

Meeting	WUTH and WCHC Council of Governors
Date	Thursday 23 July 2026
Time	14:00
Location	Clinical Skills Lab, St Catherine's Health Centre

Agenda Item	Lead	Action
1. Welcome and Apologies for Absence	Steve Igoe	Note
2. Declarations of Interest	Steve Igoe	Note
3. Minutes of Previous Meetings	Steve Igoe	Approve
3.1) Minutes of the Previous Meeting – WUTH		
3.2) Minutes of the Previous Meeting – WCHC		
4. Action Log	Steve Igoe	Note
5. Joint Chair Update – Verbal	Steve Igoe	Note
6. Appointment of Lead Governors	Cate Herbert	Approve
7. Lead Governor Update – Verbal	Sheila Hillhouse	Note

Items for Discussion and Decision

8. Board Assurance Framework (BAF)	Cate Herbert	Note
9. Statutory Transaction Strategic Outline Case	Matthew Swanborough	Note
10. Cost Improvement Programme (CIP) and Drivers of the Deficit Update – Presentation on the day	Gareth Robinson	Note
11. Committee Updates		Note
11.1) Joint Digital Committee	Haris Sultan	
11.2) Joint Finance and Performance Committee	Meredydd David	
11.3) Joint People Committee	Lesley Davies	
11.4) Joint Quality and Safety Committee	Dr Steve Ryan	
11.5) WUTH Audit and Risk Committee	Lisa Greenhalgh	
11.6) WCHC Audit and Risk Committee	Lisa Greenhalgh	
11.7) WUTH Charitable Funds Committee	Lesley Davies	
12. Integrated Performance Report	Executive Directors	Note

Wallet Items for Information

13. Group Board of Directors Minutes	Steve Igoe	Note
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Closing Business

14. Meeting Review
15. Any other Business

Steve Igoe
Steve Igoe

- 15.1) WUTH and WCHC Nominations
Committee membership – **Verbal**

Date and Time of Next Meeting

Monday 16 November, 14:00

Meeting	WUTH Council of Governors
Date	Thursday 14 May 2025
Location	Clinical Skills Lab, St Catherine's Health Centre

Members present:

SI	Steve Igoe	Joint Chair
SH	Sheila Hillhouse	Lead Public Governor
AL	Andy Liston	Public Governor
TC	Tony Cragg	Public Governor
NW	Neil Wright	Public Governor
IH	Ian Huntley	Public Governor
DF	David Funston	Public Governor
KJ	Keith Johns	Public Governor
PB	Philipa Boston (until 16:15)	Staff Governor
AK	Anand Kamalanathan (until 16:40)	Staff Governor
ABG	Andrew Bradley-Gibbons (until 15:30)	Staff Governor

In attendance:

LD	Lesley Davies	Joint Non-Executive Director & Deputy Chair
MD	Meredydd David	Joint Non-Executive Director
JC	Dr Joanne Chwalko	Joint Chief Integration and Partnerships Officer
CB	Carla Burns	Deputy Chief People Officer (deputising for DS)
MC	Matthew Swanborough	Joint Chief Strategy Officer
MS	Mark Chidgey	Joint Chief Finance Officer
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
LC	Lynn Collins	WCHC Lead Public Governor

Apologies:

RT	Dr Robert Thompson	Deputy Lead Public Governor
MP	Dr Manoj Purohit	Public Governor
PP	Peter Peters	Public Governor
JJ	Julie Jellicoe	Staff Governor
SV	Sunil Varghese	Staff Governor
SPW	Sue Powell-Wilde	Appointed Governor
GB	Gary Bennett	Appointed Governor
SR	Dr Steve Ryan	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
LG	Lisa Greenlough	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
NS	Dr Nikki Stevenson	Joint Chief Medical Officer

CD	Chris Douglas	Joint Chief Nurse
HK	Hayley Kendall	Joint Executive Managing Director
DS	Debs Smith	Joint Chief People Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications

Agenda Item	Minutes	Action
1	Welcome and Apologies for Absence SI welcomed everyone to meeting and apologies are noted above.	
2	Declarations of Interest No new interests were declared and no other interests in relation to the agenda items were declared.	
3	Minutes of Previous Meeting The minutes of the previous meeting held on 26 February were APPROVED as an accurate record.	
4	Action Log The Council of Governors NOTED the action log.	
5	Chair's Update SI outlined the national context, referring to a recent NHSE letter clarifying the role of Governors and the NHS Modernisation Bill, noting proposed Foundation Trust reforms and decisions that may remove the requirement for a Council of Governors. SI advised that the statutory transaction remains ongoing and will provide an opportunity to review the Constitution and governance structure for the future Trust, highlighting consideration of public accountability remains important and will continue to be discussed. NW queried the position regarding the election of Governors. SI advised that elections may be paused due to cost and time considerations, with a decision to be taken nearer the scheduled election period. SI provided an update on the Hantavirus situation, noting the Trust had been contacted on Friday to lead on the response, with 22 patients having arrived, 7 discharged alongside an expectation of further guests from St Helena. SI confirmed UKSA are leading on this situation, and the Trust was providing isolation accommodation arrangements, with Liverpool Infectious Diseases supporting.	

	SH queried what Governors would say if approached by a member of the public. MC advised that information is being provided regularly via UKSA issuing public briefings via its website. CH took an action to circulate the UKSA website. MC confirmed that daily staff briefings are being held, both in person and remotely, with opportunities for questions for staff. DF raised the potential risk of infection to the public following discharge from Arrowe Park. SI confirmed that this was the responsibility of UKSA. SI further noted wider system changes, including developments within the ICB, regional chair arrangements, and NHS regional structures being merged into DCSC, emphasising the importance of maintaining strategic focus during these changes. SI confirmed that a turnaround discussion would be scheduled for the next meeting as part of development session in July. The Council of Governors NOTED the verbal update.	Cate Herbert
6	Lead Governor Update SH provided an update on ongoing engagement exercise at regional and national levels in relation to public accountability, noting that a range of methods are being explored. SH encouraged Governors to contact local MPs to seek support. SH outlined the development of a storyboard to support the narrative, which when complete would be used to facilitate discussions with NHSE, enabling Governors to present the case in relation to their role in any future arrangements. The Council of Governors NOTED the verbal update.	
7	NHS Staff Survey Results CR provided an overview of the presentation, noting the WUTH response rate decreased to 42%, below both its 2024 position and the national average (47%) and WCHC maintained a 51% response rate, but this remains below the national average (62%). CR explained of the 9 People Promise elements, 5 were significantly lower for WUTH based on statistically significant changes and for WCHC 3 were significantly lower based on the 2024 score.	

	CR set out the key areas for improvement for both Trusts and the next steps, including engagement and involvement with staff to lead and shape key actions as well feedback and action on “free text” comments. IH queried the findings from the April pulse survey and if there had been any change since the annual staff survey. CB noted the lower response rates of 10–20% but advised that the survey remained a helpful indicator for taking a general temperature check. NW commented that, across both organisations, results were lower than previous years and also below average for each Trust, stating further consideration of why this was important. CB agreed and emphasised on a renewed a focus on getting back to basics as part of the action plan. ABG highlighted concerns about the anonymous nature of the survey and cultural barriers, noting that staff may not have time or the ability to complete during their working hours. CB acknowledged this as a longstanding issue, emphasising the need to build trust, noting that staff can complete the survey on their own devices. NW reflected on the implication that some staff do not complete the survey due to fear of repercussions but noted as the response levels were low the results may not be truly reflective of the workforce. AL queried what the back-to-basics approach entailed. CR highlighted key elements including knowing your manager, addressing issues promptly, regular team meetings, one-to-ones, basic management principles, return-to-work processes, and navigating the Trust website. TC commented about the importance of communicating positive actions and improvements previously taken, referencing “you said, we said” approach. CR agreed, confirming the use of “you said, we said” examples supported by both organisational and Divisional action plans. The Council of Governors NOTED the presentation.	
8	Joint Strategy (2026-2032)	

	MS presented the Joint Strategy for 2026-2032 for WUTH and WCHC, highlighting an overview the new strategic objectives, priorities, and a delivery approach to guide the organisations over the next 6 years, emphasising integration and partnership to improve health outcomes and service sustainability. MS commented that two sets of organisational values would be maintained in the short term, with a single set to be delivered once the merger is complete. AL queried feedback from staff. MS reported a positive response, highlighting alignment with the direction of travel, including a focus on quality of care, and maximising the use of community services. IH sought clarification on the strategy milestones. MS described the approach to developing annual strategic priorities, with an Executive lead assigned to each, supported by half-yearly check-ins and year-end reviews, alongside equivalent processes within Divisions and presentation through leadership sessions. AK queried the future name of the Trusts. MS confirmed that while two names are currently in use, a new name would be created with involvement from members. SI noted the progress as a positive change and endorsed the overall direction of travel. The Council of Governors NOTED the Joint Strategy.	
9	Statutory Transaction Update MS set out the upcoming statutory transaction stages and timetable so that the two Trusts would be become. MS stated the Strategic Outline Case was due to be submitted for approval (including Governor approval) in July, followed the Full Business Case (FBC) – to begin in July 2026 and complete by October for approval (including Governors) in November, review by NHSE over the Christmas and New Year period and submission to the DHSE and Secretary of State in February/March 2027. MS added throughout this due diligence and post transaction integration plan would be developed between July and October 2026 and submitted for approval to the Trust and Governors in November and NHSE over Christmas/New Year.	

	MS stated Deloitte had been appointed to provide external support to develop the SOC and FBC with supplementary funding from the ICB. SH queried the potential use of MARS and redundancy options throughout this process. CB explained those options required exploring and was subject to funding, noting that there are robust rules governing such approaches. SI outlined the aim to establish a single organisation by April 2027, highlighting the importance of progressing the transaction promptly, while noting uncertainty regarding NHSE capacity. SI emphasised that the benefits of integration are fundamental, including addressing the underlying drivers of the deficit. The Council of Governors NOTED the presentation.	
10	Committee Updates 10.1) Audit and Risk Committee MC provided this update in the absence of LG. MC alerted members that the Committee noted the increase in ID05 reflecting staff experience and the impact of organisational change on morale and culture. This would be discussed at People Committee. The Committee endorsed the risk and associated rating. MC also alerted members that the Committee noted that the revised finance forecast represented a significant update to the position but did not change the risk score which was already high. MC alerted members that the Committee approved the Joint Standing Financial Instructions (SFIs) and recommended the SFI's to Group Board for approval. MC summarised the various "Advise" and "Assure" matters from the meeting on 13 February. Members raised no questions. 10.2) Finance Business Performance Committee MD alerted members that the Committee reviewed the month 10 position, noting the Trust reported a deficit of £32.3m to date which excluding Deficit Support Funding (DSF) which is £13.6m adverse variance to plan with the most significant change compared to	

	month 9 being the recognition of the loss of income due to the impact of the Sterile Services critical incident. MD also alerted members that as approved by the Board, the Trust has confirmed to NHSE the revised forecast outturn for 2025/26, and the most immediate risk remains the cash position. MD alerted members that urgent care performance particularly 4hr and 12hr has been significantly challenging during this period due to increased flow with this compounded due to the UECUP capital and refurbishment work underway. MD summarised the various “Advise” and “Assure” matters from the meeting on 21 January. TC queried the issues relating to sterile services and if these can be resolved. MC stated that an initial capital upgrade last year addressed the immediate infrastructure requirements, with continued investment and upgrades planned to support the longevity of the equipment. TC raised the risk relating to the availability of medicines due to national drug shortages. SI acknowledged the wider NHS shortage, including in bone cement, and confirmed that work was underway to identify high-risk drugs at regional and national level. MC noted that specific drug shortages are managed on a case-by-case basis as a national issue rather than being Trust-led, adding that price inflation has been planned for in line with NHSE guidance, though risks remain. MC further highlighted mitigation through forward purchasing of energy to address cost pressures. SH sought assurance on the level of external scrutiny applied to the financial plan submission. MC advised that there had been a response from NHSE with appropriate challenge to provider processes linked to the financial plan and confirmed continued engagement through the NHSE finance escalation process, working constructively with PwC. MC noted that NHSE understand the Trust’s position and are providing support through cash applications, and while the plan has not yet been agreed, it is considered to contain an appropriate level of challenge and improvement. 10.3) Quality Committee CH provided this update in the absence of SR.	
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	CH alerted members that the Trust had breached its agreed annual trajectory for Clostridioides difficile (C diff) infections, noting the need for continued focus on fundamental infection control procedures in addition to improving patient flow. CH also alerted members that higher-grade tissue ulcers remain a concern and, as such, will be a key component of both Trusts' quality improvement plans for 2026/27, lead through a "fundamentals of care" group. CH stated there continued to be oversight, with a weekly executive-led meeting focusing focus on patients with no criteria to reside at the Trust. CH summarised the various "Advise" and "Assure" matters from the meeting on 25 March. Members raised no questions. 10.4) People Committee LD stated this report summarised the meeting which took place in January and a further meeting had been held since. 10.5) Joint People Committee LD provided a verbal update on the 30 March meeting and alerted members that sickness absence had improved overall, although the estates staff group remained a concern. LD also alerted members that recent staff survey results had showed a decrease in satisfaction reported across several areas, and it was agreed that the action plan would be updated to reflect the shared responsibility of all Divisional teams instead of only Workforce. LD advised members that the Committee received two internal audit reports on recruitment processes and payroll transitional arrangements. LD assured members that the Committee received a detailed deep dive into CSW banding following organisational change, noting an overall reduction in sickness absence and that of the 100 CSWs initially expected to move, only five had transferred across wards, with learning identified in relation to workforce transformation. LD also assured members that good progress was also noted in relation to sexual health safety changes, with assurance provided, and it was suggested that a future Board seminar be arranged to cover this area alongside employment law.	
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	SH commented that it was encouraging to hear the positive outcome of the Clinical Support Worker (CSW) organisational change, noting the strong engagement and participation with this staff group. CB agreed and added there were lessons which had been learnt that could be incorporated into the upcoming Trust wide organisational change. SH raised the question of career prospects and the importance of providing clear interview feedback, including specific areas for improvement. LD agreed, noting the need to tighten processes to ensure staff feel empowered to act on feedback. IH queried sickness absence, including both short and long term absence linked to mental health. LD recognised that returning to work can be stressful and highlighted the importance of addressing physiological barriers and ensuring staff feel supported to return to work. IH also queried the uptake of resilience training. CB outlined available support through the employee assistance programme, staff psychologist, and occupational health, but noted the difficulty in tracking uptake and correlating this with future sickness absence trends. The Council of Governors NOTED the Committee Updates.	
11	Integrated Performance Report Members acknowledged a number of Executive Directors were absent and were encouraged to submit any questions and these would be responded to. No questions were raised. The Council of Governors NOTED	
12	Ratification of Group Governance Documents The Council of Governors RATIFIED the Group Governance Documents.	
13	Board of Directors' Minutes The Council of Governors NOTED the Board of Directors' Minutes.	
14	Meeting Review	

	Members agreed the meeting had been useful and everyone had the opportunity to contribute.	
15	Any other Business No other business was raised.	

(The meeting closed at 15:00)

Meeting	WCHC Council of Governors
Date	Thursday 14 May 2026
Location	Clinical Skills Lab, SCHC

Members present:

SI	Steve Igoe	Chair
LC	Lynn Collins	Lead Governor and Public Governor – West Wirral
JB	Jenna Brassington	Staff Governor
EC	Emma Carvell	Staff Governor
GG	Gary Grady	Staff Governor
EH	Eileen Hume	Public Governor -West Wirral
KP	Karen Prior	Appointed Governor – HealthWatch
FR	Frieda Rimmer	Public Governor- South Wirral & Neston

In attendance:

CB	Carla Burns	Deputy Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
JC	Jo Chwalko	Chief Integration & Partnerships Officer
MD	Meredydd David	Non-Executive Director & Senior Independent Director
LD	Lesley Davies	Non-Executive Director & Deputy Chair
CH	Cate Herbert	Trust Board Secretary
SH	Sheila Hillhouse	Lead Governor – WUTH (observing)
MS	Matthew Swanborough	Chief Strategy Officer
DP	Denise Powell	Executive Assistant (minutes)

Apologies:

IC	Irene Cooke	Public Governor - Birkenhead
GC	Geoffrey Caton	Public Governor – Wallasey
NF	Nicola Fletcher	Nicola Fletcher, Public Governor – South Wirral & Neston
GKH	Gary Kelly Hartley	Public Governor – Wallasey
CB	Chris Bentley	Non-Executive Director
LG	Lisa Greenhalgh	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
HS	Haris Sultan	Non-Executive Director
CD	Chris Douglas	Chief Nurse
JH	Janelle Holmes	Chief Executive
AH	Alison Hughes	Director of Corporate Affairs & Communications
HK	Hayley Kendall	Executive Managing Director
GR	Gareth Robinson	Turnaround & Transformation Director
NS	Dr Nikki Stevenson	Chief Medical Officer & Deputy Chief Executive
DS	Debs Smith	Chief People Officer

Agenda Item	Minutes	Action
1	Introductions SI welcomed everyone to the meeting and explained that a number of executive colleagues were unable to attend the meeting as they were involved in supporting the Trust's response to the repatriation of British nationals from the MV Hondius cruise ship. Apologies were noted as 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 26 February 2026 were APPROVED as an accurate record.	
4	Chair's Report SI provided the following updates: Hantavirus Response WUTH had been asked by the UK Health Security Agency (UKHSA) to accommodate a number of British nationals who had been exposed to hantavirus. WUTH was selected because of the Trust's previous response when British nationals were evacuated from Wuhan at the start of the Covid pandemic. A total of 22 guests arrived over the weekend for a 72-hour isolation period in an accommodation block on the Arrowe Park site. Two further guests had since been admitted. All guests were currently asymptomatic. Seven guests had now been discharged and 13 were undergoing testing with potential discharge in the next 10 days. The outcome for the four remaining individuals was dependent on their ability to isolate safely at home for the remaining 42-day period. If they were not able to isolate safely they would remain at WUTH. WUTH had subsequently been asked to accommodate a further 10 individuals, including a family with a 15-year-old child. SI had raised concerns regarding the absence of a national Standard Operating	

Agenda Item	Minutes	Action
	Procedure (SOP) for this type of incident and he and JH (CEO) would strongly resist any requests to open a second accommodation block to house further guests The accommodation building that was currently being used had previously housed staff and ad hoc residents who been relocated over the weekend. The building had significant known issues with the concrete flooring, asbestos and cladding and enhanced fire safety measures had been put in place to mitigate this. The building had previously been earmarked for demolition with significant cost implications. UKHSA was leading the decisions on isolation and discharge arrangements for the guests. Trust staff had been asked to provide concierge support within the 'green zone', including meal deliveries. Overtime payments were being considered for staff on an individual basis and all posts could be backfilled so that normal service delivery was not impacted. In the longer-term the CEO was negotiating external support to minimise the impact on Trust staff and service provision. EH asked whether it would have been more cost effective for the guests to self-isolate at home. SI advised that UKHSA were leading on this and it had been decided that it would be safer to monitor them in one place for 72 hours and then send discharge them to their homes if it was safe to do so. LC asked what provisions would be made for the isolating family should the adults become symptomatic. SI advised that this would be managed by UKHSA. JB advised that members of her team had been asked to support with concierge duties; JC confirmed that these staff could be backfilled so that service delivery was not impacted. KP advised that HealthWatch had received a number of queries from Wirral residents but she felt that there was a lack of visible communication from the Trusts with stakeholders. MS confirmed that all external communications were being managed by UKHSA. Governance The integration of WUTH and WCHC into a single organisation was progressing well. This would result in a single Council of Governors and a requirement to revise the Constitution.	

Agenda Item	Minutes	Action
	SI referenced a letter from NHS England (dated 6 May) which articulated the uncertainty in terms of the future of Governors, however since then the King's Speech had indicated the potential removal of Governors under the proposed legislation. SI reaffirmed his strong support for the Governor role and agreed to provide regular updates throughout the year. FR queried whether the Governor elections that were due to be held later in the year would still go ahead, in view of the associated costs. SI advised that this would be reviewed when the national guidance was clearer. EH asked if there was a consensus amongst other NHS organisation regarding the future of Governors. SH advised that the position varied across the country and she was involved in a piece of work to develop a storyboard of good practice across Cheshire and Merseyside trusts which would be submitted to NHSE as part of the review. KP advised that there was strong opposition in the House of Lords to the section of the new legislation which recommended that HealthWatch be devolved into NHS bodies. In addition the Kings Fund, Patient Association and Local Government Association had all produced reports which were supportive of the role of Governors and other independent voices. The Council of Governors NOTED the Chair's Report.	
5	NHS Staff Survey Results CB presented a summary of the Trust's NHS Staff Survey results, highlighting the following key findings: • WCHC maintained a 51% response rate this year which was positive given current challenges, also a proxy indicator of how engaged people were. • The majority of People Promise themes saw no statistically significant change, with the exception of three areas; 'Reward and Recognition'; 'We are Always Learning' and 'Staff Engagement'. • Workshops had been held with Service Directors and Corporate Service Leads to share the results, support understanding of local results and identify 'hot spot' areas and key areas of focus. • A number of feedback and engagement events had been held and more were planned. • A summary of the results had been shared as part of the All Staff Briefing in March and feedback and engagement sessions had been held with Staff Side colleagues. Further workshops were planned for FTSU Champions and staff network members.	

Agenda Item	Minutes	Action
	Key areas of focus would be improving feedback and communications, clear line management structures so that staff knew who they could go to for support and enhancing support for middle managers. EC referenced the graphic which highlighted the link between providing excellent patient care and positive staff experience. The Council of Governors NOTED the WCHC Staff Survey results.	
6	WUTH and WCHC Integration Update (Statutory Transaction) MS presented an overview of the integration of Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care (WCHC). The independent review conducted by Value Circle in 2024 had looked at collaboration opportunities across all Wirral providers and a number of opportunities were identified around integration of Urgent Care, Cardiology and MSK services, which JC was now leading on. Phase 2 of the review looked at opportunities for the integration of the acute and community trusts. A range of benefits was associated with the two organisations coming together, including improving care, stabilising fragile services, improving access, addressing health inequalities and providing value for money. A 100 day integration plan was developed with input from Governors. This covered eight key areas: governance, clinical services corporate functions, finance, workforce and culture, comms and engagement and estates. From this the Two Year Integration Plan was developed including the development of a Joint Strategy, which would be discussed at agenda item 7. A single Board and executive team had been established and there was a Partnership Agreement in place between the two Trusts. Board and committee meetings had been aligned and an Integration Management Board had been established to oversee the integration process. WCHC corporate functions had TUPE-transferred to WUTH in December 2025 and an organisational change process was ongoing which would be concluded in the summer. Work on estates integration was ongoing including a review of the 16 current sites across Wirral. The plan set out how services would be moved out of hospital into the community, starting with outpatient	

Agenda Item	Minutes	Action
	therapies services which had recently relocated to St Catherine's Health Centre. The transaction was the technical process by which the two trusts would come together and it consisted of three stages: • Strategic Outline Case (SOC) – to be submitted for approval (including Governor approval) in July • Full Business Case (FBC) – to begin in July 2026 and complete by October for approval (including Governors) in November, review by NHSE over the Christmas and New Year period and submission to the DHSE and Secretary of State in February/March 2027. • Due Diligence and Post Transaction Integration Plan – to be developed between July and October 2026 and submitted for approval to the Trust and Governors in November and NHSE over Christmas/New Year. An assessment was undertaken to determine the best type of transaction and the Board had approved the acquisition of WCHC by WUTH. The ICB had also approved the transaction and provided funding to support the process. Deloitte had been appointed to provide external support to develop the SOC and FBC. MS added that Governors would be asked to contribute to the process to agree a name for the new joint organisation. The Council of Governors NOTED the update on integration.	
7	Joint Strategy 2026 - 2032 MS presented the Joint Strategy for Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care (WCHC) which had been developed following engagement with staff, local and regional stakeholders and patients. The document set out the Strategic Objectives and Priorities for the Trusts for the next six years as well as highlighting the new vision for the organisations. The Joint Strategy also detailed the delivery approach and annual strategic priority cycle for the Board, Executives and Divisions, to ensure delivery of the Strategic Objectives and Priorities. 450 staff and a number of Governors had attended engagement sessions to develop the Strategy.	

Agenda Item	Minutes	Action
	The Strategy had been developed against the national context set out in the 10 Year Plan, including moving care from hospital to community settings, transitioning from analogue to digital and shifting the focus from sickness to prevention. It had also been aligned to the Wirral Health Plan and ICB and local authority plans. Through engagement sessions with staff the following Vision had been adopted: <i>“Together we will create healthier lives and stronger communities”</i> It had been decided to retain both sets of Trust values for the time being and carry out more in-depth organisational development work as the Trusts came together to develop a single set of values. Six key objectives had been agreed, each with between four and six strategic priorities underneath. The Strategy would be delivered through eight enabling strategies, including the Clinical Services Strategy which would include strategic priorities for each of the 38 clinical services. This work had already begun with the Cardiology and Respiratory teams. EC advised that she had taken part in the work to develop the enabling strategies and underpinning actions and had found the collaborative work with WUTH colleagues to be a very positive experience. JB suggested that staff she had spoken to at WUTH did not appear to be as aware of the integration generally as colleagues at WCHC. MS noted that WUTH was a larger organisation and it was harder to reach all staff, but he felt that engagement from WUTH staff had been strong. JC added that there had also been good engagement from WUTH colleagues at recent MSK, Cardiology and Ophthalmology events. JB asked whether this applied to teams which were not currently directly affected by integration, eg Gerontology. JC advised that when clinical services were identified for integration, pathways to other services would also be reviewed and all colleagues would be engaged with. The Council of Governors NOTED the update on the Joint Strategy	
8	Briefings from Chairs of the Committees of the Board Audit Committee, 13 February 2026 (MC on behalf of Lisa Greenhalgh)	

Agenda Item	Minutes	Action
	• The Committee noted that Board Assurance Framework Risk ID07 - <i>“Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised”</i> remained high. • The new joint Standing Financial Instructions were reviewed and recommended to Board for approval. • Internal Audit reports for 2025/26 and the External Audit Plan for 2026/27 were in development and were subsequently presented at the April meeting. • The Internal Audit follow up summary showed a good level of implementation of internal audit recommendations. • The annual review of the Going Concerns Assessment was noted. • Updated Procurement, Anti-Fraud, Bribery & Corruption and Policy Management policies were approved and an extension was approved to the Conflicts of Interest policy. Finance & Performance Committee – 20 February 2026 (MD) • At Month 10 (January 2026) WCHC reported a surplus of £4.4m ahead of plan and the Trust was confident that it would be able to achieve its target. • The financial plan had been submitted to NHSE but there was more work to do on it. WCHC’s plan was compliant. The Cost Improvement Programme target for 2026/27 would be approximately £6m. • Workforce plans were in place to reduce staff numbers across both Trusts. • The biggest risk to financial sustainability was deconstruction of the block funding approach. This was being modelled and was thought to be manageable based on the information available. • The extension on the lease for the Community Integrated Care Centre on the Clatterbridge site had expired and the Trust was awaiting a decision from the ICB on future contractual arrangements. • Of the 93 operational Key Performance Indicators, 83 were green, four were amber and six were red. Urgent Community Response performance was strong, CICC bed occupancy was high and the length of stay was the lowest ever recorded. • All risks were well managed. An internal audit report on risk management provided a Moderate overall assurance rating with five recommendations, four of which had been completed • There were three high level risks in relation to the neurodevelopmental pathway, dental inhalation sedation machines (a business case was being developed) and staffing for the clinical assessment of dysphagia referrals. • In summary MD noted continued strong performance in financial and clinical areas.	

Agenda Item	Minutes	Action
	Quality & Safety Committee – 25 March 2026 (CH on behalf of Professor Chris Bentley) • The Quality Strategy Delivery Plan was being taken forward and Quality Goals for 2026/27 had been agreed. • Work was ongoing on CQC action plans in relation the Urgent Treatment Centre and Eastham Walk-in Centre People & Culture Committee – 30 March 2026 (LD) • This was the first joint meeting of the People Committee and there was a focus on sickness absence in both Trusts. At WCHC the figure was 6.67% which was an improvement but still higher than the 5% target. There was a continued focus on managing long term absence and supporting managers to deal with sickness as this would be a key driver to reduce the financial deficit. • Staff Survey – the committee noted that perception amongst some staff that the promotion process was not fair. This would continue to be monitored. • The Safer Staffing reports for both Trusts were received. WCHC's report was very good however it was noted that two wards appeared to be slightly overstaffed and the Deputy Chief Nurse was looking into this. • The committee was assured that the Trusts had a joint Sexual Safety Policy and had made considerable headway to embed it. At WCHC 92% of staff had received training. Of the 46 elements to the Sexual Safety Framework, WCHC had no red rated elements, there were six amber rated elements and 10 green and 30 elements had been closed. Named champions were in place across both Trusts and the committee suggested that Board members also receive training via a Board seminar. • The committee looked at workforce transformation and agreed to monitor how staff were feeling about the process. EH asked whether job descriptions were being rebanded as part of the merger. CB advised that there would be a requirement to review the staffing that was needed in the new organisation and develop the appropriate job descriptions, which would then go through a consultation process and be banded in line with Agenda for Change guidance. JC added that this was an opportunity to create new roles in order to deliver integrated services. JB queried whether the new staffing structures had been decided at executive level or with input from clinicians. JC advised that clinicians would be involved and gave an example where clinical leads had designed a new job description for a manager in the Virtual Wards service.	

Agenda Item	Minutes	Action
	JB highlighted delays in recruiting to some clinical posts. JC advised that clinical 'guardrails' should be in place to avoid delays and she would pick this up with JB outside of the meeting. EC queried the colour coding of the Alert/Advise/Assure report format as she felt assured by all elements. CH advised that this was a standard report format but she would review this. The Council of Governors NOTED the briefings from Committees of the Board.	CH
9	Integrated Performance Report – February 2026 Workforce (CB) • Sickness absence was now reducing which demonstrated the impact of the actions taken by the Trust, a number of which would continue. • Bank staff utilisation had decreased and there was minimal use of agency staff. • Staff turnover was slightly above target • A number of risks which had been on the risk register for some time would be reviewed. Operational Performance (JC) • Performance was generally positive and all KPIs (Key Performance Indicators) for 0-19 services remained green • Urgent Care 4-hour performance was consistently above the 95% target and the team was working very closely with the Emergency Department at WUTH to align pathways. Eastham Walk-in Centre had now reopened following staffing challenges over the winter period. • Demand for urgent care services remained extremely high and the Trusts were working with primary care colleagues to understand why people attended ED and what alternatives were available • There were staffing challenges in a number of services but Business Continuity Plans were in place • The 2 Hour Rapid Response service was going from strength to strength. This service involved paramedics or GPs providing urgent care in patients' homes to prevent admission to hospital. Quality (CH on behalf of the Chief Nurse) • There had been a reduction in incident reporting in February but work was ongoing to understand this and an update would be provided to Board in June.	

Agenda Item	Minutes	Action
	- Overall Friends & Family Test scores had been lower than expected - EC added that performance in both of these areas had improved in April. Finance (MC) - The Trust delivered its revised Month 12 forecast for 2025/26 - WCHC's RAG (red, amber, green) rating reflected its strong financial position moving into 2026/27 - The Cost Improvement Plan target for 2026/27 was 6% The Council of Governors NOTED the performance report for February 2026.	
10	Ratification of Group Governance Documents CH asked Governors to ratify the Group Governance Documents which had been approved via electronic resolution in March and had now been implemented. The Council of Governors RATIFIED the Group Governance documents.	
11	Minutes from Board of Directors in Public The Council of Governors NOTED the minutes of the Public Board of Directors meeting on 28 January 2026.	
12	Any Other Business Board Member Appraisals CH advised Governors that Board member appraisals would be scheduled in the next few months in line with the new processes.	
13.	Meeting Review No additional points were raised.	
Date and Time of Future Meetings Council of Governors Meeting -Thursday 23 July at 11am		

The meeting closed at 2.30pm

Action Log
WUTH and WCHC Council of Governors
23 July 2026

WUTH						
No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1	14 May 2026	4	To circulate the UKSA website which referenced the latest position in regard to hantavirus	Cate Herbert	Complete.	May 2026

WCHC						
No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1	14 May 2026	8	Review format/colour coding of AAA Committee Chairs reports	Cate Herbert	Complete. This is in line with the formats of other Trusts, so no proposals to amend at this stage.	July 2026

WUTH and WCHC Council of Governors

Item 6

23 July 2026

Title	Appointment of Lead Governors
Area Lead	Ali Hughes, Joint Director of Corporate Affairs and Communications
Author	James Jackson-Ellis, Corporate Governance Officer

Purpose of the Report and Recommendation	
Report For	Approval
It is recommended that the WUTH Council of Governors: - Approve the appointment of Tony Cragg as Lead Governor, from the period 1 September 2026 to 31 March 2027. It is recommended that the WCHC Council of Governors: - Approve the appointment of Eileen Hume as Lead Governor, from the period 1 August 2026 to 31 March 2027.	

Key Points to Note
This report requests approval to appoint Tony Cragg and Eileen Hume as Lead Governors of for the WUTH Council of Governors and WCHC Council of Governors, respectively, following the end of tenure of Sheila Hillhouse in September 2026 and the resignation of Lynn Collins.

Key Risks
This report relates to these key risks: BAF Risk 7 – Failure to comply with relevant codes of governance, regulation and legislative requirements

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	No
Healthier Communities – We will drive health equity and support healthier lives	Yes

Collaboration and Partnerships – We will work as one system and one organisation	No
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
n/a			

1	Narrative
1.1	Appointment of Lead Governors The NHS Code of Governance sets out the requirement for Foundation Trusts to have in place a nominated ‘Lead Governor’. The role of the Lead Governor includes: • To take the Chair of any Council of Governors’ meeting where the Chair has a conflict of interest or is unable to attend. • To serve as a point of contact between the governors and NHSE should NHSE have concerns around leadership • To serve as a point of contact between the governors and NHSE where it would be inappropriate for the Chair to contact NHSE • To act as a liaison between the Governors and the Executive, should this be required. Proposed appointments Lynn Collins, Lead Governor for WCHC, resigned in May 2026, and Sheila Hillhouse, Lead Governor for WUTH, will reach the end of her 9 year tenure in September 2026. To address this, the Corporate Governance Team wrote to WUTH and WCHC Governors in June, asking for expressions of interest in the Lead Governor role for each Trust. The only Governors who expressed interest in the role were Tony Cragg (WUTH) and Eileen Hume (WCHC). For completeness, their statements are appended to this report. For clarity, the Lead Governor role is not a joint role, and must be maintained for each statutory Trust, as the merger has not completed and both Trusts maintain their own Council of Governors. Tenure It is proposed that both appointments will run to the end of the current financial year (March 2027). This is because the Trusts are reviewing constituency boundaries to support the statutory transaction from 1 April 2026.

2	Implications
2.1	Patients • No implications
2.2	People

	• No implications
2.3	Finance • No implications
2.4	Compliance • The NHS Code of Governance sets out the requirement for Foundation Trusts to appoint a Lead Governor

Expression of Interest for WUTH Lead Governor – Tony Cragg

Dear Chairman and Fellow Governors,

I am writing to formally declare my interest in standing for the role of Lead Governor.

Before outlining my vision for the position, I must first pay tribute to Sheila. Whoever is elected to this role will find her a remarkably hard act to follow. Sheila has been an absolute exemplar of what a Lead Governor should be. Throughout her tenure, she tirelessly ensured that all governors' voices were heard, regardless of their background or tenure, and she possessed a rare skill for facilitating consensus on complex matters. Her legacy is a cohesive, collaborative Council, and we owe her a debt of gratitude.

If elected, my aim is to build upon the strong foundations she has left behind. I believe the role of a Lead Governor is unique; in many ways, it mirrors the leadership dynamic of the Trust Chair. While our statutory duties as governors remain distinct, the Lead Governor must act as a bridge, fostering a culture of mutual respect, objective challenge, and constructive collaboration between the Council and the Board.

Beyond the strategic responsibilities, I believe a critical, yet sometimes overlooked, part of this role is pastoral. A successful Council relies on the confidence of its individual members. I view it as a core duty of the Lead Governor to mentor new governors—ensuring they have the support, guidance, and encouragement they need to quickly find their feet and contribute effectively.

I am fully committed to investing the time, energy, and collaborative spirit required to serve you all and effectively represent our Council.

Thank you for your time and consideration. I would be privileged to earn your support.

Yours sincerely,

Tony Cragg

Public Governor Bebington and Clatterbridge constituencies

Expression of Interest for WCHC Lead Governor – Eileen Hume

Dear Steve and Ali,

Please accept this letter as my formal application to stand for the role of Lead Governor at Wirral Community Health and Care NHS FT.

I have a strong track record of collaborative working, impartial decision making and upholding the Seven Principles of Public Life to help the Council of Governors navigate the challenges and opportunities ahead. As a dedicated Public Governor and passionate advocate of our local community I have served nine years (the last two as Deputy Lead Governor) at WUTH before being elected as a Public Governor at Wirral Community Health and Care NHS FT last year. I have participated as part of the nominations committee, as well as membership of both the audit and finance committees for many years at WUTH.

I have developed an understanding of the Trust's strategic goals and the operational challenges facing the newly designated Better Together partnership between WCHC NHS FT and WUTH as well as understanding the statutory responsibilities outlined in the NHSE Code of Governance for Provider Trust's.

If elected as Lead Governor, my priorities would be:

- Empower the Council of Governors: by fostering a collaborative and inclusive environment, where all Governors feel able to fulfil their statutory duties.
- Strengthen Communication: enhance engagement with our public and staff members as well as colleagues at WUTH
- Support new colleagues: act as a mentor to newly elected Governors ensuring a cohesive and unified Council of Governors
- Support the WCHC FT Board of Directors

I am committed to the Nolan Principles of Public Life and am dedicated to maintaining the transparency, integrity and collaborative culture required for this role.

Thank you for considering my application

Yours sincerely

E. M.Hume

Eileen Mitchell Hume

Public Governor - Wirral West

WUTH/WCHC Council of Governors

Item 8

23 July 2026

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

Purpose of the Report and Recommendation	
Report For	Approval
This report provides the Council of Governors with the new strategic risks in the Board Assurance Framework, following work completed by Committees of the Board during April & May 2026. It is recommended that the Council: - Note the detail shared in relation to each of the risks and the new format of the BAF agreed in April 2026 - Note that further work through the Committees of the Board will continue to monitor each of the risks	

Key Points to Note
The new Joint BAF has been developed to align with the strategic objectives as set out in the new Joint Strategy. The Group Board approved the strategic objectives on 1 April 2026. A new structure for the BAF has also been agreed which will be implemented during Q1 26-27 with input from each of the Joint Committees.

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

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

Contribution to strategic objectives:

Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	No
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

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

1	Narrative
1.1	The Group Board has in place a full Board Assurance Framework which has been developed to reflect the new Joint Strategy approved in April 2026. Each of the Joint Committees of the Group Board maintains oversight of strategic risks relevant to the duties and responsibilities of the committee. These are detailed in appendix 1 with alignment to strategic objectives, Executive Lead and committee oversight included. A new structure for the BAF 26-27 has also been developed and the Committees of the Board have reviewed the development of the detail for each strategic risk in the new format.
1.2	Of the 12 strategic risks, 9 have been reviewed by the relevant Committees as described above in the governance journey. The detail for strategic risk ID07 - <i>Failure to comply with relevant codes of governance, regulation and legislative requirements</i> is included in the attached appendix for Board review. This will have continued oversight through the Audit & Risk Committees for each statutory Board but given the committee schedule this will not meet again until September 2026. The detail for strategic risks ID09 and ID10 is not included as they will both be reviewed by the Integration Management Board in June 2026.
1.3	Of the 10 strategic risks that have been reviewed, six are currently scoring high-level. These are: ID01 - Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience (RR16). ID02 - Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience (RR16). ID03 - Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care (RR16). ID05 - Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability (RR15). ID06 - Failure to embed service transformation and deliver sustainable efficiency gains (RR15). ID11 - Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care (RR15).

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

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

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

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

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

Risk Description	Consequences	Inherent risk score (I x L)	Controls		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
			Internal	External			Planned	Progress update		
Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	- Reduced ability to provide care in the most appropriate setting, leading to poorer outcomes - Increased ambulance handover delays and emergency department breaches - Reduced system flow, impacting elective capacity and planned care recovery - Reduced patient confidence, satisfaction and overall experience - Poor experience for patients and carers, particularly for frail, elderly and high-risk groups - Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times - Increased complaints, PALS concerns and potential litigation - Reduced confidence from staff, patients and stakeholders - Reduced system flow and inefficiencies across pathways - Reduced staff morale, engagement and retention - Greater reliance on temporary staffing, impacting continuity and cost	4 x 5 (20)	1) Board and Executive oversight of UEC performance	- Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews - Integrated Performance Report - NOF segmentation tracking - CQC action plans - tracking through Board and Committees	- NHSE oversight (ECIST) - Full engagement in Tier 1 meetings - CQC inspection report(s) and on-going CQC engagement - NOF segmentation publication	4 x 4 (16)	- NOF segment 4 (WUTH) - Exit criteria from financial undertakings re: UEC performance	- New engagement arrangements with NHSE – Director of Corporate Affairs	4 x 2 (8)	
			2) Clinical triage and front-door streaming	- Clinical audit of triage/streaming outcomes - Incident reporting - Incident and complaints analysis - Patient experience feedback - Divisional Performance Reviews - EARC oversight & risk reports - Integrated Performance Report - Implementation of continuous flow model to improve egress from ED - GP streaming at front door with triage to UTC	- External clinical audits - NHSE oversight (ECIST)		- Dependency on short-term escalation measures during sustained pressure	- Development of longer-term system capacity and pathway transformation plans - Executive Managing Director		
			3) Enhanced community and intermediate care pathways	- UEC improvement programme - Integration of WUTH and and WCHC clinical services - Integration Management Board / Drivers of the deficit (integration programme)	- System flow reviews - C&M UEC improvement programme - Wirral Unscheduled Care Board					
			4) Early discharge planning and discharge to assess models	- Corridor care action plan (submitted to regional team) - Long Length of Stay (LLoS) meeting chaired by CEO - LLoS metrics and delays in discharge - Internal audit reviews - NOF segmentation tracking - Local Corridor care summit held with action plans from all areas submitted to Improvement Team	- System flow metrics		- Discharge planning effectiveness varies by pathway - Mechanism for monitoring and tracking of corridor care summit action plans	- Strengthen early discharge planning, including greater use of trusted assessor and discharge to assess models - Chief Medical Officer & Chief Nurse Officer	- Corridor care action plan includes key actions to address discharge planning - ~~Wirral Corridor care summit taking place on 29.4.26~~	

- Financial penalties or loss of income linked to performance breaches
- Increased scrutiny and intervention from regulators and system partners
- Failure to meet national urgent and emergency care standards (and impact on NOF rating)



5) Daily SITREPs and senior clinical oversight

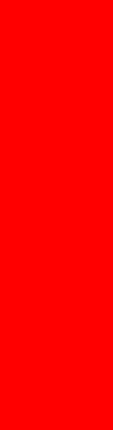
6) Patient experience monitoring and complaints management

7) Staff wellbeing and support

- Daily executive / senior leader visibility in ED
- Daily safety huddles
- Daily escalation routes
- Friends and Family Test results
- Patient Experience Strategy
- Experience of Care framework
- Sickness absence reviews
- EAP
- Clinical and professional supervision
- Rota management

- NHSE daily and weekly SITREP submissions
- Full engagement in Tier 1 meetings
- HealthWatch reviews
- National patient surveys

- NSS findings and action plans



Risk ID	02
Risk theme	Operational Effectiveness
Risk appetite	Minimal
Link to strategic objectives	Delivering Excellence - We will create the conditions for outstanding care and performance
Executive lead	Chief Medical Officer & Executive Managing Director
Committee oversight	Quality and Safety Committee Finance and Performance Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to effectively manage planned/scheduled care, adversely impacting on quality of care and patient experience	- Deterioration in patient outcomes due to delays in diagnosis and treatment - Increased clinical risk, including avoidable harm - Reduced patient confidence, satisfaction and overall experience - Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times - Increased complaints, PALS concerns and potential litigation - Reduced confidence from staff, patients and stakeholders - Failure to meet national standards and targets (e.g. RTT, cancer pathways, constitutional standards) (and impact on NOF rating) - Reduced system flow and inefficiencies across pathways - Increased pressure on unscheduled, urgent and emergency care - Reduced staff morale, engagement and retention - Greater reliance on temporary staffing, impacting continuity and cost - Financial penalties or loss of income linked to performance breaches - Increased scrutiny and intervention from regulators and system partners	4 x 5 (20)	1) Clear executive and Board oversight of planned care performance	- Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews - Integrated Performance Report - NOF segmentation tracking - CQC action plans - tracking through Board and Committees	- CQC inspection report(s) and on-going CQC engagement	4 x 4 (16)	- Exit criteria from financial undertakings re: UEC performance	- New engagement arrangements with NHSE - Director of Corporate Affairs	- Regional oversight from June 2026	4 x 3 (12)	
			2) Demand and capacity modelling to inform activity planning	- BI reports - Divisional Access & Performance meetings - Integrated Performance Report - Divisional Performance Reviews (WUTH) - Integrated Performance Board (WCHC) - Utilisation of insourcing and LLP to provide capacity to achieve new national targets - EARC oversight & risk reports (WUTH) - NOF segmentation tracking	- NOF segmentation publication		- NOF segment 4 (WUTH)				
			3) Robust waiting list management and validation processes	- RTT and waiting list reports	- NOF segmentation publication		- NOF segment 4 (WUTH) - Learning from complaints, incidents and	- Strengthen triangulation of quality			

		- Waiting list validation audits - Waiting List Health Inequalities Tool (WCHC) - Divisional Performance Reviews		patient feedback not consistently embedded	intelligence - Chief Nursing Officer	
	4) End-to-end pathway management			- Inconsistent clinical prioritisation across pathways	- Standardisation and audit of, clinical prioritisation criteria across all planned care pathways - Chief Medical Officer & Chief Nursing Officer	
	5) Workforce planning and job planning aligned to planned care demand	- Workforce and job planning reports - Productivity and compliance data - Theatre and clinic utilisation reports - Utilisation of insourcing and LLP to provide capacity to achieve new national targets		- Limited workforce flexibility to meet demand	- Job plan reviews - Executive Managing Director & Chief Medical Officer	
	6) Clinical quality monitoring across planned care pathways	- Clinical harm reviews for long wait patients - Incidents, complaints and patient experience reports - Clinical audit reviews	- National clinical audits - CQC inspection reports			
	4) Early discharge planning and discharge to assess models	- Corridor care action plan (submitted to regional team) - Long Length of Stay (LloS) meeting chaired by CEO - LLoS metrics and delays in discharge - Internal audit reviews - NOF segmentation tracking - Local Corridor care summit held with action plans from all areas submitted to Improvement Team	- System flow metrics	- Discharge planning effectiveness varies by pathway - Mechanism for monitoring and tracking corridor care summit action plan	- Strengthen early discharge planning, including greater use of trusted assessor and discharge to assess models – Chief Medical Officer and Chief Nurse Officer	- Corridor care action plan includes key actions to address discharge planning

Risk ID	03										
Risk theme	Workforce										
Risk appetite	Seek										
Link to strategic objectives	Our People – We will nurture an inclusive, compassionate culture where people thrive										
Executive lead	Chief People Officer										
Committee oversight	People Committee										
Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care.	- Poor quality of care and compromised patient safety	4 x 4 (16)	1) Clear board accountability and reporting	- Named Executive Leads accountable for Workforce Performance	- Regional oversight arrangements	4 x 4 (16)	- NOF segment 4 – WUTH	- Single IPR in development		3 x 2 (6)	
	- Reduced staff morale, engagement and productivity			- Clear reporting and escalation routes through Board and relevant committees (WSB, People)	- Board Assurance Statements		- NOF segment 1 – WCHC	- Governance arrangements sub-committee under review in WUTH and WCHC			
	- Increased staff turnover			- Workforce metrics reported through Integrated Performance Report			- Single reporting arrangements across both Trusts				
	- Over-reliance on temporary staffing			- Drivers of the Deficit Governance Structure							
	- Loss of income										
	- Loss of confidence from patients, staff, partners and commissioners		2) Workforce Planning Processes in place	- Triangulation of workforce plan to financial and activity plans	- Board Assurance Statements		- National shortages in certain roles				
	- Reduced system and stakeholder trust in the Trust's leadership and governance			- Divisional Performance Reviews	- Internal audit reports on workforce processes (ESR, data quality)		- Staff turnover rates remain above Trust target				
				- Establishment & Pay Control Panel (EPCP) in place with Executive / CEO chair	- NHSE workforce and planning submissions		- NHSE considered Trust medium-term financial plan to be non-compliant				
				- CPO is SRO for the Sickness Absence Programme (Drivers of the Deficit)	- Model hospital - peer benchmarking						
			3) Staff Experience & Staff Engagement	- People Experience Team	- National staff survey results		- Sickness absence remains above Trust target (links to drivers of the deficit)				
				- NSS action plans	- CQC inspection findings (WCHC – WIC/UTC; WUTH – Medicine & ED)		- Drivers of the Deficit Programme planned actions with identified risks				
				- Pulse surveys							
				- Health & Wellbeing Support (inc. psychological support, absence management)							

		- FTSU arrangements & network (reporting to People Committee & Board) - Appraisal completion rates - 'Well, WUTH/WCHC' programme to support return to work - HR policies and procedures including flexible working - Employee recognition scheme - New Partnership Agreement launched with Staff Side (WUTH)		- Impact of corporate services organisational change - NSS action plans on staff engagement	- Phase 2 of corporate service organisational change in progress	
	4) Strategic Organisational Development programmes in place	- Leadership development programme (for all levels) aligned to LQF - Mandatory training compliance monitoring - Continuous professional development frameworks - Talent management and succession planning	- National staff survey results - Professional regulatory requirements and accreditation standards			
	5) Equality, Diversity & Inclusion (EDI) Strategy in place	- WRES and WDES action plans - Inclusive recruitment practices - Engaged staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter				

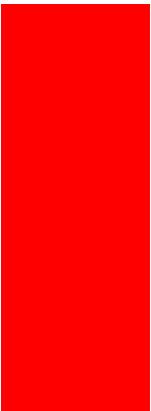
Risk ID	04
Risk theme	Workforce
Risk Appetite	Seek
Link to strategic objectives	Our People – We will nurture an inclusive, compassionate culture where people thrive
Executive Lead	Chief People Officer
Committee oversight	People Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls		Board Assurance		Current risk score (I x L)	Gaps in control / assurance		Actions		Target risk score (I x L)	Estimated date of achievement of risk score
			Internal	External	Planned	Progress update							
Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported	- Poor quality of care and compromised patient safety	3 x 4 (12)	1) Clear board accountability and reporting	- Named Executive Leads accountable for Workforce Performance	- Regional oversight arrangements	3 x 4 (12)	- NOF segment 4 – WUTH			3 x 2 (6)			
	- Reduced staff morale, engagement and productivity			- Clear reporting and escalation routes through Board and relevant committees (WSB, People)	- Board Assurance Statements		- NOF segment 1 – WCHC						
	- Increased staff sickness			- Use of culture metrics and KPIs (e.g., engagement scores, FTSU data, turnover, absence) via IPR									
	- Increased staff turnover		2) Staff Experience & Staff Engagement	- Strong FTSU arrangements (inc. policy) and Guardian	- National staff survey results		- Consistent approach to co-production and staff involvement in decision-making					- Phase 2 of corporate services organisational change in progress	
	- Widening inequalities in staff experience and progression			- Structured staff networks influencing policy	- Full understanding of the experience of multi-cultural staff across the Trust								
	- Poor learning culture			- New Partnership Agreement launched with Staff Side (WUTH)	- NSS action plans on staff engagement								
	- Loss of income			- Clear and consistent communication on values and behaviours	- Impact of corporate services organisational change								
	- Loss of confidence from patients, staff, partners and commissioners		- Employee recognition scheme										
	- Reduced system and stakeholder trust in the Trust’s leadership and governance		- Internal communications plan to support Better Together – integration programme										
	- Failure to embed NHS People Plan priorities		- NHSE Staff Experience Assessment Framework implemented										
3) Clear commitment to Equality, Diversity & Inclusion	- EDI strategy aligned to WRES, WDES and NHS People Plan	- EDS completed (jointly) with overall attainment level – Achieving	- Further development of staff networks										
	- EDI dashboard reviewed at EDI Steering Group (via PCOG)		- Deliver all actions from WRES action plan										
	- Coaching Hub established		- Deliver all actions from WDES action plan										

		- Monitoring of workforce inequalities - EDI mandatory training - Engaged staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter		
	4) Staff wellbeing and support offer	- Comprehensive offer to all staff including mental health support, occupational health, flexible working - Proactive management of safe staffing levels		
	5) Fair People Management Practices	- FFT scores (demonstrating patient satisfaction) - Transparent and fair HR policies and processes - Appraisal rate and supervision compliance monitoring - New Partnership Agreement launched with Staff Side (WUTH) - Restorative and just culture principles embedded as BAU - PSIRF policy in place	- Impact of organisational change (integration programme aligned to statutory transaction)	

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

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability	- Financial sustainability and damage to the Trusts reputations - Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions - Reduced flexibility to respond to operational pressures and demands - Declining staff morale and engagement - Reduced capacity to invest in workforce productivity and wellbeing initiatives - Reduced confidence from staff, patients and stakeholders	5 x 4 (20)	1) Financial planning and financial governance arrangements	- New Joint Finance Committee ToRs - Standing agenda item (private board) on delivery to plan - Director of Transformation & Turnaround in post - Clear executive accountability	- MIAA grip and control review (moderate assurance)	5 x 3 (15)	- WUTH in financial undertakings - CIP and financial performance accountability not consistently embedded at divisional and budget-holder level	- Engagement with NHSE to define the metrics to remove all undertakings - DCA / CFO - Regional oversight arrangements to be confirmed - DCA / CFO - Implementation of recommendations from MIAA grip and control review - CFO	- Meeting with NHSE on 22 April 2026	5 x 2 (10)	March 2027
			2) Board approved three-year MTFP aligned to system and ICB assumptions / priorities	- Resubmitted plans agreed with NHSE - Board Assurance statements confirming triangulation between workforce, finance and operational delivery - Board papers and minutes - Triangulation with workforce, finance and operations - Voluntary redundancy scheme approved by Board <i>(for specific, targeted areas)</i>	- Alignment of plans with ICB / monitored via FPRM process - Full engagement in monthly FPRM process - NHSE support for redundancy funding - Voluntary redundancy scheme approved by NHSE		- Limited ability to influence system decisions that affect long-term affordability - ICB support for decommissioning plans - NHSE support accelerate statutory transaction - Resubmitted plans have a combined gap to national control totals of £14.9m	- Regional oversight arrangements to be confirmed - DCA / CFO			
			3) Annual budget setting process aligned to MTFP trajectory					- MiAA costing review agreed through internal audit plan – CFO			
			4) Annual CIP plan with defined CIP governance	- Productivity Improvement Board monitoring CIP delivery including risks to service (chaired by CEO) - Drivers of the Deficit Programme Board reset with agreed business rhythm - Weekly CIP Assurance Group - Clinical guardrails agreed with Board - Triangulation between finance, quality and operational performance when approving or revising CIPs - People Committee tracking			-CIP schemes not sufficiently developed early in the financial year, reducing deliverability - Over-reliance on non-recurrent savings or high-risk schemes - Organisational capacity to deliver the scale of the programme - CIP implementation in divisions and against drivers of the deficit (moving from identification)	- (DoD) Programme Board sign off of current project plans – May/June 2026			



5) Clear financial KPIs with regular oversight

6) Cost pressure mitigations

delivery of the workforce plan

- Director of Transformation & Turnaround in post
- EPCP with enhanced controls in place (chaired by CEO)
- CIP SOP developed
- Monthly IPR reporting to Board
- Tracking of NOF metrics

- NOF metrics



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

Risk Description	Consequences	Inherent risk score (I x L)	Controls		Board Assurance	Current risk score (I x L)	Gaps in control / assurance		Actions		Target risk score (I x L)	Estimated date of achievement of risk score
			Internal	External			Planned	Progress update				
Failure to embed service transformation and deliver sustainable efficiency gains	- Financial sustainability and damage to the Trusts reputations - Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions - Reduced flexibility to respond to operational pressures and demands - Inability to deliver the Trust’s strategic objectives and transformation ambitions - Declining staff morale and engagement - Reduced capacity to invest in workforce productivity and wellbeing initiatives - Reduced confidence from staff, patients and stakeholders	5 x 4 (20)	1) Strategic leadership and governance	- Director of Transformation & Turnaround in post - New Joint Finance Committee ToRs - Clear executive accountability - Board and committee papers and minutes evidencing regular review of the programme - Productivity Improvement Board monitoring CIP delivery including risks to service	- Alignment of transformation plans with ICB/system priorities and programmes - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)	5 x 3 (15)	- Regular programme of board visibility	- Standing agenda item on private to provide Board with monthly updates on delivery of transformation / CIP programmes - DTT & DCA	- In progress from May 2026	5 x 2 (10)		
			2) Programme and portfolio management	- PMO assurance reports and use of programme dashboards (PIDs) - Clinical guardrails agreed with Board - Escalation reports to Productivity Improvement Board - Productivity improvements tracked as transformation benefits	- Full engagement in monthly FPRM process - Internal audit plan							
			3) Financial and benefits realisation controls 4) Integrated quality and safety controls	- Executive oversight and SRO for all CIP schemes / drivers of the deficit - New Joint Quality Committee ToRs - Quality & Equality Impact Assessments approved and monitored through Quality Committee - Clinical guardrails agreed with Board - Share oversight of strategic risks (ID01 and ID02) between Quality and Finance Committee related to service delivery - Monthly IPR reporting to Board - Tracking of NOF metrics	- MIAA grip and control review (moderate assurance) - NOF metrics - On-going and proactive engagement with CQC - On-going and proactive engagemne with ECIST - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)		- Limited real-time quality monitoring linked to transformation activity.	- Implementation of recommendations from MIAA grip and control review - CFO - Quality Committee oversight of transformation-related change and outcomes to be strengthened - DTT & CNO/CMO				

	5) Workforce and operational controls	- New Joint People Committee ToRs - Workforce report tracking People metrics - EPCP with enhanced controls in place (chaired by CEO)	- Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)		
	6) Performance management and reporting	- New Joint Finance Committee ToRs - Integrated Performance Report to Board tracking progress against efficiency metrics	- Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements - Internal Audit reviews focused on delivery effectiveness and benefits sustainability.		

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

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

	3)	Compliance with relevant codes of governance, regulation and legislative requirements	- Annual report - Code of Governance compliance (via Audit Committee) - Provider licence compliance (via Audit Committee) - Tracking of progress against NHSE enforcement undertakings	- External Audit oversight arrangements		- NHSE enforcement undertakings remain in place - Full implementation of revised regional oversight arrangements with NHSE - Board review of Board Assurance Statements - Compliance with FOIs and SARs reported to Board of Directors - Refresh of CQC preparedness programme	- Engagement with NHSE is on-going via FPRM meetings and new arrangements are being confirmed in place - FOI and SAR plans in place - CQC well-led reviews	- New oversight arrangements expected to take effect from July 2026 inc. tracking of progress against undertakings		July 2026
	4)	Partnership Governance (Wirral & CMPC)	- CEO Lead in CMPC - Wirral Provider Alliance established - Joint Chief Integration & Partnerships Officer leading WPA -	- CMPC Leadership Board updates to Board of Directors		- Place governance arrangements to reflect changing ICB designation and evolving role of HWB	- Revised Place governance to be discussed with local partners including LA - Revised Wirral Provider Alliance governance arrangements to be developed and agreed	- Both actions are in progress with local partners		September 2026

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

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities.	- Poor patient outcomes, particularly for vulnerable or underserved populations - Widening health inequalities across the population - Reduced patient experience, trust, and engagement - Failure to meet statutory duties (e.g. Equality Act, Health Inequalities duties) - Reputational damage locally and nationally - Increased demand on urgent/emergency care due to unmet need - Inefficient use of resources due to poorly targeted services - Adverse regulatory scrutiny (e.g. CQC findings)	4 x 3 (12)	1)	Clear board accountability and reporting	- Named Executive Lead accountable for Health Inequalities - Quality governance structures - Clear reporting and escalation routes through Board and relevant committees (Quality & Safety) - Reporting on inequalities metrics (access, outcomes, experience via PSQB/SOG) - Inclusion Annual Report (WCHC) - Joint Quality priorities	- Regional oversight arrangements - Board Assurance Statements - Audit programmes (clinical audit, equality audits, service reviews)	4 x 3 (12)	- NOF segment 4 (WUTH) including access to services metrics - Inconsistencies in data access, reporting and insight limiting proactive population health management and improvement - Performance dashboards with segmentation by protected characteristics and deprivation	- Improve data quality and insight	4 x 2 (8)	
			2)	Clear commitment to Equality, Diversity & Inclusion	- EDI strategy - EDI dashboard reviewed at EDI Steering Group (via PCOG)	- EDS completed (jointly) with overall attainment level – Achieving - National benchmarking data (e.g. Core20PLUS5, NHS England metrics)		- Embed health inequalities impact assessment into all strategic and operational decisions - Inconsistencies in data access, reporting and insight limit proactive population health management and improvement.			
			3)	Patient and public involvement frameworks	- Patient experience data (FFT, complaints, engagement feedback)	- CQC inspection reports (WCHC and WUTH 2025) - Compliance with AIS		- Completion of all associated actions in CQC action plans (WCHC and WUTH 2025)	- Develop and implement a clear Health Inequalities Improvement Plan aligned to		

		- Health Inequalities Waiting List Tool in place (WCHC) - Your Voice Group (WCHC) - Councils of Governors				- national priorities (e.g. Core20PLUS5) - Further embed waiting list tool	
	4) Impact assessments	- Equality Impact Assessments / Health Inequalities Impact Assessments - EIA/QEIA Standard Operating Procedures	- Audit programmes (clinical audit, equality audits, service reviews)				
	5) Workforce training	- Training in cultural competence and inclusive practice		- Lack of staff confidence in accessing and interpreting health inequalities data -	- Enhance workforce training and leadership capability in population health and inclusion		
	6) System collaboration	- Evolving trusted relationships with system partners (primary care, VCSFE, local authority) to support population health approaches - Chief Integration Officer member of JTEG with local authority - New joint strategy aligns with Cheshire and Merseyside's <i>All Together Fairer: Our Health & Care Partnership Plan 2024-29</i>	- Wirral Provider Alliance (WPA) with a shared purpose - <i>Working in partnership for better health and care in Wirral</i> - CMPC blueprint / provider strategy - National benchmarking data (e.g. Core20PLUS5, NHS England metrics)	- Fragmentation across system partners - Agreement of future governance arrangements for the WPA to support neighbourhood approaches and strategic commissioning	- Wirral-wide approach to neighbourhood development plans including multiple partners	- WPA governance review in progress	

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

Risk Description	Consequences	Inherent risk score (I x L)	Controls		Board Assurance	Current risk score (I x L)	Gaps in control / assurance		Actions		Target risk score (I x L)	Estimated date of achievement of risk score
			Internal	External					Planned	Progress update		
Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care	- Poor quality of care and compromised patient safety - Disruption to clinical systems - Reduced access to patient information - Inability to sustain critical services (due to loss of IT, estates or digital infrastructure) - Breach of data protection legislation and IG requirements leading to potential financial penalties and reputational damage - Enforcement action - Reduced staff productivity - Reduced staff morale - Loss of income - Loss of confidence from patients, staff, partners and commissioners - Reduced system and stakeholder trust in the Trust's leadership and governance	5 x 4 (20)	1) Clear board accountability and reporting	- Named Executive Leads accountable for digital, cyber security, estates and business continuity - i.e., SIRO, CIO, EPRR - Clear reporting and escalation routes through Board and relevant committees (Audit, Quality and Finance)		5 x 3 (15)	- Board approved Digital Strategy	- Finalise Digital Strategy		- Enabling strategy to be completed in H2, 26-27	5 x 2 (10)	
			2) Cyber Security Controls - implementation of nationally mandated cyber security standards and controls	- Compliance with NHS Data Security and Protection Toolkit (DSPT) requirements via self-assessment	- Internal audit plan covering cyber security controls, access management and patching compliance - NHS England / national cyber assurance feedback - External penetration testing or cyber maturity assessments							
			3) Business continuity and disaster recovery	- Capital programme reporting evidencing investment in resilience and critical infrastructure - Business Continuity and Disaster Recovery plans - Records of regular testing and exercising (table-top and live tests) - Post-incident and post-exercise reviews	- Internal audit review of BCP and disaster recovery arrangements - <i>moderate assurance</i>							

		evidencing learning and improvement		
	4) Data Protection and Information Governance	- SIRO / Information Governance Annual Report to the Board - Mandatory IG training compliance reports for staff	- Internal Audit Reviews of Digital Governance - Digital Maturity Assessment and benchmarking outcomes - Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements) - Internal audit plan testing of controls and processes in place	
	5) Third party and supplier controls	- Contract management processes confirming inclusion of cyber and BCP requirements - Supplier assurance documentation (SOC reports, compliance statements) - Regular review of critical supplier risk registers	- System / national assurance of shared or hosted platforms	
	6) System and external alignment / collaboration	- Reports evidencing participation in system-wide cyber and resilience groups (CMPC)	- Inclusion in national or regional resilience programmes	

Risk	12											
Risk theme	Data & Digital											
Risk appetite	Seek											
Link to strategic objectives	Advance Digitally - We will develop a secure, connected digital ecosystem fit for the future											
Executive lead	Chief Finance Officer / SIRO											
Committee oversight	Digital Committee											
Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance		Actions		Target risk score (I x L)	Estimated date of achievement of risk score
Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively	- Reliance on systems that are not fit for purpose impacting on service quality and patient - Reduced level of skills in the workforce - Insecurities within systems present vulnerability to cyber-attacks - Poor staff experience	4 x 4 (16)	1) Exeutive and Board Oversight of Digital and Information Risk	- Defined accountability through the SIRO, CIO/ CNIO - SIRO responsibility included JD - SIRO reports to Board and CIO attends Board - New Joint Digital Committee established ot oversee digital delivery and risk - BAF oversight (ID12) by Joint Digital Committee - Digital Governance arrangements established with minutes and action log tracking - Annual Information Governance Annual Report / Statement	- SIRO network and annual training	4 x 3 (12)	- Board approved Digital Strategy to align with new Joint Strategy - Digital Strategy delivery roadmap - Alignment to MTFP - Capital constraints impacting pace of delivery	- New strategy to be developed as part of the programme of work to develop enabling strategies - CFO	- Project scope for Q1, 26-27	4 x 2 (8)		
			2) Existing digital infrastructure is NHS compliant	- Business continuity and disaster recovery plans - DSPT / CAF self-assessment and improvement plan - Penetration testing and vulnerability assessment reports - DPIAs - IG audit findings	- Internal Audit Reviews of Digital Governance - Digital Maturity Assessment and benchmarking outcomes - Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements) - Internal audit plan testing of controls and processes in place		- Legacy infrastructure increasing security and resilience risk					

	3) Digital Programme and Change Management processes	- Digital programmes governed through project and clinical safety frameworks - Gateway reviews and post-implementation reviews - Programme and project dashboards with RAG status	- Supplier performance reports and SLA monitoring		- Programme capacity - End user engagement	
	4) Workforce capability and digital skills	- Training completion data (e.g. IG)			- Trust-wide digital skills framework (variable digital confidence) - Staff survey results relating to digital confidence and usability - Feedback from digital champions	

WUTH and WCHC Council of Governors

Item 9

23 July 2026

Title	Statutory Transaction Strategic Outline Case (SOC)
Area Lead	Matthew Swanborough, Chief Strategy Officer
Author	Matthew Swanborough, Chief Strategy Officer

Purpose of the Report and Recommendation	
Report For	Approval
It is recommended that the WUTH Council of Governors: - Note the Transaction Strategic Outline Case It is recommended that the WCHC Council of Governors: - Note the Transaction Strategic Outline Case	

Key Points to Note
In late April 2026, the Trusts commenced the development of the Strategic Outline Case (SOC) for the transaction between Wirral University Teaching Hospital and Wirral Community Health and Care NHS FT and move to a single organisational form. This followed the appointment of Deloitte in late April 2026, to support the Trust in delivering the transaction. In line with the NHSE Statutory Transaction Guidance, the first stage requirement is the completion of a Transaction Strategic Outline Case for review and approval by NHSE. The attached Transaction Strategic Outline Case (SOC) sets out the background and context, case for change, options for collaboration, vision for the new Trust, strategic benefits, financial case, deliverability, transition planning and engagement. This Case was approved by Group Board on the 1st July 2026.

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):
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Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Governance journey			
Date	Forum	Report Title	Purpose/Decision
22 nd June 2026	Transaction Task and Finish Group	Transaction Strategic Outline Case	Approved
23 rd June 2026	Integration Management Group	Transaction Strategic Outline Case	Approved
1 st July 2026	Group Board in Private	Transaction Strategic Outline Case	Approved

	Narrative
1.1	Background • In April 2025, the Trusts examined the future organisational forms for WCHC and WUTH, with the Trust Boards approving the move to a single organisation, through an NHSE transaction process. • This was based on the further delivery of clinical, quality and population benefits for the organisations and the direction of travel for many NHS Foundation Trusts who have, initially, put in place joint leadership or group arrangements. • It was noted that the transaction process would take time, with a number of stages including the development of the Strategic Outline Case (SOC) and Full Business Cases (FBC), ensuring adherence to NHSE Statutory Transaction Guidance and HM Treasury Green Book standards. • As part of this process, the Trusts set out a proposed timeline for the transaction, with an aim to commence as a new Foundation Trust by Q1 (April-June) 2027/28. • Examination of the transaction process identified the need for resourcing and expertise across the stages, specifically relating to Strategic Outline Case and Full Business Case development, due diligence and Post Transaction Integration Planning.

	• In September 2025, WCHC/WUTH gained support from Cheshire and Merseyside ICB Board, to proceed with the Transaction and for ICB funded external consultancy and legal support across the transaction stages. • In April 2026, the Trusts appointed Deloitte LLP to support with the delivery of the Transaction. To support Deloitte with the Transaction, a Task and Finish Group has been established, meeting monthly, with a detailed programme plan developed setting out the transaction process and planned approval by April 2027.
1.2	Transaction Strategic Outline Case development • In line with the NHSE Transaction Guidance, the first stage requirement is the development of a Transaction Strategic Outline Case. • Deloitte LLP have supported the Trusts in developing the SOC. This approach has included Executive and Board interviews, engagement sessions with Task and Finish Group members, information and document review, analysis and case construction.
1.3	Transaction Strategic Outline Case • The attached Transaction Strategic Outline Case, set out over 13 chapters, presents the rationale for the integration of Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) into a single, unified organisation. • The new entity will be dedicated to creating healthier lives and stronger communities across Wirral, delivering comprehensive, seamless health and care services across the full care continuum. Currently, both Trusts operate independently, which has presented challenges in delivering truly integrated care pathways and optimising resource allocation. • The document demonstrates how a unified organisation will effectively address these issues, leveraging combined strengths and expertise to enhance patient experience, improve health outcomes, and ensure long-term sustainability within the Wirral health economy. • Its primary purpose is to secure approval for proceeding with the development of a Full Business Case (FBC), undertaking Due Diligence (DD) and completing further integration planning and delivery.

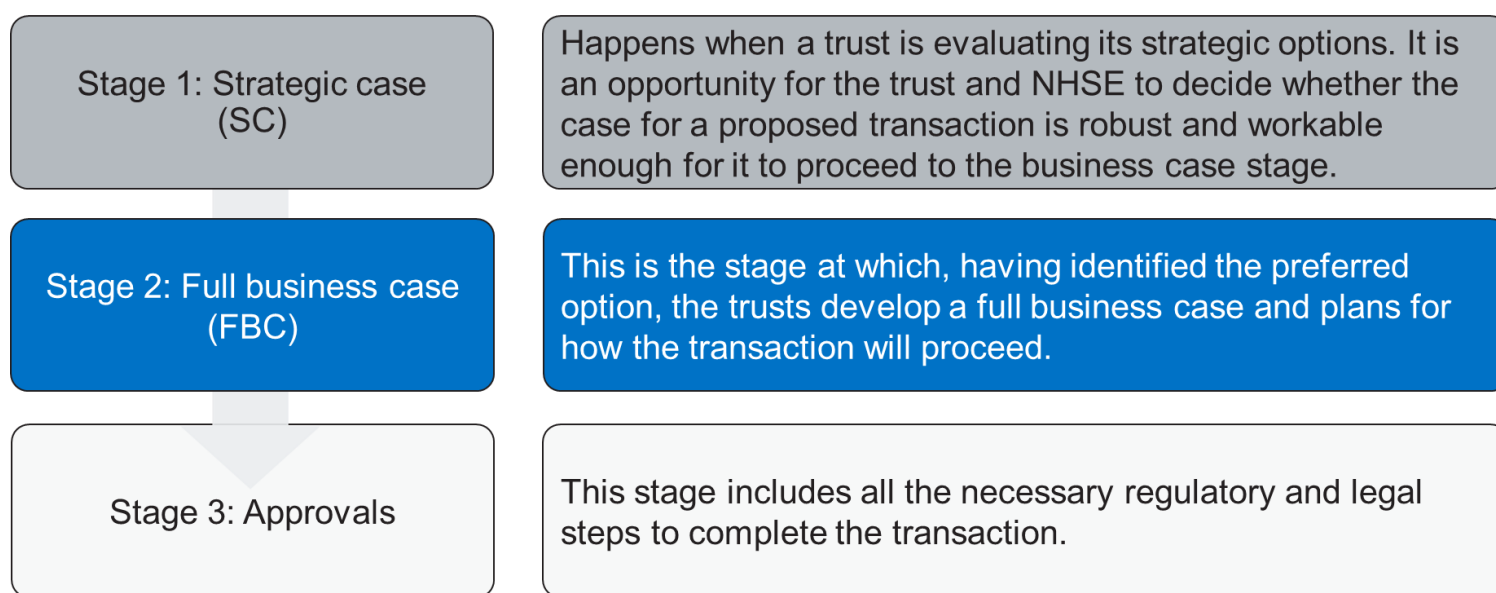
Strategic Outline Case (SOC)

Summary: Overview of key points

The integration of WCHC and WUTH

June 2026

NHS England Process Overview: Three Stages of a Transaction Business Case



We are currently at the **Strategic Outline Case (SOC)** stage of the process. A final draft of the document has been produced and is ready for review by the Board. When approved, it will be shared with NHS England.

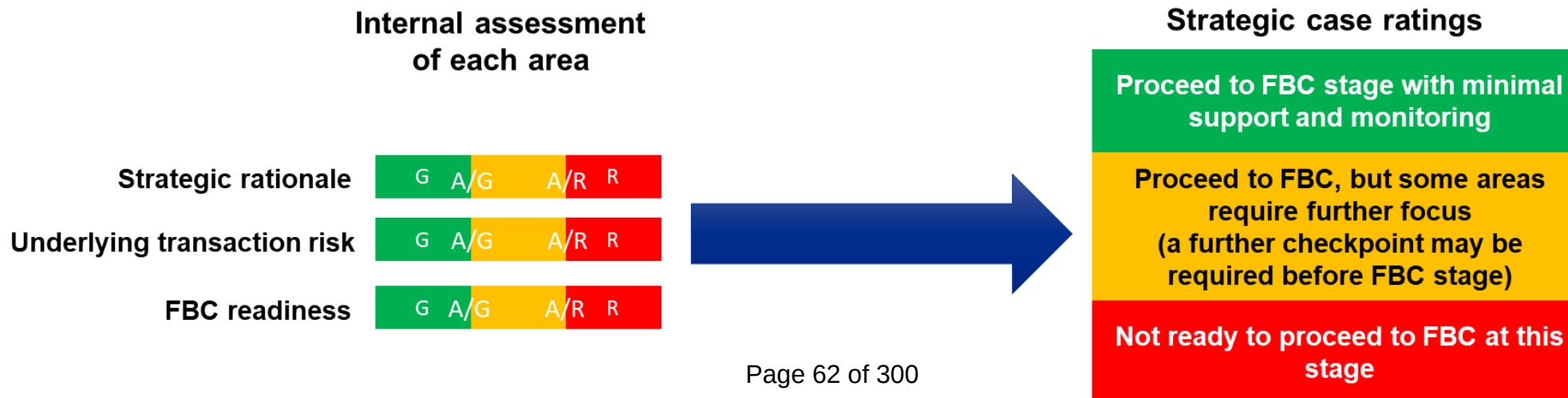
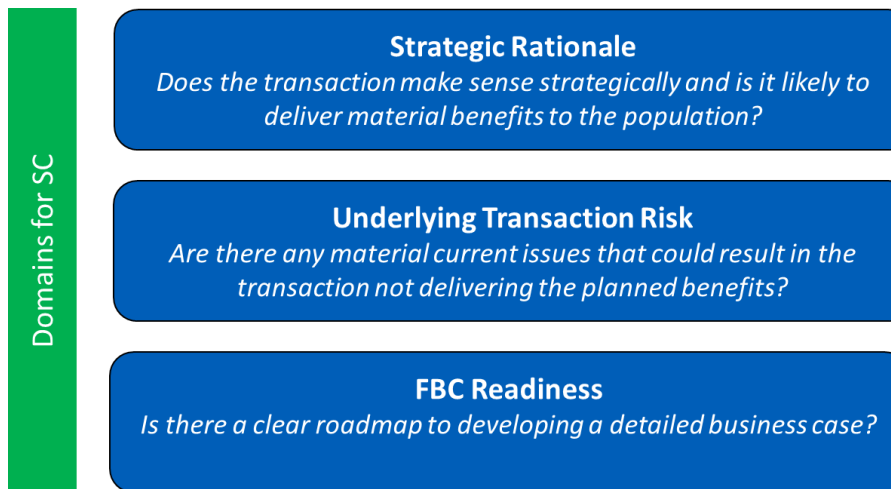
A Typical SOC Structure:



NHS England SOC Review Process Overview

Key steps in the review process

- Review considers the domains in the diagram to the right
- There is a document review, and a selection of meetings with Chairs and certain Execs (possibly Quality, Finance, HR, Transaction Delivery)
- There is a final challenge meeting
- The final SOC rating follows the approach below





SOC Contents

NHS

- 1 Context and Background
- 2 Case for Change
- 3 Options for Collaboration
- 4 Vision for the New Trust
- 5 Strategic Benefits
- 6 Financial Case
- 7 Transition Planning
- 8 Comms and Engagement
- 9 Emerging Risks

**Better
Together**
for people in our care

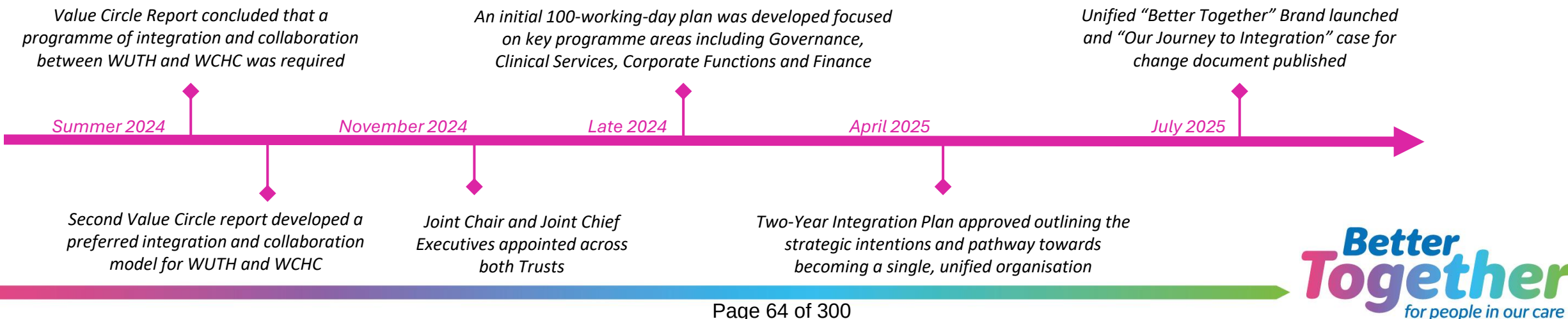
1 Context and Background

Key Drivers for the WUTH and WCHC Integration:

There is a clear **national and local strategic direction of travel** towards greater development of Place and Neighbourhood working to drive the 'left shift' of healthcare from the acute sector into the community. Bringing together WCHC (community-based, £108m income, 1,845 staff) and WUTH (secondary, tertiary, and community, £500m income, 6,400 staff) is designed to support this direction of travel. Integration of the two Trusts represents an important step in **a long journey of developing partnership working** on the Wirral through greater joint working between the Trusts and the broader development of the Wirral Provider Alliance. This integration is designed to **improve the quality of care and access to services**, and realise **significant financial savings**, estimated at approximately £14 million over three financial years, thereby contributing to a sustainable future for the NHS on the Wirral. The desired end goal of integration on the Wirral is to form an Integrated Health Organisation (IHO).

External Context (Alignment with National and Local Strategic Direction)

- **NHS Long Term Plan and Planning Guidance:** Directly supports the LTP's shifts towards prevention, community care, and digital transformation, and addresses key priorities including improved patient outcomes, reduced waiting times, workforce development, health equity, digital adoption, and sustainable, efficient services.
- **C&M 5-year Clinical and Strategic Commissioning Plan:** The integration serves as a cornerstone in the delivery of the commissioning plan for a patient-centered system of care.
- **C&M ICB Provider Blueprint:** Aligns with strategic priorities, including creation of specialist service chains and consolidation of corporate/clinical support functions on larger footprints
- **Wirral Provider Alliance:** Solidifies the Alliance's work, contributing to creating a more formal governance structure for system-wide transformation.
- **Wirral Health and Wellbeing Strategy:** Directly supports the local strategy by enhancing health outcomes, strengthening care and fostering wellbeing, reducing inequalities.



2

Case for Change

WCHC and WUTH have been attempting to collaborate for many years to deliver improved services for the people of the Wirral. There is now a significant opportunity to transcend the limitations created by having two separate organisations, build greater financial sustainability, and most importantly, work together to ensure every Wirral resident receives the high-quality care and support they deserve.

The Problem: The Cost of Fragmentation	The Solution: A Unified, Sustainable Future
• Fragmented Patient Journeys: Disjointed pathways, inconsistent access, and duplication lead to poor patient experience and safety risks. • Operational Inefficiencies: Significant duplication of corporate functions (e.g., digital, finance, HR) and suboptimal resource utilisation. • Workforce & Cultural Silos: Limits staff flexibility, hinders unified clinical pathways, and creates "us vs. them" mentality. • Escalating Demand & Health Inequalities: Current structure struggles to meet complex needs of an ageing population and address deep health disparities effectively. • Financial Instability: Perpetuates inefficiencies and hinders long-term financial sustainability for the Wirral health economy.	• Seamless Patient Care: Integrated pathways, improved access, reduced waiting times, and targeted health equity interventions. • Empowered Workforce: Enhanced career pathways and a unified, collective culture of collaboration. • Financial Sustainability & Efficiency: Addresses WUTH's structural deficit with £15m in cost savings identified over three years (in clinical, corporate, estates, etc). • Enables strategic "left shift" of care to community settings: Reducing acute pressures. • Digital Transformation: Consolidated infrastructure, enhanced data utilisation, and a holistic view of patient information. • Strengthened System Leadership: A unified voice for greater influence and resilience within the wider C&M health and care system.

This merger is a strategic imperative to overcome systemic challenges and build an integrated, patient-centred, and financially robust health system for the Wirral. The history of the two organisations means that this process must be handled carefully and sensitively: whereas WCHC is the smaller organisation, the key to a successful ‘left shift’ lies in prioritising the development of integrated community pathways and services that can care for people at home and keep them out of hospital. **We think this can result in reduced hospital admissions, shorter lengths of stay, shorter waiting times, a smaller bed base, and most importantly, improved outcomes for the people of the Wirral.** Key to this will be an approach that takes the ‘best of both’ Trusts and builds on strengths and good practice.

3

The Journey to Integration

The challenges of a fragmented Wirral NHS have been clear to WCHC and WUTH for some time. However, for various reasons, both cultural and practical (defined below), these challenges had not been addressed. In this context, two important pieces of work by thevaluecircle established a need for a programme of integration, and then recommended an approach, including joint leadership and governance. WCHC and WUTH then came together and decided to go further: pursuing a full organisational merger to gain the full benefits of integration and overcome the historic challenges, including building a collective culture of collaboration for the benefit of the people we serve.

Key Milestones & Findings

- **March 2024: Independent Review Commissioned**
 - Cheshire and Merseyside ICB commissioned thevaluecircle to review collaboration and integration opportunities between WUTH and WCHC.
 - Objectives: Develop a collaboration strategy, identify clinical, operational, and financial integration priorities, and recommend a way forward.
- **Phase 1 Report (Focus on Opportunities & Gaps)**
 - Identified significant gaps in effective collaboration across key clinical pathways (e.g., Unscheduled Care, Neuro-diverse, Ophthalmology) and corporate functions.
 - Recommended urgent integration and improvement in high-priority service areas.
- **Phase 2 Report (Integration Options & Model)**
 - Built on Phase 1, describing options for integration and recommending a specific model.
 - Key Recommendations: Appointment of Joint Chair/CEO, identification of joint senior leadership posts, and establishment of an Integrated Programme/ Management Board.

Why a Merger is now being pursued (Over Partnership or Group Model)?

- **Addressing Systemic Challenges:**
 - **Workforce:** Two separate Trusts cannot move staff effectively across pathways – any action has to be voluntary.
 - **Digital:** Staff of two separate Trusts using separate EPRs cannot collaborate effectively across care settings.
 - **Contracts:** Different contractual models for two Trusts can drive contradictory behaviours.
 - **Culture:** two separate Trusts creates an ‘us and them’ mentality that is difficult to break down without a clear signal being sent by a merger.
- **Limitations of Alternative Options to merger:**
 - **Partnership Agreement:**
 - Would not provide sufficient control over workforce, systems and resource allocation to effectively address deep-seated systemic issues and achieve the necessary level of integration.
 - **Group Model:**
 - The size and specific needs of WUTH and WCHC are too small to merit a complex group model structure, which is typically suited for larger, more diverse portfolios of trusts.

3 Transaction Options

Available Transaction Options: Based on the NHS Transactions Guidance, three potential statutory transaction types were assessed for bringing Wirral Community Health and Care NHS FT (WCHC) and Wirral University Teaching Hospital NHS FT (WUTH) into a single organisational form:

Option 1: WCHC and WUTH Merger

- Involves the dissolution of both WCHC and WUTH.
- Establishes a completely new Foundation Trust (FT).
- Property and liabilities from both Trusts transfer to the new FT.

Option 2: Acquisition of WCHC by WUTH

- Involves the dissolution of WCHC (the acquired Trust).
- Wholesale transfer of WCHC's assets and existing liabilities to WUTH (the acquiring FT).
- WUTH's Board continues; WCHC's Board falls away.

Option 3: Acquisition of WUTH by WCHC

- Involves the dissolution of WUTH (the acquired Trust).
- Wholesale transfer of WUTH's assets and existing liabilities to WCHC (the acquiring FT).
- WCHC's Board continues; WUTH's Board falls away.

Preferred Option: Option 2 has been identified as the preferred transaction type, scoring highest in the assessment criteria with a weighted score of 88.

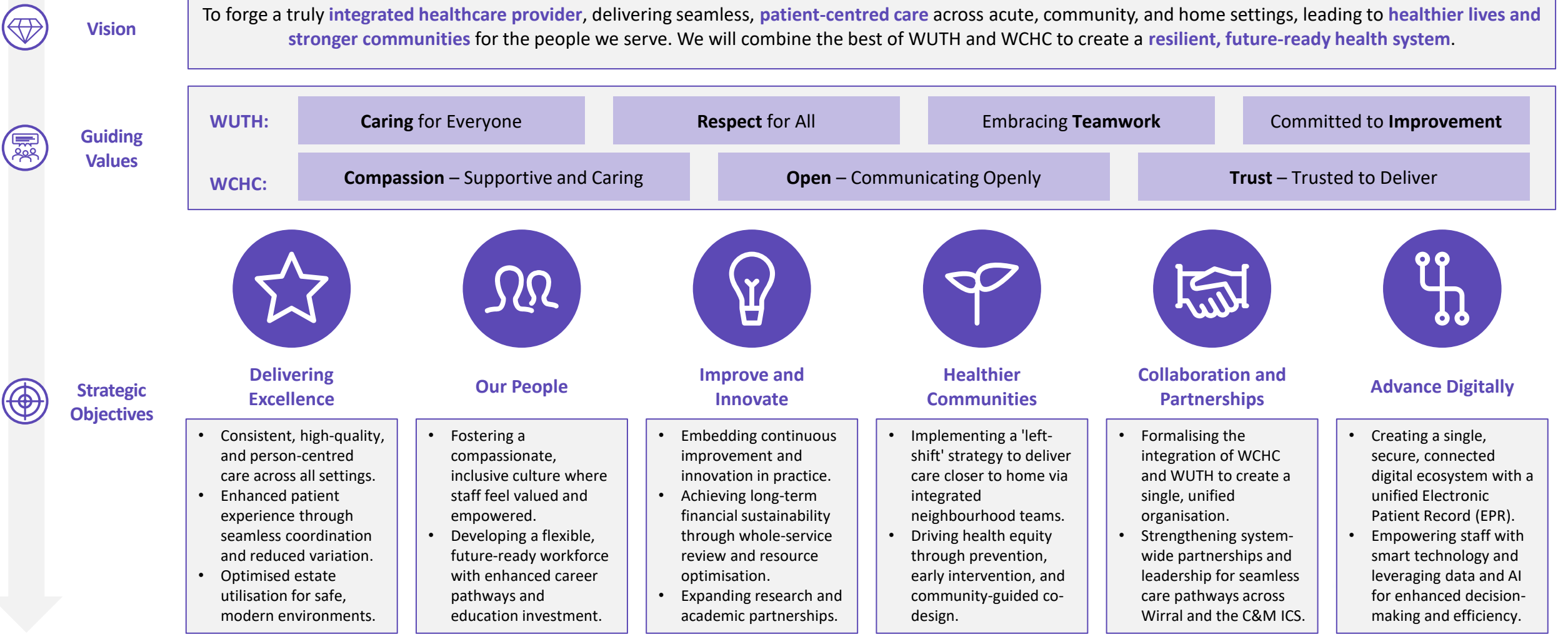
Rationale for Preferred Option:

- **Minimised Impact:** It is anticipated to have the least impact on governance, staff movements, and the transfer of assets and liabilities compared to the other options.
- **Efficiency:** This option is potentially the quickest to implement, both pre- and post-transaction, and is expected to incur the lowest legal and consultancy costs.
- **Deliverability:** It scored highest for deliverability, indicating it is highly achievable within the proposed transaction timetable and can potentially reduce overall timeframes.
- **Governance Stability:** It minimises changes to governance structures, as the acquiring Trust's (WUTH) Board continues to operate.
- **Alignment with Trends:** This approach aligns with recent trends in NHS provider transactions, where larger Foundation Trusts often acquire smaller ones.
- **Strategic Alignment & Quality:** It fully aligns with the Trusts' strategy and Two Year Integration Plan and is expected to improve the quality of care and service delivery.

Consideration: While preferred, this option will require significant and careful communication with staff and stakeholders. It is recommended to frame the transaction as a 'Merger by Acquisition' to describe the formation of a single organisation.

4

Vision for the New Trust

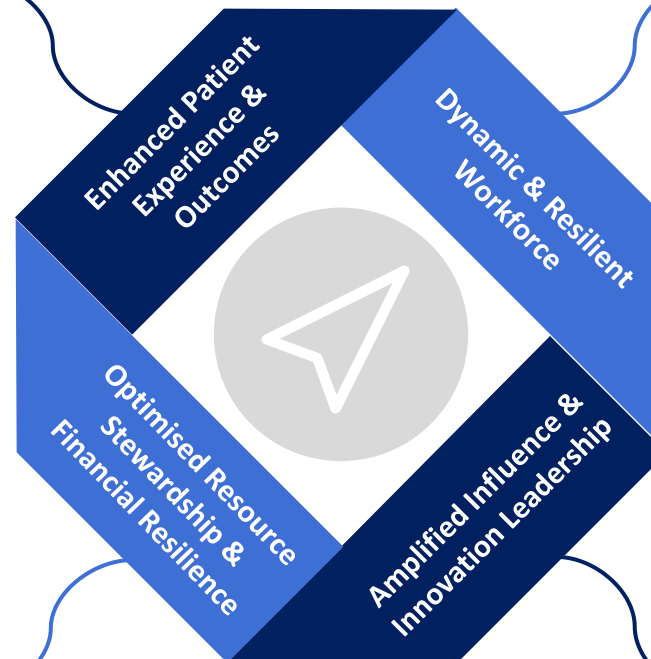


5 Strategic Benefits

The integration of WUTH and WCHC is a pivotal and transformative moment, creating a more resilient, innovative, and patient-centric health system for Wirral. This merger is a strategic imperative to **unlock significant benefits across four key pillars:**

- **Seamless, Integrated Care:** Dismantling barriers between acute, community, and primary care to create holistic patient journeys, reducing fragmentation and re-admissions.
- **Proactive Population Health:** Leveraging data and expertise for targeted prevention and early intervention, addressing health inequalities and maximising social value for Wirral communities.
- **Optimised Access & Flow:** Unified referral protocols and shared waiting list management to significantly reduce waiting times and improve patient movement.
- **Clinical Innovation:** Fostering rapid adoption of best practices and leveraging WUTH's teaching hospital status to embed cutting-edge treatments into community care.

- **Significant Financial Savings:** Targeting over £15 million in savings over three years through corporate integration and elimination of duplication, ensuring long-term financial stability and reinvestment into frontline care.
- **Enhanced Procurement Power:** Leveraging greater scale for more favourable contracts and economies of scale, maximising value for the Wirral community.
- **Efficient Asset Utilisation:** Strategic review and rationalisation of estates and assets to optimise physical infrastructure and reduce operational costs.



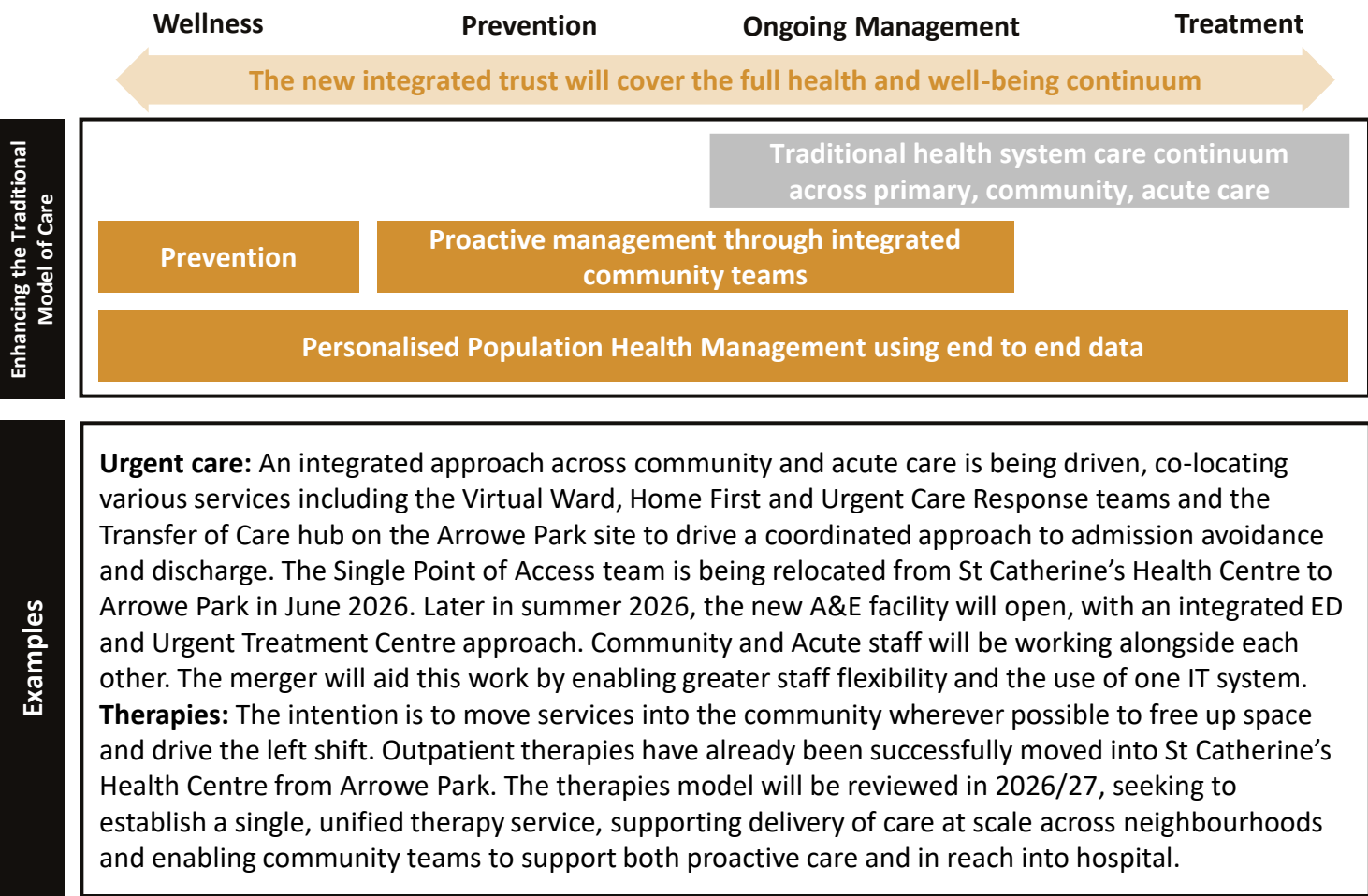
- **Expanded Career Pathways:** Creating unique professional growth opportunities for staff, including integrated roles across acute and community settings.
- **Unified Learning & Development:** Establishing a comprehensive ecosystem for continuous learning, fostering a highly skilled and adaptable workforce and focusing on leadership development.
- **Enhanced Workforce Agility:** Optimising deployment to respond to demand, address shortages, and ensure resilience across the Wirral health system.
- **Harmonised Culture:** Cultivating a single, collaborative culture built on shared values, enhancing staff wellbeing and attracting top talent.

- **Strengthened System Voice:** A more coherent and influential voice within the Cheshire & Merseyside ICS, advocating effectively for Wirral's health priorities.
- **Accelerated Digital Transformation:** Unifying digital strategies, including a single Electronic Patient Record (EPR), to drive interoperability and position Wirral as a leader in digital health.
- **Enhanced Research & Academic Impact:** Leveraging combined capabilities to attract investment, drive advancements, and position Wirral as a leading centre for healthcare innovation.
- **Long-Term Resilience:** Building a more adaptable and robust organisation capable of navigating future challenges and ensuring sustainable, high-quality care for generations.

5

Focus on Patient Benefits: Enabling the Left-shift

The merger will act as a strategic move to shift care, resources, and activity away from reactive, hospital-based services toward preventative, community-based care closer to home.



Benefits to patients of the left-shift

- **Reduced Length of Stay (LoS) in Acute Hospitals:** By managing conditions in community settings or discharging patients earlier with robust community support, the need for prolonged hospitalisation is reduced.
- **Reduced Hospital Admissions and Readmissions:** Proactive management of chronic conditions in primary care, early intervention for acute issues, and comprehensive discharge planning with community follow-up can prevent unnecessary hospital admissions and reduce the likelihood of readmissions.
- **Decreased Emergency Department (ED) Attendances:** Improved access to primary care, out-of-hours services, and community-based urgent care centres can divert patients away from EDs for non-life-threatening conditions.
- **Improved Patient Satisfaction Scores:** Care delivered closer to home, in more comfortable settings, and with greater continuity often leads to a more positive patient experience.
- **Enhanced Chronic Disease Management:** A stronger emphasis on primary and community care allows for more consistent monitoring, education, and support for individuals with LTCs.
- **Reduced Healthcare Costs (System-wide):** Shifting care to less expensive settings (e.g., home care vs. acute hospital bed) can lead to significant cost efficiencies for the healthcare system.

5 Focus on Patient Benefits: Creating a Unified, Patient-Centred MSK Pathway

Current Service Landscape

- **Effective but Fragmented:** Wirral's MSK service, delivered by WUTH and WCHC, is generally good with experienced clinical and operational leads, incorporating many best practices.
- **Dual Systems:** Operates across two distinct providers, utilising separate Electronic Patient Record (EPR) systems (Oracle Millenium and SystmOne).
- **Separate Operations:** Features separate booking and administrative teams and processes, leading to inconsistencies.
- **Distributed Locations:** Services are delivered from multiple sites (8 currently), with varying capacity and accessibility.
- **Varied Practices:** Differences in clinical job planning, rota models, and access to advanced practice support across teams.
- **Rising Waiting Lists:** The combined waiting list is currently increasing, with significant patient cancellations (30% WUTH, 21% WCHC) and DNAs (9-10%).

Case for Change: Key Challenges

- **Operational Inefficiencies:** Duplication in clinical service provision, administrative functions (finance, HR, IT, procurement), and fragmented pathways.
- **Lack of System Visibility:** No single point of visibility for overall service capacity and demand, hindering resource allocation and waiting list management.
- **Suboptimal Patient Experience:** Fragmentation leads to multiple handoffs, inconsistent care journeys, and extended waiting times, impacting patient satisfaction and outcomes.
- **Workforce Inconsistencies:** Different approaches to job planning, supervision, and access to advanced practice colleagues limit professional growth and unified best practice dissemination.
- **Financial Pressures:** Redundant systems and processes lead to higher operational costs and missed opportunities for economies of scale.
- **Limited Innovation:** Separate systems impede rapid adoption of digital tools, data analytics, and clinical innovations across the entire MSK pathway.

Post-Merger Benefits

- **Integrated, Seamless Pathways:** Unifying MSK physiotherapy (including neurological and pelvic health) under a single operating model.
- **Single EPR System:** Transitioning all MSK services to the Millenium EPR for improved clinical information continuity and data sharing.
- **Unified Booking & Admin:** Integrating teams and processes to maximise slot utilisation (target 85%) and reduce DNAs/cancellations.
- **Optimised Locations:** Consolidating sites from 8 to 4 (St Catherine's, Clatterbridge, Victoria Central, and Marine Lake as a satellite).
- **Harmonised Job Planning:** Consistent job plans and rota models across the integrated team.
- **Workforce Efficiency:** Projected reduction from 61 to 54 WTE, leading to significant staffing cost savings (from £3.30m to £2.99m).
- **Data-Driven Operational Excellence:** Implementing enhanced Business Intelligence (BI) for real-time reporting enabling proactive management.

5 Focus on Patient Benefits: Delivering Accessible and Sustainable Eye Care

Current Service Landscape

- **Fragmented Provision:** Services delivered by WUTH (acute, emergency, sub-specialties at Arrowe Park Hospital and satellite sites) and WCHC (community-based, non-emergency, stable/low-risk glaucoma at St Catherine's Health Centre), alongside private providers.
- **High & Rising Demand:** A predicted 40% increase in demand for eye services by 2038, and a 22% increase in glaucoma patients in the next 10 years.
- **WUTH Estate Constraints:** Ophthalmology department at Arrowe Park Hospital is located in a remote, difficult-to-access area with accessibility challenges.
- **WCHC Workforce Vulnerability:** Reliance on agency consultants for clinical leadership in WCHC's glaucoma service, posing a financial and operational risk.
- **Patient Experience Issues:** While staff interactions are positive, patients report long waiting times, communication difficulties, and poor accessibility.
- **Sub-optimal Pathways:** Different operating models, systems, and ad-hoc agreements across providers lead to inefficiencies and lack of a coherent patient journey.

Case for Change: Key Challenges

- **Risk of Sight Loss:** Nationally, patients are losing sight due to health service-initiated delays, particularly for chronic conditions like glaucoma and AMD, exacerbated by capacity issues and growing backlogs.
- **Operational Inefficiency & Duplication:** Separate systems, processes, and estates across WUTH and WCHC lead to duplicated efforts, sub-optimal resource utilisation, and increased costs.
- **Poor Patient Access & Flow:** Estate limitations at APH create barriers to access, long walks, and difficulties for patients with mobility issues.
- **Lack of Integrated Governance:** Ad-hoc agreements and a single SLA for WUTH's sub-contracted services create clinical governance risks and a lack of oversight.
- **Unsustainable WCHC Model:** WCHC's current model is deemed impractical to sustain its remaining ophthalmology services independently, particularly due to reliance on agency staff.

Post-Merger Benefits

- **Single Integrated Service Provider:** WUTH becomes the sole provider for Ophthalmology services, with WCHC workforce TUPED to WUTH.
- **Improved Access:** Strategic relocation of WUTH services out of APH to more accessible community sites, potentially utilising WCHC estates.
- **Reduced Waiting Times:** Streamlined pathways, risk stratification, and patient-initiated follow-up (PIFU) for stable patients will reduce backlogs.
- **Substantive Clinical Leadership:** Recruitment of a substantive consultant ophthalmologist to provide stable leadership and reduce reliance on agency staff.
- **Unified Workforce:** Integration of teams, fostering shared best practices, and consistent training.
- **Improved Governance:** Formalised contracts and SLAs will ensure robust clinical governance and oversight across all services.
- **Strategic Alignment:** The integrated model aligns with national guidance (GIRFT, RCOphth) and local priorities for improved population health and health equity.

5 Focus on Patient Benefits: Improved Cardiac Health Outcomes

Current Service Landscape

- **Dual Provision:** Both WUTH and WCHC provide a range of outpatient, community, day case, and ward-based cardiology services. General Cardiology Outpatient Clinics, Rapid Access Chest Pain Clinics, and non-invasive diagnostics (ECG, Echo, BP monitoring) are provided by both Trusts.
- **Fragmented Operations:** Services operate across seven different sites, utilise different referral routes, and employ separate patient record systems.
- **Inconsistent Performance:** WUTH receives more referrals and conducts more appointments per WTE but has significantly longer waiting times (30+ weeks) and a substantial follow-up backlog (2,500 patients). WCHC has lower referral conversion and discharge rates but shorter waiting times (4-6 weeks).
- **Unmet Demand:** There is significant unmet demand within the system, contributing to high rates of cardiology patients attending Urgent and Emergency Care.

Case for Change: Key Challenges

- **Duplication & Inefficiency:** Significant duplication in clinical service provision, administrative functions, and diagnostic services across both Trusts.
- **Confusing Patient Pathways:** Different referral routes and disparate patient record systems create confusion for referrers and disrupt continuity of clinical information, impacting care coordination.
- **Suboptimal Patient Outcomes:** Long waiting times and follow-up backlogs, particularly at WUTH, delay diagnosis and treatment, potentially leading to patient deterioration and increased reliance on urgent care.
- **Lack of System-Wide View:** The absence of a single integrated operating model prevents optimal resource utilisation, consistent best practices, and effective management of overall demand and capacity.
- **Staffing Pressures:** WUTH's integrated staff roles mean that shortfalls in one area can impact service delivery across inpatient, day case, and outpatient settings.
- **Cost Inefficiencies:** Significant non-pay budgets at WCHC are allocated to diagnostic subcontracts.

Post-Merger Benefits

- **Integrated Service Model:** Development of a single, unified Wirral cardiology service operating under one model, streamlining operations.
- **Single Referral & Triage:** Implementation of a unified Advice & Guidance, Referral, and Triage model for rapid, clinically prioritised patient access.
- **Revised Clinical Pathways:** Development of distinct, best-practice pathways for general cardiology, suspected arrhythmia/syncope, and suspected angina (including a one-stop clinic model).
- **Reduced Urgent Care Demand:** Fully modelled rapid diagnostics pathways and Cardiology SDEC to reduce unnecessary ED attendances and admissions.
- **Integrated Clinical Teams:** Development of a unified clinical workforce with an optimised skill mix.
- **Integrated Diagnostics:** Creation of a unified diagnostics function to deliver all ECG, Echo, and BP monitoring, reducing reliance on subcontracts and realising significant savings (e.g., £230k from internalising diagnostics).

6 Financial Case

	WUTH £'000				WCHC £'000			New Trust £'000
	24/25	25/26	26/27		24/25	25/26	26/27	
	Actual	Actual	Plan		Actual	Actual	Plan	Aggregated
Operating income from patient care activities	501,123	488,736	474,900		111,868	109,424	105,732	580,632
Other operating income	38,389	44,308	34,235		3,585	4,009	2,601	36,836
Operating expenses	(550,559)	(575,058)	(529,485)		(107,862)	(105,791)	(105,042)	(634,527)
OPERATING SURPLUS/(DEFICIT)	(11,047)	(42,015)	(20,350)		7,591	7,642	3,291	(17,059)
Finance Costs	(4,202)	(5,569)	(5,817)		(586)	(1,281)	(1,391)	(7,208)
Other gains/ losses	(328)	(5)	-		-	66	-	-
SURPLUS/(DEFICIT) FOR THE YEAR	(15,577)	(47,589)	(26,167)		7,005	6,427	1,900	(24,267)
Add back all impairments	5,641	3,258	-		(458)	(1,334)	-	-
Remove capital donations /grants /peppercorn lease I&E impact	207	(971)	267		-	-	-	267
Adjusted performance	(9,729)	(45,302)	(25,900)		6,547	5,093	1,900	(24,000)

This transaction is critical to the financial health of the Wirral system. WUTH has an underlying deficit that needs to be tackled, which may not be possible as a standalone organisation in the medium term. Integration provides specific financial benefits that will contribute to reducing the deficit, plus the ability to transform the delivery model and individual services on the Wirral and create a more financially sustainable system.

6 Transaction Costs

DIRECT TRANSACTION COSTS		
Area	Description	Costs £'000
Strategic Outline Case, Full Business Case Support, Due Diligence Support	External advisors to support the development of the documentation required	479
Legal Support and Due Diligence	Legal advisers to support legal aspects of the transaction	20
TOTAL		499

This transaction will be low cost, as indicated in the table above. The majority of work will be undertaken by existing Trust staff through a workstream approach. External advisers have been procured where additional capacity needs have been identified. Restructuring is currently underway in corporate services and some MARS cost may be required, but if so, this will only be approved on the basis that it provides recurrent run rate savings.

6 Financial Benefits of Integration

The Trusts are committed to operating within the allocated budget, reducing the cost base, and significantly enhancing productivity. This will be achieved by minimising waste, optimising the use of our facilities and estate, and improving patient flow. The Trusts will identify and act on efficiency opportunities at every step. By leveraging economies of scale as a larger organisation, the Trusts will benefit from increased buying power for goods and services. By bringing together and restructuring our corporate functions, the Trusts will be able to improve the quality of services at a lower cost. **Significant work has been undertaken to demonstrate these potential financial benefits in one key area: establishing a single, streamlined corporate structure.**

The financial benefits from corporate integration are recurrent and underpinned by detailed workforce modelling and organisational design work undertaken across both Trusts. The savings are phased to reflect the practical sequencing of integration and implementation of new structures:

- **Phase 1 – Single Executive Team:** A single executive team has already been established during 2025/26, with the £1m full year financial saving transacting in 2026/27. This delivers an early reduction in leadership overhead and sets the foundation for wider organisational integration.
- **Phase 2 – Senior Management Rationalisation:** The second phase focuses on the consolidation of senior management across corporate functions and estates. This includes the removal of duplicate roles and the creation of unified leadership structures aligned to the future operating model.
- **Phase 3 – Wider Corporate Team Integration:** The final phase delivers savings through the full integration of corporate teams, standardisation of processes, and further reduction in duplication across both organisations. This reflects a move to single teams operating across both acute and community services.

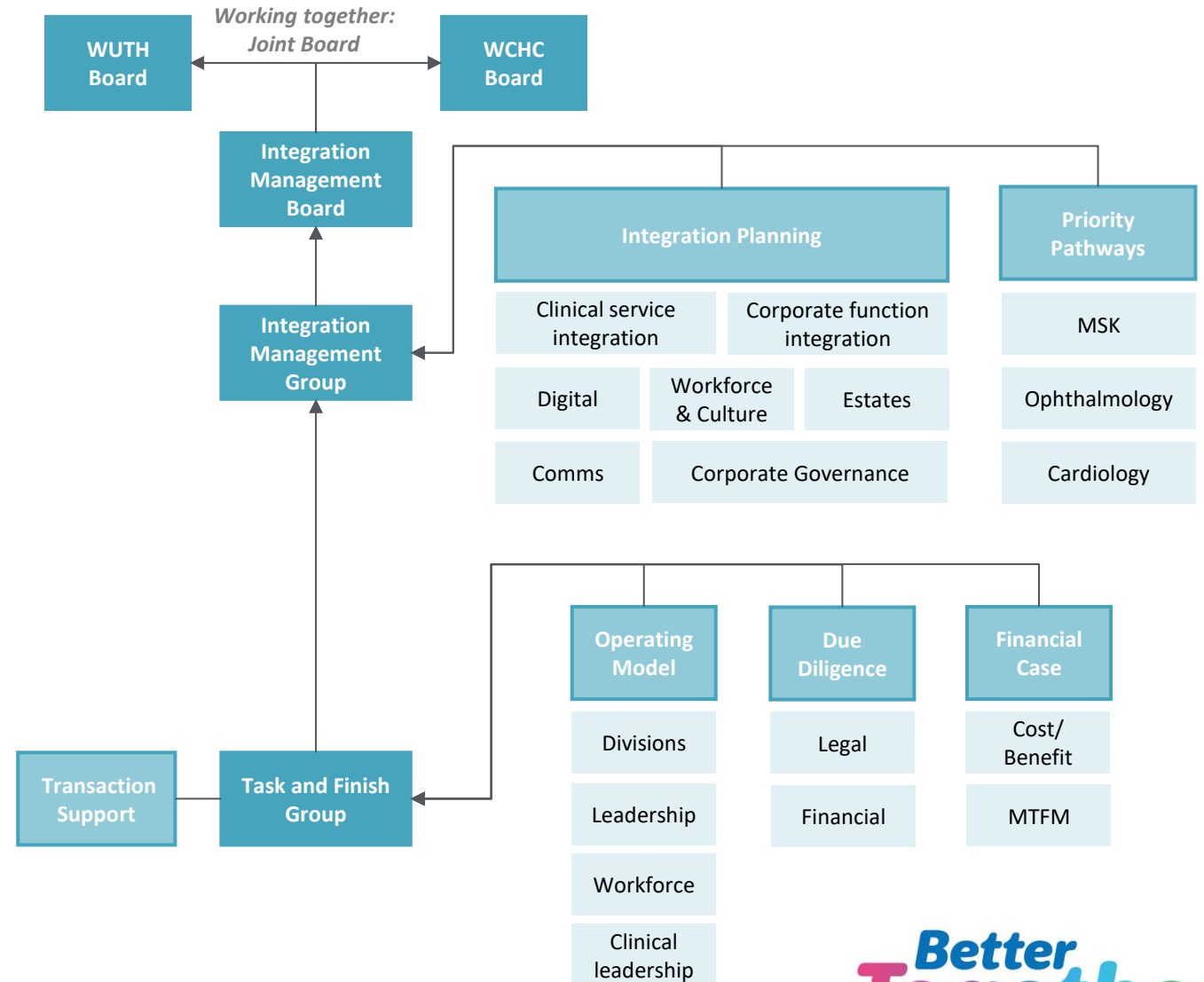
Across all three phases, the programme delivers a **total recurrent saving of £5.0m**, alongside a reduction of c.93 WTE across corporate services and senior estates management. These savings are considered deliverable as they are based on detailed establishment reviews and are aligned to the emerging organisational design for the merged entity.

In addition, Model Hospital benchmarking and other initial reviews of clinical services have **identified a further financial benefit opportunity of £10.7m** (please note this is an estimate at this stage, based on Model Hospital opportunities when compared against the sector median). Again, some of this is already being transacted in 2026/27 with £367k of savings being delivered in MSK, £134k in Cardiology, and £80k in Ophthalmology.

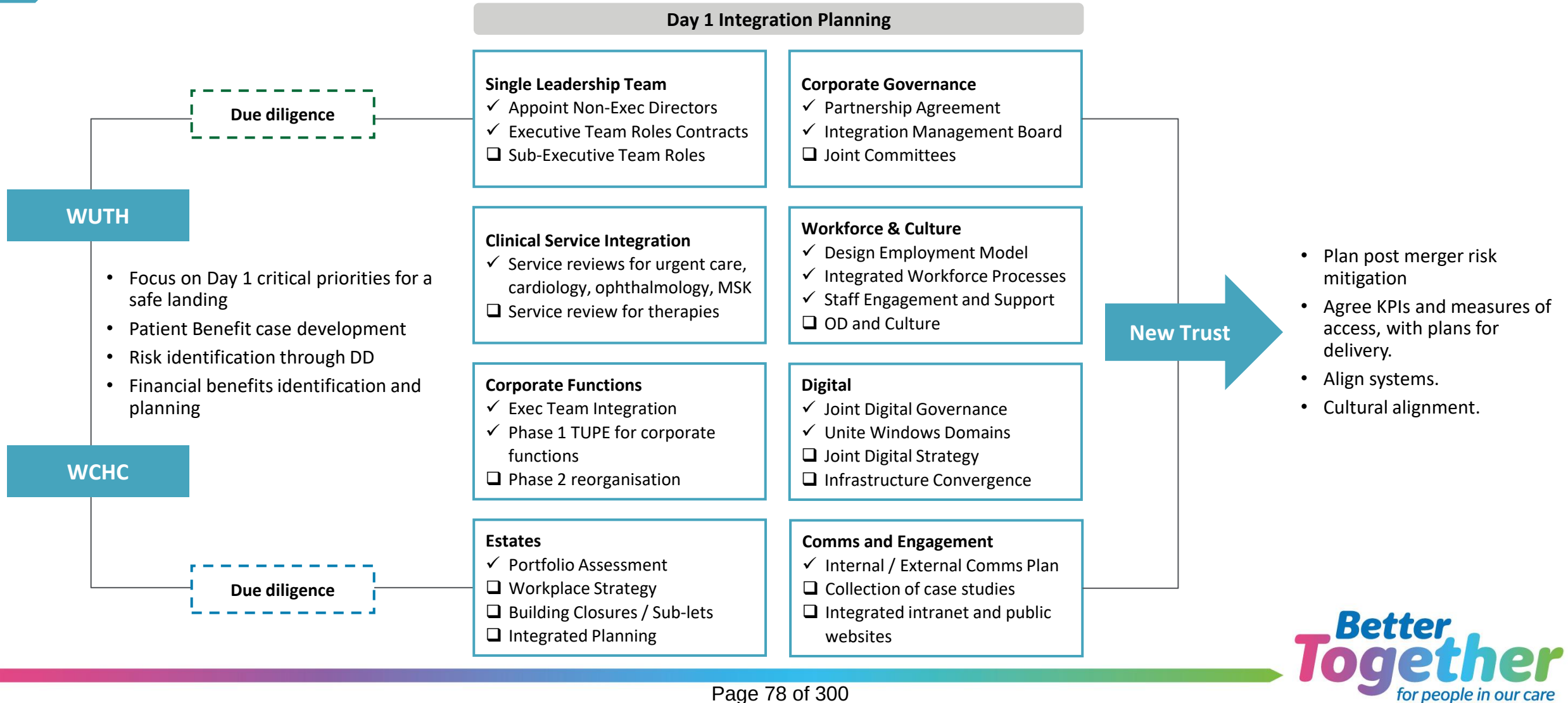
Based on the work undertaken to date, **the two Trusts are confident that the potential financial benefits can repay the costs of the transaction and make an important contribution to reducing the size of the WUTH underlying deficit.** An in-depth exercise will be carried out to quantify savings opportunities fully as part of the FBC stage.

7 Transaction Governance

- Shared ultimate decision-making through a single Exec Team and joint NEDs working as a single unitary Board.
- Integration Management Board chaired by CEO, providing check and challenge.
- The Integration Management Group leads an integration programme made up of key workstreams, ensuring coordination and the resolution of emerging challenges.
- Deloitte will provide support to the Task and Finish Group in transaction planning and delivery.
- Active WUTH and WCHC Board involvement and formal sign-off.
- Governors briefed on their role.



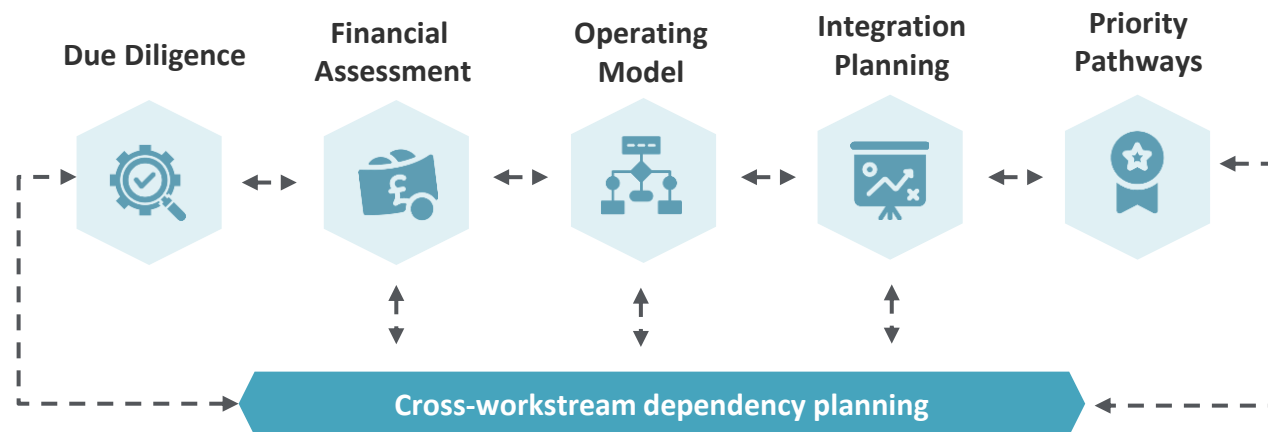
7 Integration Approach



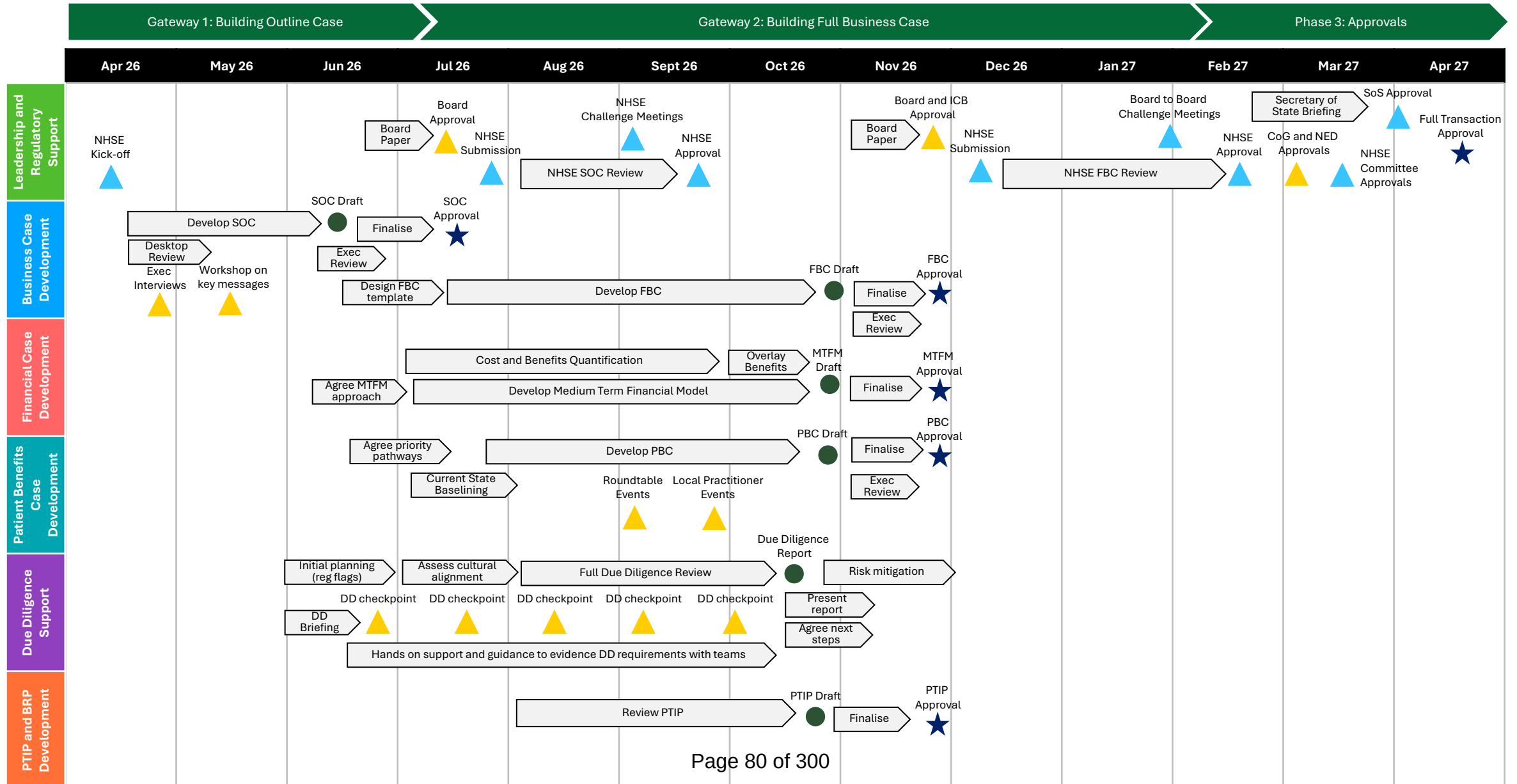
7 Integration Oversight

- Fortnightly integration workstream meetings, which will track progress, manage risks, and identify interdependencies.
- Integration Management Group will discuss progress, emerging findings, and key decisions, overseeing the corporate and clinical integration activity.
- The Task and Finish Group performs the same function but for the specific transaction arrangements.
- The Integration Management Board should receive highlight reports, ensuring clear visibility and robust assurance.

	Week 1	Week 2	Week 3	Week 4
Workstream Planning				
Integration Management Group and Task and Finish Group				
Integration Management Board				



Indicative Programme Plan



8 Comms and Engagement

Guiding Principles for Comms and Engagement Strategy



Articulate Rationale & Benefits: Clearly explain the "why" and "what's in it for them" to all audiences.



Timely, Accurate & Consistent Information: Provide regular updates on the merger process and its impacts.



Reassure & Excite Staff: Address job security, future roles, and foster enthusiasm for the new organisation.



Reassure Service Users: Ensure continuity and quality of care, access to services, and manage expectations.



Listen & Address Concerns: Actively solicit and respond to feedback from all groups.



Manage Perceptions: Maintain public confidence and align internal and external messaging.

Target Audience and Strategic Approach Overview

Key Audiences:

- **Internal:** WUTH & WCHC Staff (all levels), focused Staff Side engagement, work with Governors
- **External:** Patients/Public, Primary Care, NHS Cheshire & Merseyside ICB, Local Authority, Wirral Provider Collaborative, Media.

Comms and Engagement Approach Overview

- **Unified "Better Together" Brand:** Established July 2025, guiding all communications.
- **Consistent Messaging:** Aligned internal and external communications, drawing accurate content from the Integration Management Group (IMG) (e.g., roadmap, strategy, governance, corporate changes).
- **Multi-Channel Delivery:** Utilising a diverse range of platforms for broad reach, co-design, and feedback:
 - **Internal:** Global emails, staff bulletins, intranets, all-staff briefings, Q&A forums, executive breakfasts.
 - **External:** Press/media, social media, public websites, stakeholder newsletters, targeted partner engagement.
- **Engagement Focus:** Proactive engagement to build understanding, gather feedback, and foster a sense of shared ownership.

9 Emerging Risks

Area	Risks
Cultural & Workforce Integration	• "Us and Them" Mentality: Risk of persistent cultural divides, staff anxiety over roles, redundancies, and a perception of "takeover,". • Pace & Identity Clash: Staff may perceive the acute environment as faster-paced and more demanding, leading to cultural clashes and a sense of lost identity. • Resistance to Change: Potential for staff resistance to new practices and a "side of the desk" mentality, hindering progress and delaying clinical integration. • Legacy Ways of Working: Potential for clinical staff to stick to existing ways of working and not enable the left-shift out of hospital. • Morale & Expectations: Risk of low workforce morale due to fear of change, job security concerns, and expectations for the pace of clinical transformation.
Digital & Operational Complexity	• System Disparity: Substantial challenges integrating disparate digital systems (e.g., Cerner and System One), requiring complex, costly solutions and dual running for several years. • Underestimated Investment: Risk of underestimating the true complexity and cost of digital integration, potentially leading to technical debt and capacity bottlenecks. • Pace of Transformation: Expectation of rapid delivery may be challenging, particularly for complex clinical service integration, with initial operational integration lacking formal support.
Financial & Estate Realisation	• Savings Over-Promising: Risk of over-promising immediate financial savings, especially given existing deficits and the time required for operational shifts to translate into benefits, including barriers such as inability to flex staff. • Target Achievement: The ambitious £13.9 million savings target may be challenging to achieve as quickly or comprehensively as planned, particularly in clinical areas. • Estate Rationalisation: Increased demand for car parking at satellite sites due to service relocation could lead to patient complaints, and disposal assets may have limited market value. • Unforeseen Costs: Financial costs associated with the merger (e.g., redundancy, new digital systems) are estimates and could be higher than anticipated.
Governance, Communication & External Factors	• Systemic Fragility: Fragile relationships within the wider Provider Alliance and unclear governance structures could impede system-level decision-making. • Premature Headcount Cuts: Risk that headcount reductions rationalise the corporate function workforce before necessary system changes are complete, hampering transformation. • Communication Challenges: Managing internal and external communications during complex integration, especially with internal team changes, risks inconsistent messaging and unaddressed staff anxieties. • Siloed Risk Management: Critical financial challenges may be managed in silos, hindering a holistic approach to recovery, alongside risks from external policy or political sensitivities.

Next Steps



**Finalise and submit SOC
to NHSE**



**Attend meetings with NHSE
and answer any questions
relating to transaction**



**Receive the SOC rating and
formal approval from NHSE
to proceed to FBC stage**

Our Strategic Outline Case

Version 2.2 – 6th July 2026

**Better
Together**
for people in our care



Table of Contents

Foreword.....	3
Executive Summary	6
Introduction	28
Background and Context	30
Case for Change	51
Options for Collaboration.....	56
Vision for the New Trust	71
Strategic Benefits	79
Financial Case.....	90
Deliverability.....	97
Transition Planning.....	109
Comms and Engagement.....	116
Emerging Risks	123
Appendices.....	128





Foreword

Foreword

On behalf of our Boards and Executive Directors, I am proud to share our vision for the future of health and care across Wirral. This Strategic Outline Case (SOC) marks a pivotal moment – the beginning of a new chapter built on collaboration, integration, and a shared ambition to profoundly improve the lives of the people we serve.

The past few years have seen deepening collaboration between our Trusts, demonstrating a shared commitment to overcoming systemic challenges and delivering better care. This SOC builds on the progress we have made so far, moving beyond existing structures to proactively create a sustainable, truly integrated model of care for Wirral.

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) would like to unite to form a single, new Trust, building on the integration to date. This is more than an organisational restructure; it is a strategic imperative, a commitment to doing things differently, and a bold step towards enhancing how we deliver high-quality, compassionate, and truly integrated care to every resident within our communities.

By bringing together the expertise of a major acute hospital with the strengths of community-based health and care, we are uniquely placed to deliver seamless services that meet people's needs wherever they are – at home, in local settings, or in hospital. This move aligns with the national direction towards becoming an Advanced Foundation Trust and an Integrated Health Organisation, empowering NHS Trusts and creating a single system of care that breaks down traditional boundaries and puts people at the centre.

Our shared vision is to establish a streamlined, responsive, and integrated healthcare provider. This, operating under our 'Better Together' approach, will combine the expertise of WUTH and WCHC to deliver outstanding patient experience. As a single Trust, we will have a unique opportunity to provide integrated acute and community health care, spanning whole patient pathways. This will significantly strengthen our contribution to Wirral's developing neighbourhoods, help meet our shared system aim of providing more care closer to people's homes, and crucially, address the persistent health inequalities seen within Wirral.

This journey has been shaped with our patients, staff, partners, and communities. It reflects what matters most: better access, more joined-up care, tackling inequalities, and ensuring our services are sustainable for future generations.

As we embark on this next chapter together, removing the remaining barriers between our two Trusts, we are excited to realise the profound opportunities to improve the health and wellbeing of the people we serve in Wirral, securing a lasting legacy of improved health and wellbeing for all.

Janelle Holmes
Joint Chief Executive
WUTH & WCHC





Executive Summary

Executive Summary

This Strategic Outline Case (SOC) presents the rationale for the integration of Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) into a single, unified organisation. The new entity will be dedicated to creating healthier lives and stronger communities across Wirral, delivering comprehensive, seamless health and care services across the full care continuum. Currently, both Trusts operate independently, which has presented challenges in delivering truly integrated care pathways and optimising resource allocation.

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

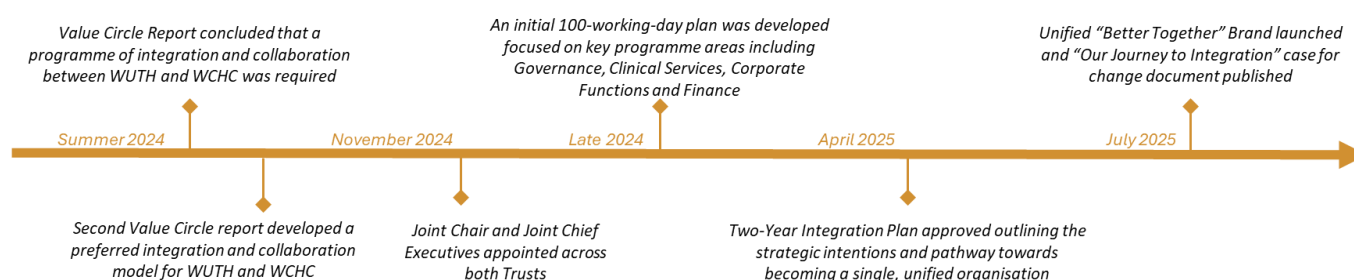
Its primary purpose is to secure approval for proceeding with the development of a Full Business Case (FBC) and undertaking further integration planning.

Background and Options for Collaboration

The Wirral health and care landscape is poised for a transformative step forward, building upon a strong foundation of existing collaboration between WUTH, a large, comprehensive acute Foundation Trust, and WCHC, a leading provider of community health services. Both Trusts serve the same population on the Wirral.

Partnership working has been a key aspect of healthcare delivery on the Wirral for many years. This journey gained significant momentum with Wirral System Review, a comprehensive assessment commissioned by the Cheshire and Merseyside Integrated Care Board (ICB) and written by The Value Circle LLP. This review developed a robust path forward for deeper collaboration across acute, community, and primary care services, identifying key clinical, operational, and financial integration priorities, and outlining an implementation roadmap. The insights from this review were pivotal, highlighting the need for a programme of integration and collaboration and a Shared Leadership Model.

The two Trusts have taken multiple steps to develop this integration programme, as shown in the diagram below:



The two Trusts have therefore undertaken a huge amount of work already to come together, with the development of the 'Better Together' brand, a single Board and Executive Team in place and the



development of a Partnership Agreement to provide the governance for the Trusts working together. The Trusts are already embarking on corporate services consolidation, with some staff transferring under TUPE arrangements from WCHC to WUTH. Reviews of clinical services where there is overlap between the Trusts, such as MSK, have been undertaken.

Moreover, the Joint Six-year Strategy (2026 – 2032) between the two Trusts has been recently published to provide strategic direction. This strategy articulates a clear ambition to establish a unified, integrated health and care system that will improve population health, streamline patient pathways, eliminate duplication, and achieve ambitious outcomes. This will also enable the development of a positive integrated organisational culture which will improve staff experience and further improve patient experience and care.

In this context of greater collaboration and integration, the Boards of the two Trusts have evaluated their options for future organisational form.

Three primary options for collaboration were considered:

1. **Continued Informal Collaboration (Do Nothing – As Is):** This option involved maintaining the current independent operational model, with existing partnership arrangements. While straightforward and avoiding immediate disruption, this option was deemed unsustainable. It would perpetuate the fragmentation, inefficiencies, and duplication that currently hinder optimal patient experience and resource allocation, failing to address the systemic challenges identified in the Wirral System Review.
2. **Form a Provider Collaborative or Group Model:** This option proposed a more formalised collaborative structure, such as a group model, where both Trusts would retain their legal identities but operate under a unified strategic framework. This model offered some benefits in terms of shared governance and reduced impact on services and staff. However, it was recognised that this approach would introduce additional layers of governance, potentially slow decision-making, and would not fully resolve the cultural and organisational barriers that impede full integration. It was seen as a potential precursor to a full merger rather than a definitive solution, and also a better solution for larger geographies or partnerships with multiple Trusts involved at scale.
3. **Organisational Merger/Acquisition (Creating a New Trust):** This option involved a formal statutory integration, leading to the creation of a single, unified legal entity. It was identified as the preferred option for WUTH and WCHC, offering the most profound strategic and operational freedom to drive significant change across Wirral. This approach fosters the most cohesive and unified working culture for staff, breaking down silos and establishing a shared vision, supported by new branding and aligned policies. Single employment contracts enable flexible staff deployment and resource pooling, and teams can use the same EPR. For patients and stakeholders, this simplifies understanding through a seamless, all-aged, 'no wrong door' access model, removing current fragmentation and disjointed experiences.

Three specific transaction options were then assessed:

- a. **Full Merger creating a new entity:** Dissolving both WUTH and WCHC to form an entirely new Trust.

- b. **Acquisition of WCHC by WUTH:** WUTH would acquire WCHC, with WCHC ceasing to exist as a separate legal entity.
- c. **Acquisition of WUTH by WCHC:** WCHC would acquire WUTH, with WUTH ceasing to exist as a separate legal entity.

The formal statutory integration, specifically the acquisition of WCHC by WUTH, was identified as the clearly preferred option.

This choice is underpinned by a compelling rationale:

- **Strategic Alignment and Patient Impact:** This option offers the highest degree of strategic alignment with the vision for a unified, integrated health and care system. It provides a 'clean slate' for developing a unified service portfolio, creating a more comprehensive provider across the full care continuum, and ensuring a truly integrated patient experience.
- **Deliverability and Simplicity:** The acquisition of WCHC by WUTH represents the simplest and most straightforward transaction type among the statutory options. It avoids the significant legal and administrative complexities associated with dissolving two existing Trusts to create an entirely new entity, as would be the case in a full merger. WUTH's existing legal and administrative infrastructure is better positioned to support the integration process, making the transaction timeline more manageable.
- **Workforce Integration:** WCHC staff would transfer to the new entity, allowing for a focused integration plan to harmonise terms and conditions and foster a unified culture. This approach is less disruptive than a full merger.
- **Financial Prudence and Efficiency:** While a full merger or WCHC acquiring WUTH would entail significant financial and operational complexities, WUTH acquiring WCHC offers a more controlled and manageable financial transition. It provides the greatest scope for driving efficiencies, removing duplication, centralising assets, and optimising resource allocation, leading to long-term financial benefits from full integration and economies of scale.
- **Governance Optimisation:** This option provides an excellent opportunity to design an optimal, fit-for-purpose governance structure for the newly enlarged entity, leveraging the strengths of both organisations while streamlining decision-making processes.

While acknowledging the complexities and significant effort required for such a large-scale transformation, the acquisition of WCHC by WUTH provides the most robust and comprehensive pathway. It ensures a sustainable, high-quality, and integrated health and care system for the people of Wirral, with a clear and manageable route to delivery.

The Wirral health and care system has therefore been on a long and thorough journey to this point of identifying that the integration of the Two Trusts is the best option for the future and selecting the means to do this.

Case for Change

The proposed integration of WUTH and WCHC is not merely an organisational adjustment; it is driven by a clear and compelling case for change.

While both Trusts deliver vital services, their current independent operations inadvertently create a fragmented system that hinders optimal patient experience and limits resource efficiency, leading to several key challenges that integration is uniquely positioned to address:

- **Disjointed Patient Pathways:** Patients often navigate complex, multiple referral systems, leading to delays, inconsistent care, and a lack of a single point of access. Different commissioning and contractual models for similar services across two Trusts can drive contradictory and conflicting incentives and behaviours. This fragmentation can be particularly challenging given Wirral's demographic profile, which includes areas of long-standing deprivation, an ageing population, and a high prevalence of long-term conditions.
- **Operational Inefficiencies:** The current organisational structure, involving two separate entities, results in the duplication of clinical functions, as well as administrative and corporate overheads. Furthermore, this structure can make effective collaboration among staff across different care settings more challenging, as personnel from the two distinct Trusts can find it difficult to work cohesively. These factors collectively suggest areas where optimising resource utilisation and enhancing operational synergy should be explored.
- **Digital Considerations:** The presence of disparate systems across the two organisations can make it more complex to establish a truly holistic view of patient data, which is vital for comprehensive care and strategic planning. As a result, the full potential for data-driven decision-making and innovation is not being entirely realised. Specifically, the reliance on separate Electronic Patient Records (EPRs) by each Trust can contribute to these challenges, leading to data silos and making seamless information exchange more difficult.
- **Workforce Challenges:** While both Trusts are committed to their staff, the current structure can complicate recruitment, retention, and professional development. For example, two separate Trusts cannot easily move staff effectively across pathways – under the current partnership working agreement, workforce sharing arrangements are reliant on voluntary staff engagement in the process. A unified organisation offers the potential to create a more attractive and supportive environment, fostering shared learning and broader career opportunities.
- **Financial Pressures:** This transaction is critical to the financial health of the Wirral system. WUTH has an underlying deficit that needs to be tackled, which may not be possible as a standalone organisation in the medium to longer term. The current model limits the ability to achieve economies of scale and optimise resource allocation effectively across the entire system.
- **Limited System Leadership and Advocacy:** Operating as separate entities can dilute the collective voice and influence of Wirral's healthcare providers, potentially limiting the ability to advocate for the community's needs and shape regional health policy effectively.

Running through all of these challenges is the cultural factor: two separate Trusts creates an 'us and them' mentality that is difficult to break down, even when intentions are good around working together and building relationships. Integration into one Trust sends a clear signal to everyone that a new culture must be created.



Unlocking Wirral's Healthcare Potential Through Integration

The proposed merger offers a powerful solution to these challenges, unlocking significant potential for the Wirral health economy by creating an integrated, efficient, and patient-centred system. This unified approach will deliver:



- **An Empowered Workforce:** Integration will foster a shared culture, enhance professional development opportunities, and improve recruitment and retention by offering broader career progression and a more supportive working environment.
- **Enhanced Financial Sustainability:** Through economies of scale, optimised resource allocation, and the elimination of duplication, integration provides specific financial benefits that will contribute to reducing the WUTH deficit, plus the ability to transform the delivery model and individual services on the Wirral and create a more financially sustainable system.
- **A Unified Patient Experience:** By streamlining processes and creating seamless care pathways, patients will benefit from single points of access, reduced waiting times, and more coordinated care across the full continuum, from acute to community settings.
- **A Digitally Enabled Future:** Integrating disparate digital systems will facilitate data-driven decision-making, enhance operational efficiency, and accelerate the adoption of innovative technologies, leading to more responsive and effective care.
- **Stronger System Leadership and Advocacy:** A single, unified Trust will have a more influential voice, enabling it to better advocate for the health needs of the Wirral population and drive strategic change within the wider Integrated Care System.

By harmonising values and objectives, the new Trust will operate with a clear, collective mission, fostering a stronger sense of identity and shared commitment to the health and wellbeing of the community. Moving from a fragmented system to a unified, integrated Trust is a necessity that will transform healthcare delivery in Wirral, ensuring a more effective, sustainable, and patient-focused future for all.

Addressing these challenges will help to improve some of the overall performance challenges facing the two Trusts, including WUTH's financial pressures and journey of continuous improvement following its 'Requires Improvement' CQC rating. In this regard WCHC's expertise in community-based care and preventative services is fundamental to creating a truly integrated care model that reaches across all settings, working with WUTH's extensive service portfolio and workforce.

The case for change is further reinforced by broader regional and national strategic drivers:

- **The Cheshire and Merseyside Integrated Care System (ICS)** champions integration, health equity, and digital transformation. This merger directly supports the ICS's strategic objectives to foster collaborative solutions and enhance system-wide resilience.



- **The Cheshire and Merseyside Provider Collaborative Blueprint** actively encourages partnerships and service consolidation among C&M providers, recognising their potential to unlock significant financial benefits (estimated at 10-15% of Trust expenditure) and address clinical service fragility.
- **The Wirral Health and Wellbeing Strategy** provides a local framework for improving health and wellbeing, with a strong focus on reducing health inequalities, particularly in areas such as long-term conditions, which the integrated Trust will be better positioned to address.
- **The NHS 10-Year Plan** further reinforces the strategic imperative, advocating for a shift towards community-based care, accelerated digital transformation, and a greater emphasis on preventative health, all of which are central to the vision for the new integrated Trust.

Therefore this transaction is in line with the national and regional strategic direction of travel.

Vision for the New Trust

The integration of WUTH and WCHC is driven by an inspiring vision for the future of healthcare in Wirral. This new, unified Trust will be a seamless, responsive, and integrated healthcare provider, dedicated to creating healthier lives and stronger communities across the region. It will embody a distinct identity, culture, and values, bringing together the strengths and best practices of both legacy organisations to deliver exceptional, patient-centred care.



Delivering
Excellence



Our People



Improve and
Innovate



Healthier
Communities



Collaboration and
Partnerships



Advance Digitally

At its core, the vision for the new Trust is to deliver excellence in every aspect of its operations, guided by six fundamental strategic objectives:

1. **Delivering Excellence:** The Trust will be defined by its unwavering commitment to delivering consistently safe, high-quality, and person-centred care across all settings. This involves implementing a 'Left Shift' strategy, moving care closer to home where appropriate, reducing unwarranted variation, and ensuring seamless patient journeys. By standardising clinical processes and leveraging best practices, the Trust will ensure that every patient receives the right care, at the right time, in the right place.
2. **Our People:** Recognising that its people are its greatest asset, the new Trust will be committed to nurturing an inclusive, compassionate culture where every member of staff feels valued, supported, and empowered. It will be an attractive employer, offering enhanced professional development opportunities, broader career pathways, and a safe, modern working environment. By valuing and supporting its staff, the Trust aims to improve recruitment and retention, ensuring a skilled and dedicated workforce for the future.
3. **Improve and Innovate:** The Trust will be a common-sense assurance organisation, capable of achieving long-term sustainability and resilience. This commitment extends beyond merely reducing double-counting costs; it will demonstrate new 'know-how' and transformation across clinical pathways, consistently redesigning how services are delivered in Wirral. This

involves leveraging data-driven insights, investing in modern tools and efficient IT systems, and fostering a culture of research and development.

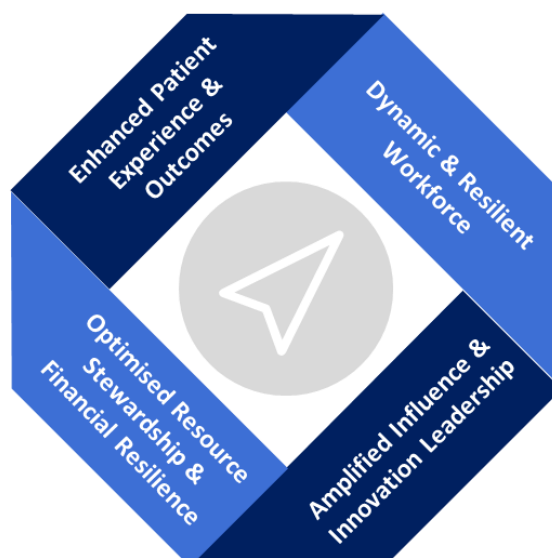
4. **Healthier Communities:** A core tenet of our vision for the new Trust will be to establish a healthier Wirral and offer all residents an equitable opportunity to achieve their full potential. This will be achieved through proactive care models, robust community engagement, and a strong focus on population health management. By working closely with local partners and communities, the Trust will identify and respond to local health needs, ensuring equitable access to services and promoting overall wellbeing.
5. **Collaboration and Partnerships:** Working as one system and one organisation will be fundamental to our success. The new Trust will act as a proactive and influential partner within the wider health and care landscape, fostering strong collaboration to deliver seamless, integrated care. This includes strengthening its collaborative efforts with system partners, including the C&M ICS, local authorities, primary care, and voluntary organisations.
6. **Advance Digital Capability:** The long-term vision for the new Trust will be to establish a unified, efficient, and future-proofed digital ecosystem that will support seamless care delivery and improve efficiency. This includes a commitment to a single, consolidated EPR by 2031, enabling seamless information sharing, enhancing data analytics, and accelerating digital transformation across all services.

This comprehensive vision ensures that the new Trust will not only respond to illness but actively promote health and wellbeing, creating a lasting legacy of improved health for all residents of Wirral. It represents a bold and optimistic blueprint for a future where healthcare is truly integrated, patient-centred, and sustainable.

Strategic Benefits

This integration is designed to unlock significant benefits, creating a unified entity that is greater than the sum of its parts. This integration will enhance patient care, empower the workforce, ensure financial resilience, and amplify innovation and influence across the region.

The key strategic benefits anticipated from this integration include:



- **Enhanced Patient Experience and Outcomes:**

- **Seamless Pathways and Single Services:** The integration will eliminate artificial barriers between acute, community, and primary care, creating seamless care pathways and ceasing the duplication of clinical services. This will lead to improved access, reduced waiting times, and more efficient movement through the care continuum.
- **Proactive and Preventative Care:** By leveraging integrated urgent care systems, virtual wards, and 'home first' initiatives, the new Trust will shift towards proactive and preventative interventions, reducing the need for more intensive and costly care.
- **Targeted Improvements:** Specific patient pathways, such as Musculoskeletal (MSK), Ophthalmology, and Cardiology, will see improvements through streamlined processes, reduced duplication, and enhanced clinical outcomes. For instance, the MSK service model will be redesigned to improve access and reduce waiting lists, while ophthalmology services will benefit from a single operating model and reduced duplication.

- **Dynamic and Resilient Workforce:**

- **Professional Growth and Wellbeing:** The integration will foster a high-performing culture that supports professional growth, wellbeing, and a shared sense of purpose. It will create broader career opportunities and enhanced leadership development programmes.
- **Attraction and Retention:** By offering a more attractive and supportive working environment, the new Trust will be better positioned to attract and retain skilled staff, addressing current workforce challenges. This includes developing an employment framework which fosters a unified, inclusive culture.
- **Shared Best Practices:** The combined expertise and shared learning from both Trusts will lead to the adoption of best practices across all services, enhancing the overall quality of care.

- **Optimising Resource Stewardship and Financial Resilience:**

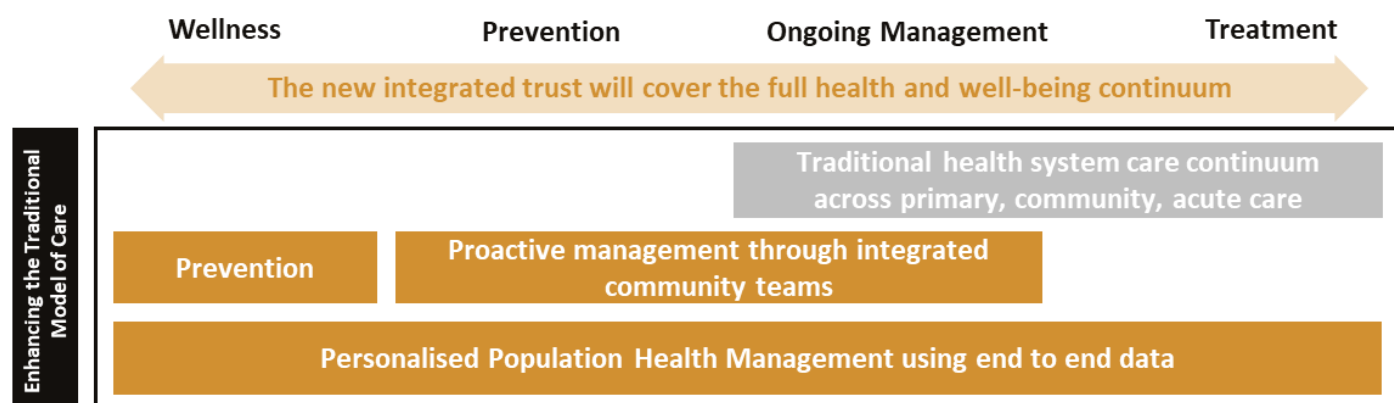
- **Economies of Scale:** The integration will generate significant financial savings and efficiencies through economies of scale, particularly in corporate functions such as IT, HR, procurement, and estates. Estimated savings of £13.9 million over three years are projected from these consolidations.
- **Improved Purchasing Power:** A larger, unified entity will command greater purchasing power, leading to more favourable contracts and significant savings on goods, services, and technology.
- **Strategic Asset Management:** The integration will enable a more strategic approach to estate management, optimising facilities, and ensuring that assets are utilised efficiently to support patient care.
- **Data-Driven Resource Allocation:** Enhanced data analytics will support more informed decision-making regarding resource allocation, ensuring that investments are directed where they will have the greatest impact.

- **Amplified Influence and Innovation Leadership:**

- **Stronger Voice:** The new Trust will command a louder voice within the healthcare system, particularly within the C&M ICS and regional health economy, enabling it to better advocate for the health needs of the Wirral population.
- **Enhanced Research and Development (R&D):** The integration will foster a more robust environment for research and innovation, leading to enhanced R&D capabilities and the adoption of new clinical practices and technologies.
- **Accelerated Digital Transformation:** A unified digital infrastructure will enable faster and more effective implementation of new technologies, improving operational efficiency and patient experience. This includes a single Electronic Patient Record (EPR) and advanced data analytics.

Enabling the Left Shift

Perhaps most importantly of all, the merger will act as a strategic move to shift care, resources, and activity away from reactive, hospital-based services toward preventative, community-based care closer to home. Again, this is in line with the regional and national direction of travel and is shown in the diagram below.



The Left Shift will deliver the following benefits:

Reduced Length of Stay (LoS) in Acute Hospitals: By managing conditions in community settings or discharging patients earlier with robust community support, the need for prolonged hospitalisation is reduced.

Reduced Hospital Admissions and Readmissions: Proactive management of chronic conditions in primary care, early intervention for acute issues, and comprehensive discharge planning with community follow-up can prevent unnecessary hospital admissions and reduce the likelihood of readmissions.

Decreased Emergency Department (ED) Attendances: Improved access to primary care, out-of-hours services, and community-based urgent care centres can divert patients away from EDs for non-life-threatening conditions.

Improved Patient Satisfaction Scores: Care delivered closer to home, in more comfortable settings, and with greater continuity often leads to a more positive patient experience.

Enhanced Chronic Disease Management: A stronger emphasis on primary and community care allows for more consistent monitoring, education, and support for individuals with Long Term Conditions (LTCs).

Reduced Healthcare Costs (System-wide): Shifting care to less expensive settings (e.g., home care vs. acute hospital bed) can lead to significant cost efficiencies for the healthcare system.

Examples of WUTH and WCHC Driving the Left Shift

The two Trusts have sought to demonstrate early benefits for patients from working together more closely and delivering the Left Shift. The examples below show that the Trusts are already making progress with their integration activity, providing assurance that they can continue to deliver.

Urgent care: An integrated approach across community and acute care is being driven, co-locating various services including the Virtual Ward, Home First and Urgent Care Response teams and the Transfer of Care hub on the Arrowe Park site to drive a coordinated approach to admission avoidance and discharge. The Single Point of Access team is being relocated from St Catherine's Health Centre to Arrowe Park in June 2026. Later in summer 2026, the new A&E facility will open, with an integrated ED and Urgent Treatment Centre approach. Community and Acute staff will be working alongside each other. The merger will aid this work by enabling greater staff flexibility and the use of one IT system.

Therapies: The intention is to move services into the community wherever possible to free up space and drive the Left Shift. WUTH Outpatient Therapies have already been successfully moved into St Catherine's Health Centre from Arrowe Park Hospital. The therapies model will be reviewed across 2026/27, seeking to establish a single, unified therapy service, supporting delivery of care at scale across neighbourhoods and enabling community teams to support both proactive care and in reach into hospital.

Other early examples of clinical integration

As well as the Left Shift, WCHC and WUTH have been keen to show other tangible and significant improvements in patient care, particularly within three identified pathways to date: MSK, Ophthalmology, and Cardiology. The work undertaken on these pathways demonstrate likely benefits from the new operating model and again provide assurance that the two Trusts can deliver improvements for patients.

MSK Pathway: The integration will revolutionise the MSK service model, creating a single, streamlined pathway that removes current duplication in clinical provision and handoffs. Patients will benefit from a significantly improved and less confusing experience, with a single point of access and coordinated care from initial referral through to treatment and follow-up. This will lead to reduced waiting lists, improved access to services, and more efficient patient movement through the care continuum.

The new Trust will leverage enhanced support for staff, including more Allied Health Professional (AHP) roles, to deliver greater patient contacts and interventions, ultimately improving clinical outcomes and patient experience. Furthermore, the integration will facilitate better communication

across the health and social care system, reduce travel times for patients, and create more efficient, patient-friendly clinical environments.

Ophthalmology Pathway: The merger will enable WUTH to become the sole provider for glaucoma services within Wirral, consolidating expertise and standardising care across the region. This strategic move will mitigate risks associated with reliance on external providers and establish a consistent, high-quality care pathway aligned with national guidance.

The new Trust will be better equipped to meet the increasing demand for ophthalmology services, particularly for conditions like glaucoma, cataracts, and age-related macular degeneration, by reducing current waiting lists and improving access to specialist eye care. The integration will also address WUTH's current estate constraints by potentially relocating some ophthalmology services to St Catherine's Health Centre, creating a more efficient patient pathway and enhancing patient experience. Streamlined referral pathways between primary care, community optometry, and specialist ophthalmology services, supported by a unified digital strategy, will improve diagnostics and patient flow, while fostering a more resilient, integrated ophthalmology workforce.

Cardiology Pathway: The acquisition will support a single operating model for cardiology services, integrating outpatient, community day care, and ward-based provision. This will involve the re-development of pathways for general cardiology, suspected arrhythmias, syncope, and suspected angina, incorporating initial screening via a single Advice & Guidance, Referral, and Triage model. This approach will ensure that care is delivered in the most appropriate setting based on clinical risk and capacity, thereby reducing unnecessary admissions. Key benefits include the creation of an integrated diagnostic hub with enhanced capacity for advanced scans (3D-ECHO, Bone, and CT), leading to improved patient flow and reduced unnecessary admissions for cardiac conditions. The integration will also streamline booking, administration, and medical secretarial functions, ensuring a more efficient and patient-friendly experience. Critically, this integration offers a decisive opportunity to address the structural deficit in cardiology services, with projected net savings from cardiology outpatients and other clinical areas being reinvested to strengthen services across Wirral.

Ultimately, the integration of WUTH and WCHC will create a unified organisation capable of delivering high quality integrated care. These benefits are not just incremental improvements but represent a fundamental transformation that will ensure a sustainable and patient-centred healthcare system for the people of Wirral.

Financial Case

The proposed merger to create a single Trust will unite two organisations currently characterised by distinct financial performance and materially different financial scales and levels of challenge.

In 2025/26 WCHC reported an adjusted performance position of a £5.1m surplus, and in 2024/25 a surplus of £6.5m was delivered. The Trust's Medium Term Financial Plan seeks to maintain this good performance, with a challenging 2026/27 financial plan predicated on achieving efficiency savings of £6m to achieve a £1.9m surplus.

WUTH delivered an adjusted deficit of £45.3m in 2025/26 and a deficit of £9.7m in 2024/25. While the 26/27 plan is anticipated to deliver an improved deficit position of £21.3m, the Trust continues to face significant financial pressures, which have resulted in the substantial deficits in recent years.



In this context, the transaction is critical to the financial health and sustainability of the Wirral system. With the considerable underlying deficit at WUTH that needs to be tackled, the benefits of integrated pathways across secondary and community care under a single combined organisation are a key lever to help address this.

In preparation for the transaction, the Trusts have estimated the revenue costs of integration:

Transaction and Integration Costs	£'000
External support with the documentation required for the transaction and integration planning	479
Legal Support	20
Total Transaction Costs	499

The Trusts are planning for the transaction to be low cost, with in-house resources and expertise utilised as much as possible to deliver the transaction. It is likely that the cost figures identified above will develop and iterate until FBC stage as the external due diligence process is undertaken, particularly in relation to the costs of integration post transaction in areas such as IT and Digital. Work in these areas is still at an early stage.

The two Trusts believe that the minimal investment of these costs is worthwhile, as the merger by acquisition presents a significant opportunity to achieve financial benefits through synergies and economies of scale.

Significant work has been undertaken to demonstrate these financial benefits in one key area: establishing a single, streamlined corporate structure:

- A single executive team has already been established during 2025/26, with the full year financial impact transacting in 2026/27.
- The second phase of work in 2026/27 focuses on the consolidation of senior management across corporate functions and estates. This is currently being worked through.
- The third and final phase of work will deliver savings through the full integration of corporate teams, standardisation of processes, and further reduction in duplication across both organisations.

Across all three phases, the programme is currently estimated to deliver a total recurrent saving of £5.0m, which equates to a reduction of c.93 WTE across corporate services and senior estates management. These financial benefits are recurrent and underpinned by detailed workforce modelling and organisational design work undertaken across both Trusts.

In addition, Model Hospital benchmarking and other initial reviews of clinical services have identified a further financial benefit opportunity of £10.7m (please note this is an estimate at this stage, based on Model Hospital opportunities when compared against the sector median).

Again, some of this is already being transacted in 2026/27 with £367k of savings being delivered in MSK, £134k in Cardiology, and £80k in Ophthalmology.



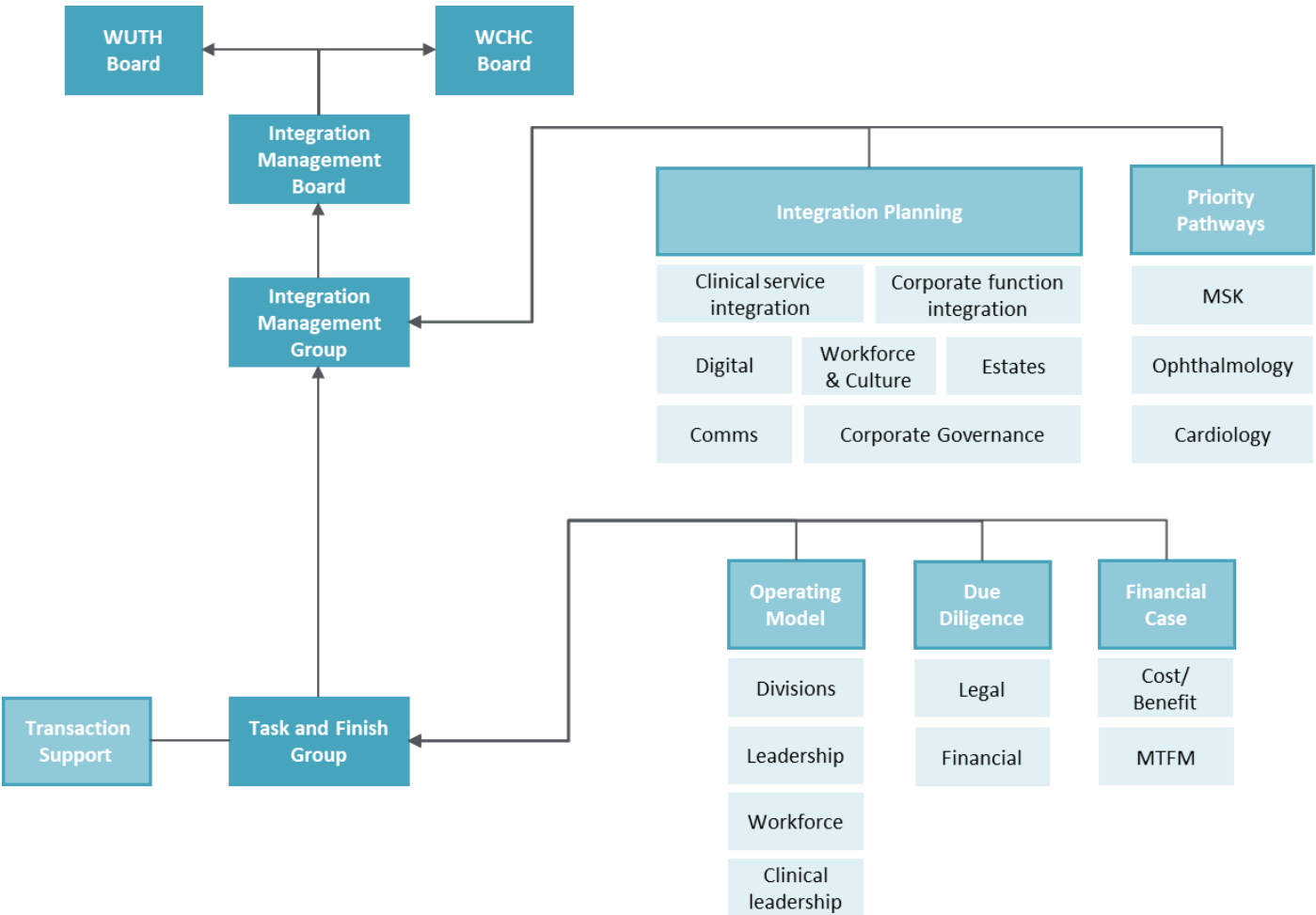
At this stage, therefore, based on the work undertaken to date, the two Trusts are confident that the potential financial benefits can repay the costs of the transaction and make an important contribution to reducing the size of the WUTH underlying deficit. An in-depth exercise will be carried out to quantify savings opportunities fully as part of the FBC stage.

To achieve the projected savings and fully realise the benefits of the integration, a dedicated programme will be established.

Deliverability

The two Trusts recognise that a transaction like this represents a significant amount of work on top of business as usual. Therefore, a robust and comprehensive framework has been established to ensure the success of the transaction with clear governance and planning, and dedicated resources in place.

Transaction Governance: A bespoke governance framework has been put in place to oversee the transaction. This framework is designed to provide clear accountability, effective decision-making, and continuous oversight. It is summarised in the diagram below.



Key elements include:



- **Integration Management Group (IMG):** The IMG leads an integration programme made up of key corporate and clinical integration workstreams, as well as overseeing the development of a new operating model for the new Trust. The Group ensures coordination and delivery of the key workstreams, and the resolution of emerging challenges.
- **Task and Finish Group:** This group leads the specific transaction planning and delivery activities that are required, including the development of documentation and the due diligence process.
- **Integration Management Board (IMB):** Both the IMG and the Task and Finish Group report into the IMB, which provides regular oversight of the programme, ensuring all key deliverables are met, risks are managed, and benefits are realised.

Ultimately, there is shared decision-making through a single Executive Team and joint NEDs working as a single unitary Board. The IMB reports up to this single unitary Board.

The IMG and Task and Finish Group will be responsible for:

- **Integration Planning and Delivery:** Developing and maintaining detailed integration plans, including post-transaction integration plans.
- **Monitoring and Reporting:** Tracking progress against milestones, managing risks, and reporting to the Board.
- **Coordination and Support:** Providing essential support and coordination across all workstreams, ensuring interdependencies are managed effectively.
- **Advisory Role:** Offering expert advice and guidance to workstream leads and the wider programme.

In terms of resourcing the transaction, this transaction is intended to be low cost. The majority of work will be undertaken by existing Trust staff through a workstream approach.

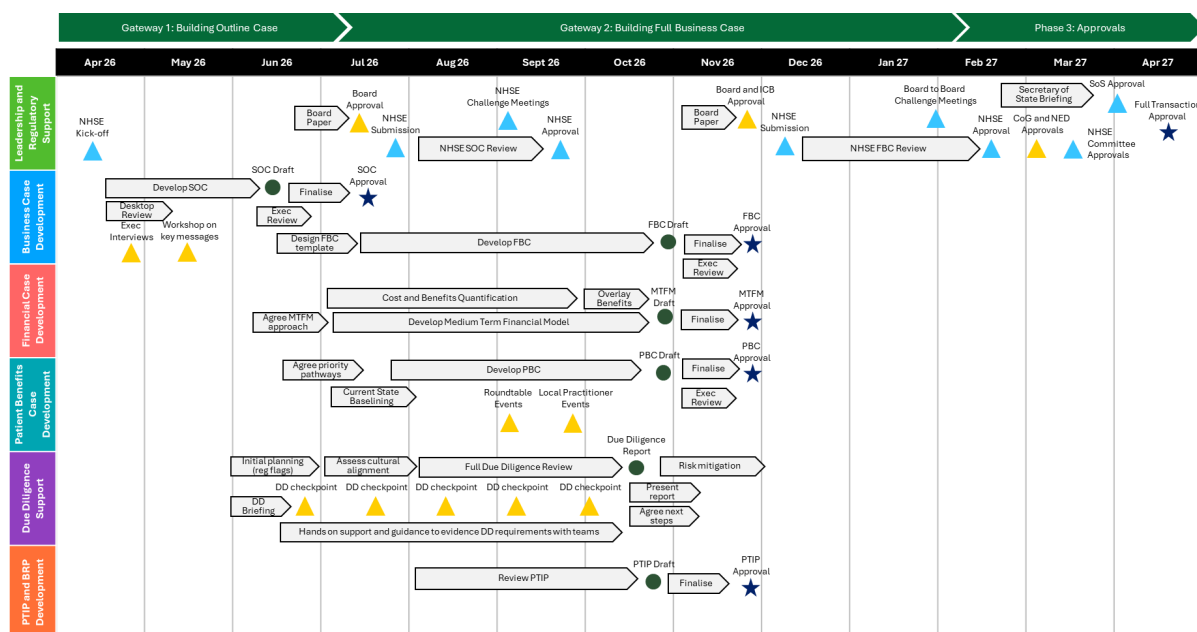
External advisers have been procured where additional capacity needs have been identified. For example, an external legal due diligence partner is being commissioned. Moreover, Deloitte have been commissioned to support the production of key transaction documents. The scope of these advisers has been restricted wherever possible to reduce cost. For example, the Trusts are preparing the PTIP document themselves.

Transaction Planning: The integration is following a structured, phased programme plan, with clear milestones identified for both pre-acquisition and post-acquisition stages. This includes:

- **Pre-acquisition (up to Day One):** Focusing on due diligence, securing necessary approvals, and establishing the foundational elements for the new entity (including the establishment of a Single Leadership Team and the consolidation of corporate functions).
- **Post-acquisition (Day 1 to 18 months and 1-3 years):** Concentrating on consolidating clinical functions, achieving operational efficiencies, and embedding the new culture.

The diagram below indicates the timeline for completing the required documentation and getting the necessary approvals up to day 1.





Furthermore, detailed integration plans have already been developed for each of the key workstreams overseen by the IMG. This work has focused on early integration priorities (for example, creating the Single Leadership Team, and the integration of Corporate Services).

Several supporting activities are embedded within the planning:

- **Communications, Engagement and Cultural Development:** A dedicated communications and engagement plan is in place to ensure transparent and timely communication with all stakeholders – staff, patients, and partners. This includes supporting cultural development to create a unified, inclusive culture for the new Trust.
- **Due Diligence:** A thorough due diligence process, covering financial, legal, operational, and clinical aspects, will be conducted to identify and mitigate any potential risks, ensuring a comprehensive understanding of the transaction.
- **Legal Form of Transaction:** The proposed legal form of WUTH acquiring WCHC has been carefully considered to be the most straightforward and deliverable option, leading to the creation of an expanded Foundation Trust.

With strong governance, comprehensive planning, and proactive risk management, the new Trust is well-positioned to achieve a successful integration.

Transition Planning

A structured approach has been designed to ensure an effective integration of WUTH and WCHC. This planning is crucial to minimise disruption, manage complexities, and ultimately deliver the full benefits of the new Trust. It provides a clear roadmap for moving from two independent organisations to a single, high-performing entity.

Crucially, this planning process has been ongoing for some time, which provides further assurance that it will be successful. Initially, the Wirral System Review detailed a range of benefits and

opportunities arising from the integration of WUTH and WCHC. These were then developed by the Trusts as part of project planning for the first 100 days of the integration programme.

The initial 100-day period of integration commenced on Wednesday 6th November 2024 and concluded on Friday 4th April 2025. The 100 Working Day Integration Plan document detailed the objectives, key programme areas, tasks and deliverables across the first 100 working days of the integration journey. The transition planning has always been built around several critical workstreams, each with clear objectives and scopes, to ensure comprehensive coverage of all integration aspects.

Following the conclusion of the 100 Working Day Integration Plan in April 2025, a longer-term Two-Year Integration Plan was developed, setting the strategic intentions for WUTH and WCHC on integration and a pathway towards becoming a single organisation. The Two-Year Integration Plan was approved by the IMB in early April 2025 and commenced delivery from this time, with monthly progress updates for each work area provided to the IMB.

Current transition planning has been built on this strong foundation: there are good relationships across the staff who have been involved in the workstreams to date, given the work has been done. For example, the below provides an overview of the key activities that have been delivered successfully to date:

- **Single Leadership Team:**
 - Consideration and appointment of Non-Executive Directors (NEDs) along with a substantive appointment to the Joint Chair Role.
 - Joint Executive Team structure and roles approved, individuals selected and appointments made (including the Joint Chief Executive Officer (CEO)).
 - Developed a plan for Sub-Executive Team Roles with a Single Leadership Team Comms Plan submitted to IMG.
- **Corporate Governance:**
 - Partnership Agreement between WCHC and WUTH implemented (subject to a cyclical review) during the interim phase prior to the merger by acquisition.
 - Establishment of the Integration Management Board with Terms of Reference (ToR) developed and shared with both Trusts' respective Boards.
 - Thorough review of current meeting cycles and alignment of Board meetings.
 - Commenced alignment of Committees and establishment of Committees in Common (CiCs) where appropriate.
- **Clinical Service Integration:**
 - Conducted service reviews and developed integration plans for urgent care, cardiology, ophthalmology, MSK, intermediate care and Therapies.
 - Commenced delivery of integration plans for urgent care, cardiology, ophthalmology and MSK services.
- **Workforce and Culture:**
 - Developed and implemented a workforce sharing agreement between WUTH and WCHC (including operating principles) for the interim period prior to full integration.
 - Reviewed national staff survey results across both Trusts to identify areas of strengths / concerns and developed an organisational methodology for use at service level.

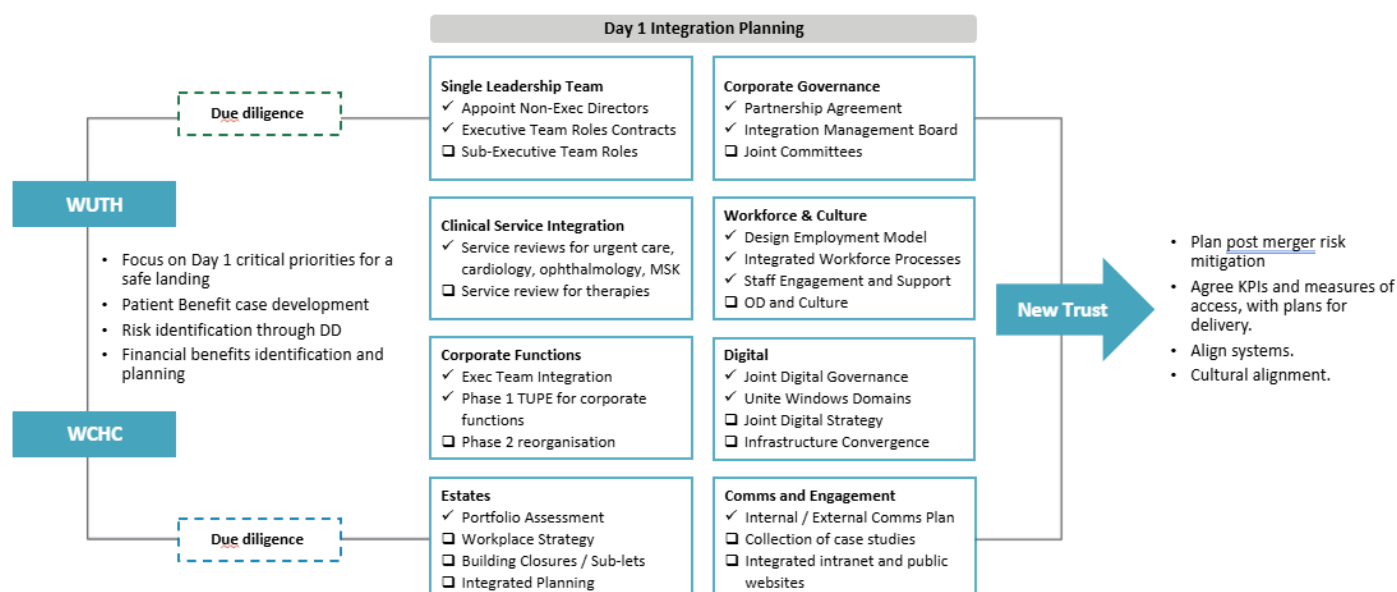
- Designed and commenced delivery of staff engagement plans and integrated staff support packages.
- Launched joint workforce redeployment process.
- **Corporate Functions:**
 - Successfully integrated Executive Teams of WUTH and WCHC.
 - Leveraged workforce sharing agreement to engage with teams in planning integration opportunities.
 - Commenced integration of all other corporate functions (including Workforce Directorate, Finance Directorate, Estates and Facilities Directorate etc.).
 - Successful TUPE transfer of corporate functions staff and commencement of joint restructuring where required.
- **Digital:**
 - Established joint digital governance including data sharing and DPIAs.
 - Commenced thorough review of options for full convergence of data versus a federated infrastructure for WUTH and WCHC.
 - Successfully conducted due diligence and united Windows domains to allow single sign on / authentication to all applications and shared resources.
 - Commenced implementation of a single IT service desk model.
 - Developing a joint digital strategy and commencing wider organisational integration and transformation activities.
- **Estates:**
 - Conducted a portfolio assessment across WUTH and WCHC estates and facilities.
 - Identified void space and areas of under occupancy to support future requirements for services to be delivered in the community.
 - Identified freehold properties and rationalisation plans for the closure, occupancy impact assessment and develop plan for relocation of services into existing Estates.
 - Accessed and assessed Clinical service strategies to enhance the Estates asset portfolio optimisation and rationalisation plan.
- **Comms and Engagement:**
 - Developed joint internal and external communication strategy and plan.
 - Launched “Better Together” integration branding.
 - Commenced delivery of the communication plan to internal and external stakeholders.

This work to date provides a very strong foundation for the future transition planning.

A programme management capability (embedded within the Task and Finish Group) will be key to the execution of the remaining activities in the transition plan. This will provide essential support, coordination, and oversight, managing integration plans, tracking progress against milestones, identifying and escalating risks, and ensuring effective communication across all workstreams.

The transition will be managed through a phased, collaborative programme. The plan is underpinned by a commitment to maintaining service quality and patient safety throughout the entire process. It is summarised in the diagram below.





Phased Integration Plan: The transition is structured into distinct phases to manage complexity and ensure readiness:

- **Pre-acquisition and Up to Day One:** This phase focuses on critical preparatory activities, including due diligence, securing necessary approvals, and establishing the foundational elements for the new entity.
- **Day 1 to 18 Months Post-acquisition:** This phase concentrates on consolidating clinical and corporate functions, achieving initial operational efficiencies, and embedding the new culture.
- **1-3 Years Post-acquisition:** This longer-term phase focuses on deeper integration, realising full benefits, and continuous improvement initiatives.

Beyond the structural workstreams, the plan places significant emphasis on:

- **Cultural Development:** Proactive initiatives to create the organisational climate which will lead to a shared culture which fosters a shared identity and values.
- **Workforce Integration:** Ensuring staff are supported through the transition, with clear communication, fair processes, and opportunities for development.
- **Communications and Engagement:** Maintaining transparent and consistent communication with all stakeholders throughout the process.

The transition plan demonstrates an organised and proactive approach to integration. By detailing the governance, workstreams, and phased plan, it provides assurance that the creation of the new Trust will be managed effectively, leading to a successful and sustainable future for healthcare in Wirral.

Comms and Engagement

Effective communication and engagement are recognised as paramount to the successful integration of WUTH and WCHC. The Comms and Engagement approach outlines a proactive and transparent strategy designed to foster trust, manage expectations, and ensure all stakeholders are informed, heard, and actively involved throughout this transformative journey.

Strategic Objectives: The communication and engagement plan is guided by clear principles to:

- **Articulate Rationale and Benefits:** Clearly explain the strategic imperative and the positive outcomes of the integration for patients, staff, and the wider community.
- **Provide Timely and Accurate Information:** Ensure consistent, reliable, and up-to-date information is shared across all channels.
- **Address Concerns and Build Confidence:** Provide clarity to staff about their roles, job security, and future opportunities, and service users about the continuity and quality of care.
- **Foster Excitement and Shared Purpose:** Generate enthusiasm for the new organisation and its potential to deliver enhanced healthcare.
- **Actively Listen and Respond:** Create channels for feedback and ensure concerns are acknowledged and addressed.
- **Manage External Perceptions:** Shape a positive narrative about the integration among external stakeholders and the public.

Key Target Audiences: The strategy is tailored to engage a diverse range of stakeholders, including:

- **Internal Stakeholders:** All staff members of WUTH and WCHC, Staff Side, and governors.
- **Service Users, Carers, and the Public:** Patients, their families, and the wider Wirral community.
- **External Partners:** The Integrated Care Board (ICB), local authorities, primary care providers, voluntary sector organisations, and local politicians.

Multi-Channel Approach: A comprehensive suite of communication channels will be utilised to ensure broad reach and effective engagement:

- **Internal Communications:** Regular staff bulletins, messages from the Chief Executive Officer (CEO), screensaver messages, intranet updates, staff briefings, webinars, and co-production sessions.
- **Public and Patient Engagement:** Trust websites, posters, social media campaigns, letters from the CEO, and dedicated engagement events.
- **Partner Engagement:** Direct correspondence, 1:1 meetings with key leaders from the ICB and local politicians, and ongoing engagement forums.

Significant engagement has already taken place during the initial phases of the integration programme, characterised by transparency and a commitment to gathering feedback. The CEO has actively participated in staff events, addressing questions and concerns directly. This foundational work will be built upon as the programme progresses to the FBC stage. The communication plan will be continuously refined and adapted based on feedback and evolving needs, ensuring it remains effective and responsive.

The Comms and Engagement approach is a vital component of the integration's success. By prioritising clear, consistent, and empathetic communication, the new Trust aims to build strong relationships, foster a shared vision, and ensure that all stakeholders feel informed, valued, and confident in the future of healthcare in Wirral.

Emerging Risks

The successful integration of WUTH and WCHC is a complex undertaking. The two Trusts have carried out a transparent and proactive assessment of potential challenges that could arise during the transition and post-integration phases. By identifying these risks early, the new Trust can implement robust mitigation strategies ensuring a smooth transition and safeguarding the quality and safety of services.

The key emerging risks and their mitigation include:

Risk	Mitigation
Patient Experience and Service Continuity: Potential disruption to care, impact on service user experience, and challenges in maintaining safety and quality during the transition period.	Developing a comprehensive service delivery transition plan to ensure an integrated, resilient service post-merger. This includes continuous monitoring of service user experience and complaints, establishing quality dashboards, and implementing active clinical audit programmes. Plans will be in place to address unforeseen events swiftly.
Cultural Development and Workforce Morale: Significant cultural differences between the Trusts, potential loss of identity, staff anxieties, and decreased morale, which could impact engagement and day-to-day operations.	Implementing a comprehensive cultural development plan to address potential differences and foster a unified organisational culture. This involves proactive communication, engagement with staff and Staff Side, and promoting opportunities for reward and recognition to build a shared sense of purpose and belonging.
System and Corporate Services Overload: The additional workload of integration could overwhelm existing system priorities and corporate services, leading to delays or reduced efficiency.	Maintaining clear organisational priorities, pausing less strategically important work, and bringing in additional resources or expertise where necessary. This ensures that critical business activities continue uninterrupted while supporting the integration process.
Financial Risks: Integration costs exceeding projections, or anticipated benefits not being fully realised, impacting the financial sustainability of the new Trust.	Conducting thorough financial due diligence to analyse cash flow, debt covenants, contingent liabilities, and tax implications. Detailed work will establish a full schedule of financial costs and benefits, with continuous monitoring to ensure projections are met.
IT / Digital Complexity and Cybersecurity: Operational disruption due to the integration of disparate systems, technologies, and processes, alongside increased	Developing a phased plan for digital integration based on capacity and contract expiry. This includes ensuring all systems are secure, implementing a robust cybersecurity framework, and adhering to a secure data migration strategy to protect sensitive information.

cybersecurity threats during infrastructure migration.

Legal, Compliance, and Performance: Challenges in ensuring legal and regulatory compliance, potential for non-compliance with CQC standards, and risks to performance metrics during transition. Undertaking detailed legal due diligence, ensuring compliance with all regulatory requirements, and establishing clear performance metrics with regular reviews to monitor progress and address any deviations promptly.

Contingency and Integration Management: Unforeseen events or the sheer complexity of executing the transaction could lead to delays or overstressing capacity. Implementing a robust programme management capability with dedicated resources and expertise to manage the integration programme. This includes establishing clear governance, managing interdependencies, and developing contingency plans for potential disruptions.

The transition programme management capability (embedded in the Task and Finish Group) will play a central role in overseeing and allocating key risks to workstreams, maintaining a comprehensive Transaction Risk Register, and working closely with the IMB and IMG to mitigate identified risks. This structured and proactive approach to risk management is fundamental to ensuring the successful and sustainable integration of WUTH and WCHC, safeguarding the delivery of high-quality care for the Wirral community.

Conclusion

This SOC demonstrates that the proposed integration of WUTH and WCHC is not merely an option, but the essential and optimal pathway to secure a thriving and sustainable future for healthcare in Wirral. The current fragmented landscape, with its inherent inefficiencies, service duplications, and limitations, simply cannot deliver the holistic, high-quality, and resilient care that our community deserves.

Only through this unified approach can we truly unlock the full potential to transform patient experience, empower our dedicated workforce, achieve robust financial resilience, and drive the innovation necessary to meet the evolving health needs of our population.

This integration represents a bold, decisive step, ensuring a healthcare system that is not only fit for purpose but a beacon of excellence, delivering healthier lives and stronger communities for generations to come. This aligns with our joint vision that “Together we will create healthier lives and stronger communities”.



Introduction

Introduction

This SOC presents the rationale for integrating WUTH and WCHC into a single, unified organisation. The newly enlarged entity will be dedicated to creating healthier lives and stronger communities across Wirral and beyond, delivering comprehensive, seamless health and care services across the full care continuum.

Currently, both Trusts run independently. While each has individual strengths, this separation presents challenges in delivering truly integrated care pathways, optimising resource allocation, and responding cohesively to the evolving health needs of the population.

Therefore, this document aims to show how a unified organisation will effectively address these issues, using the combined strengths and expertise of both Trusts to enhance patient experience, improve health outcomes, and ensure long-term sustainability within the Wirral health economy.

It also aligns with the strategic goals of the C&M ICS, fostering greater collaboration across health and social care and the direction of travel as described in the NHS 10-year plan.

The primary purpose of this document is to secure approval to proceed with the development of a FBC and to undertake further integration planning.

This document is structured to provide the:

- Background and context behind the new Trust.
- Case for change to existing organisational arrangements.
- Options for collaboration that the Trusts considered, leading to the preferred option.
- Vision for the new organisation.
- Benefits and intended advantages for service users, staff, and the wider Wirral health economy.
- Financial case supporting the transaction.
- Approach to execute this transaction, including an initial implementation roadmap, risk register and mitigations, and transition governance arrangements.



Background and Context

Background and Context

This chapter establishes the context and rationale for the proposed integration of WUTH and WCHC. It details the overarching strategic imperatives from the regional and national health landscape, outlines the current operational and financial profiles of both Trusts, and critically, demonstrates how the findings of the Wirral System Review and the subsequent Joint Strategy necessitate this work to deliver a truly integrated and sustainable health and care system for Wirral.

Cheshire and Merseyside Health and Care System

The C&M ICB, established in July 2023, is responsible for the planning and oversight of NHS services for a population of 2.7 million residents, managing an annual commissioning budget of £8.2 billion. Its foundational principle is collaborative action to integrate services, address health inequalities, and enhance health outcomes, with a vision for everyone to have a great start in life and the support to stay healthy and live longer. Its core mandate includes improving population health outcomes, reducing health inequalities, enhancing productivity, and supporting broader social and economic development.

The system faces a complex range of health and care challenges, including long-standing deprivation, an ageing population (over 22% aged 65+, 90+ expected to double by 2043), and stark health inequalities. A significant 35% of residents live in the most deprived areas, and the population is projected to grow by 10.8% by 2040, with the over-75 demographic increasing by 45%. These demographic shifts and socio-economic disparities drive rising demand for services and place considerable pressure on the 16 NHS provider Trusts and one Ambulance Service within the C&M ICB footprint.

Furthermore, the C&M health and care system faces significant clinical, workforce, and financial challenges. These include the fragility of certain clinical services, duplication of provision, persistent workforce shortages, and widespread financial viability concerns among provider Trusts, with a majority forecasting significant deficit. There is also notable variation in the integration and provision of community and acute health services across the region.

These systemic pressures underscore the need for closer collaboration and integration, a principle directly addressed by the proposed merger of WUTH and WCHC, which aims to consolidate resources and expertise to better meet these complex demands.

Nationally, there has been a discernible shift towards greater collaboration and integration of clinical services across local care systems, leading to new organisational and governance models being established. The role of C&M ICB is therefore evolving towards strategic commissioning, population health strategy, and market management, implying a transfer of functions like service development and innovation to NHS providers. This shift, coupled with the C&M ICB's commitment to delivering care closer to people's homes, proactive prevention, and digital innovation, further reinforces the strategic imperative for the proposed merger.

Cheshire and Merseyside 5-year Clinical and Strategic Commissioning Plan 2026/2031

The 5-Year Clinical and Strategic Commissioning Plan 2026/2031 for Cheshire and Merseyside articulates a profound commitment to transforming the health and wellbeing of its 2.7 million residents. Developed in alignment with the national NHS 10-Year Plan, it sets forth a strategic framework to address persistent health inequalities, enhance service quality, and secure long-term financial viability across the ICS.

The plan's vision is to empower every individual in Cheshire and Merseyside to experience a healthy start in life and receive the necessary support to maintain their health for longer. This is underpinned by a mission to proactively prevent ill health, rigorously tackle health inequalities, and rapidly improve the lives of the most vulnerable populations through collaborative partnerships. To achieve this, the strategy is built upon three fundamental shifts (in line with the 10-year Health Plan):

- **Hospital to Community:** This involves a significant reorientation of care delivery, moving away from fragmented, hospital-centric models towards integrated, outcome-focused care within neighbourhood settings. The aim is to provide proactive, preventative support closer to people's homes, thereby improving patient experience and reducing reliance on acute services.
- **Sickness to Prevention:** A core tenet of the plan is to shift investment and focus towards preventative and proactive care. This includes optimising immunisation and screening programmes, effectively risk-stratifying the population to target interventions where need is greatest, and supporting individuals with long-term conditions to better manage their health.
- **Analogue to Digital:** Recognising the transformative potential of technology, the plan champions a comprehensive digital agenda. This encompasses creating a single multi-year digital investment model, establishing a digital centre of excellence, ensuring timely and secure access to accurate health records across all care settings, and leveraging data-driven intelligence and Artificial Intelligence (AI) to inform clinical decisions, improve outcomes, and enhance operational productivity.

The plan's priorities are meticulously informed by an Integrated Needs Assessment, which highlights critical areas of concern such as widening life expectancy gaps, increasing rates of chronic conditions, and significant growth in demand for services related to neurodevelopmental conditions. These insights guide the allocation of resources across key life-course stages:

- **Living Healthy Lives:** Focusing on prevention and proactive care to address social determinants of health.
- **Starting Well:** Enhancing maternity and neonatal care to ensure the best start for children.
- **Growing Well:** Improving outcomes for children and young people, including mental health and neurodiversity support.
- **Living Well:** Addressing adult mental health, learning disabilities, neurodiversity, and optimising primary care and diagnostics.
- **Ageing Well:** Prioritising frailty and falls prevention, dementia care, and urgent and emergency care for older adults.
- **Dying Well:** Ensuring equitable access to high-quality palliative and end-of-life care.



The successful implementation of these strategic shifts and priorities is contingent upon robust enablers:

- **Clinical Leadership and Quality, Safety, and Experience:** Empowering clinical and care leaders to drive continuous improvement and ensure patient-centred, safe, and effective care.
- **Digital and Data:** Building strong digital foundations, developing 'at scale' platforms, and deploying digital tools and services to enhance efficiency and decision-making.
- **Workforce:** Diversifying, strengthening, and modernising the health and care workforce, fostering a culture of shared learning, and planning for future skill requirements.
- **Estates and Infrastructure:** Developing a modern, adaptable, and future-proof physical estate that supports new models of working and enhances service integration.
- **Financial Sustainability:** Addressing the underlying system deficit through allocative efficiency, system integration, and strategic resource realignment to redirect investment towards prevention and community-based care.

The plan also underscores the critical importance of strategic system leadership, with the ICB acting as a system convenor to strengthen collaboration across all partners. This includes working closely with local authorities, VCFSE organisations, and provider collaboratives to co-design and co-deliver solutions. A robust governance framework, including Priority Programme Boards and a Strategic Commissioning Programme Board, will assure delivery, monitor progress against clear metrics, and ensure accountability. Acknowledging a significant underlying system deficit, the financial strategy focuses on redirecting investment towards prevention and early intervention. A substantial transformation fund is earmarked to drive the "Left Shift" from hospital to community, analogue to digital, and sickness to prevention, alongside efforts to improve productivity and efficiency across existing services. This approach aims to ensure long-term financial sustainability while delivering improved population health outcomes.

The strategic integration of WUTH and WCHC is poised to serve as a cornerstone in the successful delivery of this commissioning plan. This collaborative endeavour will foster a more cohesive and streamlined patient pathway. By consolidating leadership, optimising the utilisation of physical estates, and integrating clinical and support services, this integration directly advances the plan's "Hospital to Community" shift. It facilitates the seamless delivery of care within local neighbourhood settings, thereby reducing service duplication and strategically reallocating resources from reactive hospital-based care towards prevention, early intervention, and robust community-based support. This unified operational model is anticipated to enhance consistency in access to services, elevate patient experience, and ultimately drive improved health outcomes across Cheshire and Merseyside through a more coordinated, efficient, and patient-centred system of care.

Cheshire and Merseyside Provider Collaborative Blueprint

In response to system-wide challenges, the C&M Provider Collaborative (CMPC) Blueprint (2026 to 2028) was developed to guide the direction of travel for NHS provider Trusts across Cheshire and Merseyside.

This strategic document acknowledges the significant pressures, including the long-term financial sustainability concerns of many Trusts, the fragility of clinical services due to workforce and scale



issues, noted variation in community and acute health service provision, and the inefficiency of duplicated corporate and clinical support functions.

To address these, the Blueprint sets a clear direction for provider Trusts, focusing on collaboration, integration, and efficiency.

Key priorities include:

- Encouraging the formation of Partnerships and Collaborations across Provider Trusts;
- Promoting the consolidation of clinical and clinical support services;
- Creating Service Chains for Specialist Services;
- Hosting fragile services across multiple groups;
- Aligning Community Health Services to Places/Integrated Care Footprints; and,
- Consolidating Corporate and Clinical Support Functions on larger footprints.

The Blueprint projects significant financial benefits, with potential savings of up to 10-15% of Trust expenditure.

The proposed integration between WUTH and WCHC is a direct and significant step towards realising these Blueprint projected benefits, aligning with the Blueprint's call for formal mergers and group models to achieve scale and efficiency for Cheshire and Merseyside NHS provider Trusts. This merger is essential to unlock the full potential of these strategic initiatives, providing a robust framework for the deep integration required to deliver the Blueprint's ambitious goals.

Wirral Health and Wellbeing Strategy

Complementing the above regional strategy, the Wirral Health and Wellbeing Strategy (2022 to 2027), led by the Wirral Health and Wellbeing Board, provides a local strategic roadmap for improving the health and wellbeing of all residents across the borough.

This strategy is built on the fundamental principle that health underpins opportunities, freedom, and independence, and acknowledges the persistent and significant health inequalities within Wirral.

A detailed current state assessment revealed critical local challenges:

- Life expectancy in Wirral is lower than the national average and has worsened;
- Stark disparities exist, with a child born in Greasby expected to live 12 years longer than one in Bidston;
- 1 in 3 people reside in the 20% most deprived areas;
- Cancer and circulatory problems are leading causes of mortality;
- Mental health issues significantly contribute to economic inactivity; and,
- Trends in early childhood development are concerning.

These statistics collectively paint a picture of a borough facing complex, interconnected challenges where health outcomes are heavily influenced by social and economic determinants.

The Strategy's overarching ambition is to ensure that everyone can live a healthier life, no matter who they are or where they live, pursued through five strategic priorities.



The proposed integration significantly enhances the ability to achieve each of these priorities, showing its critical importance to local health outcomes by:

- Creating opportunities to get the best health outcomes from the economy and regeneration programmes through an expanded anchor institution;
- Strengthening health and care action to address differences in health outcomes through a unified, whole-system approach;
- Ensuring the best start in life for all children and young people through more seamless and comprehensive support; by creating safe and healthy places for people to live that protect health and promote a good standard of living through better integration of health considerations into urban planning; and,
- Creating a culture of health and wellbeing, listening to residents, and working together through a larger, more coordinated engagement platform.

It is designed to accelerate and strengthen the collaborative, data-driven, and resident-centred approach essential for the Wirral Health and Wellbeing Strategy's success, ensuring a more cohesive and impactful response to the borough's unique health challenges.

Wirral System Review

The need for deeper integration was further highlighted by a Wirral System Review, commissioned by C&M ICB in March 2024. Conducted in two phases, the review addressed significant challenges within the Wirral health and care system, specifically focusing on WUTH and WCHC.

Terms of Reference were developed, and goals agreed, including developing a strategy for greater collaboration across acute, community, and primary care services, identifying clinical, operational, and financial integration priorities, and outlining an implementation roadmap.

Phase 1 (July 2024) found a fundamental need for improved collaboration due to significant NHS leadership challenges, a lack of a clear integration model, strategic misalignment, and pervasive cultural and organisational barriers. These included perceived poor behaviours, protection of organisational sovereignty, and anxieties about autonomy loss.

The report highlighted gaps in effective collaboration and made key recommendations for high-priority service areas, such as Unscheduled Care (e.g., reviewing ARI hubs, joint point-prevalence reviews, clear referral protocols) and other specialist services (Neuro-diverse pathway, Ophthalmology, Cardiovascular Disease, MSK) where a merged entity could streamline pathways and establish single provider models more effectively.

Crucially, opportunities to reduce costs through the sharing of corporate services were identified, with a full merger providing the most comprehensive framework to maximise these efficiencies.

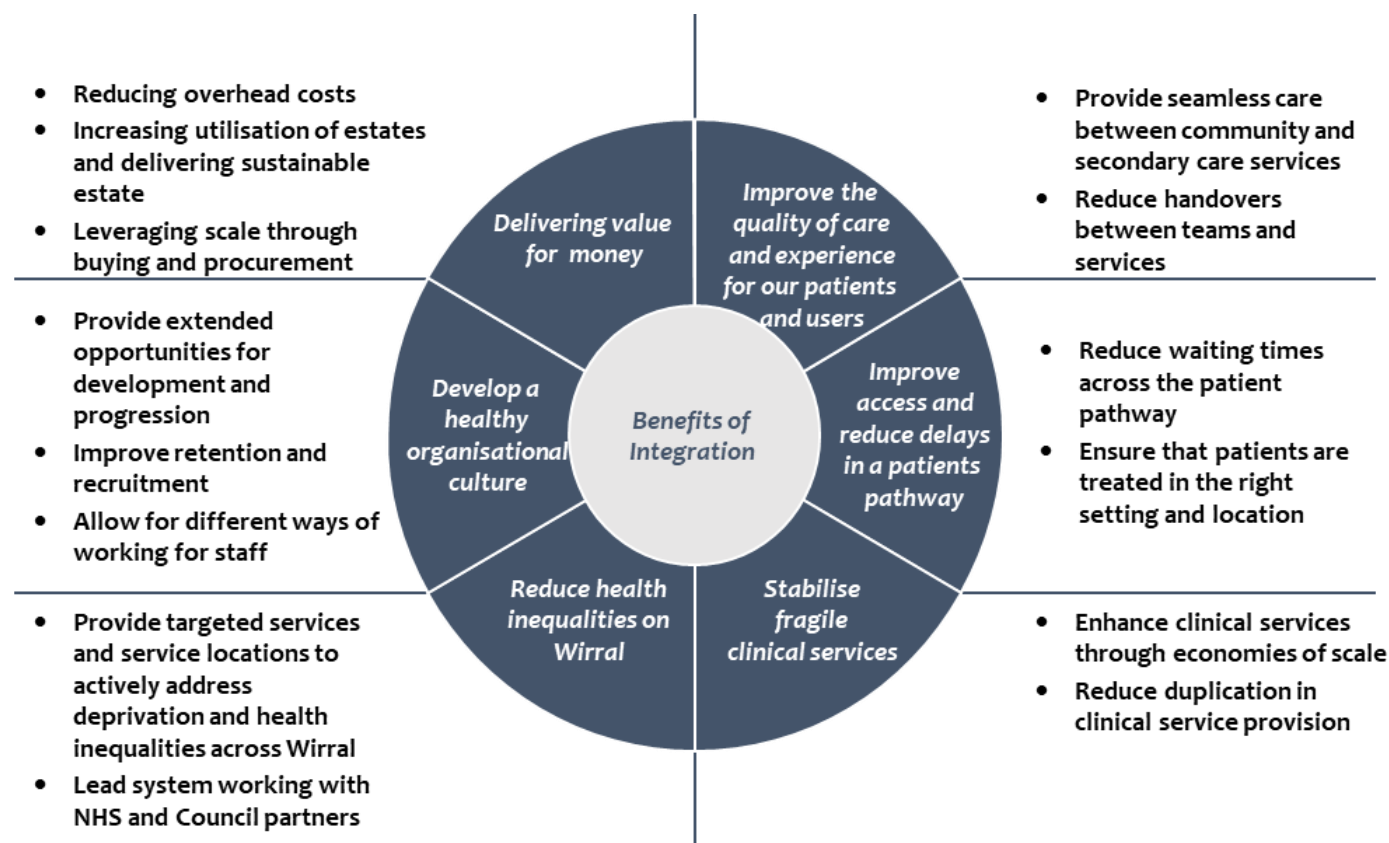
Building on these insights, Phase 2 (September 2024) concluded that a Shared Leadership Model was the preferred option for collaboration and integration, best satisfying the requirements of the 2022 Health and Care Act and provider expectations.

This model, unanimously agreed upon, recommended the appointment of a Joint Chair and Joint Chief Executive Officer (CEO) for both Foundation Trust Boards to ensure unified leadership, vision, identity, accountability, and governance. It also proposed setting up an Integrated



Programme/Management Board (IPB) with delegated authority from both Boards to oversee integration and drive change, identifying senior leadership posts for joint appointments, and reviewing Place governance arrangements to avoid duplication. The Wirral System Review report was later approved by C&M ICB, WCHC, and WUTH Boards in September and October 2024.

This showed a range of benefits from integration, further developed by the Trusts' Executive Teams in November 2024. These benefits focus on improving patient care quality and access, stabilising fragile clinical services, reducing health inequalities, fostering a healthy organisational culture, and delivering value for money. These identified benefits also formed the foundation for staff and stakeholder communications on the integration.



A financial assessment undertaken by WCHC and WUTH during the review period, utilising NHS Model Hospital data, found a cost-saving opportunity of approximately £13 million. These savings are projected across three fiscal years, stemming from efficiencies in urgent and emergency care, corporate functions, estates, and elective care.

Since the review's conclusion, considerable progress has been made in advancing the integration of WCHC and WUTH, systematically laying the foundation for full integration. Key milestones include:

- The appointment of a Joint Chair (October 2024) and Joint Chief Executive (November 2024) across both Trusts, signifying unified leadership and strategic alignment.
- An intensive 100 Working Day Integration Plan (November 2024 - April 2025) was implemented, focusing on key integration programme areas.
- Initial reviews and prioritisation of clinical services for integration were completed, and approaches to corporate functions integration and a workforce management agreement were determined.
- A Case for Change document was collaboratively drafted, articulating the compelling reasons for WCHC and WUTH to integrate as a single organisation.
- A Two-Year Integration Plan (April 2025 - March 2027) was developed and approved, setting out the strategic intentions for the integration journey with a clear pathway towards becoming a single organisation.
- Appointment of a single Board across the two Trusts (in November 2025), including Executive and Non-Executive Directors.

These progressive steps show a clear commitment to the Wirral System Review's recommendations, building a robust foundation that unequivocally points towards a full merger as the necessary and most effective mechanism to achieve a truly cohesive and effective health and care system for Wirral.

Wirral University Teaching Hospital

WUTH is a large acute Foundation Trust, serving approximately 400,000 residents across Wirral, Ellesmere Port, Neston, North Wales, and the wider Northwest region. Established as a Foundation Trust in July 2007, it is Wirral's largest employer with over 6,000 staff, forming a fundamental part of the local health and social care system.

Core Services and Facilities

WUTH delivers a comprehensive spectrum of acute, specialist, and community healthcare services primarily from two main hospital sites, complemented by a network of community-based provisions.

Arrowe Park Hospital in Upton Wirral serves as the Trust's principal acute hospital and the hub for emergency and complex care. It offers a full range of emergency and acute services for both adults and children, including a 24/7 Urgent and Emergency Care (UEC) Department, currently undergoing a significant upgrade programme to incorporate a "one front door" model with a dedicated Children's Emergency Department. Within Arrowe Park Hospital, the Wirral Women's and Children's Hospital offers specialised services such as comprehensive Maternity Services, a designated Level 3 Neonatal Unit, Gynaecology, and Paediatrics. The hospital also provides a wide array of General Acute Specialties, Critical Care facilities, extensive Outpatient Services, and Day Surgery Services.

Clatterbridge Hospital in Bebington Wirral is primarily dedicated to planned care, diagnostics, rehabilitation, and specialist outpatient services. This site offers Planned Surgical Services across various disciplines, Specialist Medical Services including dermatology, breast care, and neuro-



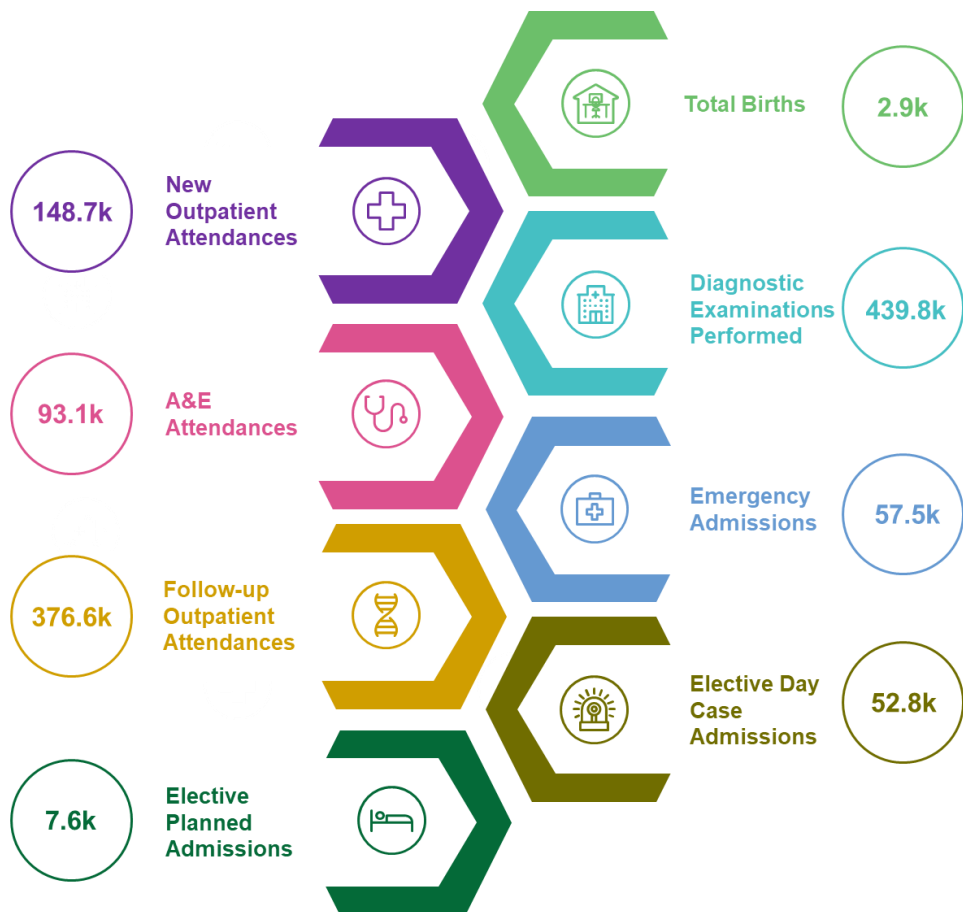
rehabilitation, and dedicated Stroke Services. Clatterbridge also hosts two state-of-the-art Advanced Diagnostics Centres equipped with modern MRI and CT scanners, significantly improving access to high-quality imaging.

Beyond its hospital sites, WUTH extends its services into the community to enhance accessibility and integrate care closer to patients' homes. This includes provisions at St. Catherine's Health Centre in Birkenhead for community paediatric services and audiology, and Victoria Central Clinical Centre in Wallasey for X-ray services and outpatient clinics. Various services are also delivered in partnership with primary care and local authorities within GP Practices, Schools, and other Community Settings, supporting integrated care pathways.

Finally, WUTH also provides a comprehensive range of specialised clinical services, often acting as a regional centre of excellence, including Renal Medicine, Dermatology, Ophthalmology, Orthopaedics, Urology (with a specialist cancer centre and robotic surgery), Gynaecology, and Neonatal Intensive Care.

Performance

WUTH's operational scale and impact are evident in its annual activity figures (from the 2024/25 annual report):



The Trust's performance against national waiting time targets is a key focus. For 2024/25, the maximum waiting time for referral to diagnosis for all screening and ultrasound-detected referrals was 75% (target 75%), while the maximum waiting time for diagnosis to treatment for all cancers

was 96% (target 96%). However, the 4-hour A&E target compliance was 66.4% (target 95%), showing ongoing pressures in urgent care.

CQC

The Trust's overall CQC rating from February 2021 is 'Requires Improvement' with results by area as follows:

Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Use of resources	Requires improvement	●

Recent focused inspections show mixed results:

- Urgent and Emergency Care (2023): 'Requires Improvement'
- Maternity Services (2023): 'Good'
- Adult Inpatient Services (2024): 'Requires Improvement'
- Medical Services (2021): 'Requires Improvement'

Following the inspections improvement action plans have been developed with the majority of actions completed. Any outstanding actions are reviewed regularly through assurance meetings with divisional leads and reported to the Trust Patient Safety and Quality Board. Additionally, the Trust continues to work with the identified CQC relationship manager and provides further assurance for organisational progress.

Recognising WCHC's achievements in obtaining 'Good' ratings in these areas in recent inspections there are opportunities for shared learning across the organisations to improve an enlarged Trust's CQC rating in the future.

Complaints referred to the Parliamentary and Health Service Ombudsman reduced by 13% in 2024/25.

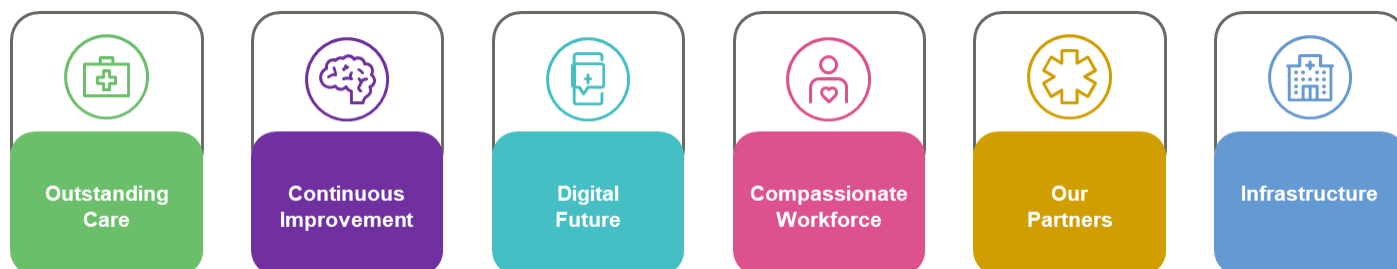
Finances

For 2025/26, WUTH reported a year-end deficit of £47.6 million, with an operational deficit of £42.0 million, compared to the planned deficit of £5.5 million.

- Total Income: £533.0 million (91.7% from NHS patient care activities).
- Total Expenditure: £575.1 million (72% pay costs, 28% non-pay costs).
- Capital Investment: £25.9 million.
- CIP Savings: £32.0 million (£8.6m non-recurrent) against a target of £32.0 million.
- Cash Balance (31 March 2026): £2.8 million.

Priorities and Achievements

WUTH's strategic framework for 2021-2026 was built around six core objectives:



These objectives are delivered through seven enabling strategies: clinical service strategy; workforce and education strategy; patient experience, quality and safety strategy; estates master plans; digital strategy; research and innovation strategy; and financial strategy.

Ongoing initiatives demonstrate progress against these priorities:

The Trust has made a major strategic investment in its Urgent and Emergency Care (UEC) Upgrade Programme at Arrowe Park Hospital, aiming to transform emergency care provision and patient experience.

Digital transformation is actively pursued through initiatives such as the MyMobility app for patient care management, investments in advanced diagnostic equipment, and ongoing efforts to enhance cybersecurity and data management.

Furthermore, the Trust has launched a new Wirral Research and Innovation Centre at Clatterbridge, fostering collaborations with universities and the National Institute for Health and Care Research (NIHR) to advance medical research and improve patient outcomes.

Workforce development and culture are guided by the People Strategy (2022-2026), which focuses on "Shaping our Future" - such Initiatives include the Harnessing Talent Framework, a new CEO Star Award, and a strong commitment to Equality, Diversity, and Inclusion (EDI), evidenced by its Bronze status for the North West Anti-Racist Charter.

However, staff survey results show areas for improvement in staff engagement and morale. In terms of sustainability, WUTH is committed to achieving Net Zero by 2040, with an interim target of an 80% reduction in carbon emissions by 2028.

The Finance strategy has been actively prioritising and pursuing improvements focusing on four domains: processes and culture; zero based budgeting; productivity based budgeting; and prioritisation and collaboration to improve their financial sustainability and enhance collaboration with WCHC.

Initiatives such as investing in renewable energy (solar PV), LED lighting, and tree planting have contributed to a 10.05% reduction in total carbon emissions (tCO₂e) in 2023/24 compared to 2020/21.

The Trust is also an active participant in the ICS and Partnership Working, engaging with the Wirral Place Partnership and the CMPC.

Challenges and Risks

WUTH continues to navigate significant and complex challenges.

Financial sustainability is still a primary concern, with a persistent operational deficit and ongoing requirements to deliver large CIPs posing a significant financial risk that affects the Trust's ability to invest and maintain services. The proposed merger aims to directly address this by using economies of scale, reducing duplication, and optimising resource allocation, thereby providing a more stable and sustainable financial foundation for the combined entity.

Workforce challenges are also critical, with difficulties in recruiting and retaining staff, particularly in key clinical areas, shown by a 7.42% overall vacancy rate and 8.22% for nursing and midwifery. Managing sickness absence, with an average attendance rate of 93.84% in 2024/25, is an ongoing priority. The merger is expected to alleviate these pressures by offering broader career pathways, enhanced training opportunities, and fostering a more resilient, integrated workforce structure that can attract and retain talent more effectively.

Patient flow and access represent another major concern, with breaches of national waiting time targets for A&E, elective care, and cancer pathways continuing to affect patient experience and outcomes. A unified system, enabled by the merger, is expected to better manage patient flow through the implementation of integrated pathways and more efficient resource deployment across acute and community settings, leading to improved access and reduced waiting times.

Maintaining consistent high-quality care across all services and addressing CQC 'Requires Improvement' ratings remains a continuous focus. Risks related to patient safety incidents, such as falls and pressure ulcers, are continuously monitored. The merger will support this goal through the establishment of shared best practices, unified governance frameworks, and a collective focus on continuous quality improvement across all services.

IT/Digital and Cybersecurity present ongoing risks. The Trust has experienced data breaches and cybersecurity incidents, highlighting the persistent need for robust information governance and cybersecurity measures to protect patient data and support service continuity. A combined IT infrastructure, facilitated by the merger, can strengthen and streamline cybersecurity measures, enhance digital resilience, and ensure more effective protection of sensitive information.

Finally, WUTH has an NHS Oversight Framework (NOF) rating of Segment 4 (as in Q4 2025/26). In the national NHS England framework, Trusts are placed into one of four core segments ranging from 1 to 4, with Segment 4 indicating that the organisation faces the most significant performance or governance challenges and requires intensive, targeted support. This integration, by fostering shared leadership, optimising resources, and enabling comprehensive service reconfiguration, is expected to provide the targeted support necessary to address performance and governance challenges, thereby facilitating a pathway towards improved oversight ratings.



Wirral Community Health and Care

WCHC is a leading provider of community health and care services, dedicated to supporting people to live independent and healthy lives. Established as a Foundation Trust on 1 April 2011, it serves a diverse population across Wirral, Cheshire East, St Helens, and Knowsley. With over 1,800 dedicated staff, WCHC is a fundamental part of the local health and social care system, committed to high-quality, compassionate, open, and trustworthy care closer to patients' homes, with a vision to be a population-health focused organisation.

Core Services and Facilities

WCHC provides a range of health and care services, from early years to complex adult care, focused on promoting well-being, preventing hospital admissions, and supporting recovery.

Community services include 0-19+/0-25 Services, offering integrated health and care for children and young people up to 25 years of age, including health visiting, school nursing, and paediatric audiology. For adults requiring transitional care, the Community Intermediate Care Centre (CICC) at Clatterbridge offers 71 beds for step-down/step-up care, effectively preventing hospital admissions with a median stay of 18 days.

Urgent care needs are addressed through a network of Urgent Care Services, including Urgent Treatment Centres (UTCs), Walk-in Centres, and Minor Injuries Units, which collaborate with WUTH's Emergency Department to manage patient flow, achieving 97.1% of patients seen within four hours. Further enhancing urgent community response, the Two-Hour Urgent Community Response (UCR) service provides rapid assessments and treatment within two hours, showing 89.4% compliance in preventing hospital admissions.

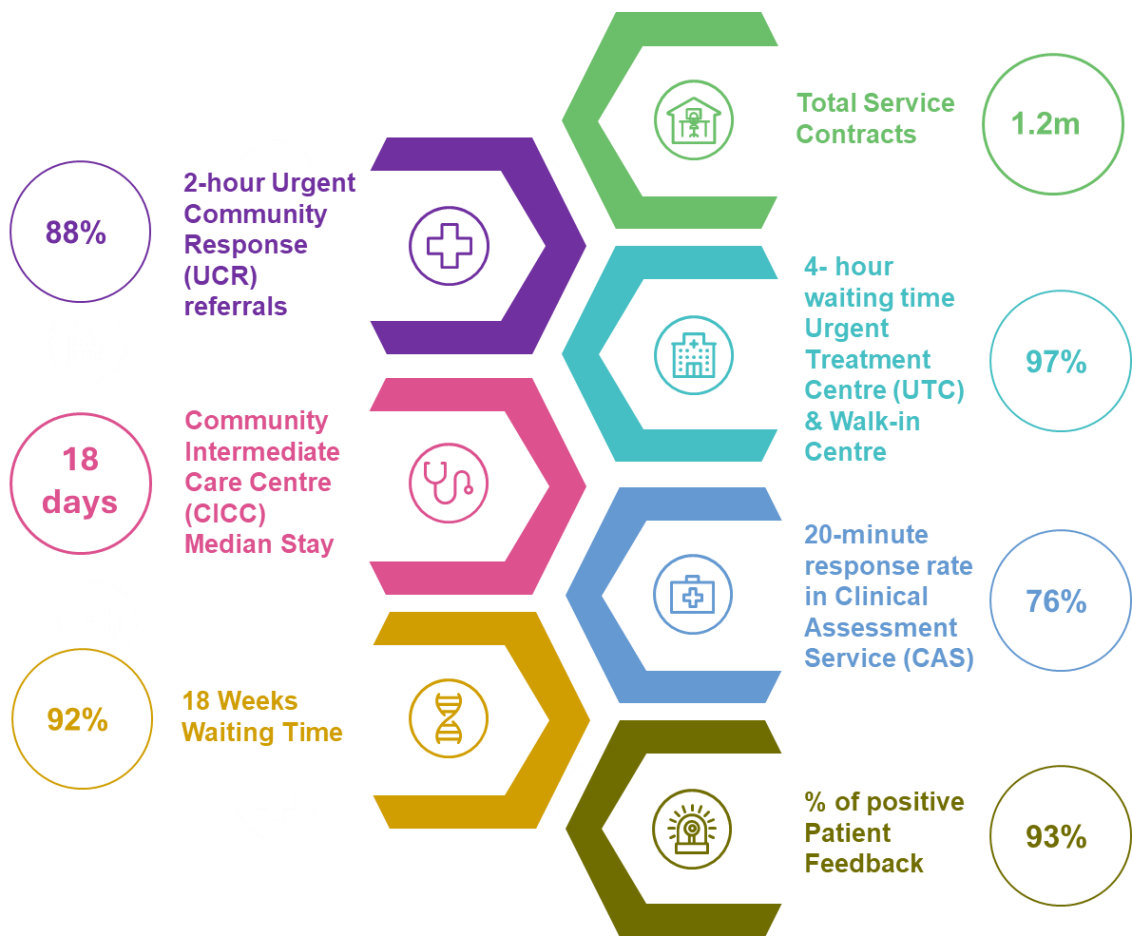
The HomeFirst Service is instrumental in supporting over 2,300 hospital discharges, significantly reducing long-term care needs. Complementing these, Community Nursing services encompass district nursing, specialist palliative care, Parkinson's and Alzheimer's support, and tissue viability services.

A broad spectrum of Therapies is also available, including adult and children's speech and language therapy, physiotherapy, occupational therapy, podiatry, and neuro-rehabilitation. Additionally, the GP Out of Hours Service ensures urgent care access outside normal surgery hours, showing month-on-month improvements in Clinical Assessment Service (CAS) performance.

Furthermore, WCHC also delivers a range of specialised clinical services, often in partnership with other healthcare providers. Notable examples include Sexual Health Wirral / ourPlace (in collaboration with Liverpool University Hospitals NHS Foundation Trust - LUHFT), dedicated Paediatric Speech and Language Therapy which has reduced waiting times from 121 to 71 weeks, Community Cardiology, and Stroke Services. These services are delivered from key community hubs such as St Catherine's Health Centre and Victoria Central Health Centre, as well as directly within GP Practices, Schools, and various other community settings across the Trust's operational footprint.

Performance

WCHC's operational scale and impact are evident in its annual activity figures (from the 2024/25 annual report):



CQC

The Trust's overall CQC rating from 2023 is 'Good', reflecting high standards of care.

The Trust actively monitors and addresses quality concerns through robust governance frameworks, including the Audit and Risk Committee and Quality Committee.

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Patient experience is a high priority, with regular surveys and feedback mechanisms, including QR codes for immediate feedback, informing continuous improvement.

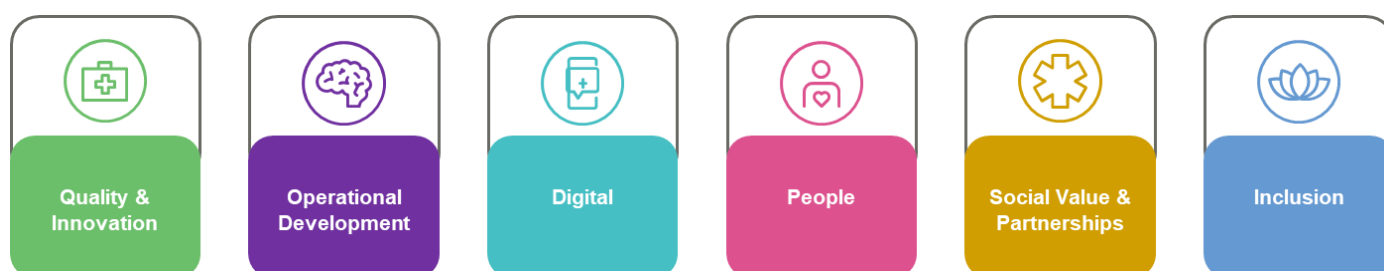
Finances

For 2025/26, WCHC reported a year-end surplus of £6.4m, significantly exceeding the planned surplus of £0.9 million.

- Total Income: £113.4 million (with 96.5% from patient care activities, primarily NHS England and ICBs).
- Total Expenditure: £105.8 million (80% pay costs, 20% non-pay).
- Capital Investment: £6.6 million.
- CIP Savings: £7.2 million (£1m non-recurrent).
- Cash Balance (31 March 2026): £15.6 million.

Priorities and Achievements

WCHC's strategic framework for 2022-2027 is built around key objectives:



Key achievements and ongoing initiatives demonstrate progress against these priorities.

The Trust is an active participant in the ICS, engaging with the Wirral Place Partnership and the CMPC to contribute to system-wide planning and service redesign. A significant development in this area is the appointment of Janelle Holmes as Joint CEO for both WCHC and WUTH in November 2024, signalling a clear strategic direction towards closer integration and collaboration for a more effective and integrated health and care system for Wirral.

Workforce development and culture are guided by the Trust's People Strategy (2022-2026), which focuses on Shaping our Future through three pillars - Looking after ourselves and each other, Belonging at WCHC, and Transforming ways of working. Initiatives include the Harnessing Talent Framework, a new CEO Star Award, and a strong commitment to Equality, Diversity, and Inclusion (EDI), shown by its Bronze status for the North West Anti-Racist Charter. The Trust has also seen a 50% increase in concerns reported to Freedom to Speak Up (FTSU) Guardians, showing a more open culture.

In terms of sustainability, WCHC is committed to achieving Net Zero by 2040, with an interim target of an 80% reduction in carbon emissions by 2028. Initiatives such as investing in renewable energy (solar PV), LED lighting, and tree planting have contributed to a 34% reduction in total carbon emissions in 2023/24 compared to 2020/21.

The Trust fosters collaborations to advance medical research and innovation, with a focus on embedding a framework for system-wide learning to improve patient outcomes. Furthermore, WCHC runs a successful NHS Cadets Programme in partnership with St John Ambulance, engaging 121 young people in health and social care careers during 2024/25.

Challenges and Risks

WCHC navigates some complex challenges, which are actively managed through its robust governance frameworks and strategic planning.

Workforce sustainability and wellbeing remain a primary concern. While the Trust employs 1,827 dedicated staff (as in 2025/26), recruiting and retaining skilled professionals, particularly in key clinical areas, presents a critical challenge. Managing sickness absence, with an average of 14.18 sick days per FTE in 2024/25, is an ongoing priority. Staff survey results from 2024 show areas for improvement in staff engagement (7.02 out of 10), morale (5.84), and recognition and reward (6.32). Addressing these through initiatives like the Staff Survey Action Plan and promoting staff wellbeing is crucial to keeping a resilient workforce. The merger with WUTH will provide access to a larger talent pool, shared HR resources for recruitment and retention, and broader career development opportunities, potentially improving staff morale and reducing sickness absence through a more robust support system.

Ensuring equitable access and outcomes across all services stays a continuous focus. Despite consistent good performance against many key performance indicators, the Trust acknowledges ongoing pressures in certain areas, shown by 17 red KPIs at year-end 2024/25. Managing increasing demand and referrals, while maintaining timely access, particularly for complex community care pathways, is a continuous challenge. The merger will enable greater capacity planning, streamlined patient pathways across a wider integrated system, and the ability to reallocate resources more effectively to address areas of high demand and improve access.

Fiscal management and investment also present ongoing considerations. While the Trust achieved a reported surplus of £7.005 million in 2024/25, the ongoing requirement to deliver efficiency savings (having delivered £6.3 million in non-recurrent savings in 2024/25) and strategically manage capital investment remains a key focus. This is essential to ensure long-term financial sustainability and the ability to invest in service improvements and infrastructure, especially given the identified major strategic risk related to financial settlement impact. The merger will unlock economies of scale, enhance bargaining power for procurement, and provide a stronger financial base for strategic capital investment, reducing the impact of financial settlement risks.

Quality improvement and assurance require continuous care. Although the Trust holds an overall 'Good' CQC rating, maintaining and enhancing quality across all services is an ongoing focus. The Trust's Quality Strategy 2022-2027 outlines continuous efforts to embed a system-wide learning framework and ensure safe, effective, and person-centred care, addressing any areas requiring further development identified through internal and external reviews. The merger will facilitate the sharing of best practices and quality improvement initiatives across both organisations, leading to a more robust and standardised approach to quality assurance and continuous learning.

Finally, digital transformation and cybersecurity present ongoing risks. While the Trust is committed to digital advancement, having achieved HIMSS Level 6, the persistent need for robust information governance and cybersecurity measures is paramount. This is crucial to protect patient data, maintain service continuity, and ensure the resilience of digital systems against evolving threats, particularly given past experiences with data breaches and cybersecurity incidents. The merger will allow for the consolidation of IT infrastructure, shared expertise in cybersecurity, and increased

investment in advanced digital security measures, strengthening overall resilience against threats and ensuring better data protection.

Underpinned by its core values of Compassion, Openness, and Trust, WCHC stays resolutely committed to delivering high-quality, safe, and person-centred community health and care. The Trust continuously strives for improvement and works collaboratively with partners across the health and care system to proactively meet the evolving needs of its diverse population. The strategic direction, particularly the joint leadership with WUTH, is a pivotal pathway towards deeper integration, aiming to forge a more seamless and resilient healthcare system for Wirral that truly empowers individuals to live independent and healthy lives within their communities.

Finally, WCHC holds a Segment 1 rating (as in Q4 2025/26) under the NHS England National Oversight Framework (NOF). This is the highest possible performance tier, indicating strong overall performance and requiring minimal external oversight. The integration of WUTH and WCHC is therefore key as it allows for the diffusion of WCHC's proven best practices and operational excellence across the wider system, providing a robust foundation and critical support for the strategic transformation and improvement of services, particularly in areas facing greater challenges.

Joint Strategy

The development of the Joint Strategy 2026-2032 is a pivotal outcome of the comprehensive Wirral System Review, which found both opportunities and challenges for enhanced collaboration between WUTH and WCHC.

This six-year strategy serves as the foundational roadmap for the proposed transaction, embodying the shared vision and integrated approach considered essential for establishing a unified health and care system across Wirral. Developed through extensive engagement with staff, patients, and partners, the strategy reflects a collective ownership of the future direction, providing a unified response to the identified challenges and opportunities.

At its core, the Joint Strategy articulates a singular, powerful vision, which aims to harmonise the distinct values of both Trusts into a shared cultural foundation for a combined entity:

Together we will create healthier lives and stronger communities

The strategy outlines six overarching and inherently integrated objectives:

- We will create the conditions for outstanding care and performance;
- We will nurture an inclusive, compassionate culture where people thrive;
- We will make improvement and innovation part of how we work;
- We will drive health equity and support healthier lives;
- We will work as one system and one organisation; and
- We will develop a secure, connected digital ecosystem fit for the future.



These objectives directly address the critical need for seamless patient pathways, improved population health outcomes, and operational efficiencies identified during the Wirral System Review.

This approach is further underpinned by a suite of integrated enabling strategies covering Clinical Service, Quality and Safety, Experience of Care, People, Improvement, Research and Innovation, Estates and Facilities, Digital, and Financial aspects, ensuring all facets of the new organisation are aligned towards common goals.

Collaboration to date

Operationally, significant preparatory work has already been undertaken, including Board, corporate and executive team alignment and initial corporate governance considerations. Significant collaboration is already in place between the Trusts, helped by a partnership agreement and workforce sharing agreement, which shows a proactive approach to integration.

Existing operational pressures and the need to optimise service delivery underscore the urgency for this merger, with current initiatives like the A&E build and relocation of outpatient therapies to St Catherine's laying groundwork for closer integration by freeing up acute estate and demonstrating successful cross-site moves.

Financially, WUTH currently operates with a substantial deficit, while WCHC has been at break-even or better. Historically, the two Trusts ran with a degree of separation, sometimes leading to underutilised assets, capacity and estate. The Acute Trust has faced persistent financial challenges, driven by urgent and emergency care demands and a lack of control over patient flow. Integration is identified as one of five key drivers to address WUTH's deficit and achieve financial sustainability, with the finance leadership, including a joint CFO, actively engaged in shaping the financial narrative. Early steps, such as the appointment of a joint Chair and Chief Executive and a single executive team, have already yielded £1 million in recurrent benefits, with further efficiencies expected from corporate restructure and consultation.

Clinically, services across WUTH, WCHC, and primary care have historically worked in silos, leading to fragmented patient journeys, duplication, and suboptimal patient experience. The Wirral Review highlighted such areas of duplication and service gaps. These findings later informed the Phase One integration plan (2024/25), which focused on pathway-driven changes in cardiology, musculoskeletal (MSK), urgent care, and ophthalmology. This phase, however, was constrained by the pre-transaction environment, limiting asset movement to 10%. Early clinical integration examples include back-office functions like appointment booking, operational teams in ophthalmology and cardiology, and the relocation of MSK physio staff to community sites. Another notable development is the redevelopment of the urgent care pathway at Arrowe Park, aiming for unified governance and patient journeys for the Urgent Treatment Centre (UTC) and Emergency Department (ED).

The formation of the new Trust presents a complex digital environment, as both existing organisations have distinct digital infrastructures and systems. A cohesive digital approach is therefore essential to support the new Trust's strategic goals and a current review of the digital function is underway to prepare the ground for the integration approach to be taken.

The proposed integration of corporate services is well under way with a period of significant organisational change within corporate services, including the transfer of corporate staff from WCHC to WUTH, as a precursor to further integration and transformation in 2026/27. This work unsurprisingly has raised concerns among staff, which are carefully being managed through the Trusts' communications and engagement and organisational development programme.

A partnership agreement has enabled joint functions from the outset, including the appointment of a single Chief Executive and Chair, followed by a single executive team and a single board with joint Non-Executive Directors. Group governance arrangements are currently being designed to establish the future governance structure of the new Trust.

National Context

The evolving roles of ICBs

As ICBs are evolving towards a greater emphasis on strategic commissioning, population health management, and reducing health inequalities, providers can play a leading role in supporting these areas. The merger of WCHC and WUTH to create a new Trust can do this in several ways.

The new Trust will enhance the combined organisation's capacity for population health management by combining resources and expertise, enabling a more comprehensive understanding of local needs and more effective interventions. It will also strengthen the organisation's ability to engage in strategic commissioning discussions with the ICB, contributing to the development and implementation of effective care pathways and service models.

Furthermore, it will help a more targeted approach to addressing health inequalities by using the expanded reach and resources of the combined organisation, promoting fair access and outcomes. This aligns with the ICB's focus on shifting care from hospital to community settings, as the merger by acquisition strengthens the foundation for integrated community-based services. Finally, the larger, integrated organisation will be better equipped to embrace digital transformation and harness technology to improve care delivery and efficiency, supporting the ICB's digital strategy.

Alignment with the NHS 10 Year Plan

For our new joint organisation, the NHS 10-Year Health Plan creates a timely opportunity for our Trust to join up hospital and community services, with a key focus on appropriately shifting care from hospital settings into the community. Our strategy will strengthen neighbourhood and place-based partnerships and use our digital and workforce strengths to deliver sustainable, person-centred care for the people of Wirral and further afield. In doing so, we will strive to build the foundations to become an Advanced Foundation Trust, and in time, an Integrated Health Organisation.

The proposed integration is strategically aligned with some of the core ambitions of the NHS 10 Year Plan, as shown in the table overleaf.



NHS 10 Year Plan Priority	How the Merger Supports This...
Shift from Hospital-Centric to Community-Based Care	The merger will create an opportunity for our Trust to join up hospital and community services and strengthen neighbourhood and place-based partnerships. This will be instrumental in driving the shift from hospital-centric to enhanced community-based care. By fostering closer collaboration between the two Trusts and their respective services, and strengthening the neighbourhood care model the new model will create a less fragmented healthcare experience and drive the shift to the community.
Accelerating the transition from analogy to digital	Utilise digital and workforce strengths to deliver sustainable, person-centred care.
Prevention and Proactive Care	Working as a single Trust would develop integrated preventative care programmes which leverage the expertise and resources across organisations and address emerging health trends. As a larger organisation, there would be additional capacity to drive community prevention and proactive care practices, encouraging people to make healthier choices and get help early.
Workforce	A single Trust can offer improved opportunities to staff through rotational work in different care settings. An expanded training offer will draw on a wider base of services to boost staff capability. This will allow a larger more stable organisation to attract and retain talent more effectively.
A New Financial Foundation	The NHS 10 Year Plan emphasises the need for sustainable and efficient healthcare delivery. Working together will reduce the duplication of administrative functions, streamline services and optimise resource allocation. This will contribute to a more sustainable and cost-effective way of delivering services. The merger will enable us to deliver efficiencies and a level of service synergy which could not be achieved as separate Trusts.
Health Inequalities Reduction	The 10 Year Plan calls for a reduction in health inequalities and emphasises the importance of equitable access to care. Working together will ensure a more consistent and equitable provision of services across the geographic area, helping to address disparities in access to care. Work to offer care closer to home, thereby improving access, and the community-based offer will be tailored to meet the needs of the specific area in which it operates.

What the Wirral background and context means for the proposed transaction

The health and care landscape across Wirral faces significant challenges, including entrenched inequalities, financial instability, workforce shortages, and fragmented service provision. The region's ageing population and high deprivation levels further increase demand on its NHS services.

Both national directives, such as the NHS 10-Year Plan, and regional strategies, including the CMPC Blueprint and the Wirral HWB Strategy, demand greater integration, a decisive shift from hospital to community care, and a unified approach to population health management.

The Wirral System Review also showed that existing structural and cultural barriers between WUTH and WCHC hindered the essential collaboration and integration needed to meet these local and regional priorities.

While the establishment of joint leadership and the development of the Joint Strategy represent progress, these initiatives inherently run within the limitations of two separate legal and organisational entities. True, deep, and sustainable integration - the kind necessary to genuinely transform patient pathways, eliminate duplication, and achieve the ambitious outcomes outlined in the Joint Strategy - cannot be fully realised without a change to organisational form.

Complexities arising from dual accountability, separate governance structures, and the potential for divergent organisational priorities will inevitably impede the speed and depth of the required transformation.

Therefore, the integration of WUTH and WCHC is the logical and necessary next step to create a truly integrated health and care system for Wirral. It offers the most robust mechanism to overcome systemic barriers, enabling a single, unified organisation with clear accountability, streamlined governance, and collective resources to deliver seamless, person-centred care.



Case for Change

Case for Change

The proposed integration of WUTH and WCHC is not merely an option; it is a strategic necessity. The case for this integration is both profound and urgent, stemming directly from the inherent inefficiencies and limitations of running as two separate organisations within the same health economy operating within a population size of just 328,000. While commendable efforts have been made to foster collaboration, the existing structural separation creates significant and persistent barriers to delivering optimal patient care, achieving workforce flexibility, and ensuring the most effective utilisation of resources across Wirral.

This integration is not merely an administrative exercise but a critical strategic pathway to overcome historical divisions, mitigate acute operational and financial challenges, and establish a truly cohesive, patient-centred, and financially sustainable health system across Wirral, for the future. The time for decisive action is now; continued separation will only perpetuate systemic issues, undermining our collective ability to deliver the high-quality, sustainable healthcare the Wirral community deserves.

The Cost of Fragmentation

Despite the individual strengths and efforts of both WUTH and WCHC, the current model, with two separately commissioned services and distinct workforces, impedes the seamless delivery of care. Healthcare needs have changed, and this evolution demands a fundamental shift away from the current fragmented approach.

Patients experience fragmented pathways, exemplified by disparate waiting times for identical services based purely on referral routes rather than clinical need. This creates confusion, delays, and a sense of being passed around. The absence of a single, intuitive point of contact forces patients to navigate multiple front doors, particularly challenging for those with complex or co-morbid conditions. Administrative burdens and communication gaps result in numerous handoffs and duplicated information gathering, increasing error risks and reducing continuity of care, directly affecting patient safety and satisfaction.

Wirral faces significant demographic shifts, including an ageing population (over 22% aged 65+, 90+ population doubling by 2043) and a high prevalence of long-term conditions. These complex care needs are poorly served by a system with organisational boundaries, leading to reactive crisis interventions rather than proactive, integrated management. The local health and care system is under sustained pressure in urgent care, patient flow, planned access, and timely discharge, worsened by the inability of two separate organisations to pool resources and streamline operations effectively.

The Wirral population experiences profound health inequalities. The current organisational separation hinders a truly integrated and targeted approach to addressing these disparities, complicating service coordination and data sharing essential for effective population health management. A fragmented system struggles to provide the holistic, community-based interventions needed to tackle entrenched issues, such as the 12-year life expectancy gap across different areas of Wirral.

Historically operating as two distinct Trusts has led to significant corporate inefficiencies and clinical service duplication, diverting valuable resources from frontline patient care. The inability to easily flex staff across organisations limits responsiveness to patient demand and worsens staffing challenges, hindering the best deployment of clinical expertise. Furthermore, there is direct duplication of critical functions such as safeguarding, digital systems, and prescribing, alongside separate corporate functions like finance, HR, and Estates. This results in significant operational inefficiencies, increased administrative burdens, and unnecessary costs. Separate estates and administrative processes also prevent optimal asset utilisation.

The current fragmented digital landscape presents a significant barrier to effective integration and efficiency. Operating with two separate EPRs and a lack of a combined approach to corporate systems leads to duplication of effort, increased licensing costs, and an absence of a holistic view of patient data and digital operations. This directly limits integrated care planning and efficient service delivery. Furthermore, the existing fragmentation creates an unsettled environment for the digital workforce, affecting morale and productivity, as existing capacity is often focused on addressing business-as-usual digital needs rather than impactful transformation.

Decades of separate working have also fostered organisational silos, hindering genuine collaboration and staff buy-in. While partnership arrangements have existed, they often struggle to overcome deep-seated "us and them" mentalities, limiting truly unified clinical pathways and a cohesive organisational culture. This also diminishes the collective influence of both Trusts within the wider health and social care landscape, making effective advocacy for patient needs and equitable resource allocation more challenging.

The Risk of Inaction

The current model, despite individual efforts, presents inherent limitations that impede the delivery of optimal, integrated care and long-term sustainability for Wirral. These systemic challenges cannot be fully resolved by maintaining the status quo. Continued separation will only entrench these issues, thereby hindering our collective potential to provide the high-quality, sustainable healthcare the Wirral community rightfully expects.

Inaction risks perpetuating suboptimal patient experiences, worsening performance pressures, deepening health inequalities, wasting valuable resources, undermining staff morale, and weakening the system's ability to respond to future health challenges.

Unlocking Wirral's Healthcare Potential

The proposed merger is a proactive, strategic choice to overcome these systemic challenges and build a healthcare system that is truly "Better Together." It is driven by a shared ambition to proactively shape the future of health and care in Wirral, improving population health, reducing health inequalities, moving services into community and neighbourhood settings and making our services stronger and more resilient.





Unified patient experience

A unified organisation would streamline these processes, enabling single policies, governance routes, and digital platforms, thereby enhancing patient pathways, reducing unnecessary admissions, and improving patient outcomes through closer multidisciplinary team working. Patients will experience a smoother journey, with fewer transfers and greater access to care in their community. Standardised referral criteria and a single point of access will significantly reduce disparate waiting times, ensuring care is based on clinical need. A single, integrated Trust can also more effectively use data and resources to deliver targeted services, addressing deprivation and health inequalities.

Empowered workforce

A unified Trust will create a more attractive, resilient, and multiskilled workforce. By creating a single, resilient workforce with greater flexibility, roles can become more appealing, aiding recruitment in hard-to-fill areas. Staff will benefit from new career development and progression opportunities across a broader range of clinical and corporate services. The merger offers a vital opportunity to overcome historical "us and them" mentalities and foster a unified organisational culture. A full merger can achieve the cultural shift needed for truly unified clinical pathways and merge clinical teams, which a partnership arrangement alone cannot deliver.

Efficient and financially stable

From a financial and commercial perspective, the case for change is compelling. The integration offers a crucial strand in addressing the structural deficit faced by WUTH by delivering joint efficiencies and creating new models of care, supported by the service delivery model of WCHC. This is not solely about transactional savings but is a transformational opportunity essential for the long-term viability of both Trusts.

By cutting duplicate corporate functions, optimising asset utilisation (including rationalising estates and freeing up valuable clinical space), and using economies of scale in procurement, significant non-pay savings can be realised.

Critically, integration enables a strategic 'Left Shift' in care delivery, moving patients out of busy acute hospital settings and into community-based care and neighbourhood settings. This approach is expected to reduce hospital congestion, improve patient flow, bring care closer to home and address issues such as corridor care and no criteria to reside, leading to recurrent savings by reducing acute admissions and length of stay.

Digitally enabled

The current digital landscape presents a significant barrier to effective integration and efficiency. A unified digital strategy, developed from the outset with digital teams, is essential to rationalise contracts, suppliers, and clinical and corporate digital systems, ensuring a cohesive and efficient digital infrastructure that supports integrated care and reduces operational inefficiencies. A merged organisation will develop a single, secure digital ecosystem across hospitals, community services, and system partners, ensuring a cohesive and efficient digital infrastructure.

This joined approach will offer a holistic view of patient data, enabling better data-driven decision-making, improved patient safety, and more effective population health management.

System leadership and advocacy

The merger will create a more robust and influential entity within the wider health and care system. This unified voice will enable more effective advocacy for patient needs and resource allocation within the wider health and social care landscape, leading to improved patient outcomes and a more fair distribution of care across the region.

A single, larger Trust will be more resilient to external pressures, better able to absorb shocks, and more capable of responding to evolving health demands.

A unified purpose

This merger is not an isolated initiative; it is deeply embedded within and strongly aligned with national and regional strategic directives for healthcare transformation. It directly supports the aims of the NHS Long Term Plan, addresses key NHS Planning Guidance Priorities, aligns with the C&M ICS *All Together Fairer* strategy, solidifies the work of the Wirral Provider Alliance, and directly supports the Wirral Health and Wellbeing Strategy. This integration is a fundamental step towards achieving broader strategic goals for a healthier, more equitable Wirral.

We are **Better Together** for the people in our care

The current two-Trust model for acute and community-based care presents inherent limitations that impede the delivery of optimal, integrated care and long-term sustainability for the people and communities we serve across Wirral. These systemic challenges cannot be resolved by maintaining the status quo; continued separation will only entrench these issues, hindering our collective potential.

The proposed merger is therefore a strategic imperative. It represents a decisive and transformative pathway to overcome historical divisions, mitigate acute operational and financial challenges, and establish a truly integrated, patient-centred, and financially robust health system. By uniting WUTH and WCHC, we seize a unique opportunity to unlock profound benefits for patients, empower our workforce, achieve significant efficiencies, and strengthen our collective influence. This integration is essential to realise our vision of healthier lives and stronger communities, ensuring a more resilient, efficient, and equitable health economy for all in Wirral.

The time to rethink how we deliver care across Wirral and beyond is now.



Options for Collaboration

Options for Collaboration

The NHS in Wirral is undergoing significant change to how providers operate and collaborate. This is to create more integrated care that improves outcomes for the people of the borough. This has provided the opportunity to consider the relationship between WUTH and WCHC as major acute and community care providers.

To this end, a *Wirral System Review* was commissioned by the Cheshire and Merseyside ICB in March 2024. This work highlighted the need for systemic change. While Wirral benefits from a clear ambition for integrated care, the review concluded that current informal governance structures and a reliance on goodwill alone would hinder the progress required to address evolving healthcare needs and national policy shifts. The review identified challenges such as fragmented decision-making and the need to unlock the full spectrum of transformational benefits necessary for long-term sustainability.

The report also provided compelling evidence for integration, outlining a range of anticipated benefits. These included significant efficiency gains through reduced overheads and consolidated procurement, enhanced workforce development opportunities, improved health equity by targeting deprivation, and substantial service improvement leading to better patient experience, reduced delays, and stabilised clinical services. Crucially, it also pointed to improved financial sustainability through economies of scale and reduced duplication.

Within this context, the report underscored that, aside from whole-system working, shared leadership and strengthened bilateral relationships would be important enablers of progress.

WUTH and WCHC have already taken a significant step by appointing a joint Chair and Chief Executive Officer, as well as forming a single Board across the Trusts, demonstrating a clear commitment to a unified strategic direction and simplified provider structure.

Shortlisting suitable options

In exploring the optimal path forward, a broad spectrum of vehicles were initially considered. These ranged from less formal arrangements such as Partnership Agreements, Alliances, Shared Service Agreements, and Lead Provider Models to more structured approaches like Group Models (e.g., NHS Group of Trusts).

While these less formal models offer value in specific contexts, they were thought not to achieve the strategic objectives identified for WUTH and WCHC. Key concerns included:

- Maintaining separate legal entities perpetuates regulatory accountabilities, leading to slow decision-making, potentially conflicting priorities, and a lack of truly unified strategic direction.
- Less formal models struggle to overcome persistent organisational silos, duplication of services, and the inability to standardise best practices across distinct entities.
- Less formal models typically deliver only incremental benefits, limiting economies of scale, hindering workforce optimisation, and impeding the ability to address systemic financial pressures through a unified strategy.
- Maintaining distinct identities can perpetuate "them and us" cultures.



- Less formal models can be vulnerable to changes in leadership and subsequent withdrawal of partnership working arrangement.
- Less formal models limit the ability to transfer large numbers of staff between organisations to support the delivery benefits.

For these reasons, a formal statutory integration, such as a merger or acquisition, was deemed the optimal viable pathway to achieve the comprehensive, sustainable, and resilient healthcare system envisioned for Wirral. This is because a statutory transaction provides unified accountability, full clinical and operational integration, maximised synergy realisation, a cohesive workforce and culture, and enduring structural stability.

Therefore, following this initial long list, a shortlist of options was determined for deeper consideration. These represent distinct pathways towards achieving the necessary level of integration and transformation:

1. **Continued Informal Collaboration (Do Nothing – As Is):** This option serves as the baseline, representing the current state of collaboration without significant structural change.
2. **Form a Provider Collaborative or Group Model:** This explores a more formal collaborative structure where Trusts retain legal identity but operate under a unified strategic framework.
3. **Organisational Merger/Acquisition (Creating a New Trust):** This option involves the full statutory integration of WUTH and WCHC into a single legal entity.

This chapter presents the rationale of these shortlisted options and why merger by acquisition was deemed the optimal choice.



Exploring the shortlisted options

Based on the executive level discussions with leaders from across both Trusts, the below outlines the views considered in exploring the selected three potential options.

Option	Pros	Cons
1: Do Nothing	- Allows focus on existing, agreed strategies and priorities for both Trusts. - Allows focus on the establishment of the IMB and new ways of working. - Avoids new governance and bureaucracy between WUTH and WCHC. - Maintains current stability and business as usual. - No disruption for internal or external stakeholders. - Avoids expenses and costs associated with change. - Avoids major internal transformation.	- Perpetuates fragmented care and disjointed patient experience, as the system remains complex and disjointed for people (hindering optimal patient experience) and organisational frameworks remain distinct. - Continues inefficiencies and duplication (e.g., separate IT, IG, incident management systems). - Retains barriers to flexible staff deployment across organisational boundaries (due to contractual and cultural barriers to employees working across both Trusts). - No drive to align cultural change and integration of working practices (harder to achieve changing culture across separate entities). - Ongoing multiple handoffs and referrals, leading to delays and inconsistent patient care. - The existing IMB falls short of a full merger's benefits. Its advisory powers prevent the operational alignment a merger achieves. It cannot overcome the persistent cultural and organisational barriers which hinder efficiency, synergy, and maximum benefit realisation.
2: Group Model	Relatively straightforward to achieve with minimal day-to-day service impact.	- Adds layers of governance and bureaucracy, potentially slowing decision-making. - Often a precursor to a full merger, not a final solution.

Option	Pros	Cons
	- Proven model with frequent examples across the NHS. - Limited disruption, primarily affecting senior organisational levels. - Potential for formalised risk-sharing and budget surplus arrangements (e.g., shared Wirral pound approach). - Both organisations retain their distinct identities.	- Many practical limitations to collaboration persist (e.g., IG, data sharing, system interoperability remain). - Finances largely remain siloed outside specific agreements. - Cultural challenges may persist, fostering an 'us and them' mentality. - Implementation can be lengthy, taking several years. - Fails to fully address CQC concerns regarding inconsistent safe care, fragmented records. - Slow cultural change in workforce due to continued separate entities. - Limited ability to transfer large numbers of staff between Trusts
3: Organisational Merger/Acquisition	- Provides greatest decision-making freedom and agile resource deployment. - Forms a stronger voice for integrated care and a community-first model within Wirral. - Removes historical limitations to service delivery, such as geographical boundaries and equity of provision. - Drives savings and efficiency through standardisation, reduced duplication. - Centralised capital and fixed asset management (e.g., estate optimisation, addressing unsuitable facilities and investing in modern facilities).	- Will be a complex and costly process to implement, requiring significant input from senior leadership across both Trusts. - External support will likely be required to ensure all legal and financial aspects of a merger are carried out successfully. - Planning and establishing the new Trust will take time. Resources will be needed to set up committees and groups, conduct reviews and manage risks. - Depending on the level of merger agreed, there may be a major disruption to the current organisational make-up in areas such as care group configuration.

Option	Pros	Cons
	• Enables a best of both approach to policy and process harmonisation for equitable care. • Greater agency to deploy staff flexibly across the region (single employment contracts allow pooling and rotation of staff). • Scales Health Equity best practice, leveraging neighbourhood teams. • Optimises resource utilisation (e.g., collaborative procurement, consolidated estates management). • Accelerates innovation and digital transformation (e.g., combining R&D capabilities, single IT systems, richer data pool for analytics, aligning with NHS 10 Year Plan). • Tackles operational performance issues and long waiting times by pooling resources, optimising patient flow, and leveraging community capacity for earlier intervention. • Unified workforce strategy offers broader career opportunities). • Creates a bigger, stronger voice for community healthcare within the Wirral system, enhancing partnerships with Wirral system partners, Local Councils, and primary care. • Synthesises best practices from both Trusts.	• Disruptive for staff who may have concerns - will require a carefully considered comms plan to address Staff Side anxieties, and avoid any misconceptions. • To ensure adequate focus on the transaction process and transition planning, dedicated temporary support will likely be required, necessitating the back-filling of roles.

Option	Pros	Cons
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- Unlocks greater financial flexibilities (e.g., Foundation Trust status enables greater freedoms across all areas of expenditure).

Preferred Option Rationale

As a result of the Board and executive-level discussions, an **organisational merger/acquisition** was identified as the preferred option for WUTH and WCHC, offering the most profound strategic and operational freedom to drive significant change across Wirral.

This approach unlocks financial benefits through economies of scale, enabling the consolidation of corporate services and the reinvestment of savings into frontline care. This empowers bold, long-term decisions, ensuring stability and future-proofing operations by aligning with the C&M ICB's population health and health inequality goals, and the NHS 10 Year Plan's shift towards community-based care. With Foundation Trust status, the new Trust would gain greater financial flexibility and autonomy across all areas of expenditure.

Importantly, a merger/acquisition fosters the most cohesive and unified working culture for staff, breaking down silos and establishing a shared vision, supported by new branding and aligned policies. Single employment contracts enable flexible staff deployment, resource pooling, and the integration of community and acute roles, offering broader career opportunities.

For patients and stakeholders, this simplifies understanding through a seamless, all-aged, 'no wrong door' access model, removing current fragmentation and disjointed experiences, and accelerating innovation and digital transformation through combined R&D capabilities and single IT systems. This will create a single major NHS Trust in Wirral that the public can refer to. It also provides a stronger voice for integrated care and a community-first model within Wirral, enhancing partnerships with local councils and primary care.

While an organisational merger/acquisition involves a complex and costly process to implement, requiring significant input from senior leadership across both Trusts and likely external support for legal and financial aspects, these are acknowledged and manageable challenges. The planning and establishment of the new Trust will take time, necessitating dedicated resources for committees, reviews, and risk management. There may also be major disruption to current organisational structures and staff may experience anxieties, which will require a carefully considered communications plan and robust change management.

However, the long-term benefits of achieving a truly integrated, efficient, and patient-centred healthcare system for Wirral communities are deemed to significantly outweigh these short-term hurdles.

In contrast, the **'Do-Nothing' option** offers no viable path for ambitious change. It perpetuates fragmented care and disjointed patient experiences, as the system remains complex and difficult for people to navigate. This option continues inefficiencies and duplication, such as separate IT, information governance, and incident management systems. It retains significant barriers to flexible staff deployment across organisational boundaries due to contractual and cultural impediments, and offers no drive to align cultural change or integrate working practices.

The ongoing multiple handoffs and referrals would continue to lead to delays and inconsistent patient care. While it allows focus on existing strategies and avoids immediate disruption, it fails to address the Wirral's complex, growing challenges, including significant health inequalities.

Even the establishment of the IMB, while beneficial for collaboration, falls short of a full merger's benefits; its advisory powers prevent the deep operational alignment and cultural transformation that

a merger achieves, and it cannot overcome the persistent cultural and organisational barriers that hinder efficiency, synergy, and maximum benefit realisation.

Similarly, the '**Group Model**' option is deemed insufficient to achieve the desired level of transformation. While it is a proven model with some benefits like formalised risk-sharing and limited disruption primarily at senior levels, it introduces additional layers of governance and bureaucracy, potentially slowing decision-making. It often serves as a precursor to a full merger rather than a final solution, and many practical limitations to collaboration persist, such as challenges with information governance, data sharing, and system interoperability. Finances largely remain siloed outside specific agreements, and cultural challenges, fostering an 'us and them' mentality, may persist. Its implementation can be lengthy, taking several years, and it ultimately fails to fully address CQC concerns regarding inconsistent safe care and fragmented records, or to drive the necessary cultural change in the workforce due to the continued existence of separate legal entities.

Therefore, despite the transitional complexities, an organisational merger/acquisition is the only option that delivers lasting benefits and comprehensively tackles the problems and issues identified in the Wirral System Review. It provides a single, unifying message and directly addresses strategic challenges, creating an integrated, efficient, and patient-centred healthcare system for Wirral communities.

Considering Statutory Transaction Options

With the direction established towards a statutory transaction (i.e. a merger or acquisition), the subsequent step was undertaken to further explore and consider the various legal and structural vehicles available to the Trusts. These, considering the implications and suitability of three primary options:

1. **WCHC and WUTH Merger:** The creation of a new, single legal entity through the merger of both WCHC and WUTH.
2. **Acquisition of WCHC by WUTH:** The acquisition of WCHC by WUTH, with WUTH continuing as the acquiring legal entity.
3. **Acquisition of WUTH by WCHC:** The acquisition of WUTH by WCHC, with WCHC continuing as the acquiring legal entity.

Please note, other potential statutory transaction types, such as a Three-Way Merger (involving more than two Trusts), Dissolution of an NHS Trust or FT without immediate re-establishment, or the Separation of an NHS Foundation Trust, were considered during the initial scoping phase. However, these were deemed inapplicable to the specific circumstances and strategic objectives of WUTH and WCHC, as they address different integration scenarios or organisational restructuring needs not in this case. The focus remained on options that directly lead to a single, unified organisational form for the two Trusts.

The above options were evaluated against criteria, including feasibility, financial implications, operational impact, governance structures, and the ability to best deliver the strategic objectives and anticipated benefits identified for the integrated organisation.

Further detail of the scoring criteria and its weighting is included in the appendix.



Assessment of each Statutory Option

Criteria	WCHC and WUTH Merger	Acquisition of WCHC by WUTH	Acquisition of WUTH by WCHC
Strategic Alignment	This option offers the highest degree of strategic alignment with the vision of a truly single, integrated organisation. It provides a 'clean slate' for developing a unified strategy, culture, and operational model without the legacy constraints of two separate entities. It fully embodies the spirit of comprehensive integration. However, while strategically aligned, the process of achieving this alignment can be complex due to the need to reconcile two distinct strategic plans into a completely new one. (Raw Score: 5, Weighted: 10)	This option strongly aligns with the strategic goal of creating a single, integrated organisation. It leverages WUTH's existing scale and infrastructure to expand its service portfolio, creating a more comprehensive provider across the care continuum. This model is increasingly common in the NHS, reflecting a pragmatic approach to integration. However, while strategically sound, the perception of an 'acquisition' rather than a 'merger of equals' might require careful management to ensure full buy-in from WCHC staff and stakeholders. (Raw Score: 5, Weighted: 10)	This option also achieves the strategic goal of integration into a single organisation. It could be argued to place community services at the heart of the integrated model, potentially fostering a primary care-led system. However, the significant disparity in scale between WCHC and WUTH makes this a less intuitive strategic fit in terms of leadership and operational capacity, potentially raising questions about the strategic rationale for the smaller entity acquiring the larger. (Raw Score: 5, Weighted: 10)
Quality	A merger facilitates the most profound integration of clinical services and pathways, enabling the development of a truly seamless, system-wide approach to patient care. It allows for the standardisation of best practices, unified clinical governance, and a consistent patient experience across all settings (acute, community, primary	Integrating WCHC's community and primary care services into WUTH's acute framework promises enhanced patient pathways, improved care coordination, and a more seamless continuum of care. This can lead to better patient outcomes, reduced readmissions, and more efficient resource utilisation across the system.	This model could theoretically promote a strong focus on community-based care and prevention, with acute services integrated around this core. However, the sheer scale and complexity of WUTH's acute services, including highly specialised care, would present a substantial challenge for WCHC to absorb and manage

Criteria	WCHC and WUTH Merger	Acquisition of WCHC by WUTH	Acquisition of WUTH by WCHC
	care). However, the transition period could introduce temporary disruption to services as new systems and pathways are established, potentially impacting quality if not managed meticulously. (Raw Score: 5, Weighted: 10)	However, the integration of different clinical cultures and operational practices requires careful planning to avoid disruption to existing high-quality services within WCHC. (Raw Score: 5, Weighted: 10)	effectively without significant disruption to quality and safety. (Raw Score: 5, Weighted: 10)
Deliverability	Once established, the new entity benefits from simplified internal processes and clear lines of accountability. However, this is generally the most complex and potentially protracted transaction type. It involves the legal dissolution of two entities and the creation of a new one, requiring extensive legal processes, regulatory approvals, and administrative effort. This complexity can extend transaction timeframes, introduce greater uncertainty, and demand significant management capacity during the transition. (Raw Score: 4, Weighted: 16)	This is generally considered the most straightforward and potentially quickest transaction type. It avoids the complexities of creating a new legal entity, leveraging WUTH's existing governance, licence, and corporate infrastructure. This significantly reduces administrative burden, legal complexities, and accelerates the transaction timeline, making it highly deliverable. However, while simpler, the integration of operational systems, IT, and clinical pathways still requires substantial effort and robust project management. (Raw Score: 5, Weighted: 20)	Legally, it is an acquisition, which is generally simpler than a merger. However, this option presents significant practical challenges due to the vast difference in scale. WCHC (annual income £108m, 1,845 WTE staff) acquiring WUTH (annual income >£500m, 6,400 WTE staff) would mean WCHC's expenditure growing by approximately 600%. This requires an unprecedented level of due diligence, a massive increase in WCHC's operational and financial capacity, and a highly complex integration effort, making it a high-risk and potentially protracted process. (Raw Score: 2, Weighted: 8)

Criteria	WCHC and WUTH Merger	Acquisition of WCHC by WUTH	Acquisition of WUTH by WCHC
Workforce and TUPE	All staff from both Trusts transfer under TUPE to a single new employer, which can eventually foster a unified workforce identity and facilitate harmonisation of terms and conditions. However, the psychological impact on staff can be significant, as both organisations cease to exist. There is a substantial requirement for complex HR work to harmonise terms and conditions across two previously distinct workforces, which can be a lengthy and sensitive process. This can lead to anxiety, industrial relations issues, and a risk of staff attrition. (Raw Score: 3, Weighted: 12)	WUTH's existing staff are largely unaffected by TUPE, simplifying one aspect of workforce integration. WCHC staff transfer to WUTH under TUPE, providing legal protection. However, the integration of WCHC staff into WUTH's existing culture, terms and conditions, and organisational structures requires careful planning. There is a risk of cultural clashes or perceived inequities if not managed sensitively. The messaging around an 'acquisition' can also impact staff morale and engagement within the acquired entity (WCHC). (Raw Score: 3, Weighted: 12)	WCHC staff are largely unaffected by TUPE. WUTH staff transfer to WCHC under TUPE. However, the integration of WUTH's significantly larger and more complex acute workforce into a smaller, community-focused organisation would present immense cultural, operational, and HR challenges. This could lead to significant staff disruption, morale issues, and potential attrition within the larger acquired entity (WUTH), as well as overwhelming the acquiring HR functions. (Raw Score: 3, Weighted: 12)
Constitution and Governance	Provides an opportunity to design an optimal, fit-for-purpose governance structure and constitution from scratch, free from legacy constraints. However, this option necessitates the most significant governance changes. The dissolution of both existing Boards and Councils of Governors creates a temporary leadership vacuum,	This option minimises governance changes significantly. WUTH's Board and constitution remain largely intact, with only WCHC's Board dissolving. This reduces the need for extensive constitutional redrafting, new elections, and streamlines the governance transition, ensuring continuity of leadership and oversight. However,	WCHC's existing Board and licence continue. However, while WCHC's Board would continue, its existing governance structures, policies, and procedures would be wholly inadequate to oversee the vastly expanded scope and complexity of the integrated organisation. Significant changes would be required, effectively

Criteria	WCHC and WUTH Merger	Acquisition of WCHC by WUTH	Acquisition of WUTH by WCHC
	requiring the establishment of interim arrangements. A completely new constitution must be drafted, approved by regulators, and new FT membership and governor elections undertaken, adding considerable legal and administrative complexity and cost. (Raw Score: 3, Weighted: 6)	WUTH's existing governance structure may need minor adjustments to accommodate the expanded scope and ensure appropriate representation of community services. (Raw Score: 5, Weighted: 10)	creating a new governance framework within the existing legal shell, which could be disruptive and challenging to implement. (Raw Score: 3, Weighted: 6)
Assets and Liabilities	The legal transfer of all assets and liabilities to the new entity is typically straightforward under Section 56 of the NHS Act, often with tax exemptions. However, despite legal clarity, the administrative effort involved in identifying, valuing, and formally transferring all assets and liabilities from two large organisations to a new one can be immense. This requires extensive due diligence, legal review, and potential re-registration of assets, increasing administrative burden and potential for delays. (Raw Score: 3, Weighted: 6)	The transfer of assets and liabilities from WCHC to WUTH is a well-defined process under Section 56A, which is generally less complex than transferring assets to an entirely new entity. This minimises legal and administrative hurdles and provides clear financial continuity. However, thorough due diligence on WCHC's assets and liabilities is still essential to identify any potential risks or unforeseen obligations before transfer. (Raw Score: 5, Weighted: 10)	Legal transfer under Section 56A. However, the transfer of WUTH's considerably larger and more complex asset base (including a major acute hospital estate) and liabilities to WCHC would require extensive due diligence and legal work. The financial and operational implications for WCHC in absorbing such a large entity would be substantial, increasing the risk and complexity of the transfer exponentially. (Raw Score: 2, Weighted: 4)
Finance	Long-term financial benefits from full integration and economies of scale are	The reduced legal and administrative complexity associated with maintaining	The significant increase in WCHC's operational expenditure (600%) and

Criteria	WCHC and WUTH Merger	Acquisition of WCHC by WUTH	Acquisition of WUTH by WCHC
	maximised. However, the extensive legal, consultancy, and administrative work associated with dissolving two entities and creating a new one, including drafting a new constitution, managing complex HR harmonisation, and extensive due diligence, is likely to result in the highest direct transaction costs compared to other options. (Raw Score: 3, Weighted: 12)	one existing legal entity, rather than creating a new one, is expected to result in lower direct transaction costs compared to a full merger. This allows for more resources to be directed towards service integration. However, while direct transaction costs are lower, the financial integration of WCHC's operations into WUTH requires careful financial planning and management to ensure a smooth transition and realise anticipated efficiencies. (Raw Score: 4, Weighted: 16)	the extensive due diligence required to absorb WUTH's financial scale would likely lead to very high transaction costs. The financial risk profile for WCHC would be dramatically altered, requiring unprecedented financial planning, risk management, and potentially external support, making this option financially challenging and high-risk. (Raw Score: 2, Weighted: 8)
Weighted Score	72	88	58

Preferred Statutory Option

Following the options appraisal, a clear consensus has been reached that a formal statutory integration, specifically **Option 2: Acquisition of WCHC by WUTH** has emerged as the clearly preferred statutory vehicle for the integration of the two Trusts. This option achieved the highest total weighted score of 88, presenting the most pragmatic, efficient, and strategically sound pathway to achieving the desired comprehensive integration.

This option offers good deliverability and operational efficiency, providing the most straightforward and efficient pathway to integration by leveraging WUTH's existing legal entity, established governance structures, and larger operational scale. This will reduce administrative complexity and legal hurdles, thereby minimising disruption and allowing for a more focused approach to service integration. Furthermore, it ensures minimised governance disruption, as the continuity of WUTH's Board and licence allows for a more stable transition, reducing the need for extensive constitutional overhauls and new elections. This streamlines the governance transition and ensures continuity of leadership and oversight during a critical period.

From a financial perspective, the acquisition model offers optimised cost-effectiveness compared to a full merger, ensuring a more financially prudent approach and allowing more resources to be directed towards patient care and service transformation.

This model also aligns with NHS best practice and trends, mirroring recent successful integration efforts where larger Foundation Trusts have effectively integrated smaller entities, demonstrating a proven pathway for achieving scale and scope benefits.

Strategically, it provides a strong platform for integrating community and primary care services (from WCHC) into a broader, acute-led framework (WUTH), creating a more cohesive and comprehensive healthcare provider for the Wirral population and facilitating seamless patient pathways and a truly integrated care model. Similarly, for workforce integration, it is deemed more manageable under this option. The acquisition of the smaller WCHC by the larger WUTH presents a more straightforward scenario for harmonising terms and conditions and integrating cultures, compared to the complexities of a full merger or a reverse acquisition.

This being said, it is acknowledged that this approach, while offering advantages, presents specific challenges, particularly regarding cultural alignment and managing the perceptions of an acquisition among staff and stakeholders. The term 'acquisition' can sometimes imply a dominant-subordinate relationship, potentially impacting morale and fostering an 'us and them' mentality. To manage these challenges, a carefully considered and robust communication and OD strategy will be developed. This will frame the integration emphasising the collaborative spirit and shared vision that has driven this journey from its inception.

It is based on the above rationale that both Boards agreed to proceed ahead with the submission of this SOC to the NHSE Transaction team, presenting the case for formal acquisition of WCHC by WUTH.



Vision for the New Trust

Vision for the New Trust

The integration of WUTH and WCHC marks a pivotal moment for health and care in Wirral. This merger is driven by a shared ambition to create a single, integrated organisation that will deliver seamless services across hospital, community, and home settings, ultimately leading to healthier lives and stronger communities for the people we serve.

This new Trust will emerge with a distinct identity, culture, and values, combining the unique strengths and best practices of both legacy organisations. It represents a commitment to moving beyond traditional organisational boundaries, fostering a collaborative environment where patients, staff, and partners feel part of a unified team.

The vision for the new Trust is to forge a truly integrated healthcare provider, delivering seamless, patient-centred care across both acute and community settings. It will embody the 'best of both organisations', leveraging the strengths of WCHC, including its CQC 'good' rating and robust governance practices, while effectively managing the scale and complexity of the acute services provided by WUTH. Operating under the unifying 'Better Together' brand, the new Trust will be guided by a joint strategy, collaboratively developed with stakeholders, to ensure a shared direction and purpose. With a new, integrated board already in place, the organisation is poised to cultivate a culture of collaboration, innovation, and shared responsibility, ultimately leading to enhanced patient outcomes and a more resilient healthcare system for the Wirral.

Our vision is not merely an aspiration but a strategic roadmap, underpinned by a clear set of objectives and priorities designed to transform health and care delivery across the region.

At the heart of this vision are a unified set of values that will guide our actions and decisions: Compassion, Open, and Trust. These values are not finalised and the shared values for the new Trust will be derived from the existing strengths of WUTH (Caring, Respect, Teamwork, Improvement) and WCHC (Compassion, Open, Trust). They will be central to fostering a supportive and inclusive culture. We will be compassionate and caring, actively listening to others; open in our communication, honest, and willing to share ideas; and trusted to deliver, ensuring our staff feel valued and safe. This foundation will enable us to work "Better Together" for people in our care.

A fundamental commitment is to implement a LeftShift strategy, moving care closer to home and into community settings, thereby reducing reliance on high-cost acute services where clinically appropriate. This will be achieved through the creation of unified clinical pathways that span acute, community, and primary care, ensuring consistent quality and access regardless of the entry point. Integrated urgent care models, such as the redeveloped Arrowe Park site, will offer single points of access, streamlining patient journeys and reducing waiting times. Furthermore, the vision includes developing a flexible and integrated clinical workforce, overcoming historical barriers to enable staff deployment across all settings, fostering professional development, and optimising service delivery models based on patient demand and best practice.

Financially, the new Trust envisions a single, robust, and commercially astute organisation, capable of achieving long-term sustainability and resilience. This goes beyond merely reducing double-running costs; it necessitates a whole service review and transformation across clinical pathways, fundamentally redesigning how services are delivered in Wirral. By building on WCHC's financial



stability, the Trust will implement a unified financial strategy, ensuring consistent planning, reporting, and control mechanisms. Efficiencies will be realised through the integration of corporate services, strategic procurement, and the rationalisation of estates, maximising value from assets and generating capital where appropriate. This financial framework will actively support the transformational Left Shift in care delivery, strategically allocating resources to enable services to move closer to communities and reduce dependence on high-cost acute settings.

Ultimately, the new Trust aspires to become a leader in integrated care, leveraging its combined strengths to innovate in service delivery, improve patient outcomes, and exert greater influence within the Wirral health and social care system, thereby maximising value for the Wirral pound and fostering a 'one organisation' culture where staff identify with the new, unified entity.



The new Trust's vision will be realised through a focused commitment to six strategic objectives, each supported by specific priorities:

Delivering Excellence

Our primary objective is to create the optimal conditions for outstanding care and performance across all our services. This means ensuring that every patient receives consistently safe, high-quality, and person-centred care, regardless of where they access our services.

Key Priorities

- **Consistent, High-Quality Care:** We will deliver care that is consistently safe, effective, and person-centred across all settings, from acute hospital environments to community-based services and care within people's homes. This involves leveraging the combined expertise of

WUTH's acute specialisms and WCHC's community reach to create a truly integrated patient journey.

- **Reduced Variation and Improved Outcomes:** By adopting evidence-based practices and shared clinical standards across the merged entity, we will reduce unwarranted variation in care delivery. This standardisation will lead to improved health outcomes for our population, ensuring equitable access to the best possible treatments and interventions.
- **Enhanced Patient Experience:** We will strengthen the patient experience by improving access to services and ensuring seamless coordination across all care pathways. This includes simplifying referral processes, reducing waiting times, and providing clear, consistent communication to patients and their families throughout their care journey.
- **Strong Safety Culture:** We are committed to embedding a robust safety culture that prioritises learning from incidents, promotes openness, and fosters accountability at all levels. This will ensure that our staff feel confident to speak up and contribute to continuous improvement in patient safety.
- **Meeting National Standards:** We will consistently meet and exceed national standards for timely and effective care, ensuring that our services are responsive to the needs of our population and align with national best practices.
- **Optimised Estate Utilisation:** We will make the best use of our combined estate to provide safe, modern, and welcoming environments for both patients and staff. This includes upgrading existing facilities, improving accessibility, and strategically planning our estate as one organisation to support high-quality care and staff wellbeing.

By focusing on these priorities, the new Trust will build on the individual strengths of WUTH and WCHC to create a unified system that is greater than the sum of its parts, setting new benchmarks for clinical excellence and patient satisfaction.

Our People

Our people are our greatest asset, and the new Trust is committed to nurturing an inclusive, compassionate culture where every member of staff feels valued, supported, and empowered to thrive. We recognise that a highly skilled, motivated, and engaged workforce is fundamental to delivering exceptional patient care.

Key Priorities

- **Compassionate and Inclusive Culture:** We will foster a compassionate and inclusive workplace culture that celebrates diversity and supports every member of staff. This involves creating an environment where all voices are heard, respected, and contribute to a shared sense of purpose.
- **Flexible and Future-Ready Workforce:** We will continue to build a flexible, highly skilled, and future-ready workforce capable of adapting to evolving health needs and service models. The merger will facilitate the creation of shared career pathways, rotational posts, and unified training programmes, offering broader development opportunities across acute and community settings.
- **Empowering Staff with Tools and Support:** Our workforce will be provided with the necessary tools, resources, and support to deliver the best possible care. This includes



investing in modern equipment, efficient IT systems, and administrative processes that reduce bureaucracy and enhance job satisfaction.

- **Safe Working Environments:** We are dedicated to ensuring safe working environments for all staff, promoting physical and psychological wellbeing. This includes robust policies, proactive risk management, and a culture that prioritises staff safety and mental health.
- **Investment in Education and Development:** We will empower our workforce through significant investment in education, leadership development, and wellbeing initiatives. By offering comprehensive training and professional growth opportunities, we will enable staff to enhance their skills, pursue their career aspirations, and make a real difference in the lives of our patients. This will also leverage the teaching hospital status of WUTH and the community education infrastructure of WCHC.

The integration will remove historical organisational barriers, allowing for greater staff mobility and shared learning, fostering a "one team" philosophy that benefits both our employees and the communities they serve.

Improve and Innovate

The new Trust will embed a culture of continuous improvement and innovation in every aspect of its operations, driving forward advancements in patient care, operational efficiency, and environmental sustainability. We will actively seek out and implement new ideas, technologies, and practices to enhance quality and outcomes.

Key Priorities

- **Embedding Improvement in Practice:** We will integrate improvement and innovation into everyday practice, encouraging teams to test new ideas, use evidence-based approaches, and address challenges in their services. This proactive approach will ensure that we are constantly evolving to meet the needs of our population.
- **Financial Sustainability and Resource Optimisation:** We are committed to achieving medium and long-term financial sustainability through the effective and efficient use of resources. The merger presents a significant opportunity to cut duplication, streamline corporate services, and improve value for money, directing investment to areas where it can make the greatest difference in patient care. This disciplined budgeting and strategic financial planning will support long-term stability.
- **Expanded Research and Academic Partnerships:** The merged Trust will expand its participation in research and academic partnerships, translating new learning and discoveries into improved patient care. Leveraging the combined research capabilities of both Trusts, we will foster a dynamic environment for clinical trials and innovative healthcare solutions.
- **Developing a Commercial Offer:** We will develop a clear commercial offer that maximises value from our assets and expertise. This includes exploring opportunities for partnerships and collaborations that generate income, which can then be reinvested into frontline services and strategic initiatives.
- **Environmental Sustainability and Net Zero:** We are dedicated to progressing our environmental sustainability goals, including working towards the NHS Net Zero target. This



involves implementing green procurement practices, optimising energy consumption, and promoting sustainable operations across all our facilities.

By fostering a culture of innovation and responsible resource management, the new Trust will be well-positioned to address complex health challenges, drive positive change, and ensure a sustainable future for health and care in Wirral.

Healthier Communities

A core tenet of our vision is to drive health equity and support healthier lives for all individuals within our communities. This involves a fundamental shift towards delivering care closer to home, focusing on prevention, early intervention, and addressing the wider determinants of health.

Key Priorities

- **Care Closer to Home:** We will deliver care closer to home through the development of integrated neighbourhood teams and local centres. This approach will bring services directly into communities, making them more accessible and responsive to local needs, and reducing reliance on acute hospital settings where appropriate.
- **Community-Guided Co-Design:** We will ensure that people in communities actively guide the design and delivery of care through co-design processes, utilising their insights and lived experiences. This collaborative approach will help us to create services that are truly relevant, culturally competent, and effective in reducing health inequalities.
- **Prevention and Early Intervention:** We are committed to removing barriers to equitable care with a strong focus on prevention and early intervention. By identifying and addressing health risks early, we can improve long-term outcomes, reduce the burden of chronic diseases, and enhance overall community wellbeing. This aligns with the Wirral Health and Wellbeing Strategy's emphasis on giving children the best start in life and creating safe, healthy places to live.
- **Anchor Institution Role:** We will leverage our role as a significant anchor institution within Wirral to maximise social benefit for our communities. This includes supporting local employment, fostering economic growth, and contributing to the social fabric of the region, thereby addressing health inequalities through broader societal impact.

The merged Trust will be a powerful advocate for population health management, integrating community and acute health services to provide holistic care that responds to the diverse needs of Wirral's residents, particularly those in deprived areas.

Collaboration and Partnerships

Working as one system and one organisation is fundamental to our vision. The new Trust will be a proactive and influential partner within the wider health and care landscape, fostering strong collaborations to deliver seamless, integrated care across the region.

Key Priorities

- **Formal Integration of WCHC and WUTH:** We will successfully conclude the integration between WCHC and WUTH to formally create a single, unified organisation. This



foundational step is crucial for streamlining governance, aligning strategies, and pooling resources effectively.

- **System-Wide Pathway Design:** We will work collaboratively with partners across the health and care system to design and deliver seamless pathways of care. This involves making the best use of our collective resources, eliminating handoffs, and ensuring a coordinated approach to patient journeys.
- **Strengthened Partnerships and Leadership:** We will strengthen our partnerships and collective leadership with primary care, local authorities, other NHS Trusts, the voluntary, community, faith, and social enterprise (VCFSE) sector, and wider system partners. This enhanced collaboration will ensure that local voices shape decisions and that our strategic direction aligns with the needs of the Wirral population.
- **Leveraging Expertise for Cheshire & Merseyside ICS:** We will leverage our combined experience and expertise to drive system working across the Cheshire & Merseyside Integrated Care System (ICS). As a larger, more influential entity, the new Trust will play a key role in shaping regional health policy and contributing to the broader goals of the ICS, including tackling inequalities and enhancing productivity.

By fostering a culture of partnership and shared responsibility, the new Trust will amplify its voice within the health economy, ensuring that community healthcare is prioritised and integrated effectively across all levels of care.

Advance Digitally

The new Trust is committed to developing a secure, connected digital ecosystem that is fit for the future, transforming how we deliver care, manage information, and empower our staff and patients. Digital innovation will be a cornerstone of our strategy, enabling greater efficiency, accessibility, and data-driven decision-making.

Key Priorities

- **Single, Secure Digital Ecosystem:** We will create a single, secure digital ecosystem that spans hospital, community services, and system partners. This includes implementing a unified electronic patient record system, ensuring seamless information sharing, and enhancing interoperability across all platforms.
- **Empowering Staff with Technology:** Our staff will be empowered with smart, user-friendly technology and strong digital skills. This involves providing comprehensive training, intuitive digital tools, and mobile solutions that reduce manual work and support clinical decision-making at the point of care.
- **Effective Use of Data and AI:** We will make effective use of data, artificial intelligence (AI), and automation to proactively enhance quality, safety, and decision-making. This includes leveraging data analytics for population health management, implementing AI-driven diagnostic support, and automating routine tasks to free up staff time for direct patient care.
- **Digital Inclusion and Accessibility:** We will drive the expansion of digital inclusion and accessibility, ensuring that technology benefits all members of our community. While promoting digital-first approaches, we will also recognise and address the needs of the digitally disadvantaged, providing alternative access routes and support.



- **Cyber-Resilient Infrastructure:** We will strengthen our cyber-resilient infrastructure to protect services and maintain the Trust's cybersecurity. This includes robust security protocols, regular audits, and continuous investment in safeguarding patient data and operational systems against evolving threats.

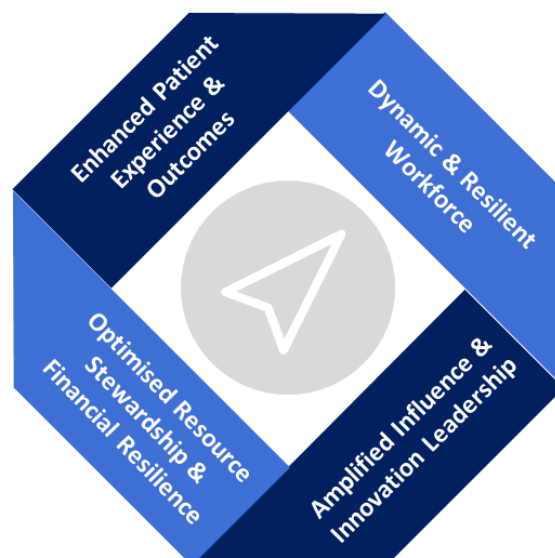


Strategic Benefits

Strategic Benefits

The integration of WUTH and WCHC represents a pivotal and transformative moment for healthcare in Wirral. This merger is not merely an administrative consolidation, but a strategic imperative designed to unlock synergistic benefits that will fundamentally reshape the health and care landscape for the better. By uniting our strengths, expertise, and resources, we will be poised to deliver a more resilient, innovative, and patient-centric health system, ensuring a healthier and more prosperous future for all in Wirral.

This chapter details the anticipated benefits, demonstrating the profound value proposition of this initiative within the context of the overall Outline Business Case.



Enhanced patient experience and outcomes

The proposed integration will allow the Trusts to re-engineer how care is delivered across Wirral, moving beyond coordinating services to truly integrating them. This will result in improved experience and better health outcomes for our diverse population, particularly addressing the unique needs of Wirral's ageing demographic and areas of high deprivation.

The unified Trust will dismantle artificial barriers between acute and community care, creating truly seamless care pathways that extend from preventative interventions to complex acute treatment and rehabilitation. Patients will experience a single, coordinated journey, eliminating fragmentation and multiple handoffs, ensuring continuity of care, reducing burden on patients and families, and optimising patient flow across the system.

Through the implementation of integrated urgent care teams, including virtual wards and 'home first' initiatives, the aim will be to prevent unnecessary hospital admissions, ensuring patients receive care in the most appropriate setting. By combining extensive community reach with acute expertise and leveraging integrated data, the new Trust will possess the capacity for proactive population health management.

This will enable the entire Wirral system to identify and address specific health needs, driving a significant Left Shift in care towards prevention and early intervention, thereby tackling health inequalities and aligning with the Wirral Health and Wellbeing Strategy. Moving care closer to communities will reduce pressure on acute services, alleviate hospital congestion, and address issues like corridor care, ultimately leading to more appropriate and timely care delivery and potentially contributing to health equity improvement.

Operating as a single entity could allow for the optimisation of patient access and flow. This would include unified referral protocols, shared waiting list management, and resource allocation, leading



to more equitable access, reduced waiting times, and more efficient patient movement through the care continuum.

The standardisation of clinical pathways is expected to reduce waiting times and unwarranted variation in access. Enhanced discharge planning and integrated rehabilitation services will facilitate quicker and safer patient discharges, reducing length of stay and preventing deconditioning.

The combined clinical expertise and scale will foster an environment for innovation, facilitating the adoption and dissemination of best practices across services.

Leveraging WUTH's teaching hospital status, the Trust could embed research and cutting-edge treatments more broadly into community care, ensuring Wirral residents and the entire system benefit from the latest advancements.

Furthermore, through integrated digital platforms and coordinated community support, patients would be better equipped with tools and information to actively manage their own health and wellbeing. This will include accessible digital health resources and support for digital inclusion, fostering greater independence and improved long-term health behaviours.

Unified safeguarding processes, policies, and digital systems, including a single EPR, will enhance patient safety, ensure consistency of care, and provide clinicians with a comprehensive view of patient information, thereby improving clinical decision-making and continuity of care.

Dynamic and Resilient Workforce

Our staff are the bedrock of our services. The transaction can create an environment that fosters professional growth, wellbeing, and a unified, high-performing workforce. The enlarged Trust will be an employer of choice, attracting talent across the region.

Staff would benefit from more opportunities for professional growth, including a wider range of integrated roles, cross-organisational secondments, and enhanced leadership development programmes. This will create dynamic career pathways spanning acute, community, and primary care settings, offering greater development for our healthcare professionals.

The creation of a single, flexible, multiskilled clinical workforce will enable more efficient deployment of staff across sites and services, enhancing responsiveness to demand and addressing shortages. This unified structure will also lead to more attractive roles with varied experience and clearer career progression, which is expected to improve recruitment and retention, particularly in hard-to-fill areas.

The Trust would also establish unified learning and development opportunities, offering shared professional development resources. This will foster a continuous learning and ensure a highly skilled, adaptable workforce capable of meeting future healthcare demands.

The merger will foster a culture of shared learning and best practice, allowing for the exchange of expertise and the implementation of consistent clinical standards and job plans.

By removing organisational barriers, the new Trust would gain flexibility in workforce deployment. This agility will enable us to respond more effectively to fluctuating patient demand, address staffing shortages, and optimally deploy clinical expertise across the entire Wirral health system, ensuring resilience and improving staff experience.



The integration offers a unique opportunity to cultivate a single, harmonised organisational culture, built on shared values. This would foster greater collaboration, mutual respect, and a stronger sense of collective purpose across all disciplines and settings, improving multi-agency working with external partners.

Finally, a unified approach to staff wellbeing and support services could ensure all employees benefit from consistent, high-quality programmes designed to promote physical and mental health. This streamlined approach will create a truly supportive work environment that can also serve as a model and resource for other health and care employers in Wirral. A unified digital environment, including a single helpdesk and consistent systems, will reduce frustration, improve access to support, and cultivate a more cohesive working culture.

Optimising Resource Stewardship and Financial Resilience

As a combined Trust, WCHC and WUTH can unlock financial and operational efficiencies, ensuring long-term sustainability and the reinvestment into frontline care and community initiatives.

The integration can provide the route to address structural financial challenges, leveraging the financial stability of WCHC.

Cost savings are anticipated from corporate integration, with over £1 million already identified in executive team savings and a target of 20% savings from corporate team restructure.

The integration programme is projected to deliver at least £13.9 million in savings over three years, crucial for meeting financial plans and addressing the Acute Trust's deficit. This will create a financially resilient entity capable of sustained investment in patient care, infrastructure, and innovation. By consolidating corporate functions and streamlining administrative processes, significant non-pay savings will be realised. This elimination of redundant systems and processes will free up substantial resources for direct reinvestment into frontline services, technology, and workforce development, enhancing service quality and capacity across Wirral.

As a larger, unified organisation, the Trust could command greater purchasing power, leading to more favourable contracts and significant savings on goods, services, and technology. This will ensure every pound spent delivers maximum value for the Wirral community, with potential benefits extending to other system partners.

Post integration, the enlarged Trust can undertake a review of the combined estate, considering how best to optimising it for the Trusts unified needs. This will lead to more efficient use of physical infrastructure, potentially freeing up valuable clinical space for community-based services or shared system use, reducing maintenance costs, and ensuring all assets contribute optimally to patient care and community needs.

Estate rationalisation, including strategic relocation of services and potential disposal of underutilised assets, will free up valuable acute space and generate capital. Procurement efficiencies, achieved through consolidating functions, will unlock economies of scale, leading to better pricing and reduced administrative costs.

A unified digital infrastructure can enable more sophisticated data analytics and business intelligence, providing a holistic view of operational performance across the entire Wirral system.



This will facilitate data-driven decision-making, identify areas for continuous improvement, and ensure resources are allocated effectively to maximise impact and value for Wirral residents.

By moving care into community settings and reducing acute admissions, it is expected to reduce high-cost ward-based care and overall Wirral system expenditure.

Amplified Influence and Innovation Leadership

A single, integrated Trust would possess a significantly stronger and more coherent voice within the C&M ICS and with national bodies. This amplified influence would enable more effective advocacy for Wirral's unique health priorities, ensuring equitable resource allocation and strategic alignment with regional and national health agendas.

A larger, unified Trust will possess greater influence in regional health and social care planning, enabling more effective advocacy for local needs and strengthening strategic partnerships with social care and other stakeholders. This will simplify engagement with external partners, moving towards more coordinated care and stronger system partnerships, aligning with national priorities for integrated care and contributing to a more robust and financially credible health system for the Wirral.

Integration would provide the scale and impetus to accelerate digital transformation across the entire care continuum. A unified digital approach, including a single EPR, will enhance interoperability, improve data sharing, and facilitate the adoption of cutting-edge technologies to revolutionise care delivery and patient engagement. This would position Wirral as a leader in digital health. Our long-term goal will be a single, consolidated EPR system by 2031, complemented by consolidated IT service management.

Leveraging combined R&D capabilities, the enlarged organisation could significantly enhance its capacity for clinical innovation. This could attract further investment, drive advancements in clinical practice, and position Wirral as a leading centre for healthcare innovation and learning.

As a larger, more influential Trust, it could amplify impact on the local economy and community. This could include increased local employment opportunities, and active participation in community development initiatives, for example, contributing directly to the social determinants of health and wellbeing across Wirral.

Finally, the integrated Trust would be more resilient and adaptable to future challenges, whether demographic shifts, technological advancements, or unforeseen health crises. Its scale, combined expertise, and unified strategic direction will enable it to navigate complex environments and continue delivering high-quality, sustainable care for generations to come.

Benefits Realisation and Quantification

The benefits outlined present an overall value proposition for the creation of the enlarged Trust. They demonstrate a clear pathway to a more integrated, efficient, and patient-centred health and care system for Wirral.

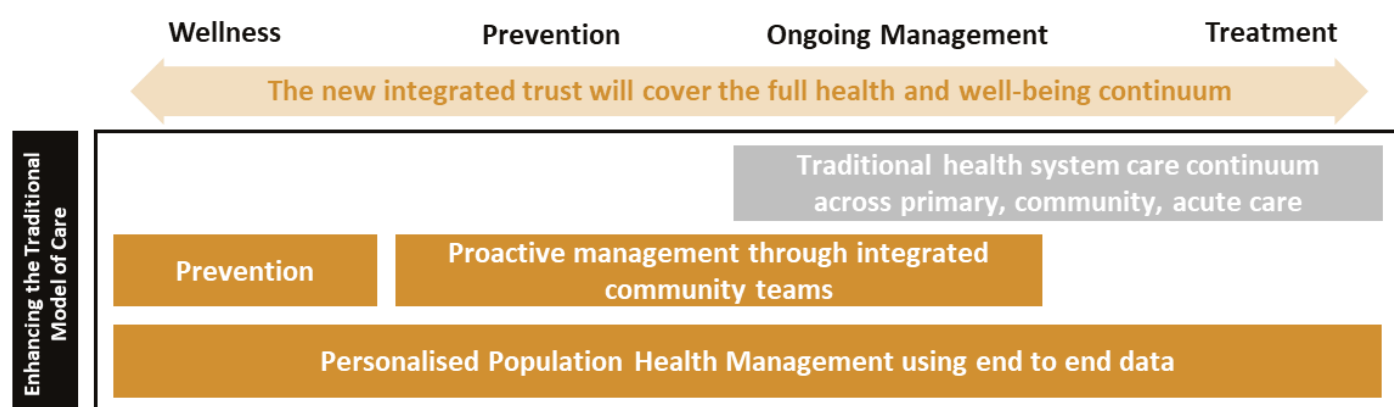
The benefits outlined will be further articulated and quantified at FBC stage. They will be measured through agreed KPIs.



Each benefit area will have a designated owner responsible for its realisation and tracking. Specific realisation activities will be outlined in the FBC and PTIP accordingly, with an indicative timeline for when each benefit is expected to accrue. Monitoring and reporting Frameworks will be established.

Enabling the Left Shift

The proposed merger between the two Trusts represents a pivotal strategic opportunity to fundamentally reorient healthcare delivery within the region. At its core, this merger is designed to accelerate the "Left Shift" – a transformative movement of care, resources, and activity away from reactive, hospital-based services towards proactive, preventative, and community-based care delivered in neighbourhood settings and closer to patients' homes. Please see the diagram below:



This strategic direction is not only aligned with the regional vision for integrated care but also directly supports the overarching objectives of the NHS 10 Year Health Plan, which advocates for stronger primary and community care to improve population health outcomes and ensure the sustainability of the health system.

The Left Shift is predicated on the principle that many health conditions can be more effectively and efficiently managed outside of acute hospital settings, leading to improved patient experience and better health outcomes. By integrating services and optimising pathways across the acute and community sectors, the merger will deliver a range of significant benefits:

- **Reduced Length of Stay (LoS) in Acute Hospitals:** By fostering seamless transitions of care, the merger will enable earlier and safer discharge for patients who no longer require acute hospital care. This will be achieved through enhanced community support services, such as virtual wards, robust home-first initiatives, and integrated rehabilitation pathways, ensuring patients receive appropriate follow-up and support in their own homes or community settings. This proactive approach minimises the need for prolonged hospitalisation, freeing up valuable acute beds for those who critically need them.
- **Reduced Hospital Admissions and Readmissions:** A key outcome of the Left Shift is the prevention of unnecessary hospital admissions and the reduction of readmission rates. This will be driven by a stronger emphasis on proactive management of chronic conditions within primary and community care settings. Integrated care teams will provide early intervention for acute exacerbations, comprehensive discharge planning with robust community follow-up, and enhanced self-management support for individuals with Long Term Conditions.

(LTCs). By addressing health needs earlier and more holistically in the community, the pressure on acute services will be significantly alleviated.

- **Decreased Emergency Department (ED) Attendances:** The merger will facilitate the development of more accessible and appropriate alternatives to the Emergency Department for non-life-threatening conditions. This includes improving access to enhanced primary care services, expanding out-of-hours provision, and establishing integrated urgent care centres. By diverting patients to the most appropriate care setting, the ED can focus on genuine emergencies, improving efficiency and patient experience across the urgent care pathway.
- **Improved Patient Satisfaction Scores:** Care delivered closer to home, in more comfortable and familiar settings, and with greater continuity of care, consistently leads to a more positive patient experience. The Left Shift prioritises patient-centred care, offering greater convenience, personalised support, and a sense of empowerment through active participation in their own health management.
- **Enhanced Chronic Disease Management:** A strengthened primary and community care infrastructure, facilitated by the merger, will allow for more consistent monitoring, education, and support for individuals living with LTCs. Multidisciplinary teams, including specialist nurses, therapists, and social care professionals, will work collaboratively to provide integrated care plans, promote self-management, and reduce the progression of chronic diseases, thereby improving overall population health.
- **Reduced Healthcare Costs (System-wide):** Shifting care from high-cost acute hospital settings to less expensive community-based alternatives (e.g., home care, outpatient clinics, virtual consultations) will generate significant cost efficiencies for the wider healthcare system. This optimisation of resource allocation ensures that public funds are utilised more effectively, delivering greater value for money while maintaining or improving quality of care.

Examples of WUTH and WCHC Driving the Left Shift

The two Trusts have already demonstrated a proactive commitment to the Left Shift, showcasing early benefits for patients through their collaborative efforts. These examples provide strong assurance that the integrated entity will be well-positioned to continue and accelerate this transformative work.

Urgent Care Integration: An advanced integrated approach across community and acute care is currently being implemented. This involves the co-location of various critical services, including the Virtual Ward, Home First, and Urgent Care Response teams, alongside the Transfer of Care hub, all situated on the Arrowe Park site. This physical integration fosters a highly coordinated approach to both admission avoidance and timely, supported discharge. Furthermore, the Single Point of Access team is scheduled for relocation from St Catherine's Health Centre to Arrowe Park in June 2026, further streamlining patient pathways. The summer of 2026 will also see the opening of a new A&E facility, designed with an integrated Emergency Department (ED) and Urgent Treatment Centre (UTC) model, where acute and community staff will work side-by-side. The merger will significantly aid this ongoing work by enabling greater staff flexibility across organisational boundaries and facilitating the implementation of a single, unified IT system, thereby removing current operational barriers and enhancing seamless patient journeys.

Therapies Service Redesign: A core objective is to strategically move therapy services into the community wherever clinically appropriate. This not only enhances patient access and convenience but also frees up valuable space within acute hospital settings, directly supporting the Left Shift agenda. Outpatient therapies have already been successfully relocated from Arrowe Park Hospital to St Catherine's Health Centre, demonstrating the feasibility and benefits of this approach. A comprehensive review of the therapies model is planned for 2026/27, with the explicit aim of establishing a single, unified therapy service across the merged organisation. This unified service will be designed to support the delivery of care at scale across neighbourhoods, empowering community teams to provide both proactive preventative care and "in-reach" services into the hospital, ensuring continuity of therapy support from admission through to discharge and beyond.

Transforming Key Clinical Services for Wirral

Beyond the overarching strategic benefits of integration, the merger presents a unique opportunity to transform specific clinical service lines that are vital to the health and wellbeing of the Wirral population. Detailed service reviews in Musculoskeletal (MSK), Ophthalmology, and Cardiology have identified significant benefits that can only be fully realised through the proposed unified organisational structure. These service-specific benefits will directly address current inefficiencies, enhance patient care, optimise resource utilisation, and foster innovation within these high-demand areas.

Musculoskeletal (MSK) Services

The MSK Service Review across WUTH and WCHC highlighted existing fragmentation, duplication, and varying patient experiences. The merger provides the strategic framework to implement a truly integrated MSK service model, delivering substantial benefits for Wirral residents.

- **Unified, Seamless Patient Journey:** The integration will establish a single operating model for MSK physiotherapy, encompassing both WUTH and WCHC services, including neurological physiotherapy and Pelvic Health. This will eliminate the current duplication in clinical provision and handoffs, creating a seamless patient pathway from initial referral through to treatment and follow-up. Patients will no longer navigate disparate systems, leading to a significantly improved and less confusing experience.
- **Enhanced Clinical Effectiveness and Advanced Practice:** The merger enables enhanced support for staff with more Advanced Practitioner roles, facilitating earlier and more comprehensive interventions. A unified clinical team will allow for consistent job planning and revised rota models leading to more treatment time and increased group sessions. This will improve clinical outcomes and patient satisfaction.
- **Optimised Productivity and Capacity Utilisation:** By integrating booking and administrative teams and implementing a single Electronic Patient Record across the combined service, the Trust will achieve significant gains in productivity. This includes a target of 85% slot utilisation, a reduction in Did Not Attends (DNAs) and cancellations, and optimised appointment numbers. These efficiencies will free up capacity, reduce waiting lists, and ensure more Wirral patients receive timely care.
- **Rationalised Infrastructure and Improved Accessibility:** The merger facilitates the consolidation of MSK services onto one floor at St Catherine's Health Centre (SCHC) and



potentially fewer satellite sites. This rationalisation of estates will improve accessibility for patients, reduce travel times (as highlighted by a 2025 travel survey), and create a more efficient clinical environment, addressing current issues with smaller, less accessible sites.

- **Improved Interface with Primary Care and Other Specialties:** The integrated model will foster better interfaces with General Practitioners (GPs) and other MSK services (Orthopaedics, Pain, Anaesthetics, Rheumatology). This will lead to clearer referral pathways, enhanced self-referral mechanisms, and faster clinical letter writing, ensuring a more coordinated approach to patient care across the wider system.
- **Workforce Efficiency and Financial Savings:** The proposed integrated model projects a reduction in MSK physiotherapy staffing from 61 to 54 Whole Time Equivalents (WTE), while maintaining or improving service delivery. This workforce efficiency, coupled with reduced estates costs and optimised productivity, will deliver significant financial savings that can be reinvested into other areas of patient care.

Ophthalmology Services

The Ophthalmology Service Review highlighted increasing demand, variation in care, and estate constraints. The merger provides the strategic leverage to address these challenges, ensuring high-quality, sustainable eye care for Wirral.

- **Unified Glaucoma Pathway and Expertise:** The merger will enable WUTH to become the sole provider for glaucoma services within Wirral, consolidating expertise and standardising care. This will mitigate the current risks associated with WCHC's reliance on agency consultants for clinical leadership in this area and ensure a consistent, high-quality glaucoma pathway for all Wirral patients, aligning with national guidance.
- **Enhanced Capacity and Reduced Waiting Lists:** By integrating services, the new Trust can strategically manage and expand capacity to meet the increasing demand for ophthalmology services, particularly for conditions like glaucoma, cataracts, and age-related macular degeneration. This will lead to a reduction in current waiting lists and ensure more timely access to specialist eye care for Wirral residents.
- **Optimised Estate Utilisation and Accessibility:** The merger provides the opportunity to address WUTH's current estate constraints at Arrowe Park Hospital (APH) by potentially relocating some ophthalmology services to St Catherine's Health Centre (SCHC). This would create a more accessible, purpose-built facility for ophthalmology, improving patient experience and operational efficiency, and leveraging existing community infrastructure.
- **Streamlined Referral Pathways and Digital Integration:** The integration will facilitate the development of streamlined referral pathways between primary care, community optometry, and specialist ophthalmology services. Furthermore, a unified digital strategy will enhance information sharing and support the development of virtual clinics and patient-initiated follow-up (PIFU), improving efficiency and patient convenience.
- **Comprehensive Emergency Eye Care:** WUTH currently provides the only emergency ophthalmology provision in Wirral. The merger will strengthen this critical service, ensuring robust and accessible emergency eye care for all residents, supported by integrated pathways with community services to manage less urgent cases appropriately.

- **Mitigation of Workforce Risks:** By consolidating services, the new Trust can mitigate the risks associated with reliance on agency consultants and develop a more resilient, integrated ophthalmology workforce. This includes fostering internal talent and creating attractive career pathways within a larger, more stable service.

Cardiology Services

The Cardiology Service Review identified duplication, fragmented pathways, and challenges in managing urgent care demand. The merger offers a clear path to an integrated cardiology service that improves patient outcomes and system efficiency.

- **Integrated Cardiology Service Model:** The merger will establish a single operating model for cardiology services, integrating outpatient, community, day case, and ward-based provision. This will eliminate duplication in service areas and create a unified approach to cardiac care across Wirral.
- **Streamlined and Revised Clinical Pathways:** The integration will enable the development of revised clinical pathways for general cardiology, suspected arrhythmias, syncope, and suspected angina. This includes implementing a single Advice & Guidance, Referral and Triage model, ensuring patients are routed to the most appropriate care setting based on clinical risk and capacity, reducing unnecessary admissions.
- **Enhanced Workforce Skill Mix and Specialist Nurse Utilisation:** The merger will facilitate the development of an integrated clinical workforce based on an optimised skill mix, with a proportionate increase in specialist nurses. This will enable specialist nurses to be fully utilised for defined clinical presentations, with consultant escalation and oversight, improving efficiency and patient experience.
- **Improved Diagnostics and Reduced Unplanned Care:** The creation of an integrated diagnostics function with enhanced capacity for ECG, Echo, and BP monitoring will improve diagnostic turnaround times. This, combined with revised pathways, is expected to reduce urgent care demands and non-elective admissions for cardiac conditions, addressing the current £1.2m cost associated with cardiology patients on the WUTH waiting list.
- **Optimised Booking and Administration:** Integrating booking, administration, and medical secretarial functions and teams will streamline processes, reduce administrative burdens, and improve patient flow, ensuring a more efficient and patient-friendly experience for cardiac patients.
- **Strategic Estate Utilisation for Community Cardiology:** The merger will allow for the exploration of further development of estates models that provide accessible clinics in cost-effective locations, consistent with an emerging Neighbourhood model. This will bring cardiology services closer to communities, improving access and reducing the need for hospital visits for routine care.
- **Addressing Structural Deficit and Reinvestment:** The integration offers a crucial opportunity to address the structural deficit by leveraging efficiencies in cardiology services. Projected net savings from cardiology outpatients (£235k), pulmonary rehab (£285k), and other areas can be reinvested to strengthen cardiac care and other vital services across Wirral.



The integration of WUTH and WCHC is a practical necessity that will yield tangible, service-specific benefits across MSK, Ophthalmology, and Cardiology. These targeted improvements will directly enhance patient care, optimise resource utilisation, and foster a more resilient and responsive health system, ensuring that the people of Wirral receive the highest quality, integrated care for these critical specialities.



Financial Case

Financial Case

This chapter sets out the current financial context for the transaction and its implications. The creation of a single Wirral Acute and Community Trust brings together two organisations with distinct financial performance and materially different financial scales and levels of challenge. The financial opportunity that arises is to increase efficiency and future sustainability.

Current and Historical Financial Position

WCHC

WCHC has a strong financial position and has consistently met or exceeded its statutory financial duty to deliver breakeven. In 2023/24 an adjusted surplus of £958k was achieved (adjusted for impairments). In 2024/25 WCHC reported an adjusted performance position of a £6.5m surplus. £2.3m of recurrent savings were made, mainly through corporate services transformation reviews and programmes and a further £4m of non-recurrent savings were achieved to meet the targeted £6.3m of efficiency savings, representing 5.8% of operating expenses. WCHC ended the year with a cash and cash equivalent balance of £7.8m.

As the Trust have exited 2025/26, WCHC's outturn position is a £6.4m surplus, with an adjusted £5.1m surplus position. The Trust exceeded their efficiency saving target of £5.7m delivering total savings of £7.2m (6.6% of operating expenses), with £6.2m delivered recurrently. The Trust's Medium Term Financial Plan seeks to maintain this good performance. The Trust has a challenging financial plan for 2026/27 with a £1.9m surplus which is predicated on achieving efficiency savings of £6m (5.4%).

Recent financial performance for WCHC is shown in the table below:

	£'000			
	23/24	24/25	25/26	26/27
	Actual	Actual	Actual	Plan
Operating income from patient care activities	103,694	111,868	109,424	105,732
Other operating income	3,817	3,585	4,009	2,601
Operating expenses	(107,411)	(107,862)	(105,791)	(105,042)
OPERATING SURPLUS/(DEFICIT)	100	7,591	7,642	3,291
Finance Costs	(615)	(586)	(1,281)	(1,391)
Other gains/ losses	(971)	-	66	-
SURPLUS/(DEFICIT) FOR THE YEAR	(1,486)	7,005	6,427	1,900
Add back all impairments (reversals)	1,461	(458)	(1,334)	-
Remove capital donations /grants /peppercorn lease I&E impact	12	-	-	-
Adjust (gains)/ losses on transfers by absorption	971	-	-	-
Adjusted Performance	958	6,547	5,093	1,900

WUTH

WUTH delivered an adjusted deficit of £23.7m in 2023/24 and an adjusted deficit of £9.7m in 2024/25. As the Trust exits 2025/26, WUTH's outturn is £45.3m deficit. The Trust faces significant financial pressures, which have resulted in substantial deficits in recent years. The Trust feels strongly that working towards integration and with other partners in Cheshire and Merseyside is critical to improving this position. While the 26/27 plan is anticipated to deliver an improved deficit position of £21.3m the Trust continues to face significant financial difficulties.

Recent financial performance for WUTH is shown in the table below:

	£'000			
	23/24	24/25	25/26	26/27
	Actual	Actual	Actual	Plan
Operating income from patient care activities	455,984	501,123	488,736	474,900
Other operating income	37,183	38,389	44,308	34,235
Operating expenses	(523,593)	(550,559)	(575,058)	(524,885)
OPERATING SURPLUS/(DEFICIT)	(30,325)	(11,047)	(42,015)	(15,750)
Finance Costs	(4,024)	(4,202)	(5,569)	(5,817)
Other gains/ losses	0	(328)	(5)	-
SURPLUS/(DEFICIT) FOR THE YEAR	(34,450)	(15,577)	(47,589)	(21,567)
Add back all impairments (reversals)	10,411	5,641	3,258	-
Remove capital donations /grants /peppercorn lease I&E impact	283	207	(971)	267
Other	41	-	-	-
Adjusted performance	(23,715)	(9,729)	(45,302)	(21,300)

Aggregated Position

The table below outlines the aggregated counterfactual position across both organisations should the proposed coming together as one new organisation not go ahead.

	£'000	
	2025/26 Actual	2026/27 Plan
Operating income from patient care activities	598,160	580,632
Other operating income	48,317	36,836
Operating expenses	(680,849)	(629,927)
OPERATING SURPLUS/(DEFICIT)	(34,553)	(12,459)
Finance Costs	(6,850)	(7,208)
Other gains/losses	61	-
SURPLUS/(DEFICIT) FOR THE YEAR	(41,162)	(19,667)
Add back all I&E impairments / (reversals)	1,924	-
Remove capital donations /grants /peppercorn lease I&E impact	(971)	267
Other	-	-
Adjusted financial performance surplus / (deficit)	(40,209)	(19,400)

This shows again that the transaction is critical to the financial health and sustainability of the Wirral system. WUTH has an considerable underlying deficit that needs to be tackled, with the benefits of integrated pathways across secondary and community care under a single combined organisation being a key lever to help address this.

Financial Costs of Merger

In this context, the Trusts have estimated the revenue costs of bringing the two Trusts together at the current time, shown in the table below:

Transaction and Integration Costs	£'000
External support with the documentation required for the transaction and integration planning	479
Legal Support	20
Total Transaction Costs	499

The Trusts are planning for the transaction to be low cost, with in-house resources and expertise utilised as much as possible to deliver the transaction. External advisors have been procured where additional capacity needs have been identified. Restructuring is currently underway in corporate



services, and some MARS cost may be required, but if so, this will only be approved on the basis that it provides recurrent run rate savings.

It is likely that the cost figures identified above will develop and iterate until Full Business Case stage as the external due diligence process is undertaken, particularly in relation to financial baseline assessment and risks, and as the costs of integration post transaction are developed in areas such as IT and Digital. Work in these areas is still at an early stage.

It should also be noted that an external financial due diligence exercise is planned as part of the FBC work.

Financial Benefits

The two Trusts believe that the minimal investment of these costs is worthwhile, as the merger presents a significant opportunity to achieve financial benefits through synergies and economies of scale providing greater financial sustainability.

The Trusts are committed to operating within the allocated budget, reducing the cost base, and significantly enhancing productivity. This will be achieved by minimising waste, optimising the use of our facilities and estate, and improving patient flow. The Trusts will identify and act on efficiency opportunities at every step. By leveraging economies of scale as a larger organisation, the Trusts will benefit from increased buying power for goods and services. By bringing together and restructuring our corporate functions, the Trusts will be able to improve the quality of services at a lower cost.

Significant work has been undertaken to demonstrate these potential financial benefits in one key area: establishing a single, streamlined corporate structure.

The financial benefits from corporate integration are recurrent and underpinned by detailed workforce modelling and organisational design work undertaken across both Trusts.

The savings are phased to reflect the practical sequencing of integration and implementation of new structures:

Phase 1 – Single Executive Team:

A single executive team has already been established during 2025/26, with the £1m full year financial saving transacting in 2026/27. This delivers an early reduction in leadership overhead and sets the foundation for wider organisational integration.

Phase 2 – Senior Management Rationalisation:

The second phase focuses on the consolidation of senior management across corporate functions and estates. This includes the removal of duplicate roles and the creation of unified leadership structures aligned to the future operating model.

Phase 3 – Wider Corporate Team Integration:

The final phase delivers savings through the full integration of corporate teams, standardisation of processes, and further reduction in duplication across both organisations. This reflects a move to single teams operating across both acute and community services.

Across all three phases, the programme delivers a total recurrent saving of £5.0m, alongside a reduction of c.93 WTE across corporate services and senior estates management.

These savings are considered deliverable as they are based on detailed establishment reviews and are aligned to the emerging organisational design for the merged entity.

Delivery will be supported through formal consultation processes, robust programme governance, and clear executive accountability.

In addition, Model Hospital benchmarking and other initial reviews of clinical services have identified a further financial benefit opportunity of £10.7m (please note this is an estimate at this stage, based on Model Hospital opportunities when compared against the sector median).

Again, some of this is already being transacted in 2026/27 with £367k of savings being delivered in MSK, £134k in Cardiology, and £80k in Ophthalmology.

At this stage, therefore, based on the work undertaken to date, the two Trusts are confident that the potential financial benefits can repay the costs of the transaction and make an important contribution to reducing the size of the WUTH underlying deficit.

An in-depth exercise will be carried out to quantify savings opportunities fully as part of the FBC stage.

To achieve the projected savings and fully realise the benefits of the integration, a dedicated programme will be established, including focused line-by-line expenditure reviews in areas like Digital and Contracts for consolidation.

The integrated Trust will therefore be more financially sustainable in the long term by addressing the core drivers of the acute deficit whilst improving productivity and supporting the integrated care model including sustainable staffing models.



Deliverability

Deliverability

This section details the Trusts' ability to manage the merger by acquisition, including governance, delivery oversight and planning.

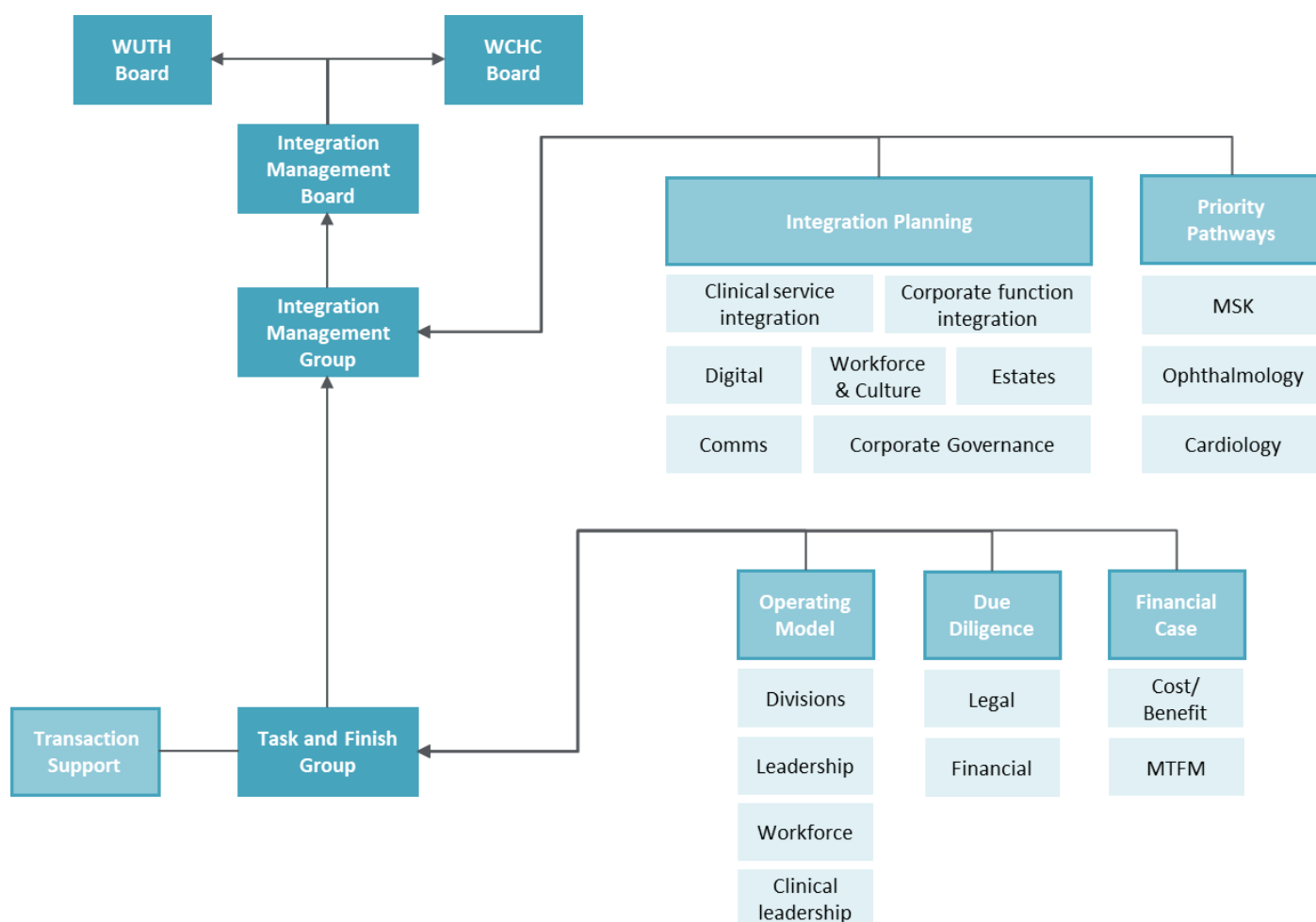
Transaction Governance

A bespoke governance framework has been put in place to oversee the transaction. This framework is designed to provide clear accountability, effective decision-making, and continuous oversight. This approach focusses on embedding governance and assurance arrangements for the integration as well as the process for key milestones.

The governance framework has the following key elements:

- Ultimately, there is shared decision-making through a single Executive Team and joint NEDs working as a single unitary Board.
- **Integration Management Group (IMG):** The IMG leads an integration programme made up of key corporate and clinical integration workstreams, as well as overseeing the development of a new operating model for the new Trust. The Group ensures coordination and delivery of the key workstreams, and the resolution of emerging challenges.
- **Task and Finish Group:** This group leads the specific transaction planning and delivery activities that are required, including the development of documentation and the due diligence process and reports to IMG.
- **Integration Management Board (IMB):** Both the IMG and the Task and Finish Group report into the IMB, which provides regular oversight of the programme, ensuring all key deliverables are met, risks are managed, and benefits are realised.

This structure is summarised in the diagram overleaf.



Integration Management Group

The Integration Management Group will comprise the Chief Executive as the Chair and the SRO for the overall Transaction and Integration, a Non-Executive Board member from each Trust, along with other Executive Directors and senior staff who, together, will be responsible for approving and managing the programme plans at every stage of the delivery process including:

- Review of key integration plans for the workstreams, and the activities required to realise them
- Service user and staff communications and engagement
- Review of a detailed risk and issue register and the proposed mitigations of risk factors affecting the successful delivery of the programme
- Review of a benefits realisation register and monitoring of delivery
- Considering and recommending to the Boards any changes to the programme scope, budget or timescale if required

The Integration Management Group will be accountable to both existing Trust Boards (via the Integration Management Board), who will have overall decision-making responsibility and accountability for the delivery and resourcing of the programme.

The Integration Management Group will meet monthly to proactively drive delivery of the programme plan and critical path. It will discuss progress, manage interdependencies, review risks and issues and make tactical decisions to support the delivery of agreed plans. It will seek assurance from the SRO and existing Trust Boards on any aspect of the programme that may pose a risk to successfully achieving the transaction and realisation of the expected benefits.

Task and Finish Group

The Task and Finish Group reports to the Integration Management Group and is chaired by the Joint Chief Strategy Officer. It oversees the key activities required for the transaction, including preparation of the key documents, including the SOC, FBC, PTIP, PBC and financial modelling, and the NHS England assurance and approval process, to ensure that all requirements are effectively and efficiently addressed.

The Task and Finish Group work closely with the support commissioned by Deloitte and programme management capability to deliver the Programme plan for the transaction.

Programme Management Capability

The Trusts know that the establishment of a programme management capability (primarily embedded within the Task and Finish Group) is important to efficiently oversee the development of the Integration Plans within the Trusts. This will play a role in coordinating submissions to NHSE as part of the transition review and assurance process, as well as monitoring the delivery of the plans.

The specific programme management tasks that the Task and Finish Group will oversee include:

- | | |
|--|--|
| 1. Project Initiation and Planning including workstream charters, milestones and critical path | 4. Risk Management including risk register updates |
| 2. Governance structure and processes including weekly progress reports | 5. Benefits identification and realisation including Day One readiness, Day 100 and beyond |
| 3. Supporting wider Stakeholder Engagement | |

The Group will ensure that the transition programme is managed in accordance with best practice, using a robust programme and project management methodology, and provide coordination and planning capability.

The workstreams are responsible for the development of the Integration Plans and quantifying synergies, communicating programme milestones and reporting progress. This will encompass all workstreams to support the delivery of transition plans and support sequencing of communications and engagement at appropriate milestones.

The programme management capability will include a core team with the necessary skills for:

- Developing, maintaining, and implementing programme plans, including post-transaction integration plans
- Co-ordinating working groups and integration of workstreams as required
- Monitoring progress and reporting to the Transition Sub-Committee
- Managing issues as they arise and escalating to the SRO and the board as necessary
- Managing change control
- Managing project advisors, ensuring that their contribution is well understood, and that the Trusts obtains the best advice and value
- Managing risks in line with programme risk management strategy
- Managing actualisation of the overarching Benefits Realisation Plan
- Proactively remove barriers to the delivery workstreams where possible

Comms and Engagement

A dedicated Comms and Engagement strategy ensures a smooth transition, maintaining confidence and managing perceptions throughout the process. A critical initial step for the Engagement and Culture Team involves undertaking regular 'temperature checks' to thoroughly understand the current cultures within both WUTH and WCHC. This deep understanding of existing norms, values, and working practices is fundamental to identifying potential areas of synergy and divergence.

Members of the Comms and Engagement and People teams will design a detailed communications plan that aligns with the overall merger objectives, outlining key messages, target audiences, channels, timelines, and success metrics. This plan will ensure the strategy addresses both the pre- and post-transaction phases, providing cross-cutting communications support for all workstreams to ensure consistent messaging across the entire integration effort.

Another priority is to identify all critical internal stakeholders (e.g., staff, Staff Side, leadership, clinical teams) and external stakeholders (e.g., Service Users, commissioners, partner organisations). The group will develop tailored engagement plans for each stakeholder group to address their specific concerns and information needs. To deliver and manage clear messaging, the Comms and Engagement Team will engage in initial activities such as crafting clear, consistent, and compelling core messages that articulate the rationale, benefits, and vision of the merger. Throughout the transition, the group will ensure all communications reflect these approved messages, maintaining a unified voice across all channels.

Resourcing the Transaction

Business as usual operations across both organisations remain paramount throughout the transaction. While a dedicated programme will manage the strategic and complex elements of the merger, it is recognised that many aspects of integration will naturally be delivered through existing processes and collaborative working. The Trusts' proven track record of collaboration, as evidenced by the Wirral Provider Alliance work and joint initiatives, provides a strong foundation for managing this complex integration both within and outside the formal programme structure.

To facilitate this, the merger work is being managed as a standalone programme. This structure ensures appropriate Board engagement and sign-off without diverting focus from day-to-day operational matters.

Executives will provide oversight within agreed portfolio areas, leveraging their subject matter expertise to support planning. Resource requirements will be proactively assessed across all clinical and corporate workstreams. Additional capacity will be constrained, and so there will be an expectation for workstreams to re-prioritise day-to-day work to enable a focus on integration activities. Where it is deemed necessary to safeguard service delivery, additional fixed-term roles and back-filling of positions will be implemented.

The programme management capability will provide targeted central support which will be further augmented by the strategic commissioning of external advisory support to ensure robust business case development and integration planning.

External advisors will be providing comprehensive support across several critical workstreams, primarily focused on guiding the Trusts through the significant organisational change. Their role can be summarised as follows:

The advisors will:

- **Lead Strategic Document Development:** Take primary responsibility for structuring, drafting, and iterating key strategic documents, including the SOC, Full Business Case (FBC), and Post Transaction Implementation Plan (PTIP). This involves identifying information requirements, conducting a gap analysis, synthesising existing materials, and producing drafts.
- **Develop Financial Models:** Create and populate the NHS England Financial Model template to illustrate forecasts, costs and efficiencies.
- **Lead the external due diligence process.**
- **Review Integration Planning:** Support integration planning sessions, provide tools and templates, and offer advice on the structure and content of implementation plans, ensuring a consistent and best practice approach to managing integration. This work will then be fed into the creation of the PTIP.

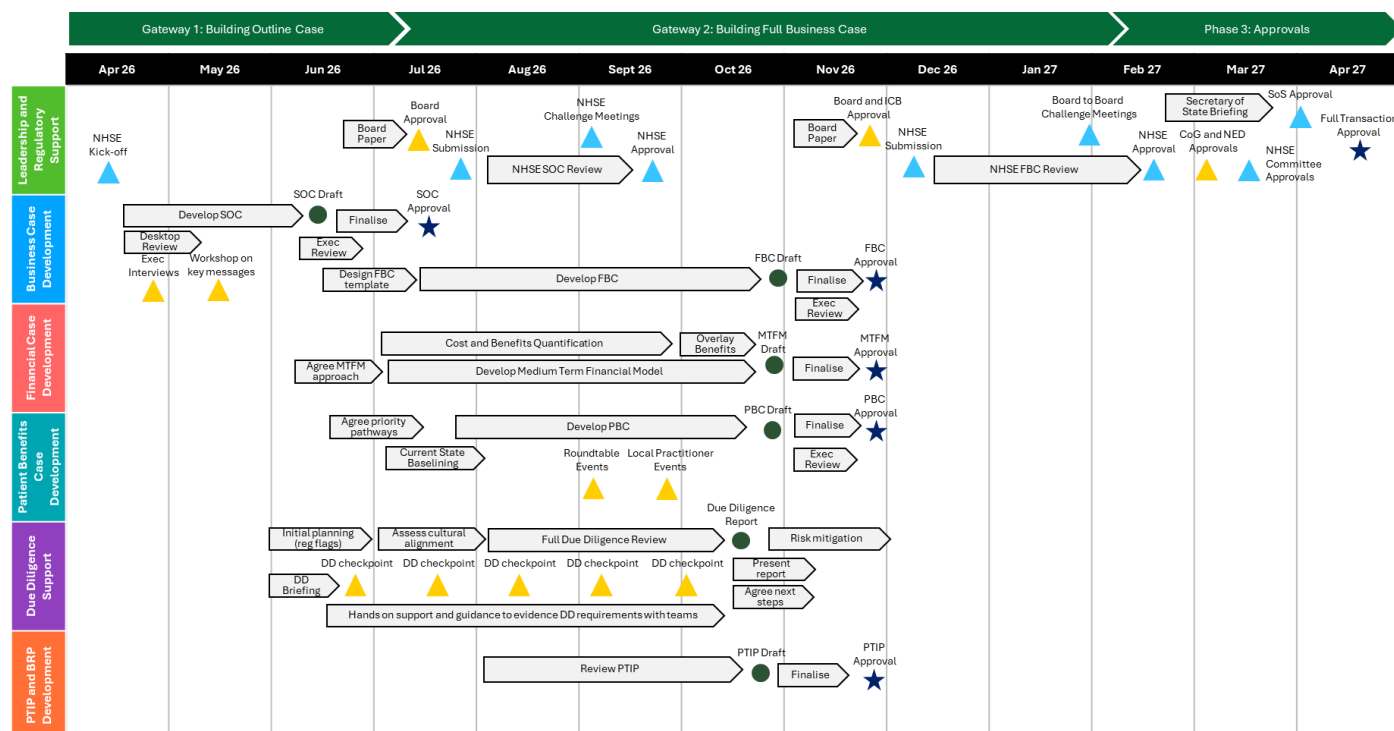
This combination of internal expertise and external support demonstrates the Trusts' commitment to a well-structured and expertly managed transaction process. It signifies a proactive approach to handling the complexities and challenges that may arise during the transaction and integration phases.

Programme Plan and Milestones

The Trusts have developed an initial programme plan for the delivery of the transaction covering the period up to the new organisation coming into being, which is provided below. Assuming receipt of the necessary approval to move to development of the FBC, this plan will be further refined in consultation with the NHSE Transaction Team. An outline programme plan for the first two years post-transaction and the integration process has also been developed. The risk of adverse impact on business as usual is recognised, and to manage this, a timetable for the transaction has been set out, which seeks to move at pace while also recognising that sufficient senior leadership time needs to be devoted to ensuring safe, high-quality care continues to be provided to all service users.



Indicative Plan for Transaction Delivery Tranche 1 – Pre-acquisition



Programme delivery plans beyond day 1 are captured in the Transition planning chapter.

Key milestones

Key milestones are as set out in the figure below. The ‘go live’ date is intended to be 1st April 2027 provided the necessary support, and approvals are received from the Joint Board, Governors, stakeholders, regulators and NHSE. The timetable below gives an indicative timeline of the key milestones, but these are subject to change as the transaction progresses.

Date	Milestones
Apr – Jun 2026	SOC development
Jul 2026	Kick off meeting between NHSE and WUTH/WCHC
Jul 2026	Board approval from WUTH and WCHC on final SOC for submission
Jul 2026	SOC Submission to NHSE
Jul - Sep 2026	NHSE undertake SOC review
Sep 2026	NHSE decision on SOC providing feedback as required
Jul – Oct 2026	FBC development
Nov 2026	Board approval from WUTH and WCHC on final FBC for submission
Dec 2026	FBC Submission to NHSE
Dec – Feb 2026	NHSE undertake FBC review
Jan 2026	Challenge meetings between NHSE and WUTH and WCHC Executive / Board
Feb 2027	NHSE issues transaction risk rating
Mar 2027	Secretary of State approval
Apr 2027	NHSE formally grants transaction
Apr 2027	Go-live of merged entity, dissolution of WCHC and enactment of new Trust name and branding

There is a high level of confidence in the ability to keep to the above timelines and key milestones, and the Trusts have earmarked resources accordingly to deliver this work at pace.

Due Diligence

Due diligence, scheduled from June to October 2026, will identify merger risks to inform the decision to proceed and to plan integration mitigation strategies.

There will be an external due diligence process.

Prior to commencement, a risk assessment will prioritise focus areas, with executives ranking each as high, medium, or low risk. Low-risk areas will receive light-touch due diligence, while high-risk areas will undergo detailed review. Both Boards will approve the risk assessment and due diligence scope.

A review will be undertaken within these parameters against all of the NHSE advised Key Lines of Enquiry.

The Trusts have engaged legal advice for legal due diligence and will receive an opinion on whether there are any indicators of risk that the transaction could not legally proceed.

Legal Form of Transaction

The proposed legal form of the transaction is for WUTH to acquire WCHC (via a merger by acquisition). Therefore, an expanded Foundation Trust will be created.

To foster the perception of a new, unified organisation, the enlarged entity will subsequently be renamed.

Transition Programme Initiation

WUTH and WCHC have taken a proactive approach to ensuring the deliverability of the acquisition by mobilising early. The successful integration of WUTH and WCHC, into a single, high-performing entity is a complex undertaking that demands a carefully planned and executed approach. To navigate this complexity, minimise disruption to patient care and staff, and ultimately realise the full benefits of the merger, a robust and structured integration framework has been designed and implemented. This framework provides a clear roadmap, guiding the transition from two independent organisations to a unified Trust, ensuring alignment and operational efficiency throughout the process.

This planning process has not been a recent undertaking but has evolved over a significant period, providing assurance regarding its thoroughness and potential for success. The initial impetus for integration stemmed from the Wirral System Review, which detailed a range of strategic benefits and opportunities that would arise from the closer integration of WUTH and WCHC. These foundational insights were then developed by both Trusts as part of the project planning for the critical initial phase of the integration programme.

Phased Integration Planning and Delivery

The integration journey has been structured into distinct, yet interconnected, phases:



The 100 Working Day Integration Plan: Following the strategic groundwork, a focused 100 Working Day Integration Plan was initiated. This intensive period commenced on Wednesday, 6th November 2024, and concluded on Friday, 4th April 2025. The plan was designed to establish immediate priorities and lay the groundwork for longer-term integration. It detailed the key objectives, critical programme areas, specific tasks, and measurable deliverables that were to be achieved within this initial timeframe. This phase was vital for building momentum, fostering early collaboration, and addressing immediate operational and governance requirements.

The Two-Year Integration Plan: Upon the successful conclusion of the 100 Working Day Integration Plan in April 2025, a comprehensive Two-Year Integration Plan was developed. This longer-term plan sets out the strategic intentions for WUTH and WCHC, outlining a detailed pathway towards becoming a single, fully integrated organisation. The Two-Year Integration Plan received formal approval from the IMB in early April 2025 and commenced delivery immediately thereafter. To ensure continuous oversight and accountability, monthly progress updates for each work area are provided to the IMB, allowing for agile decision-making and course correction as required.

Key Workstreams for Integrated Delivery

The overarching transition plan is organised around several critical workstreams, each with clearly defined objectives, scope, and dedicated leadership. This multi-faceted approach ensures comprehensive coverage of all aspects of the integration, from leadership and governance to clinical services and digital infrastructure. The following provides an overview of the key activities and successful deliverables achieved to date within each core workstream.

Single Leadership Team:

Establishing a unified and effective leadership structure is paramount for guiding the integrated organisation. This workstream has focused on creating a cohesive leadership team capable of driving the strategic vision. Key achievements include the careful consideration and appointment of Non-Executive Directors (NEDs), bringing diverse expertise and independent oversight, alongside the substantive appointment to the Joint Chair Role. Furthermore, a new Joint Executive Team structure and roles have been approved, with individuals selected and appointments made, including the Joint Chief Executive Officer (CEO). This unified executive leadership is now responsible for setting the strategic direction and ensuring operational delivery. A detailed plan for Sub-Executive Team Roles has also been developed, supported by a comprehensive Single Leadership Team Communications Plan submitted to the IMG, ensuring consistent messaging and cascading of leadership vision throughout the organisation.

Corporate Governance:

Robust corporate governance is essential for maintaining accountability, transparency, and compliance throughout the integration process. This workstream has focused on establishing the necessary frameworks to support the merged entity. A Partnership Agreement between WCHC and WUTH was successfully implemented during the interim phase prior to the merger by acquisition, providing a clear operational framework (subject to cyclical review). The Integration Management Board (IMB) has been formally established, with its Terms of Reference (ToR) developed and shared with both Trusts' respective Boards, clearly defining its mandate and authority. A thorough review of

current meeting cycles has been undertaken, leading to the alignment of Board meetings to ensure consistency and efficiency. Furthermore, the workstream has commenced the alignment of various committees and the establishment of Committees in Common (CiCs) where appropriate, streamlining decision-making and oversight across the integrated organisation.

Clinical Service Integration:

This workstream is at the heart of the merger, focusing on optimising patient pathways and enhancing clinical outcomes. Extensive service reviews have been conducted, leading to the development of detailed integration plans for key clinical areas, including urgent care, cardiology, ophthalmology, musculoskeletal (MSK) services, intermediate care, and therapies. These reviews identified opportunities for standardisation, pathway redesign, and the "Left Shift" of care. Crucially, the workstream has already commenced the delivery of integration plans for urgent care, cardiology, ophthalmology, and MSK services, demonstrating tangible progress in enhancing patient care delivery.

Workforce and Culture:

Recognising that people are the greatest asset, this workstream is dedicated to ensuring a smooth transition for staff and fostering a positive, unified organisational culture. A comprehensive workforce sharing agreement between WUTH and WCHC, including clear operating principles, has been developed and implemented for the interim period, facilitating collaboration and resource deployment prior to full integration. To understand staff sentiment and inform cultural development, national staff survey results across both Trusts have been reviewed to identify areas of strengths and concerns, leading to the development of an organisational methodology for use at service level. Proactive staff engagement plans and integrated staff support packages have been designed and are being delivered to manage change, maintain morale, and ensure staff well-being. Additionally, a joint workforce redeployment process has been launched to support staff through organisational changes.

Corporate Functions:

The integration of corporate functions is vital for achieving operational efficiencies and ensuring consistent support services across the new Trust. This workstream has successfully integrated the Executive Teams of WUTH and WCHC, providing a unified strategic leadership. The existing workforce sharing agreement has been leveraged effectively to engage with teams in planning integration opportunities across various corporate departments. Integration efforts have commenced for all other critical corporate functions, including the Workforce Directorate, Finance Directorate, Estates and Facilities Directorate, and others, aiming for streamlined processes and shared services. Significant progress has been made with the successful TUPE transfer of corporate functions staff and the commencement of joint restructuring where required, ensuring legal compliance and efficient organisational design.

Digital:

A modern, integrated digital infrastructure is fundamental to delivering high-quality, efficient healthcare. This workstream has focused on harmonising IT systems and data management. It has established joint digital governance, including robust frameworks for data sharing and Data



Protection Impact Assessments (DPIAs), ensuring compliance and data security. A thorough review of options for full convergence of data versus a federated infrastructure for WUTH and WCHC has commenced, informing the long-term digital strategy. A significant early achievement was the successful due diligence and unification of Windows domains, allowing for single sign-on and authentication to all applications and shared resources, greatly improving user experience and security. The implementation of a single IT service desk model has also commenced, providing a unified point of contact for all IT support needs. The workstream is actively developing a comprehensive joint digital strategy and commencing wider organisational integration and transformation activities to leverage technology for improved patient care and operational efficiency.

Estates:

Optimising the estates portfolio is crucial for supporting the Left Shift and ensuring efficient use of resources. This workstream has conducted a comprehensive portfolio assessment across WUTH and WCHC estates and facilities, identifying opportunities for rationalisation and strategic development. It has successfully identified void space and areas of under-occupancy to support future requirements for services to be delivered in the community, aligning with the Left Shift agenda. The workstream has also identified freehold properties and developed rationalisation plans for the closure, occupancy impact assessment, and relocation of services into existing estates, ensuring cost-effectiveness and optimal utilisation. Furthermore, it has accessed and assessed clinical service strategies to enhance the Estates asset portfolio optimisation and rationalisation plan, ensuring that the physical infrastructure supports clinical delivery.

Communications and Engagement:

Effective communication and engagement are vital for managing expectations, building trust, and ensuring all stakeholders are informed and supportive of the integration. This workstream has developed a comprehensive joint internal and external communication strategy and plan, ensuring consistent and transparent messaging. The "Better Together" integration branding has been successfully launched, providing a unified identity for the integration journey. The workstream has commenced the delivery of the communication plan to both internal staff and external stakeholders, including patients, partners, and the wider community, fostering understanding and support for the new integrated Trust.

The programme management function (embedded within the Task and Finish Group) has been established, transaction governance arrangements agreed and the integration workstreams have been identified alongside the corresponding workstream leads. Integration planning templates that will be used across the workstreams have been drafted, as have Terms of Reference documents for each workstream.

This proactive approach means that some of the initial work and decision making has commenced for the Full Business Case stage, which puts the Trusts in good stead for continued FBC work, analysis, further review and refinement.





Transition Planning

Transition Planning

This section outlines WUTH and WCHC's proposed approach to managing the transition process. It provides more detail into the key workstreams that the Trusts will establish to address the specific changes required for a successful merger by acquisition. These are designed to ensure a coordinated and efficient transition, minimising disruption and maximising value realisation.

The diagram below outlines the high-level approach to transition planning:



The Trusts have demonstrated progress in planning for the transition, as evidenced by the completed actions outlined in the accompanying diagram.

Beyond these achievements, an integration programme has been established. This programme identifies key tasks for delivery, assigns clear timeframes, and is subject to regular monitoring to ensure adherence and successful execution.

Substantial work has already been completed across several critical domains, laying a robust foundation for the integrated entity:

Significant strides have been made in aligning leadership and governance structures. This includes the successful appointment of a Joint Leadership team and the harmonisation of Board Meeting schedules to ensure cohesive decision-making and oversight.

The integration of clinical services is underway, with delivery commencing for key areas such as Urgent Care, Cardiology, Ophthalmology and MSK. This follows the development and approval of a detailed integration plan for each service.

A proactive approach has been taken to workforce integration and cultural alignment. This involves the design of a new workforce sharing agreement and a review of existing contractual arrangements, with work beginning to align these to the new framework. Staff surveys have been reviewed to identify both areas of concern and strengths, informing the roll-out of an organisational development methodology at service levels. Furthermore, a staff engagement plan, incorporating regular staff-

side engagement sessions, has been created, alongside the design of an integrated staff support package.

Integration within corporate functions has seen considerable progress, including the TUPE transfer of Corporate Function staff. A vacancy freeze and review process has been implemented, and the Workforce Sharing Agreement (WSA) framework has been reviewed, engaging teams in planning and beginning the implementation of integration opportunities. Initial consideration has also been given to the reorganisation of functions, with a project plan being developed to deliver this.

In digital, steps have been taken to ensure system integration. This includes the establishment of Trust relationships between domains and initial work towards implementing a single IT service desk model. An integrated cyber security agenda is under development, and a full review of all third-party contracts is being undertaken to identify synergies and efficiencies.

Furthermore, planning for estates optimisation is in progress. This encompasses the development of a proposal for the standardisation of parking tariffs and the identification of void and under-occupied areas to support future service requirements. An assessment of current lease expiry dates, break clauses, and rent breaks is being conducted to inform a rationalisation plan and exit strategies. Analysis of third-party supplier contract expiries is also underway to assess synergy opportunities, alongside initial consideration of joint service level agreements across the entire estate.

Moving forward, early priorities will be further defining the key tasks that must be completed to ensure a safe landing on Day 1 and establishing a critical path to achieving those key tasks. Part of this will be completing the detailed due diligence process, for which NHSE Transaction guidance will be followed. The process to provision legal due diligence support is currently underway.

Workstreams

While the Integration Management Board will remain accountable for the overall programme, they have delegated responsibility for the day-to-day management of, and delivery against, the workstream plans and critical paths, to respective workstream leads. The workstream leads will support and monitor progress against agreed milestones and report this to the Integration Management Group.

The table below shows the workstreams currently planned. Executive level sponsors will oversee the workstreams and related activities. Each sponsor will report progress into the Integration Management Group.

Workstream	Purpose	Scope
Workforce and Culture	To ensure a smooth transition for all staff and foster a unified organisational culture which supports the objectives of the new Trust.	• Manage staff transfer (TUPE – corporate functions complete) • Create employment framework which fosters a unified, inclusive culture • Single payroll • Cultural change programme



Communication	To ensure stakeholders receive appropriate and timely communications throughout the transition process.	• Manage the delivery of the unified communication and engagement plan for both internal and external communications.
Corporate Function Integration	Integrate corporate functions including financial systems, estates, corporate affairs, strategy etc., harmonise contracting arrangements and procurement processes for the new Trust.	• Full integration of corporate services across the two Trusts • Integrate financial systems, budgeting and reporting • Harmonise contracts • Identify business development opportunities • Manage the transfer and integration of charitable funds
Estates	To integrate physical infrastructure and support services.	• Integrate management of owned estates, leases and assets • Develop a unified capital investment plan • Harmonise estates management systems and facilities services • Update signage for new Trust branding
Clinical Service Integration	To harmonise clinical practices, promote health equity and foster continuous improvement.	• Standardise clinical pathways, policies and processes • Establish a unified clinical governance and accountability framework • Integrate health equity initiatives and research activities
Digital	To integrate IT systems, ensure robust information governance and leverage digital innovations for enhanced care.	• Integrate IT infrastructure, networks, data and systems • Establish common Information Governance (IG) policies • Develop a unified data management strategy and drive digital innovations • Ensure cybersecurity is maintained during transition
Corporate Governance	Establish a robust governance framework for the new Trust, ensuring effective oversight,	• Develop a new constitution, board and committee structure • Establish a new BAF

accountability and strategic direction.

- Ensure compliance with all licenses and registrations

Pre- and Post-Integration Planning

Corporate functions integration is well underway with significant progress made to date. Moving forward, both corporate and clinical integration will continue to be a major focus. This is to ensure the successful delivery of integration benefits for service users and staff. To underline this commitment, considerable senior-level resources will be dedicated to developing comprehensive pre- and post-transaction implementation plans (PTIP).

The PTIP will form an integral part of the overall transaction programme and will become increasingly prominent as the Trusts progress into the FBC stage.

This document will emphasise three main time horizons within the transaction lifecycle, each with its primary focus:

- **Tranche 1 - Pre-acquisition and up to day one:** This phase is dedicated to addressing and mitigating critical concerns identified through comprehensive due diligence. Concurrently, a key objective is to progress work on integration particularly in corporate functions and clinical spaces to establish a unified corporate identity and a cohesive culture for the newly formed entity, alongside the key priorities for 'day one' integration and service continuity priorities.
- **Tranche 2 - First 100 days and up to 18 months post-acquisition:** This phase involves further consolidating single frameworks of clinical and corporate governance, stabilising core infrastructural requirements, enhancing service resilience, and improving service quality by establishing care and delivery models that draw on the best practice across the current organisations. This will also place greater emphasis on the identification of areas of improved organisational effectiveness, both in terms of cost and quality and embedding these within the culture and operating practices of the new organisation.
- **Tranche 3 - 1½ - 3 years post-acquisition and beyond:** This represents the principal point at which integration benefits typically become tangible. It involves advancing the digital and workforce transformation agenda, delivering demonstrable improvements, and continuing to integrate services across the unified organisation. Crucially in this stage, explicit engagement with service users, carers, and the workforce will be prioritised to identify and deliver initiatives that offer the greatest value and impact from their collective perspectives. Organisationally, the new Trust will use this opportunity to evaluate the wider strategic aims and match these against current resources and future need profiles for its population, ensuring it is able to operate from a strengthened position.

Collectively plans will continue to be refined and iterated in line with the wider development of the transition programme.



Workforce Integration

Over the past two years, both Trusts have undertaken significant preparatory work towards the proposed merger, particularly in relation to Corporate Function integration which is the most advanced area of preparations.

- A joint executive team is in place, and corporate teams have been successfully integrated, fostering early collaboration.
- A single corporate governance framework has been designed and partially implemented, featuring a unified board and committees. This includes the formal establishment of joint committees for non-statutory functions such as Finance and Performance, People, Quality and Safety, and a new Digital Committee.
- The new board composition, comprising seven NEDs with a blend of experience, is also established.

Moving forward, workforce integration will focus on the senior management consultation and a full restructure of corporate teams as well as wider workforce integration planning.

This period will also involve close engagement with Staff Side. The Trusts have continuously worked in partnership with Staff Side and will ensure they continue to have close involvement with the process. Clear and consistent communication, including written correspondence to home addresses, will be maintained throughout. A phased approach to systems integration, encompassing payroll, will be adopted, minimising disruption.

In the short-term, focus is to drive a new single organisation mindset and to conduct comprehensive planning into what the new organisation should look and feel like for service users, staff and communities. As a part of this, to create an optimal working environment for all staff in the new single entity embracing agreed design principles and undertaking diagnostic assessments in areas such as cultural harmonisation is key. The priority is to create a welcoming and inclusive environment where all staff feel valued and supported.

Specific changes will be clearly defined, and staff will be provided with the necessary support to implement and embed these changes as new, ongoing practices.

Cultural Change

Another key priority in the short term will be engaging with staff and stakeholders and looking at cultural development. Our staff will be supported to celebrate the legacies of their old Trusts, while defining the new vision, values and culture for the new Trust.

A diagnostic assessment in key areas will be carried out, such as cultural harmonisation, to create a great place to work for all staff in the new Trust.

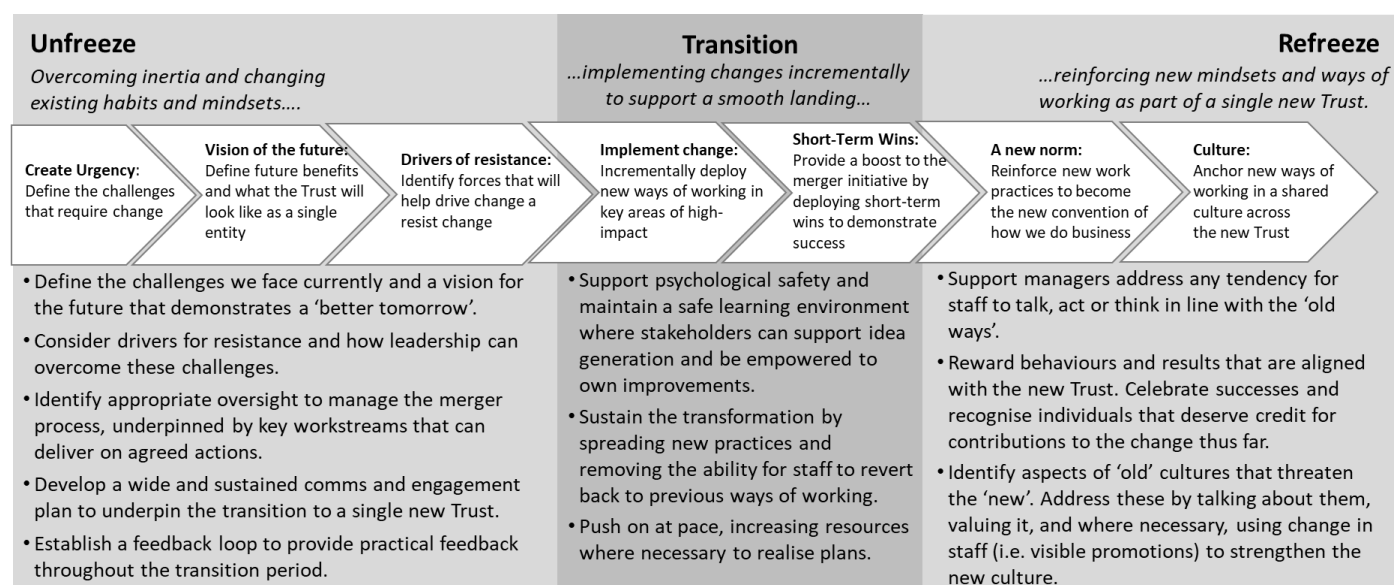
A collaborative culture, with relationships based on trust and reflective team learning are at the heart of creating a collective team ethos. This will be supported by:

1. Defining clear shared objectives that the staff across both Trusts need to achieve together within set timeframes.

2. Addressing the challenges staff face, and work with them to co-produce how acting as one team will help them to overcome these challenges in areas such as staffing, recruitment and retention, personal development and growth, and research and development.
3. Ensuring the teams work interdependently. This will be accomplished by working closely together, communicating, and coordinating with each other to deliver effective, efficient, and improved quality of care.
4. Ensuring that the various teams across the two Trusts meet regularly to review their performance and consider any areas of required improvement. This will be done through regular group meetings that will cover technical aspects of work and how people are feeling, team time-outs, and away days.

Using the NHS Culture and Outcomes Dashboard template to diagnose the cultural differences between the two organisations will be considered.

The diagram below illustrates key cultural change activities that will be undertaken while moving forward with the integration work:





Comms and Engagement

Comms and Engagement

Initial communication on the proposed merger and transaction work is underway and the CEO has addressed the transaction at staff events, fielding staff questions. A dedicated communications and engagement strategy for both internal and external audiences has also been developed.

In July 2025, the Better Together brand was established and the Journey to Integration Case for Change document was published. This document provided an update on the strategic intentions for integration and the benefits it would deliver for patients, staff and financial benefits. Subsequently, engagement on the new joint strategy commenced with staff, partners and those who use our services. This engagement activity has concluded, and the draft joint strategy was launched in early April 2026.

All stakeholders will continue to be engaged in the next steps to becoming one new organisation. These plans will be tested and refined, in line with what is understood to work for the diverse stakeholder groups.

As a guiding principle, transaction communications and engagement will be designed to:

- Clearly articulate the rationale and benefits of the merger to all audiences (both internal and external).
- Provide timely, accurate, and consistent information regarding the merger process and its impacts.
- Provide clarity to staff about their roles, job security, and the future of the organisation and where roles change, staff will be fully consulted in line with the Trust's organisational change policy.
- Foster a sense of excitement for the future of the organisations among staff.
- Reassure service users about the continuity and quality of care, access to services, and potential changes.
- Actively listen to and address concerns from stakeholders.
- Manage external perceptions of the organisation and maintain public confidence.
- Ensure all communications are consistent and aligned, both internally and externally.

To ensure the Trusts can communicate and engage with all audiences, a range of communication channels will be used to share information, co-design content and gather vital feedback.

Target Audiences

The primary target audiences for communications and engagement include:

- **Internal Stakeholders:** Staff at WUTH and WCHC along with the Council of Governors
- **External Stakeholders:** The public who use services of WCHC and WUTH, and key stakeholders of both organisations, including primary care, NHS C&M ICB, Local Authority, Staff Side and the Wirral Provider Collaborative.

Enabling Clear, Accurate and Consistent Messaging

To deliver the communications plan effectively, the following content will be obtained from the Integration Management Group (IMG) to enable accurate and timely messages to stakeholders:

- Integration roadmap including details of:
 - Clinical services integration
 - Estates
 - Digital
 - Workforce and culture
- Joint strategy development and launch including development of supporting/enabling strategies
- Details of changes to organisational governance arrangements
- Progress updates on the organisational transaction – merger by acquisition
- Details of the plan for organisational changes for corporate services

Internal Communications Plan

The purpose of the internal communications plan is to support the Wirral Integration Programme 2025-2027 and the communications that will be required for staff at both Trusts at each stage of implementation. Communications will be drafted in collaboration between both WCHC and WUTH to ensure messages are consistent. They will be timed to ensure staff at both organisations receive key messages at the same time.

Communications Channels

Both Trusts have a range of communications channels to update and interact with key stakeholders

WUTH	WCHC
Global email to all staff	Global email to all staff
In Touch Bulletin (Monday and Thursday)	The Update bulletin (Tuesday and Thursday)
Staff Side	Staff Side
Staff website / intranet – staff news section, banner, pop-up	Staff website / intranet – staff news section, banners, pop-up
Screensavers	Screensavers
Monthly All Staff Briefing	Monthly All Staff Briefing
In Touch staff magazine (three editions a year)	Senior Leadership briefing (as required)
Voodoo SMS text messaging service	Staff Facebook Group
Ask the Senior Team (Q&A process)	Managers' Briefing
Executive Breakfasts	Ask ELT (Q&A process)

Executive Breakfasts

Sequencing

The following internal communications action plan outlines key activities and ongoing actions. Messages will be cascaded using the following channels within both Trusts and in the following sequence. We will aim to align dates to ensure messages are received by both organisations at the same or close to the same time.

Method	Details	Timeframe
Global emails from Janelle Holmes to staff at WUTH and WCHC	An email to staff at both Trusts announcing that both organisations are working together. This will offer reassurance that staff will be updated as we progress through the next 12 months.	Monthly
Weekly emails to corporate services colleagues	Regular message to all corporate service staff in relation to the progress on organisational changes plans and processes.	Weekly
Monthly All Staff Briefing	Cascade important messages relating to the statutory transaction progress. Messages to encourage increased attendance at this briefing for wider cohort of staff.	Monthly
Senior Leaders Briefing at WCHC	Briefing sessions led by Janelle Holmes with senior leaders – to cascade important messages relating to the Wirral Review recommendations, actions and progress, financial position etc. Briefings to become part of corporate services organisational change engagement as necessary.	Monthly <i>First meeting took place on 12 February 2025.</i>
Breakfast with the Chief Executive and Executive Team	A monthly forum for a particular Division at WUTH to meet with the CEO and Executive Team to discuss relevant issues and ideas, including topics such as integration.	Monthly

Method	Details	Timeframe
Frequently asked questions	Ask ELT online form on StaffZone for staff to ask questions relating to the review/integration/finances etc. (similar to the process at WUTH). Answers to questions will be shared on StaffZone and in the Ask the Senior team section of the WUTH intranet. WCHC and WUTH share Q&As.	Ongoing <i>Ask ELT mailbox went live on 12 February 2025</i>
In Touch Bulletin at WUTH; The Update Bulletin at WCHC	Regular channels to share integration news and stories. Signposting to Chair and CEO messages be repeated in the bulletins of both organisations. Development of articles providing updates on clinical services programme focusing on the delivery of alternatives to ED Project and how this is benefiting both organisations and patients.	Ongoing
Staff websites at WUTH and WCHC	Articles relating to the integration work will be placed on staff news sections of both websites at WUTH and WCHC.	Ongoing
Case for Change document	A 'Case for Change' document has been developed that will be shared with both staff, stakeholders and the wider public. It follows the example produced by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust (Better Care Together).	Complete
Development of roadmap	Communications to be provided with a roadmap for 2026-27. Visual representation of the roadmap for 2026-27 which will show key milestones and	TBC

Method	Details	Timeframe
	deliverables. This will be accessible to all staff to support their understanding of the changes.	
Video for bulletins and staff websites at WCHC and WUTH	A video addressed to both organisations from Janelle and with key messages about the Case for Change. Message should generate excitement about working together collaboratively. Message to include reference to examples of where we have seen success e.g. Virtual Frailty Ward / Urgent Care, MSK collaboration. Also reference to corporate service reviews which will be led by relevant Executive Directors and involve relevant staff groups.	TBC
In Touch staff magazine	Article summarising the updates so far since the previous edition. A one-page feature on Wirral System Review.	Ongoing
WCHC Monthly Manager's Briefing	As required to reinforce messages for managers.	Bimonthly
Case studies - for bulletins and staff websites at WUTH and WCHC	Case studies - Videos / photo, quotes of staff in areas where collaboration has started. Showing how they are working together and benefits / outcomes this is providing. This will offer assurance for other services.	Ongoing
New intranet and website	Development of a phased approach to a single intranet and website. Work to commence once corporate organisational change is complete and budgets/resources combined.	Early 2027

Method	Details	Timeframe
Communications plans for individual integration programmes	Smaller scale communications plans with key messages for areas such as Cardiology, MSK, Ophthalmology and other areas as they begin integration.	Ongoing

Engagement to date

Effective communication and engagement with all stakeholders have been paramount throughout the initial phases of the Wirral Integration Programme. This has ensured transparency, fostered understanding, and gathered crucial feedback to shape the strategic direction of the proposed merger between WUTH and WCHC.

Key messages and stakeholder segmentation will continue to be refined as the Trusts move into FBC stage and will be subsequently presented as a fully agreed comms and engagement strategy and plan.



Emerging Risks

Emerging Risks

The proposed integration, while offering significant strategic benefits, also presents a range of emerging risks that require careful management to ensure a successful and sustainable merger.

The organisations are committed to proactively identifying, assessing, and mitigating risks to ensure the transaction process never compromises the quality and safety of service user care, the support for their staff, or the seamless operation of services during this transitional phase.

The Trusts' leadership team will embed risk considerations into the core of their decision-making, driving a timely and successful transaction. A comprehensive Transaction Risk Register will be developed in due course, directly informed by the detailed due diligence.

Key areas for initial focus have already been pinpointed, which will remain central to the ongoing risk management throughout the transaction. The due diligence process will be instrumental in strengthening the approach, revealing any additional risks, and enabling the crafting of effective mitigation strategies.

Risk	Mitigation
Patient experience: Potential disruption to care offer and impact on service user experience during the transition period. Technical aspects of the merger progress faster than clinical integration delaying the realisation of patient benefits.	- The Trusts have been on a journey of developing partnership working in the Wirral and the experience so far has shown its effectiveness. - Moving forwards, implement a phased approach for all service changes, supported by robust leadership to facilitate a seamless and safe day 1 transition, minimise service user impact and maintain the delivery of safe, high-quality care. - Continue to evaluate potential risks in achieving operational synergies, identifying areas of efficiencies and challenges in ability to maintain safe, high-quality care throughout the transition and post-integration phases. - Conduct a review of the care offer, including subscale services, monitoring performance in the short and medium term while establishing unified operating models for the integrated organisation. - Proactively assess and mitigate risks to service user safety, quality of care and overall experience of service users engaging with services during the transaction period. - Monitor themes and trends in service user experience and complaints, the standards of inpatient wards and community teams and have a robust risk management and escalation framework in place. - Develop and implement comprehensive quality dashboards (encompassing safety, experience, and effectiveness metrics) alongside an active clinical audit programme.
Cultural Integration: Potential for significant cultural engagement issues during the integration of the two organisations, including	Proactively identify and address integration risks, including cultural misalignment, operational complexities, and employee retention challenges, across both interim and post-integration phases.

persistent cultural divides, 'us and them' mentality and resistance to new practices leading to impacts on staff motivation and engagement, and subsequent disruption to day-to-day operations. This risk is heightened by existing challenges in the current labour market and extends beyond traditional employee retention concerns.	• Develop and implement a comprehensive cultural development plan that specifically addresses potential differences and fosters a unified organisational culture and identity. • Capitalise on established collaborative working relationships between the Trusts to facilitate a smoother integration process. • Implement a robust and proactive communications and engagement strategy to ensure transparent information flow and keep all internal and external stakeholders informed and involved in decision-making throughout the interim and post-integration phases. • Proactively prioritise addressing staff motivation and engagement through clear vision articulation, transparent communication, and fostering opportunities for input.
Workforce: Potential staff anxieties and a sense of lost WCHC identity due to uncertainty, leading to decreased morale.	• The executive team will manage and mitigate potential disruption to staff arising from the transaction, including impacts on HR, payroll, pensions and contracting. • Implement a comprehensive and clear communication strategy to all staff throughout the transaction process to minimise any anxieties and foster a sense of inclusion. Staff will be given opportunities to actively shape the culture of the new organisation. • Establish robust feedback mechanisms to ensure consistent engagement with staff and Staff Side representative throughout the transaction process which will allow any issues to be resolved quickly.
System: Fragile relationships within the wider Provider Alliance and unclear governance structure could impeded system-level decision making. Potential difficulty in managing system priorities on top of the existing transformation agenda.	• Maintain clear organisational priorities to allow pausing of less strategically important work. • Manage expectations of partners and stakeholders where necessary.
Corporate Services: Potential that corporate services are overwhelmed by the additional workload on top of usual business activities.	• Bring in additional resources or expertise to cover additional workload. • Reprioritise work where necessary. • Stop/pause non-essential activities.
Finance: Integration costs increase due to unexpected costs and benefits decrease. Risk of overpromising	• Evaluate the financial risks associated with the transaction, including an analysis of the financial sustainability of the new organisation through the due diligence process. Cash flow, debt obligations, contingent liabilities and potential tax implications will all be considered.

immediate financial savings, especially given existing deficit and the time required for operational shifts to translate into benefits. Critical financial challenges may be managed in silos, hindering a holistic approach to recovery. Historical challenges with recurrent CIP delivery highlight the need for robust monitoring.	• Undertake detailed work to establish a full schedule of financial costs and benefits through key workstreams as soon as possible. • Establish a robust monitoring and tracking process for financial costs and benefits throughout the transaction process.
Digital Complexity: Operational disruption and substantial challenges may arise through the integration of disparate digital systems (e.g. Cerner and System One), technologies, and processes. The current limitations of the Acute Trust's EPR system necessitates dual running in some areas, risking efficiency and data integrity.	• Create a phased plan for digital integration based on capacity to implement and expiry of contracts for key systems. • Ensure technical policies are aligned across both Trusts in a timely manner to reduce cyber security risk and speed up digital integration.
Cybersecurity: Incompatible IT infrastructure, data migration, and conflicting policies can introduce vulnerabilities and cause operational disruption.	• Conduct assessment and due diligence on current infrastructures to diagnose vulnerabilities and bottlenecks – Recent cyberattack incidences in the public sector have highlighted a need for more robust frameworks and security • Develop a unified cybersecurity framework that includes standardised Identity and Access Management (IAM) procedures, incident response plan and agreed infrastructure across the new Trust • Agree a Secure Data Migration Strategy to prevent data loss, corruption or exposure
Legal & Compliance: Challenges with ensuring legal and regulatory compliance because of integrating, including patient data consent and CQC.	• Work will need to be undertaken to ensure a single suite of key policies are in place across both Trusts. Carefully consider any legal and compliance risk relating to the transition to a single legal entity. • Consider existing contracting arrangements, licenses, intellectual property rights and ensure compliance with all relevant laws and regulatory bodies to prevent any delays to the process.



Performance: Risk of lower KPIs for performance measurement targets.	• Create a service delivery transition plan which ensures an integrated service during and post-merger that is resilient to increasing pressures and demands and utilises the new Trust's greater agency to provide high quality, consistent care • Agree targets, contingency and performance metrics ahead of the transition, with regular reviews and check ins to monitor progress
Contingency: Potential for unexpected issues / circumstances to arise during / after the transaction.	• Put plans in place to address unforeseen events or risk that may arise during or shortly after the transaction to mitigate against any potential disruptions.
Concurrent Integration and Transformation: executing the transaction alongside system-wide transformation risks overstressing capacity, leading to disruption, delayed benefits, or integration failure.	• Develop a clear, phased integration plan, prioritising critical merger activities and staggering the implementation of broader system transformations. Identify 'must-do' versus 'nice-to-do' elements in the short term. • Establish a robust, unified programme management capability with dedicated resources and clear accountability to oversee both the merger and transformation programmes, ensuring alignment and managing interdependencies. • Conduct a thorough assessment of current and required capacity (human, financial, technical). Ring-fence key personnel and provide additional temporary resources or external support where internal capacity is insufficient. • Invest in dedicated change management expertise to support staff through the significant transitions. Provide targeted training, clear guidance, and opportunities for feedback to foster adaptability and minimise resistance. • Identify and communicate early successes or 'quick wins' to build momentum, demonstrate value, and maintain confidence among staff and stakeholders.

The programme management function will oversee and allocate key risks to workstreams with clear ownership and progress tracking during and after the transaction. The Task and Finish Group will take ownership of overseeing the management of the Transaction Risk Register, linking with the workstreams to mitigate identified risks.



Appendices

Appendices

1. Wirral System Review: Phase One Report
2. Wirral System Review: Phase Two Report – Proposed model for collaboration and integration
3. Joint Strategy 2026-2032
4. Wirral Health and Wellbeing Strategy (2022-2027)
5. Cheshire and Merseyside Health and Care Partnership All Together Fairer: Our Health Care Partnership Plan 2024-2029
6. WUTH WCHC Transaction Type Assessment
7. WCHC WUTH Better Together – Case for Change
8. ICB Board Minutes (*pending – to be shared following initial SOC submission*)
9. Council of Governors Minutes (*pending – to be shared following initial SOC submission*)
10. Minutes Relating to Board Approval of Transaction

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.1

Report Title	Committee Updates – Joint Digital Committee
Date of Meeting	16 April 2026
Author	Haris Sultan, Chair, Joint Digital Committee

Alert	- The Joint Digital Committee wishes to alert the Group Board that: FOI and Subject Access Requests – WUTH Non-Compliance: The Committee has received and supported an improvement plan, including additional resources, digital workflow improvements and performance dashboards, and noted the SIRO is providing a further update to the Group Board in May. Clinical Coding Capacity – Workforce Pressures: Clinical coding capacity remains a significant risk nationally, and WUTH has been more acutely impacted than many other trusts. The Committee was assured there is no current financial impact and received a mitigation plan comprising: internal recruitment, and an external contract to address the backlog, AI-supported capacity is being assessed. The Committee is assured that a structured three-stage plan is in place and being actively managed with appropriate oversight. Cyber Resilience and Business Continuity: Cyber remains a material risk to every organisation. The Committee noted that a cyber incident recovery could take months rather than weeks and emphasised the need to strengthen business continuity arrangements accordingly. The Committee sought and received assurance that lessons learned from the previous cyber incident have been reviewed and embedded.
Advise	- The Joint Digital Committee wishes to advise the Group Board that: Digital Strategy Development: The 2021–26 digital strategy period has concluded. A new joint digital strategy will be developed and is expected to come to the Digital Committee in the second half of the year. The strategy will be shaped by clinical and operational priorities and aligned to the Cheshire and Merseyside digital strategy. The Wirral Digital Services Review will report to the Committee at the next meeting in June and will inform the practical roadmap toward a single organisation by 2027. BAF Risk Changes: The Committee has taken shared ownership of BAF Risk ID11 (business continuity and cyber/infrastructure failure) jointly with FBPAC. In addition, the risk appetite for BAF Risk ID12 has been changed from “open” to “seek”, reflecting the transformational role digital should play and the organisation’s appetite for innovation. Digital Workforce Competence: The Committee identified a gap in digital competence and expertise across the workforce.

	Basic EPR training (e.g. use of Serna) needs to be in place to enable staff to utilise systems to their full capability. This will be an area of ongoing focus for the Committee.
Assure	- The Joint Digital Committee wishes to assure the Group Board that: Digital Maturity: The Digital Maturity Self-Assessment (DMSA) confirms that WUTH is one of the most digitally mature trusts in the Cheshire and Merseyside system. The Committee had a comprehensive discussion on the overall digital landscape and is satisfied that a clear baseline of performance, risk and delivery confidence has been established for the new Committee. 2026/27 Digital Plan Prioritisation: A structured and transparent prioritisation process has been completed with the Executive Team for the 2026/27 Digital Plan. The plan has been reviewed through a cross-functional panel and includes clear change control arrangements. Future reports will track performance and progress against the agreed plan. Internal Audit Recommendations: Both WUTH and WCHC audit trackers have been reviewed. WUTH has 10 recommendations in progress (2 overdue, 2 complete, 6 not yet due); overdue items will be reviewed at the Audit and Risk Committee with an extension to May 2026. MIAA reviews of User and Privileged User Management (WUTH – Substantial) and IT Service Continuity and Disaster Recovery (WCHC – Substantial) received positive overall assurance opinions, with targeted medium and low-rated recommendations being actively managed.
Review of Risks	- The Committee has taken shared ownership of BAF Risk ID11 (risk of business continuity failure due to cyber/infrastructure incident) jointly with FBPAC. - The risk appetite for BAF Risk ID12 has been changed from “open” to “seek”. - The Committee questioned whether the risk score for FOI/SAR requires escalation or change and will keep this under review. - No other risks require escalation to the Board at this time; all risks are being appropriately managed through the Digital Committee governance framework.
Other comments from the Chair	- This was the inaugural meeting of the Joint Digital Committee. The Committee had a comprehensive discussion to establish its understanding of the current digital landscape across both organisations. - The Committee acknowledges that its visibility of the WCHC digital position will develop over time and this picture will mature as the Committee establishes its workplan. The next meeting is scheduled for Friday 19 June 2026.

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.2

Report Title	Committee Updates – Joint Finance and Business Performance Committee
Date of Meeting	22 April 2026
Author	Meredydd David, Chair of Finance Business Performance Committee

Alert	- The Committee wish to advise members of the Group Board of Directors that: - At the end of March 2026 (M12), WUTH is reporting a deficit of £49.5m. This is in line with the forecast that the Trust submitted to NHS England in February but, excluding DSF, is a £27.3m adverse variance to plan. This places significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). - At the end of March 2026 (M12), WCHC is reporting a surplus of £5.1m, which was a £4.2m positive variance to plan and this has been reported to NHSE. - The significant improvement required for financial sustainability will be delivered through the medium-term finance plan (MTFP). The MTFP for both Trusts for 2026/27 to 2028/29 have been submitted to NHS England and the WUTH plan has yet to be approved. - For WUTH, risk ratings for delivery of statutory targets for noting are that the RAG rating for financial stability, financial sustainability and financial efficiency were red, cash was amber and agency spend and capital were green.
Advise	- The Committee wish to advise members of the Group Board of Directors that: - The Board reviewed and agreed a revision to the original plan and budget for 2026/27 which included increasing CIP to 6%, reducing cost pressures by £2m and reducing risk/headroom by £1m, delivering an £8m improvement. This moved the combined Trusts deficit position to £24m. This has been submitted to NHSE, - At WUTH, there are challenges in meeting the 31- and 62-day cancer standards, though the Trust is forecasting to start 2026/27 achieving all cancer standards. Good progress was highlighted across breast services, and in gynaecology where significant backlogs from the previous year are being addressed through pathway standardisation. Improvements within urology services were also noted. - The Trust had participated in the national UEC sprint in March, and a number of sustainable actions had been implemented with improvements to many of the key performance indicators.

	○ WUTH has entered into a new contract with Mersey Healthcare starting on 1st April to provide additional planned care capacity. ○ An options review and opportunities for use of the Frontis site was discussed however it was agreed to pause the decision for the time being until other options were explored in more detail. ○ WCHC has substantial positive performance in most areas including urgent care at 95.3% for the 4 hour target and 83% for UCR performance. Areas for improvement include indicators at the Minor Injuries Unit and GPOOG performance. There is a significant backlog for ECGs and there is a recovery plan in place for Dental waiting times.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Good progress has already been made on identification and risk categorisation of the CIPs for both Trusts though there are gaps in evidencing detail within some plans and these need to be completed by mid-May and are expected to be completed and available. ○ Progress is being made with the estate integration programme and this needs to be aligned with clinical services integration plan. The principles for future estate and space utilisation efficiency will be benchmarked against Model Hospital data and would be reported to a future meeting. ○ For WUTH there were 10 internal audit recommendations currently being tracked, 4 of which are complete, 1 which was not accepted, and 5 which are not yet due. ○ At WCHC the one outstanding Audit recommendation related to the Contract Management Assignment Report and the delay in signing the Knowsley 0-19 contract. It was confirmed this would be resolved in the next two months
Review of Risks	• The joint BAF contains 12 strategic risks and the joint FPC has oversight of 5 of these risks with all 5 scoring high. Risk ID11 is reviewed and tracked by the Joint Digital Committee, as well as FPC solely in respect of controls and mitigations related to cyber. • There were two WCHC high level risks with ID3247 also reported on the WUTH risk register: • ID3256 (RR16) - related to equipment (4 x inhalation sedation machines) in the community dental service coming to the end of their working life and requiring replacement. Work was on-going to facilitate the capital business case. • ID3247 (RR15) - related to reduced staffing for the clinical assessment of complex dysphagia referrals. Alder Hey were unable to support Wirral referrals in the interim. Work was ongoing with Service Directors to manage communication to

	GPs and parents. This risk was also noted as a high-level risk on the WUTH risk register and had been reported to the Executive Assurance & Risk Committee (EARC).
Other comments from the Chair	• Good progress has been made against a challenging environment in delivering the final financial outturn positions in line with revised plans and expectations. The budgets and financial plans for 2026/27 are very challenging and critical to deliver. The FPC will monitor closely the delivery of the CIP, the plan for reduction in WTE and the Drivers of Deficit. FPC meetings are all now in person monthly with an agreed schedule of deep dives into areas where performance is challenging or where there is learning to share.

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.3

Report Title	Committee Updates – Joint People Committee
Date of Meeting	March 2026
Author	Lesley Davies, Chair of Joint People Committee

Alert	The Committee would like to alert the Board of Directors to the following: Integrated Performance Report - Sickness absence remained a key focus for the Committee across WUTH and WCHC. In February 2026, the overall sickness absence rate fell to 6.67%, but this remained above the Trusts' target of 5%. Mental health-related issues continued to be the main cause of absence. The Committee was assured that proactive wellbeing measures are in place, including a joint return-to-work programme delivered across both Trusts by WCHC and WUTH. In WCHC, the main areas of concern are Community Nursing, Community Response, Walk-in Centres, and parts of the 0–19 services. The Committee will continue to monitor sickness management and its impact on the Trusts' financial position. Staff Survey 2025 - Following a presentation, the Committee noted that the WUTH staff survey response rate fell to 42%, below both its 2024 level and the national average of 47%. WCHC maintained a 51% response rate, but this also remained below the national average of 62%. Across the nine People Promise elements, five scores for WUTH were significantly lower, while WCHC recorded three significantly lower scores compared with 2024. The findings have been shared with divisions to support action planning. Areas of low staff satisfaction are being explored, and actions to improve staff experience will be incorporated into the Trusts' joint People Strategy for 2026, which will return to the Committee in July 2026.
Advise	The Committee advises the Board of Directors that: The Committee received two MIAA reports: Payroll Transitional Arrangements Review: the review received a substantial assurance rating. It made three medium-risk recommendations, all due for completion by 30 April 2026. Recruitment Process Review: this audit also provided substantial assurance on recruitment processes, and the Committee noted the examples of good practice identified. The report included three medium-risk and two low-risk recommendations. The Committee requested further

	information on how these processes are being applied across the Trust to ensure a consistent approach to recruitment delivery.
Assure	The Committee wishes to assure the Board of Directors that: Sexual Safety - The Committee was assured that good progress is being made in implementing the new legislation due to take effect in October 2026. This includes the rollout of training across both Trusts, completion of a comprehensive self-assessment, and an audit. The Committee also noted; - the new elevated duty and third-party liability from October 2026, in line with the Employment Rights Act 2025; - the latest correspondence from NHS England (dated 5 December 2025) and the new actions required of the Trust - The new quarterly reporting to the Regional ISSG; and the establishment of regional and national forums for reporting and managing sexual misconduct cases. - No sexual safety cases required escalation to the Committee. Care Support Worker Deep Dive - The deep dive provided the Committee with an overview of the issues raised by staff during the 2023/24 industrial action, including the initial organisational change process for Care Support Workers (CSWs) and the revised approach developed in response to concerns raised by UNISON and CSWs. - The Deputy Chief Nurse completed a whole-system review with input from ward managers and staff. This extensive work led to revised ward models, an increase in some Band 3 posts in some wards and significantly reducing the number of ward moves originally proposed for CSWs. The Committee agreed that the positive learning from this work should inform the wider organisational change process.
Review of Risks	The Committee considered the proposed draft strategic risks for the People and Culture Committee and provide comments in advance of the presentation to the Board of Directors on 1 April 2026.
Other comments from the Chair	No other comments

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.4

Report Title	Committee Updates – Quality and Safety Committee
Date of Meeting	29 May 2026
Author	Dr Steve Ryan, Chair of Joint Quality and Safety Committee

Alert	- The Committee wish to alert members of the Group Board that: - As a result of demand pressures exceeding current capacity, compounded by staffing vacancies, impacts on timely access and flow are being seen in some services. Previous such issues in the provision of acute macular degeneration services have been significantly reduced with large reductions in previous backlogs. Currently issues are being experienced in the provision of percutaneous gastrostomy (PEG) which is resulting in increased lengths of stay for a small number of patients. There are backlogs for inflammatory bowel disease outpatient reviews and follow-up appointments. In these cases, active recruitment and business case development are being pursued. - Following significant reductions in the need for corridor care during March and April, high demand for unscheduled care in May has seen some deterioration in our position. A Trust-wide summit, involving all Divisions has identified a range of actions to be taken to improve the position and future resilience. Effectiveness of the impact of corridor care on patient quality, safety and experience will continue to be monitored by this Committee.
Advise	- The Committee wish to advise members of the Group Board that: - It reviewed its Terms of Reference and approved them and will continue to review them in the light of the new joint nature of the Committee. At this meeting the Committee considered the need to indicate some areas oversight more explicitly, such as Maternity & Neonatal Care, given changes in national guidance. - It approved the Draft Quality Accounts (2025/26) of both organisations noting that there were now integrated quality priorities; e.g. reducing the incidence and harm from tissue ulcers. Both accounts were of high quality, accessible and a fair reflection of both achievements and challenges. A busy clinical audit programme in both organisations told a compelling story of colleagues engaged in important improvement activities. - It received the monthly Maternity and Neonatal Service report which was in a new and improved format, with clearer data and information on the benchmarked

	quality of services. Work is ongoing to ensure that the Patient Safety Incident Response Framework is properly framed for use in these services and aligned with current high-quality processes and external reporting requirements. There are no issues to escalate to the Trust Board, which will receive the Quarterly Maternity Service Report at today's Joint Trust Board meeting. ○ It approved the Joint Patient Safety Incident Response Framework Policy. This unified policy will support identification of patient safety learning across shared pathways supporting future integration of services.
Assure	• The Committee wish to assure members of the Group Board that: ○ It gained assurance from the WUTH Patient Safety Quality Board Chairs Report (including PSIRF Chair's report). It noted that the Local Standard for Interventional Procedures electronic system is now up and running and is showing good compliance but will be subject to ongoing monitoring. ○ It gained assurance from the WCHC Integrated Performance Board Briefing and the WCHC Quality and Patient Experience Year End Report that an effective quality governance system was in place and indicated evidence of safe and effective care throughout the year. ○ It received assurance that the Care Quality Commission action plans for both organisations following most recent inspections were either complete (WUTH) or nearly so, with a clear timeline for completion (WCHC). Work on ensuring actions are fully and permanently embedded is ongoing as is sharing the improvement actions across both Trust' services. The CEO of Healthwatch Wirral was able to offer her collaboration in supporting the Trusts' interaction with the Care Quality Commission. ○ It gained a high level of assurance on quality, safety and safeguarding in reviewing the Mortuary Services Annual Report. We were reminded of the need for effective Board oversight in ensuring that the Fuller Enquiry phase 2 recommendations are all implemented. National guidance is still being developed, and a small number of items will need their documentation updated to reflect that - in due course. There is clear evidence of effective executive and Board oversight of the service. ○ It received assurance of effective infection prevention and control (IPC) arrangements for the Community Trust during Quarter 4, noting low levels of Health Care Associated Infection and effective management when it arises. The Committee also received and approved the Community Trust Infection Prevention and Control Annual Report including an evaluation of the Staff Flu Programme. Work is ongoing to ensure that all areas of

	the IPC Board Assurance Framework are fully compliant and to move towards an integrated IPC BAF for the Trust. Reducing a risk in staff access to FIT testing for face masks in the Community Trust was being supported by resources in WUTH for example. ○ The Annual Claims report for the Community Trust showed that there are effective systems for managing claims. It was able to review a high-level summary of open claims. There was one new claim only for 2025/26 & no themes to escalate to the Board. ○ It was assured that there is an effective and substantial clinical audit and quality improvement programme in place at the Community Trust, one spotlight example being a programme to improve contraception advice and support for clients of the Wirral Family Nurse Partnership
Review of Risks	• The Committee reviewed the Joint Board Assurance Framework risks within its oversight and responsibility (ID01, ID02, ID08) and approved them as a fair record of the risk likelihood and impact, after noting relevant controls and any identified gaps in control. It also considered risk appetite and was satisfied that the ratings were appropriate. • The Committee reviewed the High-Level Risk report for Community Trust, noting that the risks were being effectively managed.
Other comments from the Chair	• The Committee benefitted from receiving clear and helpful reports that enabled it to conduct its business.

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.5

Report Title	Committee Updates – WUTH Audit and Risk Committee
Date of Meeting	23 April 2026
Author	Lisa Greenhalgh, Chair of Audit and Risk Committee

Alert	- The Committee wish to alert members of the Board of Directors that: - Nothing to alert members to at present
Advise	- The Committee wish to advise members of the Board of Directors that: - Year-end BAF position was noted 2025 Anti-Fraud Annual Assessment was submitted and received a green rating overall. 1 component scored amber which was related to the recently implemented Failure to Prevent Fraud Offence, which is the same for all Trusts. - BAF Assurance Framework was assessed and confirmed that it is structured to meet the NHS requirements of best practice models. - Risk Management Core Controls were reviewed and resulted in a green RAG rating. 2026/27 Anti-Fraud Plan was approved
Assure	- The Committee wish to assure members of the Board of Directors that: - Grip and Control report was received with a Moderate Assurance received. PWC had reviewed the report which demonstrated a strengthened grip and control, with some further tweaks identified to strengthen the approach - Consultant Job Planning report was received with Moderate Assurance received. - Conflict of Interest report was received with Substantial Assurance received. - Key Financial Transactional Processing Controls report was received with a High Assurance opinion. - Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions. - Internal Audit Annual Report & Head of Internal Audit Opinion 2025/26 was a Substantial Assurance indication there is a good system of internal control and controls are being applied consistently.

Review of Risks	• The new BAF is agreed noting the new strategic risks aligned to the new strategic objectives in the Joint Strategy. This will continue to be developed.
Other comments from the Chair	• External Audit is progressing and all parties confirmed no issues in achieving the deadline. • The Draft Annual Governance statement was received with the final statement being presented at the next meeting.

WUTH/WCHC Council of Governors
23 July 2026

Item No 11.6

Report Title	Committee Updates – WCHC Audit and Risk Committee
Date of Meeting	23 April 2026
Author	Lisa Greenhalgh, Chair of Audit and Risk Committee

Alert	- The Committee wish to alert members of the Board of Directors that: - Nothing to alert members to at present
Advise	- The Committee wish to advise members of the Board of Directors that: - Year-end BAF position was noted 2025 Anti-Fraud Annual Assessment was submitted and received a green rating overall. 2 components scored amber overall, one on the recently implemented Failure to Prevent Fraud Offence, which is the same for all Trusts, and one for the conflict of interest declaration falling below 80%. 2026/27 Anti Fraud Plan was approved - BAF Assurance Framework was assessed and confirmed that it is structured to meet the NHS requirements of best practice models. - Risk Management Core Controls were reviewed and were positive
Assure	- The Committee wish to assure members of the Board of Directors that: - Key Financial Systems report was received with Substantial Assurance - IT Services Disaster Recovery report was received with Substantial Assurance - Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions. - Internal Audit Annual Report & Head of Internal Audit Opinion 2025/26 was a Substantial Assurance indication there is a good system of internal control and controls are being applied consistently.
Review of Risks	- WCHC High Level Risk Report was received which provided assurance all risks were being managed in line with policy. - The new BAF is agreed noting the new strategic risks align to the new strategic objectives in the Joint Strategy. This will continue to be developed.
Other comments from the Chair	External Audit is progressing and all parties confirmed no issues in achieving the deadline.

	• The Draft Annual Governance statement was received with the final statement being presented at the next meeting.
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WUTH/WCHC Council of Governors
23 July 2026

Item No 11.7

Report Title	Committee Updates – WUTH Charitable Funds Committee
Date of Meeting	9 th April 2026
Author	Lesley Davies, Chair of WUTH Charitable Funds Committee
Alert	The Committee wishes to alert the Board of Directors that: ○ The Charity has yet to agree a focus for its new campaign. The Committee asked officers to explore the options and bring a proposal to the next meeting. Current options include a wellbeing garden and improvements to the Trust's family bereavement area.
Advise	The Committee wishes to advise the Board of Directors that: ○ The Committee welcomed confirmation that the Charity has been chosen by Merseyrail as its Charity of the Year for 2026 to 2028. Further details will be shared at future meetings. ○ The Committee was also advised that in-kind donations will need an assessed financial value so these benefits can be correctly accounted for. ○ Finance – At M11, total income was £361K and costs were £197K, giving a net position of £164K. ○ The Committee ratified the 2024/25 Annual Report and Accounts, the Independent Examination Findings Report, and the Letter of Representation.
Assure	The Committee wish to assure members of the Board of Directors that: ○ A one-year strategy is being prepared for presentation to the Committee at its September 2026 meeting. A longer-term plan, informed by the views of staff and the Charity's partners, will be developed after the merger. Officers will also draw on learning from successful NHS charities to help ensure the strategy reflects good practice.
Review of Risks	It was agreed that the Charity's risk register needed a refresh to reflect the internal and external challenges. This will be presented at the next meeting and will consider • Capacity of staff • Legal and compliance • Future funds • Staff engagement • Reputation
Other comments from the Chair	The Committee recognised that, after the merger, consideration will be needed on how to bring together the charitable trusts of WUTH and WCHC and develop a charity model fit for purpose for the combined Trust.

WUTH/WCHC Council of Governors

Item 12

23 July 2026

Title	Joint Integrated Performance Report
Area Lead	Executive Directors
Author	Executive Directors

Purpose of the Report and Recommendation	
Report For	Information
It is recommended that the Council of Governors: - Note performance to the end of April 2026 (or latest available months data). - Note the summary position reflecting the latest publication of the NOF is also included in the IPR.	

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

Key Risks
This report relates to these key risks: All BAF Risks

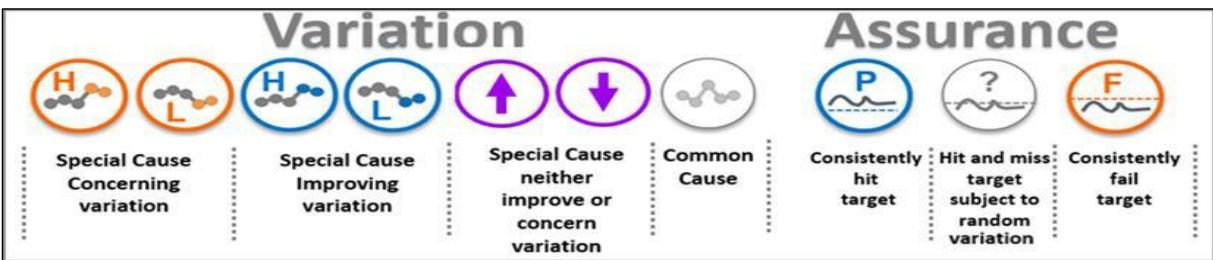
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	Forum	Report Title	Purpose/Decision
June 2026	Group Board of Directors in Public	As above	As above

1	Narrative
1.1	This is the first joint Integrated Performance Report for the Board, bringing together the two Trust's performance reports. A few amends have been made to the format, including an overall matrix for both Trusts showing all indicators, rather than individual portfolio matrices, and each Executive Director's portfolio now includes a section for WUTH and WCHC, where relevant. This report also replaces the historic WUTH COO and WUTH CFO reports, and the detail within those reports will now be included in this Joint IPR to support triangulation. Further work is being undertaken on the IPR and it is anticipated that additional indicators will be included in the next iteration of this report. This includes the development of indicators for the CMO WCHC section, and further indicators for the CPO section to triangulate with the financial plan requirements, and the addition of indicators to align with the NOF metrics. No existing indicators are planned for removal or amend. It should also be noted that the EMD portfolio indicators are also reported against the agreed national trajectories, rather than year-end targets.

2	General guidance and Statistical Process Charts (SPC)
2.1	 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.

WUTH Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Apr 26	5.53%	≤5%			5.94%
Staff turnover % - in-month rate	Apr 26	0.62%	≤1%			87.73%
Mandatory training % compliance	Apr 26	88.82%	≥90%			92.05%
Appraisal % compliance	Apr 26	87.33%	≥88%			0.83%
4-hour Accident and Emergency Target (including APH UTC)	Apr 26	62.55%	≥57.63%			61.1%
Number of inpatients not meeting the Criteria to Reside	Apr 26	182	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Apr 26	735	≤0			651
Proportion of patients more than 12 hours in ED from time of arrival	Apr 26	18.07%	≤20.84%			18.3%
Ambulance Handovers: % < 30 mins	Apr 26	65.77%	≥95%			54.7%
Ambulance Handovers: % < 45 mins	Apr 26	85.64%	≥100%			73.4%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Apr 26	65.42%	≥63.88%			59.1%
Referral to Treatment - total open pathway waiting list	Apr 26	43867	≤46923			45238
Referral to Treatment - cases exceeding 52 weeks	Apr 26	283	≤429			1421
Referral to Treatment - cases waiting 78+ wks	Apr 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Mar 26	50	≤50			136
Cancer - Faster Diagnosis Standard	Mar 26	84.05%	≥77.73%			73.0%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Mar 26	91.83%	≥91.39%			91.4%
Cancer Waits - 62 days to treatment (monthly)	Mar 26	75.86%	≥75.51%			74.5%
Diagnostic Waiters, 6 weeks and over - DM01	Apr 26	92.04%	≥94.5%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Apr 26	186	≤79			168
Clostridioides difficile (healthcare associated)	Apr 26	14	≤8			12
Pressure Ulcers - Hospital Acquired Category 3 and above	Apr 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Apr 26	0	≤0			0
Patient Safety Incidents	Apr 26	1333	-			1222
FFT Overall experience of very good & good: ED	Apr 26	73.3%	≥95%			75.7%
FFT Overall experience of very good & good: Inpatients	Apr 26	96.9%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Apr 26	97.0%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Apr 26	96.9%	≥95%			96.1%
Patient Experience: concerns received in month - Level 1 (informal)	Apr 26	283	≤173			233
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Apr 26	3	≤3			3
Falls – Moderate to Severe Harm	Apr 26	0.14	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Apr 26	92.0%	≥90%			89.1%
WUTH Average RN Night Staffing Fill Rates	Apr 26	95.0%	≥90%			90.8%
WUTH Average CSW Day Staffing Fill Rates	Apr 26	91.0%	≥90%			87.2%
WUTH Average CSW Night Staffing Fill Rates	Apr 26	104.0%	≥90%			99.8%
MRSA Cases	Apr 26	0	≤0			0
MSSA Cases	Apr 26	2	≤0			2
% of adult patients VTE risk-assessed on admission	Apr 26	96.4%	≥95%			97.2%
Never Events	2026/27	0	≤0			
NEWS2 Compliance	Apr 26	90.4%	≥90%			89.3%
Mortality (SHMI)	Dec 25	1.060	>=0.95			1.024
Agency spend	Apr 26	1.5%	≤1%			2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

WUTH Scorecard Matrix

		Assurance			
		Consistently Hits Target 	Hit and Miss Target, subject to random variation 	Consistently Fails Target 	No target set/insufficient data points
Variation	Special Cause improving 		- Duty of Candour compliance – breaches of DoC standard for serious incidents - FFT Overall Experience of very good & good : Inpatients - WUTH Average RN Day Staffing Fill Rates - WUTH Average RN Night Staffing Fill Rates - Never Events - Staff turnover % in month rate - RTT – cases waiting 78+ wks	- Agency Spend - 18 week RTT - Incomplete pathways < 18 wks - RTT - cases exceeding 52 wks - Cancer waits – reduce number waiting 62 days +	- FOI – Completed - Pay – Run Rate
	Common Cause 	- WUTH Average CSW Night Staffing Fill Rates	- Clinical coding completeness (Freeze) - Pressure Ulcers – Hospital Acquired Cat 3 and above - FFT Overall Experience of very good & good : Outpatients - FFT Overall experience of very good & good: Maternity - Patient Experience: Concerns received in month – Level 1 (informal) - Patient Experience – complaints in month per 1000 staff – Level 2 (formal) - Falls – Moderate to Severe Harm (per 1000 bed days) - WUTH Average CSW Day Staffing Fill rates - MRSA Cases - MSSA Cases - NEWS2 Compliance - Appraisal % Compliance - 4-hour ED Target (including APH UTC) - 12 hr waits from arrival in ED - RTT – total open pathway waiting list - Cancer waits - % receiving first definitive treatment within 31 days of decision to treat - Cancer waits – 62 days to treatment (monthly) - Cancer – Faster Diagnosis Standard - Diagnostic Waiters, 6 weeks and over – DM01	- FFT Overall experience of very good & good: ED - Sickness absence % - in month rate - 12 hr waits from decision to admit in ED - Ambulance Handovers % <30mins - Ambulance Handovers % <45 mins - Cancer waits – 2 week referrals (monthly)	- Non-pay run rate - Non-contract income – Run Rate - Number of inpatients not meeting the criteria to reside
	Special Cause Concerning 	- % of adult patients VTE risk-assessed on admission	- Mortality (SHMI) - Mandatory Training % compliance	- Staff Vacancy as % of workforce - Long length of stay – number of patients in hospital for 21 or more days	- FOI – Waiting List - Patient Safety Incidents

NHS Oversight Framework (NOF) Dashboard Q3, 25-26

Wirral University Teaching Hospital

TABLE 1: SCORED METRICS (Contributing to Segmentation)

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

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

WCHC Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	Apr 26	12.8%	10.4%			12.5%
Mandatory Training Compliance	Apr 26	94.8%	90.0%			95.0%
Sickness Absence	Apr 26	6.4%	5.0%			6.5%
Sickness Absence (Short Term)	Apr 26	1.2%	2.0%			1.6%
Sickness Absence (Long Term)	Apr 26	5.2%	3.0%			4.9%
Agency usage	Apr 26	0.3%	1.0%			0.9%
Variance to Agency Cap (£)	Apr 26	-203784.4	-			-175005.4
% of Agency Usage against Funded WTE	Apr 26	0.00%	-			0.6%
% of Bank Usage against Funded WTE	Apr 26	4.40%	-			3.4%
% of Contracted FTE Vacancies	Apr 26	3.8%	6.0%			5.1%
WIC & UTC Attendances seen within 4 hrs	Apr 26	96.8%	95.0%			96.1%
CIOC Occupancy Rate (Commissioned Beds)	Apr 26	97.3%	92.0%			92.2%
CIOC Median LoS (Active Beds Daily Snapshot)	Apr 26	16.3	21.0			18.7
Urgent Community Response - 2 hours	Apr 26	88.3%	70.0%			87.5%
GPOOH - UCAT Response Times (60 min response)	Apr 26	98.4%	98.0%			98.7%
GPOOH - UCAT Response Times (15 min response)	Apr 26	73.4%	65.0%			68.4%
GPOOH - UCAT Response Times (30 min response)	Apr 26	91.5%	90.0%			92.8%
GPOOH - CAS Response Times (20 min response)	Apr 26	69.4%	75.0%			69.5%
GPOOH - CAS Response Times (2hr response)	Apr 26	68.6%	90.0%			69.8%
GPOOH - NHS111 Response Times	Apr 26	66.4%	75.0%			60.2%
RTT - % of Patients Seen Within 18 Weeks	Apr 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	Apr 26	99.5%	99.0%			100.0%
UTC Attendances seen within 4 hrs	Apr 26	96.9%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	Apr 26	95.9%	95.0%			94.4%
Eastham Attendances seen within 4 hrs	Apr 26	98.6%	95.0%			93.6%
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)	Apr 26	0	0			0
No. of Incidents reported	Apr 26	416	475			477
Patient Safety Incidents	Apr 26	174	200			201
Never events	Apr 26	0	0			0
No. of ICO reportable IG Incidents	Apr 26	0	0			0
Total Complaints Received	Apr 26	4	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	Apr 26	0	0			0
Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust	Apr 26	0	0			0
No. of Incidents reported with a moderate and above harm level with safety systems learning identified for the Trust	Apr 26	0	0			0
Clostridium difficile Infections resulting in moderate or severe harm with learning identified for the Trust	Apr 26	0	0			0
MRSA Infections with learning identified for the Trust	Apr 26	0	0			0
Falls resulting in moderate or above harm	Apr 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	Apr 26	0.0%	4.6%			1.4%
No. of concerns received in month	Apr 26	11	12			12
FFT - % of People who would recommend our services	Apr 26	90.1%	90.0%			91.6%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	Apr 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	Apr 26	0	0			0
No. of reported no and low harm patient safety incidents	Apr 26	166	200			189
I&E Position	Apr 26	£0.2m	£1.9m			
Cumulative CIP	Apr 26	£0.2m	£6m			
Capital Expenditure	Apr 26	£0.1m	£4.8m			
Cash Position	Apr 26	£17.5m	£9m			
Agency usage	Apr 26	0.3%	0.1%			

WCHC Scorecard Matrix

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

Wirral Community Health and Care NHS Foundation Trust

TABLE 1: SCORED METRICS (Contributing to Segmentation)

		2025/26 - Qtr 3 Metric Performance					Metric Value Quartiles 2025/26 Q3					Domain Performance Qtr 3		2025/26 - Qtr 2 Metric Performance				Domain Performance Qtr 2	
Metric	Type	Metric Value	Provider Rank	Time Period	Performance Trajectory	Metric Target	Quartile 1	Quartile 2	Quartile 3	Quartile 4	Metric Quartile Threshold (Improve to the left)	NOF Score	Segment Quartile	Metric Value	Provider Rank	Time Period	Metric Value Quartiles	NOF Score	Segment Quartile
ACCESS TO SERVICES DOMAIN																			
% patients waiting >52 weeks (community)	Community	0.0%	1/41	Q3 2025/26	↔	-	1				0 to 0.02	1	1	0.0%	1/41	Q2 2025/26	1	1	1
EFFECTIVENESS & EXPERIENCE DOMAIN																			
Urgent Community Response 2-hour performance	Community	85.92%	21/38	Q3 2025/26	↓	70%			2.11		88.86% to 79.80%	2.11	2	90.17%	13/38	Q2 2025/26	2	1.68	1
PATIENT SAFETY DOMAIN																			
Staff survey - raising concerns	Acute/Community	6.94	18/61	2024	↔	-		1.85			6.95 to 6.81	1.85	1	6.94	18/61	2024	1	1.93	1
CQC safe inspection score	Acute/Community	2	2	2023	↔	-		2						2	2	2023	2		
PEOPLE & WORKFORCE DOMAIN																			
Sickness absence rate	Acute/Community	7.45%	58/61	Q2 2025/26	↓	-				3.94	6.52% to 7.95%	3.37	4	6.46%	54/61	Q1 2025/26	3	3.13	4
Staff survey engagement score	Acute/Community	7.02	37/61	Dec-24	↔	-			2.8		7.08 to 6.95			7.02	37/61	Dec-24	3		
FINANCE & PRODUCTIVITY DOMAIN																			
Planned surplus/deficit	Acute/Community	0.85%	6/61	Q3 2025/26	↔	Breakeven/ Surplus	1				2.39 to 0	1.09	1	0.85%	6/61	Q2 2025/26	1	1	1
Variance YTD to plan	Acute/Community	2.27%	1/61	Dec-25	↑	-	1				2.27 to 0.21			2.04%	2/61	Sep-25	1		

CMO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Apr 26	96.4%	≥95%			97.2%
Never Events	2026/27	0	≤0			
NEWS2 Compliance	Apr 26	90.4%	≥90%			89.3%
Mortality (SHMI)	Dec 25	1.060	>=0.95			1.024

Highlights

Percentage of adult patients having a completed VTE risk assessment on admission remains within target with 96.4 % compliance in month and a mean of 97.2%

There are no reported Never Events for this financial year. The last reported Never Event was in June 2025

NEWS 2 compliance at 90.4% in month with mean at 89.3%

SHIM remains in as expected range, although there has been an upward trend due to coding backlog issues

Areas of Concern

Forward Look (Actions)

Continued focus on areas of lower compliance.
Planned move to new risk assessment tool in January 2027
Will strengthen prescription of VTE prophylaxis

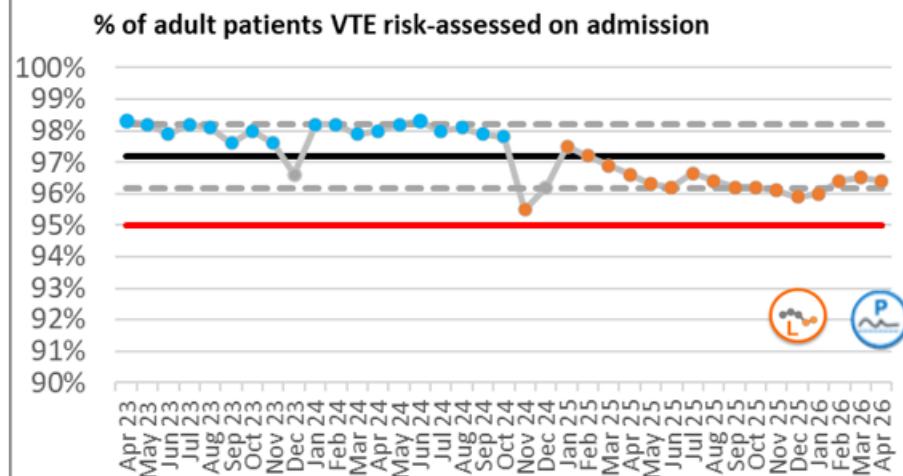
Electronic LocSSIP to be introduce from June, completing the final open action on the LocSSIP action plan

Ward level breakdown of compliance available on live dashboard and monitored at DQB and DPR

Continued monitoring of mortality trends through MRG .
Coding backlog now cleared

% of adult patients VTE risk assessed on admission

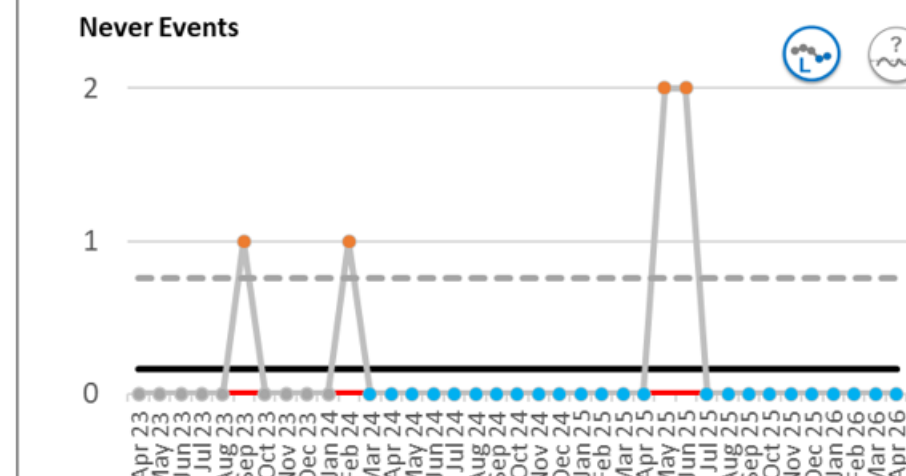
CQC Domain : Safe



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

Never Events

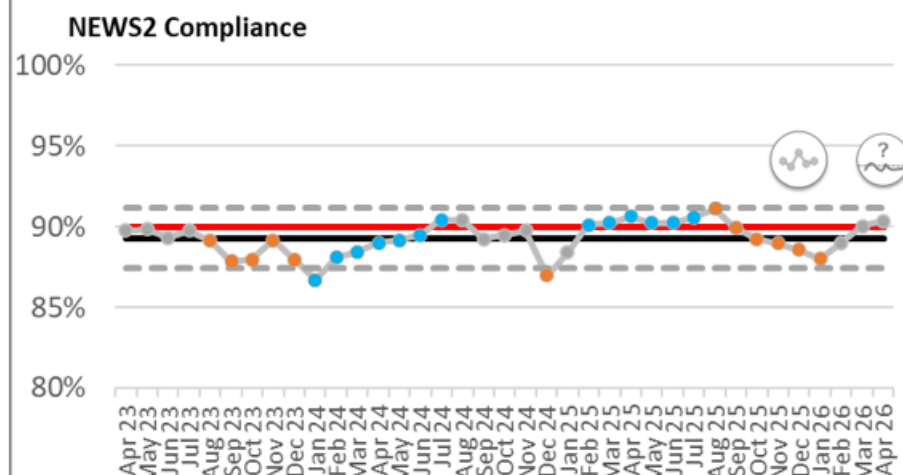
CQC Domain : Safe



2026/27
0
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

NEWS 2 Compliance

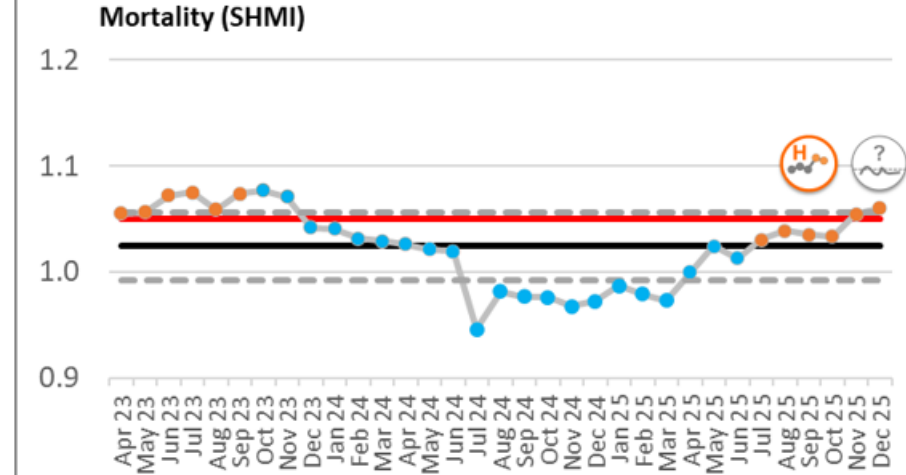
CQC Domain : Well-led



Apr-26
90.4%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Dec-25
1.0603
Variance Type
Special cause concerning variation
Threshold
≥0.95
Assurance
Hit and miss target subject to random variation

CNO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Apr 26	14	≤8			12
Pressure Ulcers - Hospital Acquired Category 3 and above	Apr 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Apr 26	0	≤0			0
Patient Safety Incidents	Apr 26	1333	-			1222
FFT Overall experience of very good & good: ED	Apr 26	73.3%	≥95%			75.7%
FFT Overall experience of very good & good: Inpatients	Apr 26	96.9%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Apr 26	97.0%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Apr 26	96.9%	≥95%			96.1%
Patient Experience: concerns received in month - Level 1 (informal)	Apr 26	283	≤173			233
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Apr 26	3	≤3			3
Falls – Moderate to Severe Harm	Apr 26	0.14	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Apr 26	92.0%	≥90%			89.1%
WUTH Average RN Night Staffing Fill Rates	Apr 26	95.0%	≥90%			90.8%
WUTH Average CSW Day Staffing Fill Rates	Apr 26	91.0%	≥90%			87.2%
WUTH Average CSW Night Staffing Fill Rates	Apr 26	104.0%	≥90%			99.8%
MRSA Cases	Apr 26	0	≤0			0
MSSA Cases	Apr 26	2	≤0			2

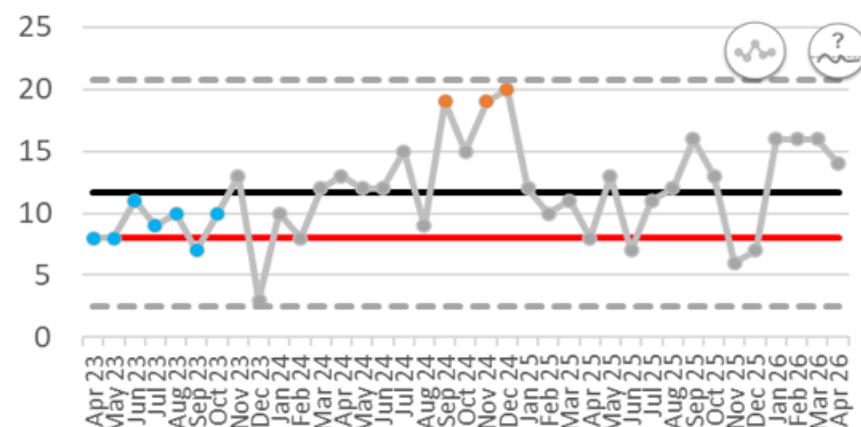
Clostridioides difficile (healthcare associated)		
Highlights In April there were 14 cases of <i>C.diff</i> which is a slight reduction from previous months. Of the 14 cases, there were 11 HOHA and 6 COHA CDTs. 1 patient was known to have a history of CDT/CDE, and 7 patients had known exposure to CDT/CDE.	Areas of Concern - Ward outbreak detected from sentinel surveillance on ward 25 - Delay in obtaining stool samples - Delay in isolation due to high levels of occupancy	Forward Look (Actions) - Task & Finish Group planned for May to discuss reactive use of HPV in place of Misting for CDT/CDE patients - Development of a Trust wide CDI improvement plan
Pressure Ulcers Hospital acquired Category 3 and above		
Highlights There have been no Category 3 or 4 pressure ulcers reported in April 2026	Areas of Concern - Incomplete Purpose T on admission - Documentation on description of pressure ulcer (wound assessment completed) - Categorisation of pressure ulcers - Correct use of equipment and availability - Use of Medical Photography on detection of pressure damage or ongoing monitoring.	Forward Look (Actions) - Quality Improvement Project- collaborative with focus areas. - Review of pressure relieving equipment usage and availability - Review of education and delivery.
Friends and Family Test		
Highlights Overall experience in ED remains consistently below target	Areas of Concern Themes related to waiting times and poor experience/; environment whilst waiting	Forward Look (Actions) - Opening of new department planned for July 26 with improved waiting area - Corridor Care Summit held with overarching action plan

Complaints		
Highlights - Reduction in both informal concerns (289 vs 310) and formal complaints (20 vs 30), indicating a moderation in activity at the start of 2026/27. - Overall activity remains above historical norms, with informal concerns continuing to represent sustained pressure across services. - Backlog position improved, with open complaints reduced (87 vs 100) and overdue cases decreasing (39 vs 47). - Emergency Department remains the most significant single hotspot across both reporting routes, although activity is broadly distributed across services.	Areas of Concern - Timeliness performance deteriorated significantly, with compliance within 40 working days falling to 15% (from 32%) and average response times increasing to 76 days. - Despite reduced caseload, backlog pressures persist, indicating ongoing challenges in case complexity and flow through the system. - Variability in divisional performance and investigation quality continues to impact consistency and prolong resolution times. - Elevated activity remains concentrated in Access & Admission, Communication, and Treatment & Procedure themes, reflecting continued operational pressure.	Forward Look (Actions) - Maintain focus on increasing weekly closure rates and improving consistency of case progression to reduce overdue complaints further. - Continue delivery of the Complaints Improvement Plan, including strengthened divisional ownership and governance arrangements. - Sustain targeted training and performance oversight to improve investigation quality, timeliness, and standardisation. - Prioritise clearance of older and high-risk cases to support recovery in 40-working-day compliance and reduce average response times.
Falls – Moderate to Severe Harm		
Highlights Good uptake with face to face hoverjack training by ward areas and staff are using it more frequently than they previously had	Areas of Concern 3 falls with harm reported over April – 2 fractured neck of Femur and 1 subdural haematoma 38% of patients who fell had assistive technology in place Neurological observations not being undertaken as per policy.	Forward Look (Actions) New falls policy has been written and incorporates NICE guidance giving clearer direction for neurological observations as current policy is ambiguous – awaiting review at fundamentals of care. Awareness of neurological observations has been added to the patient safety study days.
Staffing		
Highlights All fill rates above threshold for CSW and RN day and night.	Areas of Concern Although improving position for CSW day fill rate- remains area of focus. Successful ED CSW recruitment event Staffing escalation areas outside of core establishment an ongoing challenge.	Forward Look (Actions) Support for ongoing CSW recruitment events planned Training / progression plans to support CSW retention Plan for recruitment of newly qualified RNs in progress
MRSA/MSSA Cases		
Highlights In April, there were 0 cases of MRSA bloodstream infections reported. 2 MSSA bloodstream infections were reported in April, both community onset hospital associated (COHA). Of the 2 cases, 1 infection was potentially line related in a child with complex medical needs, the child was known to have had a previous bloodstream infection.		

Clostridioides difficile (healthcare associated)

CQC Domain : Safe

Clostridioides difficile (healthcare associated)



Apr-26

14

Variance Type

Common cause variation

Threshold

≤8

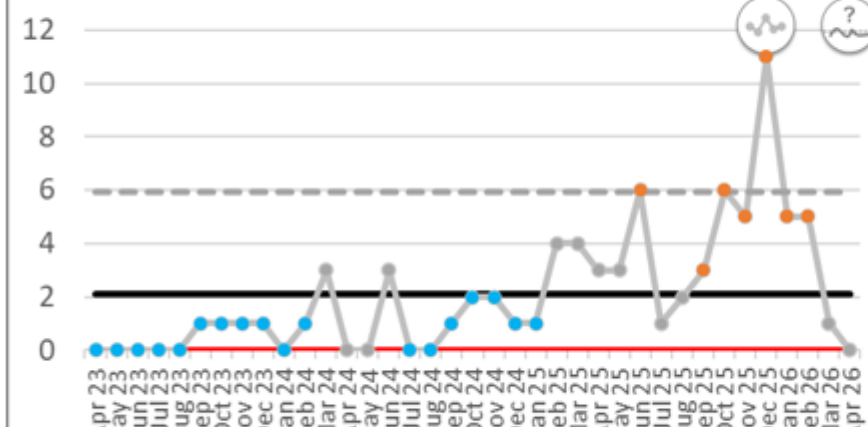
Assurance

Hit and miss target
subject to random
variation

Pressure Ulcers – Hospital Acquired Category 3 and above

CQC Domain : Safe

Pressure Ulcers - Hospital Acquired Category 3 and above



Apr-26

0

Variance Type

Common cause
variation

Threshold

≤0

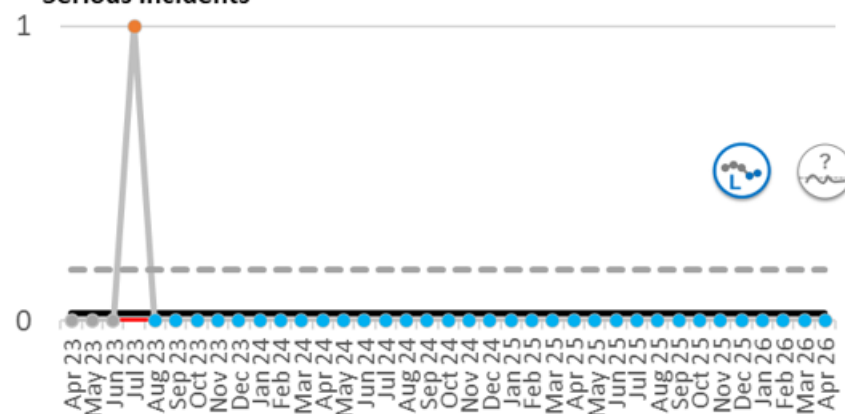
Assurance

Hit and miss target
subject to random
variation

Duty of Candour Compliance

CQC Domain : Well-led

Duty of Candour compliance - breaches of DoC standard for Serious Incidents



Apr-26

0

Variance Type

Special cause improving
variation

Threshold

≤0

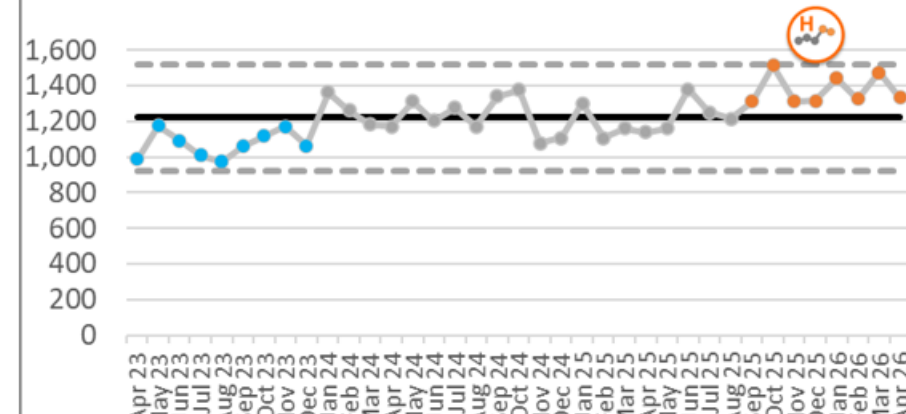
Assurance

Hit and miss target
subject to random
variation

Patient Safety Incidents

CQC Domain : Safe

Patient Safety Incidents



Apr-26

1333

Variance Type

Special cause
concerning variation

Threshold

-

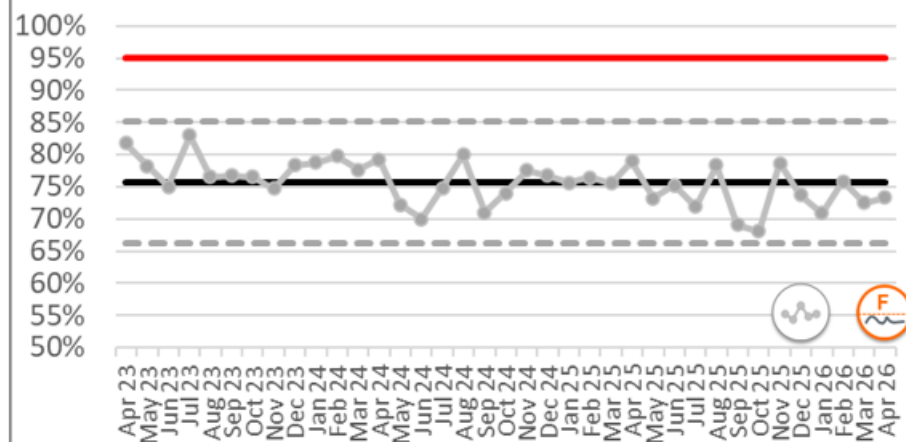
Assurance

Not applicable

FFT Overall experience of very good & good – ED

CQC Domain : Caring

FFT Overall experience of very good & good: ED



Apr-26

73.3%

Variance Type

Common cause variation

Threshold

≥95%

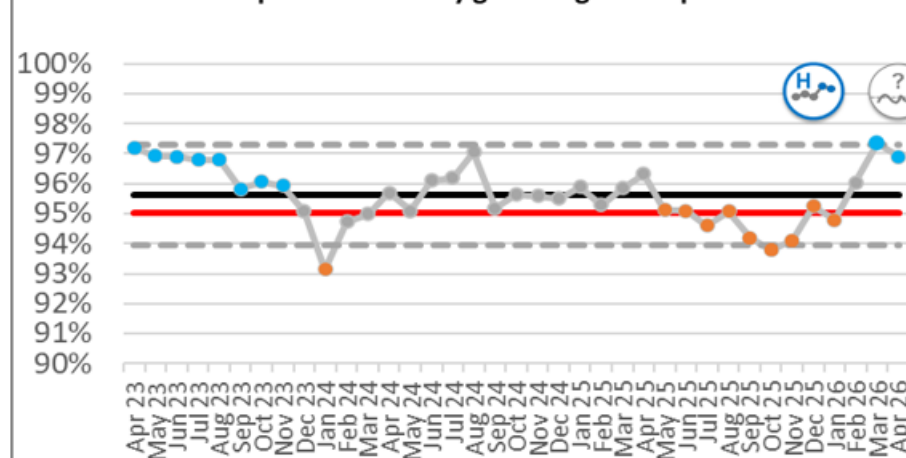
Assurance

Consistently fail target

FFT Overall experience of very good & good – Inpatients

CQC Domain : Caring

FFT Overall experience of very good & good: Inpatients



Apr-26

96.9%

Variance Type

Special cause improving variation

Threshold

≥95%

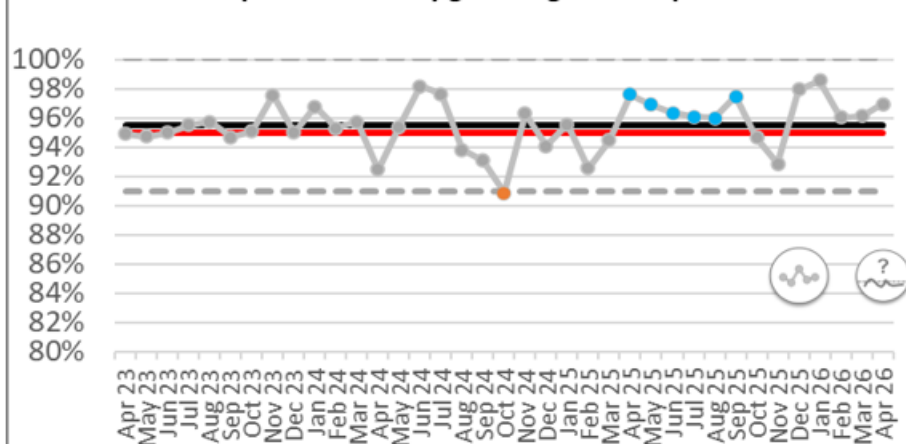
Assurance

Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

CQC Domain : Caring

FFT Overall experience of very good & good: Outpatients



Apr-26

97.0%

Variance Type

Common cause variation

Threshold

≥95%

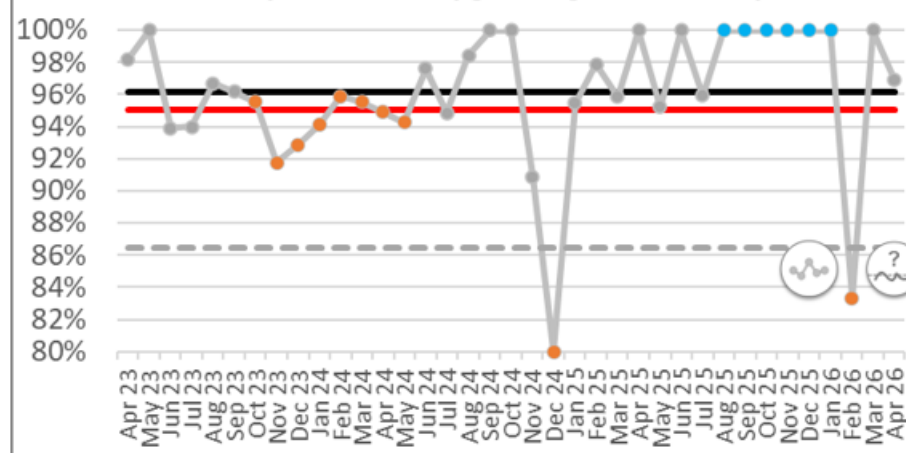
Assurance

Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Apr-26

96.9%

Variance Type

Common cause variation

Threshold

≥95%

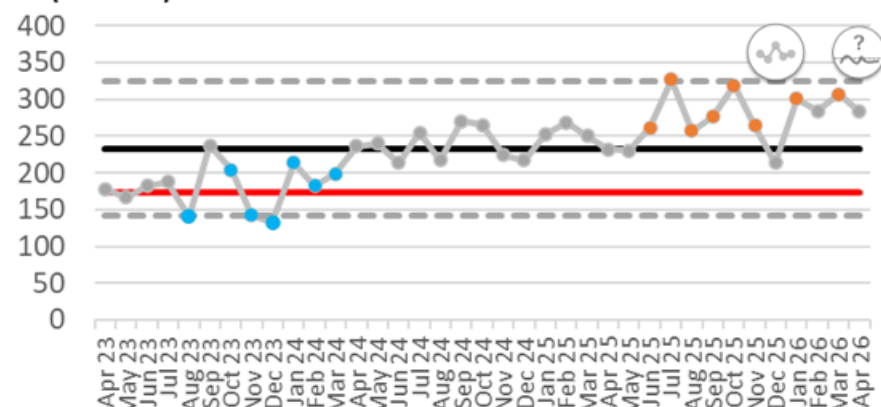
Assurance

Hit and miss target subject to random variation

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

CQC Domain : Responsive

Patient Experience: concerns received in month - Level 1 (informal)



Apr-26

283

Variance Type

Common cause variation

Threshold

≤173

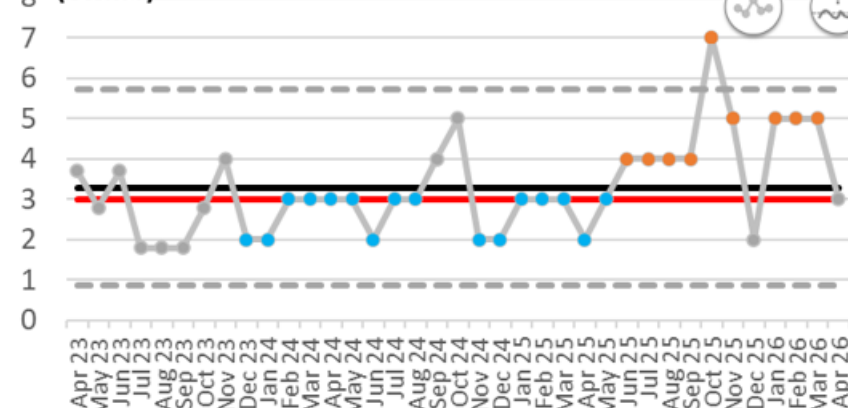
Assurance

Hit and miss target
subject to random
variation

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

CQC Domain : Responsive

Patient Experience: complaints in month per 1000 staff - Levels 2 (formal)



Apr-26

3

Variance Type

Common cause variation

Threshold

≤3

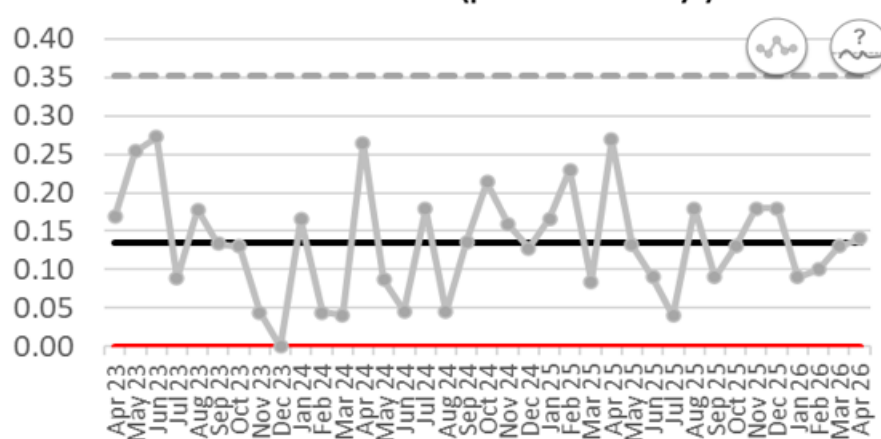
Assurance

Hit and miss target
subject to random
variation

Falls – Moderate to Severe Harm

CQC Domain : Safe

Falls – Moderate to Severe Harm (per 1000 bed days)



Apr-26

0.14

Variance Type

Common cause variation

Threshold

≤0

Assurance

Hit and miss target
subject to random
variation

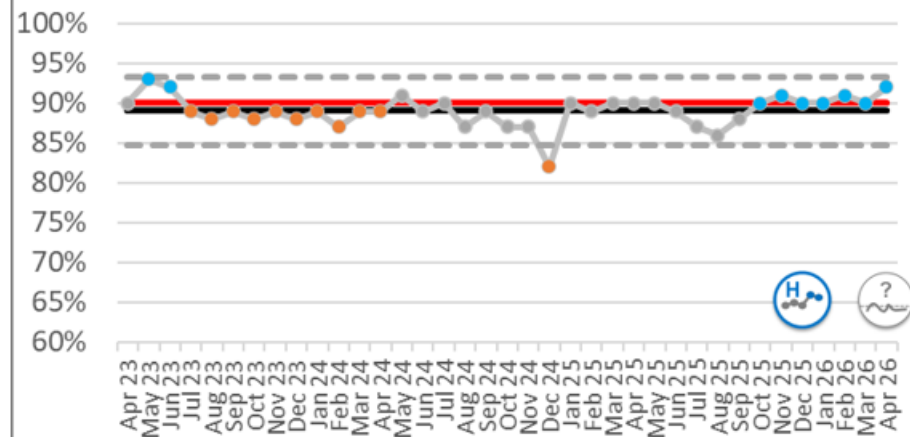
Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

Average Registered Nurse Day Staffing Fill Rates

CQC Domain : Safe

WUTH Average RN Day Staffing Fill Rates



Apr-26

92.0%

Variance Type

Special cause improving variation

Threshold

≥90%

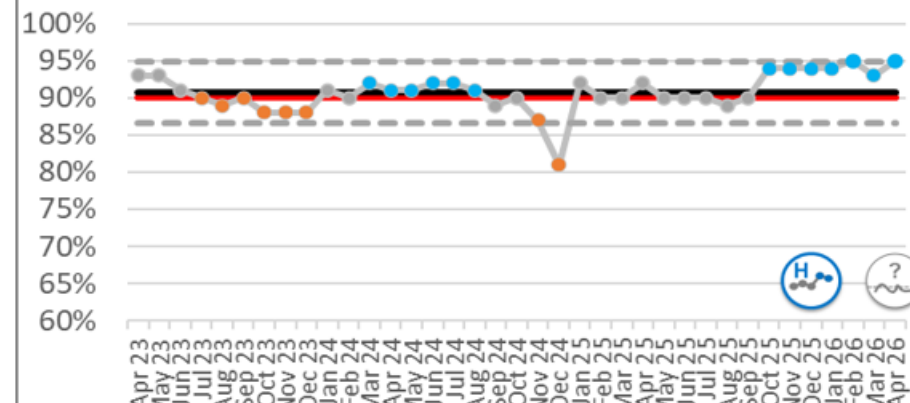
Assurance

Hit and miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse

CQC Domain : Safe

WUTH Average RN Night Staffing Fill Rates



Apr-26

95.0%

Variance Type

Special cause improving variation

Threshold

≥90%

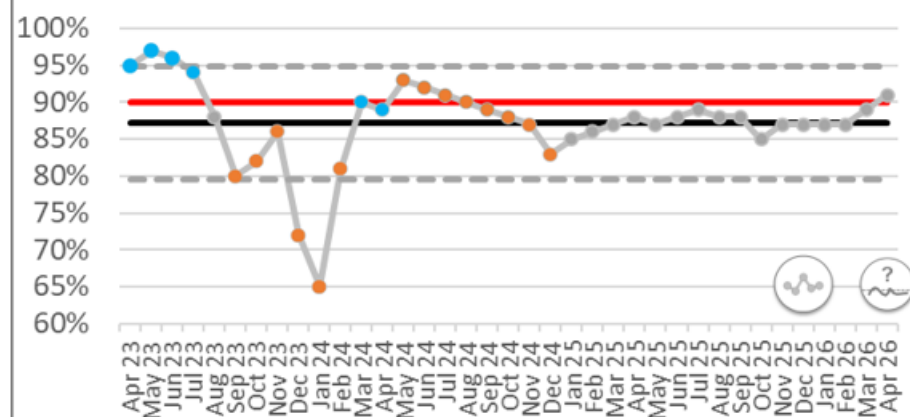
Assurance

Hit and miss target subject to random variation

Average Clinical Support Worker Day Staffing Fill Rates

CQC Domain : Safe

WUTH Average CSW Day Staffing Fill Rates



Apr-26

91.0%

Variance Type

Common cause variation

Threshold

≥90%

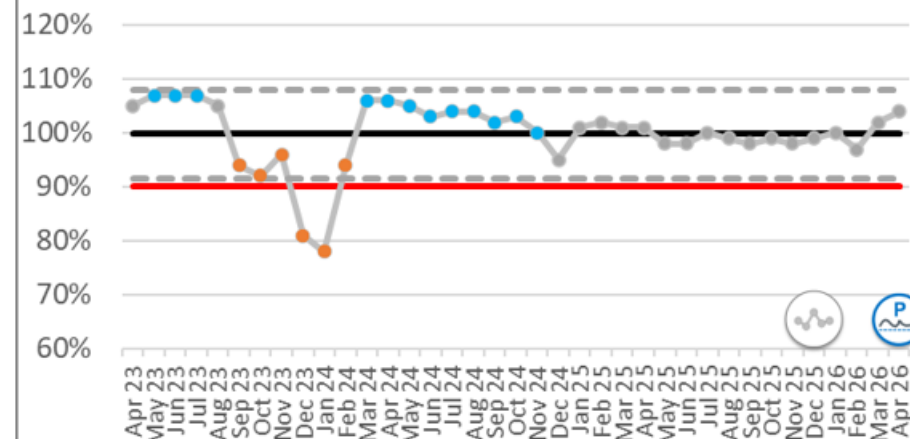
Assurance

Hit and miss target subject to random variation

Average Clinical Support Worker Night Staffing Fill Rates

CQC Domain : Safe

WUTH Average CSW Night Staffing Fill Rates



Apr-26

104.0%

Variance Type

Common cause variation

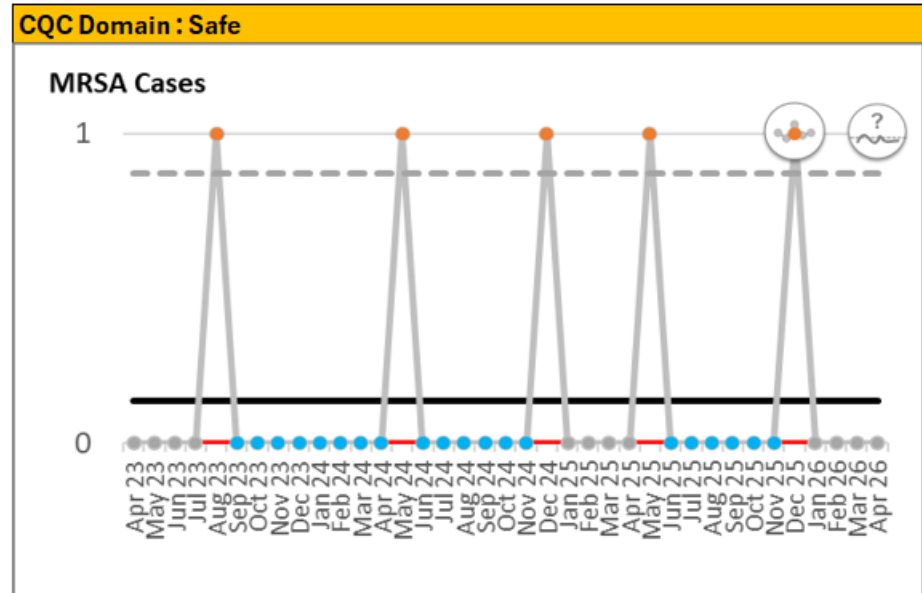
Threshold

≥90%

Assurance

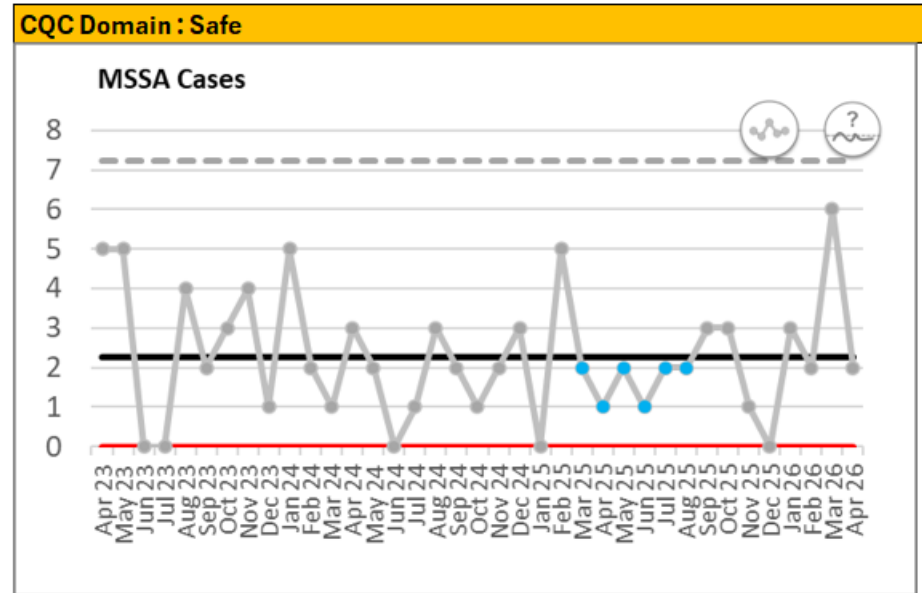
Consistently hit target

MRSA Cases



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

MSSA Cases



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

Quality and Governance Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)	Apr 26	0	0			0
No. of Incidents reported	Apr 26	416	475			477
Patient Safety Incidents	Apr 26	174	200			201
Never events	Apr 26	0	0			0
No. of ICO reportable IG incidents	Apr 26	0	0			0
Total Complaints Received	Apr 26	4	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	Apr 26	0	0			0
Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust	Apr 26	0	0			0
No. of Incidents reported with a moderate and above harm level with safety systems learning identified for the Trust	Apr 26	0	0			0
Clostridium difficile infections resulting in moderate or severe harm with safety systems learning identified for the Trust	Apr 26	0	0			0
MRSA infections with learning identified for the Trust	Apr 26	0	0			0
Falls resulting in moderate or above harm	Apr 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	Apr 26	0.0%	4.6%			1.4%
No. of concerns received in month	Apr 26	11	12			12
FFT - % of People who would recommend our services	Apr 26	90.1%	90.0%			91.6%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	Apr 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	Apr 26	0	0			0
No. of reported no and low harm patient safety incidents	Apr 26	166	200			189

Highlights

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

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

The Trust's FFT score for M1 is green RAG rated at 90.1%.

Areas of Concern

During M1, the following areas are reporting a red RAG rated position:

- Number of incidents reported
- Number of patient safety incidents reported
- Total complaints received

Total number of incidents is reporting a position of concerning special cause variation; however, this is improving, with incident reporting increasing over the last two consecutive months. Communications across Trust services continue to be disseminated, highlighting the importance of incident reporting to support a learning culture.

Patient safety incident reporting and complaints received are both reporting common cause variation. Robust monitoring remains in place, with no new themes or trends identified.

Forward Look (Actions)

The red RAG rated areas continue to be closely monitored throughout the Trust's governance framework to identify action to deliver improvement.

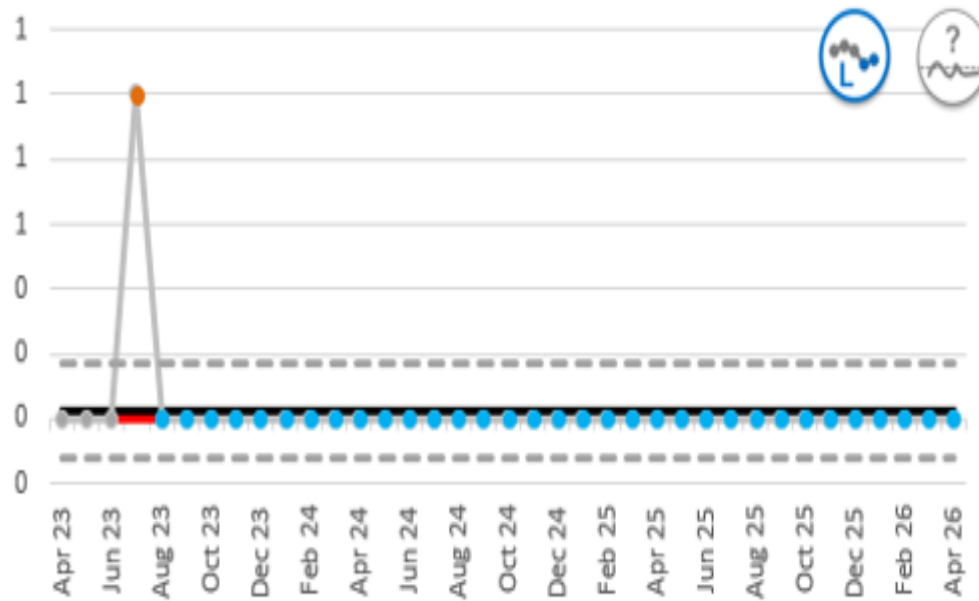
Clinical Risk Management Group continue to track improvement plans, with new quality improvement driver diagrams for 2026/27 being developed for the following joint quality priorities:

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

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

CQC Domain : Safe

Serious untoward incidents - reported via StEIS (Exc. IPC Contract)

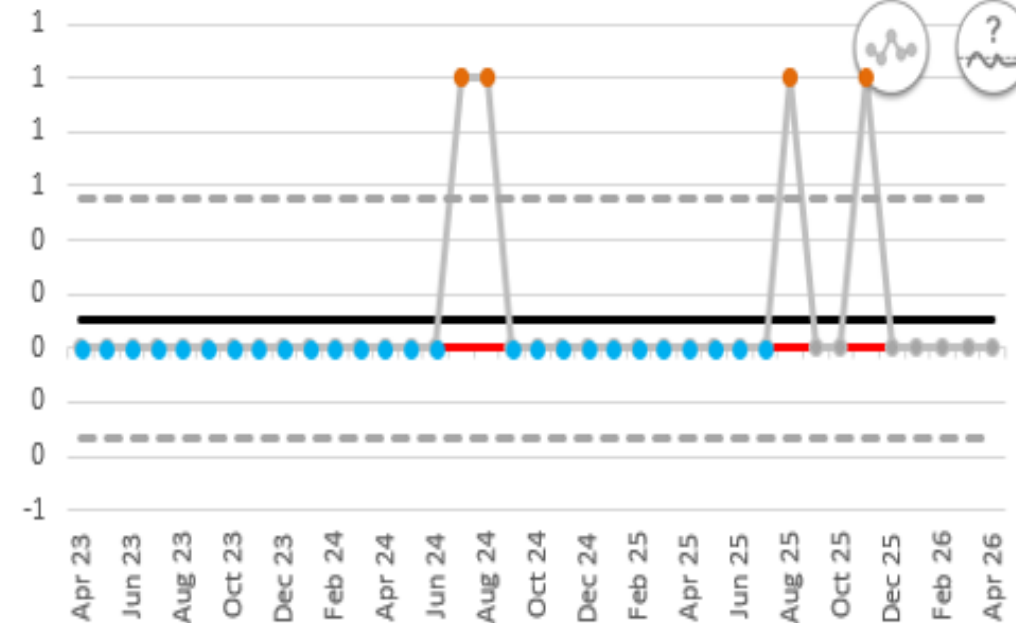


Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

No. of ICO reportable IG incidents

CQC Domain : Safe

No. of ICO reportable IG incidents

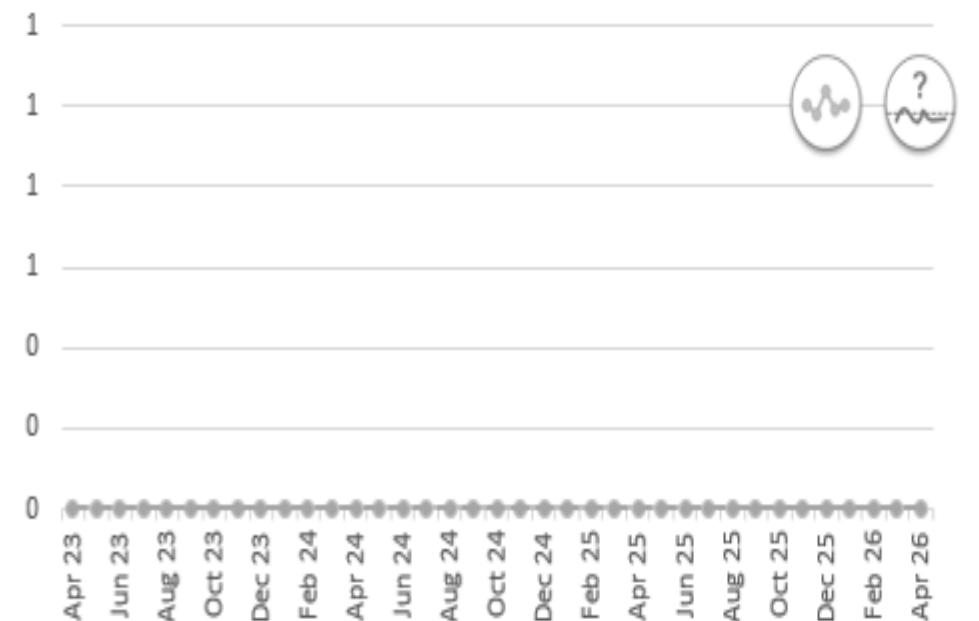


Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events

CQC Domain : Safe

Never events

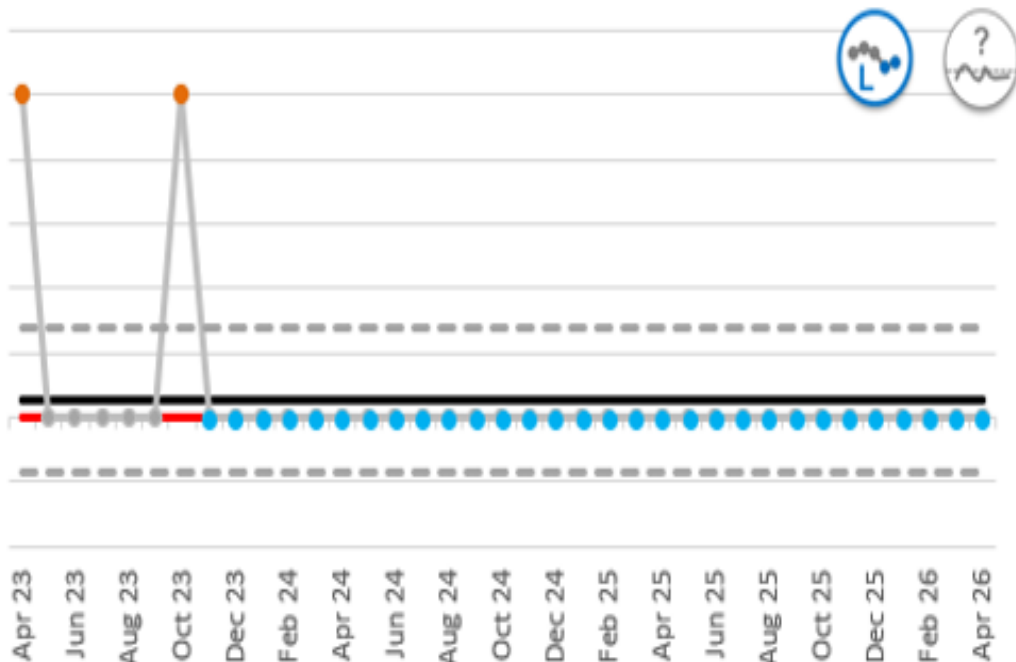


Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Serious untoward incidents – reported via StEIS (IPC Contract)

CQC Domain : Safe

Serious untoward incidents - reported via StEIS (IPC Contract)



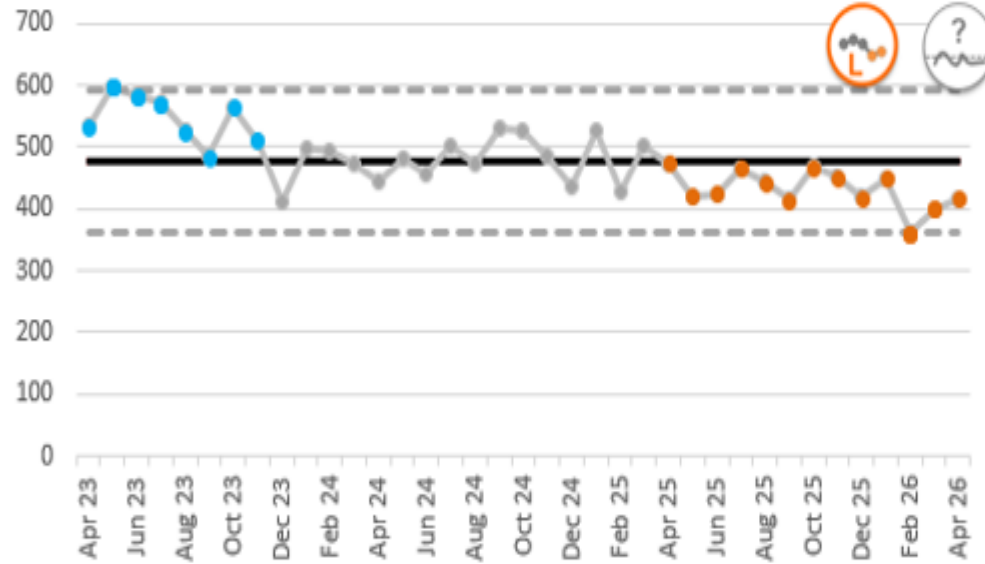
Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Number of Incidents reported

Patient Safety Incidents

CQC Domain : Safe

No. of Incidents reported



Apr-26

416

Variance Type

Special cause
variation - Concerning

Threshold

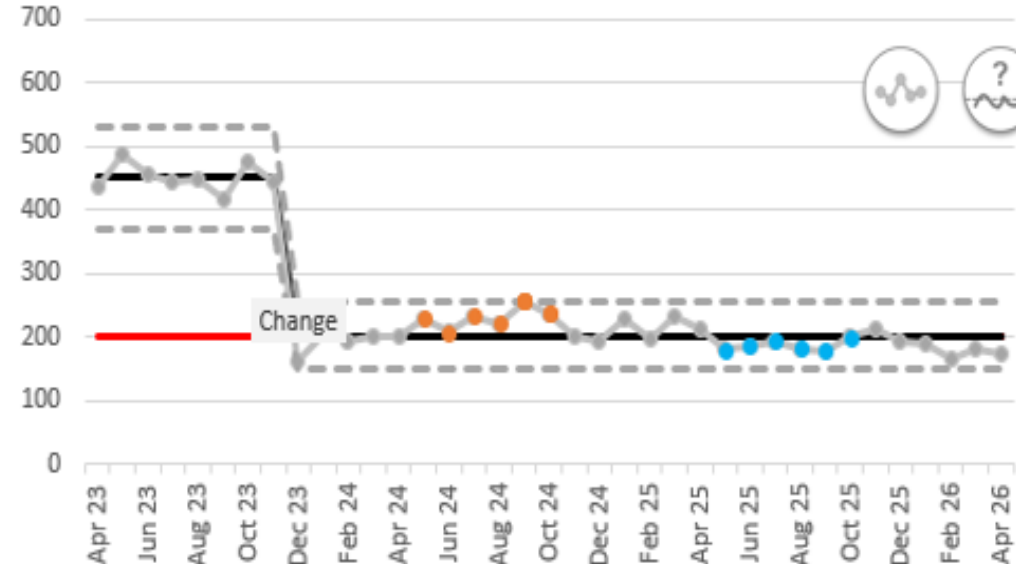
475

Assurance

Hit & miss target
subject to random
variation

CQC Domain : Safe

Patient Safety Incidents



Apr-26

174

Variance Type

Common cause
variation

Threshold

200

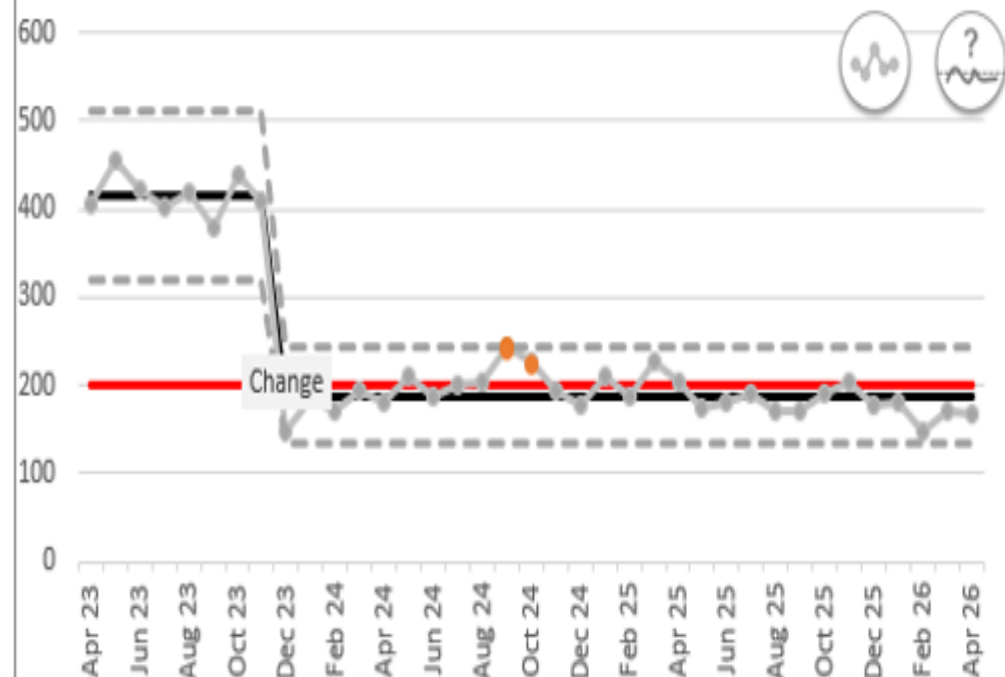
Assurance

Hit & miss target
subject to random
variation

No. of reported no and low harm patient safety incidents

CQC Domain : Safe

No. of reported no and low harm patient safety incidents



Apr-26

166

Variance Type

Common cause
variation

Threshold

200

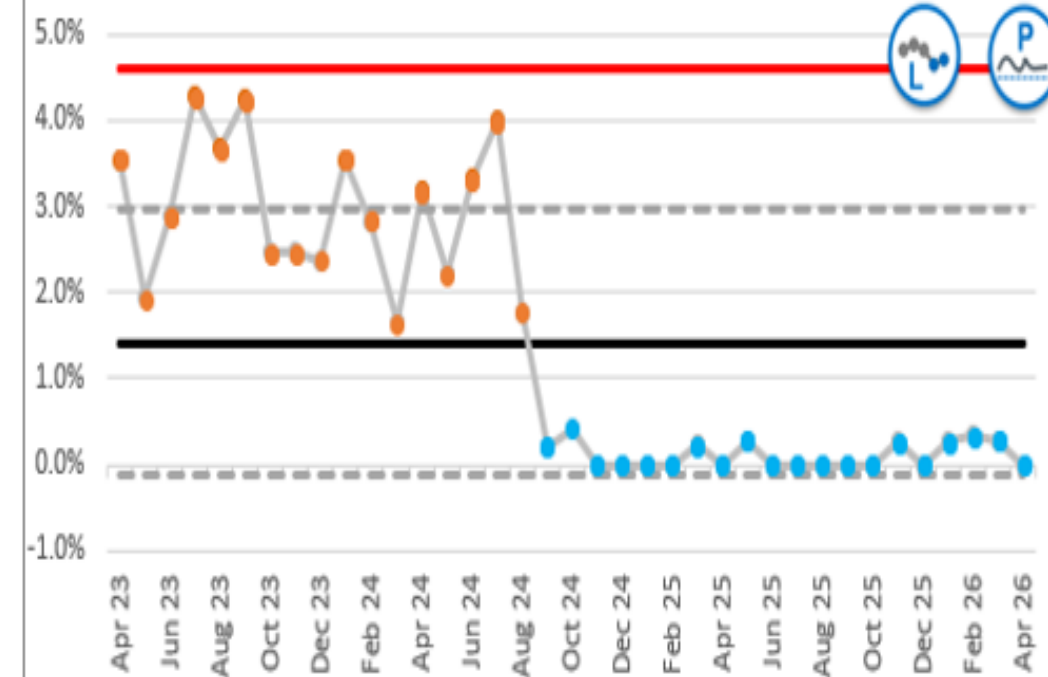
Assurance

Hit & miss target
subject to random
variation

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

CQC Domain : Responsive

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



Apr-26

0.0%

Variance Type

Special cause
variation - Improving

Threshold

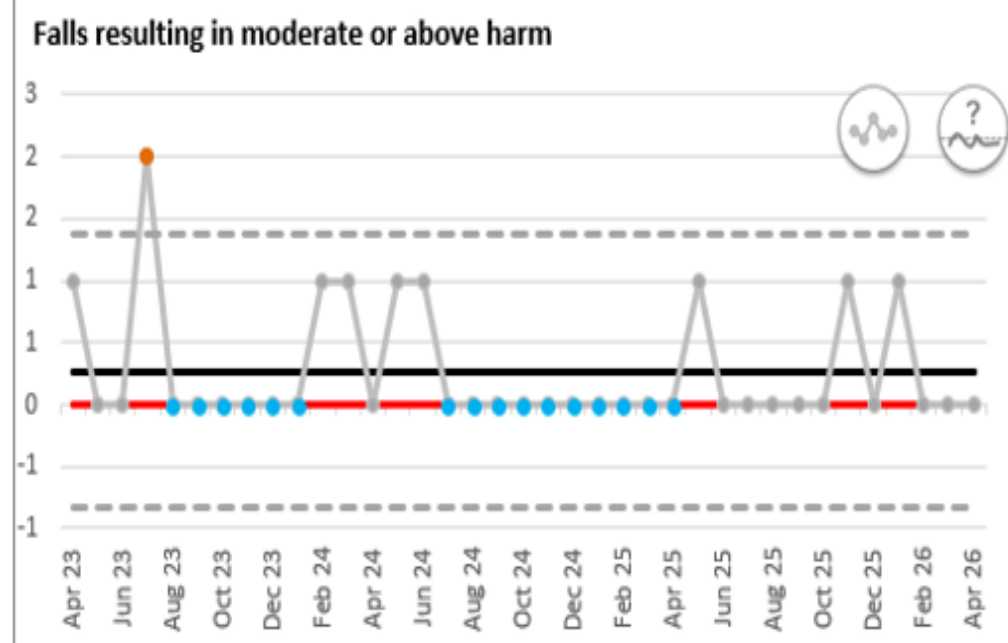
2.2%

Assurance

Consistently hit target

Falls resulting in moderate or above harm

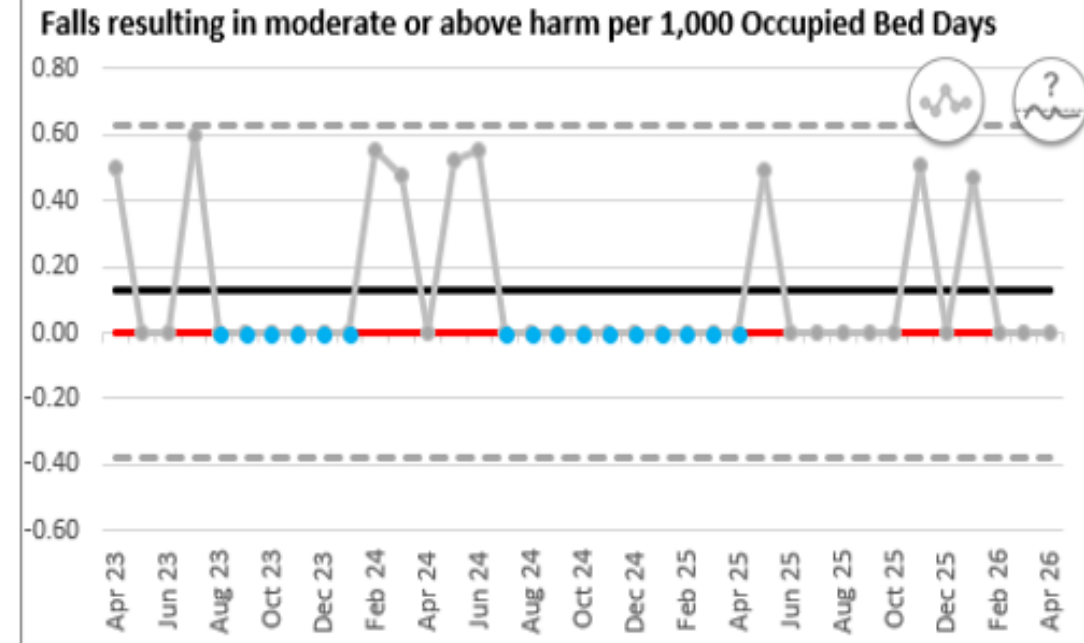
CQC Domain : Safe



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

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

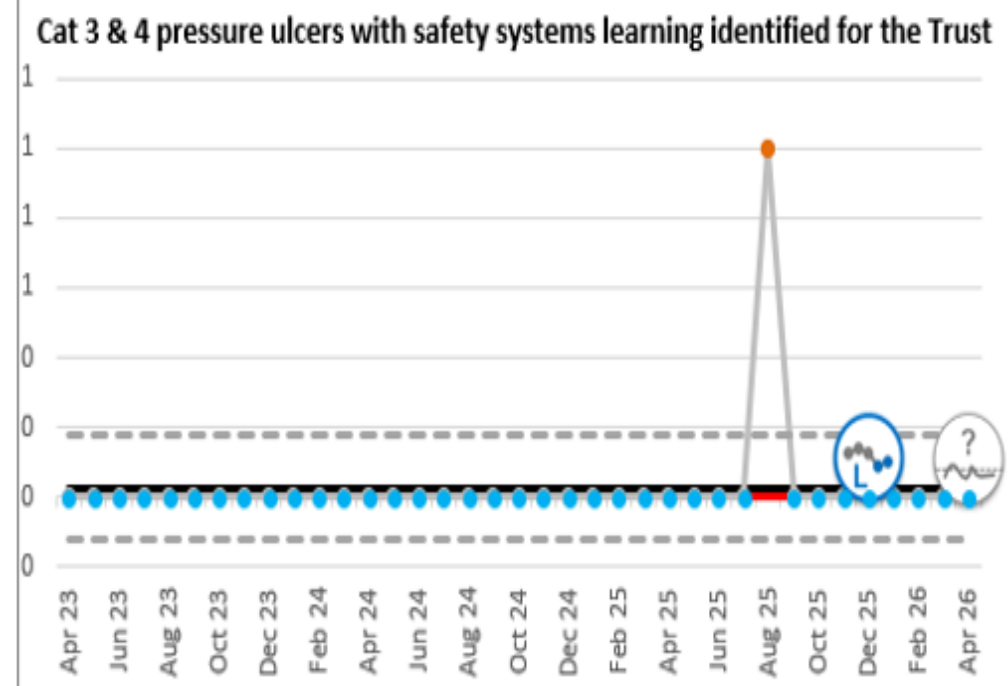
CQC Domain : Safe



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

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

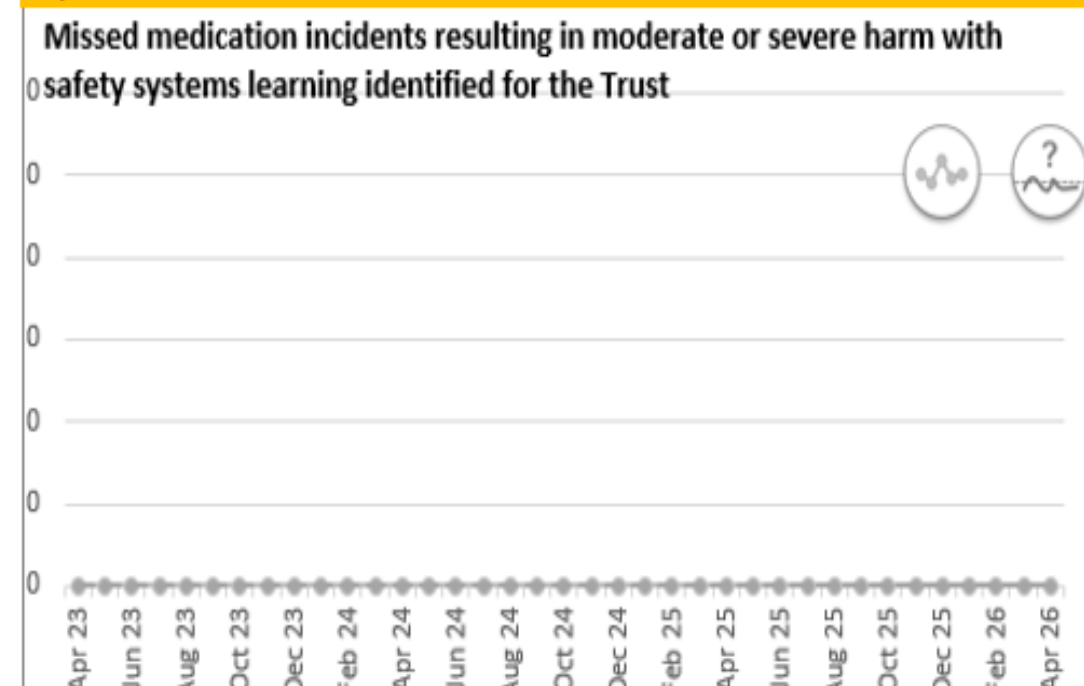
CQC Domain : Safe



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

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

CQC Domain : Safe



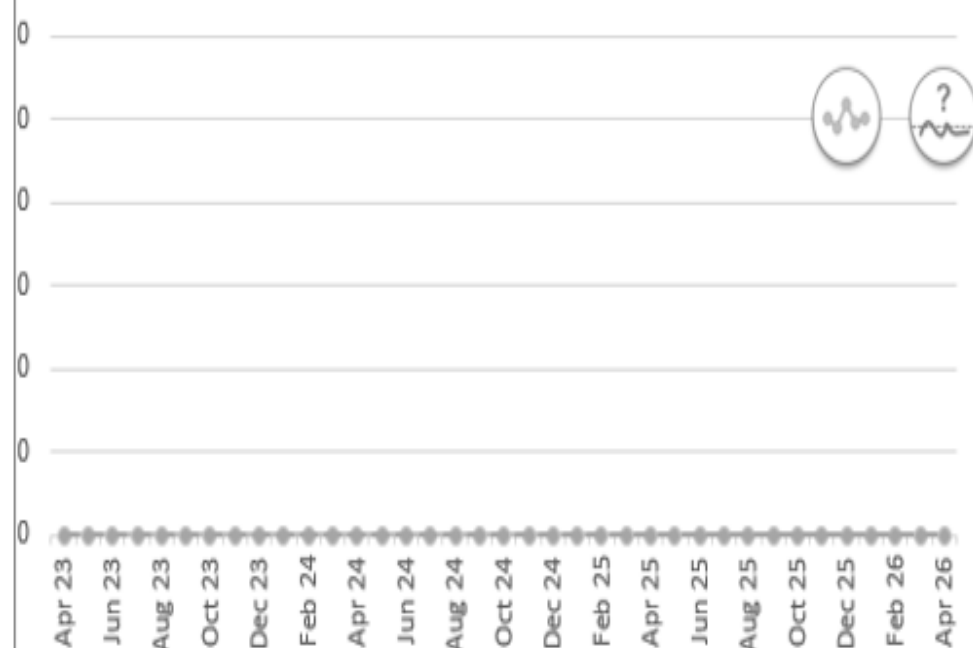
Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

MRSA infections with learning identified for the Trust

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

CQC Domain : Safe

MRSA infections with learning identified for the Trust



Apr-26

0

Variance Type

Common cause
variation

Threshold

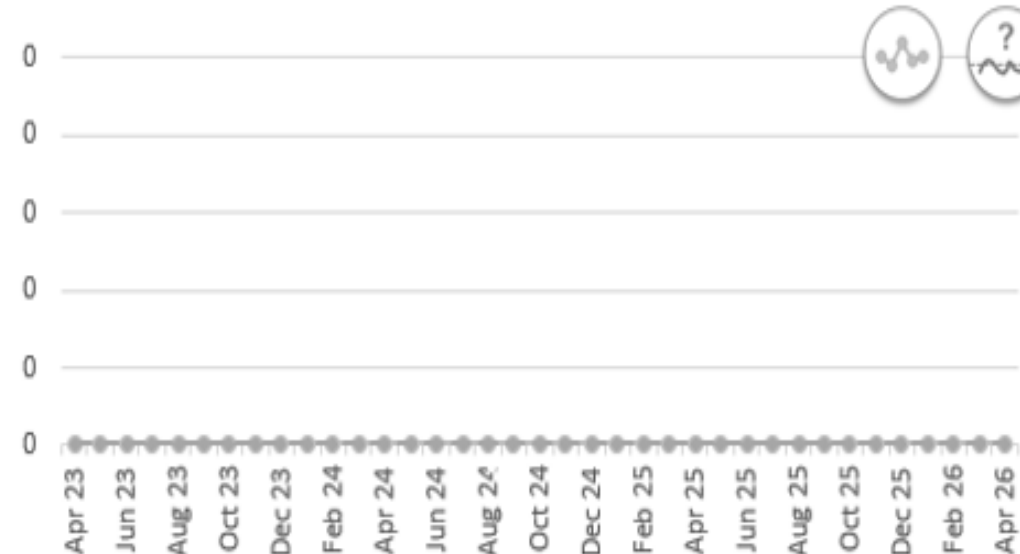
0

Assurance

Hit & miss target
subject to random
variation

CQC Domain : Safe

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



Apr-26

0

Variance Type

Common cause
variation

Threshold

0

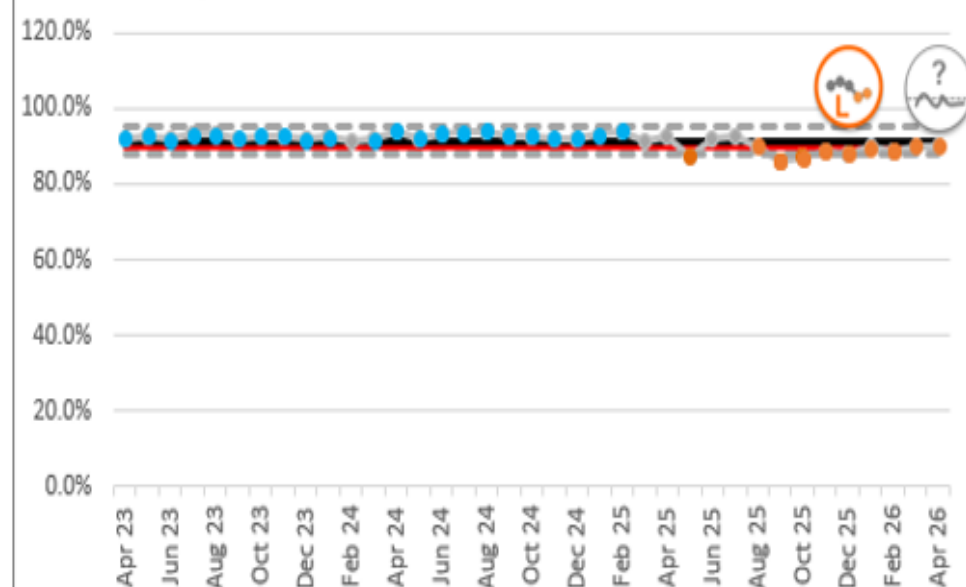
Assurance

Hit & miss target
subject to random
variation

FFT - % of People who would recommend our services

CQC Domain : Safe

FFT - % of People who would recommend our services



Apr-26

90.1%

Variance Type

Special cause
variation - Concerning

Threshold

≥90%

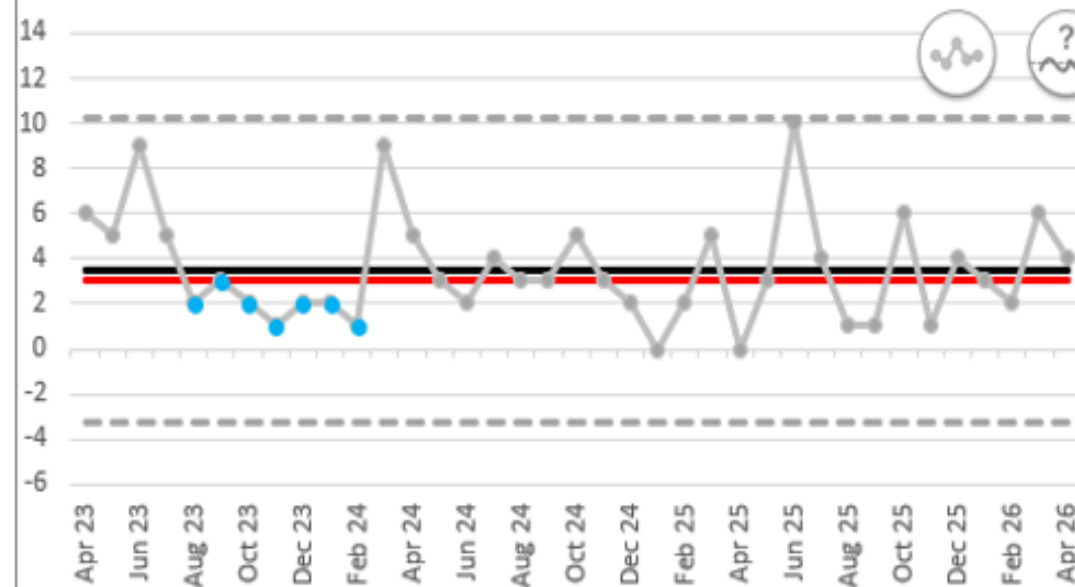
Assurance

Hit & miss target
subject to random
variation

Total Complaints Received

CQC Domain : Responsive

Total Complaints Received



Apr-26

4

Variance Type

Common cause
variation

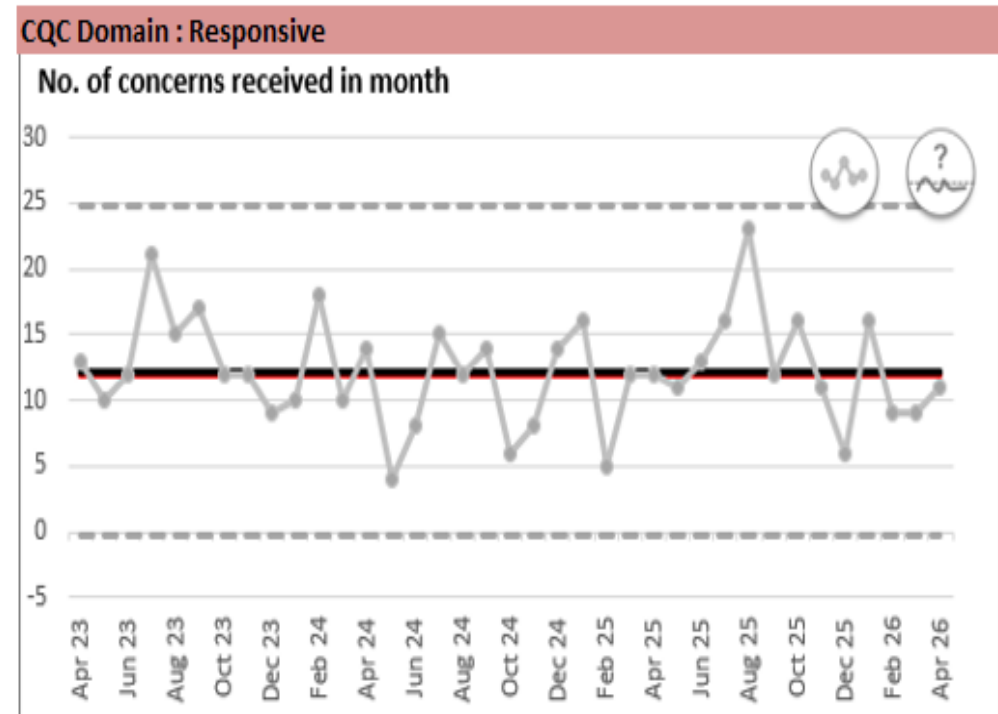
Threshold

3

Assurance

Hit & miss target
subject to random
variation

No. of concerns received in month



Apr-26
11
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

EMD Operations Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Apr 26	62.55%	≥57.63%			61.1%
Number of inpatients not meeting the Criteria to Reside	Apr 26	182	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Apr 26	735	≤0			651
Proportion of patients more than 12 hours in ED from time of arrival	Apr 26	18.07%	≤20.84%			18.3%
Ambulance Handovers: % < 30 mins	Apr 26	65.77%	≥95%			54.7%
Ambulance Handovers: % < 45 mins	Apr 26	85.64%	≥100%			73.4%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Apr 26	65.42%	≥63.88%			59.1%
Referral to Treatment - total open pathway waiting list	Apr 26	43867	≤46923			45238
Referral to Treatment - cases exceeding 52 weeks	Apr 26	283	≤429			1421
Referral to Treatment - cases waiting 78+ wks	Apr 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Mar 26	50	≤50			136
Cancer - Faster Diagnosis Standard	Mar 26	84.05%	≥77.73%			73.0%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Mar 26	91.83%	≥91.39%			91.4%
Cancer Waits - 62 days to treatment (monthly)	Mar 26	75.86%	≥75.51%			74.5%
Diagnostic Waiters, 6 weeks and over - DM01	Apr 26	92.04%	≥94.5%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Apr 26	186	≤79			168

Highlights

4-hours

Overall, 4-hour performance, including APH UTC, improved by 2 percentage points compared with April. Improvement in UTC workforce stability since Quarter 4 of 2025/26 has supported this recovery.

Reduction in 12-hour waits

The proportion of patients waiting more than 12 hours in ED reduced by 2 percentage points compared with the previous month, indicating some improvement in patient flow.

Ambulances handover

Although ambulance handover performance remains non-compliant against the standard, the Trust continues to perform comparatively strongly both nationally and across Cheshire and Merseyside.

Referral to Treatment

The Trust achieved caseload, 18-week referral, 52 and 65-week targets for April 2026.

Cancer 28-day standard

The Trust achieved the 28-day faster diagnosis standard in March 2026.

Areas of Concern

4-hours

Type 1 4-hour performance remains a significant concern and continues to be adversely affected by ED crowding. Attendances in April were 15% higher than in April 2025, increasing operational pressure across the department.

12-hour waits in ED

Despite improvement since April, 12-hour performance remains in the lower national quartile, indicating that sustained improvement is still required.

Cancer 31-day and 62-day standards

The Trust underachieved against the 31 and 62-day standards. 62-day performance is forecast to be achieved in April 2026.

Forward Look (Actions)

ED flow and handovers

Work will continue to focus on improving patient flow through ED, particularly during periods of peak demand in the late afternoon and early evening when ambulance arrivals often occur in surges. A system improvement plan is in place for 2026/27 focus on reducing attendances to ED with utilising out of hospital services that meet the patients needs other than the emergency department.

New ED go-live (UECUP completion)

The new ED pathway, scheduled to go live on 27th July, is expected to improve internal flow and reduce ambulance handover delays through a more effective department layout and process.

Operational focus

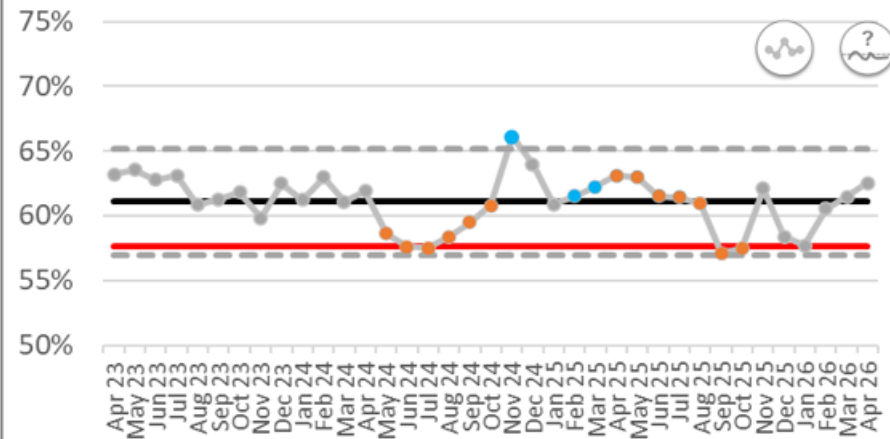
Continued emphasis will be placed on workforce stability, same-day emergency care pathways, and timely admission/discharge processes to support improvements in 4-hour and 12-hour performance. In line with the need to expand the offer of SDEC in the

		Trust Recent approval from the system for capital funding that will support the build of a dedicated SDEC unit. The works are planned for quarter 3, 2026/27 with a planned completion date for early 2027/28. RTT The positive impact of additional validation on Performance in March and April is recognised. Review of the capacity of the validation team is being undertaken which includes exploration of AI and RPA solutions in order to maintain levels of validation to support performance. Divisions are currently developing bids to access RTT related budget included in annual plans in order to deliver increased activity. Cancer Divisions have compiled cancer improvement plans for 2026/27 by tumour site to address pressures on 31-day performance and requirements to increase performance in line with agreed trajectories. Diagnostic performance Diagnostic performance in April was impacted by non-obstetric ultrasound. Weekly tracking of performance in May has seen this recover to above target levels. Non-obstetric ultrasound is high volume meaning small disruptions in service have an impact on overall performance. The Division is undertaking review to develop plans that more resilience to referral increases or staffing pressures.
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4-hour Accident and Emergency Target (including APH UTC)

CQC Domain : Responsive

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



Apr-26

62.6%

Variance Type

Common cause variation

Threshold

≥57.63%

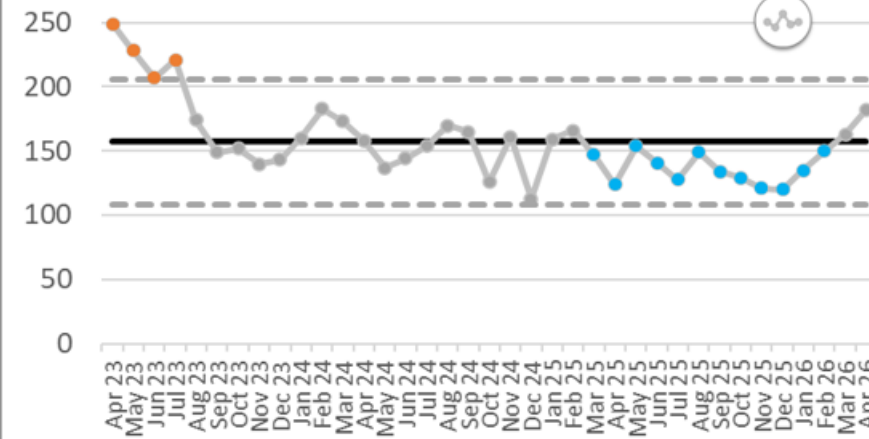
Assurance

Hit and miss target
subject to random
variation

Number of inpatients not meeting the Criteria to Reside

CQC Domain : Responsive

Number of inpatients not meeting the Criteria to Reside



Apr-26

182

Variance Type

Common cause variation

Threshold

-

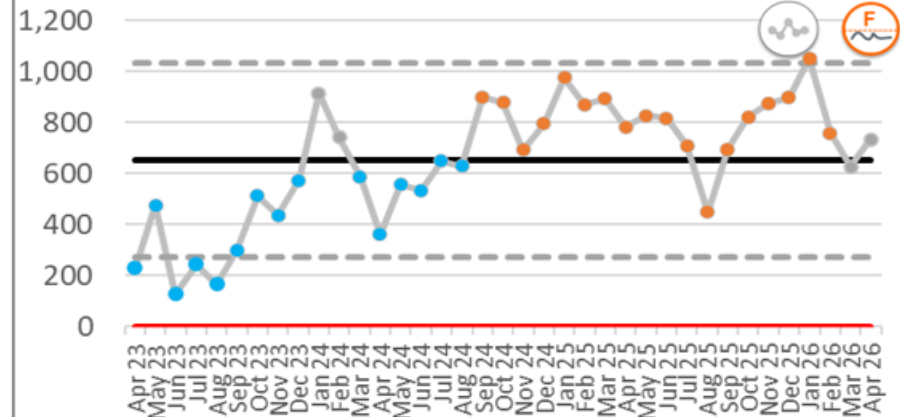
Assurance

Not applicable

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

CQC Domain : Responsive

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



Apr-26

735

Variance Type

Common cause variation

Threshold

≤0

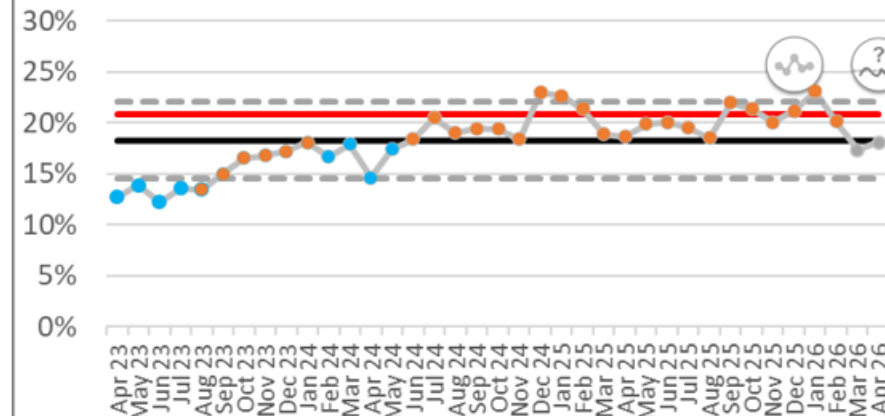
Assurance

Consistently fail target

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

CQC Domain : Responsive

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



Apr-26

18.1%

Variance Type

Common cause variation

Threshold

≤20.84%

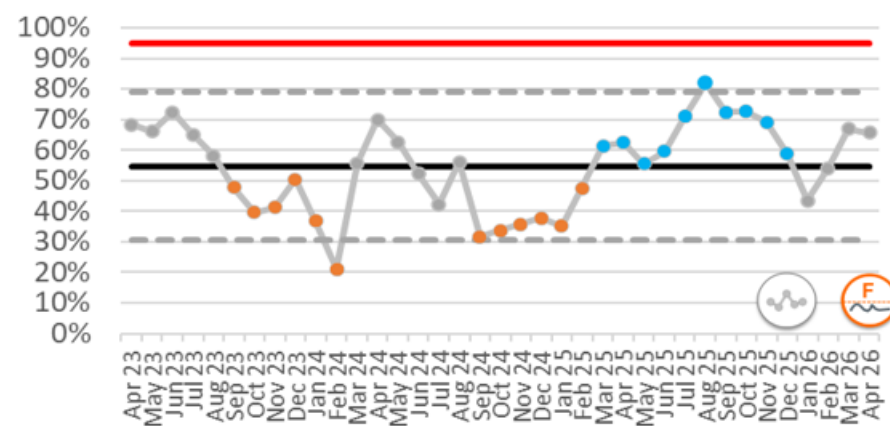
Assurance

Hit and miss target
subject to random
variation

Ambulance handover % < 30 minutes

CQC Domain : Responsive

Ambulance Handovers: % < 30 mins



Apr-26

65.8%

Variance Type

Common cause variation

Threshold

≥95%

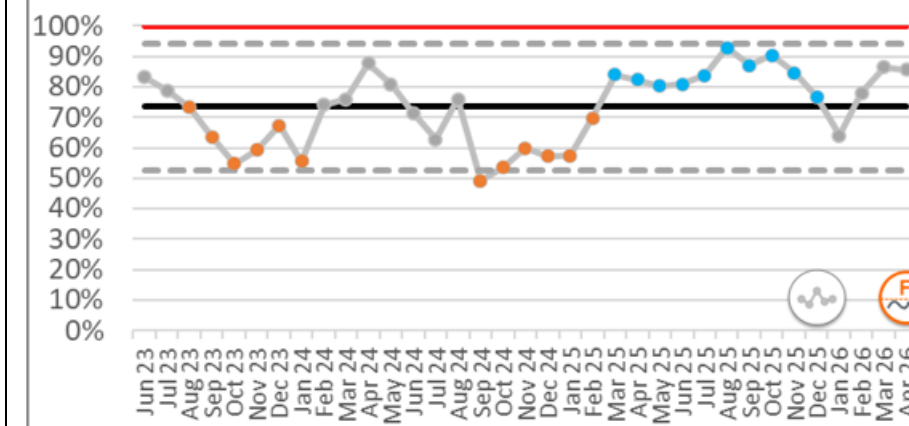
Assurance

Consistently fail target

Ambulance handover % < 45 minutes

CQC Domain : Responsive

Ambulance Handovers: % < 45 mins



Apr-26

85.6%

Variance Type

Common cause variation

Threshold

≥100%

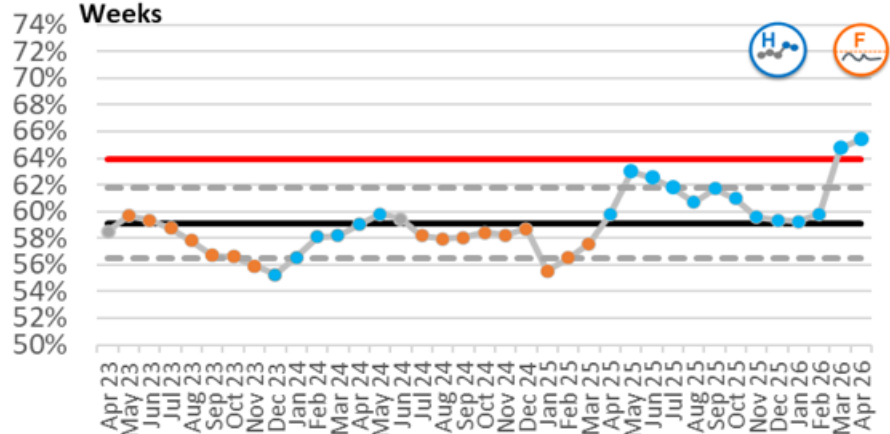
Assurance

Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

CQC Domain : Responsive

18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Apr-26

65.4%

Variance Type

Special cause improving variation

Threshold

≥63.88%

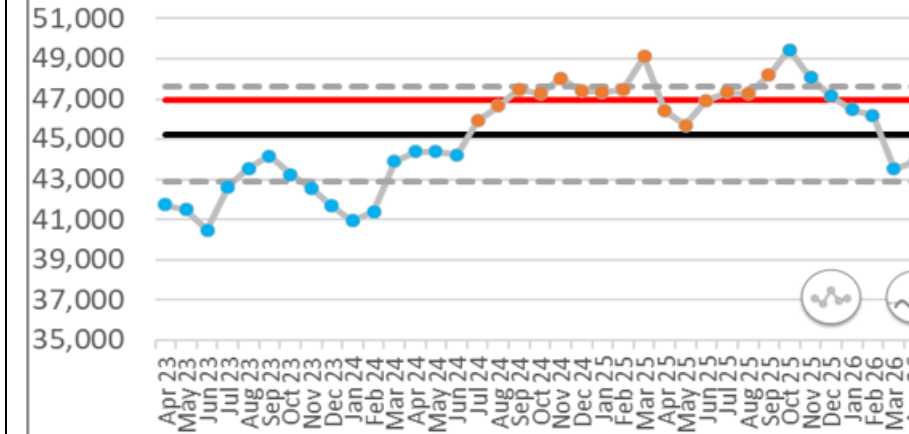
Assurance

Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive

Referral to Treatment - total open pathway waiting list



Apr-26

43867

Variance Type

Common cause variation

Threshold

≤46923

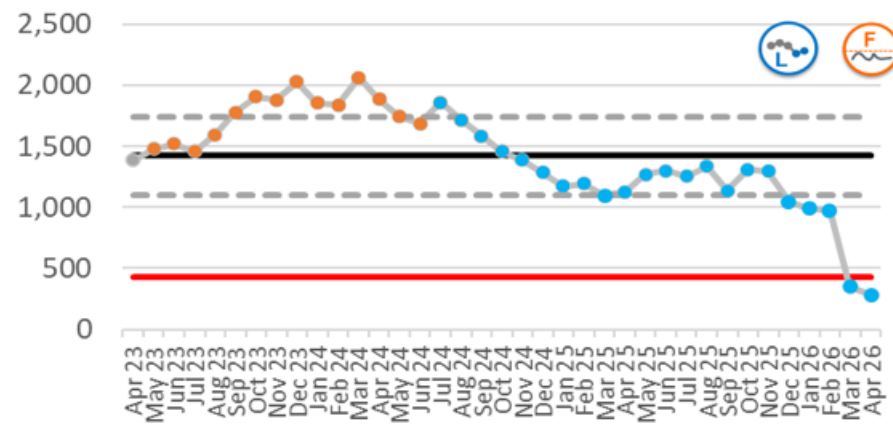
Assurance

Hit and miss target subject to random variation

Referral to Treatment – cases exceeding 52 weeks

CQC Domain : Responsive

Referral to Treatment - cases exceeding 52 weeks



Apr-26

283

Variance Type

Special cause improving variation

Threshold

≤429

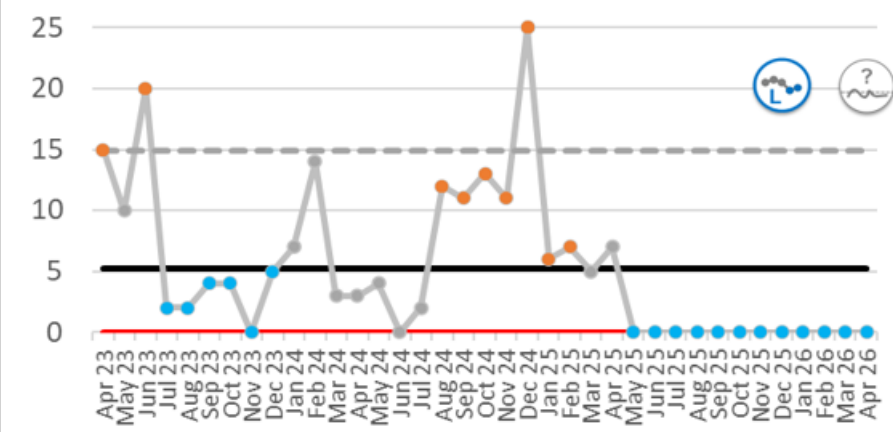
Assurance

Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

CQC Domain : Responsive

Referral to Treatment - cases waiting 78+ wks



Apr-26

0

Variance Type

Special cause improving variation

Threshold

≤0

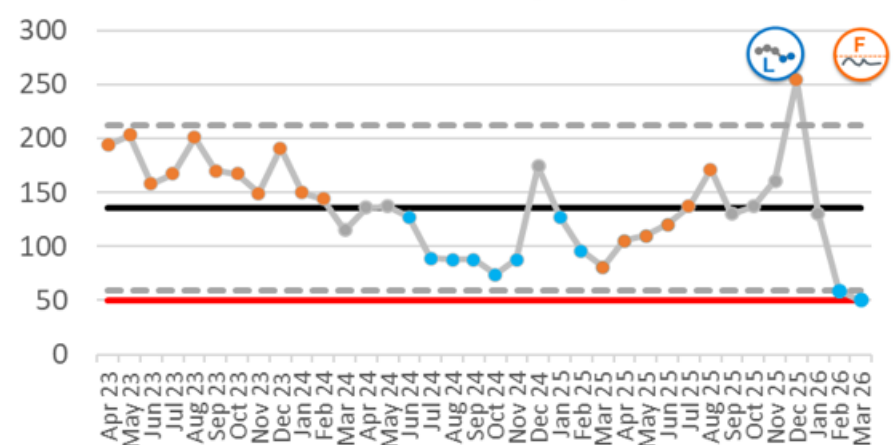
Assurance

Hit and miss target subject to random variation

Cancer Waits – reduce number waiting 62 days +

CQC Domain : Responsive

Cancer Waits - reduce number waiting 62 days +



Mar-26

50

Variance Type

Special cause improving variation

Threshold

≤50

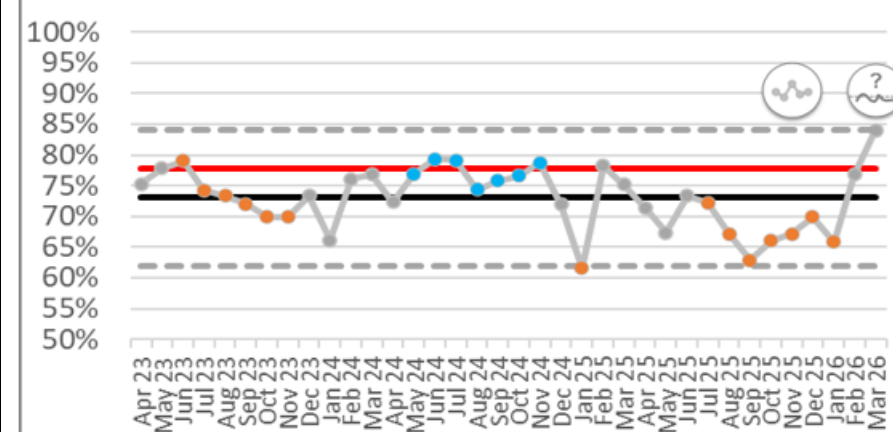
Assurance

Consistently fail target

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive

Cancer - Faster Diagnosis Standard



Mar-26

84.1%

Variance Type

Common cause variation

Threshold

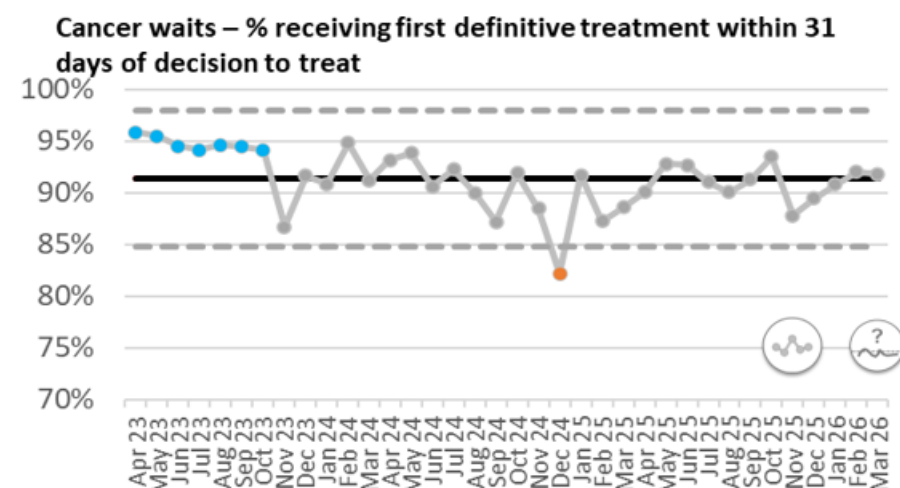
≥77.73%

Assurance

Consistently fail target

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

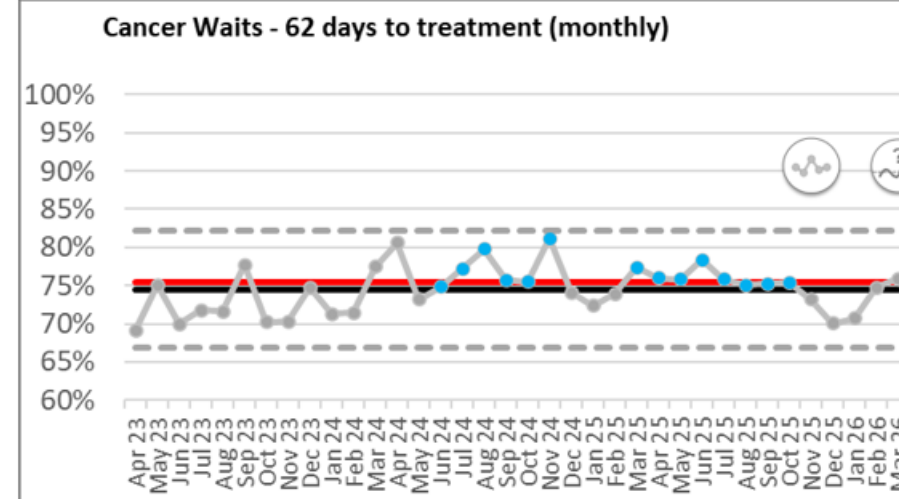
CQC Domain : Responsive



Mar-26
91.8%
Variance Type
Common cause variation
Threshold
≥91.39%
Assurance
Hit and miss target subject to random variation

Cancer waits - 62 days to treatment (monthly)

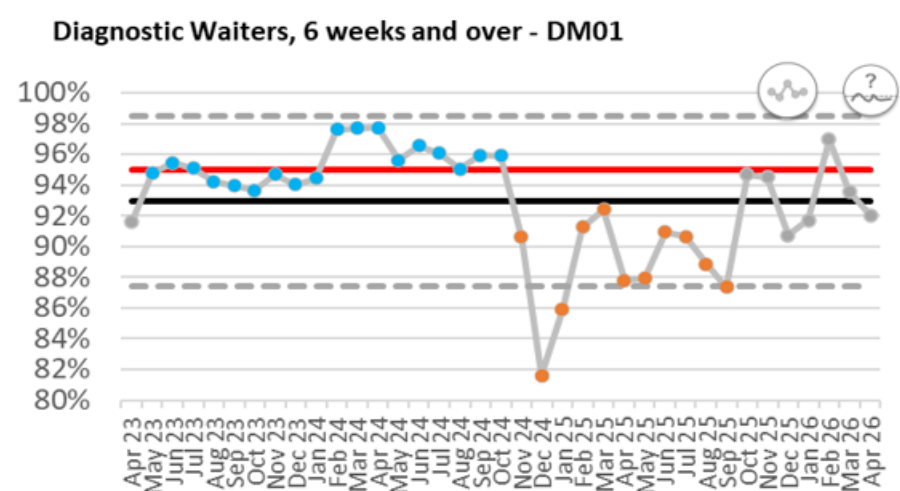
CQC Domain : Responsive



Mar-26
75.9%
Variance Type
Common cause variation
Threshold
≥75.51%
Assurance
Hit and miss target subject to random variation

Diagnostic Waiters – 6 weeks and over – DM01

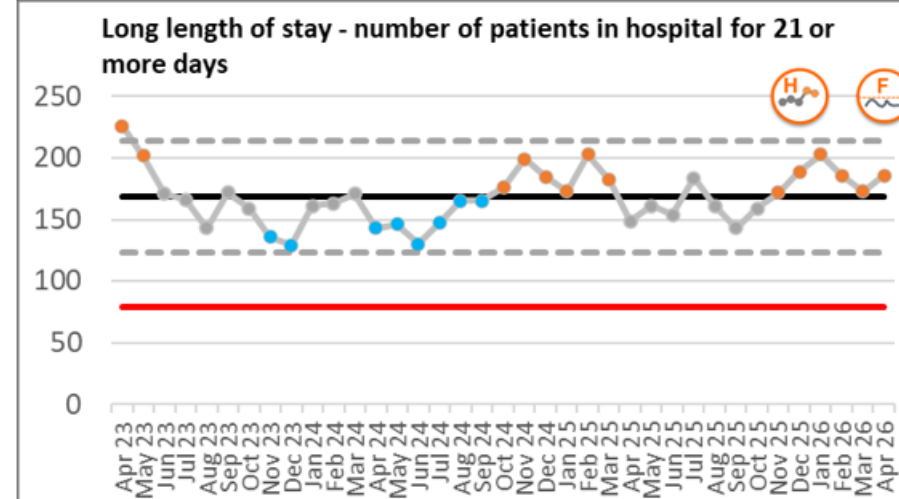
CQC Domain : Responsive



Apr-26
92.0%
Variance Type
Common cause variation
Threshold
≥94.5%
Assurance
Hit and miss target subject to random variation

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

CQC Domain : Effective



Apr-26
186
Variance Type
Special cause concerning variation
Threshold
≤79
Assurance
Consistently fail target

Operational Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
WIC & UTC Attendances seen within 4 hrs	Apr 26	96.8%	95.0%			96.1%
CICC Occupancy Rate (Commissioned Beds)	Apr 26	97.3%	92.0%			92.2%
CICC Median LoS (Active Beds Daily Snapshot)	Apr 26	16.3	21.0			18.7
Urgent Community Response - 2 hours	Apr 26	88.3%	70.0%			87.5%
GPOOH - UCAT Response Times (60 min response)	Apr 26	98.4%	98.0%			98.7%
GPOOH - UCAT Response Times (15 min response)	Apr 26	73.4%	65.0%			68.4%
GPOOH - UCAT Response Times (30 min response)	Apr 26	91.5%	90.0%			92.8%
GPOOH - CAS Response Times (20 min response)	Apr 26	69.4%	75.0%			69.5%
GPOOH - CAS Response Times (2hr response)	Apr 26	68.6%	90.0%			69.8%
GPOOH - NHS111 Response Times	Apr 26	66.4%	75.0%			60.2%
RTT - % of Patients Seen Within 18 Weeks	Apr 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	Apr 26	99.5%	99.0%			100.0%
UTC Attendances seen within 4 hrs	Apr 26	96.9%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	Apr 26	95.9%	95.0%			94.4%
Eastham Attendances seen within 4 hrs	Apr 26	98.6%	95.0%			93.6%

Highlights

Urgent care access performance remained strong across most sites, with attendances generally seen within the 4-hour standard.

WIC/UTC 4-hour performance continue to show sustained delivery

UCAT response time performance was maintained across key priority standards.

Community and intermediate care beds show a positive position, including occupancy and length of stay

Areas of Concern

CAS Response Times

CAS response times remain below the expected standard and continue to require close operational oversight. Performance is being affected by sustained pressure on out-of-hours capacity and demand, which is limiting the ability to consistently allocate dedicated GP resource to these cases. In practice, clinicians are prioritising the most acute cases first, meaning that some lower-acuity CAS cases may wait longer, although this is managed within a clinically safe process. Shift managers and GP coordinators continue to review caseloads to mitigate risk and support timely clinical response wherever possible.

Response time for NHS 111

NHS 111 response times continue to be impacted by the ongoing focus on emergency department streaming and increasing face-to-face capacity within UTC/GPOOH as part of the wider unplanned care improvement plan. While this work supports system flow and reduces pressure elsewhere, it has created competing demands on clinical resource, with an impact timeliness for other case types. Clinical teams and shift managers are actively managing this through triage, real-time workforce deployment, and risk-based prioritisation to maintain patient safety.

Forward Look (Actions)

Plans to address the ongoing performance challenges include a review of the workforce model to ensure the balance between ED streaming, CAS, and NHS 111 demand is aligned against live activity and risk.

Strengthen ringfenced GP capacity for CAS response periods where feasible, particularly during predictable peaks in out-of-hours demand.

Undertake demand and acuity analysis of CAS and NHS 111 cases to identify opportunities for pathway redesign, skill mix optimisation, or alternative clinical handling.

Monitor the impact of ED streaming on wider service responsiveness and report trade-offs transparently through routine performance review.

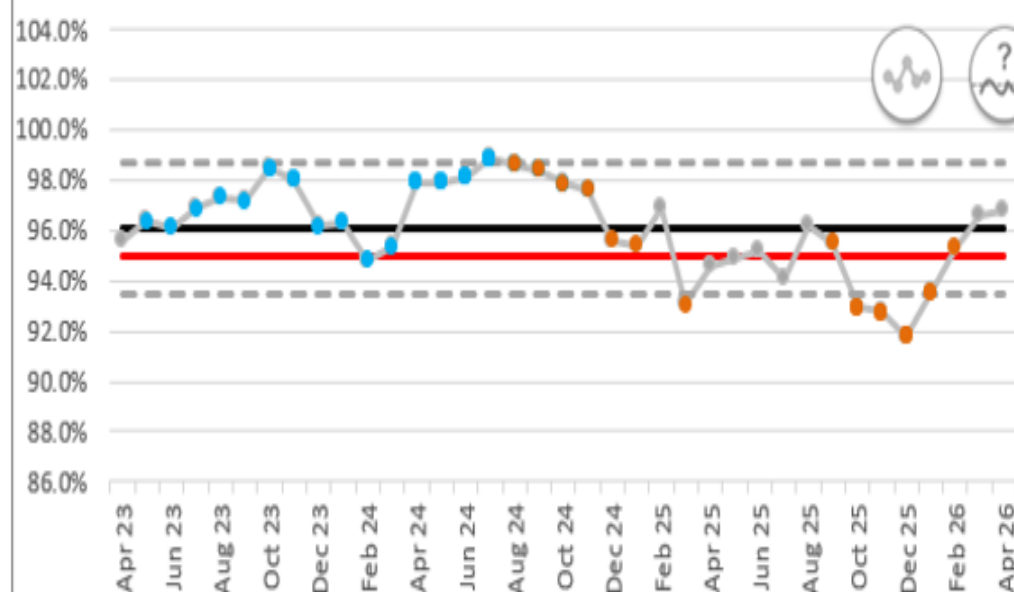
Develop targeted improvement actions focused on reducing delays in lower-performing response categories while maintaining safe prioritisation of higher-acuity patients.

Several of the actions are part of the wider urgent and Emergency Care Improvement plan and the review of the model for the urgent care services.

WIC & UTC Attendances seen within 4 hrs

CQC Domain : Responsive

WIC & UTC Attendances seen within 4 hrs



Apr-26

96.8%

Variance Type

Common cause
variation

Threshold

≥95%

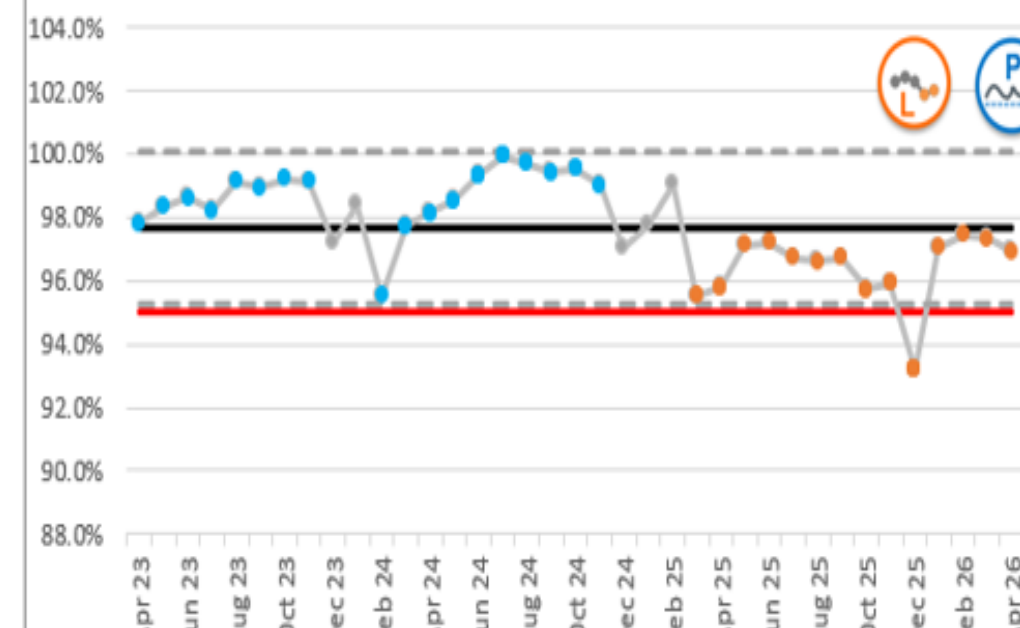
Assurance

Hit & miss target subject
to random variation

UTC Attendances seen within 4 hrs

CQC Domain : Responsive

UTC Attendances seen within 4 hrs



Apr-26

96.9%

Variance Type

Special cause
variation - Concerning

Threshold

≥95%

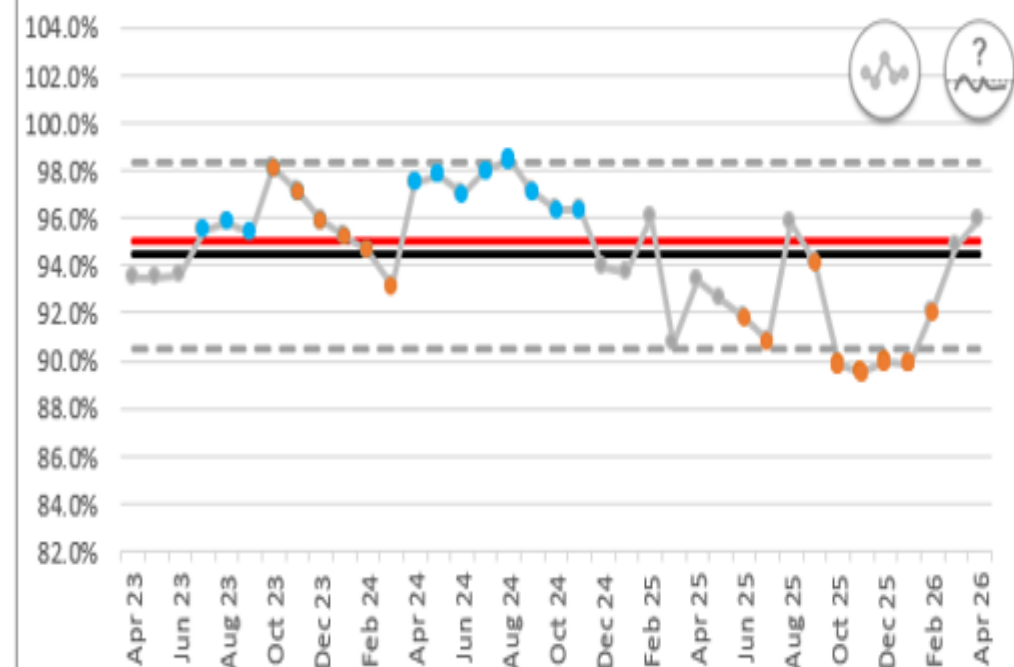
Assurance

Consistently hit target

VCHC Attendances seen within 4 hrs

CQC Domain : Responsive

VCHC Attendances seen within 4 hrs



Apr-26

95.9%

Variance Type

Common cause
variation

Threshold

≥95%

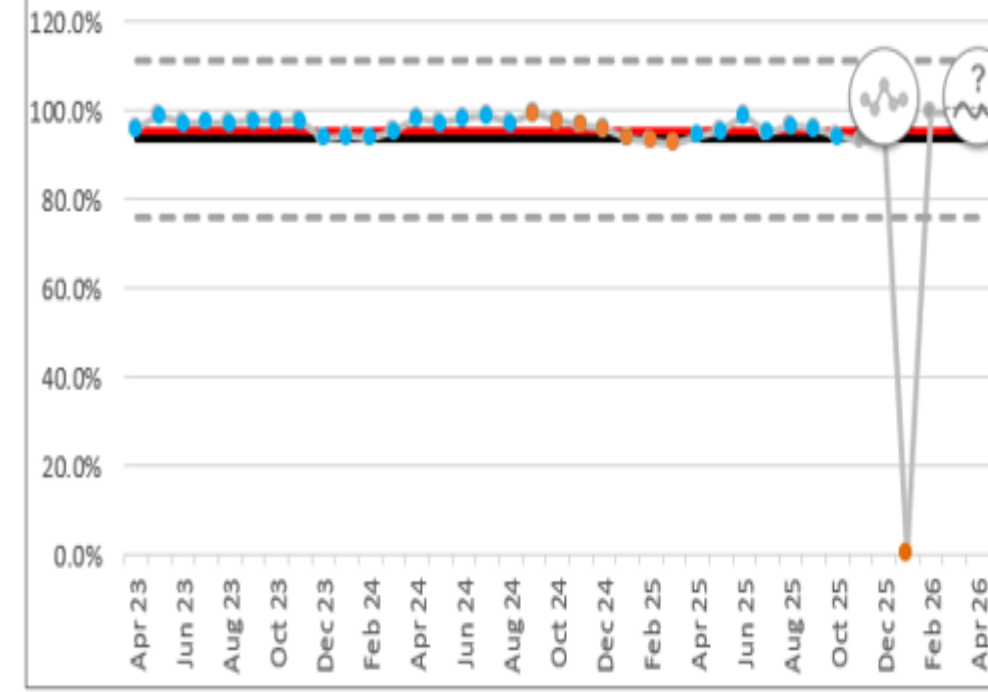
Assurance

Hit & miss target
subject to random
variation

Eastham Attendances seen within 4 hrs

CQC Domain : Responsive

Eastham Attendances seen within 4 hrs



Apr-26

98.6%

Variance Type

Common cause
variation

Threshold

≥95%

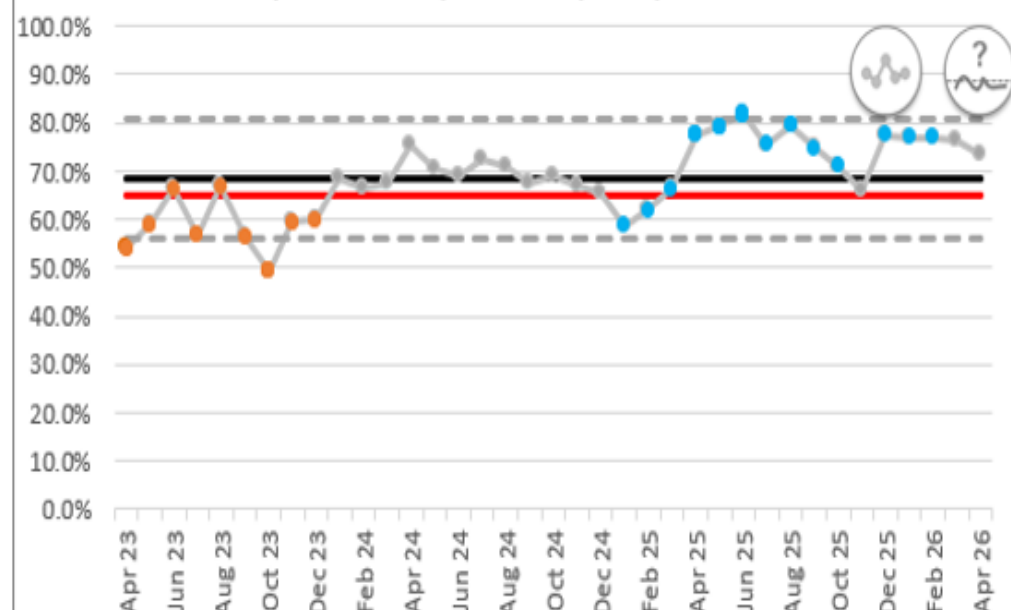
Assurance

Hit & miss target subject
to random variation

GPOOH - UCAT Response Times (15 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (15 min response)



Apr-26

73.4%

Variance Type

Common cause
variation

Threshold

≥65%

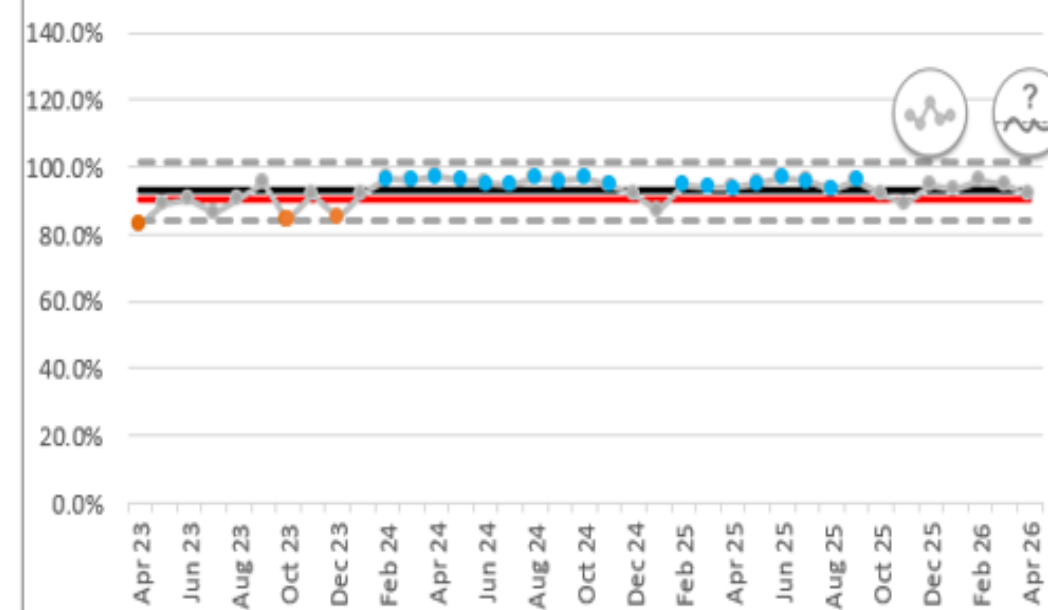
Assurance

Hit & miss target subject
to random variation

GPOOH - UCAT Response Times (30 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (30 min response)



Apr-26

91.5%

Variance Type

Common cause
variation

Threshold

≥90%

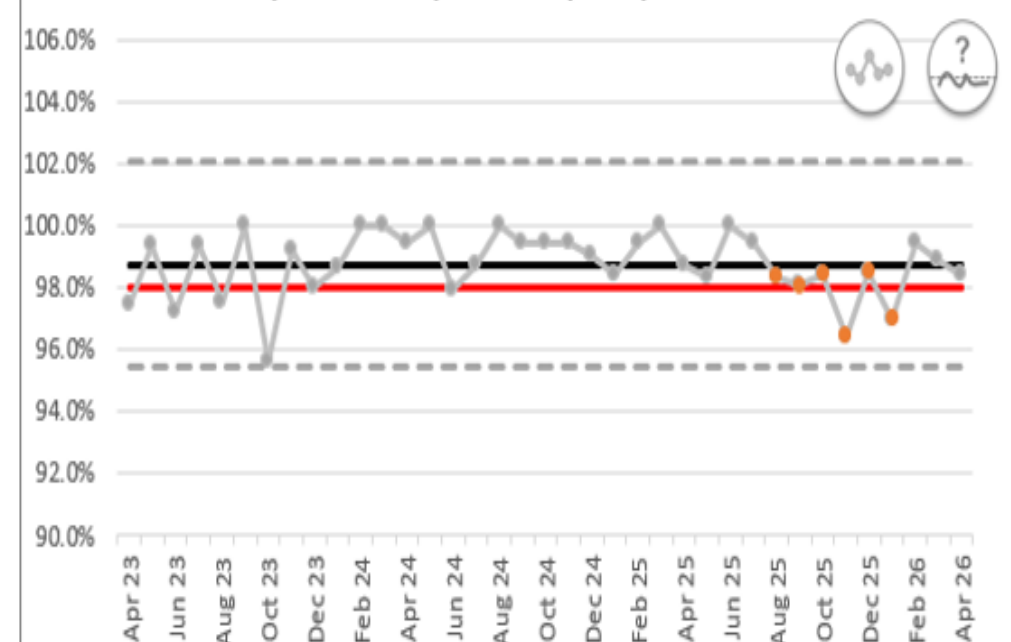
Assurance

Hit & miss target subject
to random variation

GPOOH - UCAT Response Times (60 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (60 min response)



Apr-26

98.4%

Variance Type

Common cause
variation

Threshold

≥98%

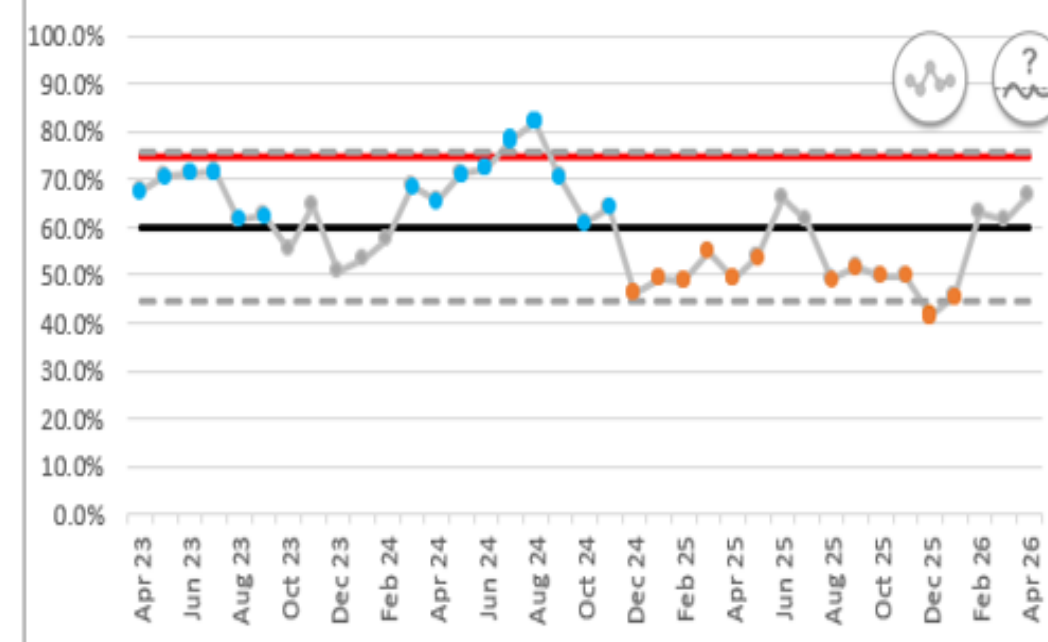
Assurance

Hit & miss target subject
to random variation

GPOOH - NHS 111 Response Times

CQC Domain : Responsive

GPOOH - NHS111 Response Times



Apr-26

66.4%

Variance Type

Common cause
variation

Threshold

≥75%

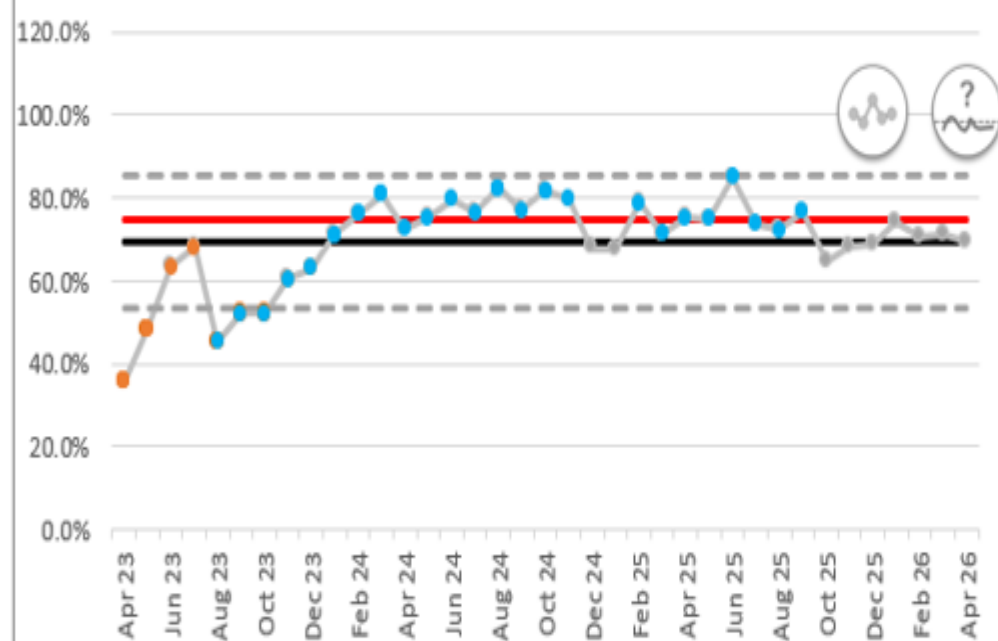
Assurance

Hit & miss target subject
to random variation

GPOOH - CAS Response Times (20 min response)

CQC Domain : Responsive

GPOOH - CAS Response Times (20 min response)

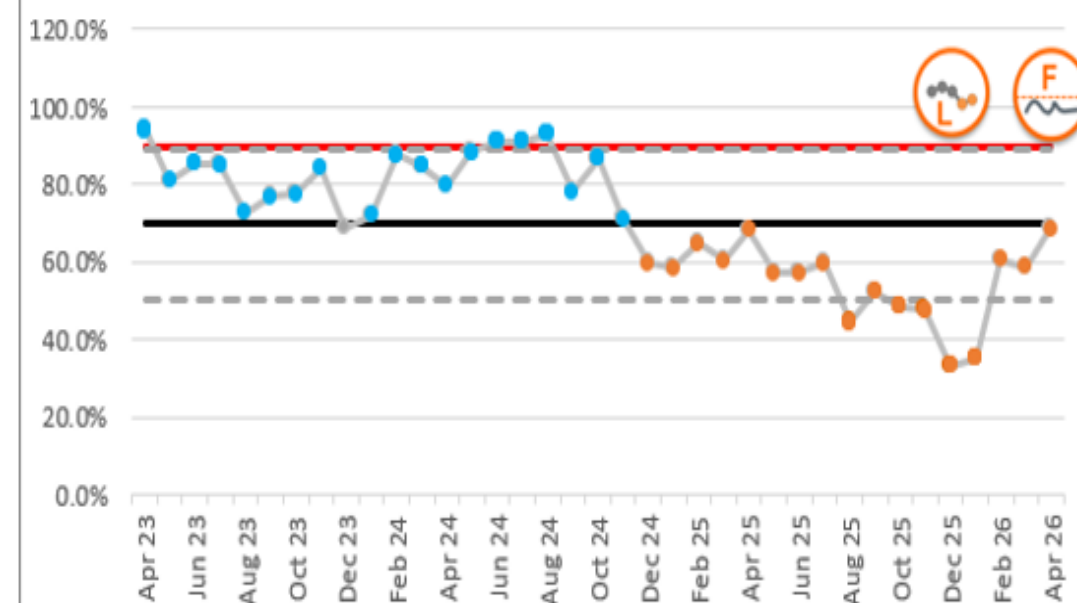


Apr-26
69.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

CQC Domain : Responsive

GPOOH - CAS Response Times (2hr response)

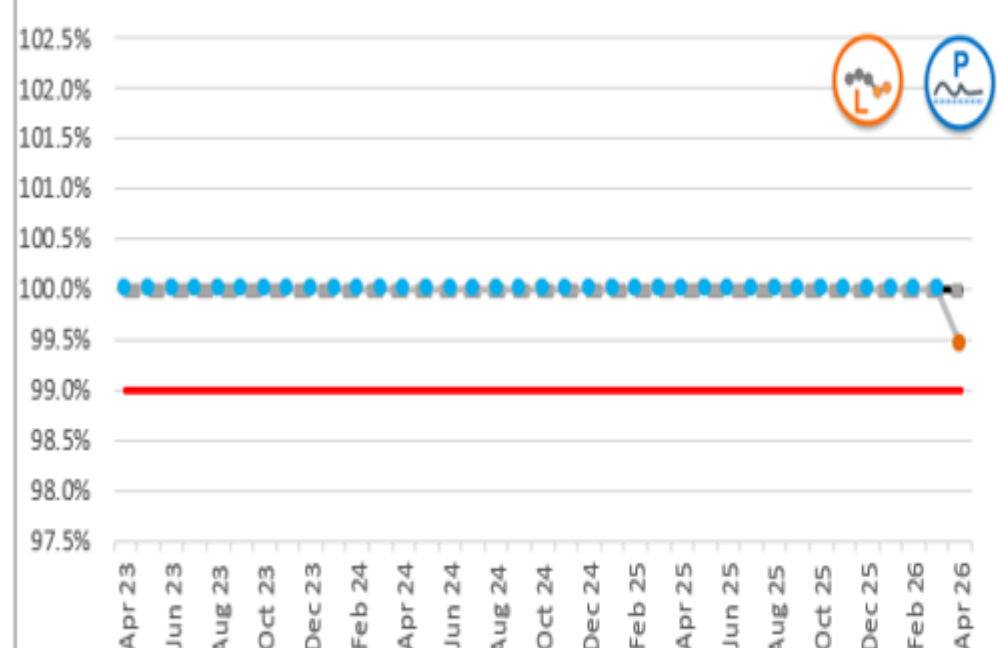


Apr-26
68.6%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Consistently fail target

DM01 - % of Patients Waiting under 6 weeks

CQC Domain : Responsive

DM01 - % of Patients Waiting with a Wait Under 6 weeks

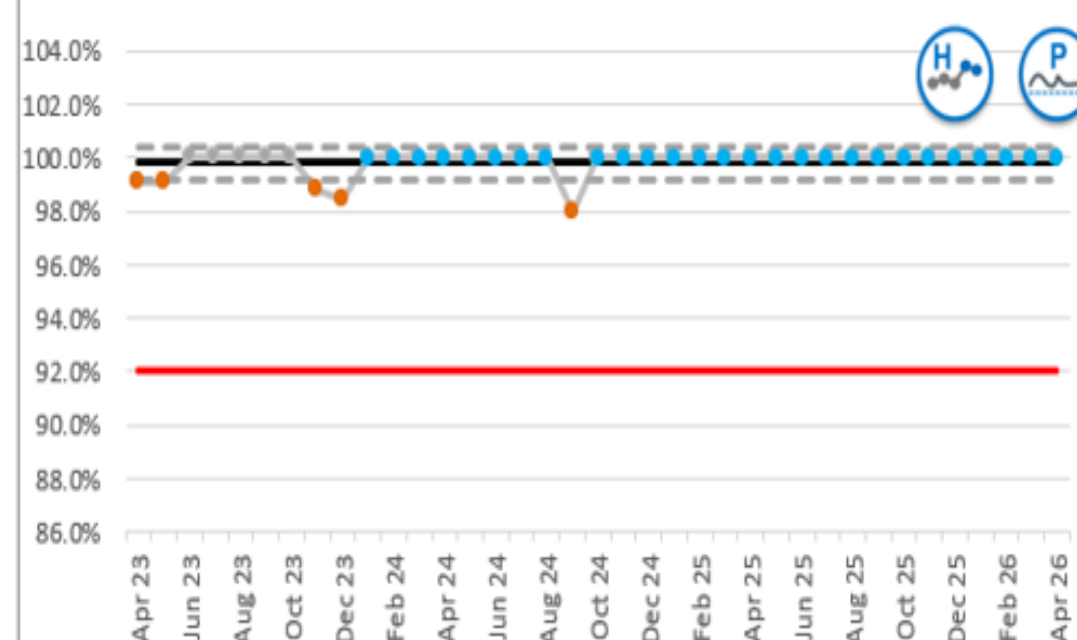


Apr-26
99.5%
Variance Type
Special cause variation - Concerning
Threshold
≥99%
Assurance
Performance consistently achieves the target

RTT - % of Patients seen within 18 Weeks

CQC Domain : Responsive

RTT - % of Patients Seen Within 18 Weeks

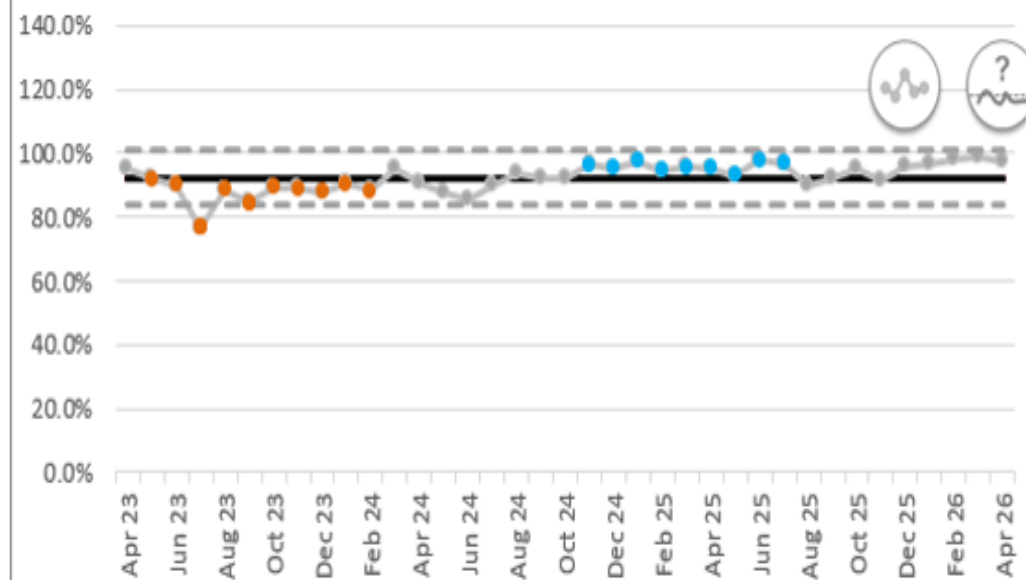


Apr-26
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target

CICC Occupancy Rate (Commissioned Beds)

CQC Domain : Responsive

CICC Occupancy Rate (Commissioned Beds)



Apr-26

97.3%

Variance Type

Common cause
variation

Threshold

≥92%

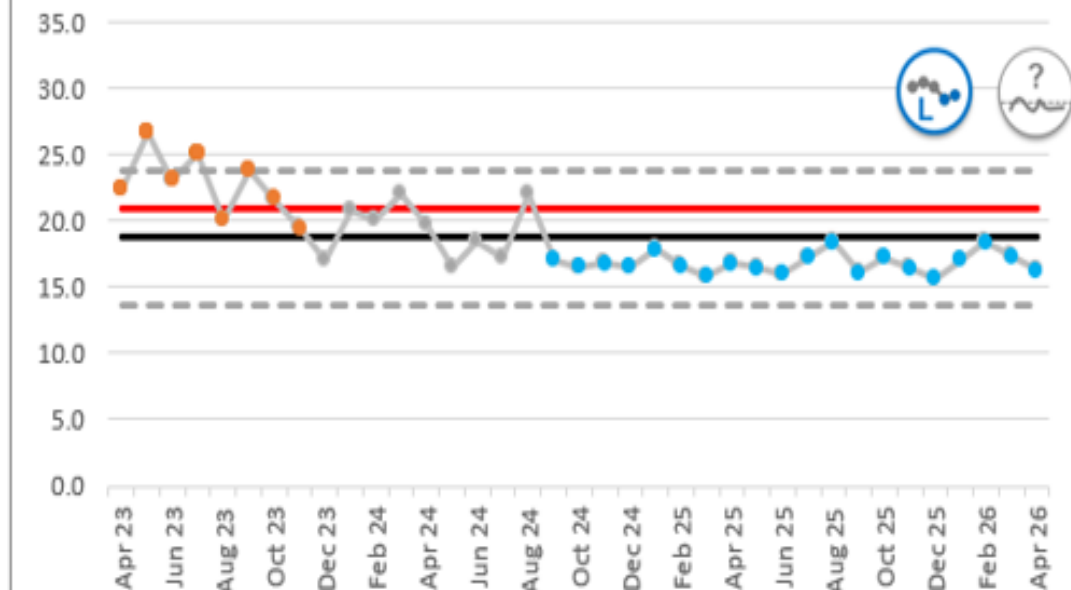
Assurance

Hit & miss target subject
to random variation

CICC Median LoS (Active Beds Daily Snapshot)

CQC Domain : Responsive

CICC Median LoS (Active Beds Daily Snapshot)



Apr-26

16

Variance Type

Special cause
variation - Improving

Threshold

21

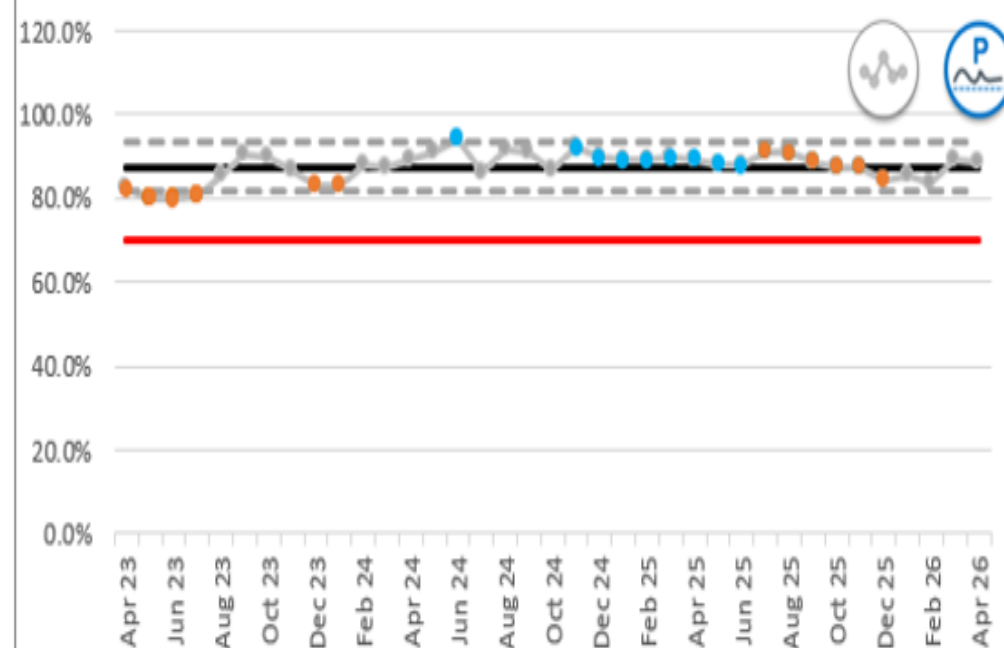
Assurance

Hit & miss target
subject to random
variation

Urgent Community Response - 2 hours

CQC Domain : Responsive

Urgent Community Response - 2 hours



Apr-26

88.3%

Variance Type

Common cause
variation

Threshold

≥70%

Assurance

Consistently hit target

Waiting Lists

0-19/25 Performance

Waiting list movement in Month - April 2026				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	61% (-13%)	92% (-4%)	99% (-1%)	574 (-2)
Specialist Medical	85% (-5%)	100% (0%)	100% (0%)	3002 (555)
Specialist Medical - Dental	45% (3%)	68% (10%)	84% (12%)	274 (10)
Therapies	52% (-7%)	78% (-1%)	89% (0%)	4691 (132)

0-19/25 Services - April 26								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	89.1%	89.1%	90.9%	90.9%	90.7%	90.7%	92.2%	92.2%
12 month reviews	88.1%	88.1%	93.8%	93.8%	92.9%	92.9%	93.3%	93.3%
2.5 year reviews	88.4%	88.4%	88.5%	88.5%	94.0%	94.0%	95.1%	95.1%
Breastfeeding 6-8 weeks	61.5%	61.5%	35.4%	35.4%	37.4%	37.4%	44.1%	44.1%

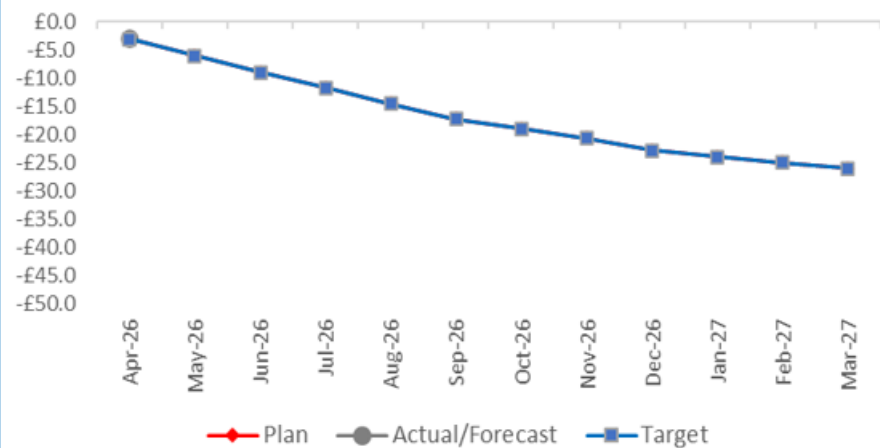
CFO Finance Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Apr 26	1.5%	≤1%	?	?	2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

I&E Position

CQC Domain : Use of Resources

I&E Position



Apr-26

-£2.9m

Variance Type

Position doesn't meet the plan

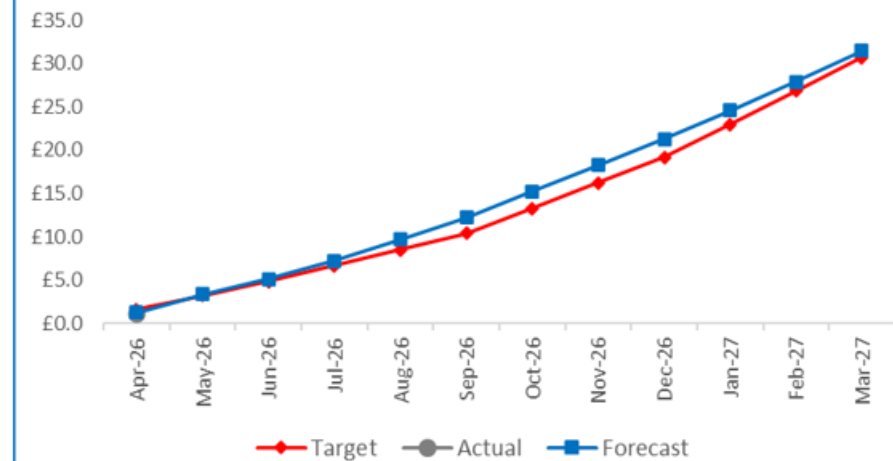
Target

-£3.0m

Cumulative CIP

CQC Domain : Use of Resources

Cumulative CIP



Apr-26

£1.2m

Variance Type

Position meets the plan

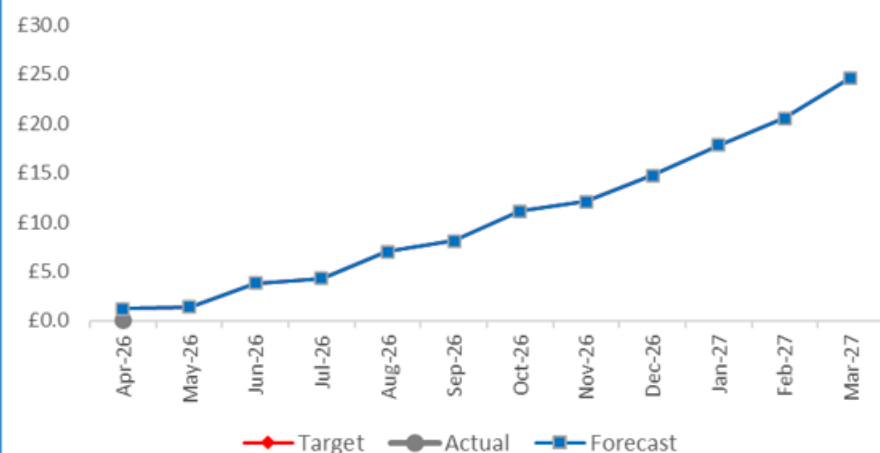
Target

£1.6m

Capital Position

CQC Domain : Use of Resources

Capital Expenditure



Apr-26

£0.1m

Variance Type

Position meets the plan

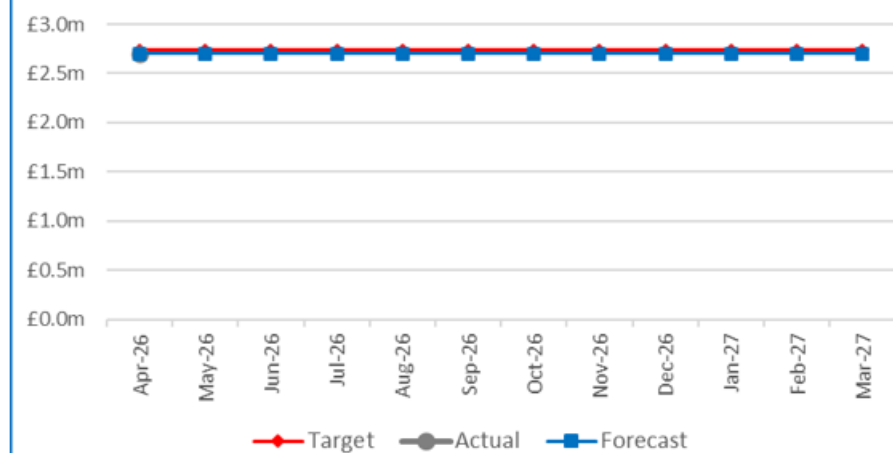
Target

£1.2m

Cash position

CQC Domain : Use of Resources

Cash Position



Apr-26

£2.7m

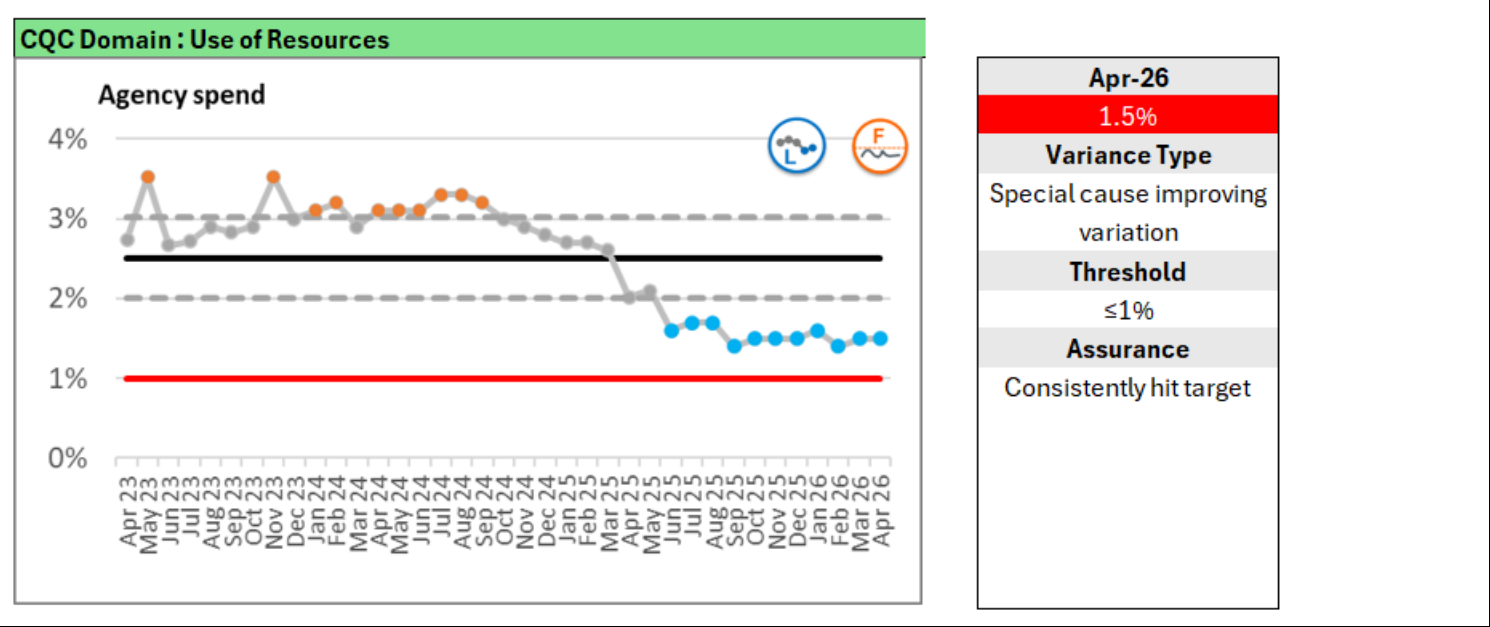
Variance

Position doesn't meet the plan

Target

£2.7m

Agency spend %



Finance

Executive Summary

At the end of April 2026 (M1), the Trust is reporting a balanced position against plan year to date. The M1 position includes the impact of industrial action, which is assumed to be funded from a combination of local and national mitigations.

The Trust's financial plan is yet to be agreed with NHSE and therefore remains subject to revision.

The Trust identified three key risks in the Trust plan:

- Full CIP Delivery: The primary risk to achieving the 2026/27 financial position is delivery of our CIP target of £30.7m. The current risk adjusted forecast for delivery is £23.1m.
- Activity / Casemix: After accounting for the impact of industrial action, estimated elective income is in line with plan at M1.
- Maintaining Grip and Control: Additional actions to support delivery of the agreed plan have been maintained, with enhanced controls across variable pay, non-core spend, discretionary non-pay, elective income, and a non-clinical vacancy freeze remaining in effect.

The deficit continues to exert significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M1 was £2.7m, in line with NHSE's stipulated minimum cash balance. The Trust is adhering to the agreed cash mitigation plan, but until a sustainable financial position is achieved, this remains a significant issue. The revenue support applications for April and May were approved, and the application for June has been submitted.

It is important to note that management of risks against this plan alone does not deliver long-term financial sustainability. The significant improvement required for sustainability will be delivered through the medium-term finance plan (MTFP).

The risk ratings for delivery of agreed KPIs in 2026/27 are:

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Apr 26	1.5%	≤1%			2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

The Board is asked to:

- Note the report.

- Note that the plan has not been approved by NHSE and that further measures are required to meet the mandated control total.
- Note that the Trust's most immediate finance risk remains the cash position, that the Trust continues to follow the agreed processes for mitigating this issue and therefore to
- Approve that the CFO submits additional applications based on confirmed need.
- Approve the revisions to the capital budget.

I&E Position

Narrative:

The table below summarises the M1 position:

Cost Type	In Month		
	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£39.8m	£39.5m	-£0.2m
Other Operating Income	£3.4m	£3.8m	£0.4m
Total Income	£43.2m	£43.4m	£0.2m
Employee Expenses	-£33.9m	-£34.1m	-£0.2m
Operating Expenses	-£12.6m	-£12.4m	£0.2m
Non Operating Expenses	-£0.5m	-£0.3m	£0.2m
CIP	£0.9m	£0.5m	-£0.4m
Total Expenditure	-£46.2m	-£46.3m	-£0.1m
Reported Position	-£3.0m	-£2.9m	£0.0m

Key variances within the YTD position are:

Clinical Income – after adjusting for IA, clinical income is £0.2m off plan, driven by £0.1m lost elective activity in Surgery and £0.1m in respect of high cost drugs and devices.

Other Operating Income – positive variance of £0.4m driven by increased HEE monies.

Employee Expenses - £0.2m adverse variance principally driven by remaining escalation capacity and additional bank spend due to IA offset by our risk provision.

Operating expenses – £0.2m positive variance mainly driven by reduced spend on supplies within Estates.

The Trust's agency costs remained at 1.5% of total pay bill for the month, which is above the revised target of 1.0% set by NHSE.

Cumulative CIP

Narrative:

The Trust has delivered £1.2m of recurrent CIP at M1 against a profiled target of £1.6m, resulting in an early shortfall against plan. This is offset by underspends elsewhere that the Trust is currently reviewing to confirm whether the improvement in run rate can be transacted as CIP.

For 2026/27 as a whole, the CIP target is 6%, equivalent to £30.7m and 305 WTE. At the start of the year, schemes identified total £30.9m, which is 101% of target, but this reduces to £23.0m on a risk-adjusted basis. This means the overall value identified is encouraging, but the deliverability of the programme remains the more significant issue and will require continued grip through operational and divisional governance routes.

Elective Activity

Narrative:

After accounting for Industrial Action, elective and day case activity is £0.1m below plan at M1 - this is driven by Trauma and Orthopaedics. The level of underperformance remains subject to estimation and coding assumptions.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2026/27 at M1:

Description	Approved Budget at M1
CDEL	
Internally Generated	£9.765m
Internally Funded	£4.386m
ICB/PDC/WCHC	£5.175m
Estates Safety	£5.288m
Charity	£0.000m
Confirmed CDEL	£24.614m
Total Funding for Capital	£24.614m
Capital Programme	
Estates, facilities and EBME	£8.013m
Operational delivery	£10.956m
Medical Education	£0.075m
Transformation	£1.000m
Digital	£0.900m
UECUP	£1.708m
PDC commitments	£0.295m
ICB hosted	£1.668m
Charity	£0.000m
Approved Capital Expenditure Budget	£24.614m
Total Anticipated Expenditure on Capital	£24.614m
Under/(Over) Commitment	£0.000m

This includes the assumed external funding and cost of Same Day Emergency Care scheme, which has yet to receive full approval from NHSE.

Cash Position

Narrative:

The cash balance at the end of M1 was £2.7m. NHSE has continued to approve cash support, the requirements for which are driven by having a non-cash backed deficit.

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

Management of payments - continued daily management of payments to and from other organisations both NHS and non NHS.

Analysis/CFO oversight - Continued daily monitoring and forecasting of the Trust cash position and our Public Sector Payment Performance metrics.

Debt recovery - Monitoring and escalation of any aged debt delays.

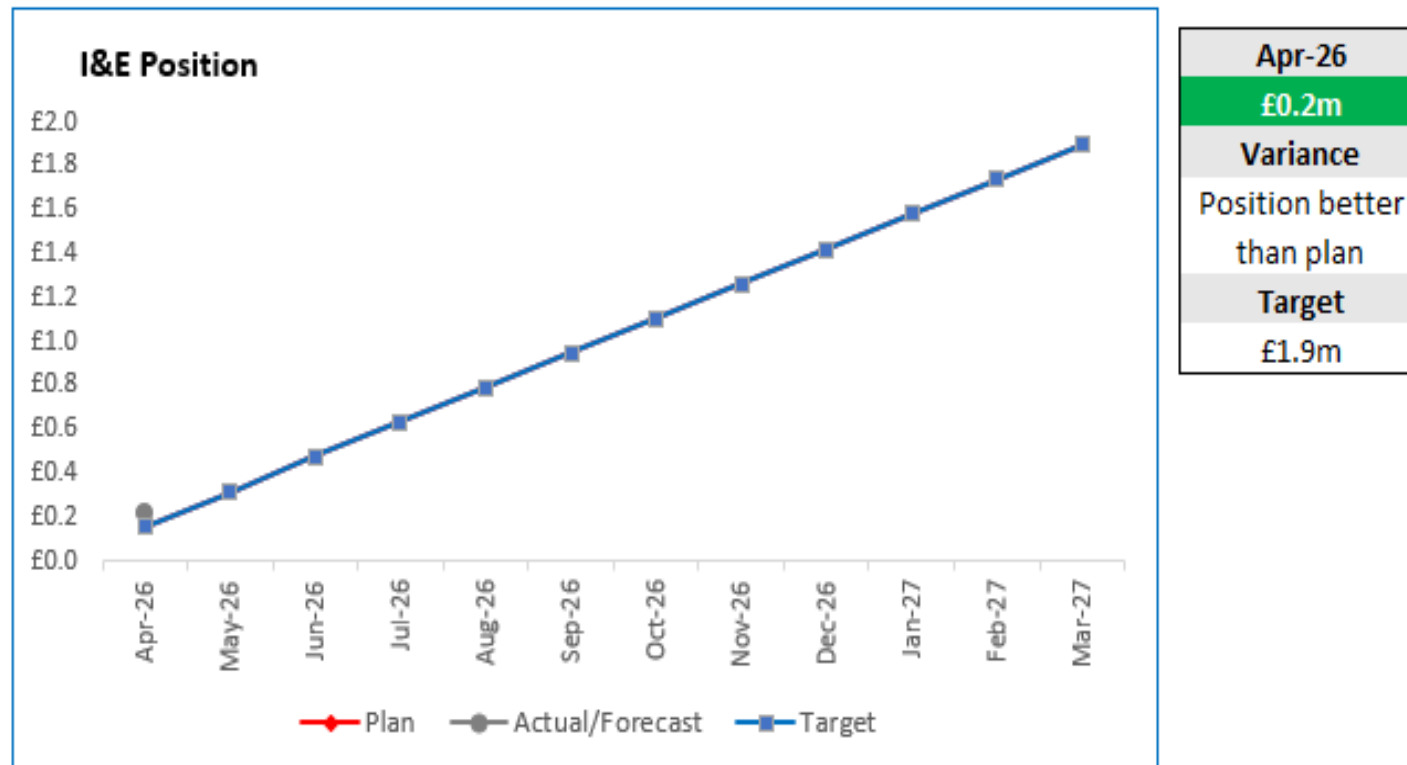
Support - the national process for applying for cash support.

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

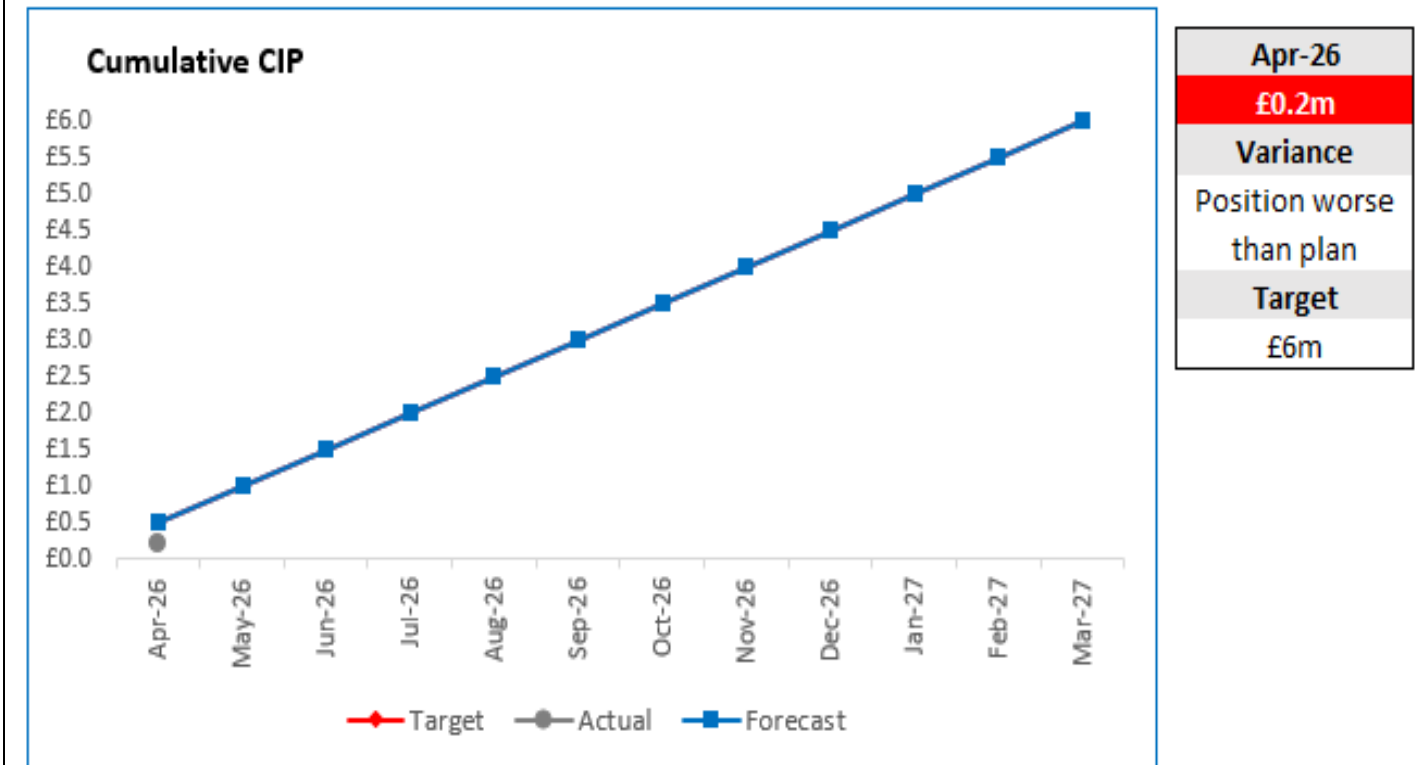
Finance Summary - WCHC

Statutory Financial Targets	RAG (M1)	RAG (Forecast)
Financial stability	●	●
Agency spend	●	●
Financial sustainability	●	●
Financial Efficiency	●	●
Capital	●	●
Cash	●	●

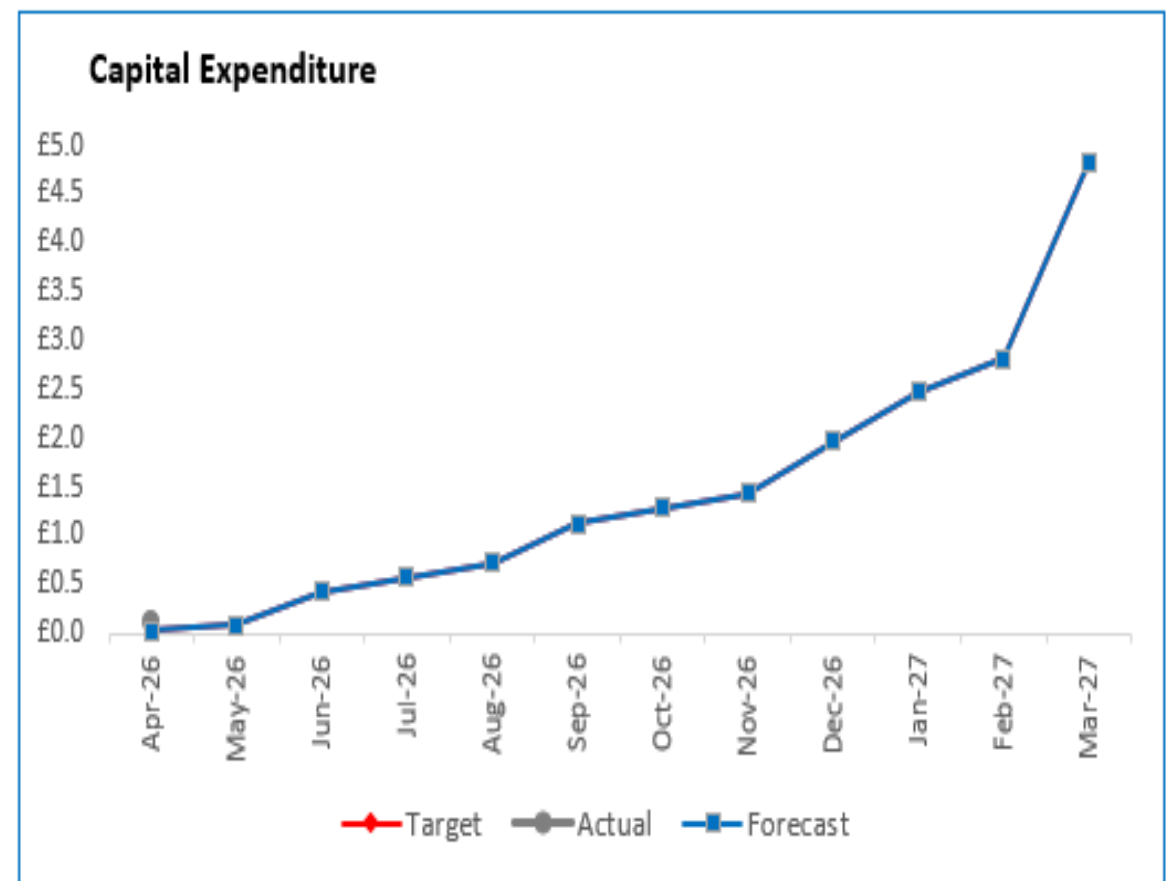
I&E Position



Cumulative CIP

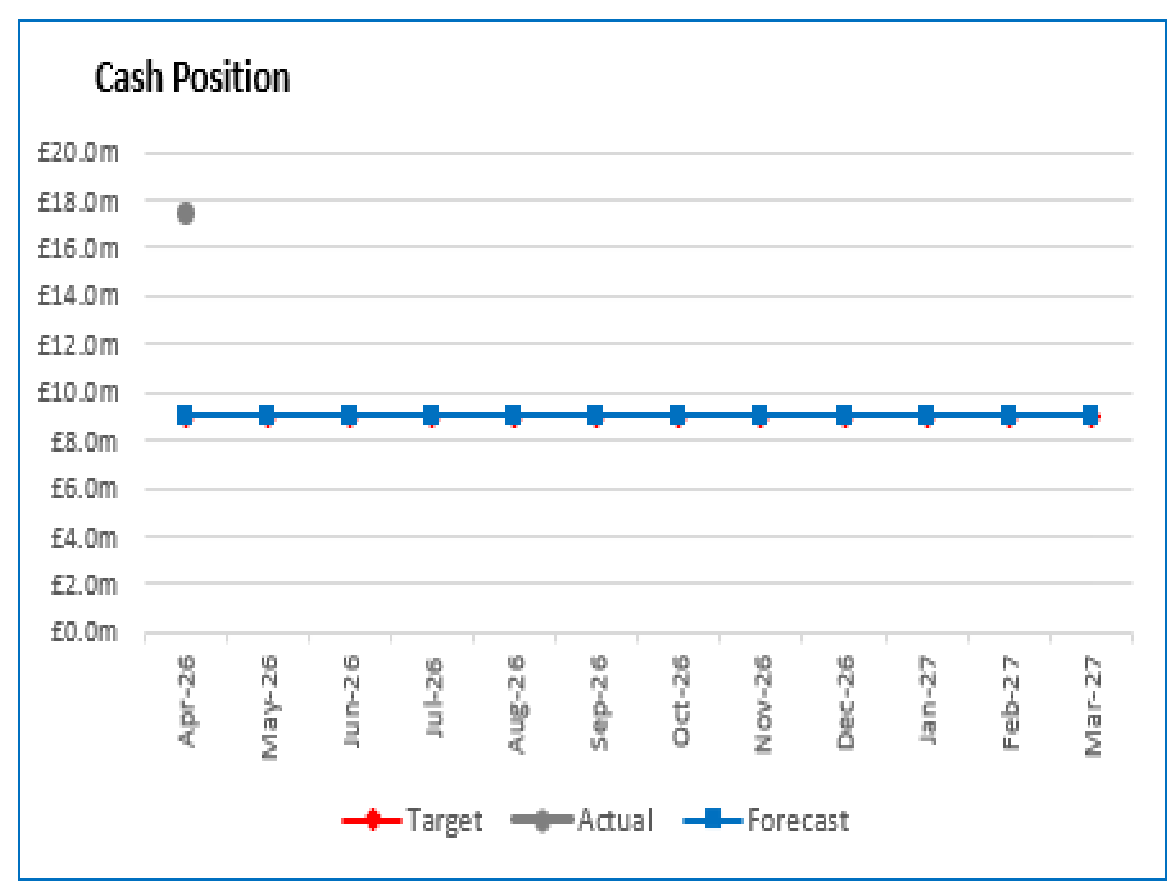


Capital Expenditure



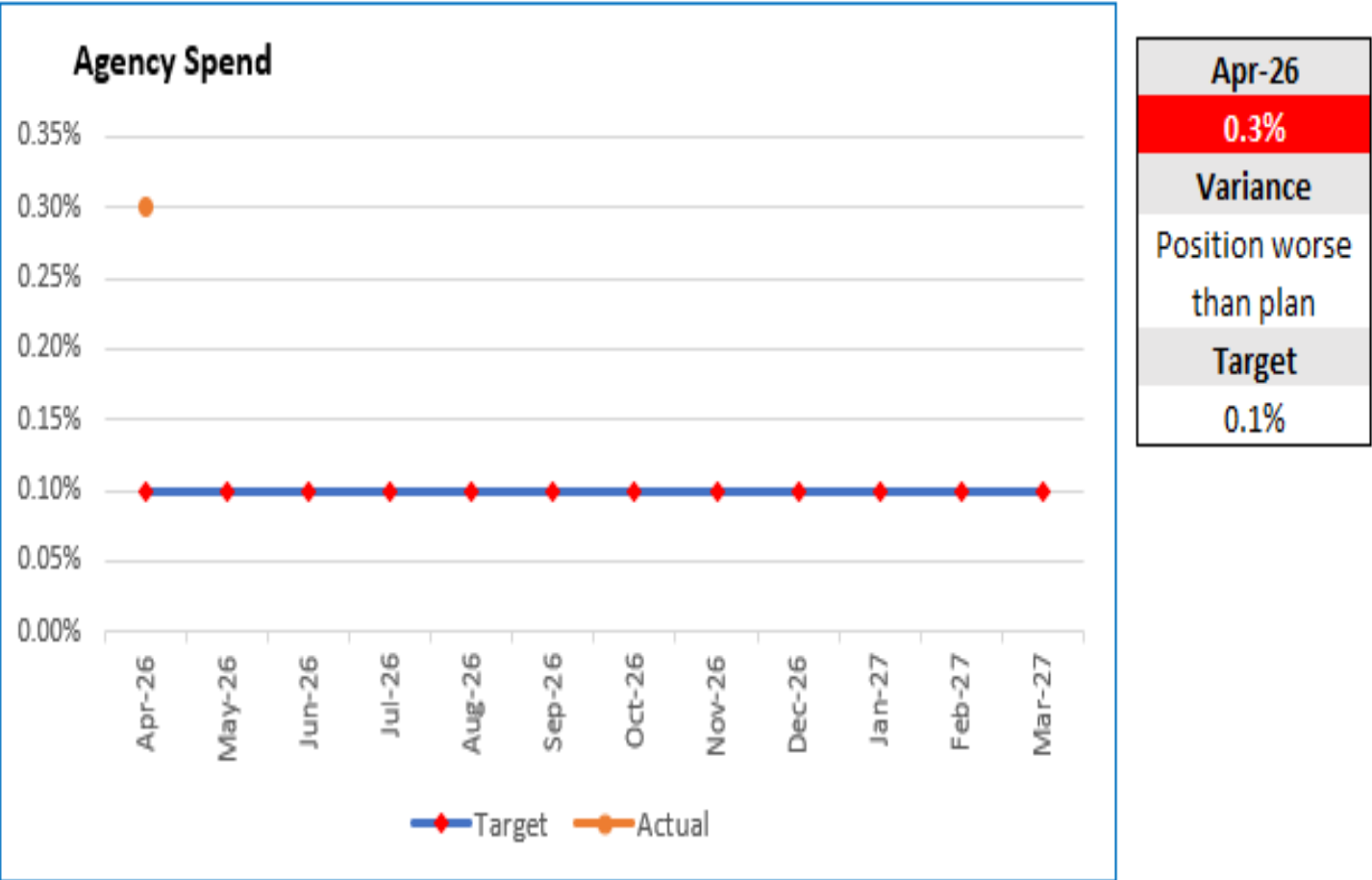
Apr-26
£0.1m
Variance
Position better than plan
Target
£4.8m

Cash Position



Apr-26
£17.5m
Variance
Position better than plan
Target
£9m

Agency Spend



Finance

Executive Summary

At the end of April 2026 (M1), the Trust is reporting a £0.1m surplus to plan, with the overall year to date position presented with no variance to plan. The reported position reflects favourable performance across pay and non-pay expenditure, partially offset by an early shortfall in delivery of the Cost Improvement Programme (CIP).

While the reported financial position is positive at this early stage, the planned workforce and CIP positions for 26/27 are not yet realised and therefore the Trust has not yet delivered the required fully sustainable underlying improvement. For example workforce total numbers are above plan, equivalent to 2.2%, driven by CIP not yet delivered.

The risk ratings for delivery of agreed KPIs in 2026/27 are:

KPI	Latest data period	Measure	Target	Variance	Assurance	Mean
Agency Spend	Apr-26	0%	<=1%			
I&E Position	Apr-26	£0.2m	£0.2m			
Cumulative CIP	Apr-26	£0.2m	£0.5m			
Capital Expenditure	Apr-26	£0.1m	£0.0m			
Cash Position	Apr-26	£17.5m	£9.0m			

The Board is asked to:

- Note the report.
- Note that full CIP delivery is required to achieve the planned sustainable financial position.

I&E Position

Narrative:

The table below summarises the M1 position:

Cost Type	In Month		
	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£8.8m	£8.8m	-£0.0m
Other Operating Income	£0.2m	£0.2m	£0.0m
Total Income	£9.0m	£9.0m	£0.0m
Employee Expenses	-£7.0m	-£6.8m	£0.3m
Operating Expenses	-£1.6m	-£1.5m	£0.1m
Non Operating Expenses	-£0.6m	-£0.5m	£0.0m
CIP	£0.4m	£0.0m	-£0.4m
Total Expenditure	-£8.9m	-£8.8m	£0.0m
Reported Position	£0.2m	£0.2m	£0.1m

The Trust is reporting a £0.2m surplus at M1. This is attributable to positive variances in pay and non-pay, partly offset by a shortfall in CIP delivery. There is no variance to plan in respect of income, with the majority of income being received via block contract.

Employee expenses have a £0.3m positive variance, with underspends across a number of services and corporate areas. This is supported by a substantive pay underspend of £0.394m, despite unachieved CIP of £0.185m.

Agency costs are £0.017m adverse in month, driven by Specialist Medical Services, while bank costs are £0.254m adverse, driven by Specialist Medical Services (£0.098m), Community Response (£0.089m) and Nursing (£0.045m).

Operating expenditure has a positive variance of £0.1m, with underspends across all categories and divisions.

The month 1 position therefore remains positive overall, but until savings are recurrently delivered within CIP the underlying position will need continued review.

Cumulative CIP

Narrative:

The Trust's CIP target for 2026/27 is 6%, equivalent to £6.0m and 64 WTE, this target is profiled equally across the year. At M1, the target is £0.5m, with £0.2m achieved.

The key focus for month 2 onwards will therefore be on converting the identified opportunities and underspends into transacted, recurrent benefit and ensuring that delivery improves sufficiently to deliver the full year target.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2026/27 at M1:

Description	Approved Budget at M1
CDEL	
Internally Generated	£3.678m
ICB/PDC	£1.167m
Estates Safety	£0.031m
Confirmed CDEL	£4.876m
Total Funding for Capital	£4.876m
Capital Programme	
Estates, facilities and EBME	£0.371m
Operational delivery	£1.276m
Transformation	£0.160m
Digital	£0.560m
PDC commitments	£1.167m
IFRS16	£1.342m
Approved Capital Expenditure Budget	£4.876m
Total Anticipated Expenditure on Capital	£4.876m
Under/(Over) Commitment	£0.000m

Cash Position

Narrative:

The cash balance at the end of M1 was £17.5m.

CPO Workforce Summary - WUTH						

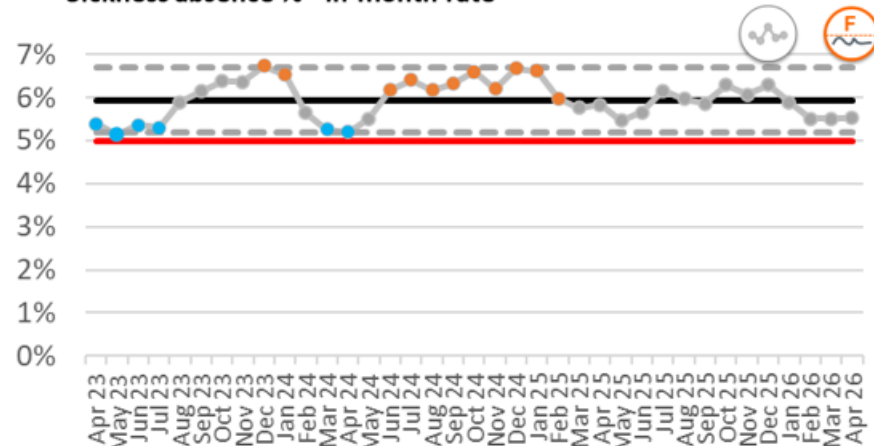
Sickness Absence Both Corporate Support (4.29%) and Medicine & Acute Division (4.66%) were below target.	Sickness Absence Sickness absence levels continue to be above the Trust’s 5% target and following a period of active reduction post winter have stabilised at 5.5% with a narrow variance. Latest performance is 5.53% in-month which is a very slight increase of 0.02% since March (5.51%) but an improved in-month position compared to April 25 (5.84%). The rolling sickness absence has improved each month and is currently at 5.92%. This is also an improved position on the rolling sickness rate compared to April 25 (6.16%). LT sickness increased to 3.65% and ST decreased to 1.90%. The current in-month top 3 reasons are: • Mental health (34.77%) • MSK (8.51%) and • Gastro (7.87%). Surgery has the highest sickness rate at 6.42%, followed by Estates, Facilities & Capital (6.39%), W&C (6.36%) and Clinical Support Division (5.65%). The three main staff groups for sickness are: Additional Clinical Services (7.54%), Estates and Ancillary (6.93%) and Nursing and Midwifery (5.66%). BAF risk 4 currently stands at 16 due to the increased likelihood of sickness absences, significant period of change for corporate services and the impact Trust financial pressures are having on delivery (vacancy freeze etc). Sickness absence has been identified as one of the ‘drivers of the deficit’ and included within the medium-term financial plan. Through last year’s Sickness Absence project extensive work has been undertaken across the Trust consisting of targeted interventions tailored to the requirements of the Trust, all in addition to BAU sickness absence management. This has resulted in the rolling sickness absence reducing from 6.13% to 5.94% achieving cost avoidance of £726K (from staff groups roles backfilled via premium spend). The Trust has a robust Attendance Management Policy which is working well however, we recognise that some staff groups (Estates and Ancillary, Additional Clinical Services (CSWs) and Nursing and Midwifery) are more affected than others and therefore require targeted Trust level plans to ensure further improvements to reduce sickness back within tolerance ≤5%. The Trust continues to implement a wide range of supportive interventions as well as robust application of the policy. Due to the success of the sickness absence project a new 3-year Sickness Transformation project is underway with the aim of reducing	Sickness Absence Sickness Transformation Project • Objective to reduce Trust wide sickness to <5% within 3 years, with a longer-term target to meet the NHS 10-year plan target of 4.3%. For 2026 the target at £1m contributing to the Trust Cost Improvement Programme broken down into divisional plans with specific targets plus “Everyday Counts” communications campaign. • 4 Workstreams: ➢ Workstream 1: Targeted Staff Group / Divisional specific action plans ➢ Workstream 2: Strengthening leadership and management accountability ➢ Workstream 3: Proactive Wellbeing Support ➢ Workstream 4: Strengthening Trust Policy and process to further drive change Proactively supporting physical health and wellbeing: • Aligned with the top reason for sickness, Wellbeing Surgeries took place in April & May. • Active promotion of Mental Health during May – which is Mental Health Awareness month, with a range of activities including a dedicated drop-in event. • Smoking cessation clinic for staff • Continuation of the communication campaign ‘Every Day Counts’ aimed at raising awareness that the Trust are proactively tackling sickness, current focus on debt awareness. • Latest cohort of the Well WUTH & WCHC RTW programme in-progress (7 attendees in total across both Trusts) • New Well WUTH and WCHC intranet site in-development • WUTH Psychotherapist has provided additional psychological support post traumatic event and to support staff to safe from suicide • Cervical Screening Living Well Bus (mobile clinic) attending in August. Early screening is key to prevent cancers and promote health. • New psychological intervention process, support and training being designed for managers to help staff post a significant event. • New ‘Well in Work’ programme currently in design. Managing Absence: • Following the pilot of Well WUTH & WCHC the first cohort in January returned 12 out of the 15 staff, 2 remained absent due to complex health and 1 retired. The March cohort is currently being evaluated and the May programme has commenced. • New Resident Doctors’ RTW SOP agreed at JLNC. • Continuation of sickness absence training.
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	sickness initially to within the tolerance $\leq 5\%$ and then further, as detailed in the NHS 10-year plan, and delivering significant savings through reductions in premium backfill outlay.	• High impact action plans for each Division focused on hot spots. • HR drop-in sessions provide managers with access to dedicated HR resource to support with case management. • The Attendance Management Policy continues to be embedded, and numbers of final stage hearings continue to increase. • Local Sickness Audits remain on going and are reported into WSB as BAU within the Performance Report.
Mandatory Training Compliance % Trust compliance has increased from March onwards. Across 25/26 Q4 and 26/27 Q1, Trust compliance dropped below the 90% KPI due to an increase in staff required to undertake fire safety e-learning (86.11% compliance in April 26 compared to 47.22% compliance in Jan 26) and changes from the final implementation stages of the core skills training framework v1.1. This drop was anticipated and rapid improvement has been sustained with compliance once again close to target.	Mandatory Training Compliance % Whilst overall compliance is increasing, some courses have low compliance figures e.g: • Resuscitation L3 for Adults (60%) and Paediatrics (56.73%) • IPC Level 2, and Resuscitation L2 (paediatric) are also below 80%. Discussions are on-going with the course SME's to discuss what further support is required to increase compliance.	Mandatory Training Compliance % The Trust is awaiting the new updated core skills training framework. This was due in May however due to council elections and a change in health secretary, this has been moved back with no confirmed date for publication. The Trust is ready to support both PVP and Moving Handling to become fully aligned along with any additional changes the new framework indicates.

Sickness absence % in month rate

CQC Domain : Safe

Sickness absence % - in-month rate



Apr-26

5.5%

Variance Type

Common cause variation

Threshold

≤5%

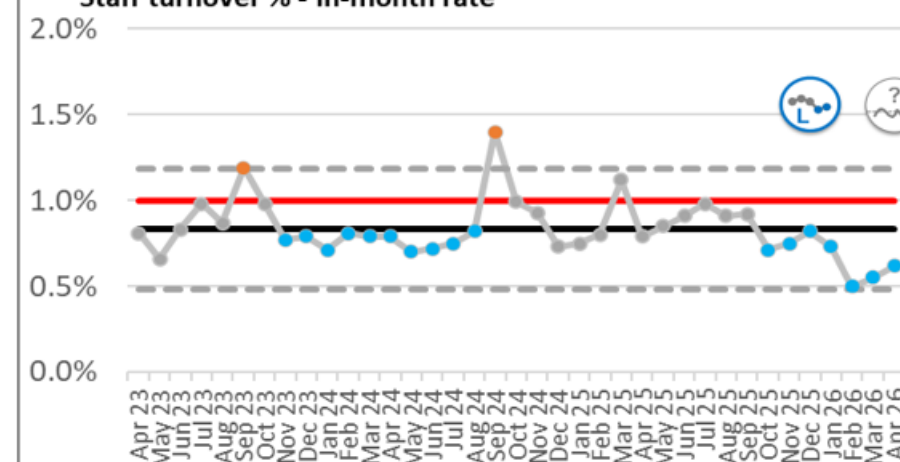
Assurance

Consistently fail target

Staff turnover % in month rate

CQC Domain : Safe

Staff turnover % - in-month rate



Apr-26

0.6%

Variance Type

Special cause improving variation

Threshold

≤1%

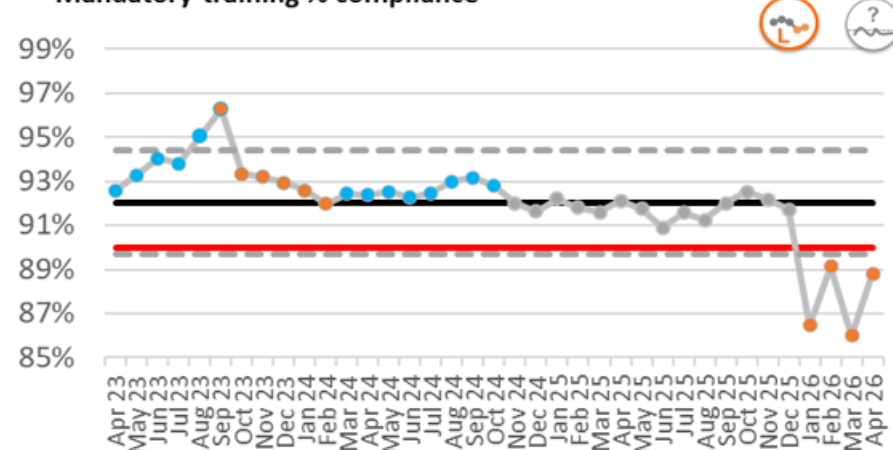
Assurance

Hit and miss target subject to random variation

Mandatory training % compliance

CQC Domain : Safe

Mandatory training % compliance



Apr-26

88.8%

Variance Type

Special cause concerning variation

Threshold

≥90%

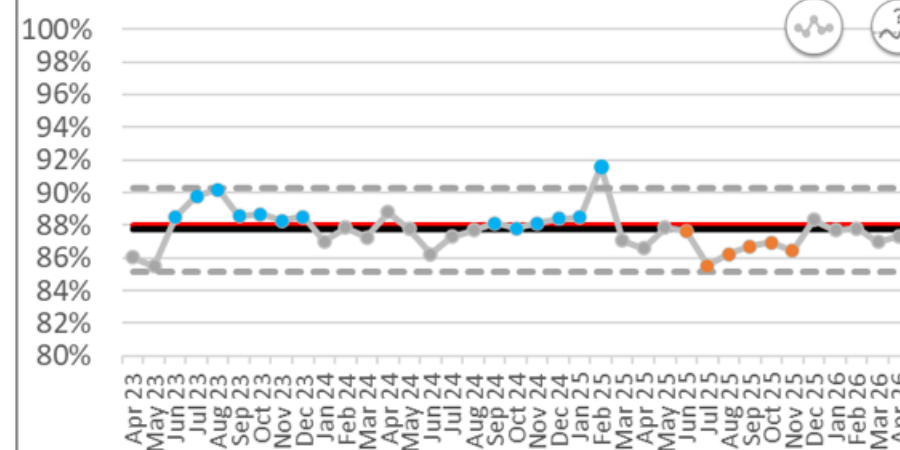
Assurance

Hit and miss target subject to random variation

Appraisal % compliance

CQC Domain : Well-led

Appraisal % compliance



Apr-26

87.3%

Variance Type

Common cause variation

Threshold

≥88%

Assurance

Hit and miss target subject to random variation

Workforce Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	Apr 26	12.8%	10.4%			12.5%
Mandatory Training Compliance	Apr 26	94.8%	90.0%			95.0%
Sickness Absence	Apr 26	6.4%	5.0%			6.5%
Sickness Absence (Short Term)	Apr 26	1.2%	2.0%			1.6%
Sickness Absence (Long Term)	Apr 26	5.2%	3.0%			4.9%
Agency usage	Apr 26	0.3%	1.0%			0.9%
Variance to Agency Cap (£)	Apr 26	-203784.4	-			-175005.4
% of Agency Usage against Funded WTE	Apr 26	0.00%	-			0.6%
% of Bank Usage against Funded WTE	Apr 26	4.40%	-			3.4%
% of Contracted FTE Vacancies	Apr 26	3.8%	6.0%			5.1%

Highlights

Turnover %

Whilst turnover is above target, target is under review as higher turnover will support required headcount reductions in line with the Trust's workforce plan.

Areas of Concern

Sickness Absence

Sickness absence remains a cause for concern as it is above the Trust ≤5% target at 6.4% with a clear contribution from long-term sickness across the year. The in-month rate shows a slight (0.11%) increase compared to March 2026 and the rolling remains elevated but static at 7.06%.

Long term sickness peaked at 6.25% in August'25 and following extensive sickness absence work this has reduced month by month for 6 out of the 8 months (apart from the expected seasonal increase in Nov and Dec) and is down to 4.62% in April'26.

The top 3 reasons are:

- Mental health (anxiety, stress, depression) (42.89%)
- Gastro (11.34%)
- MSK (10.86%)

Localities with the highest sickness absence are Specialist Medical (8.54%), Community Response (7.19%), Nursing (7.54%), Corporate (12.32%) and Children's (5.77%). Only Therapies are below target (4.63%). All areas have demonstrated an improvement in-month except for Nursing (1.8% increase, rising from 5.74% in March to 7.54% in April).

Recorded RTW discussions improved to 81%.

Forward Look (Actions)

Sickness Sustainability Project

- Objective to reduce Trust wide sickness to <5% within 3 years, with a longer-term target to meet the NHS 10-year plan target of 4.3%. For 2026 the target is a 1.1% reduction to 6%.
- 4 Workstreams:
 - Workstream 1: Strengthening leadership and management accountability
 - Workstream 2: Proactive Wellbeing Support
 - Workstream 3: Service Specific Targeted Action Plans
 - Workstream 4: Strengthening Trust Policy and Process to further drive change

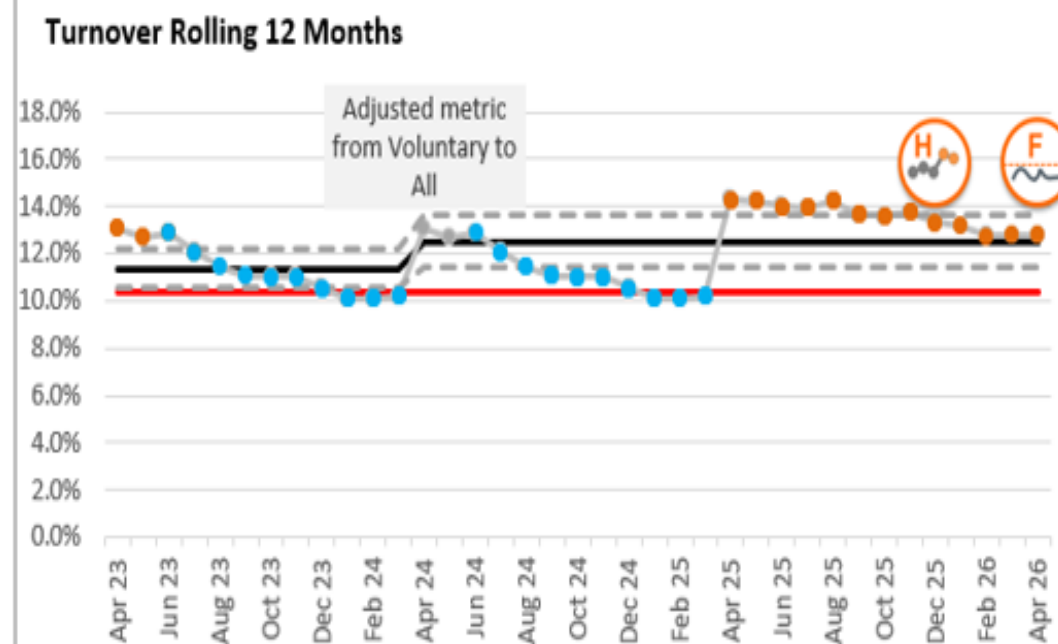
Proactively supporting health & wellbeing:

- Aligned with the top reason for sickness, Wellbeing Surgeries took place in April and May.
- Active promotion of Mental Health during May – which is Mental Health Awareness month, with a range of activities including a dedicated drop-in event.
- Mental Health First Aiders their departmental areas and contact details promoted on Staff Zone.

	The risk score on the register has been reviewed and increased to a 15 bringing it in line with WUTH and reflecting the likelihood. Sickness absence has been identified as a 'driver of sustainability' to reduce absence, increase worker availability and increase productivity. Through the new Sickness Transformation project building on the extensive work that was delivered through the sickness absence interventions last year, 4 workstreams of work are being undertaken aiming to reduce both the rolling sickness absence and bank usage.	• Continuation of communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness focus on stress awareness. • Latest cohort of the Well WUTH & WCHC RTW programme in-progress (7 attendees in total across both Trusts) • New Well WUTH and WCHC intranet site in-development. • WUTH Psychotherapist has provided additional psychological support post traumatic event and has supported managers with a new workshop keeping staff safe from suicide and improve mental health. • Further effective wellbeing conversation training being delivered. • EAP uptake has increased this quarter to 26.7%. • New 'Well in Work' programme currently in design. Managing Absence: • Following the pilot of Well WUTH & WCHC the first cohort in January returned 12 out of the 15 staff, 2 remained absence due to complex health and 1 retired. The March cohort is currently being evaluated and the May programme has commenced. • Continued focus on LTS cases ensuring plans to return to work and formal progression as per policy. • Exploration of an OD led listening event for Urgent Care Centre staff. • Further review undertaken of PAM OH Reports to assess quality. • Sharing of example high impact action plans down to ward/team level with Service Lead to improve focus and accountability • PAM triage process, cases medically triaged an allocated the most appropriate practitioner and appointment length based on the case specifics / history etc. • Case conferences reinvigorated for complex cases. • Active utilisation of the Health Indicators Report to drive management actions related to managing sickness absence. • Extension of the EAP Health assured 'Active Care' day one intervention for staff absence with stress and/or anxiety. • Local Sickness Audits reported through PCOG.
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Turnover (Voluntary) – Rolling 12 Months

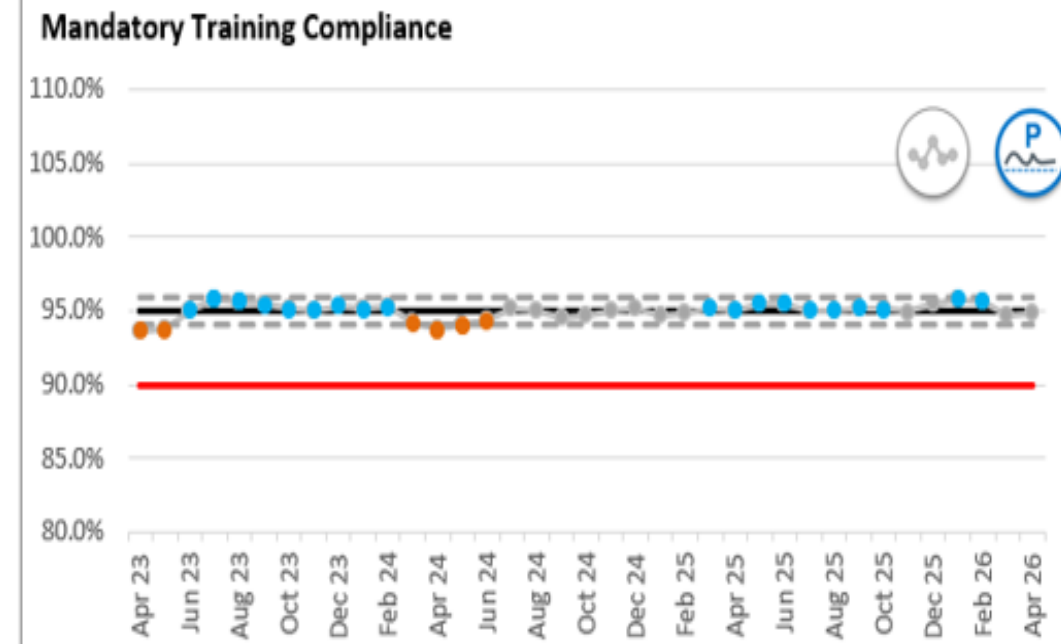
CQC Domain : Safe



Apr-26
12.8%
Variance Type
 Special cause variation - Concerning
Threshold
 $\leq 10.4\%$
Assurance
 Performance consistently fails the target

Mandatory Training Compliance

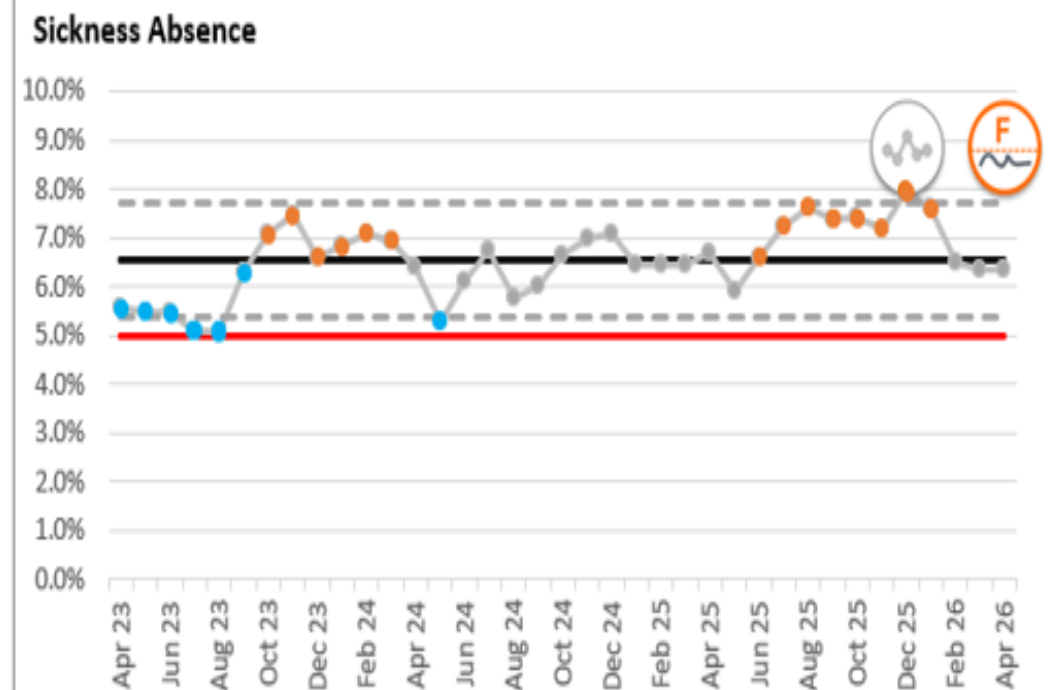
CQC Domain : Safe



Apr-26
94.8%
Variance Type
 Common cause variation
Threshold
 $\leq 90\%$
Assurance
 Performance consistently achieves the target

Sickness Absence

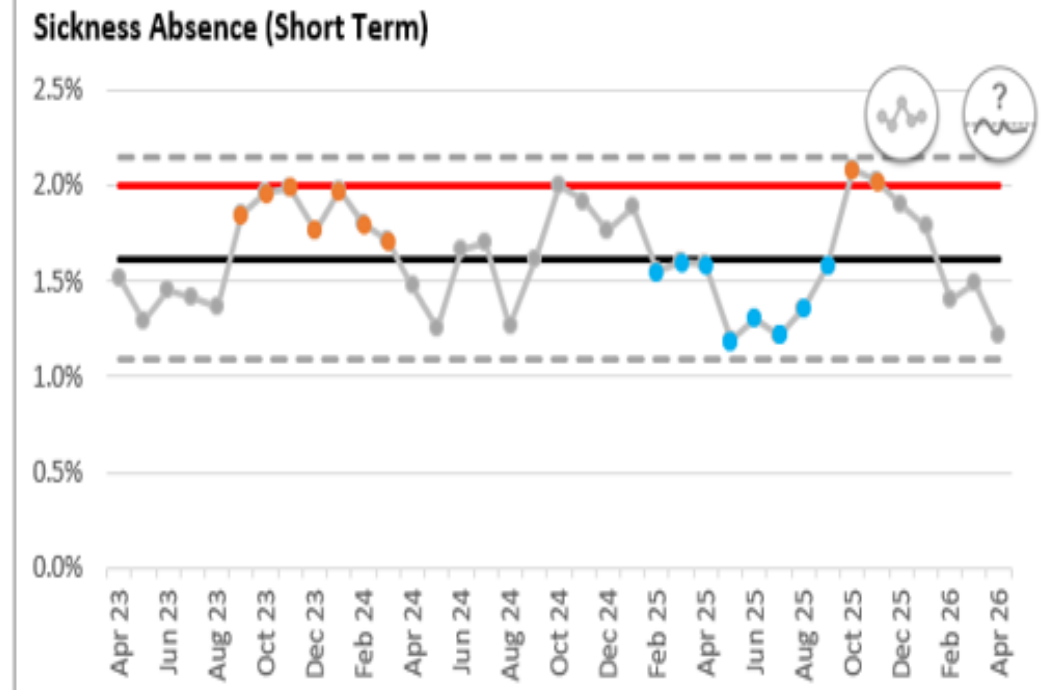
CQC Domain : Safe



Apr-26
6.4%
Variance Type
 Common cause variation
Threshold
 $\geq 5\%$
Assurance
 Performance consistently fails the target

Sickness Absence (Short Term)

CQC Domain : Safe

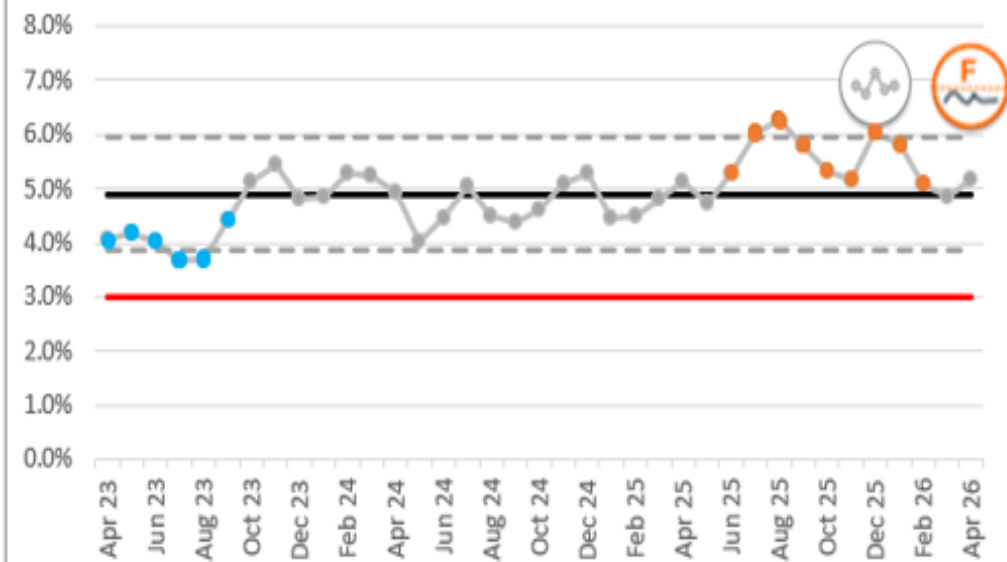


Apr-26
1.2%
Variance Type
 Common cause variation
Threshold
 $\geq 2\%$
Assurance
 Hit & miss target subject to random variation

Sickness Absence (Long Term)

CQC Domain : Safe

Sickness Absence (Long Term)

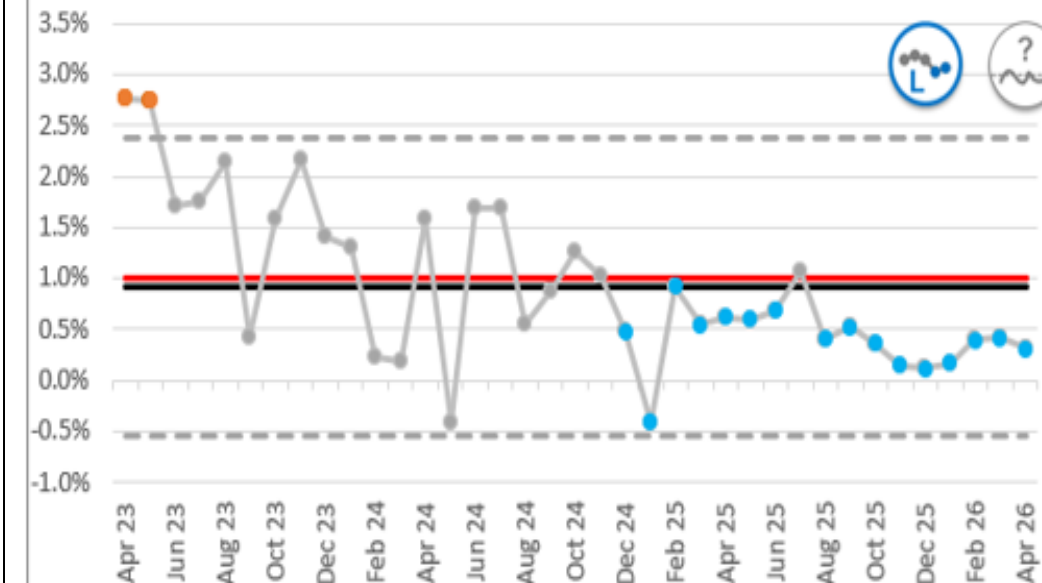


Apr-26
5.2%
Variance Type
Common cause variation
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

CQC Domain : Well-led

Agency usage

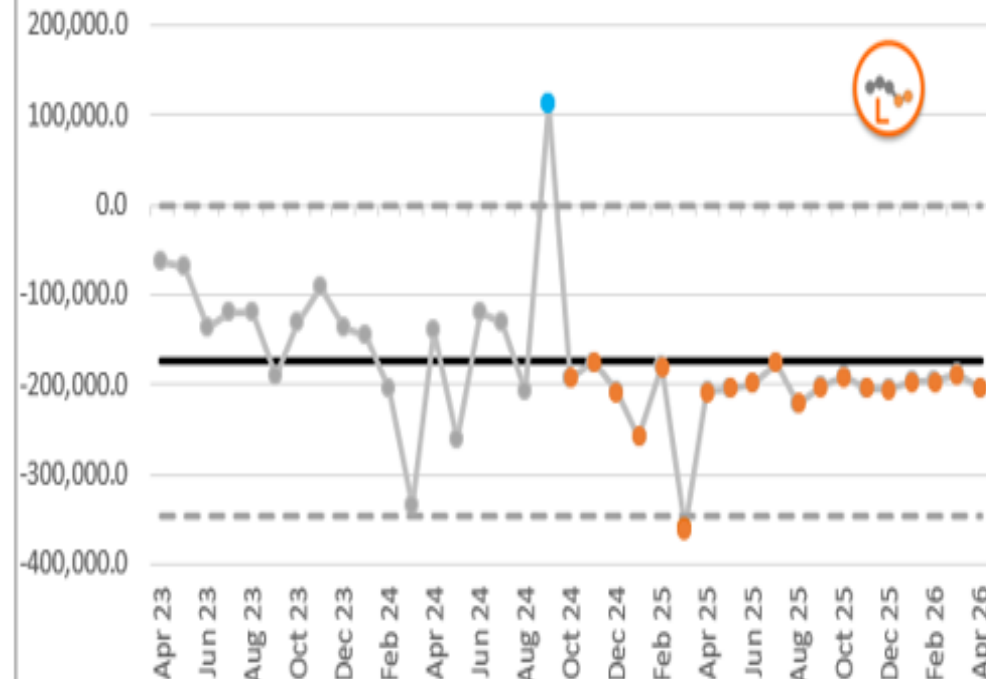


Apr-26
0.3%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

CQC Domain : Well-led

Variance to Agency Cap (£)

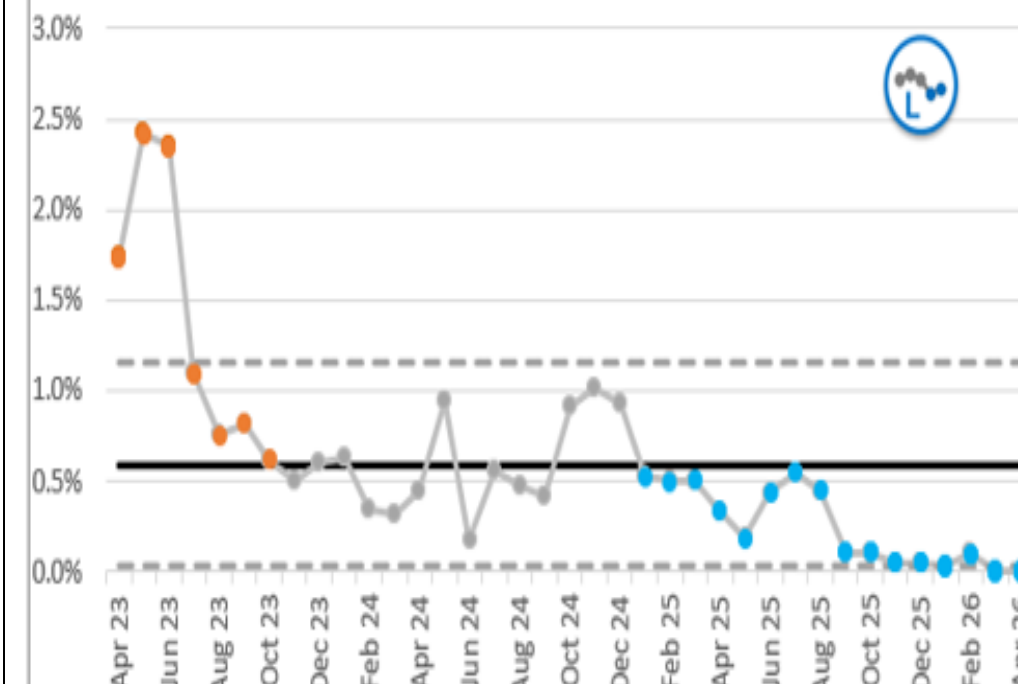


Apr-26
-£203,784.40
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

CQC Domain : Well-led

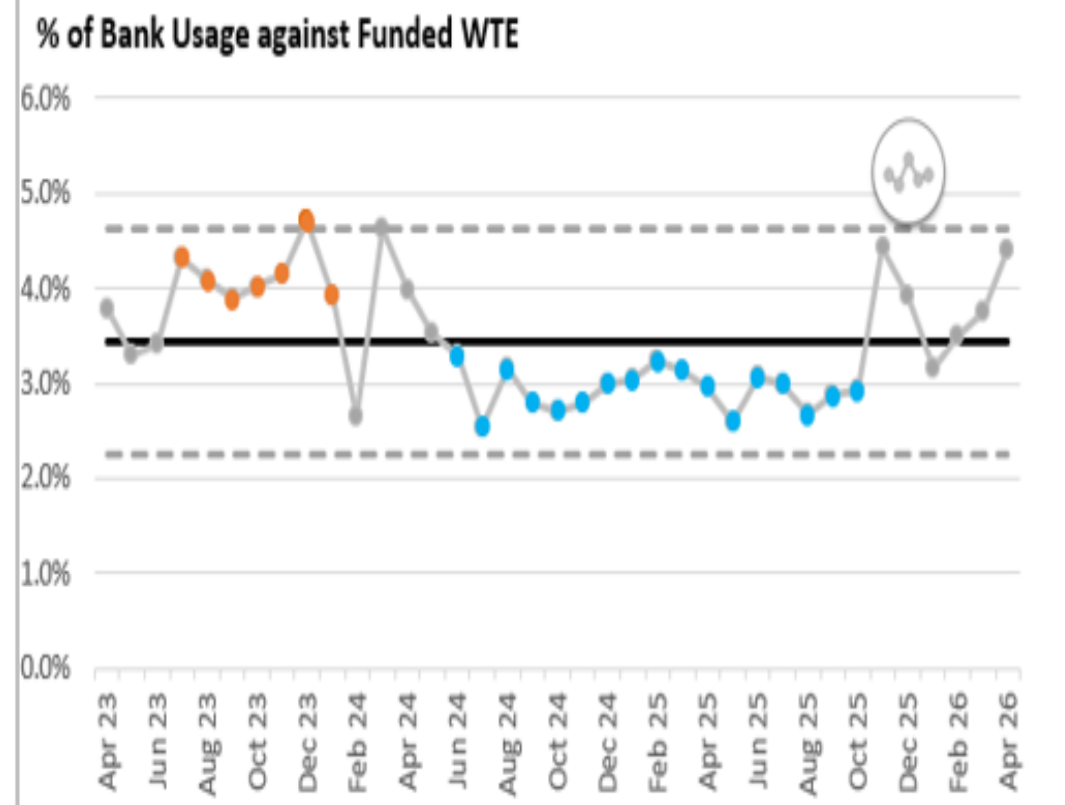
% of Agency Usage against Funded WTE



Apr-26
0.0%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Bank Usage against Funded WTE

CQC Domain : Well-led



Apr-26

4.4%

Variance Type

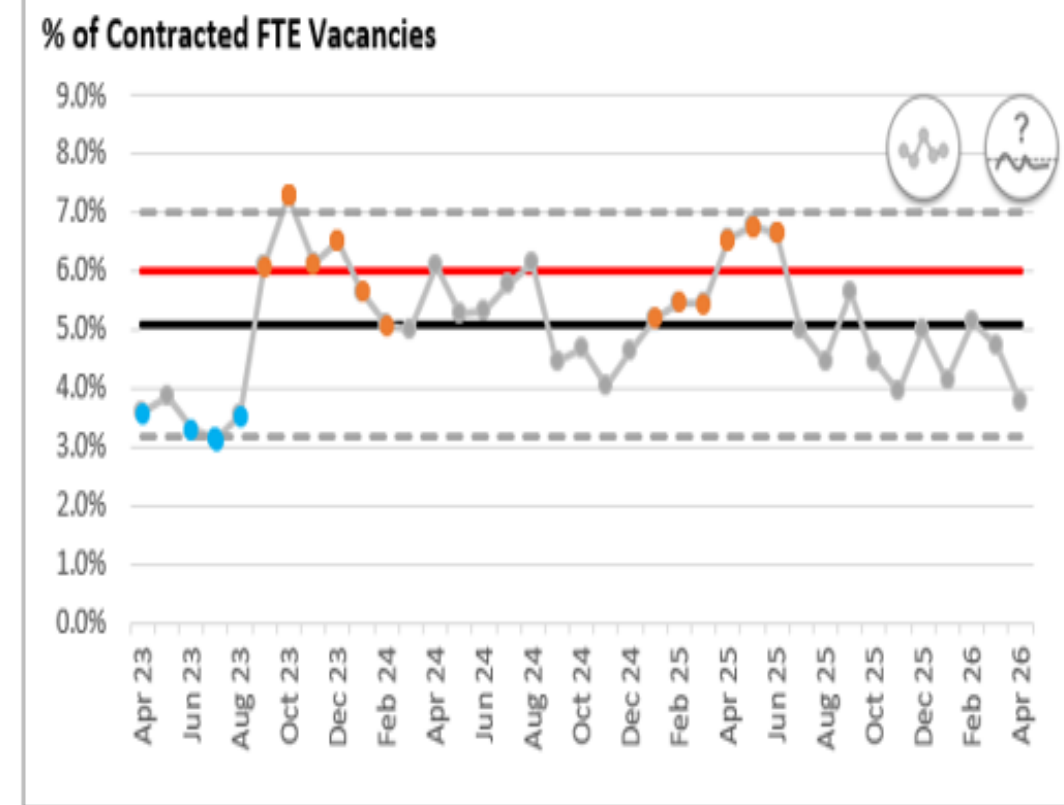
Common cause
variation

Threshold

Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led



Apr-26

3.8%

Variance Type

Common cause
variation

Threshold

≥6%

Assurance

Hit & miss target
subject to random
variation

Meeting	Group Board of Directors in Public
Date	Wednesday 1 April 2026
Location	Hybrid

Members present:

SI	Steve Igoe	Joint Chair
SR	Dr Steve Ryan	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
LG	Lisa Greenhalgh	Joint Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
NS	Dr Nikki Stevenson	Joint Chief Medical Officer & Deputy CEO
HK	Hayley Kendall	Joint Executive Managing Director
MS	Matthew Swanborough	Joint Chief Strategy Officer
MC	Mark Chidgey	Joint Chief Finance Officer
JC	Dr Joanne Chwalko	Joint Chief Integration & Partnerships Officer
CD	Chris Douglas	Joint Chief Nursing Officer
DS	Debs Smith (from 10:45)	Joint Chief People Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications

In attendance:

CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 23
GG	Gary Grady	WCHC Governor
EH	Eileen Hume	WCHC Governor
LC	Lynn Collins	WCHC Governor
SH	Sheila Hillhouse	WUTH Lead Public Governor
RT	Robert Thompson	WUTH Deputy Lead Public Governor
MT	Mark Taylor	Member of the Public

Apologies:

CM	Chris Mason	Chief Information Officer
GR	Gareth Robinson	Joint Director of Transformation & Turnaround

Agenda Item	Minutes	Action
1	Welcome and Apologies for Absence SI welcomed members to the meeting. No apologies were received.	

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 WUTH and WCHC meetings held on the 28 January were APPROVED as an accurate record.	
4	Action Log The Group Board NOTED the action log.	
5	Patient Story The Board received a video story highlighting a mum's story of her bereavement journey after unexpectedly losing her 22 year old son. The video story described the excellent clinical care, however the bereavement experience in terms of information and making memories did not meet the mum and her family's expectation. CB reported that considerable work had been undertaken in this area, with support from the individual in the patient story, while recognising that further development is required. CD highlighted the importance of alignment with the national framework, noting that the Bereavement Strategy is due to be launched later in the year and that the Bereavement Suite has now been relocated to improve accessibility. LD queried whether volunteers could provide additional support. CD advised that this could be explored with a focus on identifying appropriate individuals, confirming that staff are already involved as part of the improvement plan. SI reflected that the patient story shared was powerful and welcomed that actions were already being progressed. SR noted that paediatrics and maternity services are more advanced in managing deaths within maternity, and suggested drawing on their valuable learning. CD acknowledged that there are lessons to be learned across Divisions, including the role of bereavement midwives, and advised that opportunities to utilise charitable funds could also be explored. HS highlighted the potential for collaboration with hospices to inform development of this strategy. MD emphasised the complexity of navigating bereavement processes within the hospital setting, as well as other situations noting that clearer information and support, such as leaflets or face-	

	to-face guidance, could benefit patients and families beyond end-of-life situations. JH referenced the Patient Experience Strategy, which included the use of video resources to support patients prior to procedures, and emphasised the importance of continued learning and improvement to enhance end-of-life care and ensure patients feel supported, while recognising that further opportunities for development remain. The Group Board NOTED the video story.	
6	Joint Chair Update SI reported that finalisation of financial plan was progressing well and thanked the team for their continued work. SI commented about the importance of delivering the agreed plans both at Trust and system level. SI added he had undertaken service visits across both Trusts, with particular praise for digital developments within orthopaedics, which have received an HSJ award, alongside positive observations regarding therapeutics within WCHC, including speech and language services. SI highlighted a number of upcoming meetings, including with the Countess of Chester to discuss horizontal integration and meetings with the ICB regarding the financial plan submission. The Group Board NOTED the verbal update.	
7	Joint Chief Executive Officer Report JH gave an update regarding Better Together - Journey to Integration, highlighting the statutory transaction remained ongoing and the new Joint Strategy would launch in April. JH reported NHSE and the Local Maternity and Neonatal System (LMNS) Annual Maternity Visit took place on 5 March and initial verbal feedback had been positive. JH added the Digitally Supported Arthroplasty Service team at WUTH had been shortlisted for the HSJ Digital Awards 2026 in the category Empowering Patients Through Digital. JH stated WUTH had welcomed and received a visit from the President of the British Geriatrics Society and positive feedback had been received regarding the progress and the collaborative approach demonstrated by the teams. JH referenced a number of appointments to NHS Cheshire and Merseyside and NHS England North West.	

	JH provided an overview of the various national developments since the last meeting, including the publication of the national cancer plan for England, changes to nursing graduate pay and job progression, and the publication of the 2026/27 NHS Standard Contract. JH reported at WUTH in January and February there were three RIDDORs (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive. No Patient Safety Incident Investigations were opened under the Patient Safety Incident Response Framework. JH stated a quality priority collaboration event was held in March for WUTH and WCHC staff to discuss our first joint quality priorities for 2026/27. The four priorities are falls, pressure ulcers, medications, and discharge. JH highlighted the various WUTH and WCHC employee of the month and standout winners for January and February and explained a staff recognition week took place during March to celebrate and thank the various award winners. The Group Board NOTED the report.	
8	WCHC Integrated Performance Report HK explained 4-hour performance for the Urgent Treatment Centre and Walk In Centres was on target at 95.3% in month, however high-level risks remain regarding workforce. Resilience is improving with reductions in sickness absence; however some challenges remain, particularly in the Minor Injuries Unit which may have to temporarily close. Eastham WIC re-opened on 9 February after a temporary closure due to safe staffing levels. HK added the dental waiting list remained a concern due to demand and ongoing staffing challenges. Options were being explored to increase capacity. HK explained CICC occupancy for M11 was well above target at 97.7% and length of stay at 18 days against a 21-day target. LD queried what the driver was regarding the Minor Injuries Unit. HK explained this was due to Advanced Nurse Practitioner sickness absence and workforce challenges. SR enquired about the dental waiting list, suggesting liaising with the ICB regarding this as they had recently launched a children's dental campaign.	

	HK agreed, stating this was a new 10 year contract and the team would review the available options with the clinical lead. SI queried the 2026/27 performance targets and the achievability of these. HK stated the Trust finished 2025/26 in line with the agreed trajectories and was in a strong position to continue deliver into the new financial year. CD highlighted there has been a reduction in incident and patient safety incident reporting during M11, resulting in concerning special cause variation for overall incident reporting. Further analysis is in progress to understand the reason for this reduction and to identify which incident codes have been subject to reduced reporting. MC reported at the end of February, the Trust is reporting a surplus of £4.8m against a planned deficit of £0.067m, a positive variance to plan of £4.867m. At M11 the Trust has transacted £4.9m of CIP against a full year target of £6.6m. This shortfall will be fully mitigated by additional CIP and non-recurrent underspends. The Group Board: • NOTED performance to the end of February 2026 (or latest available months data); and • NOTED the summary position reflecting the latest publication of the NOF is also included in the IPR	
9	WUTH Integrated Performance Report DS reported sickness absence levels are above the Trust's 5% threshold but continue to demonstrate improvement. DS added mandatory training compliance dipped below target in January 2026 due to a risk identified during alignment with Core Skills Training Framework relating to fire awareness. DS explained targeted action throughout January and February has resulted in a 22.26% increase to almost 70% for fire awareness level 1. MD queried the timeframe for achieving the mandatory training compliance target. DS stated the Trust is aiming to reach 90% overall compliance for mandatory training by the end of April 2026. CD reported in February there were 16 C Diff cases, which is the same as last month. CD added at least 6 of these patients were on a Norovirus outbreak ward at the time of diagnosis. 4 patients were known to have a history of C Diff. CD stated there was 1 Hospital Acquired Pressure Ulcer Category 3 and 4 (Category 3 and above) Pressure Ulcers that worsened in our care.	

	CD highlighted the Trust recorded 284 informal concerns (Level 1) and 28 formal complaints (Level 2). Both figures represent a modest reduction from January, with informal concerns down 6% and formal complaints down 15% month-on-month. Despite this improvement, activity remains above historical averages. Members discussed the difference in the number of complaints compared to WCHC, noting a significant number originated from the Emergency Department which was operationally very challenged. The nature of complaints was also more complex. Members acknowledged a new Divisional Director of Nursing was in place and the Governance Support Unit had been asked to provide additional support to deal with the number of open complaints. LG suggested the Trusts should also consider recording and publishing compliments. MD queried the increase in pressure ulcers. CD advised this reflects normal variation, with ongoing collaborative work likely to identify underlying causes and potential spikes in reporting. It was noted that tissue viability services exist across both Trusts, with opportunities to strengthen joint working being explored. HK reported that mattress management has been a challenge, with 70 specialist mattresses purchased to improve access and support regular checks. SI queried if a mattress replacement programme was in place. HK confirmed a rolling programme is not yet established but is in development, with audits ongoing and scope for strengthening this area. NS stated NEWS2 compliance was slightly below target. Ongoing work on areas of non-compliance is monitored through Divisional DPRs, with live reporting on BI portal accessible to all ward managers. NS added the 4 Never Events occurred in 2025/26 and this KPI would be reset as of 1 April. MC stated that the Trust is reporting a deficit of £36m, which, excluding DSF, is a £15.2m adverse variance to plan. Non recurrent mitigations have been deployed to support delivery against the plan, including £2.6m of income in respect of Industrial Action, which has helped to partially mitigate the variance. MC stated that the Trust is on track to deliver the revised forecast and there are no risks highlighted to impact this. The risk ratings for the financial targets on financial stability, sustainability, and	
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	efficiency are red, while the agency spend and capital are green. Cash is amber for M10 and red for the full year forecast, and it should be noted that the cash position has been supported by NHSE through cash applications. There is no guarantee that this support will continue. The Group Board: • NOTED performance to the end of February 2026 (or latest available months data); • NOTED the summary position reflecting the latest publication of the NOF is also included in the IPR; • NOTED the Trust has reported an adverse variance to plan; • NOTED that the Trust's most immediate finance risk remains the cash position and APPROVED that the CFO submits additional applications based on confirmed need; and • NOTED that, as approved by the Board, the Trust has confirmed to NHSE a revised forecast outturn for 2025/26 of a £49.5m deficit, representing a £27.4m adverse variance against the plan	
10	Executive Managing Director Report HK reported in February that the Trust attained an overall performance of 108% against plan for outpatients and an overall performance of 99.5% against plan for elective admissions. HK added the national outpatient sprint continues in quarter 4, where Trusts will receive income for over delivering against quarter 4 outpatient plan in order to increase referral to treatment performance above March 2026 target levels. HK explained in February the Trust achieved trajectory for RTT caseload but was over trajectory for percentage of patients waiting 18 weeks or under, and the number and percentage of 52-week waiters. HK stated the Trust did not meet the national cancer standards for January and explained a robust mitigation plan was in place at Divisional level. HK highlighted for unscheduled care in February, type 1 performance was reported at 46.18% and the number of patients waiting over 12 hours reduced compared to the previous month, however, it remained above trajectory. HK added corridor care reduced during the month and there was a further increase in the proportion of patients in acute beds with no criteria to reside. SR queried the impact of mental health patients on the running of the department.	

	HK advised that work undertaken over winter with the Director of Operations and CWP which has resulted in a significant reduction in patient volumes MD acknowledged the improvements delivered through the recent sprint and queried whether these were driven by additional funding, or renewed focus, and how they could be sustained. HK advised that continued focus will be required to sustain improvements for the benefits of both patients and staff. HK added from a planned care perspective, previous funding had ceased but RTT requirements remain and a business case under review to explore alternative options. HS queried whether delays in unscheduled care were cultural or operational. HK advised this is primarily cultural, particularly within ED and reset was underway involving the medical team. HS sought clarity regarding mental health provision, including first aiders, and whether a crisis centre is being built. HK confirmed that space has been built and is expected to be completed in 2026/27, in addition to currently available rooms. DS stated that WUTH had 130 mental health first aiders and WCHC had 54. The Group Board NOTED the report.	
11	WUTH Board Assurance Framework (BAF) AH provided an overview of the year-end position of the strategic risks, noting the BAF has tracked 12 strategic risks during the year. AH added of the 12 strategic risks, 6 are scored 15 or above - ID1, 2, 3, 4, 6 and 11, and 2 risks have achieved their target risk rating in year - ID10 and 12. AH provided an overview of the new BAF, noting the new 12 strategic risks have been aligned to the new strategic objectives as described in the new Joint Strategy. AH added these new strategic risks were aligned to Joint Committees and had a responsible Executive Director lead. AH referenced the new BAF template, which was in progress and would continue to be developed with a full review of the current actions and controls.	

	Members discussed the BAF and agreed the position and controls were accurate reflected the current environment. Members also welcomed the new strategic risks and the alignment in the new Joint Strategy. The Group Board: • APPROVED the year-end position on each of the strategic risks as reviewed by the sub-committees of the Board; • APPROVED the recommendations for strategic risks for 2026-27; and • NOTED the completion of the Assurance Framework Review 25-26 which will be reported in full to the Audit & Risk Committee	
12	WCHC Board Assurance Framework (BAF) AH presented the BAF, noting the year-end position showed nine strategic risks tracked during 2025/26 and a position was provided for each, including the proposed year-end position following review by the relevant sub-committees of the Board. AH added at year-end there remained one high-level risk - ID07 - which was monitored via the People & Culture Committee. No risk had achieved its target risk rating, but each had been tracked for gaps and completion of actions. Any outstanding actions would be reviewed and aligned with the new strategic risks for 2026-27. AH set out the same strategic risks for 2026/27 as mentioned in the previous agenda item. Members discussed the BAF and agreed the position and controls were accurate reflected the current environment. The Group Board: • APPROVED the year-end position on each of the strategic risks as reviewed by the sub-committees of the Board; • APPROVED the recommendations for strategic risks for 2026-27; and • NOTED the completion of the Assurance Framework Review 25-26 which will be reported in full to the Audit & Risk Committee	
13	Lead Governors Reports SH welcomed the reduction in corridor care. SH expressed a keenness for Governors to be part of future walkabouts which will enhance engagement with individual NEDs. SH also referenced the work ongoing regionally and nationally regarding the future role of the Governors and any future public accountability model.	

	LC reported that recent Governor elections had been positive, with strong attendance at induction sessions, and confirmed that a Council of Governors meeting will take place in April. The Group Board NOTED the verbal updates.	
14	Committee Chairs Reports – WUTH Audit and Risk Committee LG alerted members that the Committee noted the increase in ID05 reflecting staff experience and the impact of organisational change on morale and culture. This would be discussed at People Committee. The Committee endorsed the risk and associated rating. LG also alerted members that the Committee noted that the revised finance forecast represented a significant update to the position but did not change the risk score which was already high. LG alerted members that the Committee approved the Joint Standing Financial Instructions (SFIs) and recommended the SFI's to Group Board for approval. LG summarised the various “Advise” and “Assure” matters from the meeting on 13 February. The Group Board NOTED the report.	
15	Committee Chairs Reports – WUTH Finance Business Performance Committee MD alerted members that the Committee reviewed the month 10 position, noting the Trust reported a deficit of £32.3m to date which excluding Deficit Support Funding (DSF) which is £13.6m adverse variance to plan with the most significant change compared to month 9 being the recognition of the loss of income due to the impact of the Sterile Services critical incident. MD also alerted members that as approved by the Board, the Trust has confirmed to NHSE the revised forecast outturn for 2025/26, and the most immediate risk remains the cash position. MD alerted members that urgent care performance particularly 4hr and 12hr has been significantly challenging during this period due to increased flow with this compounded due to the UECUP capital and refurbishment work underway. MD summarised the various “Advise” and “Assure” matters from the meeting on 21 January. The Group Board NOTED the report.	
16	Committee Chairs Reports – WUTH Quality Committee	

	SR alerted members that the Trust had breached its agreed annual trajectory for Clostridioides difficile (C diff) infections, noting the need for continued focus on fundamental infection control procedures in addition to improving patient flow. SR also alerted members that higher-grade tissue ulcers remain a concern and, as such, will be a key component of both Trusts' quality improvement plans for 2026/27, lead through a "fundamentals of care" group. SR stated there continued to be oversight, with a weekly executive-led meeting focusing focus on patients with no criteria to reside at the Trust. SR summarised the various "Advise" and "Assure" matters from the meeting on 25 March. The Group Board NOTED the report.	
17	Committee Chairs Reports – WUTH People Committee LD explained the Deputy Chief People Officer provided a verbal update at the last meeting and that this report summarised that update. The Group Board NOTED the report.	
18	Committee Chairs Reports – WCHC Audit Committee LG alerted members that risk ID07 remains high and has continued oversight by the People and Culture Committee. LG also alerted members that the Committee approved the Joint Standing Financial Instructions (SFIs) and recommended the SFI's to Group Board for approval. LG summarised the various "Advise" and "Assure" matters from the meeting on 13 February. The Group Board NOTED the report.	
19	Committee Chairs Reports – WCHC Finance and Performance Committee MD alerted members that the Committee reviewed the month 10 position, noting a reported surplus of £4.4m ahead of plan. There was confidence that the Trust would achieve its target outturn. MD also alerted members that the Committee discussed the 2026–29 financial plan, which set out a compliant position anchored by a £0.9m surplus in 26/27 which was the same level of surplus for 25/26. The efficiency requirement totalled £5.0m in year one and £2.18m in subsequent years.	

	MD added that working figures are required by the plan to move from 1,507 whole time equivalents to 1,348. This was primarily through infrastructure and support roles with bank and agency usage falling year on year. The biggest financial risks were the deconstructing of the block contract and delivery of the CIP. MD summarised the various “Advise” and “Assure” matters from the meeting on 20 February. The Group Board NOTED the report.	
20	Committee Chairs Reports – WCHC Quality and Safety Committee CB stated there are no issues to alert to from the last meeting of the Committee recognising that the position in relation to all high-level risks and strategic risks was discussed and mitigations reviewed, and a number of important reports were received by the Committee for assurance. CB added that the issues previously raised as alerts have been followed up through reports and updates to the last meeting, namely the CQC reports of the UTC and Walk-in Centre and the internal audit on Clinical Supervision. CB summarised the various “Advise” and “Assure” matters from the meeting on 25 March. The Group Board NOTED the report.	
21	Committee Chairs Reports – WCHC People and Culture Committee LD explained the Deputy Chief People Officer provided a verbal update at the last meeting and that this report summarised that update. The Group Board NOTED the report.	
22	Committee Chairs Reports – Joint People Committee LD provided a verbal update on the 30 March meeting and alerted members that sickness absence had improved overall, although the estates staff group remained a concern. LD also alerted members that recent staff survey results had showed a decrease in satisfaction reported across several areas, and it was agreed that the action plan would be updated to reflect the shared responsibility of all Divisional teams instead of only Workforce.	

	LD advised members that the Committee received two internal audit reports on recruitment processes and payroll transitional arrangements. LD assured members that the Committee received a detailed deep dive into CSW banding following organisational change, noting an overall reduction in sickness absence and that of the 100 CSWs initially expected to move, only five had transferred across wards, with learning identified in relation to workforce transformation. LD also assured members that good progress was also noted in relation to sexual health safety changes, with assurance provided, and it was suggested that a future Board seminar be arranged to cover this area alongside employment law. The Group Board NOTED the verbal update.	
23	WUTH Quarterly Maternity and Neonatal Services Report JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were two areas of partial compliance. These were related to midwifery staffing below Birth Rate+ acuity and recommendations from national reports not implemented. JL added the business case approved by Board continued to be recruited to and work to address recommendations related to estates and triage was underway. JL stated there were no Patient Safety Investigation Incidents (PSIIs) or Newborn Safety Incidents (MNSI) declared for Maternity Services or Neonatal Services in January and February. JL gave an update on the Maternity Incentive Scheme (MIS) Year 8, noting no technical guidance had been released yet and this was expected in the spring. JL referenced the Perinatal Mortality Reviews Summary Report (PMRT) for quarter 3 2025/26 which summarised the number of stillbirths and perinatal deaths. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 97% compliance against the 6 elements based on evidence as of 31 December 2025. JL added the Trust continued to work towards full implementation of this. JL summarised the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services.	

	JL provided an update on the midwifery workforce using the Birth Rate + workforce tool, noting the Board had recently approved an increase in the establishment to meet the safe staffing levels and recruitment was underway. JL set out the annual Maternity CQC survey results, noting the improved position and positive results. JL highlighted the NHSE and LMNS annual maternity visit had taken place on 5 March and summarised the key strengths identified. SR commented from a recent maternity safety walkabout that there was a noticeable positive difference in the environment, with staff experiencing increased capacity to provide care, taking time to reflect, and considering opportunities for further service improvement enabled by the additional time available. Members thanked JL for their continued hard work, strengthened by good triangulation and consistency of high quality reporting. The Group Board: • NOTED the report and associated appendices; • NOTED the Perinatal Clinical Surveillance Assurance report; • NOTED the position of the Maternity and Newborn Safety Investigations (MNSI) and any declared PSII's; • NOTED the submission of the Trust's position with Maternity Incentive Scheme Year 7 and potential changes for MIS Year 8; • NOTED the summary of expected reports for maternity and neonates in 2026; • NOTED the PMRT reports for Q2 25/26; • NOTED the progress of the Trust's position with Saving Babies Lives v3; • NOTED the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals'; • NOTED the progress with the Maternity Portal Online Programme; • NOTED the results of the CQC 2025 maternity survey; • NOTED the outcome of the UNICEF accreditation; and • NOTED the feedback of the joint NHSE and Northwest Regional visit in March 2026	
24	WUTH Learning from Deaths Report Q3 2025/26 NS summarised the mortality comparators, stating for the reporting period the Summary Hospital Level Mortality Indicator (SHMI) was within the expected range.	

	NS added Hospital Standardised Mortality Ratio (HSMR) had increased and remains in the above expected range, noting this was due to the impact of coding backlogs during 2025 which members had previously been made aware of. NS provided a summary of adult in patient deaths and case reviews, stating that, of the 441 deaths, 19 cases were escalated for review by the Medical Examiner and the Mortality Review Group reviewed a random selection of deaths to identify learning. NS also provided a summary of the perinatal and neonatal deaths and the outcome of the PRMT reviews. NS stated general learning from mortality reviews included lack of treatment escalation planning/lack of recognition of dying phases as well as copying and pasting medical records in the EPR and prescribing errors, noting these did not result in harm. NS indicated regarding external benchmarking respiratory failure has been flagged as requiring further review and an audit of those deaths was underway and will be reported back through the Morality Review Group. The Group Board NOTED the report.	
25	WCHC Learning from Deaths Report Q3 2025/26 NS reported during the quarter 4, deaths were investigated through the mortality group structure. This includes a total of 7 child deaths. NS added of the 7 child deaths, 1 occurred in a patient who had received an element of care by the Trust and on review the death was not related to the care provided by the Trust. The other 6 were deaths that occurred in the community. The Group Board NOTED the report.	
26	WUTH Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2025 Assessment DS gave an overview of the 2025 Equality Delivery System (EDS) self-assessment and the ratings for domain 1, 2 and 3, noting the proposal was to maintain the same ratings for domain 2 and 3 similar to last year as achieving activity. DS advised for domain 1, commissioned or provided services a different service was assessed each year, indicating it was MSK services this year and does not represent a like for like comparison. This was rated as developing activity. DS stated due to this this change the Trust was proposing to the rated as developing activity instead of achieving activity.	

	The Group Board: • NOTED the report; and • RATIFIED the EDS recommended rating	
27	WCHC Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2025 Assessment DS advised an identical process was undertaken for WCHC and similar to WUTH the proposal was to be rated as developing activity, due to the changes in domain 1 rating. The Group Board: • RECEIVED assurance regarding the content of the report in relation to the Trust being an inclusive place to work and receive treatment; and • RATIFIED the EDS recommended rating	
28	Staff Survey Results DS provided an overview of the presentation, noting the WUTH response rate decreased to 42%, below both its 2024 position and the national average (47%) and WCHC maintained a 51% response rate, but this remains below the national average (62%). DS explained of the 9 People Promise elements, 5 were significantly lower for WUTH based on statistically significant changes and for WCHC 3 were significantly lower based on the 2024 score. DS set out the key areas for improvement for both Trusts and the next steps, including engagement and involvement with staff to lead and shape key actions as well feedback and action on “free text” comments. Members commented that upcoming year and the 2026 staff survey results were likely to be challenging and may deteriorate further. DS commented that organisational pressures and the merger was creating an uncertain environment for staff, while emphasising areas within both Trusts’ control and the need to deliver the merger at pace. JH observed that other NHS providers are experiencing similar levels of demand and change, noting the importance of understanding why some providers appear to perform better. SR raised the importance of career progression opportunities for staff and queried this.	

	DS stated this would be looked at in further detail, noting there had been feedback regarding perceptions of unfairness in promotion processes and concerns regarding equitable access. LD emphasised the importance of consistent recruitment practices and documentation to improve perceptions. DS noted that some improvements have been implemented, including enhanced interview feedback, acknowledging that previous feedback had not always supported development. The Group Board: • NOTED the decline in staff satisfaction and the statistically significant different decline in a number of areas; and • NOTED the key areas for improvement and focus on ensuring basics which should be applied locally and across the organisation.	
29	WUTH Charity Annual Report and Accounts 2024/25 AH stated the WUTH Board of Directors had approved this electronically and had been submitted to the Charity Commission in line with the 31 January deadline.	
30	Group Governance Manual AH stated this document had been approved by the Group Board in Private in March and subsequently approved by both Council of Governors. The Group Board NOTED the Group Governance Manual.	
31	Questions from Governors and Public No questions were raised.	
32	Meeting Review Members agreed it had been a good meeting, and everyone had the opportunity to contribute.	
33	Any other Business There was no other business.	

(The meeting closed at 12:15)