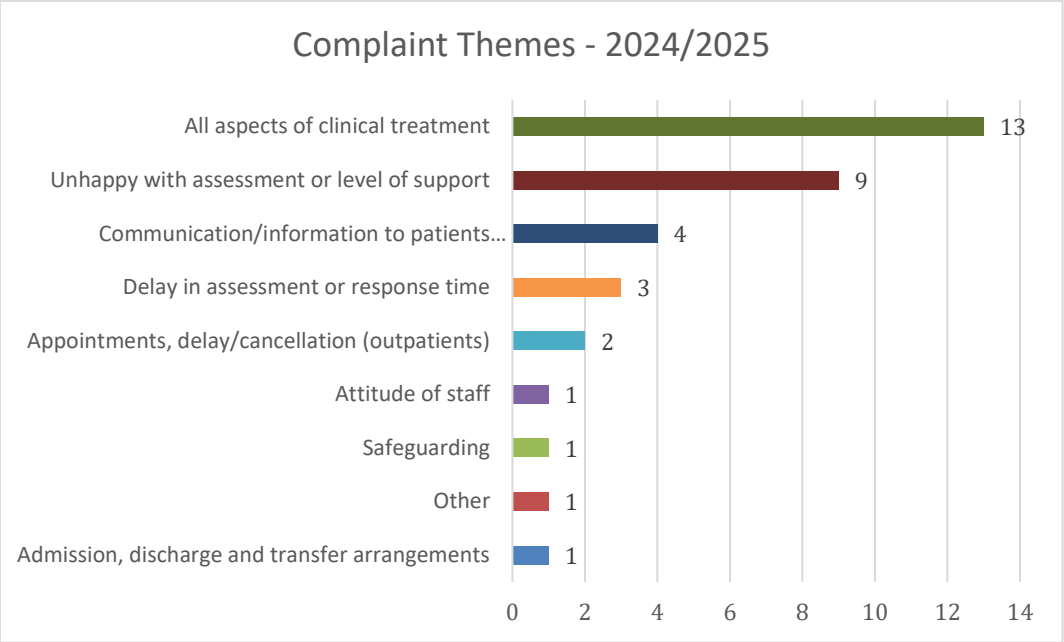
Chart 1: Comparison of complaints received by quarter



Total number of 2024/2025 complaints received by theme

23. The themes for complaints during the reporting period are as follows:

Chart 2 – Complaints received by theme



24. Analysis and findings from each complaint identified which complaints were upheld, partially upheld and not upheld by the Trust.

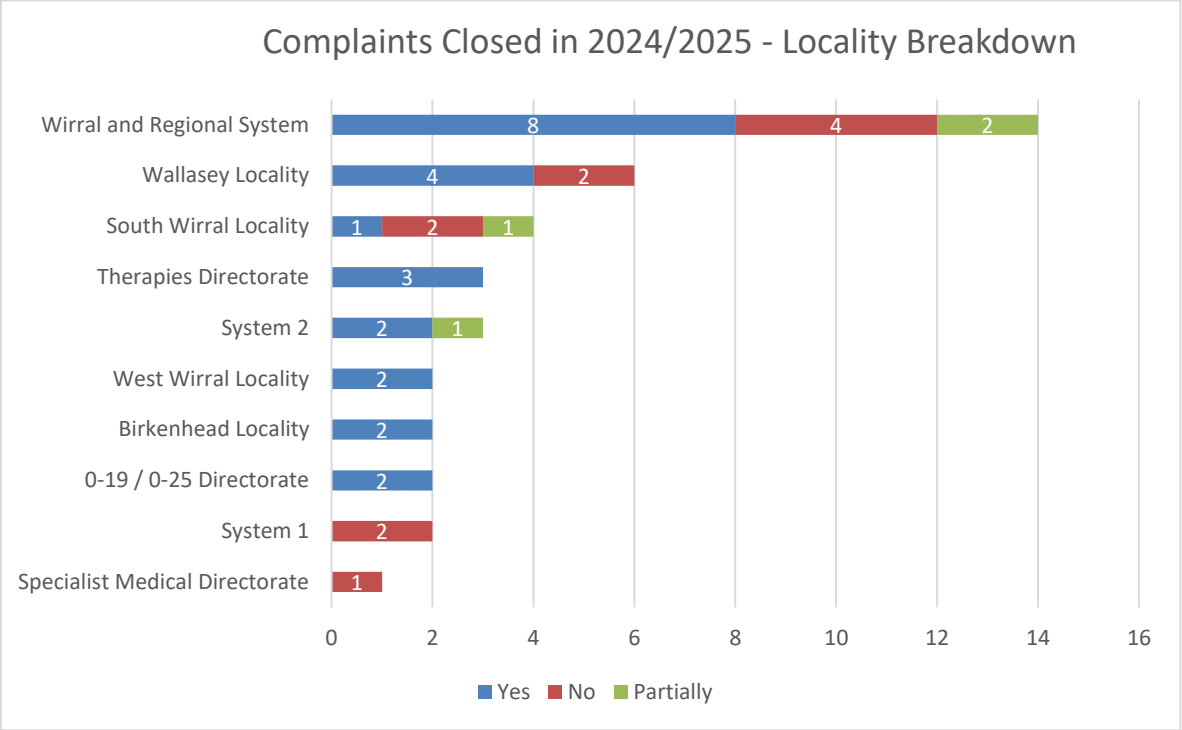
Closed 2024/2025 Complaints		
Upheld	**Not Upheld**	**Partially Upheld**
24	11	4

25. Of the 39 complaints closed during 2024/25, 11 were carried over from the 2023/24 annual period.

26. Of the 35 complaints received during 2024/25, 7 have been closed in quarter 1 of 2025/26.

27. A further breakdown of the 39 complaints closed during 2024/2025, and whether they were upheld / partially upheld or not upheld by Locality is detailed in Chart 3.

Chart 3: Upheld/Partially Upheld and not Upheld complaints by Locality



NB. Organisational Structure changed from 01/11/2024.

28. For all partially upheld and upheld complaints an action plan is requested to evidence learning for Trust services.

29. Action plans are tracked through the Trust's Clinical Risk Management Group to ensure themes or emerging trends can be identified quickly. This governance mechanism also provides the opporutnity for relevant learning to be disseminated across all Trust services where applicable.



Learning and Improvements made from Upheld and Partially Upheld complaints:

30. This section of the report will focus and analyse the top 5 complaint themes and give greater understanding of learning and the improvements implemented.

Complaint Theme: All aspect of clinical treatment

31. There were 13 complaints received where 'all aspect of clinical treatment 'was recorded as the primary subject of concern. All 13 were in relation to health complaints, 7 were upheld, 1 partially upheld and 5 were not upheld.

Improvements made

- Staff supported during supervision sessions to enhance skills to support compassionate communication with patients
- Improvements made to the Falls Safety Plan
- To monitor clinical supervisions through SAFE report and ensure compliance for all staff
- Ensure staff training is up to date and reflects identified learning and improvement
- Review of themes and trends at CRMG and Safety Risk and Learning Review Panel

Complaint Theme - Unhappy with assessment or level of support

32. There were 9 complaints received categorised as 'unhappy with assessment or level of support', 9 were in relation to health complaints of which 6 were upheld, 1 partially upheld, and 2 not upheld.

Improvements made

- Team leads have shared action plans and lessons learnt from complaints with staff to improve wider learning across services
- Links to WCHC website shared with parents for strategies on what to implement for children whilst waiting for assessment
- Use of Isla to support early identification and support e.g. speech sounds
- Review of themes and trends at weekly CRMG and Safety Risk and Learning Review Panel

Complaint Theme: Communication / information to patients

33. There were 4 complaints received where 'Communication / information to patients' was listed as the primary subject of concern. All 4 were in relation to health services with 2 being upheld and 2 not upheld.

Improvements made

- Proactively asking certain patients, who have capacity, if they would like their family to be informed about their treatment
- Training completed to ensure staff are following the correct processes/procedure
- Staff debriefs and discussions to take place in supervision sessions
- Procedures and training to be regularly reviewed
- Review of themes and trends at CRMG and Safety Risk and Learning Review Panel
- To use feedback forms to understand patient experience

Complaint Theme: Delay in assessment or response time

34. There were 3 complaints received where 'Delay in assessment or response time' was recorded as the primary subject of concern. All 3 were in relation to health care provision and were all upheld.

Improvements made

- Work being undertaken within the Wirral system, with an aim of providing a multi-disciplinary response at the point of identifying children's needs
- Introduced a shared pathway for children who do not have their onward referral completed
- Training package developed and delivered to staff
- Communication has been made much clearer when advising parents of expected delays for children who are waiting for follow up appointments
- Review of themes and trends at weekly CRMG and Safety Risk and Learning Review Panel
- To use feedback forms to understand patient experience

Complaint Theme: Appointments delay / cancellation (outpatients)

35. There were 2 complaints received where 'Appointments delay / cancellation (outpatients)' was recorded as the primary subject of concern. All 2 were in relation to health care provision and were upheld.

Improvements made

- Staff 1 to 1s have been held to discuss complaints and look at staff reflections
- Letters have been reviewed to ensure that there are sufficient opportunities to inform parents when next steps of the pathways are completed
- Letters added to patient record as per individual request
- Continue collaborative working with WUTH as part of overall pathway changes
- Review of themes and trends at weekly CRMG and Safety Risk and Learning Review Panel

36. It is important to note that the outcomes from learning through action plans and service improvements have significantly strengthened processes and governance. Notably, there have been no recurring themes in complaints, indicating sustained progress.

Parliamentary and Health Service Ombudsman (PHSO)

37. There have been 0 referrals to the PHSO during the reporting period.

38. All complaints were responded to and managed in accordance with WCHC's Complaints Policy (GP1).

39. Lessons learned from complaints are a valuable tool to assist in the quality of services provided and improve the patient's overall experience.

40. For upheld or partially upheld complaints where learning for the Trust has been identified, action plans are developed by the service and monitored at locality SAFE/OPG meetings and at the Trust-wide CRMG and Safety Risk and Learning Review Panel.

Concerns, Patient Contacts, and Friends and Family Test received

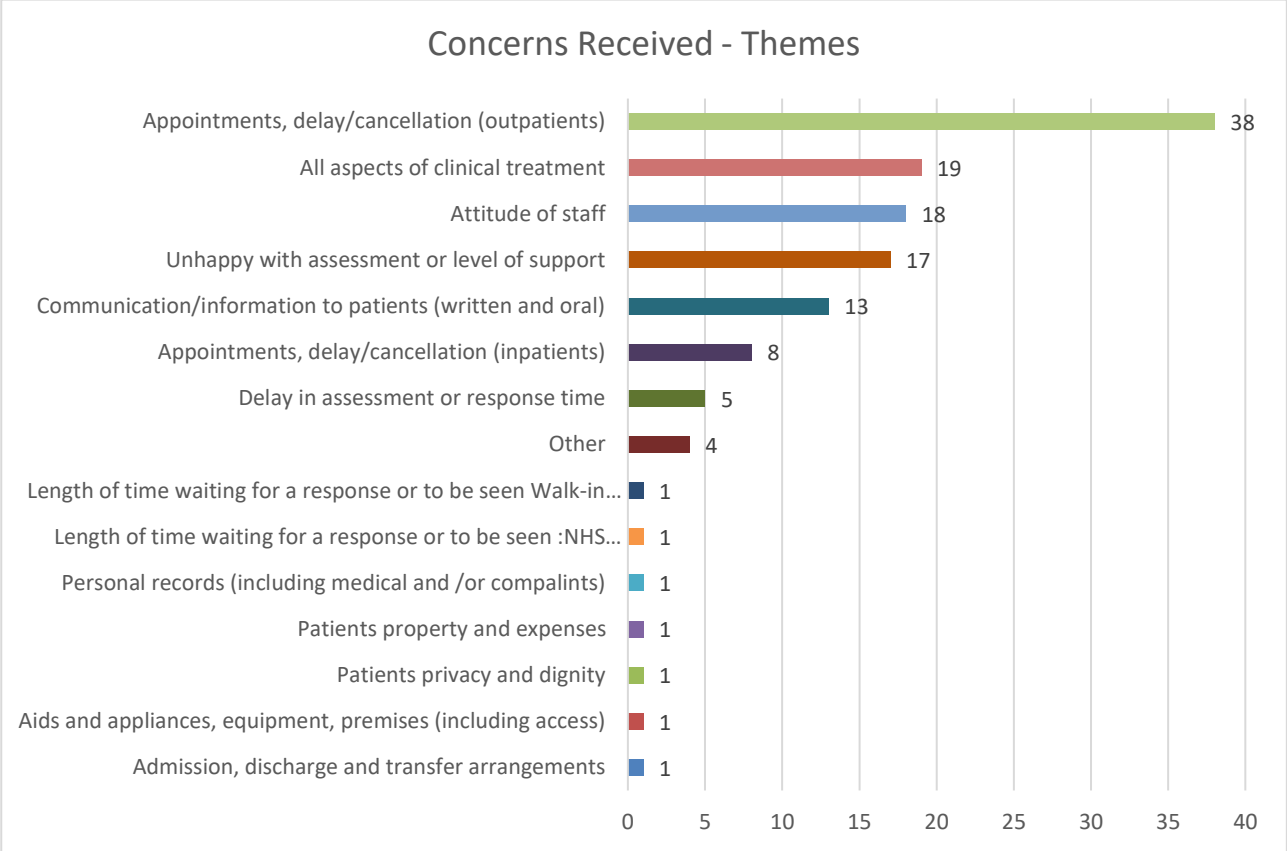
41. A Total of 1,222,426 patient contacts were recorded in 2024/2025 and are detailed below:

0-19 / 25	Cheshire East Health Visiting & School Nursing Service	80,275
	Knowsley 0-25 Service	36,880
	Let's Talk Service	236
	School Nursing - Wirral	17,976
	St Helens 0-19 Service	31,979
	Wirral Health Visiting Service	43,538
Community Response	Community Intermediate Care Centre (CICC)	221,525
	Community Integrated Response Team (CIRT)	94,689
	Single Point of Access (SPA)	27,280
	Teletriage	2,684
Nursing	Community Nursing	335,221
	Parkinson's / Alzheimer's	2,254
	Specialist Palliative Care	9,427
	Tissue Viability	631
Specialist Medical	Community Cardiac Service & Diagnostics	34,772
	Deep Vein Thrombosis	10,895
	Dental Service	6,307
	Long COVID Service	1,802
	Ophthalmology	2,464
	Sexual Health Wirral	16,056
	Urgent Treatment Centre / Walk-in Centre's	89,417
Therapies	Adult Bladder & Bowel	11,011
	Adult Dietetics	8,574
	Adult Speech & Language	4,539
	Ageing Well & Frailty	9,124
	Musculoskeletal & Pelvic Health	43,988
	Paediatric Bladder & Bowel	4,229
	Paediatric Dietetics	2,506
	Paediatric Speech & Language	8,189
	Podiatry	37,327
	Rehabilitation at Home	17,004
	Weight Management Service	6,809
	Wheelchair Service (West Cheshire & Wirral)	2,818
Total		**1,222,426**

42. All concerns are subject to local management by the relevant service, facilitating a prompt, proportionate flexible response, which is agreeable with the complainant. The formal complaints process is fully explained and made accessible to all individuals raising a concern with the Trust, to ensure escalation if initial local resolution cannot be achieved.

43. There were 127 concerns received in 2024/2025.

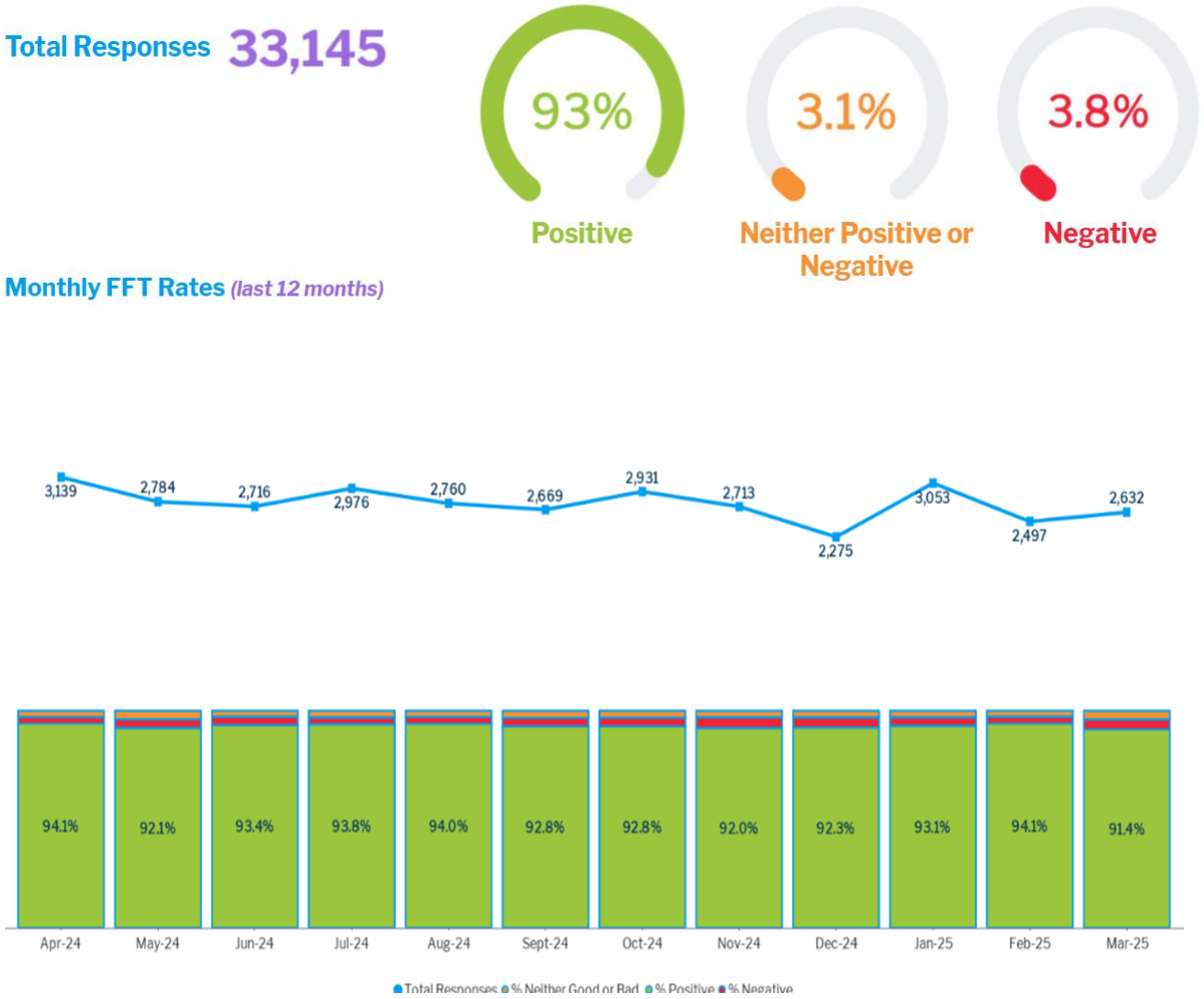
Chart 4: Total number of concerns received by subject



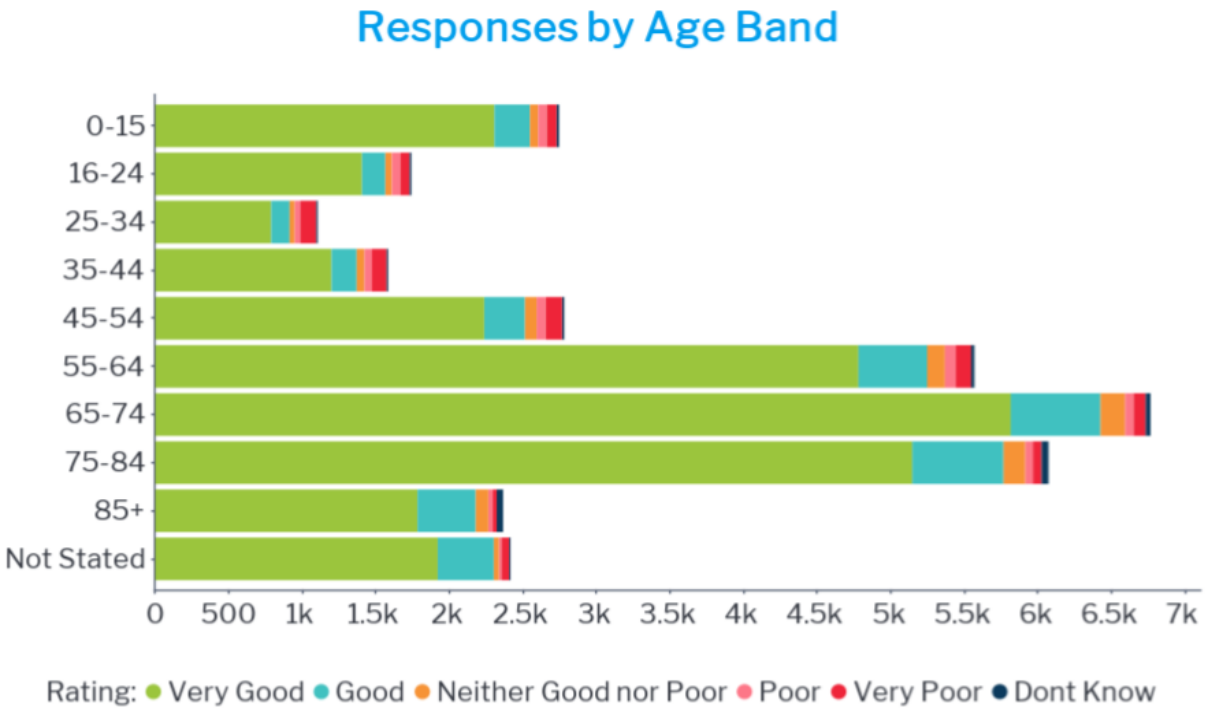
NB Please note that there can be multiple themes for concerns

44. All concerns are resolved at local service level and are monitored for themes and trends both at team level and at CRMG.

45. The below graphic shows Friends and Family test (FFT) across the trust for the period 2024/2025. 33,145 were completed with positive feedback equating to 93%.



Age of patients completing the Friends and Family test



Equality and Diversity Monitoring

46. All complainants are offered the opportunity to provide equality and diversity information at the point of acknowledgment of their complaint. These are recorded on Datix and where required reasonable adjustments are made to the communication or format of the response.

47. 0 people shared they had a disability

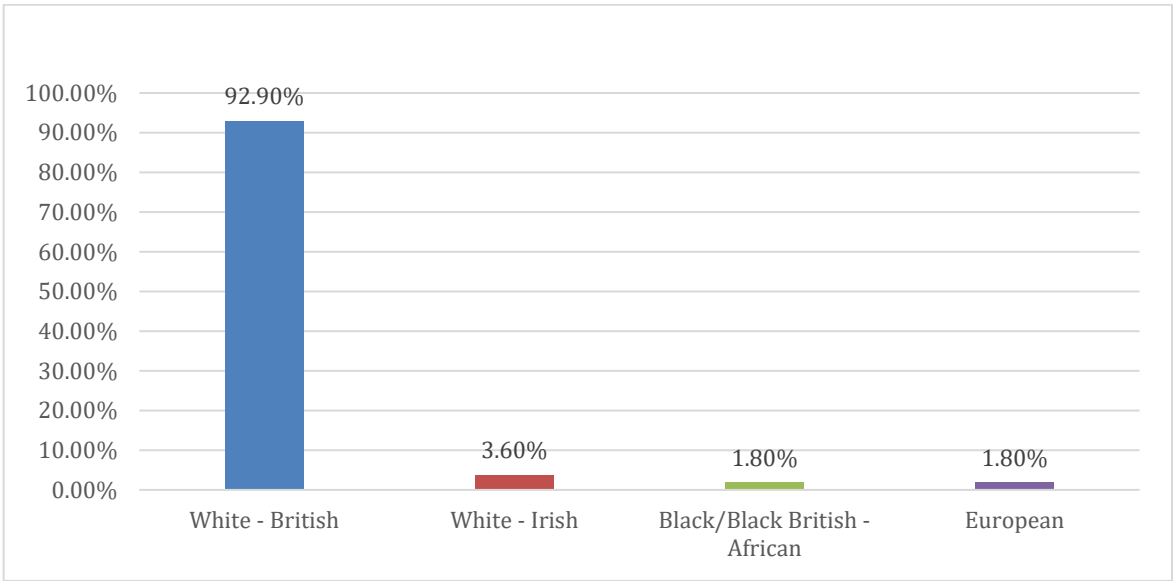
48. Reasonable adjustments were applied to support the process on one complaint.

49. All People who access Trust services have the right to be treated fairly and routinely involved in decisions about their treatment and care. They can expect to be treated with dignity and respect and will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

50. Ethic Origin is actively collected for complaints and concerns. The chart below reflects the local demographic; however, it may also show that further work is required to ensure the complaints process is equitable.

51. The Trust's Equality Delivery System (EDS) 2024-2025, is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England, in active conversations with patients, public, staff, staff networks, community groups and trade unions and to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

Chart 5: Ethnic Origin



Better Health Outcomes

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
- When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse

- Screening, vaccination and other health promotion services reach and benefit all local communities

Improved access and experience

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences of the NHS
- People's complaints about services are managed respectfully and efficiently

52. The Trust analyses complaints equality data to ensure that there is no evidence that individuals with protected characteristics are unfairly treated or disadvantaged.

Priorities for 2025/26

53. As part of the Trust's Quality Strategy, the Trust are committed to further strengthen and embed existing processes to better understand people's experiences of care, collaborating with patients, service users, families, carers and frontline staff to improve the quality-of-service delivery. The Patient Safety Partners will continue to visit services and talk to patients in receipt of care provided by the trust to understand what is working well and where improvement is required.

54. The Complaints Team will introduce and review processes and procedures and will align this to Patient Safety Incident Response Framework (PSIRF) principles. This will be from the beginning of the process when receiving the complaint right through to the release of the final complaint response letter.

55. We will triangulate and analyse data through attending the Patient Risk and Learning Review Panel each month.

56. For the Complaints Team to attend 'Your Voice' group each month and present information in relation to Friends and Family Test, Complaints and Concerns.

57. The PSIRF methodology will support the understanding of what matters most to the person. We will learn from people's experiences of care and embed this into both learning and development across the Trust.

58. In line with the NHS Complaint Standards document (2022), the Trust's approach to this will continue to proactively consider:

- A person's confidence in raising concerns or a complaint
- A person's knowledge in how to raise a complaint or concern
- Engage with the person raising the complaint to make sure they fully understand
- Making information available in a format that people find easy to understand
- What matters most to the person aligning this to PSIRF methodology
- Making sure that there is a strong commitment to the duty of candour so there is a culture of being open and honest when something goes wrong
- Signpost the person to support and advice services, including independent advocacy services, at an early stage
- Ensure that any staff members specifically complained about are made aware at the earliest opportunity
- Staff involved in carrying out complaint investigation are properly trained to do so and have the level of authority and autonomy to carry out a fair investigation
- A person's feelings around the response they have received, including the overall outcome and whether their complaint has made a difference. if something went wrong, an explanation of the impact it had

- To provide an explanation of any wider learning we have acted on/will act on to improve our service for other users
- A meaningful apology for any failings
- A person's overall experience with regards to how their complaint was managed
- Provide details of how to contact the Parliamentary and Health Service Ombudsman if the individual is not satisfied with our final response

59. Trust learning will consider equality and inclusion to ensure we have considered individual rights and needs as part of the Trust's management of care and complaints. Learning from experiences and engagement will form part of all Trust-wide governance processes.

60. To ensure that all equality and diversity forms sent to patients when complaining have a direct link to your experience email inbox. This will ensure that forms will be completed and managed by the complaints team centrally.

61. A new complaint handling training course will continue to be delivered in 2025/2026 to all relevant staff that investigate and respond to complaints and concerns. This will support and enhance staff knowledge and skills in relation to complaints. We will be looking to incorporate identified learning by introducing 'Martha's Rule' to the training to ensure staff have full understanding of why this is important.

62. We will continue to align our system and processes with Patient Safety Incident Response Framework (PSIRF) principles, working closely and compassionately with patients and families.

63. We will utilise Patient Safety Partners to quality assure a sample of anonymised complaints response letters. This will ensure they are personalised and clearly communicated.

Paula Simpson
Chief Nurse

Contributors:
Ian Salisbury Senior Complaints Officer
Ben Bowsley Datix and Compliance Manager

18 June 2025

Board of Directors in Public **Item 31**

03 September 2025

Title	Annual Safeguarding Report 01 April 2024 – 31 March 2025
Lead Director	Paula Simpson, Chief Nurse
Author	Jude Blease Head of Safeguarding
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to share the contents of the Annual Safeguarding Report: 01st April 2024 – 31st March 2025 to the Board of Directors for information.

Key Risks

This report provides evidence and monitoring in relation to Strategic Risk ID01, within the Trust's Board Assurance Framework: Failure to deliver services safely and responsively to inclusively meet the needs of the population: Current Risk Rating 12 (L3xC4) with an 'Averse' Risk Appetite. There are no new BAF escalations identified, based on the content of this report

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

Contribution to WCHC strategic objectives	
Populations	Yes
Safe care and support every time	Yes
People and communities guiding care	No
Groundbreaking innovation and research	No
People	Yes
Improve the wellbeing of our employees	No
Better employee experience to attract and retain talent	No
Grow, develop and realise employee potential	Yes
Place	Yes
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
10.06.25	Safeguarding Assurance Group	**Annual Safeguarding Report**	Approved
09.07.25	Quality and Safety Committee	**Annual Safeguarding Report**	The committee was assured on the strength of safeguarding governance across the organisation / Approved
03.09.25	Board	**Annual Safeguarding Report**	For approval

1	Narrative
1.1	WCHC is committed to ensuring that all staff are aware of their role in relation to safeguarding vulnerable children and adults. The Safeguarding Service provides a comprehensive proactive provision, which responds to the needs of staff and individuals. The service is committed to the promotion of safeguarding within everyday practice, focusing upon prevention and early intervention, ensuring that all statutory functions are discharged, and that best practice is adhered to, thereby equipping the workforce to undertake their duties and

	fulfil personal and organisational responsibilities with regards to safeguarding the public. The annual report highlights achievements during 2024/2025. It provides a synopsis of the excellent work completed by the Safeguarding Team throughout the year including an overview of our daily business activities to ensure our communities remain safe. The document gives an overview of the structure of the Partnerships, related inspections, and priorities for each place. The report provides a summary of future priorities for the Safeguarding Team, so we continually improve our service delivery to safeguard the communities of WCHC.

2	Implications
2.1	**Quality/Inclusion** No identified implications
2.2	**Finance** No financial implications
2.3	**Compliance** As part of our Safeguarding Children, Young People, Children in Care and Adults at Risk Commissioning Standards the Annual Report should be presented at board level with the expectation that this will be made public.

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

NHS

Wirral Community Health and Care

NHS Foundation Trust



Safeguarding Annual Report 2024/25

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Introduction

1. The purpose of this report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust (WCHC) Board regarding activity in relation to safeguarding governance for the reporting period 01 April 2024 - 31 March 2025.

2. This report demonstrates continued organisational compliance with statutory duties and local safeguarding frameworks. A full index of abbreviations is listed in Appendix 1.

3. WCHC is committed to everyone, ensuring that safeguarding principles are placed at the heart of everything we do. We have an excellent reputation for safeguarding standards, and we take a proactive approach to promoting the wellbeing and welfare of the populations we serve.

4. Wirral Community Health and Care NHS Foundation Trust Safeguarding Teams provide support, advice, education, and training, in safeguarding matters, to all our staff. Our aim is to ensure the prevention of harm, exploitation, and abuse of everyone, through the provision of high quality care, responding effectively to concerns and allegations whilst working collaboratively with our partner agencies.

5. The Safeguarding Team assures that all statutory functions are achieved, and that best practice is adhered to. This is to guarantee that all quality care delivered by our organisation promotes a safety culture that supports our vision. It places safeguarding and promotion of the welfare of children, young people, and adults at risk, above all other aims.

Leadership & Governance

6. The Chief Nurse is the Executive Lead for Safeguarding providing strategic leadership across the organisation. The Executive Lead is responsible for ensuring that safeguarding is recognised as a key organisational priority and that it is embedded across all areas of service provision within the organisation.

7. All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children, a Named Nurse for Children Looked After, and a Named Nurse for Adults to provide expert advice and support to Trust employees and promote good practice within the organisation as per the Children Act (2004) and Care Act (2014).

8. The Trust's Safeguarding Team is led by Head of Safeguarding, supported by named professionals who have specific roles for Safeguarding Adults and Children as described in the Intercollegiate Safeguarding Competencies for Adults (2024) and Children (2019). The team is supported by specialist staff and administration staff across both adults and children.

9. Each operational team is supported by Safeguarding Link professionals for children and adult Safeguarding Champions.

Key Achievements 1 April 2024 – 31 March 2025 - Time to Shine

Trust wide:

10. The Safeguarding Team is committed to ensuring that all staff are aware of their role in relation to Safeguarding Children and Adults at Risk and consistently demonstrate organisational compliance with statutory duties and local safeguarding frameworks.

11. During 2024 and 2025, we have successfully submitted evidence of compliance to Commissioners and Designated Professionals in relation to:

- Section 11 of the Children Act 2004 for Wirral, Cheshire East, St Helens and Knowsley.

- The Safeguarding Accountability and Assurance Framework (SAAF) for Safeguarding Children and Safeguarding Adults and the Quarterly KPI Reporting Template for Children in Care. During this period, we have received positive feedback from the Integrated Care Board (ICB) and our Public Health Commissioners.

- Our two-year Commissioning Standards document remains in date with the Trust having a compliance RAG rating of 62 green areas and 1 amber rated area against 63 standards.

- During Q4 2023-2024, safeguarding governance for children were subject of a review by Mersey Internal Audit Agency, rated as **Substantial**. In 2024-2025 the two actions from the audit have been tracked at the Safeguarding Assurance Group and completed with good assurance.

- The NHSE data collection framework for our Looked After Children and Prevent datasets to support the governments counter terrorism strategy.

- We have participated in one inspection with the Local Authority, Inspecting Local Authority Children's Services (ILACS), one mock SEND inspection and one mock JTAI inspection. We have provided continued support with Wirral, Cheshire East and Knowsley Local Authorities ILACS action plans to allow us to work towards further improved services across the partnership.

- The Safeguarding Team have completed 18 audits throughout 2024-2025 to measure our continuous quality improvement, identify any learning and provide assurance.

12. Throughout the year the Safeguarding Team has also worked to support all Trust services and our partner agencies ensuring our staff provide the best possible service, to continue to keep our communities safe.

- A Safeguarding Strategic Plan 2024-2025 was developed with four goals identified. Good assurance has been evidence against these goals and approved by the Trust's Quality and Safety Committee.

- As part of Safeguarding Adult Week November 2024, the Safeguarding Adults Team hosted an online training event with guest speaker Ian Porter on 'Hoarding and the Unbearable Lightness of Professional Curiosity' This Multiagency event for the Trust was

well attended and received positive feedback.

- We have represented the Trust at a multi-agency Safeguarding Adults Partnership Board event.

- We have completed a Trust wide Mental Capacity Act Audit across Adults and Children with an overwhelming 541 responses across all services. The audit showed a strong level of understanding of the Mental Capacity Act.

- The Safeguarding Adult Team held a Safeguarding Champion Celebration in November for those staff that have achieved their competency. Certificates and badges were presented to them from the Deputy Chief Nurse and Head of Safeguarding.

- We have continued to work in partnership with Merseyside Police with preventative measures to support safer sleep across Wirral Knowsley and St Helens Place.

- We have supported the changes with Wirral Local Authority as part of the Families First for Children Pathfinders funding which was awarded in April 2024 and has now been extended into 2026. These changes are in the process of being rolled out across our other three places. We represent the Trust at the newly formed multi-agency Operational Child Protection and Pathfinder meetings.

- We have represented the Trust at a Wirral multi-agency Safeguarding Children's Partnership event on the use of Systemic Practice.

- The Safeguarding Team assumed responsibility for attendance at Channel Panel for Wirral Place in support of the Prevent programme to address the causes of radicalisation. We have two safeguarding practitioners who share this responsibility, and we are working with our partners to adopt a similar process across Knowsley, St Helens and Cheshire East in support of the 0-19 and 0-25 services that we offer.

- We have represented the Trust at an event held for National Child Exploitation Day, attended by over 100 hundred multi-agency professionals in St Helens. We delivered a presentation to attendees on the roles of 0-19 and the Safeguarding Team in supporting children exposed to Child Exploitation.

- We have developed and delivered as part of a multi-agency group a training package on Neglect for professionals.

- The Safeguarding Children Team have developed a programme for bitesize training sessions and delivered 42 training sessions across the Trust covering various subjects including:

  Mental Capacity Act awareness,
  Voice of the Child
  Domestic Abuse
  Court Reports,
  Safeguarding referrals,
  Contextual Safeguarding,
  Review Health Assessments,
  Use of Assessment Tool,

Record Keeping,
Child Safeguarding Practice Review
Rapid Review learning and
Child Exploitation.

- Together the Safeguarding Team have trained 1092 staff across the Trust to a Level 3 standard for Adults and Children.

- Working with the ICB we have supported with the delivery of two bespoke Safeguarding and Education Health Care Plan (EHCP) training events with the 0-19 Service, in Cheshire East.

- The Safeguarding Team within Cheshire East attended and delivered training with the School Nurses as part of their refresher training.

- We have attended at the Safeguarding Partnership learning week in Cheshire East to promote and educate other professionals on the roles of Safeguarding Specialist Nurses.

- WCHC have supported with the delivery of multi-agency child exploitation training for the Cheshire East partnership throughout the year delivering training to over 120 multi agency professionals

- We have worked with our System Support to create a new robust safeguarding platform for the Trust Safeguarding Team within the electronic record keeping system.

- A quality initiative has been created and implemented to support robust data collection. A monthly meeting is held between Safeguarding, Business Intelligence and System Support representatives to identify and improve data collection for audits, and reporting both locally and nationally.

- The Team have participated in a NSPCC scoping exercise in Cheshire East on Child Sexual Abuse and recognised in the report as having a gold standard approach to data collection and interpretation.

- Following a learning review, we have worked with 0-19 Services designing and delivering a training package around unconscious bias and safeguarding.

- We have been pivotal working alongside the HR department with the implementation of the Sexual Safety Charter for the Trust. This work has included a new policy Preventing Sexual Misconduct in the Workplace, a new confidential reporting mechanism, adopting an eLearning training package, changes to the Level 3 Safeguarding training to raise awareness, and brand new guidance held on the Trust Intranet StaffZone, to support all of our staff.

- Compliance with safeguarding training and supervision remains positive across all services.

- The below safeguarding policies have been reviewed and updated to ensure they meet current legislation.

    - SG05 - Failure to Gain Access Policy.

- Adoption Protocol has been updated in line with NHSE guidance and now sits within GP06 Records Management Policy
- SOP 153 Multiagency Risk-Assessment Conference (MARAC) Process
- SOP 165 Management of Child Death Notifications

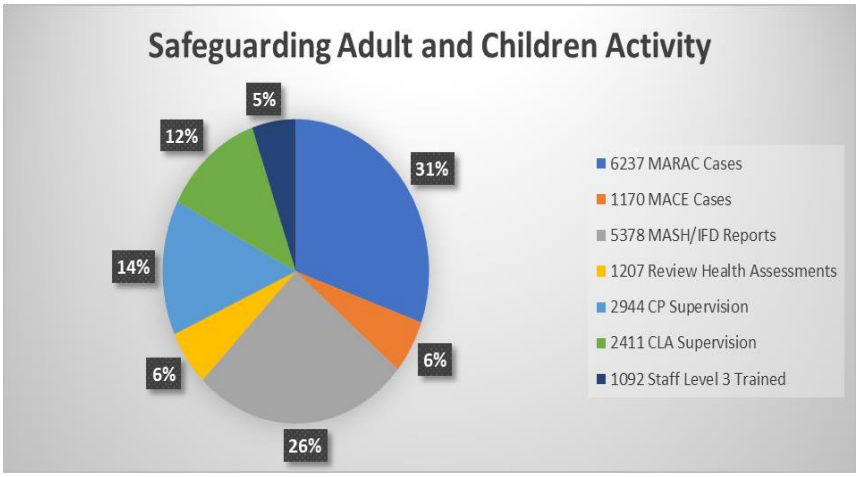
13. The Safeguarding Team provides a comprehensive proactive service, which responds to the needs of staff and individuals. We are committed to the promotion of safeguarding within everyday practice, focusing upon prevention and early intervention.

14. The table below and pie charts provide an overview of a range of our daily business activities as a Safeguarding Team. This data has also been captured under each place highlighting the bespoke work that is completed to continually safeguard our communities.

Safeguarding Adult and Children 2024-2025	Activities Trust Wide
Number of cases heard and contribution to safety planning at MARAC	**6237**
Number of cases heard and contribution to safety planning at MACE	**1170**
Number of MASH / IFD reports completed	**5378**
Number of Review Health Assessments completed	**1207**
Number of supervision sessions completed for children on a Child Protection Plan	**2944**
Number of Child in Care cases discussed during supervision	**2411**
WCHC staff trained to Level 3 Safeguarding adult and children standard	**1092**

15. The chart shows the range of some of the activities conducted by the Safeguarding Team as a percentage of their time throughout 2024-2025.

*MARAC – Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, MASH Multi Agency Safeguarding Hub, IFD Integrated Front Door

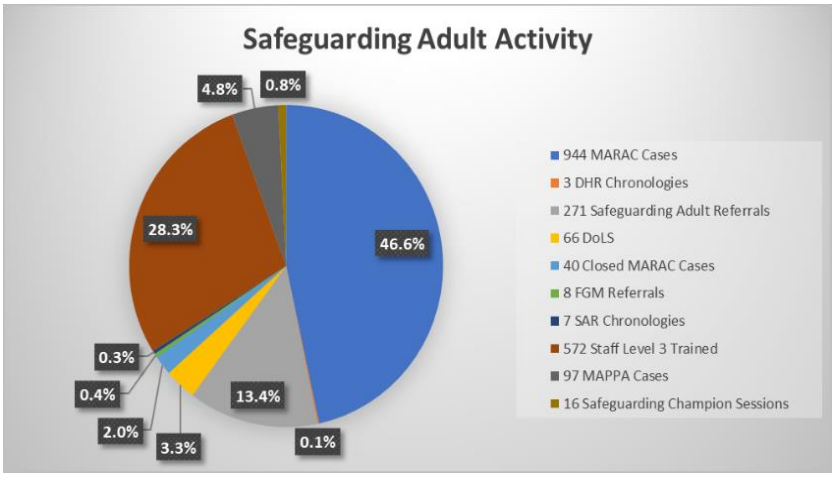


Safeguarding Adults:

16. The table below shows a range of some of the activities conducted by the Adult Team throughout 2024-2025. There has been an increase of closed MARAC cases since 2023-2024 from 30 to 40. These cases which are the highest risk and are often around honor-based abuse and forced marriage. The volume is increasing due to the criteria and Domestic Abuse legislation.

Safeguarding Adults 2024-2025	Activities
Number of cases heard and contribution to safety planning at MARAC	944
Number of WCHC staff trained to Level 3 Safeguarding Adults standard	572
Number of safeguarding referrals into ASC CADT / MASH of these 25% were quality assured	271
Number of DoLS requested from CICC, which are monitored via Safeguarding Adults Team.	66
Number of heard cases and contributions to the safety planning within closed MARAC	40
Number of FGM referrals all of which were reported via NHS England dataset as required.	8
Number of SAR requests for chronologies for SAR consideration.	7
Number of DHR requests for chronologies for DHR consideration	3
Number of MAPPA meetings attended	97
Number of Safeguarding Champion sessions delivered including safeguarding supervision.	16

17. The chart shows the range of some of the activities conducted by the Adult Team as a percentage of their time throughout 2024-2025.



*MARAC - Multi Agency Risk Assessment Conference, ASC - Adult Social Care, CADT - Central Advice and Duty Team, MASH - Multi Agency Safeguarding Hub, DoLS - Deprivation of Liberty Safeguards, CICC - Community Integrated Care Centre, FGM - Female Genital Mutilation, SAR Safeguarding Adult Review, DHR -Domestic Homicide Review.

Safeguarding Children Wirral Place:

18. The table below shows a range of some of the activities conducted by Wirral Place Children Safeguarding Team throughout 2024-2025. The 2401 MASH reports include the number of requests and does not reflect the access to both Cheshire West Partnership Trust (CWP) systems and Wirral University Teaching Hospital (WUTH) systems which would equate to on average over 7200 patient records being accessed. In April the MASH nurses also added access to the GP systems for reports adding more time on each individual screened. It is expected that these figures will rise to just under 10,000 for 2025 - 2026

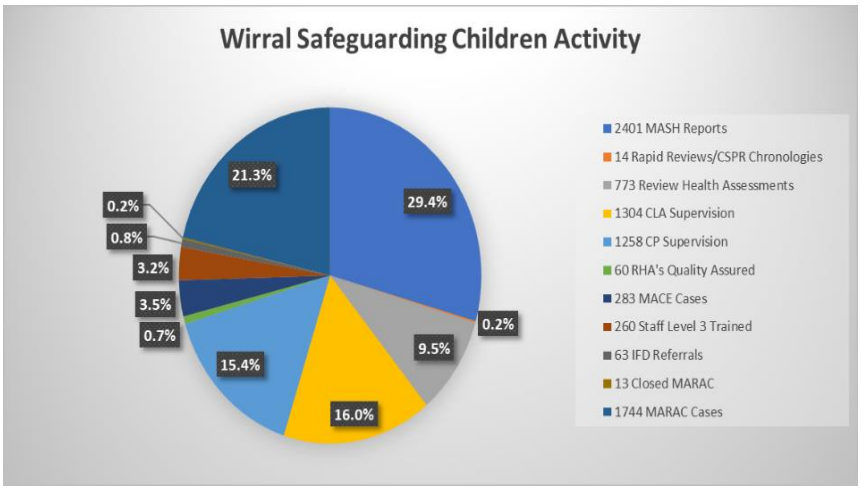
Safeguarding Children Wirral Place 2024-2025	Activities
Number of MASH reports completed	2401 / 7203
Number of children researched to support the IDVA contribution to safety planning at MARAC	1744

Number of children discussed and contribution to safety plans at closed MARAC	**13**
Number of supervision sessions completed for Children Looked After	**1304***
Number of supervision sessions completed for children on a Child Protection Plan	**1258**
Number of Review Health Assessments completed	**773**
Number of Review Health Assessments quality assured	**60**
Number of cases heard and contribution to safety planning at MACE	**283**
Number of staff trained to Level 3 Safeguarding Children standard	**260**
Number of referrals made to IFD of which 100% are quality assured	**63**
Number of rapid reviews / CSPR chronologies completed	**14**

19. The chart shows the range of some of the activities conducted by Wirral Place Childrens Team as a percentage of their time throughout 2024-2025.

*The data for CLA supervision includes were there has been twice yearly supervision.

* MASH Multi Agency Safeguarding Hub, MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door.



Safeguarding Children Cheshire East Place:

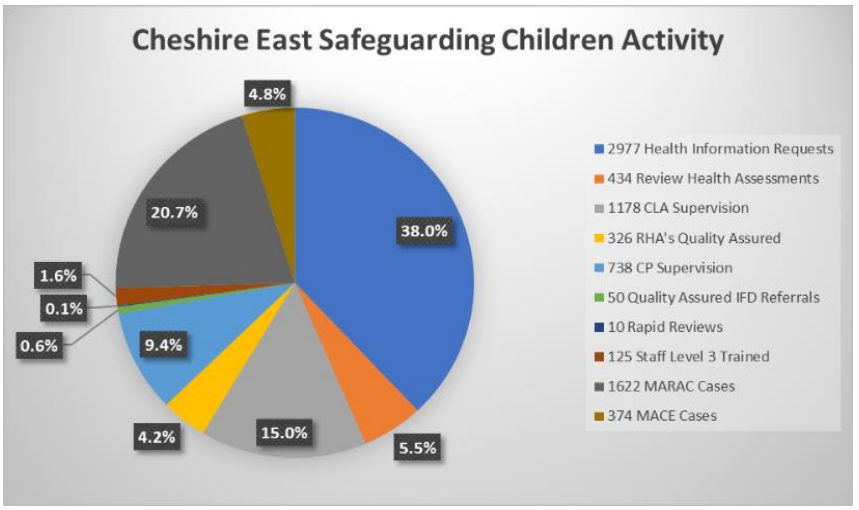
20. The table below shows a range of the activities conducted by Cheshire East Place Children Safeguarding Team throughout 2024-2025.

Safeguarding Children Cheshire East Place 2024-2025	Activities
Number of Health information requests completed with 0 breaches	**2977**
Number of children discussed and contribution to safety planning at MARAC	**1622**
Number of Review Health Assessments completed	**434**
Number of Supervision sessions completed for Cared for Children	***1178**
Number of Supervision sessions completed for children on a Child Protection Plan	**738**
Number of Review Health Assessments quality assured (100%)	**326**
Number of cases heard and contribution to safety planning at MACE	**374**
Number of staff trained to Level 3 Safeguarding Children standard	**125**
Number of referrals made to ChECS of which 100% quality assured	**50**
Number of rapid reviews / CSPR chronologies completed	**10**

21. The chart shows the range of some of the activities conducted by Cheshire East Place Safeguarding Childrens Team as a percentage of their time throughout 2024- 2025.

*The data for Cared for supervision includes were there has been twice yearly supervision

** MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door. CSPR Child Safeguarding Practice Reviews.



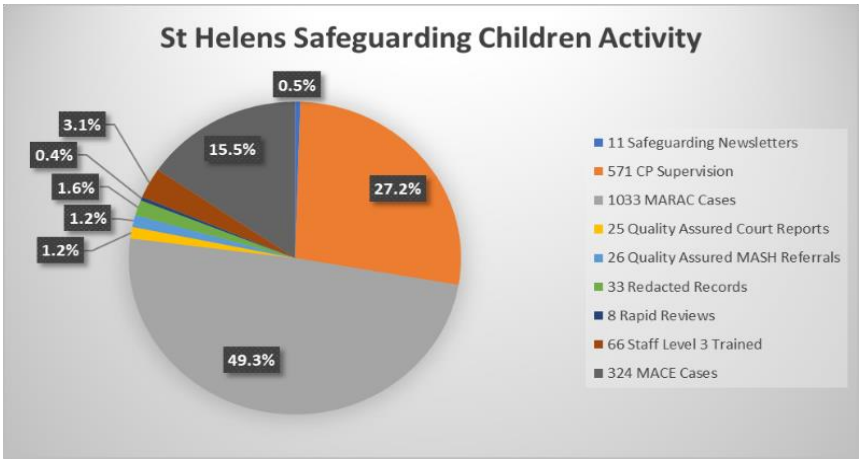
Safeguarding Children St Helen's Place:

22. The table below shows a range of some of the activities conducted by St Helen's Place Children Safeguarding Team throughout 2024-2025.

Safeguarding Children St Helens Place 2024-2025	Activities
Number of children discussed and contribution to safety planning at MARAC	**1033**
Number of supervision sessions completed for children on a Child Protection Plan	**571**
Number of cases heard and contribution to safety planning at MACE	**324**
Number of service user records redacted for court	**33**
Number of reports quality assured for 0-19 service for court	**25**
Number of staff trained to Level 3 Safeguarding Children standard	**66**
Number of referrals made to MASH of which 100% quality assured	**26**
Number of rapid reviews / CSPR chronologies completed	**8**
Number of Safeguarding Newsletters shared with 0-19 and Partner Agencies	**11**

23. The chart shows the range of some of the activities conducted by St Helens Place Childrens Safeguarding Team as a percentage of their time throughout 2024-2025.

*MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, MASH Multi Agency Safeguarding Hub, CSPR Child Safeguarding Practice Reviews.



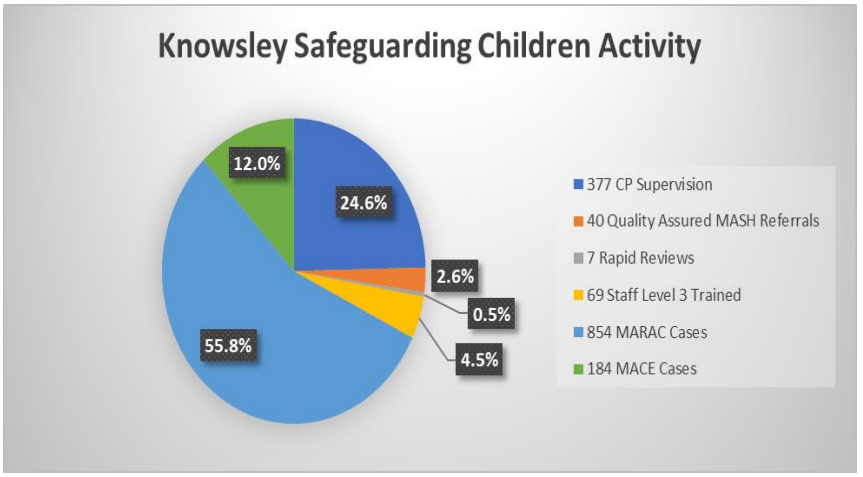
Safeguarding Children Knowsley Place:

24. The table below shows a range of some of the activities conducted by Knowsley Place Children Safeguarding Team throughout 2024- 2025.

Safeguarding Children Knowsley Place 2024-2025	Activities
Number of children discussed and contribution to safety planning at MARAC	**854**
Number of supervision sessions completed for children on a Child Protection Plan	**377**
Number of cases heard and contribution to safety planning at MACE	**184**
Number of staff trained to Level 3 Safeguarding Children standard	**69**
Number of referrals made to IFD of which 100% are quality assured	**40**
Number of rapid reviews / CSPR chronologies completed	**7**

25. The chart shows the range of some of the activities conducted by Knowsley Place Childrens Safeguarding Team as a percentage of their time throughout 2024-2025.

*MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door, CSPR Child Safeguarding Practice Reviews.



Section 1: Analysis of Safeguarding Children Related Inspections

26. The below provides a summary of the relevant inspections that have taken place during 2024-2025.

Safeguarding Service	System wide Inspections	Outcome
Wirral Safeguarding Children	**ILACS JTAI**	**Rated as Requires Improvement Sept 2023 Inspection Dec 2022**
Cheshire East Safeguarding Children	**ILACS JTAI**	**Rated as Inadequate March 2024 Inspection July 2022 - Actions completed**
Knowsley Safeguarding Children	**ILACS JTAI**	**Rated as Inadequate November 2024 Inspection July 2022**
St Helens Safeguarding Children	**ILACS JTAI**	**Rated as Good July 2023 No JTAI – Joint Area Review 2008**

27. In January 2018, Ofsted adopted the ILACS (Inspection of Local Authority Children's Services) framework for inspecting services for children in need of help and protection, children in care and care leavers. The framework outlines a system of inspection activity which focuses on the effectiveness of the following local authority services and arrangements;

- to help and protect children, and enable families to stay together and get the help they need
- the experiences and progress of children in care wherever they live, including those children who return home
- the arrangements for permanence for children who are looked after, in stable, loving homes, including adoption
- the experiences and progress of care leavers

Ofsted describes ILACS as a whole system of inspection which aims to apply a proportionate and risk based approach.

28. Previously each organisation has been notified with details of the cases being reviewed and staff have formed part of any inspection however more recent ILACS have concentrated on Local Authority staff only. All WCHC staff are briefed for any inspection and remain on standby throughout the whole process should the need arise for them to be called upon.

Safeguarding Children Wirral Place:

29. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 18th to 29th September 2023
Graded: Requires improvement to be good in all areas.

30. What needs to improve – system wide actions:
- The response to 16- and 17-year-old homeless children, to ensure that they are made aware of their rights and entitlements.
- The awareness-raising and identification of, and response to, children living in private fostering arrangements.

- The quality of decision-making, to ensure that children come into care in a timely way.
- The timely progression of permanence plans for children, to ensure that they are not subject to statutory intervention for too long.
- Escalation by IROs, to robustly challenge plans for children.
- Transition planning for 16- and 17-year-old children in care, to ensure that they feel better prepared for leaving care.
- The offer to care leavers so that it is consistently accessible and understood to ensure that all care leavers receive their full entitlements.

31. WCHC are supporting the areas of improvement; by ensuring the child's voice is present in all arenas and they are able to be part of their care plan for the future. WCHC 0-19 Teams complete the health assessments and complete the care leavers health passport empowering them with health information to take into the adult world of higher education, training or employment.

32. **Joint Targeted Area Inspection (JTAI)**
The key findings from the December 2022 JTAI of Early Help Services did not identify any actions directly for Health. As an integral part of the Wirral Childrens Safeguarding Partnership (WSCP), however, WCHC have worked closely with children's services to support changes to practice across 0-19 ensuring support for our families is identified at the earliest opportunity.

Safeguarding Children Cheshire East Place:

33. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 26th February to 8th March 2024
Graded: Inadequate - Three areas require improvement to be good however the fourth area was rated as inadequate therefore the overall judgement is inadequate.

34. What needs to improve – system wide actions:
- Senior leaders' oversight of performance to ensure that there is a coherent approach to continuous improvement.
- The quality, consistency and responsiveness of support, advice and guidance for care leavers, including those who are homeless, with additional vulnerabilities, and those who are over 21 years of age.
- The quality of management oversight and supervision to ensure that consistent, good social work practice is in place.
- The quality of plans for children to ensure that they are more child-focused and drive forward positive change in a timely way.
- The quality and frequency of visits to children so that the visits are purposeful and in line with assessed needs.
- The sufficiency of suitable placements that can meet children and young people's assessed needs.
- The effectiveness of child protection chairs and independent reviewing officers (IROs) to escalate, challenge and scrutinise plans for children.

35. The inspection report was released in May 2024 and an action plan has been formulated and implemented, there are two main area's which relate to Health and the 0-19 Service:

- Health care summary passports
- Improvement in timely health assessment and information which includes initial health assessments and review health assessments.

36. Extensive work has been undertaken in relation to the Health Care summaries, including gathering children and young peoples' views on the document and their insight and ideas for improvement. Following this engagement work, the Health Care summaries have been renamed for Cheshire East as "My Health Care Summary" and the document has been modernised to include QR codes to support services both locally and nationally. Alongside this a bespoke Unaccompanied Asylum Seeking Children (UASC) My Health Care Summary has also been designed. This ensures our migrant young people have access to health information relevant to their needs and is in a format to support young people where English is their second language.

37. Joint working between the Integrated Care Board and Local Authority to establish new processes in relation to Initial Health Assessments (IHA) has been ongoing throughout the year. A new set of documentation has been designed which will support children and young people entering care and three training sessions to the Local Authority have taken place to support the implementation of this process.

38. **Joint Targeted Area Inspection (JTAI)**
Inspection dates: 11th to 15th July 2022. The report highlighted a heavy focus on processes rather than evaluation and systematic analysis of the frontline work across multi agency services. A comprehensive action plan for health was established in 2022 and completed during 2023.

39. In February 2024 the Department for Education DfE reported that systems and processes are in place to protect children who are at risk of, or are victims of, criminal and sexual exploitation and leaders are clear on their priorities to ensure the service continues to build on these foundations. As such, they were content to step down the specific JTAI related monitoring, provided that the Council maintained a tight grip on services and maintained the progress made so far.

Safeguarding Children St Helen's Place:

40. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 10th to 21st July 2023
Graded: Good - Two areas good, experience and progress of children who need help and protection requires improvement and the experience and progress of care leavers is outstanding.

41. What needs to improve – system wide actions:
- The effectiveness of the response to children experiencing neglect.
- The timeliness of entering pre-proceedings for children who need this support.

- The response to 16- and 17-year-olds who are homeless.
- The stability and consistency of children's social workers.
- Safeguarding of disabled children.

42. WCHC are supporting the above improvements, by ensuring the appropriate 0-19 practitioners have attended Neglect and Graded Care Profile 2 (GCP2) training equipping them with the knowledge and tools to identify and respond to Neglect.

43. The Safeguarding Team are part of the multi-agency professionals reviewing the tools used to identify Neglect. It has been identified the GCP2 is not being utilised across the agencies owing to the complexities of the document, therefore the development of a new tool is in progress.

44. The 0-19 practitioners make certain the voice of the child and a child's lived experience is at the forefront of all decision making securing positive outcomes for children in St Helens. The 0-19 Practitioners deploy professional challenges utilising the Safeguarding Children's Partnership multi-agency resolution procedure in order that best outcomes are achieved in a timely manner.

45. **Joint Targeted Area Inspection (JTAI)**
St Helens have not been subject of a JTAI in 2024-2025, the last being a Joint Area Review in 2008. The Safeguarding Children's Partnership alongside partner agencies have been proactive in their preparation for any upcoming JTAI focusing on the learning from JTAI's completed in the neighboring boroughs.

Safeguarding Children Knowsley Place:

46. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 18th to 29th November 2024.
Graded: Inadequate.

47. What needs to improve – system wide actions:
- The leadership capacity of social work practice which meets professional and practice standards, to drive the quality of social work interventions with children.
- The identification of, and response to, risk by social workers in relation to children in need and children subject to child protection plans.
- The quality of social work practice and management oversight for disabled children.
- The quality of social work practice, specifically assessments, plans and planning.
- The social work response to domestic abuse and neglect.
- The quality of help and support for children with vulnerabilities, specifically young carers and children aged 16 and 17 years who present as homeless.
- The quality of visiting and direct work with children and young people, including life-story work.
- The quality of support, advice and guidance for care-experienced young people, including those with additional vulnerabilities, to ensure that this is timely, consistent and responsive to levels of need, up to the age of 25.

- The caseloads of personal advisers (PAs), to enable them to provide timely advice, support and guidance to care-experienced young people.
- The quality of supervision and management oversight of social workers and PAs, so that children and young people receive a timely and consistent service that is responsive to their needs.

48. The Service Lead and Named Nurse for Knowsley are working together to create a process for providing information to care leavers to support them regarding their health once they attain 18 years. Work is continuing with the Service Lead and Named Nurse along with Business Support as to early identification of care leavers, children / young people who are homeless, young people aged 18-25 who have SEND.

49. **Joint Targeted Area Inspection (JTAI)**
Knowsley have not been subject of a JTAI in 2024-2025, the last being in 2022.

Section 2: Statutory Framework and National Policy Drivers

50. There are significant differences in the laws and policies that shape how we safeguard children and adults. The legal framework to protect children is contained within the newly revised Working Together to Safeguard Children (2023) and for adults the Care Act (2014).

51. The overarching objective for both however is to enable children and adults to live a life free from harm, abuse, or neglect. The report provides a summary of how Wirral Community Health and Care discharges its statutory duties in relation to:

- Children Act (1989,2004)
- Working Together to Safeguard Children (2023)
- Section 11 of the Children Act (2004)
- Care Act (2014)
- Mental Capacity Act (2005),
- Deprivation of Liberty Safeguards amendment in (2007)
- Domestic Abuse Act (2021)
- Counter Terrorism and Security Act (2015)
- CQC Registration standards, Health and Social Care (2008) – Regulation 13: Safeguarding Service Users from abuse and improper treatment.

Working Together to Safeguard Children (2023)

52. The Children Act (1989) and Section 11 of the Children Act (2004) places a statutory duty on all NHS Trusts to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions.

53. The statutory guidance, Working Together to Safeguard Children, was updated and the revised version published in December 2023.

- The guidance strengthens how safeguarding partners work together and with relevant agencies. It makes it clear that successful outcomes for children relies on help, support, and protection. The document clarifies roles and responsibilities of safeguarding partners strengthening accountability around information sharing, independent scrutiny, funding, and reporting. It further clarifies support for disabled children and their families, the multi-agency response to harm from outside the home.

- A shared responsibility emphasises that the successful outcome for children depends on the strong multi agency partnership working across the whole system including effective work with parents' carers and families.

- The introduction of who can act as a Lead Practitioner. There is requirement for a review of local processes and the introduction of revised procedures in respect of who the most appropriate lead practitioner should be for Child in Need in supporting children and their families. This decision must consider practitioner knowledge and skills, resources and commissioned service requirements. Work is currently ongoing throughout all the partnerships to agree the local changes for Section 17. Once agreed the partnerships are

to ensure multi-agency training reflects the new arrangements and includes specific training for the roles and responsibilities for those lead practitioners.

The Counterterrorism and Security Act (2015)

54. Prevent awareness and training is included within all levels of safeguarding adults and children training and the Trusts onboarding induction session. All safeguarding training is recorded and included within the Trusts compliance reporting, specific to role required skills and knowledge.

55. Training compliance is provided on a quarterly basis to the ICB through the Safeguarding Accountability and Assurance Framework (SAAF) and nationally via the Prevent duty data set.

56. The Safeguarding Team provide advice and support for staff reporting cases and liaise with the Counter Terrorism Policing Northwest to share information to assist the Channel Panel process. The Trusts Prevent Lead ensures that staff are provided with the appropriate training in line with the contest framework.

57. Compliance for Prevent Training at the end of 2024-2025 reported at 96.7%.

58. In 2024-2025 information was shared from WCHC to Wirral Channel Panel regarding 26 adult cases and 9 children's cases have been referred to the panel an increase from 24 for adults in 2023-2024.

59. Cheshire East, St Helens and Knowsley Place are working with their relevant leads to adopt a similar practice currently being delivered within Wirral Place to demonstrate the Trust's commitment to support the government's strategy to prevent radicalisation.

Section 3: Safeguarding Partnerships

Wirral Safeguarding Adult Partnership Board (WSAPB)

60. Wirral Safeguarding Adults Partnership Board (WSAPB) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all adults at risk across Wirral. The partnership board includes senior managers from the Local Authority, local NHS services, Police, Fire and Rescue Services, Probation, Age UK Wirral, and Healthwatch.

61. The below diagram shows the Wirral Safeguarding Adults Partnership Board governance structure:

WIRRAL SAFEGUARDING ADULTS PARTNERSHIP BOARD

STRUCTURE



62. WSAPB developed three subgroups and a task and finish group to initiate key strands of the boards work.

63. The Named Nurse Safeguarding Adults attends the subgroups and the task and finish groups. The Quality & Performance Group has made a commitment to look at qualitative data and develop a framework with Adult Social Care in order that the group will be able to identify themes and trends that will inform audit work.

64. The Communication and Engagement Group aims to ensure the experiences of local people, including adults at risk, carers, advocates, and those working with adults with care & support needs, are heard and used to improve the ways services work. A series of engagement sessions held with those that work within safeguarding on the Wirral which highlighted what is working well and barriers that are faced with. These findings have been fed through to Board.

65. The group has undertaken a survey of those working with adults with care & support needs to understand how organisations support their staff. It has looked at the impact of hoarding disorders and agreed that this should be a driving force in the board's work. Launching multi-agency training workshops. This training will go beyond mere 'awareness-raising' and focus on increasing participants' hoarding literacy in relation to personalised assessment / formulation, practice-based issues, and skills enhancement.

66. The Operational Subgroup aims to support the development and roll out of Adult Safeguarding policies and procedures and to ensure that partner agencies operate in accordance with them. It has revised and will be publishing a new Multi-Agency Risk Assessment model tool (MARAM). The group has overseen the roll out of Wirral Hoarding Improvement Project aimed at raising awareness of those that exhibit hoarding behaviours.

67. The Safeguarding Adults Review (SAR) sub-group is a collaboration between the Wirral, Knowsley, St Helens and Sefton Safeguarding Adults Boards. The group receives and considers all referrals and then makes a recommendation to the Chair of each Safeguarding Adults Board Chairs who will make the final decision.

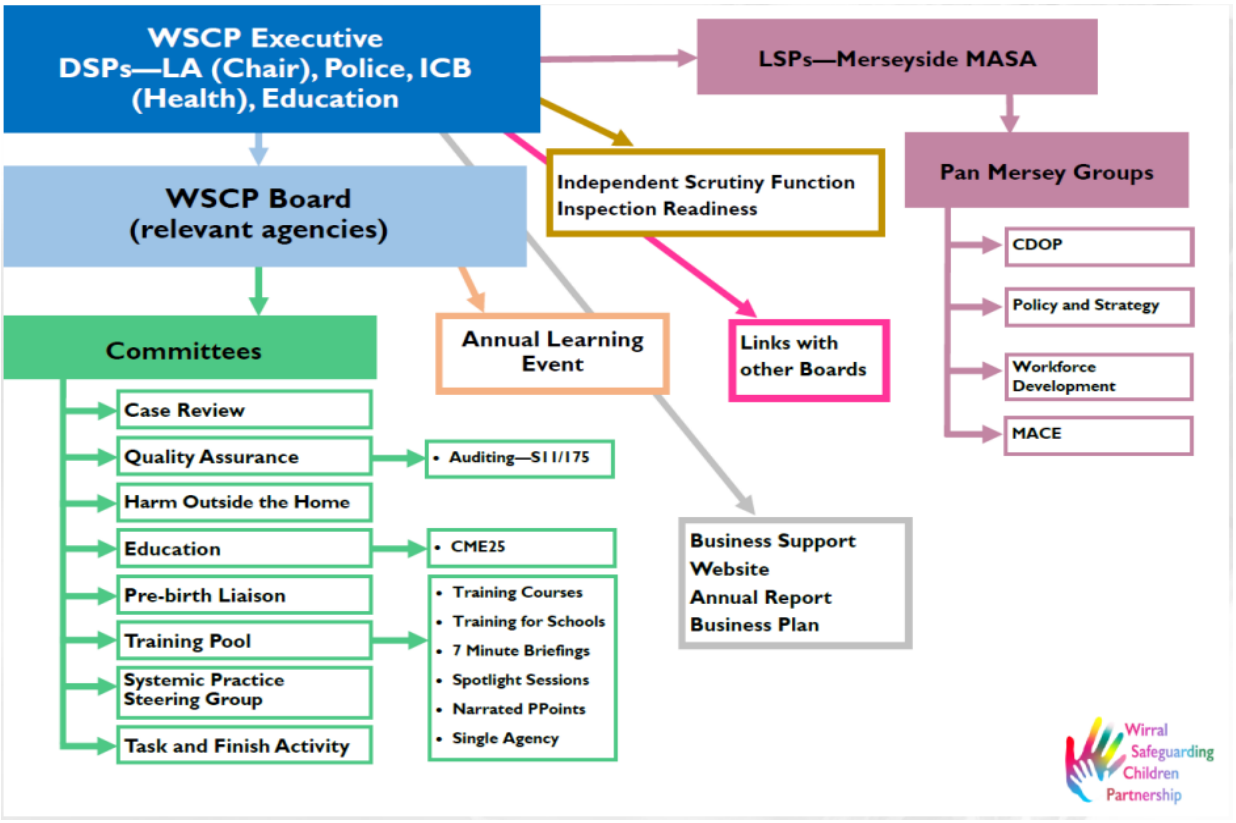
68. In addition, the Board is keen to further develop its work with other partnerships on the Wirral such as the Children's Partnership, Safer Wirral Partnership and the Domestic Abuse Alliance for greater collaboration in the future to improve the support offered to all generations.

69. The Head of Safeguarding represents the Trust at the Wirral Safeguarding Adults Partnership Board.

Wirral Safeguarding Children's Partnership (WSCP)

70. Wirral Safeguarding Children's Partnership (WSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Wirral. The partnership consists of the Director of Children's Services, Superintendent Merseyside Police and the Associate Director Integrated Care Board.

71. The below diagram shows the Wirral Executive Committee governance structure:



72. WCSP has agreed shared priorities for the partnership for 2024-2025, which have been adopted by all areas to improve frontline multi-agency practice through working on the key identified priorities.

- Embedding Systemic Practice
- Strengthening the Relationship with the Education Sector
- Embedding Change: Working Together, Family Help, WSCP Structure and Social Work Framework.

73. WCHC have supported the priorities by being part of the Neglect Strategy Task and Finish Group, contributing to the roll out of the Systemic Practice model which builds on Supporting Families Enhancing Futures (SFEF) and ensuring frontline staff attend the training to improve practice. The Safeguarding Team have also supported the Domestic Abuse Agenda working with the Adult Team in Multi Agency Risk Assessment Conference (MARAC).

74. The Named Nurse attends three of the eight Committees, Quality Assurance, Harm Outside the Family Home and Systemic Practice. The Named Nurse also attends the Pathfinders Operational Group which is part of wider government reform of children's services originally based on Stable Homes Built on Love and recently set out in the policy statement Keeping Children Safe, Helping Families Thrive. The Pre-birth liaison committee is attended by the 0-19 service, and the Case Review Committee is represented by the Designated Nurse and Doctor with named professionals attending by invitation.

75. The Named Nurse has supported multi-agency audits as part of the Quality Committee with the most recent audit being Neglect and GCP2.

76. Within Wirral Place the Section 11 Audit takes the form of 6 questionnaires over the year and evidence of compliance is included. The Named Nurses then attend a scrutiny panel to provide full assurance, with exemplary feedback being achieved in 2024

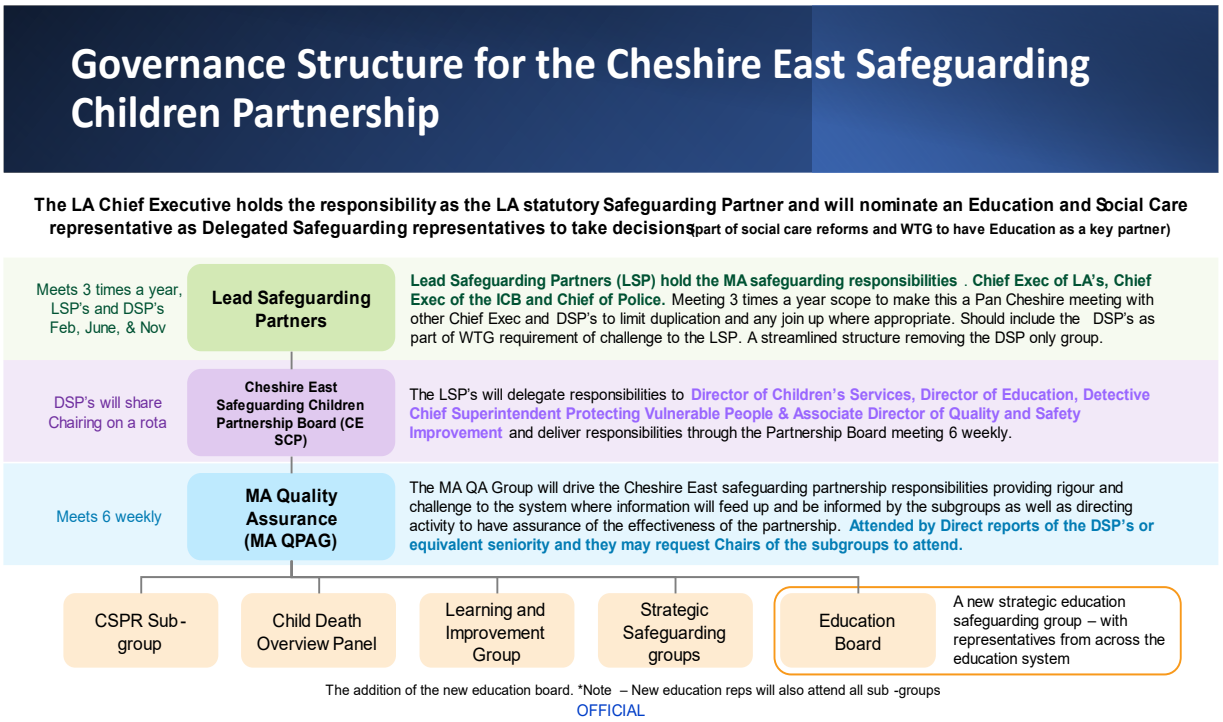
77. The Named Nurses have supported the introduction of the Pathfinders changes across Child Social Care (CSC) and are members of the newly formed Multi Agency Child Protection Team which looks at themes across the system to identify gaps in support. Funding for this model has been confirmed to be extended for a further year into 2026.

78. During the reporting period, the WSCP held a very successful one day network event for all partner agencies on Wirral. This was attended by 300 staff with 30 partner agencies represented. The safeguarding children's team attended supported by Sexual Health Wirral and the Family Nurse Partnership to raise awareness of the services offered by WCHC.

Cheshire East Safeguarding Children's Partnership (CESCP)

79. Cheshire East Safeguarding Children's Partnership (CESCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Cheshire East. The partnership consists of the Director of Childrens Services, Chief Superintendent Cheshire Police and Associate Director Integrated Care Board.

80. The below diagram shows the Cheshire East Corporate Safeguarding governance structure.



81. CESCP agreed shared priorities for the partnership for supporting the protection and wellbeing of children and young people in Cheshire East:

- Contextual safeguarding
- Education as a protective factor
- Sexual abuse
- Neglect

82. WCHC has supported the priorities by the Named Nurse being an active part of the Neglect Strategic Board, Child Sexual Abuse Group, Child Exploitation Strategic Group, the Domestic Violence Partnership Task Group, and Learning and Improvement Group. In January 2024 following a restructure of the Partnership further new groups were created Good Health and Wellbeing for Cared for Children Group, Child Safeguarding Practice Review (CSPR) and Rapid Review sub-group and the Multi Agency Quality Assurance Group which the Named Nurse also attends.

83. The Child Exploitation Nurse continues to support the partnership with the delivery of multiagency contextual safeguarding training four times a year.

84. Partnership Audits have been completed on contextual safeguarding, child protection, police protection powers and neglect. Alongside this the Named Nurse for Cheshire East introduced two new audits this year to examine adverse childhood experiences (ACE's) and child exploitation. These audits have led to a larger piece of work to examine age of experiencing ACE's and if there is any correlation to vulnerability to exploitation. This work is ongoing through multi-agency collaboration, with the intention of identifying where distinct pieces of early help packages of care could be introduced to lower the risk factors.

85. The Named Nurse has attended the Sexual Abuse Task and Finish Group and been part of the NSPCC snapshot audit completed with the partnership to form the underpinning framework of this priority.

86. The Named Nurse has been part of the Neglect strategic group which has created the new neglect strategy and the design of the new neglect screening tool which is currently being tested to replace the Graded Care Profile (GCP2).

87. The Head of Safeguarding represents the Trust at the Cheshire East Safeguarding Children Partnership Board**.**

88. Cheshire East had a Section 11 Audit completed by the CESCP and no areas were identified that required further action.

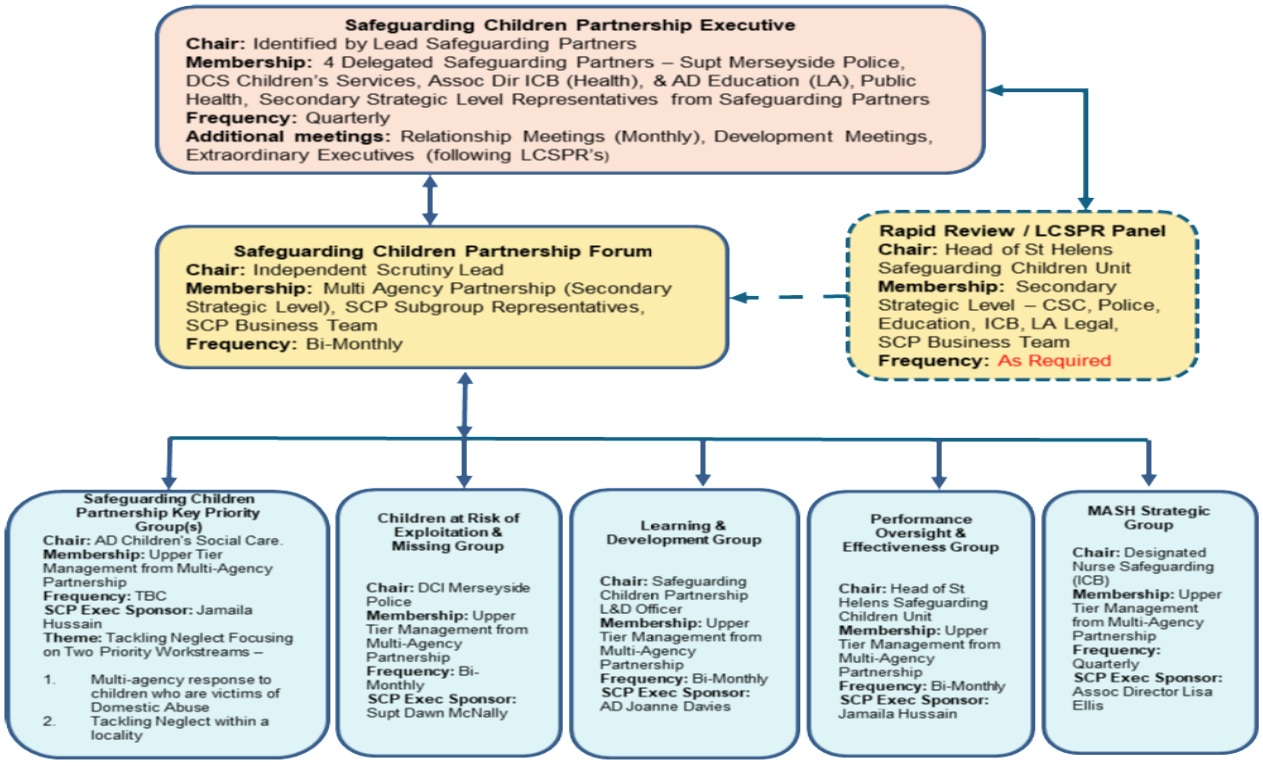
89. Work has been undertaken with the Service Lead for elective home educated children to develop new processes and pathways to support how WCHT are notified children are home educated.

90. In February 2025 WCHC were part of the CESCP learning week which included all agencies. A WCHC stand was held which showcased the work of the Cared for Children Team and the Child Exploitation Nurse role and how they contribute towards the contextual safeguarding strategy.

St Helens Safeguarding Children's Partnership (SHSCP)

91. St Helens Safeguarding Children's Partnership (SHSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in St Helens. The partnership consists of the Director of Children's Services, Superintendent Merseyside Police and Associate Director Integrated Care Board.

92. The below diagram shows the St Helens Safeguarding Children Partnership Executive Committee governance structure.



93. St Helens SCP agreed the priority work for 2024-2025 is Neglect, owing to it being a continuing significant area of concern in the borough.

94. The Named Nurse continues to deliver the Neglect training session developed in 2023-2024 to partner agencies. This training is multi-agency and focuses on all aspects of neglect including health and education. WCHC have committed to supporting 0-19 practitioners to attend this training. This ensures staff are equipped with the correct tools and knowledge to support practice.

95. The Named Nurse attends several partnership / subgroup meetings including, Children at Risk of Exploitation (CARE) Group, Neglect Operational Group, Domestic Abuse Operational Group, Learning & Development Group, Families First Board, Multi Agency Safeguarding Hub Operational Board, Private Fostering Strategic and Operational Group, Safeguarding Health Forum and Performance Management subgroup.

96. The Head of Safeguarding represents the Trust at the St Helens Safeguarding Children Partnership Forum and the Neglect Priority Strategic Group.

97. In 2024-2025 the Section 11 Audit for St Helens consisted of an online questionnaire completed and submitted by the Named Nurse with supporting evidence. This was followed up with a scrutiny panel which was attended by the Head of Safeguarding and Named Nurses for St Helens and Knowsley. Good assurance was given, and no actions identified for the Trust.

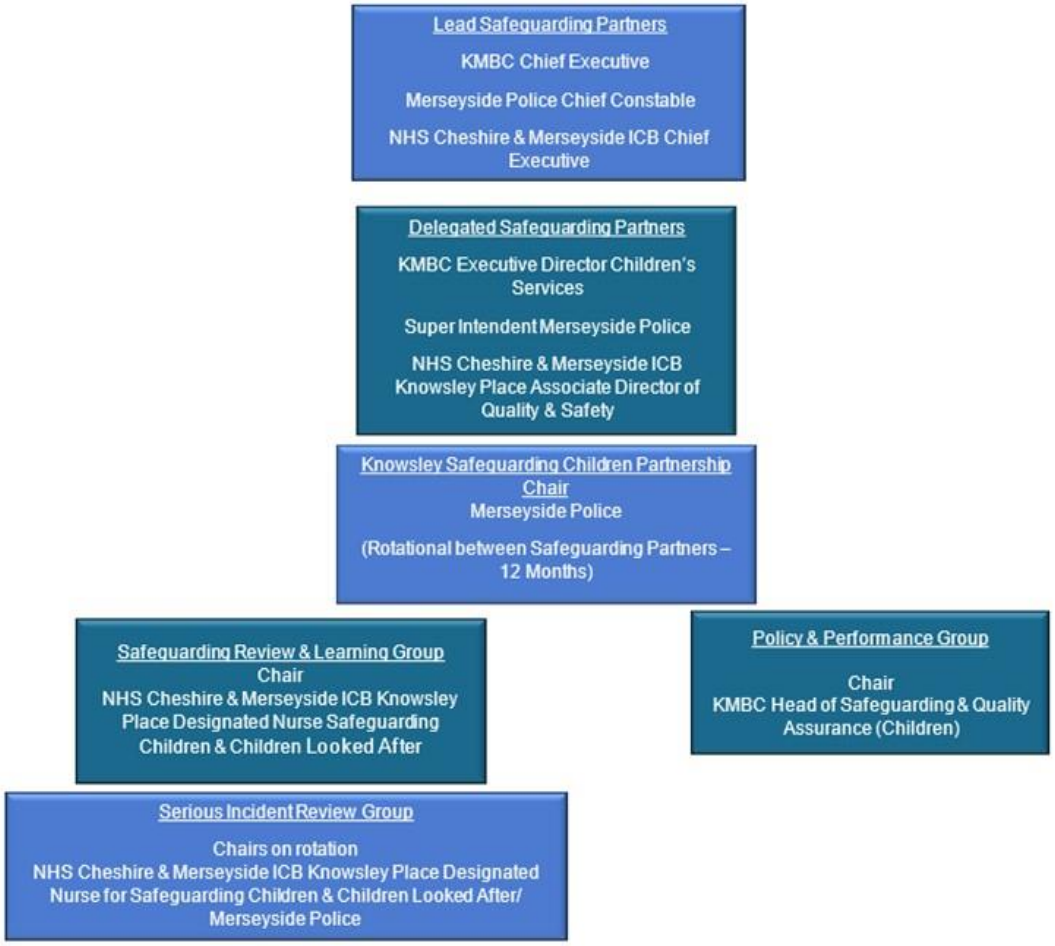
98. The Named Nurse has supported several multi-agency audits in 2024-2025. These have included voice of the child, referrals to Children's Social Care where domestic abuse is a concern and health agencies working together to support children at risk of Child Exploitation / Child Sexual Exploitation (CE / CSE). A further audit was completed that reviewed agency's responses following a child attending A&E or requiring hospital admission related to substance misuse. This piece of work resulted in the development of best practice which has been rolled out to the 0-19 teams to support their work.

99. St Helens Safeguarding Partnership have completed preparation work for JTAI with the theme being Domestic Abuse through the Lens of a Child. Domestic Abuse will be a priority for St Helens SCP alongside Neglect in 2025-2026.

Knowsley Safeguarding Children's Partnership (KSCP)

100. Knowsley Safeguarding Childrens Partnership (KSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Knowsley. The partnership consists of the Director of Childrens Services, Superintendent Merseyside Police and the Associate Director Integrated Care Board

101. The below diagram shows the Knowsley Safeguarding Childrens Partnership governance structure:



102. KCSP has agreed shared priorities for the partnership to improve frontline multi-agency practice through working on the key identified priorities for 2024-2025:

- Provision of clear strategic leadership with focus on systems improvement.
- Early intervention in the identification and resolution of any barriers in safeguarding practice.
- Providing a clear line of sight to safeguarding practice.
- Development of scrutiny functions to monitor the effectiveness of multi -agency arrangements
- to safeguard and promote the welfare of all children.

103. To support these priorities the Named Nurse continues to work in partnership to review the Multi Agency Safeguarding Hub (MASH) process which will ensure the right services are provided to children and young people at the right time. WCHC now support the MASH Nurse employed by Merseycare by providing health updates for MASH strategy meetings, the daily morning meeting and MASH screenings.

104. The Named Nurse has delivered multiagency training for the use of the Neglect and Graded Care Profile 2 tool to ensure multiagency staff have the skills and knowledge and are able to evidence neglect. One of the Specialist Nurses is working in partnership to review the Neglect and Graded Care Profile 2 tool with the aim of an improved tool for Knowsley and St Helens.

105. WCHC has worked in partnership with our health partners in Knowsley where children and young people have presented with challenging mental health concerns to achieve the best outcomes for them. This includes working with the Integrated Care Board (ICB) Dynamic Support Database (DSD) / Keyworker Service to assess support for young people presenting

with complex mental health needs at the earliest opportunity to avoid admissions to Tier 4 mental health services where safe to do so. This has included attending a monthly tracker meeting that discusses all complex children for the area with and without a diagnosis of Autistic Spectrum Conditions (ASC) or any Learning Disability (LD).

106. The Named Nurse attends the Neglect Subgroup, Domestic Abuse Operational Group, Safeguarding Review and Learning Group, Contextual Safeguarding Implementation Group and the Policy and Performance Group.

107. The Specialist Nurses attend the Harmful Sexual Behaviour Panel to inform and contribute to plans ensuring appropriate decisions are made for young people.

108. The Head of Safeguarding represents the Trust at the Knowsley Safeguarding Childrens Partnership.

109. In 2024-2025 the Section 11 Audit consisted of a scrutiny panel which was attended by the Head of Safeguarding and Named Nurses for St Helens and Knowsley. Good assurance was given, and no actions identified for the Trust.

110. The Named Nurse has completed internal audits including an audit to review Child in Need (CIN) group supervision attendance, frequency and themes, the walkabout audit which assesses staff skills and knowledge regarding safeguarding children, an audit to assess the quality of referrals to children's social care, and an audit of Level 3 Safeguarding Children training. The Quality and Governance Team have completed a Trust wide record keeping audit which included voice of the child, and our Safeguarding Adults Team have completed a Trust wide audit to assess staff knowledge and skills around mental capacity assessments, which has provided good assurance.

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Section 4: Assurance and Compliance for Safeguarding

111. The purpose of the Safeguarding Accountability and Assurance Framework (SAAF) is to set out the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations and 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 Integrated Care Board (C&M ICB)

112. Compliance is measured through the following processes:
    - Submission of NHS C&M ICB Commissioning Standards 2023-2024 self-assessment.
    - Safeguarding & CiC / CLA assurance frameworks (SAAF) submitted quarterly to the ICB with performance against key standards tracked.
    - Quarterly KPI Reporting Template submitted in conjunction with the Quality Report for Children in Care.
    - Compliance against Section 11 audits evaluated in each of our four places.
    - Compliance against Section 14 audit for adults.

113. WCHC Safeguarding is required to evidence assurance and compliance locally regionally and nationally, via the NHSE portal for Prevent and Child in Care. The portal is also used for Commissioning Standard actions however there are no action plans for the Trust following the last Inspection.

114. The Safeguarding Assurance Group (SAG) provides opportunity for challenge and assurance to the safeguarding arrangements within WCHC, monitoring compliance, benchmarking with external standards and clinical effectiveness indicators including Care Quality Commission (CQC) outcomes and addresses any gaps in service.

115. The SAG meets quarterly and is chaired by Chief Nurse. Attendees include Head of Safeguarding, Named Nurses for children and adult safeguarding and Service Director 0-19. The SAG receives assurance regarding Trust wide and place-based updates with mandatory compliance, risks, tracking of action plans following audits alongside compliance with Safeguarding Commissioning Standards and Assurance Framework.

Safeguarding Commissioning Standards

116. The NHS Cheshire and Merseyside Integrated Care Board Safeguarding Accountability and Assurance Framework (SAAF) outlines the core responsibilities in relation to safeguarding assurance and sets out a vision to improve the quality of safeguarding arrangements across Cheshire & Merseyside. The framework endeavors to keep the population at the heart of all safeguarding intentions and improvements. It will maintain focus and take a personalised approach to supporting meaningful improvements to individuals and make the most effective use of the expertise across safeguarding in Cheshire and Merseyside.

117. The new commissioning standards which sit alongside the SAAF is a 63-point document with 10 key lines of enquiry. These include our leadership, accountability, policies and processes

for safeguarding children and adults.

118. During Q3 2023-2024, the Trust completed a self-assessment against each of the 63 standards, providing a significant submission of supporting information to the ICB, to evidence compliance with each standard. The ICB have confirmed their assessment of the information provided supports the following compliance BRAG rating:

- 62 fully green BRAG rated areas.
- 1 amber BRAG rated area.

119. The one amber BRAG rated area relates to the identification of a named doctor and named nurse for child in care (CiC) which, in accordance with the standards should be dedicated posts and not combined with responsibilities for adult or child safeguarding.
In Wirral and Cheshire East Places the named nurses cover both the safeguarding role and the CiC role. This reflects the operational ICB model and the current commissioned services. Furthermore, and most importantly this position has not affected our service delivery.

120. The Commissioning Standards self-assessment will be repeated in Q3 2025-2026.

Safeguarding Accountability and Assurance Framework – Children

121. The Safeguarding Accountability and Assurance Framework (SAAF) for 2024-2025 aimed at achieving consistency across the ICB. There are between forty and forty-seven indicators tracked with a range of eighteen to twenty-six RAG rated; these differ slightly across the Trust owing to commissioning placed based agreements. They are a combination of both quantitative and qualitative returns.

Quarterly KPI Reporting Template – Children in Care (CiC)

122. The ICB Quarterly KPI Reporting Template for Children in Care (CiC) has fourteen indicators, all of these are RAG rated. Three indicators included in the return relate to children residing out of area which does not fall within WCHC responsibility and is therefore not included in this report.

123. Due to differences in Commissioning the CiC service, placed based agreements have been made in both Cheshire East and Wirral therefore data will vary going forward to reflect the Commissioning Service requirements.

124. In Cheshire East four indicators relate to Initial Health Assessments (IHA) which is not a requirement in Wirral as this is provided by Wirral University Teaching Hospital (WUTH).

The below data provides the number of review health assessments (RHAs) for Wirral and Cheshire East placed in borough and those placed in borough from other areas.

Indicator	Tolerance	Wirral	Cheshire East
Percentage and number of RHAs due and completed within month (Wirral / CE child residing within borough)	100%	496 93.4%	274 92.6%
Percentage and number of RHAs due and completed within month (out of borough child placed within area)	100%	113 72.9%	160 82.1%
Number of RHAs Quality Assured and number that meet required standard (Wirral / CE child residing in borough)	100%	35 100%	57 100%
Number of RHAs Quality Assured and number that meet required standard (Wirral /CE child residing out of borough)	100%	119 90.2%	146 83.9%

125. For those children placed in Wirral, the Safeguarding Team are dependent on the assessments being requested; this can sometimes be late which will have a detrimental impact on our data. When our children are placed out of borough (OOB) WCHC is reliant on other area completing the relevant assessment. The Named Nurses have a clear escalation pathway and will highlight to the Designated Nurse when appropriate to do so. The Safeguarding Team have worked with 0-19 and deliver bitesize training sessions regarding what is expected for a good RHA, this work will continue.

Indicator	Tolerance	Wirral	Cheshire East
Number and percentage of Care Leaver health passports due and issued before/within month of 18th birthday (residing in borough)	100%	30 63.8%	61 100%
Number and percentage of Care Leaver health passports due and issued before/within month of 18th birthday (residing out of borough)	100%	8 53.3%	30 100%

126. The above data shows the number and percentage of care leaver passports issued. The data was a new requirement for Q3 therefore only six months of data has been collated. Prior to this Wirral Place had a different data collection process. Care leavers have a choice to receive their health passport, whilst it is always encouraged, some will refuse, and their voice has to be respected. For those care leavers residing out of the borough Wirral Place has been reliant on other areas completing the health passports. Cheshire East Place has utilised a specialist nurse to carry out this role, which has proved successful. Wirral Place has developed a plan to replicate this work for 2025-2026.

Safeguarding Accountability and Assurance Framework – Safeguarding Adults

127. The Safeguarding Accountability and Assurance Framework (SAAF) for 2024-2025 aimed at achieving consistency across ICB. There are thirteen indicators and eight are RAG rated.

128. This information has been included under key achievements, the training data below and Safeguarding Adults Health and Care Activity.

129. WSAPB have specified that the Chapter 14 audit information from health providers can be obtained through the Safeguarding Accountability and Assurance Framework.

Safeguarding Training

130. The tables below show the training data for WCHC staff for 2024-2025

Measure	Tolerance	Wirral	Cheshire East	Knowsley	St Helens
Level 1 Adult Safeguarding Training for all staff	90%	98	100	100	100
Level 2 Adult Safeguarding Training for eligible cohort	90%	96.6	100	100	100
Level 3 Adult Safeguarding Training for eligible cohort	90%	94.7	96.9	98.9	96.4
Level 4 Adult Safeguarding Training for eligible cohort	90%	85.7	100	100	85
Mental Capacity Act & Deprivation of Liberty Safeguards	90%	95.5	96.9	98.9	99

Measure	Tolerance	Wirral	Cheshire East	Knowsley	St Helens
Level 1 Children Training for all staff	90%	98.45	100	100	100
Level 2 Children Training for eligible cohort	90%	94.8	100	100	100
Level 3 children Training Core for eligible cohort	90%	95.2	96.9	94.1	95.7
Level 4 Children Training for eligible cohort	90%	90.7	100	100	84.2
Child Exploitation Awareness training	90%	93.5	96.9	100	100

Measure	Tolerance	Wirral	Cheshire East	Knowsley	St Helens
Level 1 Children Looked After Training for all staff	90%	98.5	N/A	N/A	N/A
Level 2 Children Looked After Training for eligible cohort	90%	94.8	N/A	N/A	N/A
Level 3 Children Looked After Training for eligible cohort	90%	94.6	97.8	94.1	95.7
Level 4 Children Looked After Training for eligible cohort	90%	90.7	100	100	85

131. All training for Adult and Childrens Safeguarding is above the 90% tolerance except for two staff members in St Helens and one Executive/Board member for a short period whilst awaiting a course from external providers.

Measure	Tolerance	Trust wide 2024-20245
Executive/Board Training	90%	87.5
Prevent Strategy/Awareness Training	90%	98.3
Prevent Strategy/Health WRAP Training	90%	95.2

Safeguarding Supervision

132. Over the past year, the supervision compliance for staff carrying formal safeguarding children cases has been above the required compliance of 90%. This was with the exception of Knowsley Place owing to reduced resources for a short period of time. 100% of staff in the workplace receive safeguarding supervision.

Measure	Wirral	Cheshire East	Knowsley	St Helens
Number of children requiring safeguarding supervision	371	224	295	212

Look After Children (Wirral term for Child in Care)

133. The data (taken from Wirral Local Authority) in the reporting period shows that Wirral Children Looked After (CLA) has reduced which reflects the local authority's commitment to reduce the number of children in care. The number of children placed out of borough has remained static which is a positive trend in keeping children close to their birth area.

Measure	2023/2024	2024/2025
Average number of Wirral children with Child Looked After status	774	723.5
Average number of Wirral children with Child Looked After status placed Out of Borough	160.5	144.5
Average number of Children Looked After placed in Wirral from Out of Borough	303	313.5
Average total number of Wirral Children Looked After living in Wirral	613.5	579
Number and Percentage of supervisions completed for all CLA children living in Wirral	*694 / 90.2%	**1376/ 95%

*This data reflects the number of cases at time of reporting, but the supervision is completed twice yearly thus double.
** All looked after children have supervision every six months The previous year does not reflect the twice yearly figure of 1388

Cared for Children (Cheshire East term for Child in Care)

134. Whilst there has been a decrease in the average number of Cared for Children in Cheshire East both placed out of borough and placed in borough there has been a significant increase in the amount of Cared for Children moving during each quarter. The transient movement of places has created an increase in administration work to ensure the children's health needs are not missed. The impact of multiple moves is both emotionally overwhelming for the children and creates significant disruption to their physical health needs being addressed. There has been an increase in the amount of RHA requests with late notification due to the moves and often once the RHA has been completed in Cheshire East the children have moved to another placement out of the area.

Measure	2023/2024	2024/2025
Average number of Cheshire East children with Cared for status	**545**	**539**
Average number of Cheshire East children with Cared for status placed Out of Borough	**210**	**199**
Average number of Cared for Children placed in Cheshire East from Out of Borough	**250**	**207**
Average total of Cared for Children living in Cheshire East	***585**	**547**
Number and Percentage of supervisions completed for Cared for Children living in Cheshire East	**467 / 94.7%**	****1109 / 102%**

*New data collection has identified the number of Cared for Children is 585 for 2023 - 2024 rather than 795 as previously reported, which included Cheshire East children placed out of area

** All cared for children have supervision every six months some also have reactive supervision hence why the number shows more than 100%. The previous year does not reflect the twice yearly figure of 934

135. In Cheshire East, there has also been a decrease in the number of Unaccompanied Asylum-Seeking Children from the previous year however the previous UASC young people have now become care leavers and continue to require a bespoke needs led service.

136. Cheshire East has ten neighboring local authorities and often children can live in one area and be registered with a GP in a different ICB area. This can present with challenges in accessing services, particularly healthcare. WCHC Cared for Children's Team work closely with out of area teams and Cheshire Merseyside ICB to ensure that the NHS England Responsible Commissioning guidance is applied.

Mersey Internal Audit Agency

137. During Q4 2023-2024, safeguarding governance for children were subject of a review by Mersey Internal Audit Agency. This took place across all four areas Wirral, Cheshire East, Knowsley, and St Helens.

138. The review identified the following:

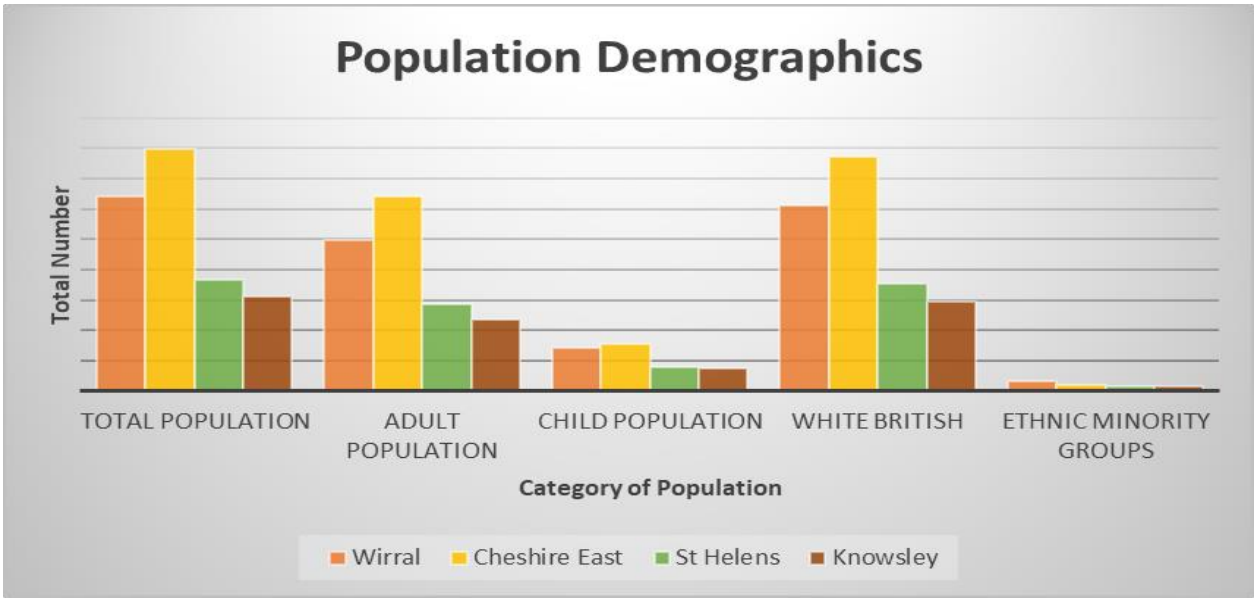
- there was a good system of internal control designed to meet the system objectives and that controls were generally being applied consistently.
- there is an established team structure across the four areas with defined responsibilities.
- there was good representation and engagement by the Trust with local partnerships including attendance at the local safeguarding boards

139. The overall assurance opinion was rated as **Substantial**.

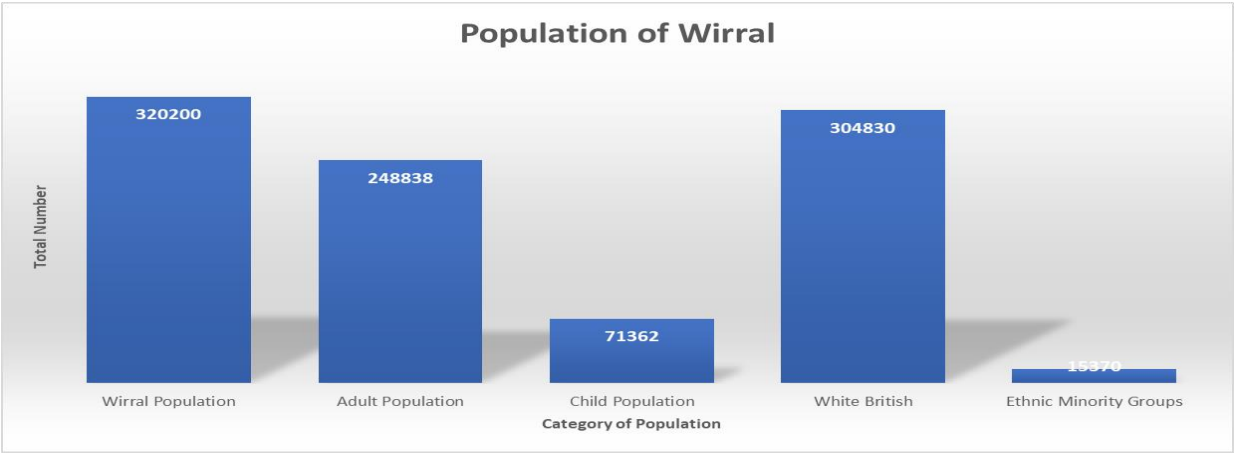
140. In 2024-2025 the two actions from the audit have been tracked at the Safeguarding Assurance Group and are completed.

Section 5: Safeguarding Children Activity

Trust Wide:



Safeguarding Children Wirral Place



141. The population of Wirral is 320,200 predominantly White British (95.2%) with ethnic minority groups existing, particularly Polish Indian and Chinese, and the main language being spoken excluding English is Polish. (Census, 2021).

142. There are approximately 71,362 children (0 to 19 years) therefore 22.3% of the population living in the borough. Of all children, 15.7% 16,056 live in poverty. The current rate of Children Looked After is 120 per 10,000.

143. The 2019 Indices of Deprivation ranked Wirral as the 77th most deprived authority in England.

144. The most deprived areas are in the east of the Borough within the traditional industrial towns of Birkenhead and Wallasey. Most of the statutory work for partner agencies is with families from these areas. Challenges include high levels of poverty, a high prevalence of neglect and

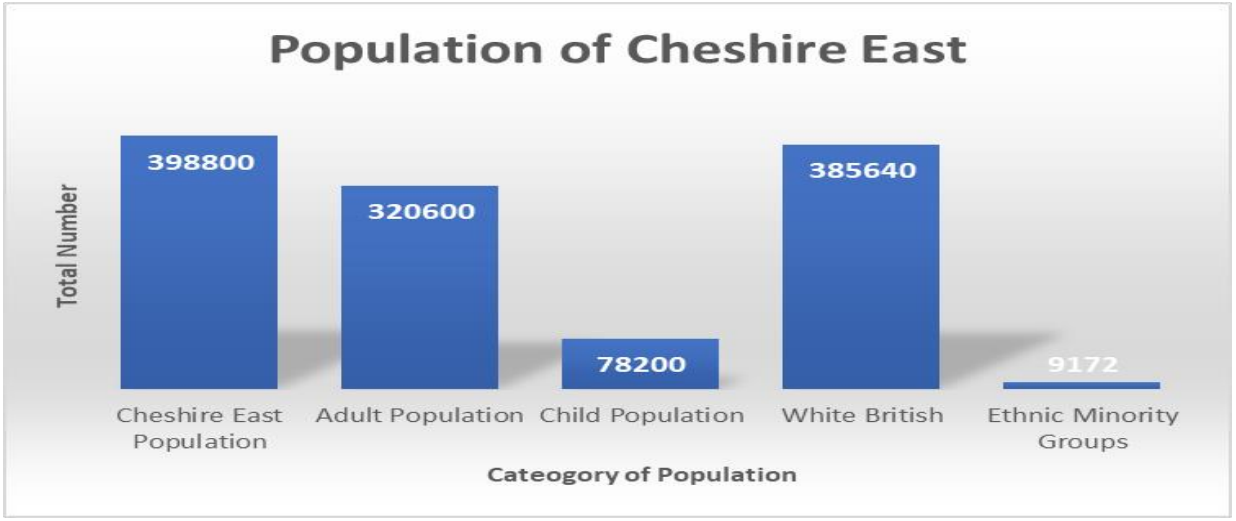
domestic abuse, and social and public health issues such as high rates of alcohol and substance misuse.

145. The table below shows a range of the safeguarding children activity levels across Wirral for the reporting period 2024-2025

Measure	Q1	Q2	Q3	Q4
Number of Strategy Meetings attended (0-19 service)	235	341	279	255
Number of initial child protection case conferences attended	44	65	52	64
Number of children on a child protection plan	348	365	332	353

146. The data shows an increase in Q2 however figures over the year have remained consistent. The Pathfinder model focuses on early intervention and supporting families to stay together (Stable Homes Built on Love 2023) so may account for a rise in CP cases whilst this new process is embedded.

Safeguarding Children Cheshire East



147. The population of Cheshire East is 398,800 predominantly white British at 96.7%. Black and ethnic minority background residents form 3.2% of the population. Approximately 5% of the residents in Cheshire East are from European countries. Cheshire East also has a large travelling community with multiple permanent traveler sites throughout the area.

148. There are approximately 78,200 children (0 to 19 years) therefore 20% of the population being aged under 19 in the borough. The current rate of Children Looked After is 88 per 10,000.

149. In Cheshire East, there are eighteen areas which are within the top 20% of the most deprived areas in England, affecting 33,350 people or 8.6% of Cheshire East's population.

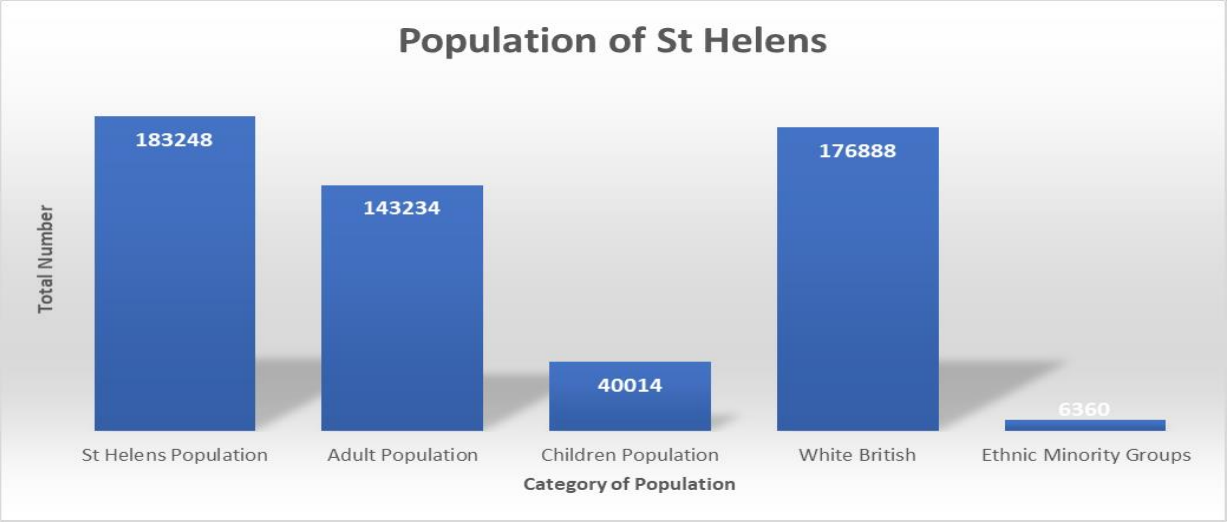
150. The table below shows a range of the safeguarding children activity levels across Cheshire East for the reporting period 2024-2025

Measure	Q1	Q2	Q3	Q4
Number of Strategy Meetings attended (0-19 service)	291	312	309	332
Number of initial child protection case conferences attended	64	75	43	60
Number of children on a child protection plan	240	261	234	229

151. The number of strategy meetings attended has slowly increased during the year with the highest number being recorded in Q4, the impact of this will be seen in Q1 2025-2026 through initial child protection conferences. The data collection has been strengthened from Q4 with the introduction of a child protection list supplied by the Local Authority this enables responsive data cleansing of flags.

152. There has been a development of a strategy plus process to ensure all children in Cheshire East are being represented at strategy meetings from a Health perspective including those home educated, educated outside of the borough or not previously known to be living in the area. The strategy plus process will also ensure practitioners who have cases which fall into select criteria are immediately supported with safeguarding supervision. This process will be implemented in Q1 2025-2026.

St Helens Safeguarding Children



153. The population of St Helens is 183,248 and is predominately White British with ethnic minority groups existing, particularly Asian. (Census, 2021).

154. There are approximately 40,014 children (0 to 19 years) therefore 21.8% of the population aged under 19 in the borough.

155. The most deprived areas are in the east of the Borough. This includes the Town Centre and Parr area. Most of the statutory work for partner agencies is with families from these areas. Challenges include high levels of poverty, a high prevalence of neglect and domestic abuse, and social and public health issues such as high rates of alcohol and substance misuse and obesity. Family hubs are now situated in these areas with preventative work ongoing to

address identified issues.

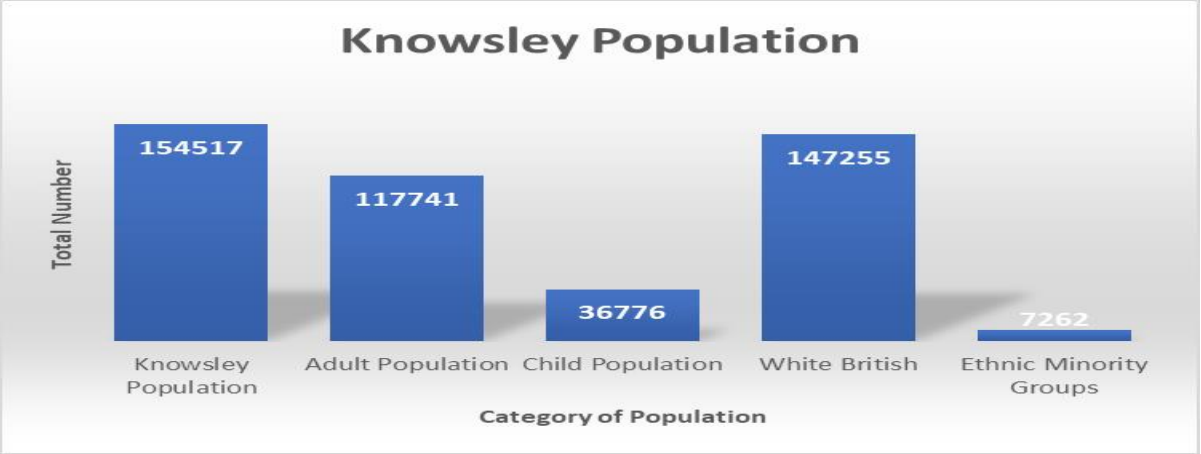
156. The 2019 Indices of Deprivation ranked St Helens is ranked as the 26th most deprived local authority in England out of 317. Almost a quarter of St Helens Residents live in the most 10% deprived areas in the country.

157. The table below shows a range of the safeguarding children activity levels across St Helens for the reporting period 2024-2025

Measure	Q1	Q2	Q3	Q4
Number of Strategy Meetings attended (0-19 service)	194	212	143	88
Number of initial child protection case conferences attended	30	54	39	45
Number of children on a child protection plan	192	206	197	208

158. The number of children on a Child Protection Plan's has remained stable within the reporting period. The increase in Strategy Meetings in Q1 from Q4 103 in the previous year (2023-2024) correlates with the increase in Initial Child Protection Conferences in Q2.

Knowsley Safeguarding Children



159. The population of Knowsley is 154,517, predominately White British 95.3%, with ethnic minority groups also existing, particularly Asian. (Census, 2021).

160. There are approximately 36,776 children (0 to 19 years) therefore 23.8 % of the population being aged under 19 in the borough.

161. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households which equates to 16,518 households.

162. The 2019 Indices of Deprivation ranked Knowsley as the 2nd most deprived authority in England.

Measure	Q1	Q2	Q3	Q4
Number of Strategy Meetings attended (0-19 service)	127	161	178	161
Number of initial child protection case conferences attended	61	35	34	75
Number of children on a child protection plan	180	210	200	258

163. The data identifies an increase in strategy meetings in Q2, Q3 and Q4. Some of this increase is owing to a local agreement with partners to work with Mersey Care NHS Foundation Trust following a gap in the service commissioning and provision being identified. Collaboration work is ongoing to strengthen these processes.

Child Sexual Exploitation and Criminal Exploitation

164. There is a dedicated multi–disciplinary team for Child Exploitation (CE) within the Integrated Front Door which supports the young people who are victims, and they will act as an expert resource across Wirral. The WSCP also has a dedicated committee for Harm Outside the family home which the Named Nurse attends. Its aim is to ensure the risk to Wirral young people is managed and has strategic oversight by all partners. There is a fortnightly Multi Agency Child Exploitation (MACE) meeting which the Specialist Children's Safeguarding Nurses (SCSN) attend, and a weekly triage meeting introduced in 2024 to assess what is heard in MACE.

165. An ongoing theme has been the increasing numbers of young people who are using violence in this cohort. Catch 22 who completed the return interview, has noted mental health as a key factor after missing episodes. This information will always be considered when developing a care plan and ongoing support.

166. Cheshire East Pace have two Child Exploitation Specialist Nurses. They attend two meetings a Contextual Safeguarding Screening Meeting held weekly and then a bimonthly Contextual Safeguarding Operational (CEOPs) meeting. The nurses work regularly with all young people identified as high risk, working alongside our partner agencies to ensure that all health needs are met.

167. In St Helens the SCSN attend MACE meetings twice monthly to support young people who are victims of CSE/CE. The SCSN's share proportionate health information and are part of the multi-agency partners making plans to keep the young people safe. The Named Nurse attends CARE group (Children at risk of Exploitation) which is the dedicated operational group for the partnership, who have a shared commitment to ensure the risk for young people in St Helens is managed and remains a focus for all partners.

168. In Knowsley SCSN also attend MACE meetings twice monthly, where relevant health information is shared to support young people who are victims of CSE/CE. KSCP has a dedicated contextual safeguarding child exploitation and missing performance group which the

Named Nurse attends.

169. There is an increase in the number of children being exploited for Organised Crime Gangs (OCGs) locally and unaccompanied asylum seeking children (UASC) being exploited in local businesses such as car washes, nail bars and cannabis farms. WCHC Safeguarding Team regularly supports ongoing partnership operations in order to continuously protect our communities.

Safeguarding Liaison/CDRP (Child Death Review Panel)

170. All Local Safeguarding Children Partnerships (LSCPs) are required to have arrangements in place to review the reasons for all child deaths. This is done through information sharing between Child Death Review Partnerships (CDRP), with review of this information at Child Death Overview Panels (CDOP). Partnerships have a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) resident within their geographical footprint.

171. Due to the geographical areas within which Wirral Community Health and Care Trust provides services to children, there are two separate CDRPs and CDOPs.

172. The Pan Merseyside CDRP is a group of the five Local Safeguarding Children Partnerships, Knowsley, Liverpool, Sefton, St. Helens, and Wirral). The Pan Cheshire CDRP includes the LSCPs from Cheshire East, Cheshire West and Chester, Halton, and Warrington. Both CDRPs publish guidelines for the management of Sudden Unexpected Death in Children (SUDIC) which are broadly similar as they are based on national guidelines.

173. The focus of a Child Death Review Panel is on identifying any modifiable factors, such as smoking in pregnancy, smoking, high maternal BMI, low maternal BMI, unsafe sleeping, mental health, alcohol/substance use, domestic abuse and chaotic / poor home conditions that may help prevent unnecessary future child deaths or harm.

174. The below shows the number of child deaths across WCHC 2024-2025

Measure	Wirral	Cheshire East	Knowsley	St Helens
Expected deaths	11	15	8	5
Unexpected deaths	5	9	2	6
Total of all child deaths	16	24	10	11
% of unexpected Deaths	52%	37.5%	20%	54%
Age Range of child – less than 1 week	4	1	2	3
Age Range of child – less than 1 year	4	10	5	2
Age Range of child – between 1 and 4 years	2	3	1	1
Age Range of child – between 5 and 14 years	4	7	1	2
Age Range of child – between 15 and 18 years	2	3	1	3

175. All unexpected deaths are documented within the Trust reporting system Datix. They are discussed within the biweekly Clinical Risk Management Group (CRMG) and then further reviewed at the Mortality Review Group heal each quarter. All unexpected child deaths will be subject of a SUDiC meeting / Joint Agency Review (JAR) meeting. The relevant Health Practitioner will attend and is supported by the Safeguarding Team.

176. A new Standard Operating Procedure (SOP) around the reporting of deaths within WCHC has been approved and implemented.

177. The Trust continue to work in partnership with Merseyside Police Safer Sleep. This preventative partnership working will enable WCHC to offer further support to the family to reduce any risks.

Child Safeguarding Practice Reviews

178. Please see summary of all cases referred through for consideration of rapid reviews and those meeting the threshold for a full Child Safeguarding Practice Review (CSPR)

* Pseudonym used to protect the child's identity

Activities	Place	Child Safeguarding Practice Reviews 2024-2025
Child 1	Wirral	Rapid review submitted for 3 family members after SUDIC of child at 7 weeks. Awaiting outcome
Child 2	Wirral	Rapid review submitted for 4 children who attended a school on Wirral in relation to abuse. Independent reviewers have met the families. Awaiting outcome
Child 3	Wirral	Rapid review submitted for 7 family members after ALTE/SUDIC of 12-week-old child. Awaiting outcome
Child Ryan*	Wirral	Update from 23/24 report. The Learning review is complete now and the case review committee are overseeing the action plan. We will be creating a 7-minute briefing to publish on the website.
Child Jack*	Wirral	Update from 23/24 report A rapid review was completed but a CSPR was not commenced, instead it was recommended to take forward the learning from the RR. The action plan was being overseen by the case review committee and has now been completed.
Child Sophie*	Wirral	Rapid Review submitted, and initial meeting completed, chronologies shared and viewed. CSPR continues
Child 4	Cheshire East	Rapid Review submitted, and initial meeting completed, chronologies shared and viewed. CSPR held awaiting on going police investigations
Child 5	Cheshire East	Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Partnership learning identified awaiting CESCP 7-minute briefing
Child 6	Cheshire East	Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Awaiting draft partnership report
Child 7	Cheshire East	Rapid Review submitted, and initial CSPR meeting completed, chronologies shared and viewed. Review being held by out of area place
Child X	Cheshire East	Rapid Review submitted, and initial meeting completed, Draft report received from external area who are conducting the CSPR.
Child 8	Cheshire East	Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Awaiting draft partnership report
Child 9	Cheshire East	Rapid Review submitted, and initial meeting completed, chronologies shared and viewed. This did not meet threshold for CSPR. Local learning identified and disseminated
Child 10	Cheshire East	Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Awaiting draft partnership report
Child 11	Cheshire East	Rapid Review submitted, and initial meeting completed, chronologies shared and viewed. This did not meet threshold for CSPR. Local learning identified and an action plan has been created to address the local learning

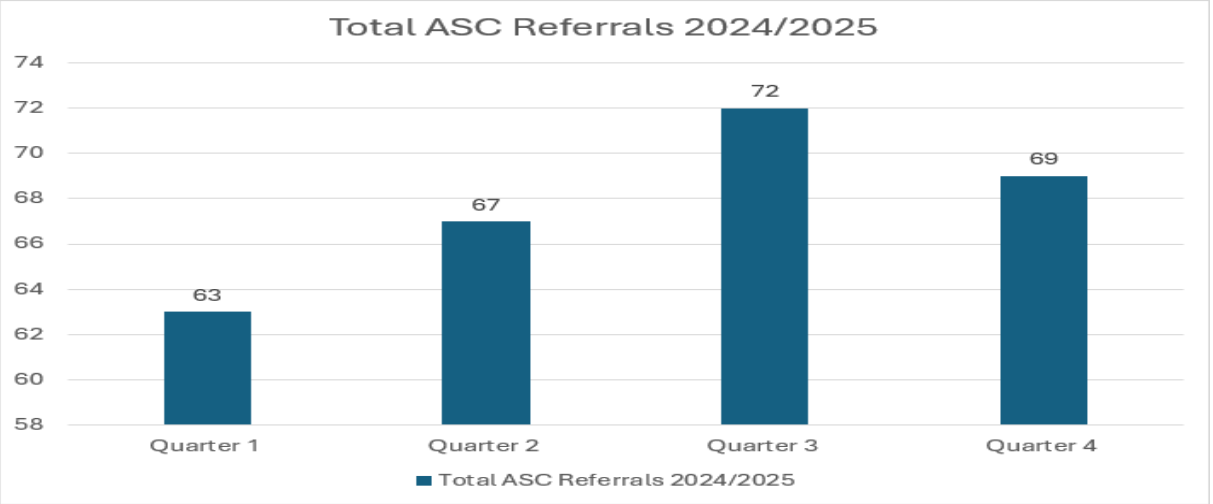
Child 12	**St Helens**	**Rapid Learning Review submitted, and initial meeting completed, Family involving a number of children, chronologies shared and viewed. This did not meet threshold for CSPR. Multi-agency reflective practice review completed with agencies involved; report shared with all agencies involved.**
Child E	**Knowsley**	**Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Did not meet the threshold for a CSPR or Local Learning Review.**
Child F	**Knowsley**	**Child not known to Knowsley 0-25 service, KSCP signposted to Liverpool 0-25 service. Did not meet the threshold for CSPR or Local Learning Review.**
Child G	**Knowsley**	**Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Did not meet threshold for CSPR or Local Learning Review – single agency learning identified for another organisation outside of Knowsley.**
Child I + J (siblings)	**Knowsley**	**Rapid review submitted and initial review meeting attended; chronologies shared and viewed. Met the threshold for a Local Learning Review.**

179. Following the completion of Rapid Reviews and Child Safeguarding Practice Reviews any learning and actions identified from these will be completed and shared across the whole Trust.

Section 6: Safeguarding Adults Health and Care Activity

Safeguarding Adults Referrals into Adult Social Care

180. The Safeguarding Adult Team Quality Assure and provide feedback on 25% of the referrals sent into Adult Social Care from WCHC staff. Data is also collated on the outcomes of all referrals. There has been a notable increase in staff now following the robust process of completing via the orange dot on SystmOne (S1) rather than a telephone contact to Central Advice and Duty Team (CADT)



Safeguarding Adult Referrals for 2024-2025 Outcomes

Measure	Q1	Q2	Q3	Q4
ASC Referral	63	67	72	69
No further action	26	28	27	30
Other	0	2	0	0
Sign Post	11	9	8	7
Case Management	17	16	22	19
Section 42	9	12	11	9
Strategy Meeting requests	0	0	1	0
Attend Strategy Meetings	0	0	1	0
Remain Open	2	0	4	4

Domestic Abuse Agenda

181. The Domestic Abuse Agenda continues to be a significant priority area within WCHC. As an integrated health and care organisation, the Safeguarding team represents WCHC at daily MARAC on behalf of the organisation and for Wirral GP practices as outlined within the commissioned service specification. This representation ensures timely sharing of information. WCHC Domestic Abuse Practitioner has also supported a number of staff across the

organisation who have been victims of Domestic Abuse.

Domestic Abuse/Multi Agency Risk Assessment Committee (MARAC)

182. Daily MARAC continues due to the high prevalence of Domestic Abuse in Wirral. This enables a timelier approach in ensuring safety plans were in place for victims and children.

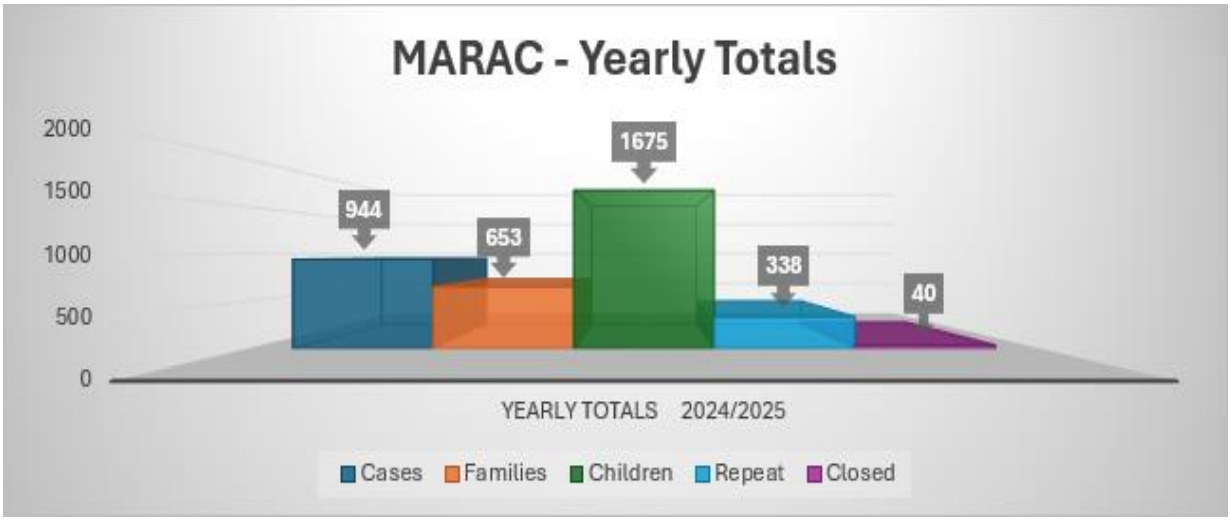
183. A 6-month review of Wirral MARAC has been commissioned and is being completed by Safelives, this commenced in March 2023, the outcome of which remains outstanding with planned workshops and feedback in Q1 2025-2026

184. Domestic Abuse Alliance Committee and the Strategy 'Domestic Abuse No Excuse' was launched in November 2020-2025 with 5 key priorities:

    Priority 1: Be there when we are needed.
    Priority 2: Increase safety to those at risk, without adding to their trauma.
    Priority 3: Reduce opportunities for Perpetrators to abuse.
    Priority 4: support people to live the life they want after harm occurs.
    Priority 5: Create a kinder brighter future for the next generation

185. Representatives from WCHC are committed to working in partnership to ensure the strategy priorities are implemented across WCHC. The Named Nurse Safeguarding Adults is part of the Domestic Abuse Alliance workshops for the priorities for the 2025-2030 strategy.

186. What we know about Domestic Abuse on Wirral in 2024-2025
    - There were 944 high risk cases heard a decrease from 1076 cases heard in 2023-2024
    - There were 1,675 children discussed compared to 1,663 children in 2023-2024
    - There was a decrease in repeat cases with 338 heard compared to 443 in 2023-2024
    - There were 40 closed MARAC cases compared to 30 closed MARAC cases in 2023-2024 an increase of 10 closed MARAC on the previous year.



Multi Agency Public Protection Arrangements (MAPPA)

187. WCHC Safeguarding Adults Team is the “single point of contact” (SPOC) ensuring that relevant information is shared between Wirral Community NHS Trust and Wirral GPs with regards to the Multi Agency Public Protection Arrangements (MAPPA) queries and actions.

188. This ensures that as a result of the potential risk an offender/ex-offender may pose information is shared appropriately in order to safeguard the public and any staff.

189. During the reporting period WCHC attended 97, 2 hour MAPPA meetings and shared appropriate information, contributed to risk management and completed actions as required. There was an increase from 50 meetings in the previous year; this is a 94% increase in volume.

Harmful Practices and Female Genital Mutilation (FGM)

190. There were 8 Female Genital Mutilation (FGM) cases reported from WCHC in 2024-2025 a decrease of 4 reported in 2023-2024. The National reporting processes were followed and recorded on NHS FGM dataset as required.

191. There were 40 closed MARAC cases discussed during 2024-2025 this was an increase of 10 on the previous year. These cases pose the highest risk and include the risk of Honor Based Abuse and forced marriage.

Community Intermediate Care Centre (CICC)

192. Following the opening of the Inpatient beds at Community Intermediate Care Centre (CICC) during January 2021 the Safeguarding Adults Team has continued to support the staff with bespoke Safeguarding Training sessions around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Specific training sessions in Domestic Abuse was also delivered with the Therapy staff, this included asking about Domestic Abuse and the process to follow if recognising the increase in disclosure of Domestic Abuse within the elderly population.

193. Monitoring of the DoLS applications is undertaken by the Safeguarding Specialist Nurse utilising Trust Information Gateway (TIG) and Business Intelligence (BI)

Safeguarding Adult Week 18th November 2024

194. Safeguarding Adults Governance team celebrated Safeguarding Adult Week by hosting an online event with key speaker Ian Porter who is leading on Wirral Hoarding Improvement Project (W.H.I.P) This was well received by Trust staff with many linking in with Ian after for support on managing Hoarding situations.

195. Safeguarding Adults Team supported WSAPB in an Adult Safeguarding Awareness event and Networking Event at Tranmere Rovers. There were over 120 professionals that attended over the day with 32 organisations represented with information stands.

Safeguarding Adult Champion Programme

196. The Safeguarding Champions provide a crucial role across the organisation, supporting the Safeguarding specialists to promote the Safeguarding agenda within their teams, services and divisions.

197. In 2024-2025 there were 19 staff that attended the Champion Programme.

198. The programme offers 9 workshop sessions on a rolling programme cycle. Each session is held (approximately) every two weeks, for a maximum of 2 hours that incorporate a variety of safeguarding topics, including Safeguarding Supervision, Adult Safeguarding and S42 Enquiries, Mental Capacity & Best Interests, Deprivation of Liberty safeguards (DOLs), Domestic Abuse, Harmful Practice and Modern Slavery & Human Trafficking.

199. Each champion receives a Safeguarding Adults Champion Toolkit which provides opportunity for self-assessment, a variety of resources together with the competency framework. Following completion of the workshop sessions, champions will complete 15 competencies. Once the champion is successfully signed off, they will meet on a quarterly basis for safeguarding supervision with a safeguarding practitioner. The workshop sessions comprise of presentation and group discussion around key safeguarding themes:

200. All the Safeguarding Champions receive safeguarding supervision from the specialist nurses safeguarding adults, this is facilitated quarterly individually or as a group. The Champions then facilitate group safeguarding supervision within their area of work supported by a safeguarding adult specialist nurse.

201. A Celebration Day organised and attended by the Safeguarding Adults Team, took place in November 2024 as part of Safeguarding Adult Week. The Champions, who had completed the training, and the competency framework were presented with their certificates and badges from the Deputy Chief Nurse and Head of Safeguarding.

202. A further Celebration Day will be scheduled to take place in Safeguarding Adult week in November 2025, for our new Safeguarding Adult Champions.

Safeguarding Adult Reviews / Domestic Abuse Death Related Reviews (DARDR)

203. Three Safeguarding Adult Reviews (SAR) and four Domestic Abuse Death Related Death Reviews (DARDR) have progressed during the reporting period any identified learning and actions will be monitored via The WSAPB and Community Safety Partnership and internally through SAG with escalations to Quality and Safety Committee.

Activities	Safeguarding Adults 2024-2025
SAR 19	Requested by WCHC following concerns that agencies did not work together however it had been delayed due to an ongoing Police investigation. This SAR is now published with no individual recommendations for the Trust the overall learning has been shared.
SAR 24	Commenced March 2023 and is now published with no individual recommendations for the Trust, the learning has been shared.
SAR 25	Commenced March 2024 and the final draft has been shared with the WSAPB Board but is not yet published.
DHR 4	Commenced November 2023 closed and sent to Home Office as no agency information and involvement. Home Office requested if be recommenced so recommenced November 2024 and continues with likely completion in Q2 2025-26.
DHR 5	Commenced November 2025 with the final draft sent to the home office on September 2024
DHR 6	Commenced November 2023 the final draft is now with the home office and there was no learning for any agency
DHR 7	Commenced in January 2025

Section 7: Future Priorities 2025-2026

204. Future priorities for 2025-2026 include.

- Safeguarding delivery plan including,
    - Safeguarding Goal 1: 90% of the Voice of the People to be captured.
    - Safeguarding Goal 2: 90% Attendance at Child Safeguarding Meetings
    - Safeguarding Goal 3: 90% Attendance at MAPPA and MARAC Meeting
    - Safeguarding Goal 4: 90% Attendance at Safeguarding Training

- To further embed a fully integrated approach to safeguarding governance supported by a safeguarding dashboard that can be interrogated at organisational, divisional, and service level.

- The Safeguarding Adult Team will continue to support staff with bespoke support with any gaps in knowledge around MCA and utilising the Safeguarding Champion Programme to share learning within the teams.

- A plan for a celebration event during Safeguarding Adult week in November 2025 for all the Champions who have successfully completed the programme and been signed off.

- Safeguarding Adult Team will deliver 3 campaigns utilising the support of the Communications Team to remind staff to report safeguarding abuse via the orange dot on SystmOne and to record any invite and attendance at Section 42 strategy meetings, the risks of online abuse and how to identify it and the need to ask about Domestic Abuse at each contact when it is safe to do so.

- To continue the work to align all four safeguarding areas process to ensure best practice is delivered across all of Wirral Trust services.

- To support the Wirral Safeguarding Children's Partnership ‘Big Learn’, in November 2025 to showcase WCHC services including Safeguarding, Sexual Health and Family Nurse Partnership.

- To further strengthen the Safeguarding Links role within Wirral teams by recruiting new practitioners and developing their safeguarding knowledge.

- To support 0-19 to embed the Child in Need group supervision process within teams to build greater safeguarding resilience in the workforce and harness and develop the skills already gained.

- To work in partnership with WSCP to embed the Pathfinder changes into practice to improve outcomes for children and families

- To increase staff confidence in understanding Gillick and Fraser competence when working with children

- To support St Helens SCP and Knowsley SCP in the priority work being completed around Neglect and Domestic Abuse and disseminate learning and changes in practice to the 0-19 workforce.

- The St Helens Safeguarding Team will support St Helen's Partnership National Child Exploitation event in March 2026 and showcase the work of WCHC in supporting children and young people being exploited.

Conclusion and Recommendations

205. The Annual Report demonstrates how WCHC continues to adapt to changing priorities and has achieved its statutory duties in order to effectively safeguard patients and staff that use our services.

206. The Quality and Safety Committee is asked to receive the content of the Safeguarding Annual Report, note the excellent achievements made over the past year and be assured of the Trust's commitment to continue to safeguard our communities.

Paula Simpson, Chief Nurse

Author:

Jude Blease

Head of Safeguarding

3rd July 2025

Appendix 1: Safeguarding Abbreviations

ASC	Adult Social Care
BRAG	Blue, Red Amber Green rated
CADT	Central Advice and Duty Team
C4C	Cared for Child (Looked After Children in Children East)
CDOP	Child Death Overview Panel
CDRP	Child Death Review Panel
CE	Child Exploitation
CESCP	Cheshire East Safeguarding Children Partnership
CIC	Child in Care
CICC	Clatterbridge Integrated Care Centre
CLA	Children Looked After (local term)
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CSPR	Child Safeguarding Practice Review
CRMG	Clinical Risk Management Group
CWP	Cheshire Wirral Partnership Trust
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GCP2	Grade Care Profile 2
ICB	Integrated Care Board
IFD	Integrated Front Door
ILACS	Inspection of Local Authority Children's Services
JAR	Joint Agency Review
JTAI	Joint Targeted Area Inspection
KPI	Key Performance Indicators
KSCP	Knowsley Safeguarding Children's Partnership
L&D	Learning & Development
LeDeR	Learning Disability Mortality Review
LPS	Liberty Protection Safeguards
LSCP	Local Safeguarding Children Partnership
MACE	Multi Agency Child Exploitation
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference

MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MIAA	Mersey Internal Audit Agency
MRG	Mortality Review Group
MSARG	Merseyside Safeguarding Adult Review Group
NEET	Not in Education, Employment or Training
NHSE	National Health Service England
OCG	Organised Crime Group
OOB	Out of Borough
RAG	Red, Amber Green rated
RHA	Review Health Assessment
SAAF	Safeguarding Accountability and Assurance Framework
SAFE	Standards Assurance Framework for Excellence
SAG	Safeguarding Assurance Group
SAR	Safeguarding Adult Review
SEND	Special Educational Needs and Disabilities
SENDIAS	Special Educational Needs and Disability Information Advice and Support Services
SENDLO	Special Educational Needs and Disabilities Local Offer
SFEF	Supporting Families Enhancing Futures
SHSCP	St Helens Safeguarding Children's Partnership
SOP	Standard Operating Procedure
SOS	Signs of Safety
SPOC	Single Point of Contact
SUDiC	Sudden Unexpected Death in Childhood
S1	SystmOne
UASC	Unaccompanied Asylum-Seeking Children
WCHC	Wirral Community Health and Care NHS Foundation Trust
WSAPB	Wirral Safeguarding Adult Partnership Board
WUTH	Wirral University Teaching Hospital

Board of Directors in Public **Item 32**

03 September 2025

Title	Director of Infection Prevention and Control Annual Report: 01 April 2024 – 31 March 2025
Lead Director	Paula Simpson, Chief Nurse
Author	Helen Wilcox, Head of Infection Prevention & Control
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to share the contents of the Director of Infection Prevention and Control Annual Report: 01 April 2024 – 31 March 2025 with the Board of Directors for information.

The report demonstrates compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and compliance with the ten-criterion outlined in the Act. The report also provides assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards.

Key Risks

This report provides evidence and monitoring in relation to Strategic Risk ID01, within the Trust's Board Assurance Framework: Failure to deliver services safely and responsively to inclusively meet the needs of the population: Current Risk Rating 12 (L3xC4) with an 'Averse' Risk Appetite. There are no new BAF escalations identified, based on the content of this report.

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

Contribution to WCHC strategic objectives

Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	No
Groundbreaking innovation and research	No
People	Choose an item.
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	No
Grow, develop and realise employee potential	No
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
10 September 2025	Quality and Safety Committee	Director of Infection Prevention and Control Annual Report: 01 April 2024 – 31 March 2025	For assurance and support submission to Board of Directors following amendment.
9 July 2025	Quality and Safety Committee	Director of Infection Prevention and Control Annual Report: 01 April 2024 – 31 March 2025	For assurance and support submission to Board of Directors.

1	**Narrative**
1.1	The annual report provides an overview of the significant achievements made to assure trust standards in relation to IPC practice and associated regulatory compliance. These are clearly evidenced throughout the report and include: • Six criterion of the IPC BAF are fully compliant, with four partially compliant • Trust wide achievement of 97.1% compliance with Level 1 IPC training • Trust wide achievement of 89.5% compliance with Level 2 IPC training • 87.1% completion of the Trust's hand hygiene audit programme with 100% compliance and 88.2% peer reviewed • Zero Community Trust attributed cases of Clostridioides difficile infection • Zero Community Trust attributed MRSA bacteraemia cases • A robust programme of IPC audit to monitor environmental standards • National recognition of collaborative work on UTI improvement and hydration • Responsive, flexible service provision to Trust staff and to the wider community of Wirral Place The Head of IPC is proud of the achievements made during the annual reporting period, and the IPC Team have worked flexibly and responsively to ensure staff have been supported throughout the reporting period.

2	Implications
2.1	**Quality/Inclusion** Quality & Equality Impact Assessment completed and attached No. Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services.
2.2	**Finance** Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action.
2.3	**Compliance** This report demonstrates compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and demonstrate compliance with the ten-criterion outlined in the Act and to provide assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards.

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

Infection Prevention Control

You're in safe hands

NHS

Wirral Community Health and Care

NHS Foundation Trust



Director of Infection Prevention and Control Annual Report 2024/25

Director of Infection Prevention and Control Annual Report
01 April 2024 – 31 March 2025

Executive Summary

1. The Director of Infection Prevention and Control annual report provides a summary of the infection prevention and control activity undertaken in 2024/25. This year, as a trust, we have forged closer working relationships across NHS Cheshire & Merseyside and in particular with infection prevention & control (IPC) colleagues working in Wirral University Teaching Hospitals NHS Foundation Trust (WUTH), to ensure better outcomes for people and populations receiving care form our services.

2. The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Code of Practice) outlines the regulations relating to the prevention and control of infection. Within this, the Code of Practice sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention.

3. This annual report is set out against each criterion of the Code of Practice to support assurance to the Board of Directors of the IPC activity carried out across the Trust throughout 2024/25.

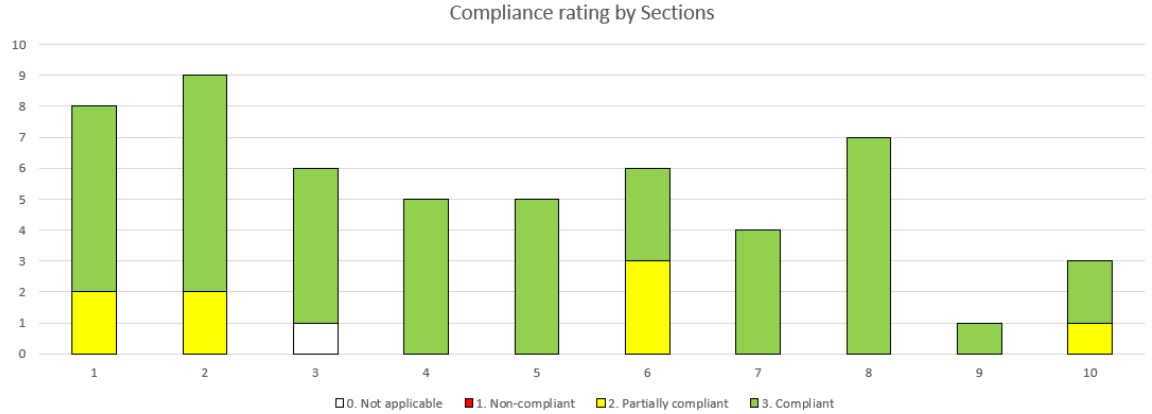
4. The report highlights the vast work undertaken by the IPC Team during 2024/25, with the team continuing to respond flexibly to ensure staff working in community services have been supported to deliver care in a safe way.

5. Reducing the risk of infection through robust infection prevention and control practice continues to remain a key quality and safety priority for Wirral Community Health and Care NHS Foundation Trust (WCHC).

6. A revised National IPC Board Assurance Framework was published by NHS England on 8 April 2024. It remains an evidence-based approach that is used to maintain the safety of staff and people using our services and provides assurance to the Board of Directors via the Quality and Safety Committee.

7. Within the IPC BAF, there are no areas of non-compliance and 8 areas of partial compliance across 4 criteria, with the remaining 6 criteria being fully compliant. Where there are areas of partial compliance, mitigations are in place to assure standards of quality and safety. Actions have been incorporated into the IPC annual work programme for 2025/26 and will be subject to robust monitoring throughout Trust governance.

Figure 1: Infection Prevention and Control Board Assurance Framework Overall Summary



8. During 2024/2025, the IPCS continued to support and educate staff to promote safe and effective IPC practices as well as providing support to the wider Wirral Place system.

9. In June 2024, the IPC team were delighted to be shortlisted for a Health Service Journal Patient Safety awards for the collaborative work on UTI improvement and hydration and were recognised nationally as finalists in the category of Best use of integrated care and partnership working in patient safety award.

10. In 2024/2025 WCHC continued to provide an Infection Prevention and Control Service (IPCS) to the wider community of Wirral through its commissioned service with Wirral Borough Council.

11. Key priorities for 2025/26 will be to:

- maintain organisational focus on IPC as it remains an integral factor in patient safety, with an improved focus on collaborative and integrated ways of working
- support and lead on integrated quality improvements
- implement 'The Gloves Are off' Quality Improvement Project

CRITERION 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 that their environment and other users may pose to them.

12. The IPC Team have provided advice, support and leadership to all trust services to support compliance with IPC practices and to actively contribute to quality improvement and patient safety.

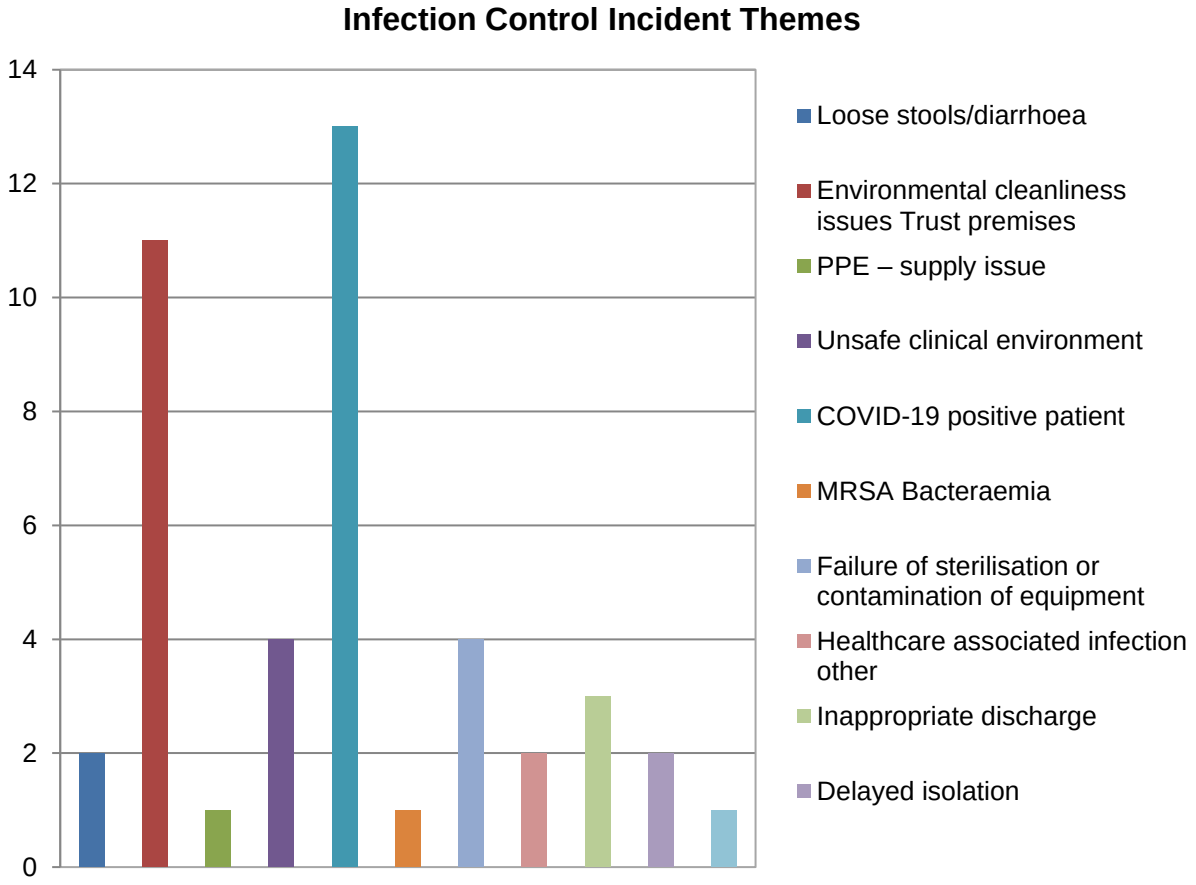
13. Following a review at the IPC Group, it was agreed that the national Infection Prevention and Control Board Assurance Framework (IPC BAF) would be used to support evidentiary compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and to demonstrate compliance with the ten-criterion outlined in the IPC BAF.

14. The initial review highlighted full compliance across 6 standards and partial compliance against 4 standards. Areas of partial compliance were included in the work of the IPC team and any outstanding objectives will be carried forward into the IPC workplan for 2025/26.

15. In accordance with the Trust's IPC governance assurance framework, all identified risks have been effectively managed via the operational risk register during 2024/25, with monitoring via the Trust's IPC group, reporting to the Quality and Safety Committee.

16. During the reporting period there were 44 infection control incidents, the breakdown of the incidents is outlined in figure 2.

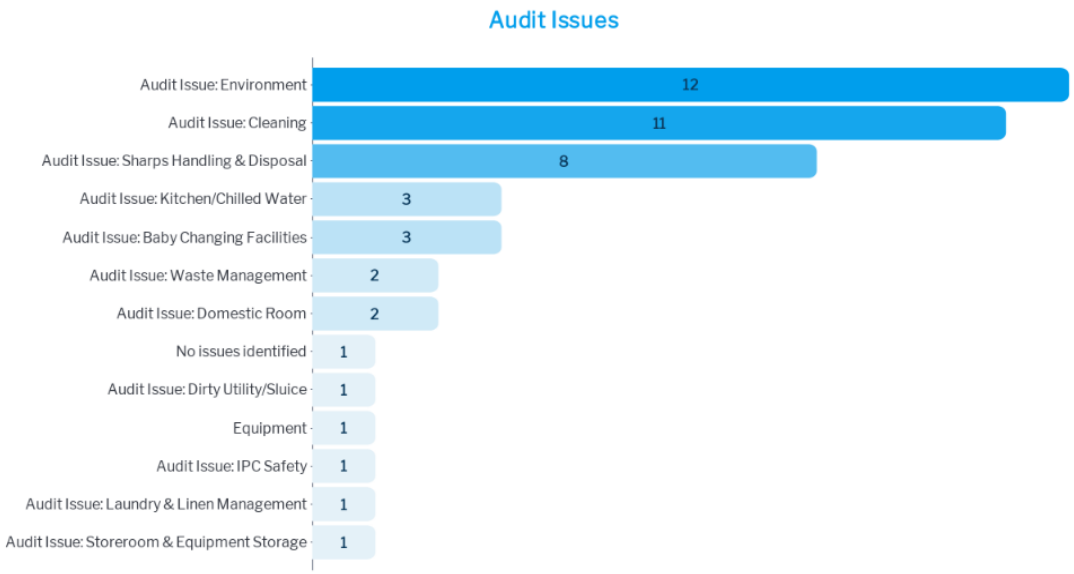
Figure 2: Number of Infection Prevention and Control Incidents and Themes Reported 1 April 2024 to 31 March 2025



17. Following review at service level, all IPC themed incidents are reviewed at the IPC Group in accordance with the Trust's governance framework. A theme emerged relating to environmental cleaning standards in Wirral sites. These incidents were managed by the Head of Capital Projects and Estates in accordance with the trust's internal governance processes.

18. During the reporting period, a total of 27 IPC environmental audits of Wirral premises were completed by the IPC Team. In addition to this, 5 IPC focused visits were undertaken in Regional Services to establish an understanding of IPC standards across these areas.

Figure 3: IPC Environmental Audit Themes and Trends



19. In response to the audits undertaken, action plans were developed which are tracked via Directorate Safe Operations Performance Group (Safe/OPG), with high level assurance provided to the IPC group via Directorate reports.

20. In addition to the annual IPC environmental audit programme, the IPC team have undertaken regular supportive visits to trust services and bases to support the implementation of appropriate IPC standards, including enhanced support to the Community Intermediate Care Centre (CICC) and supporting the mobilisation of the new Sexual Health service.

21. To support IPC governance and assurance processes, 3 IPC assurance audits are held on SAFE for completion by all patient facing services. Compliance is reviewed at Directorate Safe/ OPG meetings and assurance provided to the Safe Operations Group (SOG) and the IPCG.

22. The Trust has continued to monitor hand hygiene compliance across all frontline clinical services on a quarterly basis and compliance is tracked via the Trust's Standards Assurance for Excellence (SAFE) system and reported by exception to the IPC Group and SOG.

23. An annual audit of compliance with the uniform and workwear standards and IPC practice was completed by the clinical audit team and a trust wide action plan was produced and monitored through SOG.

24. During 2024/25, 87.1% of eligible staff completed the hand hygiene audit with 100% compliance with the required standards. To provide a greater level of assurance, audits are also peer reviewed, to observe standards in clinical practice; 88.2% of completed audits have been peer reviewed.

Figure 4: Hand Hygiene Essential Steps Compliance and Completion Rates



CRITERION 2:
The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

25. The IPC Team work closely with the Estates team to ensure that IPC standards are considered as part of any refurbishments. The team have continued to provide support to the Head of Capital Projects & Estates and Operational Services to ensure IPC is considered as part of any service re-design, which included the:

- relocation of the Urgent Treatment Centre
- refurbishment of the Dental surgeries on the VCHC site
- mobilisation of a new Sexual Health Service
- waste survey across SCHC

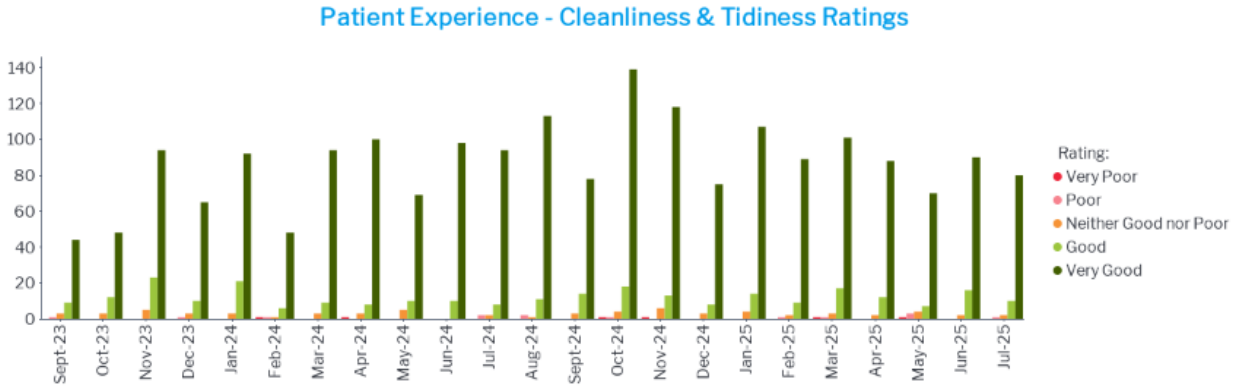
26. The Trust's Health, Safety and Fire Manager had previously established a Water Safety Group (WSG), incorporating relevant areas of ventilation, which reports directly into the Estates management Group (EMG). Following discussion and agreement at the IPCG, this group was

disbanded, and water safety and ventilation are now a standing agenda items of the Estates Management Group.

27. Patient Led Assessments of the Care Environment (PLACE) were successfully completed in 2024, with the Trust achieving an average of 98.22% across the 8 assessed areas, which sees a slight increase from 2023 where the assessed metrics scored 98.06%. The areas where marks were lost were not related to IPC.

28. As part of the Trusts commitment to collecting service user feedback, data is also collected in response to people's experience of the cleanliness of the care environment. This is reviewed at the quarterly IPC Group.

Figure 5: Patient Experience - Cleanliness and Tidiness Ratings



29. The contract for the provision of Soft Facilities Management (SFM) was awarded to Eric Wright Facilities Management and commenced on 1st July 2024. The trust remains partially compliant with the Board Assurance Framework (BAF) due to lack of assurance of compliance with the NSHC and attainment of expected standards of cleanliness. Actions are being progressed to gain full assurance, and progress is monitored through the IPC group. It is anticipated that full compliance will be achieved early in 2025/26.

30. The IPCT continue to work closely with the Medical Devices Safety Officer and Health, Safety & Fire Manager to ensure correct processes are in place for the decontamination of medical devices and have worked closely with the Community Intermediate Care Centre's (CICC) Service Lead to support improvements in decontamination processes across the three wards within the CICC.

CRITERION 3:
Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

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31. The Lead Pharmacist represents the Trust at the Wirral Place Medicines Optimisation Group and participates in Wirral Place Antimicrobial Stewardship (AMS) activities.

32. For World Antimicrobial Awareness Week (18 to 24 November 2024) the Medicines Management Team together with the IPC Team promoted TARGET, "treating your infection" patient resources for adults and signposted parents and carers of children to the NHS Cheshire and Merseyside ICB Super Bodies resources. Both resources explain when antibiotics are not required, usual durations of common infections and when it is necessary to seek urgent medical advice.

33. All practitioners within the Trust accessed ICB approved antimicrobial guidelines (Pan Mersey) via the trust website.

34. All patient group directions that authorise the supply of antibiotics were based on Pan Mersey and national (NICE) evidence-based guidelines.
35. During 2024/25 the Medicines Management Team conducted 5 audits of antibiotics associated with a high risk of *Clostridioides difficile* prescribed within the Urgent Treatment Centre. In each of the audits, 20 patient records were examined by extracting information from the electronic patient record. The exception to this were the quinolone audits due to the low number of prescriptions for these antibiotics, all the quinolones prescribed were audited.

36. Audit findings were monitored at service level and at the Medicines Governance Group. The results were also discussed at the quarterly V300 Non-Medical Prescribing Forums. Results of the audits were reported back to individual prescribers via their line manager and when a training need was identified, extra training was provided.

37. The percentage compliance with Cheshire and Merseyside Formulary (formerly Pan Mersey) and NICE guidelines was as follows:

Date Prescribed	Date presented at Medicines Governance Group	Antibiotic	% compliance against local and national antimicrobial guidelines	Total number of items prescribed in drug group during stated month
Jun 24	Aug 24	Co-Amoxiclav	100%	106
Aug 24	Oct 24	Quinolones	100%	6
Oct 24	Dec 24	Cephalosporins	85%	53
Dec 24	Feb 25	Co-Amoxiclav	100%	125
Feb 25	Apr 25	Quinolones	100%	7

38. In addition, a point prevalence study was undertaken in March 2025 where all antimicrobial prescribing undertaken by Trust Services for a 24-hour period was reviewed. The audit results are currently being evaluated to establish if prescribing was in line with guidelines. Interim results show adherence to guidelines, but it was recognised that documentation in patient records could be improved to ensure that patients are consistently signposted to TARGET resources. The Medicines Management team will work with service leads to embed the practice of documenting the signposting to TARGET resources.

39. In addition to the audits, the Trust requires all practitioners who prescribe, administer or advise on antibiotics to complete antimicrobial resistance awareness training. At the end of 94.7% of eligible staff had completed the training.

40. Training compliance rates are tracked monthly at service level throughout the organisation, with trajectories for improvement developed where required, reporting by exception to SOG.

CRITERION 4:
The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

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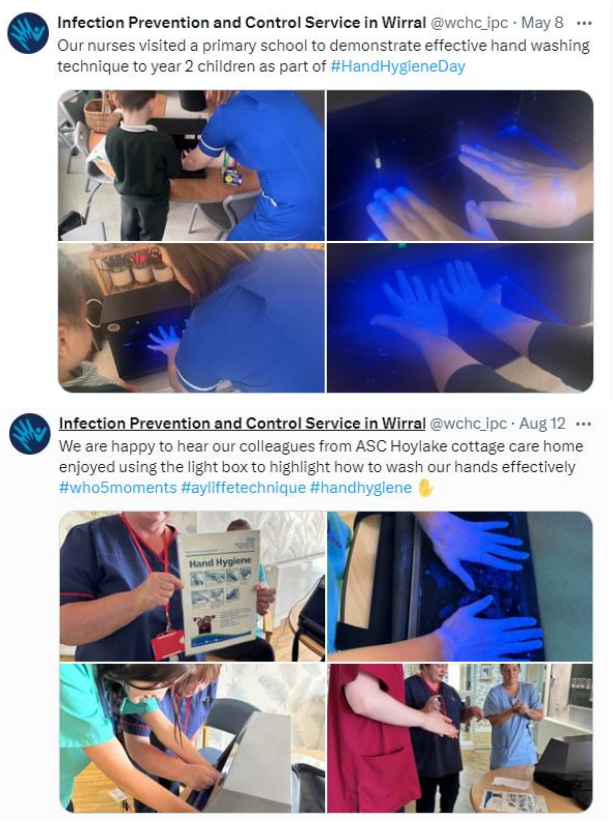
41. Communication is key in promoting effective IPC and the IPC Team have taken a proactive approach in promoting IPC at every opportunity, this has included:

    - Contacting patients in the community with *Clostridioides* difficile infection to provide education and advise
    - Delivery of a programme of activity to recognise the World Health Organization's Global Hand Hygiene Day which is celebrated each year in May
    - Supporting the promotion of World Sepsis Day which occurs each year in September

- Delivering a robust communications plan, produced in collaboration with the Trusts Communications and Marketing team, to recognise International Infection Prevention Week in October
- Attending a joint public engagement event with colleagues from Wirral University Teaching Hospital NHS Foundation Trust, providing education and advice on infection prevention and control to members of the public
- Attending a Carers Network event to support and celebrate Wirral's unpaid carers as part of National Carers Week
- Collaborated with Bladder and Bowel service to share key messages across the local health economy on the prevention and management of urinary tract infections and catheter management and passports
- Sharing seasonal messages with the local health and care community regarding winter illness and viral gastroenteritis
- Supported Healthwatch Wirral's Winter Wellness event working collaboratively with WUTHs IPC team to engage with the community to raise awareness about infection prevention
- Continued to utilise the trusts social media platforms to share key messages
- A review of content published on the IPC website was undertaken in conjunction with the trust Communications team, and information has been refreshed and updated
- The IPCT promoted nutrition and hydration week to healthcare professionals and members of the public

42. Resources and information continue to be made available on the dedicated digital hub for all IPC related information for providers of community care which includes WCHC staff.

Figure 6: Communication and Engagement Examples 2024/25













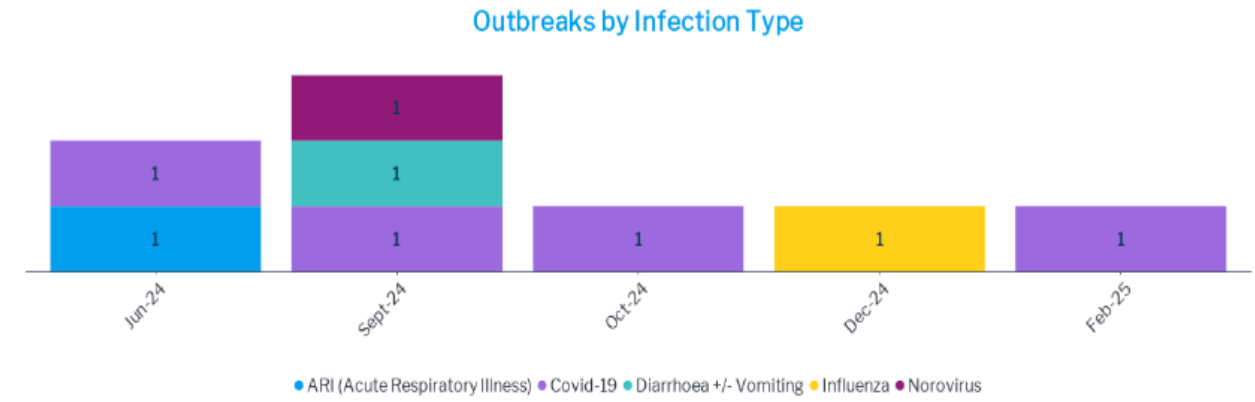




CRITERION 5:
That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

43. During the reporting period, 8 outbreaks of infection were identified within the Community Intermediate Care Centre (CICC), all were managed well and in accordance with IPC guidance.

Figure 7: Outbreaks within CICC



44. To support a cycle of continuous learning and improvement a review of each outbreak is undertaken through Outbreak Control Groups. Any subsequent actions are monitored via the trusts existing governance routes.

45. The IPC team supported a review of Cheshire & Merseyside's response to outbreaks by attending, alongside the LSMS and Emergency Preparedness Resilience & Response (EPRR) Lead, through attendance at the UKHSAs Exercise Nexus event.

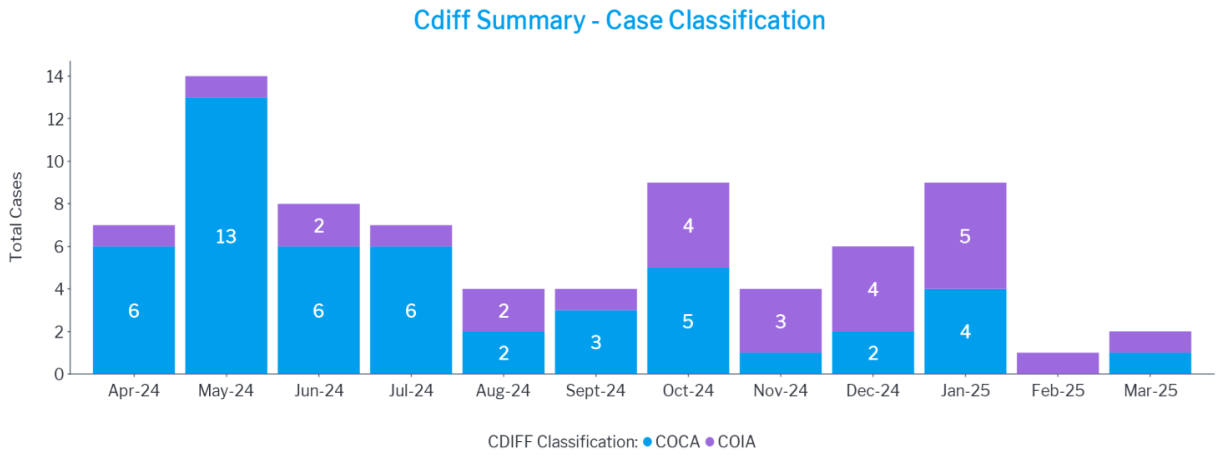
46. During 2024/25, one person was identified to have a community associated MRSA bacteraemia which was reported to the IPCT as part of the Local Authority contract. The persons care journey was reviewed and the case was not attributable to Trust services. Learning was identified as part of the system wide patient safety investigation, which was shared with relevant system partners.

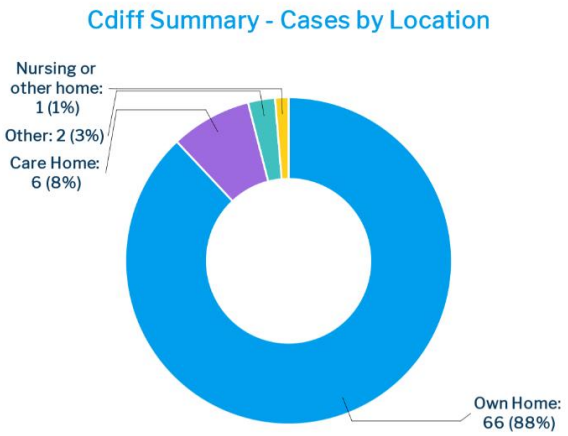
47. The IPCS completed rapid infection control reviews of 75 community attributed cases of *Clostridioides* difficile infection (CDI) as part of the Local Authority contract for the wider Wirral system. Of the 75 PIRs undertaken by the IPCS:

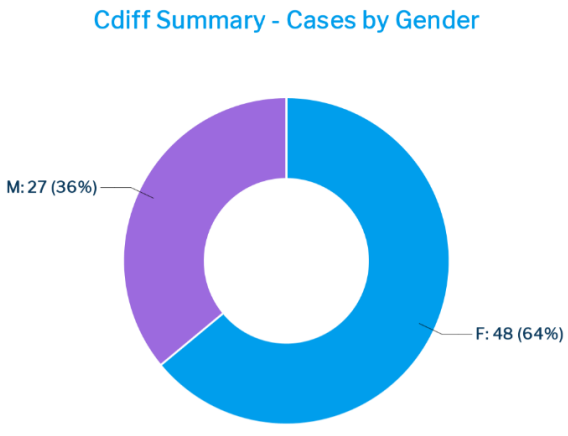
- 49 cases were community onset community associated (COCA)
- 26 cases were community onset indeterminate association (COIA)

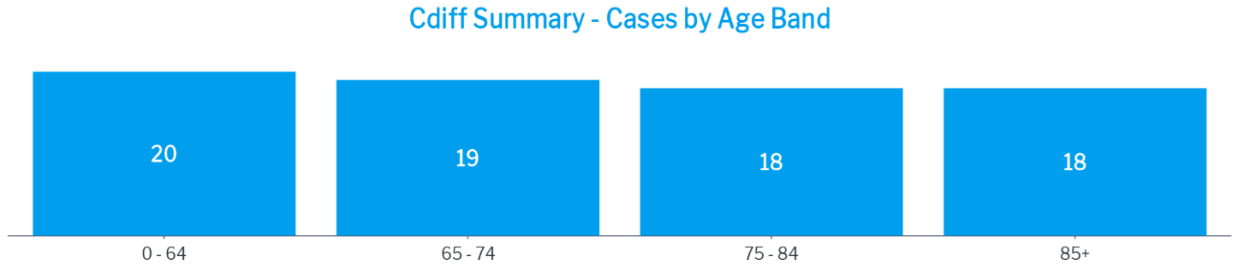
48. The cases were not found to be attributed to trust services. Where learning was identified it was shared with appropriate services.

Figure 8: Community Attributed *Clostridioides* difficile Toxin Positive Cases 2024-2025









49. The IPC team are working collaboratively at a system level to support a reduction in cases of *C.diff* across the local health economy. This includes the development of a system wide C.diff strategy and working closely with system partners to progress priority areas for improvement.

50. The IPCS have established a joint NHS review panel with WUTHs IPC Team to review people who have received care in both acute and community settings and to identify system learning.

51. The team have also continued to support a system wide improvement project group to drive improvements in the management of Urinary Tract Infections (UTIs) and hydration, to reduce Gram Negative Blood Stream Infection (GNBSI).

52. Following the launch of the Patient Safety Incident Response Framework (PSIRF) the IPC team have worked to align Healthcare Associated Infection (HCAI) reviews with the framework, and are continuing to review how the principles of PSIRF can be applied in IPC, working with system colleagues to ensure a cohesive approach to patient safety IPC incidents.

53. To enable prompt recognition of risk of infection for staff, patients and the public the IPCS worked with the Clinical Systems Team to create a template for staff to complete within patients Electronic Health Records.

54. In response to the evolving situation in Central African regions relating to increasing cases of Clade 1 mpox virus infection (MPXV), the IPC team developed guidance to support relevant services in the management of suspected and/or confirmed cases. This included establishing a focused Task and Finish group to review preparedness plans developed in 2022 following the global outbreak and a case scenario walkthrough of the Urgent Treatment Centre and Walk in Centre on the VCH site.

CRITERION 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.

55. During the reporting period, compliance with mandatory and role essential IPC training was:

- Level 1 97.1%
- Level 2 89.5%
- Aseptic Technique 90.3%

56. In addition to mandatory and role essential training programmes, the IPC Team have provided informal training to higher risk areas of the Trust including:

- CICC on the fundamentals of the National IPC Manual (NIPCM) to support compliance with the IPC Board Assurance Framework
- Urgent Care services
- Home First Team on hand hygiene and bare below the elbow
- The Right Care Hub on C.diff and unexplained diarrhoea management
- 0-19/25 services on hand hygiene and bare below the elbow
- Community Nursing teams on hand hygiene and standard infection control precautions (SICPs)
- Senior Leadership teams on the importance of Bare Below the Elbows (BBE)

57. The IPCS have provided regular themed updates through internal communications to staff to ensure they are aware of their responsibilities to prevent and control infection.

58. To ensure the health and safety of staff who may be required to wear a Filtered Face Piece level 3 (FFP3) mask within their role a review of the trusts fit testing compliance, training and responsibility has been completed with support from the LSMS / EPRR Lead.

CRITERION 7:
The provision or ability to secure adequate isolation facilities.

59. All inpatient wards at the Community Intermediate Care Centre provide single room ensuite accommodation that can be used for patients requiring isolation where appropriate.

60. Isolation facilities are available at Trust Walk in Centres and Urgent Treatment Centre where required.

61. The IPC Team have worked with operational services to ensure adequate isolation facilities in the event a person presents with suspected mpox or other communicable disease.

CRITERION 8:
The ability to secure adequate access to laboratory support as appropriate.

62. Laboratory services for the trust are provided by Chester and Wirral Microbiology Service. The laboratories operate according to the requirements of national accreditation bodies for the investigation and management of disease/infections. There is nothing to report by exception for 2024/25.

63. IPCS have supported the Sexual Health service with the planning and implementation of an onsite laboratory at VCHC for point of care diagnostics, as part of the mobilisation of the new service specification.

CRITERION 9:
That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

64. All IPC policies are tracked through the IPC Group to ensure that review dates are not exceeded, where extensions have been required this has been granted by the Quality and Safety Committee.

65. The following policies have been approved by the Quality and Safety Committee during 2024/25:

- IPC07 Cleaning and Disinfection
- IPC22 Safe Management of Linen and Laundry
- IPC25 Outbreak Management and Isolation

66. In response to the high rates of Gram-Negative Blood Stream Infection (GNBSI) in the northwest and recognising that invasive devices are one of the main causes of blood stream infection, the IPCS developed a quality improvement initiative with an aim of identifying if improvements in clinical practice was required. An audit was completed reviewing practice versus policy for specific clinical interventions including catheterisation and PICC line insertion.

67. To measure compliance with infection prevention and control standards an annual IPC fundamentals audit was completed focusing on compliance with bare below the elbow and hand hygiene. Results of the audit were shared with services and a trust action plan developed and monitored through SAFE.

CRITERION 10:
That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

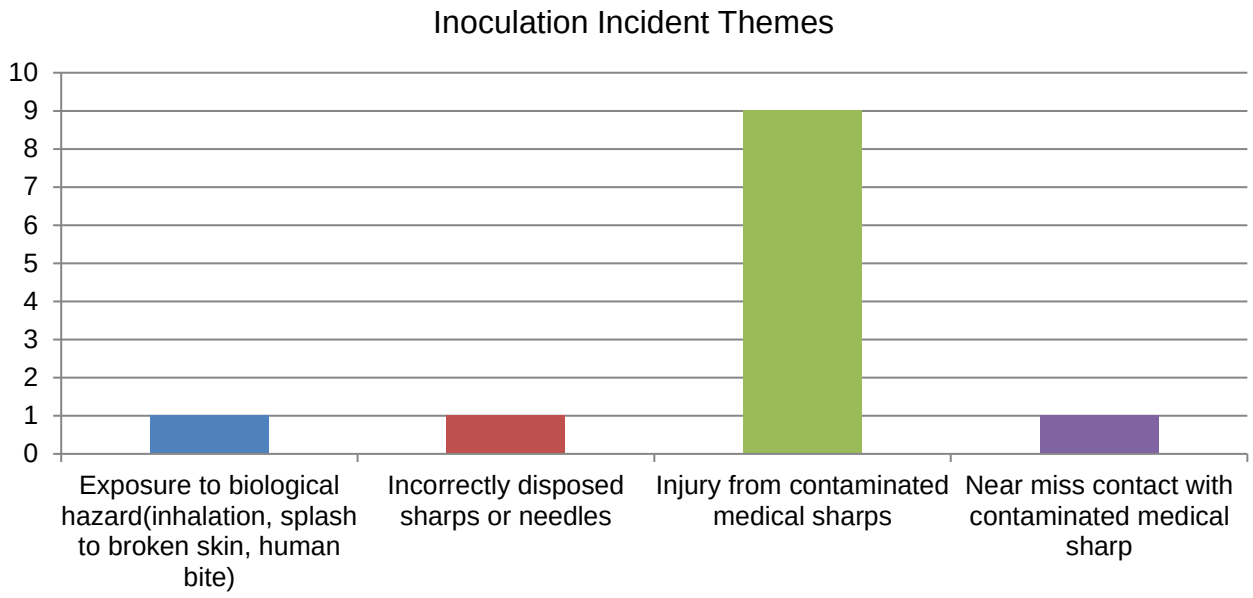
68. Occupational Health Services are provided via People Asset Management (PAM) who are the contracted occupational health service for Trust staff and are managed by the Chief People Officer function. To ensure staff are appropriately supported, the IPC Team signpost Trust staff to PAM where occupational health specialist advice is required.

69. The Trust ended its staff seasonal influenza vaccination programme on 28th February 2025. Vaccination levels at the end 2024/25 were 47.7% of healthcare workers had received their seasonal flu vaccination. An evaluation of the influenza vaccination programme has been completed by the lead for the staff flu programme.

70. Learning from the programme will inform planning for 2025/26.

71. During the reporting period there have been 12 inoculation incidents which have all been appropriately managed in accordance with Trust policy. Themes and trends are continually monitored, and all inoculation injuries are reviewed by the Head of IPC, a theme relating to injuries sustained as part of the self-administration of insulin was noted. A Task & Finish group will be established early in 2025/26 to ensure actions to reduce the incidence of these injuries are put in place.

Figure 9: Number of Inoculation Incidents and Themes April 2024 to March 2025



72. An external audit was completed by the Trusts provider of sharps waste containers to provide an independent assessment of the Trust sharps safety practices. Overall, the Trust performed very well with any identified learning shared with Service Leads for action at service level.

Summary

73. The IPC team have delivered a robust IPC activity programme The annual work programme for 2025/26 will continue to deliver against key national standards including The Health and Social Care Act 2008: code of practice on the prevention and control of infections, NHS England IPC Board Assurance Framework and the National IPC Manual.

74. The IPC team have continued to collaborate with regional and local system partners on preparedness projects, response to national and local outbreaks of infection and quality improvement initiatives.

75. Effective IPC practices require commitment from all staff, including both clinical and non-clinical staff groups and WCHC remains committed to continuous quality improvement to ensure sustainable improvement in infection prevention and control practice whilst supporting a zero tolerance of avoidable infection and harm to our patients and staff.

76. Collaborative work on UTI improvement and hydration which we were nationally recognised as finalists for the Health Service Journal (HSJ) awards in the category of Best use of integrated care and partnership working in patient safety award.

77. Contributing and leading on aspects of the C.diff strategy and implementing a PSIRF approach for infection control reviews of Healthcare Associated Infections (HCAIs). Empowering services to take ownership for IPC through the launch of self-audits and checklists for ASC, educational settings and primary care dental services.

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Contributors:
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Laura McGuffie, Senior Administrator

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 33**

03 September 2025

Title	NHS 10 Year Plan
Area Lead	M Swanborough, Chief Strategy Officer
Author	M Swanborough, Chief Strategy Officer
Report for	Information

Executive Summary and Report Recommendations

In July 2025 the NHSE published the 10 Year Plan, this report and supplementary presentation provides an overview of three key shifts in healthcare delivery outlined in the plan.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

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

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

Contribution to 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
July 2025	Executive Team	**NHS 10 Year Plan**	Noted

1	Narrative
1.1	The attached paper provides a briefing of the 10 Year Plan, which was released in July 2025. This includes an overview of the three key shifts in healthcare delivery outlined in the plan, namely: 1. **From Hospital to Community:** Shifting from hospital-centric to neighbourhood-based care, with integrated teams serving populations of around 50,000. Neighbourhood Health Centres will provide extended-hours access to GPs, nurses, mental health services, and social care, promoting preventive care and reducing hospital visits. 2. **From Analogue to Digital:** Transforming the NHS into a connected system, centred on the NHS App and interoperable digital records, with AI and remote monitoring supporting early intervention and efficiency. 3. **From Treatment to Prevention:** Embedding a population health approach across the system, with ambitious goals on smoking, obesity, mental health, and health inequalities. The briefing also describes the supporting reforms and organisational changes as well as the key considerations for WUTH.

2	Implications
2.1	**Patients** • Change in access and availability of clinical services
2.2	**People** • Improved working environment and training for staff
2.3	**Finance** • Movement of funding to support establishment of neighbourhood health services
2.4	**Compliance** • Nil

NHS
Wirral Community Health and Care
NHS Foundation Trust

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

NHS 10 Year Plan

Briefing

September 2025

Executive Summary

Context

The National Health Service (NHS) in England is facing challenges with access to care, outcomes, and staff morale. In July 2025, the government launched a bold 10-Year Health Plan ("Fit for the Future") aimed at reforming the NHS to ensure its long-term sustainability. This agenda coincides with efforts in Wirral to integrate services, where Wirral Community Health & Care (WCHC) and Wirral University Teaching Hospital (WUTH) are preparing to merge into a single integrated provider.

Plan Overview

The 10-Year Plan outlines three key shifts in healthcare delivery:

1. **From Hospital to Community:** Shifting from hospital-centric to neighbourhood-based care, with integrated teams serving populations of around 50,000. Neighbourhood Health Centres will provide extended-hours access to GPs, nurses, mental health services, and social care, promoting preventive care and reducing hospital visits.
2. **From Analogue to Digital:** Transforming the NHS into a connected system, centred on the NHS App and interoperable digital records, with AI and remote monitoring supporting early intervention and efficiency.
3. **From Treatment to Prevention:** Embedding a population health approach across the system, with ambitious goals on smoking, obesity, mental health, and health inequalities.

Implications for Wirral

The national Plan aligns closely with WUTH and WCHC priorities. The area faces significant health inequalities, particularly in and around Birkenhead, where life expectancy is lower than in wealthier areas. The Plan's focus on "levelling up" offers valuable support. The shift to neighbourhood-based care complements Wirral's approach, and the planned WCHC-WUTH merger positions the borough to become the integrated provider envisioned by the Plan.

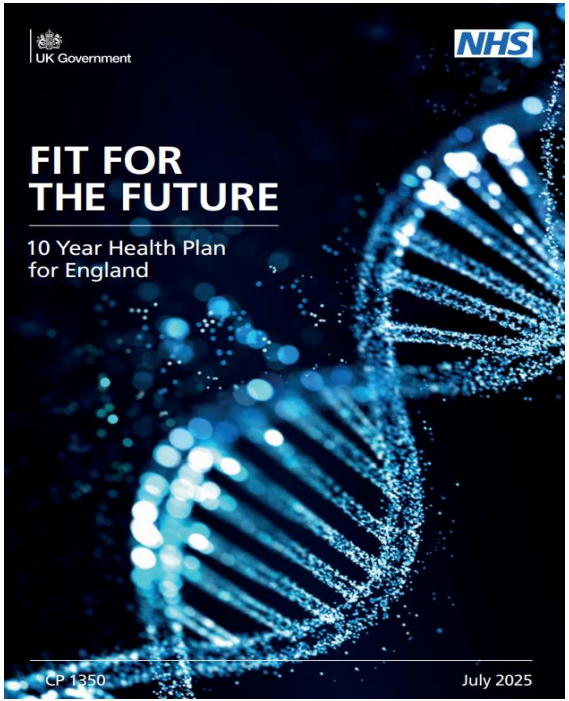
Overview

Overview of the 10-Year Health Plan for England: *Fit for the Future*

The *Fit for the Future* plan sets out a bold and ambitious 10-year vision for transforming the National Health Service (NHS) in England. Launched in July 2025, the plan responds to mounting pressures on the health system—rising demand, persistent health inequalities, workforce shortages, outdated infrastructure, and public concerns around access and outcomes. It offers a comprehensive framework to modernise the NHS by 2035, aiming to secure its long-term sustainability, improve population health, and restore public trust.

At its core, the Plan seeks to rewire how health and care are delivered, moving away from fragmented, reactive, and hospital-focused models, toward more integrated, preventative, and digitally enabled care. It identifies **three core shifts** in delivery, supported by foundational reforms to finance, workforce, and governance.

1. **From Hospital to Community: A Neighbourhood-Based Service**
2. **From Analogue to Digital: A Modern, Connected NHS**
3. **From Treatment to Prevention: Promoting Health**



1. From Hospital to Community

NHS Wirral Community Health and Care NHS Foundation Trust

NHS Wirral University Teaching Hospital NHS Foundation Trust

Overview of the 10-Year Health Plan for England: *Fit for the Future*

1. From Hospital to Community: A Neighbourhood-Based Service

At the heart of the Plan is a move away from hospital-centric care toward a **Neighbourhood Health Service**, serving local populations of around **50,000 people**. This involves establishing **Neighbourhood Health Centres** as integrated community hubs, offering:

- Extended-hours access to GPs
- Community nursing and therapy
- Mental health support
- Social care and voluntary services



Each centre will be led by a multi-disciplinary team that can coordinate holistic, wraparound care closer to where people live. The goal is to **prevent unnecessary hospital admissions**, support people to manage their health locally, and reduce fragmentation across health and care services.

The Plan indicates that this shift to neighbourhood-based care will be phased, with early implementation in high-need areas and full national coverage expected by 2030. The approach is explicitly designed to **tackle inequalities**, with initial rollouts targeted at areas with poor outcomes and high deprivation.

The Plan also details the redesign of outpatient services, including patient initiated follow up, use of digital and apps, virtual clinics and delivery in community settings.

In addition, the Plan details expanding access to urgent and emergency care services at home and in the community.

2. From Analogue to Digital

Overview of the 10-Year Health Plan for England: *Fit for the Future*

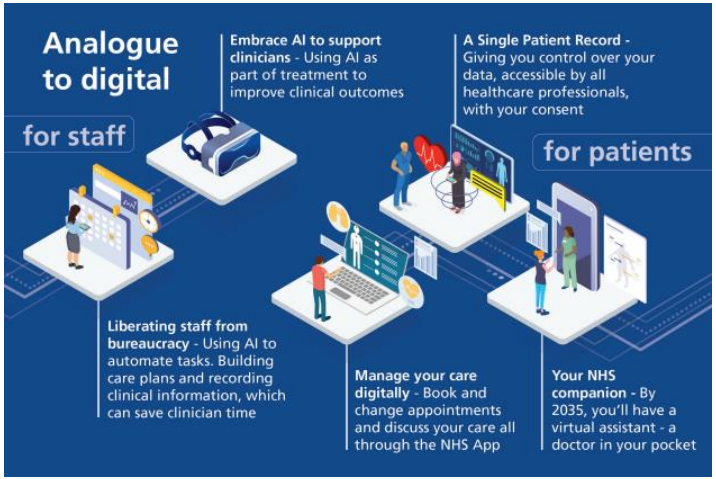
2. From Analogue to Digital: A Modern, Connected NHS

The second transformation is the creation of a **"digital front door"** to the NHS, led by the expansion of the **NHS App** as the primary gateway to services. By 2028, every patient in England via the app should be able to:

- Book appointments
- Access test results and health records
- Consult with clinicians remotely
- Receive personalised reminders and guidance

The plan sets out an ambition for a fully connected, digitally enabled NHS in which patient data – within a **single patient record** – can flow seamlessly across care settings.

Systems will be expected to adopt interoperable digital tools, enhance use of the NHS App, and expand technologies such as **AI** and **remote monitoring** to support early intervention, and improve productivity.



3. From Treatment to Prevention

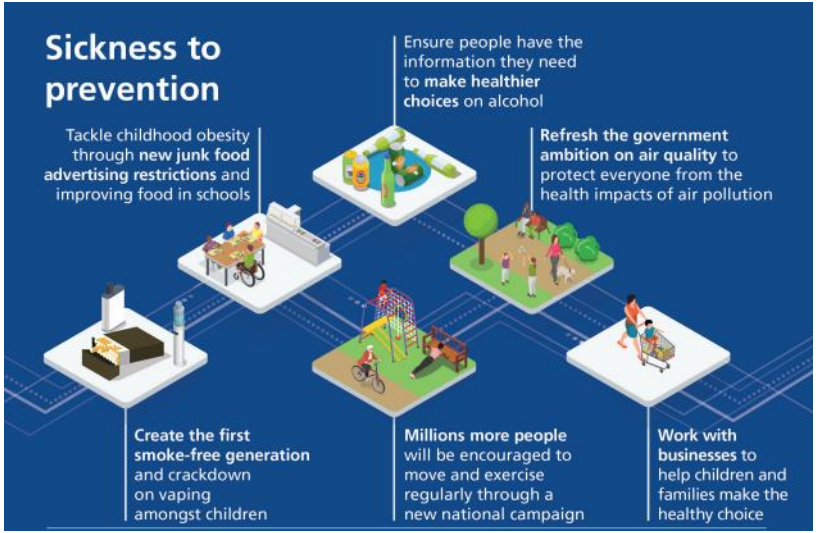
Overview of the 10-Year Health Plan for England: *Fit for the Future*

3. From Treatment to Prevention: Promoting Health

The Plan marks a decisive shift toward **prevention**, committing the NHS and partners to a national health improvement mission. Key commitments include:

- **Halving the healthy life expectancy gap** by 2035
- Supporting the national ambition to reduce smoking prevalence below 5% by 2030
- Tackling obesity through prevention and early intervention
- Increasing access to mental health support in community and neighbourhood settings
- Expanding social prescribing and community-led approaches to care

Public health will be embedded across the NHS and coordinated with local authorities and the voluntary sector. ICSs will be expected to lead place-based preventative strategies, supported by a stronger focus on outcomes and reducing inequalities.



Supporting Reforms

Supporting Reforms: Finance, Workforce, and Accountability

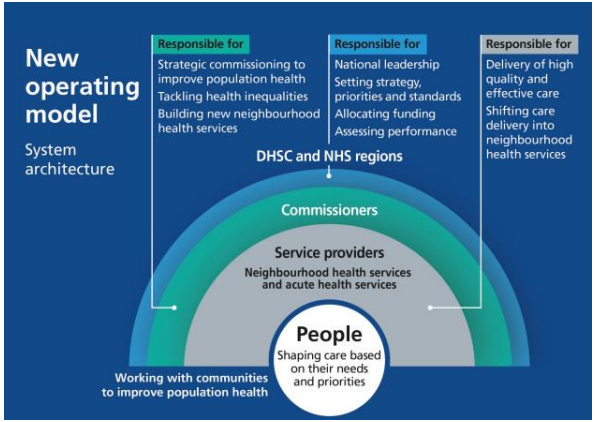
To underpin these shifts, the Plan proposes several structural reforms:

- **Multi-Year Budgets and Incentives:** ICSs will transition to multi-year financial frameworks to enable longer-term planning. Payment systems will move beyond activity-based funding, shifting toward outcome-focused models that support prevention, integration and care quality.

- **Workforce Innovation:** The Plan anticipates significant changes to roles, training, and deployment. It emphasises the need for more flexible workforce models, with staff training and equipped to work across care settings. It also supports investment in training, digital tools to ease administrative burdens, and a stronger focus on staff well-being and leadership development.

- **Devolution and Local Control:** While national standards and accountability remain, greater flexibility will be given to local systems to design and commission services that meet their populations' specific needs. This includes exploring new models of integrated providers holding single budgets for all services and formation of Integrated Health Organisations (IHOs). The Plan also highlights the move to reinvigorate the FT model.

- **Transparency and Choice:** The Plan reinstates a focus on **patient choice**, particularly in primary and elective care. It promises greater transparency on local performance (e.g., waiting times, cancer outcomes), helping patients and communities hold systems to account.a



Key Considerations / Conclusion

Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Key Considerations

As WUTH and WCHC progresses toward delivering the ambitions of the *Fit for the Future* Plan, several factors will be critical to success:

1. **Neighbourhood Implementation Readiness**
   Delivering care through neighbourhood teams will require clear accountability, multidisciplinary workforce alignment, and strong collaboration with primary care, local government, and community partners.

2. **Digital Maturity and Integration**
   Advancing digital interoperability and NHS App integration is a near-term priority. Investments in shared care records, data infrastructure, and virtual care must align with national timelines and local delivery models.

3. **Prevention and Health Equity**
   Preventive approaches must be embedded across care pathways, with a strong focus on reducing inequalities—particularly in high-need areas across the Wirral. Coordinated delivery with local authority partners will be essential.

4. **Workforce Transformation**
   The integrated organisation offers a platform for new roles, flexible deployment, and shared culture. Supporting multidisciplinary teams and new models of working will be essential for sustainable delivery.

5. **Governance and Performance Assurance**
   With wider scope and visibility, robust governance is needed to ensure accountability, outcome tracking, and effective risk management across the integrated service portfolio.

6. **System Alignment and Local Voice**
   The integrated provider will play a leading role in place-based transformation. Maintaining strong engagement with system partners will be key to securing alignment, influence, and resources within the ICS.

7. **Delivery Focus and Phased Rollout**
   Implementation should be paced to match capacity and maintain quality. A phased approach, grounded in realistic milestones, will help maintain momentum while ensuring operational stability.

Conclusion

The 10-Year Plan sets out an ambitious vision to transform the NHS through prevention, local delivery, and digital innovation. Success will depend on collaboration, investment, and flexibility to meet local needs. WUTH and WCHC are well-placed to lead this shift, with integration already underway and a clear focus on neighbourhood care, digital transformation, and health equity. The development of the Joint Strategy and merger of WCHC and WUTH provides the scale and structure to deliver on the Plan's ambition.

References

- **Department of Health and Social Care.** *Fit for the Future: 10-Year Health Plan for England*. (July 2025). https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

- **NHS Providers.** *On the Day Briefing: 10-Year Health Plan*. https://nhsproviders.org/resources/on-the-day-briefing-10-year-health-plan

- **Carnall Farrar.** *Fit for the Future: The NHS 10-Year Health Plan for England – CF Briefing*. https://www.carnallfarrar.com/fit-for-the-future-the-nhs-10-year-health-plan-for-england/

- **NHS Confederation.** *Ten-Year Health Plan: What You Need to Know*. https://www.nhsconfed.org/publications/ten-year-health-plan-what-you-need-know

Board of Directors in Public **Item 34**

03 September 2025

Title	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common
Area Lead	Janelle Holmes, Joint Chief Executive
Author	David McGovern, Director of Corporate Affairs (WUTH), Ali Hughes, Director of Corporate Affairs (WCHC)
Report for	Approval

Executive Summary and Report Recommendations

Cheshire and Merseyside (C&M) providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. CMPC has come about through a process borne from bringing together its two forerunners CMAST and MHLDC to focus on work of shared provider delivery: acute, specialist and community services. Working together has achieved real and tangible benefits since the pandemic and been consolidated since. All providers consider this next step will provide further opportunities and opportunities for at scale working where this makes sense.

Following a review requested by the system leaders and sponsored by Trust CEOs, Trust company secretaries have engaged in a process of seeking to build upon the established and available collaboration mechanisms within C&M that have been shown to work and support a track record of collaboration.

In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures where these can be shown to work.

C&M cosecs have worked together and drawn upon the expertise and advice of Hill Dickinson to support the redrafting and reframing of a CMPC Joint working agreement and Committees in Common terms of reference. This approach continues the chosen route of governing collaborative delivery and ongoing potential within the system.

The CMPC Leadership Board recommends the enclosed documents for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration.

It is recommended that the WUTH Board of Directors:

- Endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed (appendix 1)
- Adopt and sponsor 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

- Explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making

It is recommended that the WCHC Board of Directors:

- Endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed (appendix 2)
- Adopt and sponsor 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
- Explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making

Key Risks
This report relates to these key risks: • BAF Risk 12 (There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.)

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
N/A			

1	**Narrative**
1.1	All providers within C&M have some familiarity and individual experiences of differing means of the proposed way of working. This report therefore seeks to briefly orientate an approach and structure of the two documents and then goes on to highlight, at a headline level, changes and areas of development as proposed by Hill Dickinson or Trust company secretaries to aid clarity, understanding and to respond to the current and changed environment. **Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:** • Covers: vision; function; priorities and headline areas of focus • Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making • Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA:

- Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
- Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
- Sets aims and objectives of CiC
- Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
- Quorum
- Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
- To note: NWAS is proposed as a participant of the meeting rather than as a Member

Changes and variation from previous documentation (or familiar approaches): further detail, and to be read in conjunction with JWA and draft CiC:

Terms of References:

- Updates of names and terminology – organisations, CMPC etc
- Added definitions – to reflect content of documents at request of company secretaries
- Refer to the full breadth of CMPC responsibilities – including community – but also not seek to restrict nor curtail future Trust Board choices
- Additional words without altering meaning of sentences to support clarity
- Reframing of section 2.1 (ToR) to reorder theme stated aims and objectives.
- Add to ICB reference 'and regulator or those charged with performance management'
- Specifying MS Teams or equivalent as an option for a CiC meeting

Joint working agreement:

- Provide further clarity on the route for determining any costs arising from collaborative arrangements (section 6)
- Provide further clarity on the route for calculating any exist costs or transition arrangements arising from a cessation of collaborative arrangements (section 6)
- Additional parameters on timescales for stages of any dispute resolution (section 10)

A request was also made from one Trust for definition and adoption of an information sharing agreement (something explored on numerous occasions in the past by Leadership Boards). If the will exists for this it is proposed that this is developed by Trust Company Secretaries (with legal support and input) and proposed to Leadership Board for adoption.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

	The document delivers both a foundation and framework for CMPC development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMPC develops and the ask of the system, for it, expands, varies or diminishes. Given the position of the system currently (recovery) it is both noteworthy and encouraging that the provider collaborative is being referred to and described as a key system decision making forum. The pace of change required within C&M means that the scope and ambition for collaboration may change and vary over time – by agreement. These documents provide a framework for responding to such challenges but are by their very nature a product of a point in time and are not intended nor expected to cover every eventuality or current live discussions

2	Implications
2.1	**Patients** • No implications
2.2	**People** • No implications
2.3	**Finance** • Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within C&M
2.4	**Compliance** • No implications

Draft No: 2
Date of Draft: June 2025

Dated 2025

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT

Between

(1) **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

(2) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

(3) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(4) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(5) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(6) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(7) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(9) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(10) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(11) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(12) **MERSEY CARE NHS FOUNDATION TRUST**

(13) **EAST CHESHIRE NHS TRUST**

(14) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(15) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

(16) **WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST**

and

(17) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

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1 **Introduction**

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMPC CiCs;
CMPC CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMPC CiC**" shall be interpreted accordingly.
CMPC Leadership Board	the CMPC CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMPC CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of a CMPC CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMPC as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMPC but is not forming a CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMPC CiC will be different.

1.5 The CMPC Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMPC Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident, clear and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMPC are to:

2.2.1 Deliver the CMPC vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMPC's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMPC CiCs acting through the CMPC Leadership Board.

2.5 More specifically the CMPC CiCs and the CMPC Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMPC development:

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Delivery and co-ordination of the community programme to support alignment with other programmes;

2.5.3 Further development of community based alternatives to hospital admission and standardisation of the community services offer in Cheshire and Merseyside as per the Neighbourhood health guidance;

2.5.4 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.5 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.6 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.7 Coordinating and enabling CMPC members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.8 Coordinating and enabling CMPC members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.9 Responding to and coordinating CMPC action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.10 The CMPC Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMPC will provide

both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMPC may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMPC Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMPC workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMPC will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 **Rules of working**

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMPC CiCs as the **CMPC Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMPC openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Recognising the relationship between acute, mental health, community and specialist providers ensuring that information is shared where this impacts on other sectors;

3.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.9 Recognising and respecting the collective view and keeping to any agreements made between the CMPC CiC's;

3.1.10 Maintain CMPC collective agreed position on shared decisions in all relevant communications;

3.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.12 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMPC CiCs shall meet together as the CMPC Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-18).

4.1.1 Meetings of the CMPC Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMPC Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMPC Leadership Board – Decisions to be made under the CMPC CiC delegations - CiC CEOs;

C. CMPC Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMPC CiCs shall work collaboratively with each other as the CMPC Leadership Board in relation to the committees in common model.

4.3 Each CMPC CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMPC CiC or its duty to act in the best interests of its Trust, each CMPC CiC shall seek to reach agreement with the other CMPC CiCs in the CMPC Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMPC CiCs meet in common, as the CMPC Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2026.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMPC Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMPC Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMPC Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMPC Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMPC CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMPC Leadership Board.
Matter involves or impacts all CMPC Trusts and comes within the delegation under the	Matter to be dealt with through the CMPC CiCs at the CMPC Leadership Board in

[1] Chairs will be invited to CMPC Leadership Board meetings, at least quarterly.

CMPC CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMPC Trust will report back to its own Board and the CMPC Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMPC Trust Board meetings. The CMPC Trust chairs may (as well as their quarterly CMPC meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMPC on an informal basis. In addition, the CMPC Leadership Board will seek to ensure that each CMPC programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMPC CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMPC (or if relevant, section of the meeting), may be held in public except where a resolution is agreed by the CMPC Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMPC meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Any exit plan, when required or proposed by a Trust, will be drafted for consideration by the Leadership Board with support by the CMPC DoFs. . it is a necessity that an agreed exit plan deals with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMPC CiC Chairs varying the Agreement under clause 10.6.2.

6.1.4 cost apportionment, where appropriate, will be applied on a proportionate fair shares basis

6.2 An exit plan approach is drafted shall be inserted into this Agreement at Appendix 18 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMPC CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMPC Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 19) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMPC CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMPC Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMPC Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMPC is committed to clear, consistent and transparent communication across the CMPC Trusts and with system partners' where appropriate. It is specifically recognised that CMPC Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMPC and the CMPC Trusts may be asked to represent both their own organisations and CMPC in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMPC Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMPC activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMPC across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be

inserted into this Agreement at Appendix 19 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMPC CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMPC Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMPC's decision-making processes.

9.2 The CMPC Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMPC website. It is proposed that such policies will either be CMPC developed or CMPC will support the adoption and application of the policy of the CMPC Chair and/or Meeting Lead.

9.3 All CMPC Leadership Board, committee and sub-committee members, and employees acting on behalf of CMPC, will comply with the CMPC policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMPC. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMPC Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMPC Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMPC Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMPC Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMPC CiCs at the CMPC Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMPC Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMPC Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMPC Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMPC Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMPC Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMPC Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMPC Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMPC Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 The above process (10.5) will seek to be addressed within one calendar month and no longer than 6 weeks unless, in such circumstances, as all parties agree to a longer time frame

10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMPC Leadership Board may decide to recommend their Trust's Board of Directors to:

10.7.1 terminate the Agreement;

10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.7.3 agree that the Dispute need not be resolved.

11 **Variation**

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 **Counterparts**

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **CHESHIRE AND WIRRAL PARTNERSHIP NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL COMMUNITY HEALTH AND CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1– TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

V 3-refresh June 2025

CMPC LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMPC TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE OR CMPC	THE PARTNERSHIP FORMED BY THE TRUSTS TO WORK TOGETHER TO IMPROVE QUALITY, SAFETY AND THE PATIENT EXPERIENCE; DELIVER SAFE AND SUSTAINABLE NEW MODELS OF CARE; AND MAKE COLLECTIVE EFFICIENCIES. THIS OPERATES WITHIN THE NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM.
CMPC AGREEMENT	THE JOINT WORKING AGREEMENT SIGNED BY EACH OF THE TRUSTS IN RELATION TO THEIR PROVIDER COLLABORATIVE WORKING AND THE OPERATION OF THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC TOGETHER WITH THE OTHER CMPC CICS;
CMPC CICS	THE TRUST CIC AND THE OTHER RESPECTIVE COMMITTEES ESTABLISHED BY EACH OF THE TRUSTS TO WORK ALONGSIDE EACH OTHER AND "**CMPC CIC**" SHALL BE INTERPRETED ACCORDINGLY;
CMPC Leadership Board	The Leadership Board is a regular meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC Leadership Board can also be used as the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference.

CMPC PROGRAMME STEERING GROUP	THE GROUP, TO PROVIDE PROGRAMME SUPPORT AND OVERSIGHT OF THE DELIVERY OF AGREED COLLABORATIVE ACTIVITIES;
CMPC PROGRAMME LEAD	NAMED LEAD OFFICER OR ANY OF SUBSEQUENT PERSON HOLDING SUCH TITLE IN RELATION TO CMPC;
CMPC PROGRAMME SUPPORT	ADMINISTRATIVE INFRASTRUCTURE SUPPORTING CMPC;
MEETING LEAD	THE CIC MEMBER NOMINATED (FROM TIME TO TIME) IN ACCORDANCE WITH PARAGRAPH 7.6 OF THESE TERMS OF REFERENCE, TO PRESIDE OVER AND RUN THE CMPC CIC MEETINGS WHEN THEY MEET IN COMMON;
MEMBER	A PERSON NOMINATED AS A MEMBER OF AN CMPC CIC IN ACCORDANCE WITH THEIR TRUST'S TERMS OF REFERENCE, AND MEMBERS SHALL BE INTERPRETED ACCORDINGLY;
NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM OR "C&M ICS"	THE INTEGRATED CARE SYSTEM (ICS) FOR CHESHIRE AND MERSEYSIDE BRINGING TOGETHER NHS ORGANISATIONS, COUNCILS, AND WIDER PARTNERS IN A DEFINED GEOGRAPHICAL AREA TO DELIVER MORE JOINED UP CARE FOR THE POPULATION.
NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE BOARD OR "C&M ICB"	THE INTEGRATED CARE BOARD (ICB) FOR CHESHIRE AND MERSEYSIDE. AN NHS ORGANISATION ESTABLISHED ON JULY 1, 2022, THAT LEADS AN INTEGRATED CARE SYSTEM (ICS). ICBS ARE RESPONSIBLE FOR PLANNING AND FUNDING MOST NHS SERVICES IN THEIR AREA, MANAGING THE NHS BUDGET, AND ENSURING SERVICES ARE IN PLACE TO MEET THE HEALTH NEEDS OF THE LOCAL POPULATION.
Wirral University Teaching Hospital NHS Foundation Trust CiC	THE COMMITTEE ESTABLISHED BY WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST, PURSUANT TO THESE TERMS OF REFERENCE, TO WORK ALONGSIDE THE OTHER CMPC CICS IN ACCORDANCE WITH THESE TERMS OF REFERENCE;

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST NHS FOUNDATION TRUST	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST OF ARROWE PARK ROAD, UPTON, WIRRAL. MERSEYSIDE CH49 5PE, UNITED KINGDOM;
TRUSTS	THE COUNTESS OF CHESTER HOSPITAL NHS FT, LIVERPOOL UNIVERSITY HOSPITALS NHS FT, WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT, WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT, THE CLATTERBRIDGE CANCER CENTRE NHS FT, LIVERPOOL HEART AND CHEST HOSPITAL NHS FT, THE WALTON CENTRE NHS FT, LIVERPOOL WOMEN'S NHS FT, ALDER HEY CHILDREN'S HOSPITAL NHS FT, EAST CHESHIRE NHS TRUST, MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST AND MID CHESHIRE HOSPITALS NHS FT, MERSEY CARE NHS FOUNDATION TRUST, BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST, CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST, WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST AND "**TRUST**" SHALL BE INTERPRETED ACCORDINGLY;
WORKING DAY	A DAY OTHER THAN A SATURDAY, SUNDAY OR PUBLIC HOLIDAY IN ENGLAND;

1.2 The Wirral University Teaching Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMPC to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMPC but is not forming its own CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each respective individual CMPC CiC will be different.

1.5 Each Trust has entered into the CMPC Agreement on **[DATE]** and agrees to operate its CMPC CiC in accordance with the CMPC Agreement.

2 AIMS AND OBJECTIVES OF THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

2.1 The aims and objectives of the Wirral University Teaching Hospital NHS Foundation Trust CiC are to work with the other CMPC CiCs on system work or matters of significance as delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 Leadership

Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams.

Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.2 Delivery

Consider different employment models for service line specialities including contractual outcomes and governance arrangements;

Review the key deliverables and hold the Trusts to account for progress against agreed decisions;

Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

Establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

Improve the quality of care, safety and the patient experience delivered by the Trusts;

Deliver equality of access to the Trusts service users; and

Ensure the Trusts deliver services which are clinically and financially sustainable.

2.1.3 Collaborate

Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance;

Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board and regulator or those charged with performance management;

Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC;

Ensure compliance and due process with regulating authorities regarding service changes;

Oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.2 REVIEW THE CMPC AGREEMENT AND TERMS OF REFERENCE FOR CMPC CICS ON AT LEAST A BIENNIAL BASIS

3 ESTABLISHMENT

3.1 The Wirral University Teaching Hospital NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Wirral University Teaching Hospital NHS Foundation Trust CMAP CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

3.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall work cooperatively with the other CMPC CiCs and in accordance with the terms of the CMPC Agreement.

3.3 The Wirral University Teaching Hospital NHS Foundation Trust CiC is a committee of Wirral University Teaching Hospital NHS Foundation Trust's board of directors and therefore can only make decisions binding Wirral University Teaching Hospital NHS Foundation Trust. None of the Trusts other than Wirral University Teaching Hospital NHS Foundation Trust can be bound by a decision taken by Wirral University Teaching Hospital NHS Foundation Trust CiC.

3.4 The Wirral University Teaching Hospital NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance

for NHS Provider Trusts). The Wirral University Teaching Hospital NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 FUNCTIONS OF THE COMMITTEE

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Wirral University Teaching Hospital NHS Foundation Trust's Constitution.

4.2 Wirral University Teaching Hospital NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 FUNCTIONS RESERVED TO THE BOARD OF THE FOUNDATION TRUST

Any functions not delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Wirral University Teaching Hospital NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Wirral University Teaching Hospital NHS Foundation Trust to delegate functions to another committee or person.

6 REPORTING REQUIREMENTS

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Wirral University Teaching Hospital NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Wirral University Teaching Hospital NHS Foundation Trust's Board for inclusion on the private agenda of Wirral University Teaching Hospital NHS Foundation Trust's next Board meeting in order that Wirral University Teaching Hospital NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall send the minutes of Wirral University Teaching Hospital NHS Foundation Trust CiC meetings to Wirral University Teaching Hospital NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of Wirral University Teaching Hospital NHS Foundation Trust's Board meeting.

6.3 Wirral University Teaching Hospital NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by Wirral University Teaching Hospital NHS Foundation Trust's Board for inclusion on the agenda of Wirral University Teaching Hospital NHS Foundation Trust's Board meeting.

7 MEMBERSHIP

7.1 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall be constituted of directors of Wirral University Teaching Hospital NHS Foundation Trust. Namely the Wirral University Teaching Hospital NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Wirral University Teaching Hospital NHS Foundation Trust CiC Member shall nominate a deputy to attend Wirral University Teaching Hospital NHS Foundation Trust CiC meetings on their behalf when necessary ("Nominated Deputy").

7.3 The Nominated Deputy for Wirral University Teaching Hospital NHS Foundation Trust NHS Foundation Trust's Chief Executive shall be an Executive Director of Wirral University Teaching Hospital NHS Foundation Trust.

7.4 In the absence of the Wirral University Teaching Hospital NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Wirral University Teaching Hospital NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Wirral University Teaching Hospital NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

AND WHEN A NOMINATED DEPUTY IS ATTENDING A WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC MEETING, FOR THE PURPOSES OF THESE TERMS OF REFERENCE, THE NOMINATED DEPUTY SHALL BE INCLUDED IN THE REFERENCES TO "MEMBERS".

7.5 The chair of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall be nominated by the Wirral University Teaching Hospital NHS Foundation Trust CiC.

7.6 When the CMPC CiCs meet in common, one person nominated from the Members of the CMPC CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 NON-VOTING ATTENDEES

8.1 The Members of the other CMPC CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Wirral University Teaching Hospital NHS Foundation Trust CiC. The Wirral University Teaching Hospital NHS Foundation Trust 's Chair shall be invited to meetings of the CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMPC JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Wirral University Teaching Hospital NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMPC CiCs.

8.3 The CMPC Programme Lead shall have the right to attend the meetings of Wirral University Teaching Hospital NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMPC CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Wirral University Teaching Hospital NHS Foundation Trust CiC.

9 **MEETINGS**

9.1 Subject to paragraph 9.3 below, Wirral University Teaching Hospital NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall meet with the other CMPC CiCs as the CMPC Leadership Board in accordance with the CMPC Agreement (as set out in clause 4 of the CMPC Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMPC CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMPC Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall be confidential to the Wirral University Teaching Hospital NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Wirral University Teaching Hospital NHS Foundation Trust Board.

10 **QUORUM AND VOTING**

10.1 Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC have a responsibility for the operation of the Wirral University Teaching Hospital NHS Foundation Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall have one vote. The Wirral University Teaching Hospital NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 **CONFLICTS OF INTEREST**

11.1 Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in Wirral University Teaching Hospital NHS Foundation Trust Constitution/Standing Orders, the CMPC Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Wirral University Teaching Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

11.2 All Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall declare any new interest at the beginning of any Wirral University Teaching Hospital NHS Foundation

Trust CiC meeting and at any point during a Wirral University Teaching Hospital NHS Foundation Trust CiC meeting if relevant.

12 ATTENDANCE AT MEETINGS

12.1 Wirral University Teaching Hospital NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, Wirral University Teaching Hospital NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend Wirral University Teaching Hospital NHS Foundation Trust CiC meetings (in person) and fully participate in all Wirral University Teaching Hospital NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) i.e MS Teams or equivalent to speak to the other or others, and be heard by the other or others simultaneously.

13 ADMINISTRATIVE

13.1 Administrative support for the Wirral University Teaching Hospital NHS Foundation Trust CiC will be provided by CMPC Programme Support (or such other route as the Trusts may agree in writing). The CMPC Programme Support will:

13.1.1 draw up an annual schedule of CMPC CiC meeting dates and circulate it to the CMPC CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMPC CiC meetings; and

13.1.3 take minutes of each Wirral University Teaching Hospital NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Wirral University Teaching Hospital NHS Foundation Trust CiC meeting.

13.2 The agenda for the Wirral University Teaching Hospital NHS Foundation Trust CiC meetings shall be determined by the CMPC Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE Wirral University Teaching Hospital NHS Foundation Trust CIC

The Board of each Trust within CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Wirral University Teaching Hospital NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Wirral University Teaching Hospital NHS Foundation Trust CiC meeting with a view to Wirral University Teaching Hospital NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Wirral University Teaching Hospital NHS Foundation Trust's Board). Any proposals discussed at the Wirral University Teaching Hospital NHS Foundation Trust CiC meeting outside of these parameters would come back before Wirral University Teaching Hospital NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMPC Agreement and which may be supplemented or further defined by an annual CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to Wirral University Teaching Hospital NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMPC programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Wirral University Teaching Hospital NHS Foundation Trust CiC referred to it by the CMPC Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMPC Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMPC Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMPC priorities or programmes (including as required by any agreed CMPC annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information;

	Decisions delegated to Wirral University Teaching Hospital NHS Foundation Trust CiC
	b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMPC Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

APPENDIX 2 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one seventeenth of any professional advisers' fees incurred by and on behalf of CMPC in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMPC Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMPC and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMPC CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMPC as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMPC CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 3 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

SUGGESTION from one Trust that - Competition-sensitive information needs inclusions: How will the CMPC ensure compliance with competition law, especially in the absence of a finalised Information Sharing Protocol (Appendix 19)?

Is there a boiler plate ISA that could be provided? The CEOs (while there has been some change within the group) were mainly of the view that this was not a necessity nor deal breaker however the comment suggests to me we may be entering territory where ISA could be used as a reason not to as vs to do something

FURTHER safeguards are in place to ensure that shared data (especially financial or workforce-related) is handled in compliance with GDPR and FOIA obligations? Should a breach of data submitted by a Trust to CMPC occur who is liable. I think my response to this is the hosts of CMPC functions have to declare the breach but costs associated with CMPC activities are not borne by the host alone but by all members as this is a shared / membership endeavour? Fyi – we have 3 host employers atm

HILL DICKINSON

Draft No: 2
Date of Draft: June 2025

Dated 2025

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT

Between

(1) **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

(2) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

(3) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(4) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(5) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(6) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(7) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(9) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(10) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(11) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(12) **MERSEY CARE NHS FOUNDATION TRUST**

(13) **EAST CHESHIRE NHS TRUST**

(14) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(15) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

(16) **WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST**

and

(17) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

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1 **Introduction**

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMPC CiCs;
CMPC CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMPC CiC**" shall be interpreted accordingly.
CMPC Leadership Board	the CMPC CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMPC CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of a CMPC CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMPC as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMPC but is not forming a CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMPC CiC will be different.

1.5 The CMPC Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMPC Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident, clear and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMPC are to:

2.2.1 Deliver the CMPC vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMPC's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMPC CiCs acting through the CMPC Leadership Board.

2.5 More specifically the CMPC CiCs and the CMPC Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMPC development:

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Delivery and co-ordination of the community programme to support alignment with other programmes;

2.5.3 Further development of community based alternatives to hospital admission and standardisation of the community services offer in Cheshire and Merseyside as per the Neighbourhood health guidance;

2.5.4 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.5 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.6 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.7 Coordinating and enabling CMPC members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.8 Coordinating and enabling CMPC members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.9 Responding to and coordinating CMPC action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.10 The CMPC Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMPC will provide

both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMPC may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMPC Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMPC workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMPC will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 **Rules of working**

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMPC CiCs as the **CMPC Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMPC openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Recognising the relationship between acute, mental health, community and specialist providers ensuring that information is shared where this impacts on other sectors;

3.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.9 Recognising and respecting the collective view and keeping to any agreements made between the CMPC CiC's;

3.1.10 Maintain CMPC collective agreed position on shared decisions in all relevant communications;

3.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.12 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMPC CiCs shall meet together as the CMPC Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-18).

4.1.1 Meetings of the CMPC Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMPC Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMPC Leadership Board – Decisions to be made under the CMPC CiC delegations - CiC CEOs;

C. CMPC Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMPC CiCs shall work collaboratively with each other as the CMPC Leadership Board in relation to the committees in common model.

4.3 Each CMPC CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMPC CiC or its duty to act in the best interests of its Trust, each CMPC CiC shall seek to reach agreement with the other CMPC CiCs in the CMPC Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMPC CiCs meet in common, as the CMPC Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2026.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMPC Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMPC Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMPC Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMPC Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMPC CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMPC Leadership Board.
Matter involves or impacts all CMPC Trusts and comes within the delegation under the	Matter to be dealt with through the CMPC CiCs at the CMPC Leadership Board in

[1] Chairs will be invited to CMPC Leadership Board meetings, at least quarterly.

CMPC CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMPC Trust will report back to its own Board and the CMPC Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMPC Trust Board meetings. The CMPC Trust chairs may (as well as their quarterly CMPC meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMPC on an informal basis. In addition, the CMPC Leadership Board will seek to ensure that each CMPC programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMPC CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMPC (or if relevant, section of the meeting), may be held in public except where a resolution is agreed by the CMPC Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMPC meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Any exit plan, when required or proposed by a Trust, will be drafted for consideration by the Leadership Board with support by the CMPC DoFs. . it is a necessity that an agreed exit plan deals with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMPC CiC Chairs varying the Agreement under clause 10.6.2.

6.1.4 cost apportionment, where appropriate, will be applied on a proportionate fair shares basis

6.2 An exit plan approach is drafted shall be inserted into this Agreement at Appendix 18 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMPC CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMPC Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 19) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMPC CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMPC Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMPC Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMPC is committed to clear, consistent and transparent communication across the CMPC Trusts and with system partners' where appropriate. It is specifically recognised that CMPC Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMPC and the CMPC Trusts may be asked to represent both their own organisations and CMPC in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMPC Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMPC activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMPC across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be

inserted into this Agreement at Appendix 19 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMPC CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMPC Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMPC's decision-making processes.

9.2 The CMPC Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMPC website. It is proposed that such policies will either be CMPC developed or CMPC will support the adoption and application of the policy of the CMPC Chair and/or Meeting Lead.

9.3 All CMPC Leadership Board, committee and sub-committee members, and employees acting on behalf of CMPC, will comply with the CMPC policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMPC. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMPC Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMPC Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMPC Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMPC Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMPC CiCs at the CMPC Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMPC Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMPC Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMPC Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMPC Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMPC Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMPC Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMPC Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMPC Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 The above process (10.5) will seek to be addressed within one calendar month and no longer than 6 weeks unless, in such circumstances, as all parties agree to a longer time frame

10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMPC Leadership Board may decide to recommend their Trust's Board of Directors to:

10.7.1 terminate the Agreement;

10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.7.3 agree that the Dispute need not be resolved.

11 **Variation**

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 **Counterparts**

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **CHESHIRE AND WIRRAL PARTNERSHIP NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL COMMUNITY HEALTH AND CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1– TERMS OF REFERENCE FOR WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC

V 3-refresh June 2025

CMPC LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMPC TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE OR CMPC	THE PARTNERSHIP FORMED BY THE TRUSTS TO WORK TOGETHER TO IMPROVE QUALITY, SAFETY AND THE PATIENT EXPERIENCE; DELIVER SAFE AND SUSTAINABLE NEW MODELS OF CARE; AND MAKE COLLECTIVE EFFICIENCIES. THIS OPERATES WITHIN THE NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM.
CMPC AGREEMENT	THE JOINT WORKING AGREEMENT SIGNED BY EACH OF THE TRUSTS IN RELATION TO THEIR PROVIDER COLLABORATIVE WORKING AND THE OPERATION OF THE WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC TOGETHER WITH THE OTHER CMPC CICS;
CMPC CICS	THE TRUST CIC AND THE OTHER RESPECTIVE COMMITTEES ESTABLISHED BY EACH OF THE TRUSTS TO WORK ALONGSIDE EACH OTHER AND "**CMPC CIC**" SHALL BE INTERPRETED ACCORDINGLY;
CMPC Leadership Board	The Leadership Board is a regular meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC Leadership Board can also be used as the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference.

CMPC PROGRAMME STEERING GROUP	THE GROUP, TO PROVIDE PROGRAMME SUPPORT AND OVERSIGHT OF THE DELIVERY OF AGREED COLLABORATIVE ACTIVITIES;
CMPC PROGRAMME LEAD	NAMED LEAD OFFICER OR ANY OF SUBSEQUENT PERSON HOLDING SUCH TITLE IN RELATION TO CMPC;
CMPC PROGRAMME SUPPORT	ADMINISTRATIVE INFRASTRUCTURE SUPPORTING CMPC;
MEETING LEAD	THE CIC MEMBER NOMINATED (FROM TIME TO TIME) IN ACCORDANCE WITH PARAGRAPH 7.6 OF THESE TERMS OF REFERENCE, TO PRESIDE OVER AND RUN THE CMPC CIC MEETINGS WHEN THEY MEET IN COMMON;
MEMBER	A PERSON NOMINATED AS A MEMBER OF AN CMPC CIC IN ACCORDANCE WITH THEIR TRUST'S TERMS OF REFERENCE, AND MEMBERS SHALL BE INTERPRETED ACCORDINGLY;
NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM OR "C&M ICS"	THE INTEGRATED CARE SYSTEM (ICS) FOR CHESHIRE AND MERSEYSIDE BRINGING TOGETHER NHS ORGANISATIONS, COUNCILS, AND WIDER PARTNERS IN A DEFINED GEOGRAPHICAL AREA TO DELIVER MORE JOINED UP CARE FOR THE POPULATION.
NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE BOARD OR "C&M ICB"	THE INTEGRATED CARE BOARD (ICB) FOR CHESHIRE AND MERSEYSIDE. AN NHS ORGANISATION ESTABLISHED ON JULY 1, 2022, THAT LEADS AN INTEGRATED CARE SYSTEM (ICS). ICBS ARE RESPONSIBLE FOR PLANNING AND FUNDING MOST NHS SERVICES IN THEIR AREA, MANAGING THE NHS BUDGET, AND ENSURING SERVICES ARE IN PLACE TO MEET THE HEALTH NEEDS OF THE LOCAL POPULATION.
Wirral Community Health and Care NHS Foundation Trust CiC	THE COMMITTEE ESTABLISHED BY WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST, PURSUANT TO THESE TERMS OF REFERENCE, TO WORK ALONGSIDE THE OTHER CMPC CICS IN ACCORDANCE WITH THESE TERMS OF REFERENCE;

WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST OF ST CATHERINE'S HEALTH CENTRE, DERBY ROAD, BIRKENHEAD, WIRRAL CH42 0LQ;
TRUSTS	THE COUNTESS OF CHESTER HOSPITAL NHS FT, LIVERPOOL UNIVERSITY HOSPITALS NHS FT, WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT, WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT, THE CLATTERBRIDGE CANCER CENTRE NHS FT, LIVERPOOL HEART AND CHEST HOSPITAL NHS FT, THE WALTON CENTRE NHS FT, LIVERPOOL WOMEN'S NHS FT, ALDER HEY CHILDREN'S HOSPITAL NHS FT, EAST CHESHIRE NHS TRUST, MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST AND MID CHESHIRE HOSPITALS NHS FT, MERSEY CARE NHS FOUNDATION TRUST, BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST, CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST, WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST AND "**TRUST**" SHALL BE INTERPRETED ACCORDINGLY;
WORKING DAY	A DAY OTHER THAN A SATURDAY, SUNDAY OR PUBLIC HOLIDAY IN ENGLAND;

1.2 The Wirral Community Health and Care NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMPC to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMPC but is not forming its own CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each respective individual CMPC CiC will be different.

1.5 Each Trust has entered into the CMPC Agreement on **[DATE]** and agrees to operate its CMPC CiC in accordance with the CMPC Agreement.

2 AIMS AND OBJECTIVES OF THE WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC

2.1 The aims and objectives of the Wirral Community Health and Care NHS Foundation Trust CiC are to work with the other CMPC CiCs on system work or matters of significance as delegated to the Wirral Community Health and Care NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 Leadership

Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams.

Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.2 Delivery

Consider different employment models for service line specialities including contractual outcomes and governance arrangements;

Review the key deliverables and hold the Trusts to account for progress against agreed decisions;

Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

Establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

Improve the quality of care, safety and the patient experience delivered by the Trusts;

Deliver equality of access to the Trusts service users; and

Ensure the Trusts deliver services which are clinically and financially sustainable.

2.1.3 Collaborate

Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance;

Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board and regulator or those charged with performance management;

Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC;

Ensure compliance and due process with regulating authorities regarding service changes;

Oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.2 REVIEW THE CMPC AGREEMENT AND TERMS OF REFERENCE FOR CMPC CICS ON AT LEAST A BIENNIAL BASIS

3 ESTABLISHMENT

3.1 The Wirral Community Health and Care NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Wirral Community Health and Care NHS Foundation Trust CMAP CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Wirral Community Health and Care NHS Foundation Trust CiC.

3.2 The Wirral Community Health and Care NHS Foundation Trust CiC shall work cooperatively with the other CMPC CiCs and in accordance with the terms of the CMPC Agreement.

3.3 The Wirral Community Health and Care NHS Foundation Trust CiC is a committee of Wirral Community Health and Care NHS Foundation Trust's board of directors and therefore can only make decisions binding Wirral Community Health and Care NHS Foundation Trust. None of the Trusts other than Wirral Community Health and Care NHS Foundation Trust can be bound by a decision taken by Wirral Community Health and Care NHS Foundation Trust CiC.

3.4 The Wirral Community Health and Care NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance

for NHS Provider Trusts). The Wirral Community Health and Care NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 FUNCTIONS OF THE COMMITTEE

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Wirral Community Health and Care NHS Foundation Trust's Constitution.

4.2 Wirral Community Health and Care NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 FUNCTIONS RESERVED TO THE BOARD OF THE FOUNDATION TRUST

Any functions not delegated to the Wirral Community Health and Care NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Wirral Community Health and Care NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Wirral Community Health and Care NHS Foundation Trust to delegate functions to another committee or person.

6 REPORTING REQUIREMENTS

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Wirral Community Health and Care NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Wirral Community Health and Care NHS Foundation Trust's Board for inclusion on the private agenda of Wirral Community Health and Care NHS Foundation Trust's next Board meeting in order that Wirral Community Health and Care NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Wirral Community Health and Care NHS Foundation Trust CiC shall send the minutes of Wirral Community Health and Care NHS Foundation Trust CiC meetings to Wirral Community Health and Care NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of Wirral Community Health and Care NHS Foundation Trust's Board meeting.

6.3 Wirral Community Health and Care NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by Wirral Community Health and Care NHS Foundation Trust's Board for inclusion on the agenda of Wirral Community Health and Care NHS Foundation Trust's Board meeting.

7 MEMBERSHIP

7.1 The Wirral Community Health and Care NHS Foundation Trust CiC shall be constituted of directors of Wirral Community Health and Care NHS Foundation Trust. Namely the Wirral Community Health and Care NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Wirral Community Health and Care NHS Foundation Trust CiC Member shall nominate a deputy to attend Wirral Community Health and Care NHS Foundation Trust CiC meetings on their behalf when necessary ("Nominated Deputy").

7.3 The Nominated Deputy for Wirral Community Health and Care NHS Foundation Trust's Chief Executive shall be an Executive Director of Wirral Community Health and Care NHS Foundation Trust.

7.4 In the absence of the Wirral Community Health and Care NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Wirral Community Health and Care NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Wirral Community Health and Care NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

AND WHEN A NOMINATED DEPUTY IS ATTENDING A WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC MEETING, FOR THE PURPOSES OF THESE TERMS OF REFERENCE, THE NOMINATED DEPUTY SHALL BE INCLUDED IN THE REFERENCES TO "MEMBERS".

7.5 The chair of the Wirral Community Health and Care NHS Foundation Trust CiC shall be nominated by the Wirral Community Health and Care NHS Foundation Trust CiC.

7.6 When the CMPC CiCs meet in common, one person nominated from the Members of the CMPC CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 NON-VOTING ATTENDEES

8.1 The Members of the other CMPC CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Wirral Community Health and Care NHS Foundation Trust CiC. The Wirral Community Health and Care NHS Foundation Trust 's Chair shall be invited to meetings of the CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMPC JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Wirral Community Health and Care NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMPC CiCs.

8.3 The CMPC Programme Lead shall have the right to attend the meetings of Wirral Community Health and Care NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMPC CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Wirral Community Health and Care NHS Foundation Trust CiC.

9 **MEETINGS**

9.1 Subject to paragraph 9.3 below, Wirral Community Health and Care NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Wirral Community Health and Care NHS Foundation Trust CiC shall meet with the other CMPC CiCs as the CMPC Leadership Board in accordance with the CMPC Agreement (as set out in clause 4 of the CMPC Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMPC CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Wirral Community Health and Care NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMPC Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Wirral Community Health and Care NHS Foundation Trust CiC shall be confidential to the Wirral Community Health and Care NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Wirral Community Health and Care NHS Foundation Trust Board.

10 **QUORUM AND VOTING**

10.1 Members of the Wirral Community Health and Care NHS Foundation Trust CiC have a responsibility for the operation of the Wirral Community Health and Care NHS Foundation Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Wirral Community Health and Care NHS Foundation Trust CiC shall have one vote. The Wirral Community Health and Care NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 **CONFLICTS OF INTEREST**

11.1 Members of the Wirral Community Health and Care NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in Wirral Community Health and Care NHS Foundation Trust Constitution/Standing Orders, the CMPC Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Wirral Community Health and Care NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Wirral Community Health and Care NHS Foundation Trust CiC.

11.2 All Members of the Wirral Community Health and Care NHS Foundation Trust CiC shall declare any new interest at the beginning of any Wirral Community Health and Care NHS Foundation

Trust CiC meeting and at any point during a Wirral Community Health and Care NHS Foundation Trust CiC meeting if relevant.

12 **ATTENDANCE AT MEETINGS**

12.1 Wirral Community Health and Care NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, Wirral Community Health and Care NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend Wirral Community Health and Care NHS Foundation Trust CiC meetings (in person) and fully participate in all Wirral Community Health and Care NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Wirral Community Health and Care NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) i.e MS Teams or equivalent to speak to the other or others, and be heard by the other or others simultaneously.

13 **ADMINISTRATIVE**

13.1 Administrative support for the Wirral Community Health and Care NHS Foundation Trust CiC will be provided by CMPC Programme Support (or such other route as the Trusts may agree in writing). The CMPC Programme Support will:

13.1.1 draw up an annual schedule of CMPC CiC meeting dates and circulate it to the CMPC CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMPC CiC meetings; and

13.1.3 take minutes of each Wirral Community Health and Care NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Wirral Community Health and Care NHS Foundation Trust CiC meeting.

13.2 The agenda for the Wirral Community Health and Care NHS Foundation Trust CiC meetings shall be determined by the CMPC Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE Wirral Community Health and Care NHS Foundation Trust CIC

The Board of each Trust within CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Wirral Community Health and Care NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Wirral Community Health and Care NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Wirral Community Health and Care NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Wirral Community Health and Care NHS Foundation Trust CiC meeting with a view to Wirral Community Health and Care NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Wirral Community Health and Care NHS Foundation Trust's Board). Any proposals discussed at the Wirral Community Health and Care NHS Foundation Trust CiC meeting outside of these parameters would come back before Wirral Community Health and Care NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMPC Agreement and which may be supplemented or further defined by an annual CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to Wirral Community Health and Care NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMPC programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Wirral Community Health and Care NHS Foundation Trust CiC referred to it by the CMPC Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMPC Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMPC Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMPC priorities or programmes (including as required by any agreed CMPC annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information;

	Decisions delegated to Wirral Community Health and Care NHS Foundation Trust CiC
	b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMPC Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

APPENDIX 2 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one seventeenth of any professional advisers' fees incurred by and on behalf of CMPC in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMPC Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMPC and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMPC CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMPC as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMPC CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 3 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

SUGGESTION from one Trust that - Competition-sensitive information needs inclusions: How will the CMPC ensure compliance with competition law, especially in the absence of a finalised Information Sharing Protocol (Appendix 19)?

Is there a boiler plate ISA that could be provided? The CEOs (while there has been some change within the group) were mainly of the view that this was not a necessity nor deal breaker however the comment suggests to me we may be entering territory where ISA could be used as a reason not to as vs to do something

FURTHER safeguards are in place to ensure that shared data (especially financial or workforce-related) is handled in compliance with GDPR and FOIA obligations? Should a breach of data submitted by a Trust to CMPC occur who is liable. I think my response to this is the hosts of CMPC functions have to declare the breach but costs associated with CMPC activities are not borne by the host alone but by all members as this is a shared / membership endeavour? Fyi – we have 3 host employers atm

Public Board of Directors **Item 35**

03 September 2025

Title	Annual Declaration of Interests - Board of Directors 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

In accordance with Standing Order 8 'Declaration of Interests and Register of Interests' in the Trust's Corporate Governance Manual and General Policy 7 'GP07 - Managing Conflicts of Interest' all members of the Board of Directors must declare interests which are relevant and material on an annual basis.

The annual declaration of interests process has been completed and the register of interests for 2025-26 for all members of the Board of Directors is included at appendix 1. The register includes all newly appointed joint NEDs and any interim joint Director roles.

Where post holders have changed or left roles since the start of the financial year, and are no longer members of the Board, their interest(s) remain with a note confirming the date they left the role.

All declarations included have been approved for publication on the Trust's public website.

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.

These interests will also be reported in the Trust's Annual Report 2025-26.

In addition, at each meeting of the Board of Directors, and its committees, members are asked to declare any further interests since the date of the last declaration and to notify of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes.

It is recommended that the Board.

- Approves the register of interests for members of the Board for 2025-26
- Notes that the register, as presented, will be published on the Trust's website

Key Risks

The potential risks associated with any declared interests are considered by line managers with advice, when required from the Head of Corporate Governance or the Director of Corporate Affairs. The appropriate mitigation is put in place, and this is recorded on the declaration of interests register.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
21.8.24	Board of Directors	Annual Declaration of Interests - Board of Directors 24-25	Approved

1	Narrative
1.1	See Executive Summary above and appendix 1.

2	Implications
2.1	**Quality/Inclusion** Not applicable.
2.2	**Finance**

	None.
2.3	**Compliance** As part of the Trust's commitment to transparency and in line with NHS England guidance on Managing Conflicts of Interest and local policy, all staff identified as decision-making are required to complete a Declaration of Interests form.

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 ☐ Reducing environmental impact ☐

Wirral Community Health and Care NHS Foundation Trust

Declaration of interests - April 2025 - March 2026

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
A	Bennett	Chief Strategy Officer **Left post in August 2025*	Board	Indirect	Family member is a Communications Manager for Knowsley Council.	03/02/2020	Ongoing
C	Bentley	Non-Executive Director	Board	Financial	Professor Chris Bentley Consulting Ltd.	01/02/2019	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial Personal Interest	Orbis Programme and Medical Advisory Committee (the programme involves several countries and reviews and approves promising cancer treatments).	2018	Ongoing
C	Bentley	Non-Executive Director	Board	Financial and Professional	Visiting lecturer teaching on public health modules - Liverpool University.	2013	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial and Professional	Visiting lecturer teaching on public health modules - Sheffield Hallam University.	2010	Ongoing
C	Bentley	Non-Executive Director	Board	Non- Financial and Professional	Visiting lecturer teaching on public health modules - Sheffield University.	2009	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
C	Bentley	Non-Executive Director	Board	Non-Financial personal interest	Chairman of Trustees - Sheffield Health International Partnerships - small charity providing links between Sheffield NHS/social care and the developing world, particularly Uganda at present.	2012	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial professional	Member of the National Advisory Committee on Resource Allocation, the chair of the Technical Advisory Group. DHSC/NHS England/NHS Improvement.	2008	Ongoing
C	Bentley	Joint Non-Executive Director	Board	Financial interest / Loyalty interest	Joint Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	11/08/2025	Ongoing
R	Chapman	Interim Chief Finance Officer	Board	Financial	Non-Executive Director of Magenta Living.	08/04/2025	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
J	Chwalko	Chief Operating Officer / Interim Deputy CEO / Director of Integration & Delivery	Board	NIL	NIL.		
M	David	Non-Executive Director	Board	Non-financial	Chair of the Board - the University of Chester	01/08/2022	31/07/2025
M	David	Non-Executive Director	Board	Financial	Director of TEMD Solutions, an education leadership consultancy	01/05/2018	01/05/2025
M	David	Non-Executive Director	Board	Non-financial professional	Deputy lieutenant, Cheshire Lieutenancy	12/12/2017	19/06/2030
M	David	Non-Executive Director	Board	Financial	Chair of Governors – Furness College, Cumbria	01/06/2025	31/08/2026
M	David	Joint Non-Executive Director	Board	Financial interest / Loyalty interest	Joint Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	July 2025	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
L	Davies	Non-Executive Director	Board	Financial	Chair – Cheshire College South and West	09/01/2025	Ongoing
L	Davies	Non-Executive Director	Board	Financial	National Leader for Governance – Department for Education	01/03/2023	Ongoing
L	Davies	Joint Non-Executive Director	Board	Financial interest / Loyalty interest	Joint Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	11/08/2025	Ongoing
D	Henshaw	Chair	Board	Financial	Chair - National Museums Liverpool	01/04/2020	Ongoing
D	Henshaw	Chair	Board	Financial	Chair - Natural Resources Wales	01/04/2020	Ongoing
D	Henshaw	Chair	Board	Financial	Trust – National Museums Liverpool	01/04/2022	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
D	Henshaw	Chair	Board	Financial interest / Loyalty interest	Joint Chair of Wirral Community Health and Care NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust.	01/11/2024	Ongoing
J	Holmes	Chief Executive	Board	Financial interest / Loyalty interest	Joint CEO of Wirral Community Health and Care NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust.	11/11/2024	Ongoing
A	Hughes	Director of Corporate Affairs	Board	NIL	NIL		
S	Igoe	Non-Executive Director	Board	Financial	Chartered Accountant – Fellow of the Institute of Chartered Accountants	1988	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
S	Igoe	Non-Executive Director	Board	Financial	Non-Executive Director – Lancashire and South Cumbria ICB	01/04/2025	Ongoing
S	Igoe	Interim Non-Executive Director	Board	Financial	Interim Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	01/04/2025	30/09/25
S	Igoe	Joint Non-Executive Director	Board	Financial interest / Loyalty interest	Joint Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	01/10/25	30/09/27
R	Mehra	Interim Medical Director	Board	NIL	NIL		
D	Murphy	Chief Digital Information Officer	Board	NIL	NIL		

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
E	Robinson	Associate Non-Executive Director	Board	Financial	My substantive role as Head of Work-based Learning and Enterprise at LIMU.	03/1997	Ongoing
E	Robinson	Associate Non-Executive Director	Board	Indirect interest	Family member works at the ICB.	08/2024	Ongoing
E	Roche	Interim Medical Director **Left post in June 2025*	Board	Financial	Clinical Lead and CQC Registered Manager for One Wirral CIC.	01/04/2024	Ongoing
E	Roche	Interim Medical Director **Left post in June 2025*	Board	Non-financial professional	As Interim Medical Director I represent the Trust as a Board member of the Wirral Research Collaborative.	01/04/2024	Ongoing
E	Roche	Interim Medical Director **Left post in June 2025*	Board	Indirect interest	Family member is a Consultant in Public Health Medicine in the Cheshire & Mersey Region, and working for NHSE since June 2024.	2019	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
E	Roche	Interim Medical Director **Left post in June 2025*	Board	Financial / Indirect interest	NHSE employed appraiser of GPs. Worked for NHSE North West ad hoc role since 2016.	2016	Ongoing
P	Simpson	Chief Nurse	Board	Non-financial / personal	A family member works as an auditor at Mersey Internal Audit Agency.	01/04/2018	Ongoing
D	Smith	Joint Chief People Officer	Board	Financial	Joint Chief People Officer for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	October 2024	Ongoing
H	Sultan	Joint Non-Executive Director	Board	Financial	Joint Non-Executive Director for Wirral Community Health & Care NHS Foundation Trust and Wirral University Teaching Hospital.	16/07/2025	Ongoing
M	Swanborough	Director of Strategy & Partnership	Board	Indirect	Partner employed in management position at Manchester University NHS Foundation Trust.	01/09/2021	Ongoing

First Name	Surname	Job Title	Board / Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
M	Swanborough	Interim Joint Chief Strategy Officer	Board	Financial interest / Loyalty interest	Interim Joint Chief Strategy Officer for Wirral Community Health & Care NHS Foundation Trust & Wirral University Teaching Hospital.	04/08/2025	Ongoing

* Interest has ended, and will remain on the register for 6 months in line with the Policy GP07 Managing Conflicts of interest.