

Meeting	Group Board of Directors in Public
Date	Wednesday 2 September
Time	09:00
Location	Hybrid

Agenda Item	Lead	Presenter	Action
1. Welcome and Apologies for Absence	Chair		Note
2. Declarations of Interest	Chair		Note
3. Minutes of the Previous Meeting	Chair		Approve
3.1 Group Board of Directors in Public Minutes - 3 June			

WUTH and WCHC Statutory Board Minutes

3.2 WUTH Board of Directors in Public Minutes - 3 June			
3.3 WCHC Board of Directors in Public Minutes - 3 June			
4. Action Log	Chair		Note

Standing Items

5. Patient Story	Chief Nursing Officer		Note
6. Chair Update – Verbal	Chair		Note
7. Chief Executive Officer Report	Chief Executive Officer		Note
8. Integrated Performance Report	Executive Directors		Note
9. Board Assurance Framework (BAF)	Director of Corporate Affairs & Communications		Approve
10. Lead Governors Report – Verbal	Lead Governors		Note

Joint Committee Chairs Reports

11. Joint Quality and Safety Committee	Dr Steve Ryan		Assure
12. Joint Digital Committee	Haris Sultan		Assure
13. Joint People Committee	Lesley Davies		Assure
14. Joint Finance and Performance Committee	Meredydd David		Assure

WUTH and WCHC Statutory Board Committee Chairs Reports

15.	WUTH Charitable Funds Committee	Lesley Davies		Assure
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Regulatory Reports

16.	WUTH Maternity and Neonatal Services Report	Chief Nursing Officer	Divisional Director of Nursing & Midwifery	Discussion
17.	WUTH Infection Prevention and Control Annual Report 2025/26	Chief Nursing Officer		Assure
18.	WCHC Freedom to Speak Up Annual Report 2025/26	Chief Nursing Officer	Freedom to Speak Up Lead	Assure
19.	WUTH Freedom to Speak Up Annual Report 2025/26	Chief People Officer	Freedom to Speak Up Lead	Assure
20.	WUTH Learning from Deaths Report Q4 2025/26	Chief Medical Officer		Note
21.	WCHC Learning from Deaths Report Q4 2025/26	Chief Medical Officer		Assure
22.	WUTH Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26	Executive Managing Director		Assure
23.	WCHC Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26	Executive Managing Director		Approve
24.	WUTH Mortuary Board Assurance Statement	Chief Nursing Officer		Approve
25.	WCHC Policy Update – Managing Conflicts of Interest	Director of Corporate Affairs & Communications	Company Secretary	Approve

WUTH and WCHC Statutory Board Regulatory Reports

26.	WUTH Accountable Officer Controlled Drugs Report 2025/26	Chief Medical Officer	Director of Pharmacy	Note
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Closing Business

27.	Questions from Governors and Public	Chair
28.	Meeting Review	Chair
29.	Any other Business	Chair

Date and Time of Next Meeting

Wednesday 4 November, 09:00

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

Members present:

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

In attendance:

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

Apologies:

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

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

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

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

	Incident Investigations opened, ensuring continuous safety reviews. JH gave an oversight of staff recognition and engagement, noting the monthly all-staff briefings continue with strong attendance; events marked World Administrative Day, International Nurses Day, and Dying Matters Week; and multiple staff and volunteer awards recognised outstanding contributions across clinical and support services. CB queried the plans on neighbourhood health frameworks and the associated governance arrangements, notably who would be the Accountable Officer and what governance arrangements would be put in place. JH advised that, from a Wirral perspective, work was further ahead due to Wirral Provider Alliance and ICB changes. Clare Watson is leading this work, with partners considering future models and associated commissioning arrangements, which remain to be determined. JC explained that neighbourhoods are being explored through the Wirral Provider Alliance, using the national framework. Six footprints have been agreed with partners. Work is also progressing to identify and assess potential neighbourhood health centre locations, including Arrowe Park, St Catherine's and Health on the High Street options. JC advised that governance and compliance arrangements would sit with the ICB, while overall responsibility in Wirral would rest with the Health and Wellbeing Board. JC was satisfied with progress to date and noted that neighbourhoods are a system responsibility rather than being Trust-led. LD asked whether partners outside the health sector would be included as part of neighbourhood arrangements and referenced the hub model. JC confirmed that this detail is being worked through, including representation from the Council. There is sufficient representation around the table to inform discussions and support development of the model. SR asked about the Frontis building, including its role in COVID and hantavirus responses, and whether future use of the building had been considered. JH advised that discussions had taken place with the national team and that the building remains a valuable asset capable of supporting these functions. A business case is being developed to determine how best to take the proposal forward.	
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	The Group Board NOTED the report.	
8	Joint Integrated Performance Report RM reported that as of April 2026 there were zero Never Events. All LOCSSIP actions had been completed. SHMI remained within the expected range, although an upward trend had been identified due to a coding backlog. This had now been corrected, and improvements would be reflected in forthcoming quarters. CD explained C Diff cases had a slight reduction from the previous month, there were zero hospital-acquired category 3 or 4 pressure ulcers, staffing fill rates above thresholds with recruitment efforts, and zero MRSA but two MSSA bloodstream infections, reflecting ongoing quality and safety monitoring efforts at WUTH. SR asked about the isolation of patients and whether improvements had been seen through reducing corridor care. CD advised that there had been a reduction in May, with six cases recorded. Appropriate recognition of cases and prompt isolation remained key priorities. Work had also moved towards the use of HPV cleaning rather than ward misting. HK reported continued improvements in four-hour performance, with the year finishing ahead of all trajectories. RTT performance had improved, and the Trust remained on track to achieve the 28-day Faster Diagnosis Standard by year-end. Type 1 performance remained a significant challenge. Although only small increases had been seen, these were important in supporting sustainability. Attendances were 15% higher than planned, with walk-in activity contributing significantly to demand. New pathways introduced from July onwards were expected to deliver further improvements. HK added twelve-hour performance remained challenged, although new Divisional leadership team were in place and improvements to SDEC processes were being implemented. Elective RTT pathway improvements were being delivered through the Q2 programme. DM01 performance was below the 95% target due to non-obstetric ultrasound activity but was expected to be compliant for May. SR asked what was driving the increasing number of patients meeting criteria to reside. HK explained that increasing patient numbers continued to impact on 12-hour waits. The most complex pathways were primarily within Pathway 3, where patients were often unsuitable for CICC. Improvements had been seen in recent weeks, with ongoing work alongside the Council. Opportunities were also being explored	

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

DS noted that appraisal processes were not yet fully embedded across the Trust to the same degree as mandatory training. A strategic programme of work over the next two years would incorporate appraisal delivery as part of wider cultural improvement initiatives.

Members agreed that the improvements in sickness absence were positive and aligned with the objectives of the drivers of the deficit programme.

DS further reported that from a WCHC perspective, turnover remained in line with the workforce plan. Sickness absence continued to exceed the threshold at 6.4%. As previously reported to the Board, this would take time to address, with the same programme and principles now being targeted within WCHC.

MD noted that turnover reporting combined controlled and uncontrolled turnover and asked whether future presentations could separately identify turnover resulting from planned WTE reductions.

DS advised that this was difficult to present clearly. However, from a Board perspective, turnover remained in line with plan and was not considered a concern.

The Group Board:

- **NOTED** performance to the end of April 2026 (or latest available months data);
- **NOTED** the summary position reflecting the latest publication of the NOF is also included in the IPR;
- **NOTED** that the WUTH plan has not been approved by NHSE and that further measures are required to meet the mandated control total;
- **NOTED** that WUTH's most immediate finance risk remains the cash position, that the Trust continues to follow the agreed processes for mitigating this issue and therefore to;
- **APPROVED** that the CFO submits additional applications based on confirmed need for WUTH;
- **APPROVED** the revisions to WUTH's capital budget; and
- **NOTED** that full CIP delivery is required to achieve the planned sustainable financial position for WCHC

Board Assurance Framework (BAF)

AH reported multiple Joint Committees reviewed and agreed on risk appetites and ratings for various strategic risks between April and May 2026, with ongoing oversight planned.

AH added of twelve strategic risks, nine have been reviewed; six currently score as high-level risks, including management of unscheduled and planned care, workforce challenges, financial plan delivery, service transformation, and cyber-attack risks.

In light of current organisational performance, JH suggested that the risk ID01 should be reviewed again by the relevant Committee and expressed the view that the current score of 16 may need to be increased.

CB welcomed the progress being made and highlighted the importance of having visibility of WCHC controls and assurance arrangements.

JH agreed and noted that the BAF should be reviewed to ensure WCHC mitigations are clear. JH also highlighted the reputational perspective, noting that all NOF1 measures on the BAF were currently rated red.

AH advised that a Joint Strategy was in place and that organisational risks were being mapped. It was noted that these points would be considered as part of the next iteration of the BAF.

CB sought assurance regarding internal audits perspective on the approach being taken.

AH confirmed that internal audits had already reviewed and tested the arrangements and that there was a level of assurance with the current approach.

MD commented that there had been robust discussions within the Committees and that assurance was being triangulated effectively across both organisations.

CB commented that risks from each Trust are currently discussed in different forums, making alignment more challenging across the two Trusts.

AH explained that risks are presently considered through Executive Assurance and Risk Committee at WUTH and Integrated Performance Board at WCHC. Work had commenced to improve consistency in thematic reporting, with the next ambition being the development of a single report bringing together organisational risks across both Trusts.

The Group Board:

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

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

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

LD advised members that integration work was progressing well. However, there remains a risk that the planned implementation timetable could move from April 2027 to August 2027, with associated implications for financial delivery and workforce establishment reductions. The Committee also received the Nursing and Midwifery workforce report, noting shortages in Clinical Support Workers (CSWs). Recruitment activity was reported as positive, with 13 appointments having been made within the Emergency Department.

LD assured members that the Committee had received the end-of-year People Strategy report for 2025/26 and had also considered priorities for the 2026/27 People Strategy. Employee relations activity remained low as a proportion of the workforce. The Committee also received assurance regarding the work of the Guardian of Safe Working and staffing oversight arrangements.

LD reported that the Committee had discussed the BAF and considered opportunities to strengthen the way staff experience and culture is reflected. It was agreed that further detail on this aspect would be brought to the July meeting.

SI highlighted the need to manage staff morale in the context of workforce changes.

DS agreed and advised that this must be Board-led, noting that employee experience had already been affected by organisational pressures and uncertainty at the time of the staff survey.

DS acknowledged that integration would bring change and, given the NHS financial position. She noted that colleagues across both Trusts were keen to work together clinically to improve patient care and services and emphasised that organisational culture must be owned and led by the Board.

MD emphasised the importance of communication at every level of the Trust and highlighted the need for managers to be well developed and trained in change management. He also noted the importance of having a consistent script and message.

DS referenced the corporate services organisational change as a relevant example for this.

LG suggested sharing a staff story on integration.

AH reported that work was being progressed using case studies from Cardiology and MSK to demonstrate both clinical improvements and impacts on employee experience, involving colleagues from both Trusts.

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

	CD welcomed the new slides and the clear display of information, noting that it provided the Board with useful assurance and enabled appropriate scrutiny. HK queried whether there were any concerns regarding Standard 4 compliance, specifically the Tier 1 and Tier 2 staffing gaps referenced and sought clarification on the risks associated with these gaps. JL advised that further work was required and suggested exploring whether rota arrangements could be amended before increasing the establishment. JL noted that an approved workforce action plan was required and suggested this should align with forthcoming inquiry recommendations. LG queried the reference in section 9.1 regarding reductions in maternity staffing and sought assurance that no headcount reductions were taking place. DS agreed to confirm if there were any planned maternity headcount reductions. SR acknowledged the implementation of the new MOSS system, noting that it is an external alerting system and does not generate organisational alerts. JL agreed and stated that a MOSS test had been undertaken successfully. JH highlighted the importance of staff morale and asked how staff could be reassured that the organisation remains a safe place to have babies. JL advised that communications with staff focus on positive developments and improvements, with the role of the Maternity Champion being a key element of this approach. The Group Board: • NOTED the report and associated appendices. • NOTED the Quality Oversight Model (PQOM) report. • NOTED the position of the Maternity and Newborn Safety Investigations (MNSI) and any declared PSII's. • NOTED the position of MIS Year 8 and the board oversight requirements supported by the Quality Committee and Maternity and Neonatal Assurance Meeting. • NOTED compliance of 100% with Saving Babies Lives v3. • NOTED continued compliance with Ockenden, the Three-Year Delivery Plan and the Maternity Programme on-line Portal (MPOP).	Debs Smith
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	• NOTED the position with the maternity self-assessment requiring annual Board oversight. • NOTED the maternity staffing paper and compliance with Birthrate plus recommendations. • NOTED the neonatal staffing paper required to the Board 6 monthly and the improvements required to be BAPM compliant. • NOTED the PMRT reports for Q3 and Q4 25/26. • NOTED the MBRRACE UK Perinatal Mortality Report for 2024; and • NOTED the official feedback from the NHSE visit held in March 2026.	
20	WUTH Biannual Establishment Review CD set the outcome of the biannual review which used the adult safer nursing care tool, noting most adult inpatient wards maintain current staffing levels, with some skill mix changes and a few proposed adjustments. CD added Maternity uses Birthrate Plus tool with full establishment recruited, Children's services face risks related to staffing and patient transfers, Neonatal and Critical Care units follow national guidance with some gaps in supportive roles noted. CB asked whether there is an equivalent process for WCHC and, as services move towards a neighbourhood-based model, how neighbourhood baselines will be established and how a similar evaluation approach could be applied to community services and WCHC. CD advised that the Safe Nursing Staffing Tool has been applied in three wards in WCHC. However, the tool is designed for acute settings and does not translate well to community environments. Work is underway to explore how the tool can be adapted for intermediate care settings. CD noted that there is currently no national tool for assessing community workforce requirements and that opportunities to develop this are being explored. From next year, a combined establishment review will be undertaken. SR asked whether this work feeds into WISE accreditation as a means of demonstrating to the public where high-quality care is being provided. CD confirmed that WISE is currently under review and that this work could be incorporated as part of that review. The Group Board NOTED the report.	

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

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

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

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

(The meeting closed at 12:15)

Meeting	WUTH Board of Directors in Public
Date	Wednesday 3 June 2026
Location	Hybrid

Members present:

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

In attendance:

CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SH	Sheila Hillouse	Lead Public Governor
TC	Tony Cragg	Public Governor
MT	Mark Taylor	Observer

Apologies:

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

Agenda Item	Minutes	Action
1	Welcome and Apologies for Absence SI welcomed members to the meeting. Apologies are noted above.	
2	Declarations of Interest No interests were declared and no interests in relation to the agenda items were declared.	
3	Committee Chairs Reports – WUTH Audit and Risk Committee	

	LG explained there were no areas to alert members to and summarised the various “Advise” and “Assure” matters from the meeting on 23 April. LG highlighted a meeting would take place later in June to approve the Quality Account and Annual Report and Accounts. The Group Board NOTED the report.	
4	Committee Chairs Reports – WUTH Charitable Funds Committee LD alerted members that the Charity has yet to agree a focus for its new campaign. The Committee asked the team to explore the options and bring a proposal to the next meeting. Current options include a wellbeing garden and improvements to the Trust’s family bereavement area. LD summarised the various “Advise” and “Assure” matters from the meeting on 9 April. The Group Board NOTED report.	
5	Questions from Governors and Public No questions were raised.	
6	Meeting Review No comments were made.	
7	Any other Business No other business was raised.	

Meeting	WCHC Board of Directors in Public
Date	Wednesday 3 June 2026
Location	Hybrid

Members present:

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

In attendance:

CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
SH	Sheila Hillouse	Lead Public Governor
TC	Tony Cragg	Public Governor
MT	Mark Taylor	Observer

Apologies:

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

Agenda Item	Minutes	Action
1	Welcome and Apologies for Absence SI welcomed members to the meeting. Apologies are noted above.	
2	Declarations of Interest No interests were declared and no interests in relation to the agenda items were declared.	
3	Committee Chairs Reports – WCHC Audit and Risk Committee	

	LG explained there were no areas to alert members to and summarised the various “Advise” and “Assure” matters from the meeting on 23 April. LG highlighted a meeting would take place later in June to approve the Quality Account and Annual Report and Accounts. The Group Board NOTED the report.	
4	Questions from Governors and Public No questions were raised.	
5	Meeting Review No comments were made.	
6	Any other Business No other business was raised.	

Action Log
Group Board of Directors in Public
2 September 2026

No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1	3 June	19	To confirm if any headcount reductions applied to maternity and neonatal services	Jenny Grant	Complete. There are no planned WTE reductions within maternity and neonates.	September 2026
2	3 June 2026	24	To clarify and confirm who the accountable Executive Director should be for the mortuary, as the guidance states this should be the Chief Nurse, but the licence holder is the CMO	Dr Nikki Stevenson/Chris Douglas	Complete. The Chief Nursing Officer is now the accountable Executive Director for the mortuary.	September 2026

Group Board of Directors in Public
02 September 2026

Item 7

Title	Chief Executive Officer Report
Area Lead	Janelle Holmes, Chief Executive
Author	Janelle Holmes, Chief Executive

Purpose of the Report and Recommendation	
Report For	Information
It is recommended that the Board: Note the report	

Key Points to Note
This report is to provide members with an update on activity undertaken across Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health & Care NHS Foundation Trust (WCHC) since the last meeting and draw the Boards' attention to any local and national developments.

Key Risks
This report relates to these key risks: No key risks identified.

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
This is a standing report to Group Board.			

1	Narrative
1.1	Performance Both Trusts continue to operate in the context of continued demand on services, but positive performance with recovering referral to treatment standards, 4 hour accident and emergency, cancer waits and sustained performance across community services. This reflects the continued commitment, professionalism and flexibility of staff working in both Trusts with teams responding proactively to demand and working collaboratively to support the delivery of care for the Wirral population. Performance across both Trusts is also actively monitored through the National Oversight Framework (NOF) and a summary of the position is included in the Joint Integrated Performance Report.
1.2	Local News and Developments Appointment of Jenny Grant as Joint Chief People Officer for WUTH and WCHC I am delighted to welcome Jenny Grant as the new Joint Chief People Officer for WUTH and WCHC following a comprehensive recruitment process. Jenny joins from Aintree University Hospital, bringing more than 20 years of NHS experience in senior HR and organisational development roles. With a strong background in workforce development and organisational change, she will play a key role in supporting staff and leading the workforce agenda as the two organisations complete their integration. Urgent and Emergency Care Upgrade Programme (UECUP) project completion - Urgent and Emergency Care Facility now open The new Urgent and Emergency Care Facility at Arrowe Park Hospital is now fully operational, marking the completion of the Urgent and Emergency Care Upgrade Programme and the largest capital development at the site since 1982. Delivered while emergency and urgent care services remained fully operational, the project reflects significant collaboration and commitment across Wirral University Teaching Hospital, Wirral Community Health and Care NHS Foundation Trust, and partner organisations. The new facility provides a single point of access for urgent and emergency care, improving patient pathways, flow, and the overall patient experience for both adults and children. This investment will deliver long-term benefits for patients, families and staff through enhanced access to safe, timely and high-quality care.

I would like to acknowledge the UECUP project team for their vision, leadership and perseverance, and offer my sincere thanks to every team and individual who has played a part in bringing this development to life.

New NHS Oversight Framework (NOF) 2026/27 published

The publication of the NHS Oversight Framework (NOF) 2026/27 introduces a more streamlined, rules-based approach to oversight, aligned to the NHS operating model and the ambitions of the 10-Year Health Plan.

The framework applies to both community and acute providers and places greater emphasis on accountability, value-based care, operational performance, financial sustainability and organisational capability.

Provider segmentation will continue to be informed by objective performance metrics and capability assessments. For community providers, the framework reinforces the strategic shift from hospital to community care, prevention and neighbourhood-based services, while acute providers will remain focused on delivery of elective recovery, urgent and emergency care performance, patient flow and productivity.

The NOF also signals a more proportionate approach to intervention, with greater freedoms for high-performing organisations and targeted support where performance or capability concerns are identified.

Update on the NHSE legal undertakings

The Trust continues to work constructively with NHS England in relation to its legal undertakings and remains fully engaged with all associated oversight arrangements.

The Trust is working collaboratively with NHS England to agree exit criteria that will reflect the improvements made.

The Board will continue to receive updates as this work progresses, with a clear focus on maintaining strong governance, sustainable improvement and assurance for patients, partners and regulators.

Wirral 0-19 contract

Following a competitive procurement process and the successful conclusion of the standstill period, the Trust is delighted to have been awarded the Wirral 0-19 Healthy Child Programme contract

This is a significant contract that supports the health, wellbeing and development of children, young people and families across both localities. Building on our strong track record of delivering this service over many years, we look forward to continuing to work with partners to provide high-quality, accessible and responsive care that improves outcomes for local communities.

This success also reflects the dedication, professionalism and commitment of our staff, whose hard work and focus on delivering excellent services for children and families have been instrumental in securing these important contracts for the future.

NHSE - Board and executive assurance: cyber security risk

The Head of Cyber Security at NHSE and the DHSC has written to all NHS trusts and integrated care boards to [ask for assurances that cyber security risks are being managed effectively](#). The letter from Tom Wechsler asked health leaders to show that they have *'clear, sustained programmes for improvement'* regarding cyber security, and recommends that each NHS organisation should formally appoint a member of the executive team responsible for cyber security to assist the board of directors in meeting their accountabilities. For the Trusts this is the Chief Finance Officer / Senior Information Risk Owner (SIRO) supported by the Chief Information Officer who work to ensure that the right cyber security measures are in place, that risks are checked and managed, and that improvements are carried out across the organisation. The letter also recommends that organisations *'gain assurance of their emergency preparedness'*.

The Joint Digital Committee will receive assurance on the Trusts response to this letter at its next meeting in September 2026. This will include our current tracking and audit processes and our approach going forwards including our internal communications and engagement plan. These actions have also been referenced on the relevant risk on the BAF - ID11- *Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care*. This will be further reported to the Board in the AAA report from the Chair of the Digital Committee at the next meeting.

Highly commended for the Professional Development Award in the Medium-sized hospitals category

WUTH has been recognised with a 2026 Royal College of Obstetricians and Gynaecologists (RCOG) Training Evaluation Form (TEF) Award, placing us among the top-performing training units nationally based on trainee feedback across education, training and professional development. The RCOG has also invited us to share the factors behind our success to help spread good practice across the UK.

Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS)

The Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) has awarded the Wirral COPD, Pulmonary Rehabilitation & Oxygen Service PRSAS accreditation for five years following an assessment on 23 April 2026, subject to annual reviews and a full reaccreditation in the fifth year. The letter congratulates the team on their high standard of achievement and includes a report detailing assessment findings, strengths, and recommendations for further improvement.

Publication CQC 2025 Adult Inpatient Survey Benchmark Results

The results of the 2025 Care Quality Commission (CQC) Adult Inpatient Survey have recently been published. Overall, the findings provide positive assurance, with Wirral University Teaching Hospital performing broadly in line with national benchmarks. The Trust was rated as “about the same” as other trusts across the majority of survey questions and all 12 survey domains, reflecting a generally positive experience reported by patients receiving inpatient care.

As with all patient feedback, the Trust is carefully reviewing the results to identify opportunities where the experience of care can be further enhanced. While the survey highlights a small number of areas for improvement, the findings will be considered alongside other sources of patient insight through the Trust's established quality, safety

and patient experience governance arrangements. This work will inform ongoing improvement activity and support the Trust's continued focus on delivering safe, compassionate and high-quality care.

A total of 405 patients responded to the survey, representing a 34.4% response rate, compared with a national average of 38%. The survey reflects the experiences of patients admitted during November 2025.

A detailed analysis of the results, including benchmarking against peer organisations and a supporting improvement plan, will be presented to the September Patient Safety and Quality Board (PSQB) and the Joint Quality and Safety Committee for further consideration and oversight.

2025 National Cancer Patient Experience Survey - results published

I am pleased to report that the survey has highlighted strong performance and significant improvement in cancer services at Wirral University Teaching Hospital (WUTH), with feedback from 210 patients showing high levels of confidence and satisfaction across the cancer pathway.

Patients reported positive experiences of receiving dignified and respectful care, having a named point of contact and access to relevant support information.

WUTH outperformed the national average in key areas, with 85% of patients reporting that the wait for diagnostic test results was about right and 91% saying treatment waiting times in clinics or day units were appropriate.

The Trust improved in 29 survey areas compared with the previous year, including notable gains in areas previously scoring below the national average. Several cancer services, including Breast, Colorectal, Haematology, Prostate, Skin and Urology, achieved 100% positive responses across multiple survey questions, and overall patients rated their care 8.9 out of 10.

The results reflect the commitment of clinical teams to delivering compassionate, high-quality care and will continue to inform further service improvements.

WUTH achieves 7th gold award in preventing accidents and protecting safety

WUTH has achieved its seventh consecutive Gold Award from Royal Society for the Prevention of Accidents (RoSPA) in recognition of sustained excellence in health and safety performance. The award highlights the Trust's continued commitment to maintaining safe environments for patients, staff, visitors and contractors, supported by a strong culture of continuous improvement.

Better Together - Journey to Integration

The Better Together Programme continues to make strong progress across both its strategic and operational priorities.

Following the launch of the Joint Strategy in April 2026, which brought together the collective strengths of both organisations and set out a shared vision to improve services,

	outcomes and experiences for patients and staff, work has continued at pace to translate this vision into tangible improvements. Enabling strategies, including the Clinical Services Strategy, are now being developed to support the delivery of integrated, accessible and person-centred care across our communities. A significant milestone has been reached with the completion and submission of the Strategic Outline Case (SOC) to both the Cheshire and Merseyside Integrated Care Board and NHS England. The Trusts look forward to continuing engagement with system partners as the statutory transaction process progresses and to working collaboratively to ensure the proposed arrangements deliver long-term benefits for patients, communities and staff. Alongside this work, both Trusts continue to pursue every opportunity for greater service collaboration and integration. The recently opened Emergency Department, co-located with the Urgent Treatment Centre, provides a strong example of the benefits that can be achieved when services are designed and delivered together, improving patient access, flow and experience. Progress continues across corporate and clinical services, with the Corporate Services organisational change programme remaining on track and clinical integration advancing in areas such as MSK and Cardiology. These achievements reflect the commitment, professionalism and hard work of colleagues across both organisations. As teams increasingly come together to deliver shared objectives, their dedication and willingness to embrace new ways of working are helping to build the foundations for a more integrated and sustainable future for health and care services across our communities.
1.3	Regional and National News and Developments Cheshire and Merseyside Provider Collaborative (CMPC) Annual Work Plan 2026/27 The CMPC Annual Work Plan shows the impact made across Cheshire and Merseyside in 2025/26 and the collaborative's plans for 2026/27. These include delivery of the CMPC Provider Strategy (CMPC Provider Blueprint) which sets out a shared framework for how providers can align over the next three years. Through it providers will work at scale, flexibly and over time, to strengthen services, reduce fragility and support neighbourhood-based care. Aldey Hey awarded Advanced Foundation Trust status Alder Hey Children's NHS Foundation Trust has been recognised as one of the first Advanced Foundation Trusts, marking a significant milestone as the only children's Trust in this initial phase, reflecting strong partnership across NHS, local government, academia, and other sectors committed to improving outcomes for children and young people. I have written to Aldey Hey sending congratulations on behalf of the Boards of WUTH and WCHC. Update on NHS England Northwest Regional Executive Team

	The NHS England Northwest Regional Executive Team is undergoing several changes including the retirement of Regional Medical Director Michael Gregory, Clare Duggan and James McLean leaving their posts, the appointment of Bridget Lees as acting Regional Chief Nurse, and the secondment of Scott McLean as Regional Director of Delivery and Transformation, with further senior digital appointments anticipated. Minimum standards of patient experience - electives NHS England has outlined minimum standards for patient experience in elective care, requiring trusts to communicate referral status within 28 days, provide clear communication and regular updates while patients wait, offer information about appointments at least 21 days in advance, promptly reschedule cancellations, and inform patients when care is complete, with trusts expected to assess and publicly report their compliance and progress. Trust Boards should assess their current performance against each standard and set out how they will improve where they are not meeting a standard. Trust Boards are also expected to publish a statement in 2026/27 setting out their approach to complying with the minimum standards, followed by an annual statement reflecting their assessment of progress against them. This requirement is being managed through our Executive Managing Director and will travel through our committee and Board approval process during 26/27.
1.4	WUTH Health and Safety There was two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported between May and July. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There was one Patient Safety Incident Investigations (PSII) opened between May and July under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance.
1.5	Published Reports of Interest The following are some reports recently published and of interest to members of the Board, staff and public. • DHSC - Health Bill: fact sheets. This collection of fact sheets, published by the DHSC, provides an overview of key aspects of the new Health Bill. It includes a summary of the Bill itself; how it will enable the creation of a single patient record; the role and functions of the restructured DHSC; data and digital functions; oversight of the health system; an overview of integrated care boards as strategic commissioners and proposed legislative changes affecting patient safety and patient voice. https://www.gov.uk/government/collections/health-bill • Kings Fund - Analysis of the NHS Modernisation Bill 2026. The King's Speech outlined the government's plans to reform how the NHS is led and managed through the proposed NHS Modernisation Bill, with significant changes to the way national and local parts of the system are structured and governed. To help make sense of what this bill could mean in practice, the Kings Fund has brought together

all their latest analysis and commentary at – <https://www.kingsfund.org.uk/insight-and-analysis/projects/nhs-modernisation-bill-2026>

- **Public Policy Projects - Beyond bed management: enabling whole-system patient flow through digital intelligence.** This report summarises the insights from a roundtable organised by Public Policy Projects in March 2026, exploring how patient flow can be improved across the whole care system. It finds that problems with patient flow can be linked to governance as well as technology. It looks at the potential of digital tools and makes various recommendations on how NHS organisations can improve patient flow. https://publicpolicyprojects.com/wp-content/uploads/2026/05/PPP_DDT26_RT1_Report_Beyond_bed_management.pdf
- **Kings Fund - Health inequalities in a nutshell.** Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They remain one of the most pressing challenges facing the UK today – and where you live can have a big impact on your years of healthy life. In this updated explainer, the Kings Fund highlights the scale and urgency of the issue. <https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/health-inequalities-nutshell>
- **Foundation Trust Programme: policy framework.** NHS England has published its policy framework underpinning the advanced foundation trust programme, alongside a guide for applicants offering information for trusts that are seeking to apply. The policy framework sets out the overarching policy intent and principles of the programme. Meanwhile, the guide for applicants sets out the eligibility criteria to apply to become an advanced foundation trust; the assessment criteria to be met to be approved as an advanced foundation trust; the assessment process, including the responsibilities of both applicants and NHS England; and the possible outcomes of the application and what they mean for the applicant. <https://www.england.nhs.uk/long-read/advanced-foundation-trust-programme-policy-framework/>
- **NHS England – NHS Operating Framework 2025/26 Q4 segmentation results, and 2026/27 NHS Oversight Framework.** NHSE has published the 2025/26 Q4 segmentation results and public performance dashboard, including NHS league tables for acute, mental health, community and ambulance trusts. A detailed version is available to NHS staff via the Model Health System. [NHS England » Segmentation and league tables](#). The 2026/27 NHS Oversight Framework has also been published, setting out how NHS England will oversee and assess NHS trusts, foundation trusts and ICBs, and support improvement. [NHS England » NHS Oversight Framework 2026/27](#)
- **NHSE - Minimum standards of patient experience – electives.** NHSE has written to trusts setting out the new minimum standards for planned patient care. The standards define clearly and simply the very minimum patients and carers should expect when they are referred to an elective pathway – including what they should expect at the time of referral, while they are on the waiting list and information about their appointments. The standards have been developed with patients, unpaid carers, patient representative organisations alongside clinicians and NHS teams. <https://www.england.nhs.uk/publication/minimum-standards-for-planned-patient-care/>
- **NHS College of Leadership and Management - NHS leadership and management framework.** This framework aims to set clear expectations for all NHS leaders and managers, including line managers. It includes a code of practice and leadership and management standards for all NHS leaders and

managers. It also contains a self-assessment tool to enable evaluation against the expected standards of managers.
<https://lmframework.leadershipacademy.nhs.uk/>

The Board will also be aware of several significant national reviews and inquiries published over recent months (see below), including;

- Lord Mann Review of Antisemitism and Other Forms of Racism in the NHS and Healthcare Regulatory System,
- Independent Review of Maternity Services at Nottingham University Hospitals, the National Maternity and Neonatal Investigation, and
- Findings relating to post-death care arising from the Fuller Inquiry and Nottingham maternity review.

The Trusts are actively considering each of these reviews, their findings and recommendations through existing governance arrangements, working with clinical and corporate leaders to assess local applicability, identify any actions required and ensure that learning is embedded across the organisation.

This approach provides assurance that the Trusts are responding proactively to national learning, strengthening services where required and maintaining a continued focus on delivering safe, inclusive and high-quality care for patients, families and staff.

- **DHSC - Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system.** Lord John Mann, the government independent advisor on antisemitism, was commissioned by the Secretary of State of Health & Social Care and the Prime Minister to lead a review into how the NHS and its regulatory system recognises, reports, and tackles antisemitism and other forms of racism, following multiple cases of intolerable antisemitism. The report sets out a comprehensive set of recommendations to strengthen accountability, improve reporting and investigation processes, and embed an anti-racist culture across the health system to ensure that patients and staff are better protected from discrimination and abuse.
<https://www.gov.uk/government/publications/lord-mann-review-on-antisemitism-and-other-forms-of-racism-in-the-nhs>
- **DHSC - Findings, conclusions and essential actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust.** This independent review of maternity services at the Nottingham University Hospitals NHS Trust (led by Donna Ockenden) considered the quality of care relating to newborn, infant and maternal harm at the trust. This report covers the findings, conclusions and essential actions of this independent review of maternity services. Based on a review of over 2,500 family cases that formed part of this investigation, the final report outlines: local actions for learning that staff at the trust must do; system-wide learnings; and immediate and essential actions to improve maternity and neonatal care.
<https://www.gov.uk/government/publications/ockenden-review-into-maternity-services-at-nottingham-university-hospitals-nhs-trust-final-report>
- **National Maternity and Neonatal Investigation - Independent Investigation into Maternity and Neonatal Services in England: final report and recommendations.** Baroness Amos (chair of this investigation) has found that the maternity and neonatal system in England is no longer fit to consistently deliver high-quality, compassionate care to every woman and family, and requires

	urgent reform to put safety at its centre, embed a focus on listening to women, and ensure anti-racist practice at every level. This report highlights key areas of concern, identifies barriers to delivering change and sets out a robust package of eight recommendations aimed at delivering long-term systemic and cultural transformation in maternity and neonatal care for the 21st century. The report also includes an additional set of actions that can be taken now, which will make a significant difference to the experience of women and families and the ability of staff to provide safe care. https://www.matneoinv.org.uk/final-reports/. • Department of Health & Social Care (DHSC) - Findings on post-death care and key actions required following the Fuller Inquiry and Nottingham maternity review. The DHSC has issued a letter to trust and ICB senior leaders detailing the key actions required to strengthen post-death care following the Fuller Inquiry and recent Nottingham maternity review. The DHSC has provided supporting documentation which includes a board assurance statement which should be returned by Friday 31 July. https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/
1.6	Communications and Engagement Better Together Awards 2026 Following the launch of the inaugural Better Together Awards bringing the best of both WCHC and WUTH together, we have received a fantastic 271 nominations from across both organisations. Highlighting the incredible work of individuals and teams over the last year, the nominations will now be judged by staff panels to give us our shortlist due to be announced in September. Thank you to everyone who took the time to submit a nomination. Everyone who received a nomination should be very proud. Sharing these stories of exceptional achievements allows us to celebrate and recognise together at the awards event on Friday 20 November. In addition, we received 112 nominations from patients and service users for the People's Choice Award recognising those individuals and teams who have delivered exceptional care and a great patient experience. Employee Recognition - Award Winners At the Monthly All Staff Briefing in July 2026, we were pleased to recognise and congratulate colleagues as follows: • Katie Dennis, winner of the June Employee of the Month - Patient Care Award • IT and Switchboard, winners of the June Team of the Month - Support Services Award • Alix, Emma, Noeleen, Nicola and Arlene (Cheshire East 0-19+ Service), winners of the Standout Winners for June Celebrating Biomedical Science Day at WUTH

During June, colleagues across WUTH came together to celebrate Biomedical Science Day and recognise the important contribution our laboratory teams make to patient care every day.

To mark the occasion, Biomedical Scientists from Laboratory Medicine hosted a display stand in the main foyer at Arrowe Park Hospital, giving colleagues and visitors the opportunity to learn more about Biomedical Science and the role laboratory medicine plays across healthcare.

NHSE visit for National Healthcare Estates and Facilities Day

As part of our celebrations for National Healthcare Estates and Facilities Day in June, we were pleased to welcome colleagues from NHSE.

Vajid Mahmood, NHSE Associate Director of Estates Assurance and Ian Stenton, NHSE National Head of Sustainability visited WUTH to celebrate and thank the staff in our Estates, Facilities and Capital Planning teams for their hard work and dedication.

Vajid said: "Our Estates workforce plays such a vital part in delivering our services. We are here representing NHS England, celebrating the day with all the staff, and more importantly, thanking everyone for their hard work every day. Whether you are a porter, a cleaner or director of estates, every single member of the team plays a vital role in delivering critical services for our patients. Ultimately we are all here for our patients."

I would like to extend my thanks to all colleagues in the Estates & Facilities Teams and to those who supported this visit.

Group Board of Directors in Public
02 September 2026

Item 8

Title	Integrated Performance Report
Area Lead	Executive Directors
Author	Executive Directors

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

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

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

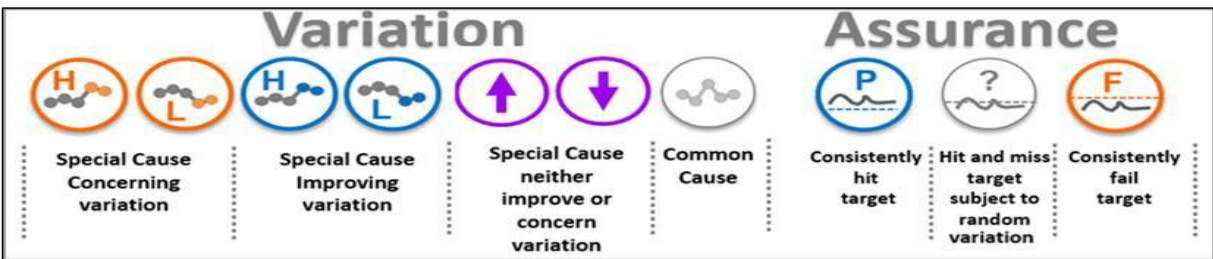
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

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

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

1	Narrative
1.1	This is the joint Integrated Performance Report for the Board, bringing together the two Trust's performance reports. A few amends have been made to the format, including an overall matrix for both Trusts showing all indicators, rather than individual portfolio matrices, and each Executive Director's portfolio now includes a section for WUTH and WCHC, where relevant. 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	Jul 26	5.83%	≤5%			5.91%
Staff turnover % - in-month rate	Jul 26	0.84%	≤1%			87.52%
Mandatory training % compliance	Jul 26	89.56%	≥90%			91.92%
Appraisal % compliance	Jul 26	84.73%	≥88%			0.82%
4-hour Accident and Emergency Target (including APH UTC)	Jul 26	59.97%	≥58.29%			61.1%
Number of inpatients not meeting the Criteria to Reside	Jul 26	135	≤126.6027			158
Patients waiting longer than 12 hours in ED from a decision to admit	Jul 26	575	≤1584			656
Proportion of patients more than 12 hours in ED from time of arrival	Jul 26	17.52%	≤19.24%			18.3%
Ambulance Handovers: % >15 mins	Jul 26	75.64%	≤74.99%			79.4%
Ambulance Handovers: % > 45 mins	Jul 26	11.09%	≤0%			16.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Jul 26	65.22%	≥65.63%			59.6%
Referral to Treatment - total open pathway waiting list	Jul 26	43975	≤45332			45207
Referral to Treatment - cases waiting 65+ wks	Jul 26	0	≤0			9
Referral to Treatment - % of 52+wk waiters	Jul 26	0.70%	≤0.86%			1.95%
Cancer Waits - reduce number waiting 62 days +	Jun 26	66	≤44			130
Cancer - Faster Diagnosis Standard	Jun 26	79.65%	≥79.52%			73.5%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Jun 26	94.20%	≥92.1%			91.5%
Cancer Waits - 62 days to treatment (monthly)	Jun 26	78.04%	≥76.36%			74.8%
Diagnostic Waiters, 6 weeks and over - DM01	Jul 26	94.96%	≥94.5%			93.1%
Long length of stay - number of patients in hospital for 21 or more days	Jul 26	188	≤79			170
Clostridioides difficile (healthcare associated)	Jul 26	17	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Jul 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Jul 26	0	≤0			0
Patient Safety Incidents	Jul 26	1333	-			1230
FFT Overall experience of very good & good: ED	Jul 26	68.1%	≥95%			75.4%
FFT Overall experience of very good & good: Inpatients	Jul 26	96.3%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Jul 26	97.7%	≥95%			95.7%
FFT Overall experience of very good & good: Maternity	Jul 26	94.7%	≥95%			96.3%
Patient Experience: concerns received in month - Level 1 (informal)	Jul 26	297	≤173			239
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Jul 26	7	≤3			3
Falls – Moderate to Severe Harm	Jul 26	0.131	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Jul 26	89.0%	≥90%			89.2%
WUTH Average RN Night Staffing Fill Rates	Jul 26	90.0%	≥90%			91.0%
WUTH Average CSW Day Staffing Fill Rates	Jul 26	88.0%	≥90%			87.3%
WUTH Average CSW Night Staffing Fill Rates	Jul 26	104.0%	≥90%			100.1%
MRSA Cases	Jul 26	0	≤0			0
MSSA Cases	Jul 26	2	≤0			2
% of adult patients VTE risk-assessed on admission	Jul 26	97.5%	≥95%			97.2%
Never Events	2026/27	1	≤0			
NEWS2 Compliance	Jul 26	90.2%	≥90%			89.3%
Mortality (SHMI)	Mar 26	1.015	<1			1.024
Agency spend	Jul 26	1.3%	≤0.8%			
I&E Position	Jul 26	-£10.7m	-£10.8m			
Cumulative CIP	Jul 26	£6.6m	£6.7m			
Capital Expenditure	Jul 26	£3.1m	£3.9m			
Cash Position	Jul 26	£2.6m	£2.7m			
Staff Vacancy as % of workforce	Jul 26	18.5%	≤7%			11.7%
Subject Access requests - waiting list	Jul 26	2817	≤2952			
FOI – Waiting List	Jul 26	148	≤150			
Clinical coding completeness (Freeze)	Jun 26	99.9%	≥100%			93.9%

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 - FFT Overall Experience of very good & good : Outpatients - RTT – cases waiting 65+ wks	- Sickness absence % - in month rate - 18 week RTT - Incomplete pathways < 18 wks - Cancer waits – reduce number waiting 62 days + - % of 52+ wk waiters	
	Common Cause 	- WUTH Average CSW Night Staffing Fill Rates - % of adult patients VTE risk-assessed on admission - Mortality (SHMI) - 12 hr waits from decision to admit in ED	- Staff turnover % in month rate - Clinical coding completeness (Freeze) - Clostridioides difficile (healthcare associated) - Pressure Ulcers – Hospital Acquired Cat 3 and above - FFT Overall experience of very good & good: Maternity - Falls – Moderate to Severe Harm (per 1000 bed days) - WUTH Average RN Day Staffing Fill Rates - WUTH Average RN Night Staffing Fill Rates - WUTH Average CSW Day Staffing Fill rates - MRSA Cases - MSSA Cases - Never Events - NEWS2 Compliance - 4-hour ED Target (including APH UTC) - Number of inpatients not meeting the criteria to reside - 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 - Ambulance Handovers % > 15mins	- FFT Overall experience of very good & good: ED - Ambulance Handovers % > 45 mins	
	Special Cause Concerning 	-	- Appraisal % Compliance - Mandatory Training % compliance - Patient Experience: Concerns received in month – Level 1 (informal) - Patient Experience – complaints in month per 1000 staff – Level 2 (formal)	- Staff Vacancy as % of workforce - Long length of stay – number of patients in hospital for 21 or more days	- Patient Safety Incidents

Wirral University Teaching Hospital
TABLE 1: SCORED METRICS (Contributing to Segmentation)

		2025/26 - Qtr 4 Metric Performance					Metric Value Quartiles 2025/26 Q4					Domain Performance Qtr 4		2025/26 - Qtr 3 Metric Performance				Domain Performance Qtr 3	
Metric	Type	Metric Value	Provider Rank	Time Period	Performance Trajectory	Metric Target	Quartile 1	Quartile 2	Quartile 3	Quartile 4	Quartile Threshold (Improve to the left)	NOF Score	Segment Quartile	Metric Value	Provider Rank	Time Period	Metric Value Quartiles	NOF Score	Segment Quartile
ACCESS TO SERVICES DOMAIN																			
% patients waiting <18 weeks (absolute)	Acute	64.75%	66/130	Mar-26	⬆️	63.30%			64.75%		64.83% to 62.11%	2.64	3	59.30%	81/131	Dec-25	3	3.13	4
% patients waiting <18 weeks (vs plan)	Acute	1.45%	51/130	Mar-26	⬆️	0%		1.45%			2.49% to 0.99%			-2.36%	82/131	Dec-25	3		
% patients waiting >52 weeks	Acute	0.80%	55/130	Mar-26	⬆️	1.00%		0.80%			0.54% to 0.96%			2.22%	87/131	Dec-25	3		
% patients waiting >52 weeks (community)	Community	45.61%	73/78	Mar-26	↔️	-				45.61%	8.69% - 100%			*	-	-	-		
% urgent referrals diagnosed within 28 Days	Acute	75.28%	89/117	To Mar-26	⬆️	80.02%				75.28%	75.53% to 0%			67.72%	107/118	To Dec 2025	4		
% patients treated within 62 days	Acute	73.79%	41/118	To Mar-26	⬆️	77.50%		73.79%			76.71% to 70.24%			72.86%	51/118	To Dec 2025	2		
% A&E patients seen within 4 hours	Acute	70.87%	87/123	To Mar-26	⬆️	66.34%			70.87%		74.01% to 70.19%			70.83%	87/123	To Dec 2025	3		
% A&E attendances >12 hours	Acute	21.95%	121/122	To Mar-26	⬆️	21.85%				21.95%	11.23% to 100%			22.74%	122/123	To Dec 2025	4		
EFFECTIVENESS & EXPERIENCE DOMAIN																			
Summary Hospital Level Mortality Indicator	Acute	2	-	Q4 25/26	↔️			2				2.15	2	2	-	Oct24 - Sep25		1.94	2
Discharge delays (bed days lost) - including zero days	Acute	0.78	63/128	Mar-26	⬇️	-		0.78			0.53 to 0.8			0.54	35/127	Dec-25	2		
CQC inpatient satisfaction	Acute	2	-	Q4 25/26	↔️			2						2	-	2024			
PATIENT SAFETY DOMAIN																			
Staff survey - raising concerns	Acute	6.01	118/134	2025	⬇️					6.01	6.14 to 0	3.31	4	6.17	113/134	2024	4	3.04	4
MRSA infections (rate)	Acute	2	-	To Mar-26	↔️	0		2			1 to 3.5			2	-	To Dec 2025	2		
C-Difficile infections (rate)	Acute	1.37	-	To Mar-26	⬇️	<1				1.37	1.31 to 4			1.22	-	To Dec 2025	3		
E-Coli infections (rate)	Acute	1.28	-	To Mar-26	⬇️	<1			1.28		1.17 to 1.33			1.12	-	To Dec 2025	2		
PEOPLE & WORKFORCE DOMAIN																			
Sickness absence rate	Acute	6.30%	107/134	To Dec-25	⬇️	-			6.30%		5.89% - 6.47%	3.44	4	6.03%	123/134	To Sep 2025	4	3.54	4
Staff survey engagement score	Acute	6.35	126/134	2025	⬇️	-				6.35	6.55 to 0			6.56	119/134	Dec-24	4		
FINANCE & PRODUCTIVITY DOMAIN																			
Combined finance score (planned vs variance)	All Trusts	4	-	Q4 25/26	↔️					4		3.8	4	4	-	Q3 2025/26	4	3.47	4
Planned surplus/deficit	Acute	-4.45%	104/134	Q4 25/26	↔️	Breakeven/ Surplus				-4.45%	-3.99% to -100%			-4.45%	104/134	Apr-25	4		
Variance YTD to plan	Acute	-7.54	133/134	Mar-26	⬇️	>0%				-7.54	-1.49% to -100%			-3.62	125/134	Dec-25	4		
Implied productivity level	Acute	-0.74%	116/134	Dec-25	⬇️					-0.74%	0.92% to -100%			1.50%	87/134	Sep-25	3		

WCHC Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	July 26	11.3%	12.0%			12.4%
Mandatory Training Compliance	July 26	94.4%	90.0%			95.0%
Sickness Absence	July 26	6.2%	5.0%			6.5%
Sickness Absence (Short Term)	July 26	2.2%	2.0%			1.6%
Sickness Absence (Long Term)	July 26	4.0%	3.0%			4.9%
Agency usage	July 26	0.5%	1.0%			0.9%
Variance to Agency Cap (£)	July 26	-188433	-			-177198
% of Agency Usage against Funded WTE	July 26	0.1%	-			0.6%
% of Bank Usage against Funded WTE	July 26	3.6%	-			3.5%
% of Contracted FTE Vacancies	July 26	4.6%	6.0%			5.0%
WIC & UTC Attendances seen within 4 hrs	July 26	96.6%	95.0%			96.10%
CICC Occupancy Rate (Commissioned Beds)	July 26	93.7%	92.0%			95.5%
CICC Median LoS (Active Beds Daily Snapshot)	July 26	15.1	21			18.6
Urgent Community Response - 2 hours	July 26	88.8%	70.0%			87.6%
GPOOH - UCAT Response Times (60 min response)	July 26	99.4%	98.0%			98.8%
GPOOH - UCAT Response Times (15 min response)	July 26	77.1%	65.0%			69.2%
GPOOH - UCAT Response Times (30 min response)	July 26	96.1%	90.0%			93.0%
GPOOH - CAS Response Times (20 min response)	July 26	74.2%	75.0%			69.7%
GPOOH - CAS Response Times (2hr response)	July 26	81.0%	90.0%			70.9%
GPOOH - NHS111 Response Times	July 26	79.7%	75.0%			61.9%
RTT - % of Patients Seen Within 18 Weeks	July 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	July 26	100.0%	99.0%			100.0%
UTC Attendances seen within 4 hrs	July 26	99.1%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	July 26	93.4%	95.0%			94.3%
Eastham Attendances seen within 4 hrs	July 26	97.9%	95.0%			93.9%
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)	July 26	0	0			0
No. of Incidents reported	July 26	517	475			481
Patient Safety Incidents	July 26	230	200			203
Never events	July 26	0	0			0
No. of ICO reportable IG incidents	July 26	0	0			0
Total Complaints Received	July 26	3	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	July 26	0	0			0
Missed medication incidents resulting in moderate or severe harm	July 26	0	0			0
No. of Incidents reported with a moderate and above harm level	July 26	0	0			0
Clostridium difficile infections resulting in moderate or severe harm	July 26	0	0			0
MRSA infections with learning identified for the Trust	July 26	0	0			0
Falls resulting in moderate or above harm	July 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	July 26	0.7%	4.6%			1.4%
No. of concerns received in month	July 26	14	12			12
FFT - % of People who would recommend our services	July 26	90.1%	90.0%			91.5%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	July 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	July 26	0	0			0
No. of reported no and low harm patient safety incidents	July 26	215	200			190

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

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

Wirral Community Health and Care NHS Foundation Trust

TABLE 1: SCORED METRICS (Contributing to Segmentation)

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

* arrow denotes improvement or deterioration from previous score

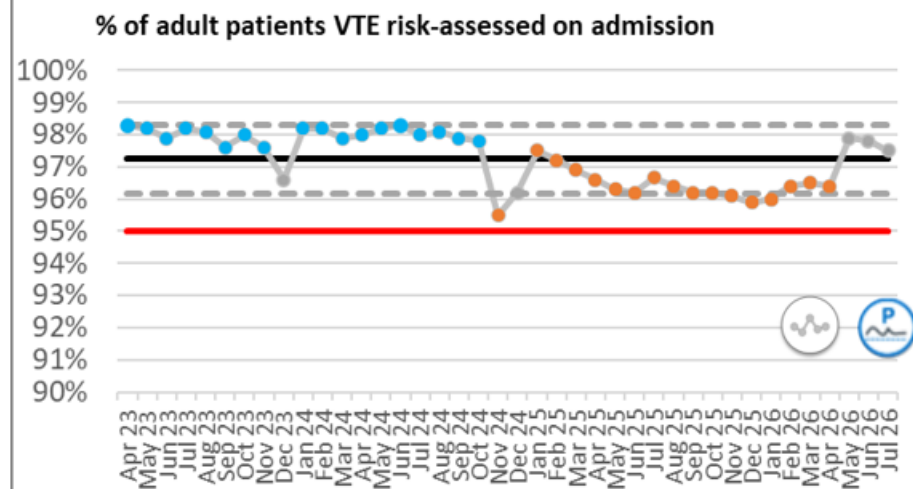
CMO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Jul 26	97.5%	≥95%			97.2%
Never Events	2026/27	1	≤0			
NEWS2 Compliance	Jul 26	90.2%	≥90%			89.3%
Mortality (SHMI)	Mar 26	1.015	<1			1.024

Highlights	Areas of Concern	Forward Look (Actions)
VTE assessment performance remains strong at 97.5%, and above the 95% target One Never Event reported in this financial year NEWS 2 Compliance is above the 90% trust wide target for July SHIMI remains in the “As expected” range, although marginally above the target of 1	Never event relates to a surgical case from December 2024, but declared in July 2026. Although the incident fulfilled the criteria for a Never Event the patient did not suffer serious or long lasting harm as a result Assurance rating is inconsistent, and mean is 89.3%	Continue monitoring and targeting areas of lower Compliance All actions on LocSSIPs action plan have now been completed. Audits or WHO checklist and LocSSIPs have been strengthened and are monitored through DQB and PSQB Performance monitored through DQB and DPRs. Live BI reporting identifies areas of low compliance for targeted action. Leadership structure around deteriorating patient current being reviewed and strengthened SHIMI monitored through MRG. No individual diagnostic groups currently in the “above expected” range. Actions to address coding backlogs from 2025 that may have led to raised SHIMI are now completed.

% of adult patients VTE risk assessed on admission

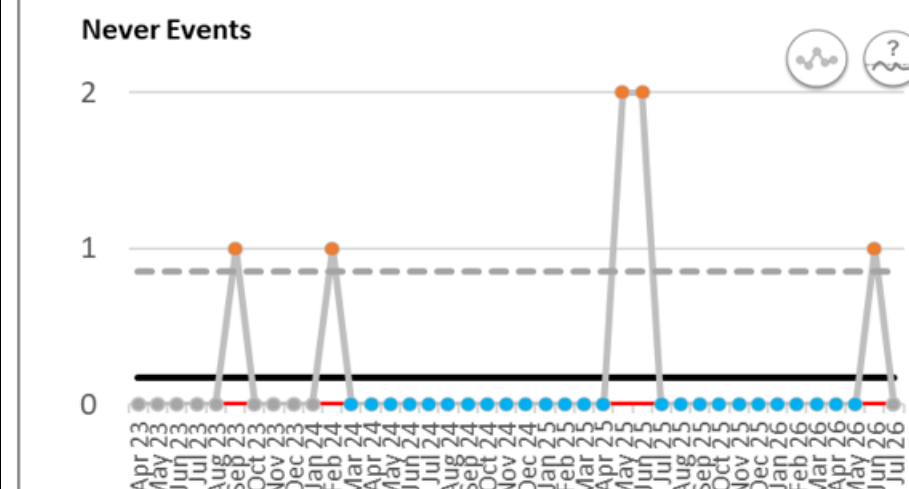
CQC Domain : Safe



Jul-26
97.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

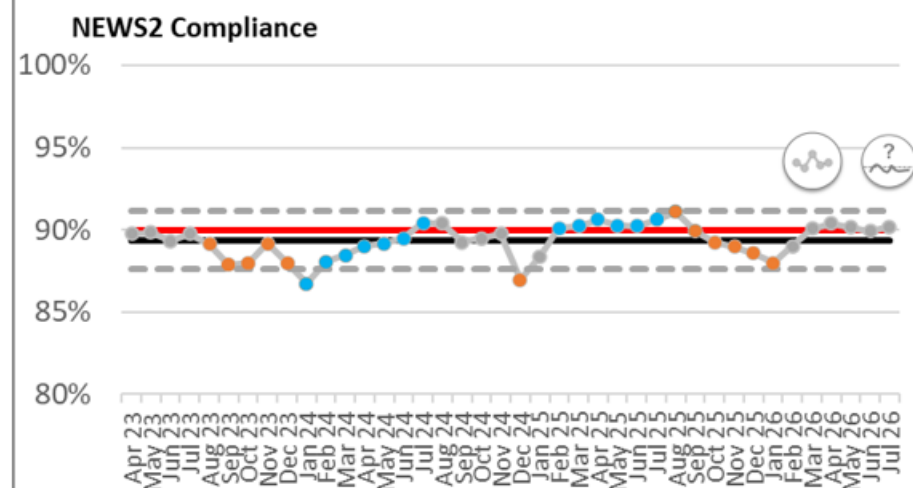
CQC Domain : Safe



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

NEWS 2 Compliance

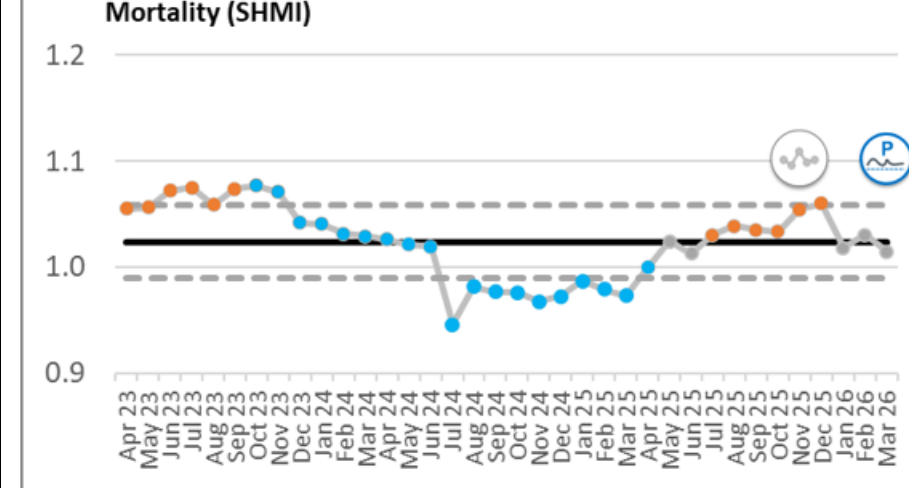
CQC Domain : Well-led



Jul-26
90.2%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Mar-26
1.0145
Variance Type
Common cause variation
Threshold
<1
Assurance
Consistently hit target

CNO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Jul 26	17	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Jul 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Jul 26	0	≤0			0
Patient Safety Incidents	Jul 26	1333	-			1230
FFT Overall experience of very good & good: ED	Jul 26	68.1%	≥95%			75.4%
FFT Overall experience of very good & good: Inpatients	Jul 26	96.3%	≥95%			95.7%
FFT Overall experience of very good & good: Outpatients	Jul 26	97.7%	≥95%			95.7%
FFT Overall experience of very good & good: Maternity	Jul 26	94.7%	≥95%			96.3%
Patient Experience: concerns received in month - Level 1 (informal)	Jul 26	297	≤173			239
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Jul 26	7	≤3			3
Falls – Moderate to Severe Harm	Jul 26	0.131	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Jul 26	89.0%	≥90%			89.2%
WUTH Average RN Night Staffing Fill Rates	Jul 26	90.0%	≥90%			91.0%
WUTH Average CSW Day Staffing Fill Rates	Jul 26	88.0%	≥90%			87.3%
WUTH Average CSW Night Staffing Fill Rates	Jul 26	104.0%	≥90%			100.1%
MRSA Cases	Jul 26	0	≤0			0
MSSA Cases	Jul 26	2	≤0			2

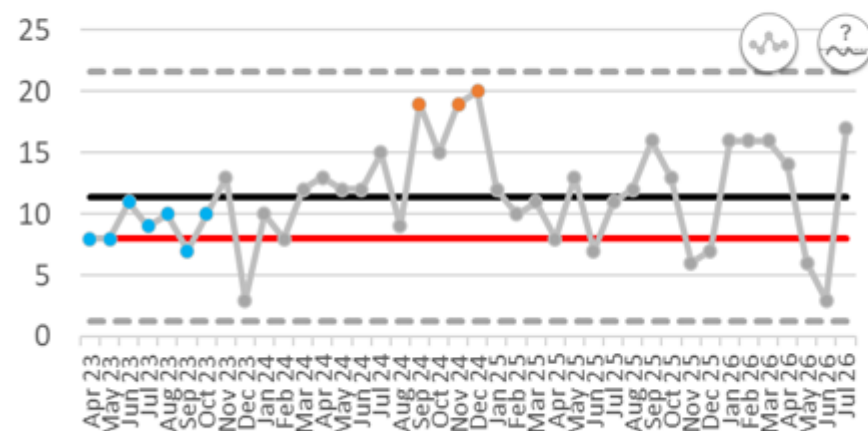
Clostridioides difficile (healthcare associated)		
Highlights In July there were 17 patients with healthcare associated <i>C.difficile</i> , 12 HOHA and 5 COHA. 2 patients had a previous history of CDI and 3 patients had known exposure to CDT/CDE. Increase may be due to operational pressures and Norovirus outbreaks experienced in the previous month.	Areas of Concern - Bristol Stool Chart not completed accurately - Delay in isolating symptomatic patients - Cleaning concerns on wards	Forward Look (Actions) CDT Quality Improvement Planning meeting to be held in September
Pressure Ulcers Hospital acquired Category 3 and above		
Highlights There has been one Category 3 pressure ulcer worsened in care and one new category 3 reported in July 2026.	Areas of Concern - Partial completion of Purpose T - Incorrect pathway identified - Skin check only completed 24 hours after admission not within 6 hours - Incorrect mattress documented - Wound assessments not documented. - Patient end of life pressure ulcer deteriorated.	Forward Look (Actions) - Review the management of patient's that are end of life in terms of pressure ulcer prevention and comfort. - Improve education delivery and competency as part of the QI PU improvement plan.
FFT Overall experience of very good & good: Maternity		
Highlights Maternity FFT score 0.3% below the ≥95%	Areas of Concern 1 response rated as Poor and 1 response rated as Neither. Feedback related to pain management and perception of miscommunication with assistance with infant feeding advice	Forward Look (Actions) Feedback shared with division and aligned teams. Feedback to be monitored for themes as this is an isolated experience Specific Infant feeding team in place with National Guidance

FFT Overall experience of very good & good: ED	FFT Overall experience of very good & good: ED	FFT Overall experience of very good & good: ED
Highlights Significant reduction in ED FFT score 68.1% compared with mean 75.4%	Areas of Concern Waiting times Overcrowding Environmental concerns i.e. cleanliness	Forward Look (Actions) The new urgent and emergency care department has been opened New assessment / triage system gone live New digital FFT system will be launched 1 st September providing timely access to feedback
Complaints		
Highlights - Informal concerns remained stable overall despite sustained demand, with reductions across several clinical divisions. - Access & Admission concerns reduced significantly compared with June.	Areas of Concern - Formal complaints increased significantly to 38 in July, substantially above the 2025/26 monthly average of 24. - Open caseload and response delays increased, with growth in older overdue complaints. - Emergency Department complaint activity remains significantly above other services. - Acknowledgement performance decreased to 74%, reflecting reducing staffing levels in the Patient Experience Team due to long-term sickness versus increased demand. - Infrastructure concerns rose to 55 (from 32), driven predominantly by car parking, and Corporate Departments and Estates, Facilities & Capital both recorded significant increases in informal activity.	Forward Look (Actions) - Increase complaint closure rates and reduce overdue investigations. - Prioritise resolution of the oldest complaint cases.
Falls – Moderate to Severe Harm		
Highlights Learning being identified in ward areas following falls incidents Medicine has weekly falls review meetings Surgical wards present the falls daily to ADN's /Matrons and learning identified	Areas of Concern Common themes coming through RECs is neurological observations – staff not following policy, staff are not equipped with pen torches to undertake these observations as ward managers not able to order.	Forward Look (Actions) - New Falls policy awaiting final sign off in Sep - Launch of Falls champion network – first meeting 17th Sep - Launch of yellow falls boxes for all clinical areas
Staffing		
Highlights RN and CSW fill rates remain above 90% in most areas.	Areas of Concern Although improving position for CSW day fill rate- remains area of focus. Successful ED CSW recruitment and staff due to commence in post .	Forward Look (Actions) Support for ongoing CSW recruitment planned Training / progression plans to support CSW retention
MRSA/MSSA Cases		
Highlights In July there were 0 MRSA bloodstream infections and 2 MSSA bloodstream infections reported, 1 HOHA and 1 COHA. The source of the infection was determined to be due to a peripheral cannula for one patient and a diabetic foot ulcer for the other patient.	Areas of Concern	Forward Look (Actions) Learning from reviews are reported to the Vascular Access Steering Group

Clostridioides difficile (healthcare associated)

CQC Domain : Safe

Clostridioides difficile (healthcare associated)



Jul-26

17

Variance Type

Common cause
variation

Threshold

≤8

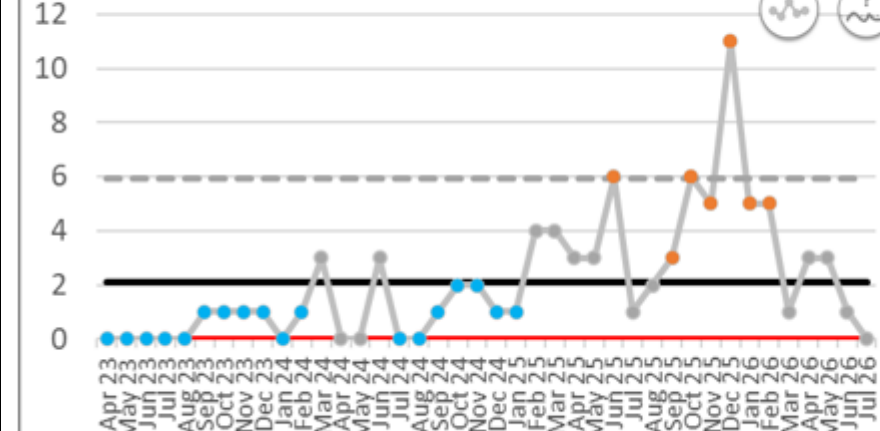
Assurance

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



Jul-26

0

Variance Type

Common cause
variation

Threshold

≤0

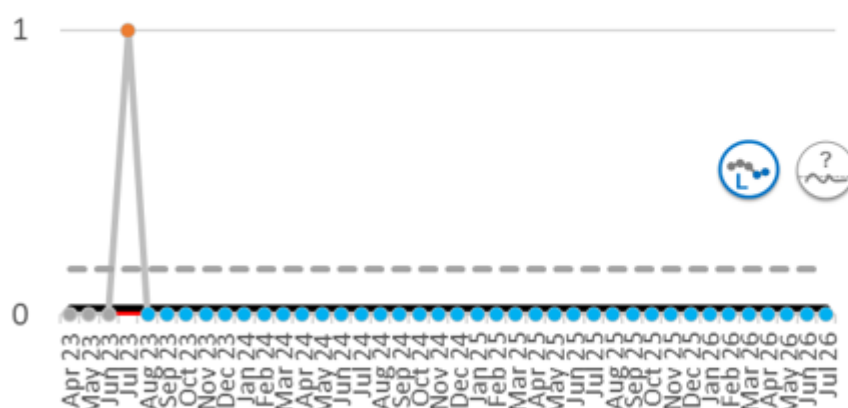
Assurance

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



Jul-26

0

Variance Type

Special cause
improving variation

Threshold

≤0

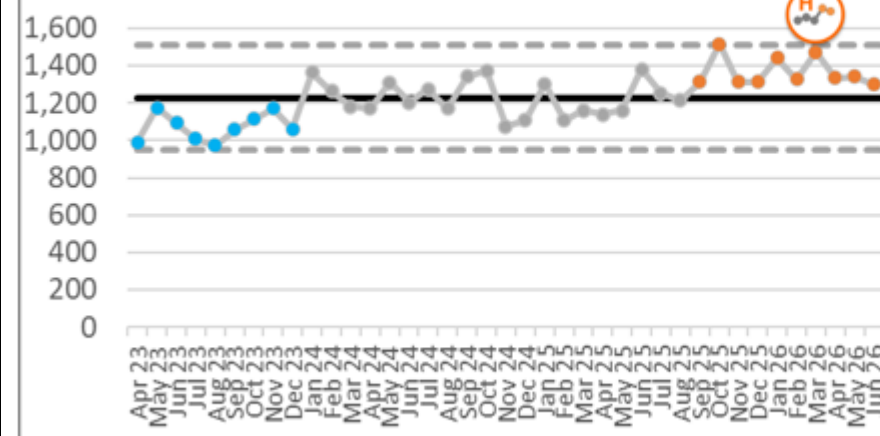
Assurance

Hit and miss target
subject to random
variation

Patient Safety Incidents

CQC Domain : Safe

Patient Safety Incidents



Jul-26

1333

Variance Type

Special cause
concerning variation

Threshold

-

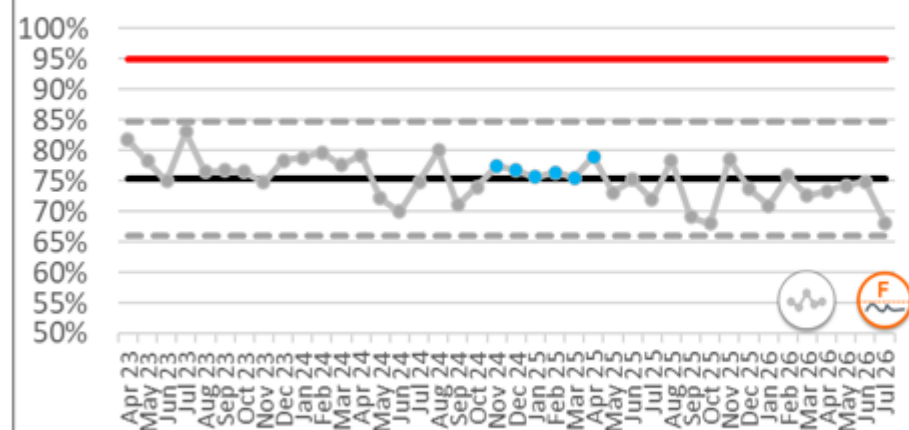
Assurance

Not applicable

FFT Overall experience of very good & good – ED

CQC Domain : Caring

FFT Overall experience of very good & good: ED



Jul-26

68.1%

Variance Type

Common cause
variation

Threshold

≥95%

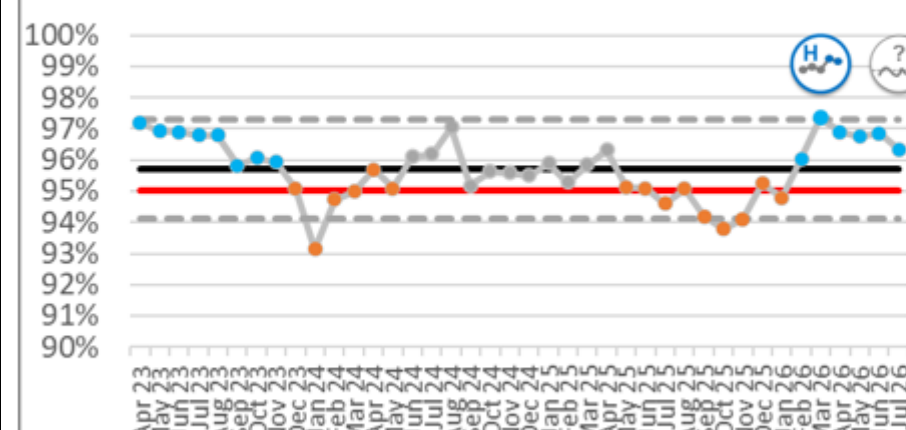
Assurance

Consistently fail target

FFT Overall experience of very good & good – Inpatients

CQC Domain : Caring

FFT Overall experience of very good & good: Inpatients



Jul-26

96.3%

Variance Type

Special cause
improving variation

Threshold

≥95%

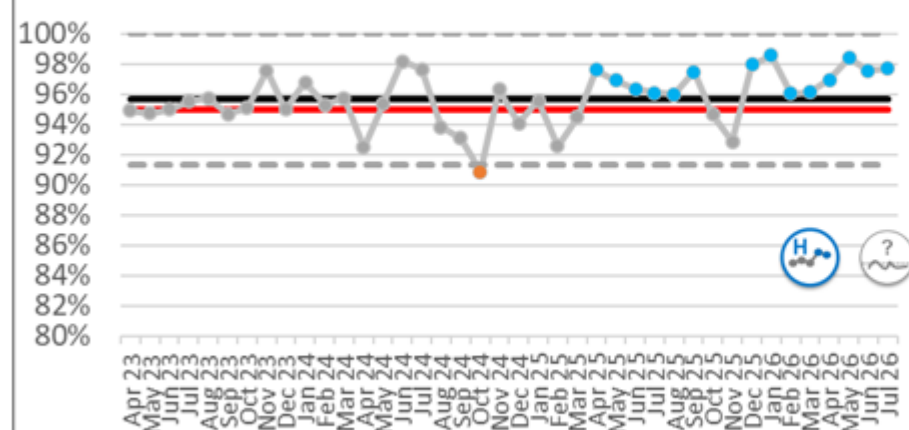
Assurance

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



Jul-26

97.7%

Variance Type

Special cause
improving variation

Threshold

≥95%

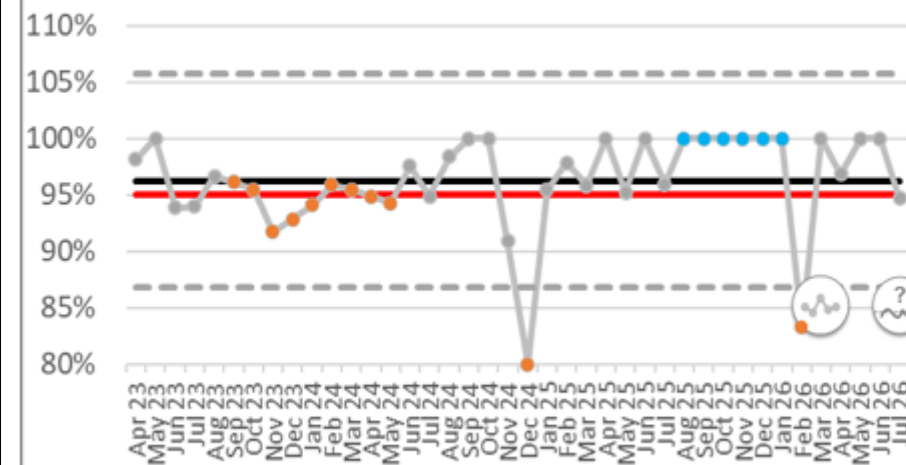
Assurance

Hit and miss target
subject to random
variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Jul-26

94.7%

Variance Type

Common cause
variation

Threshold

≥95%

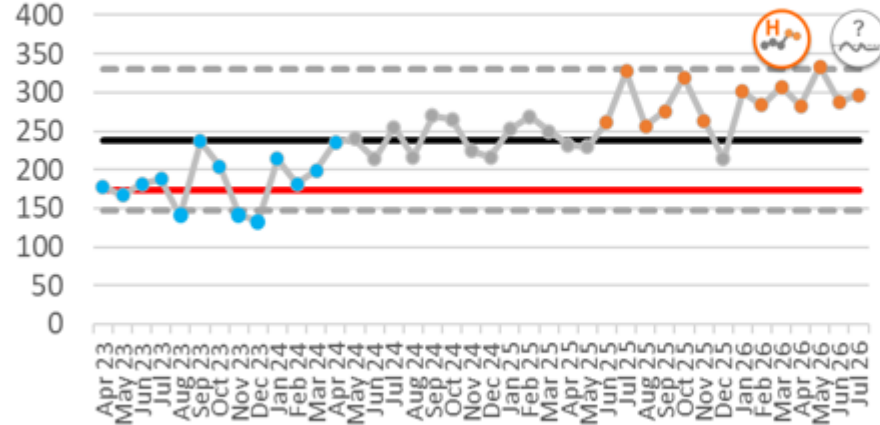
Assurance

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)



Jul-26

297

Variance Type

Special cause concerning variation

Threshold

≤173

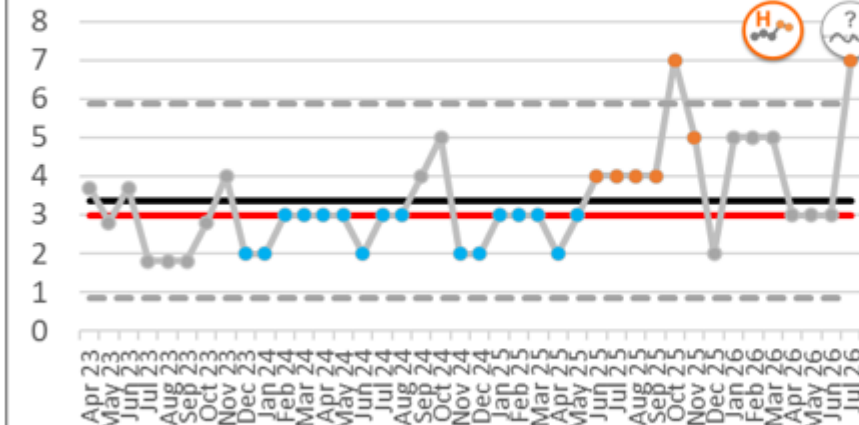
Assurance

Hit and miss target subject to random variation

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

CQC Domain : Responsive

Patient Experience: complaints in month per 1000 staff - Levels 2 (formal)



Jul-26

7

Variance Type

Special cause concerning variation

Threshold

≤3

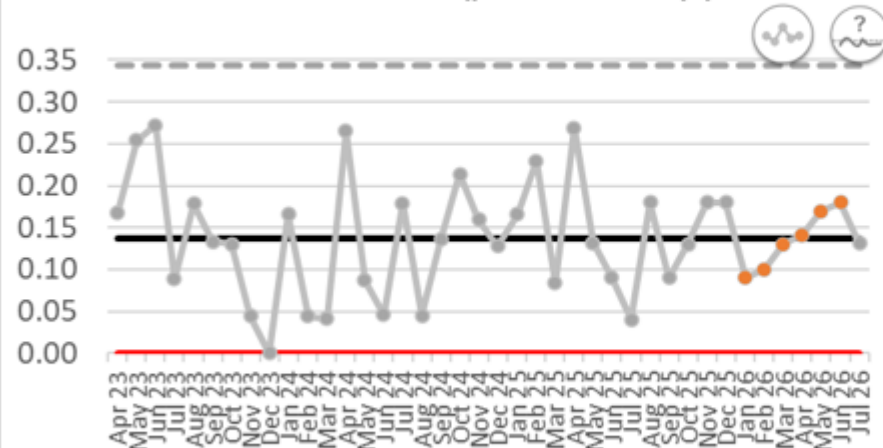
Assurance

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)



Jul-26

0.131

Variance Type

Common cause variation

Threshold

≤0

Assurance

Hit and miss target subject to random variation

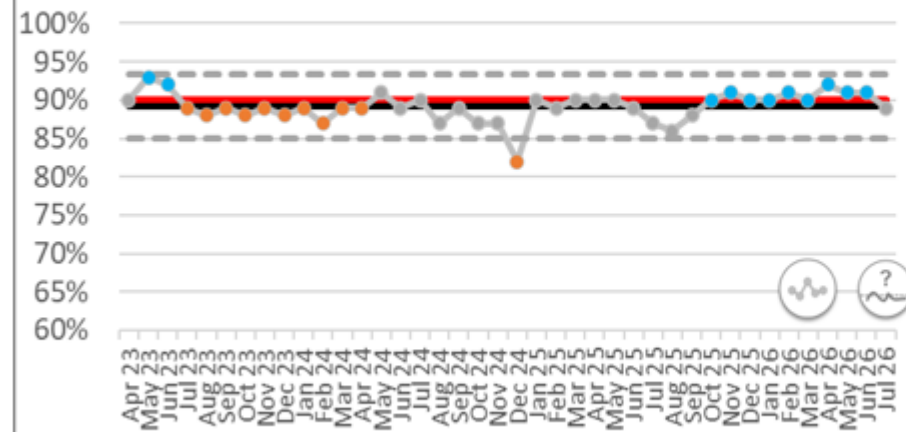
Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

Average Registered Nurse Day Staffing Fill Rates

CQC Domain : Safe

WUTH Average RN Day Staffing Fill Rates



Jul-26

89.0%

Variance Type

Common cause
variation

Threshold

≥90%

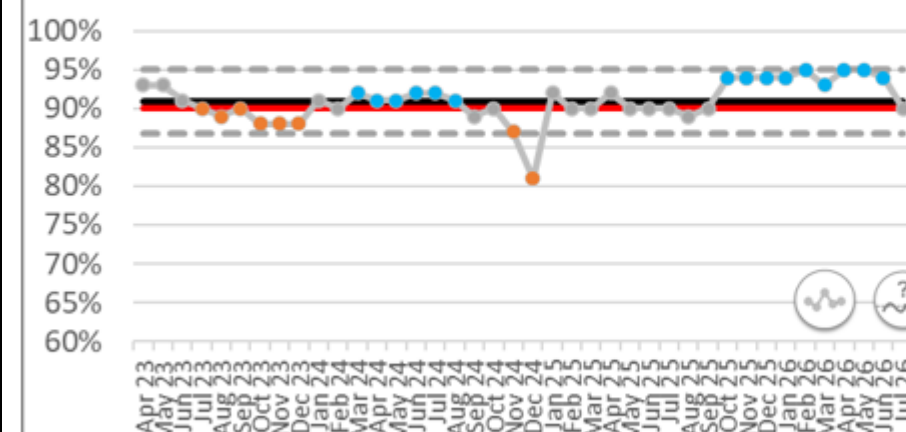
Assurance

Hit and miss target
subject to random
variation

Average Registered Nurse Night Staffing Fill Nurse

CQC Domain : Safe

WUTH Average RN Night Staffing Fill Rates



Jul-26

90.0%

Variance Type

Common cause
variation

Threshold

≥90%

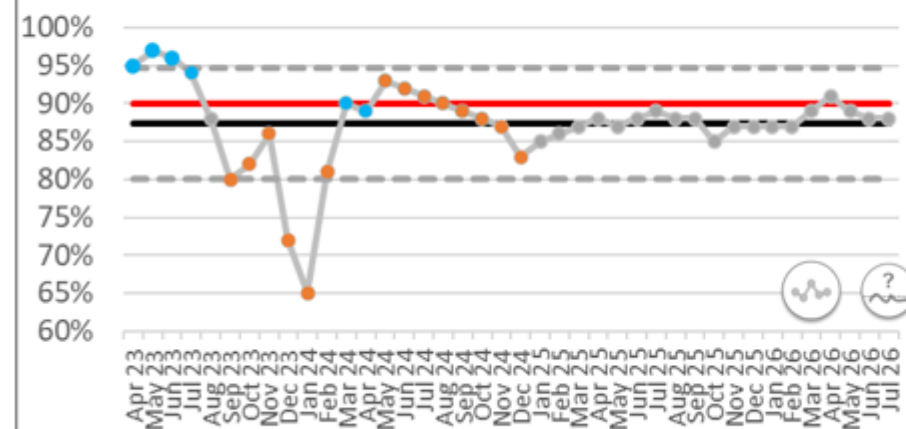
Assurance

Hit and miss target
subject to random
variation

Average Clinical Support Worker Day Staffing Fill Rates

CQC Domain : Safe

WUTH Average CSW Day Staffing Fill Rates



Jul-26

88.0%

Variance Type

Common cause
variation

Threshold

≥90%

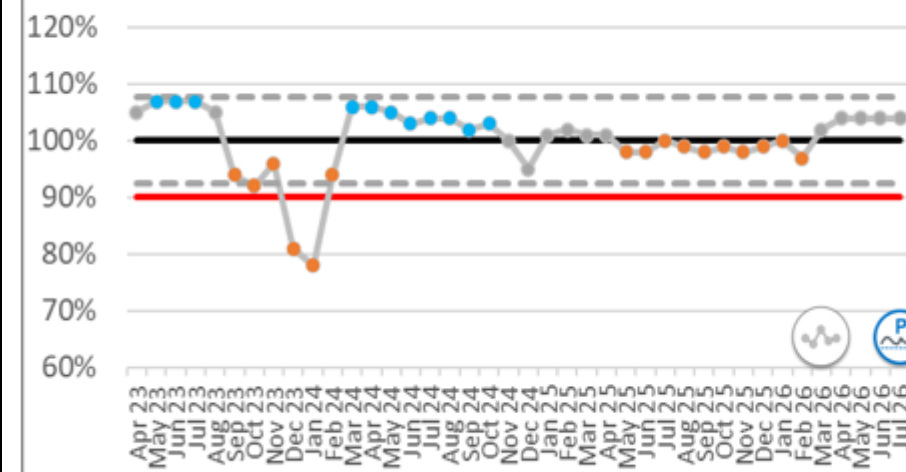
Assurance

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



Jul-26

104.0%

Variance Type

Common cause
variation

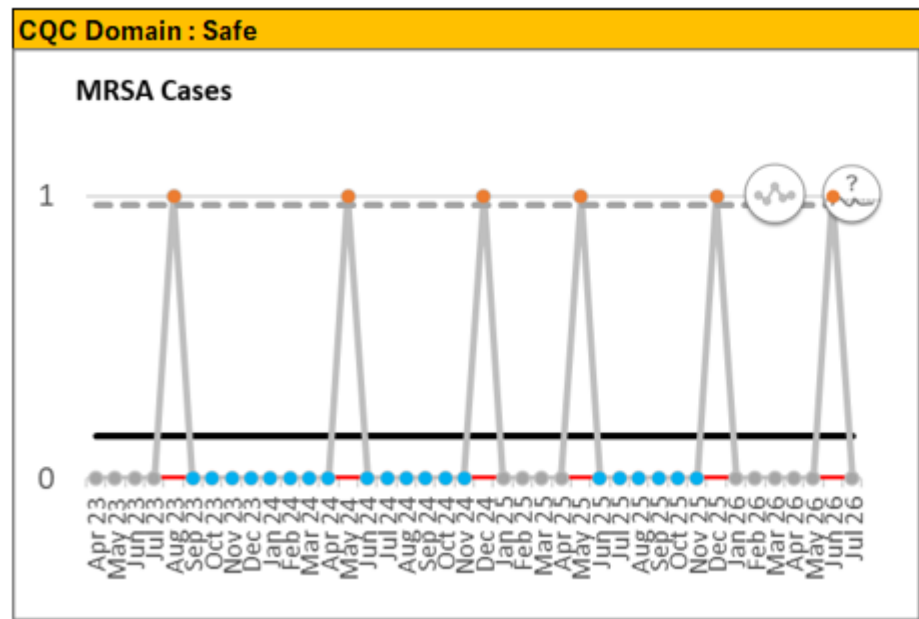
Threshold

≥90%

Assurance

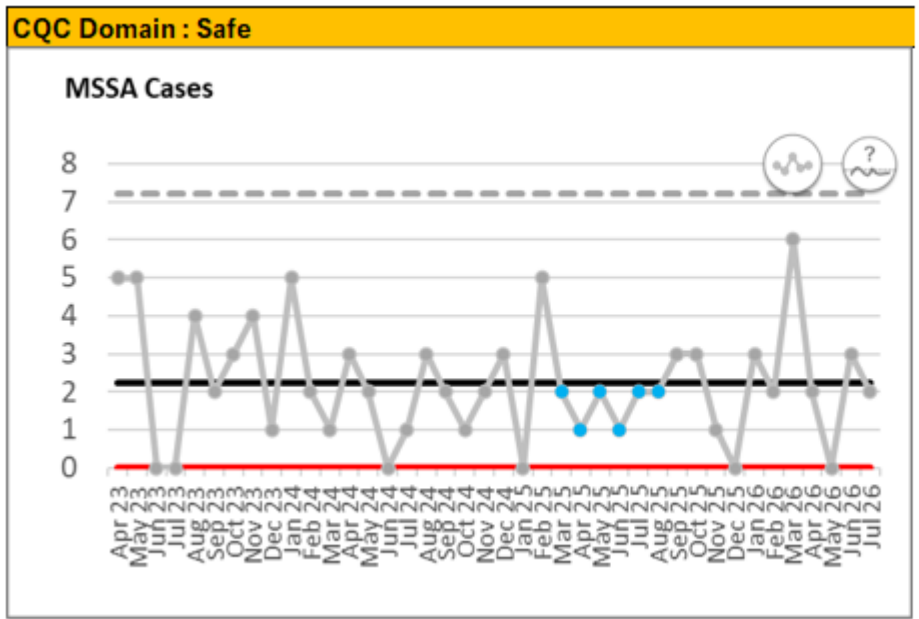
Consistently hit target

MRSA Cases



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

MSSA Cases



Jul-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)	July 26	0	0			0
No. of Incidents reported	July 26	517	475			481
Patient Safety Incidents	July 26	230	200			203
Never events	July 26	0	0			0
No. of ICO reportable IG incidents	July 26	0	0			0
Total Complaints Received	July 26	3	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	July 26	0	0			0
Missed medication incidents resulting in moderate or severe harm	July 26	0	0			0
No. of Incidents reported with a moderate and above harm level	July 26	0	0			0
Clostridium difficile infections resulting in moderate or severe harm	July 26	0	0			0
MRSA infections with learning identified for the Trust	July 26	0	0			0
Falls resulting in moderate or above harm	July 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	July 26	0.7%	4.6%			1.4%
No. of concerns received in month	July 26	14	12			12
FFT - % of People who would recommend our services	July 26	90.1%	90.0%			91.5%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	July 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	July 26	0	0			0
No. of reported no and low harm patient safety incidents	July 26	215	200			190

Highlights

The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust quality governance framework. This is evidenced by the patient safety outcomes achieved. The following quality and safety metrics are all reporting zero for July 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 M4 is green RAG rated at 90.1%.

Areas of Concern

During the previous reporting month, two falls resulting in moderate or above harm were reported at the Community Intermediate Care Centre. After-action reviews are in progress to identify safety systems learning for improvement.

During M4, there was one quality metric reporting a red RAG rated position:

- Concerns received

Concerns received are effectively triangulated with other data sources to identify emerging themes and trends. This is tracked at service level, reporting to SOG and reporting by exception to the Integrated Performance Board. From the data received in July 2026, learning has been identified in relation to how waiting times at the Trust's UTC and Walk-in-Centre services are communicated. This learning has been incorporated into service quality improvement plans, evidencing responsiveness to feedback.

Forward Look (Actions)

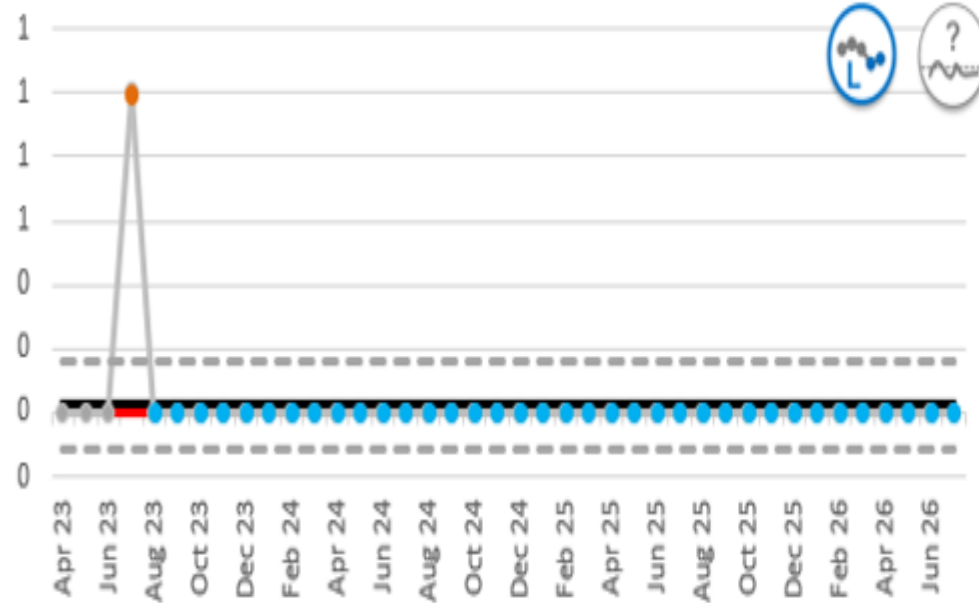
Clinical Risk Management Group continue to track improvement plans, with new quality improvement driver diagrams for 2026/27 developed for the following joint quality priorities:

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

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

CQC Domain : Safe

Serious untoward incidents - reported via StEIS (Exc. IPC Contract)

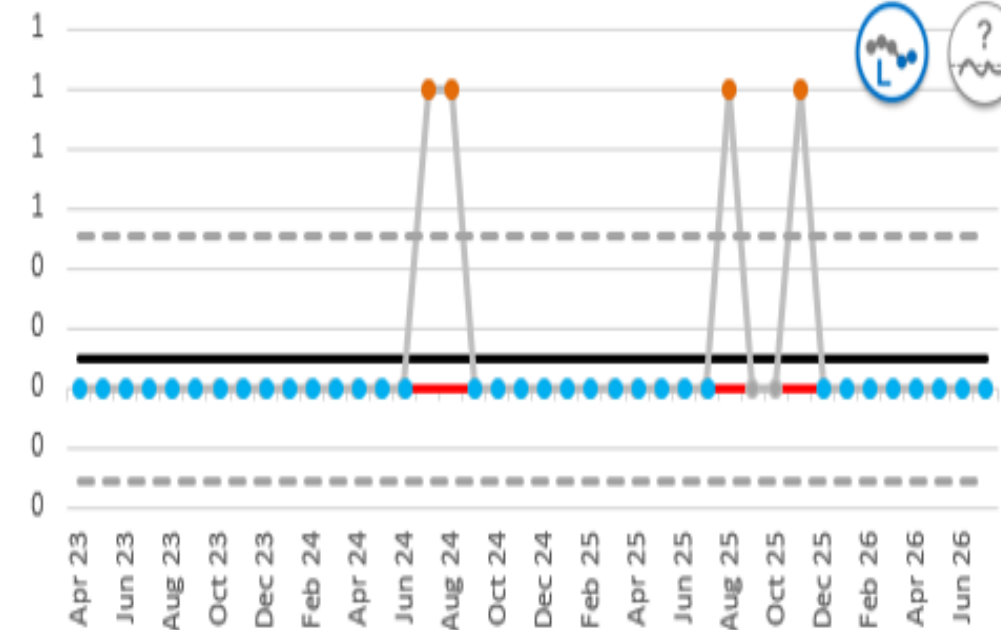


Jul-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

No. of ICO reportable IG incidents

CQC Domain : Safe

No. of ICO reportable IG incidents

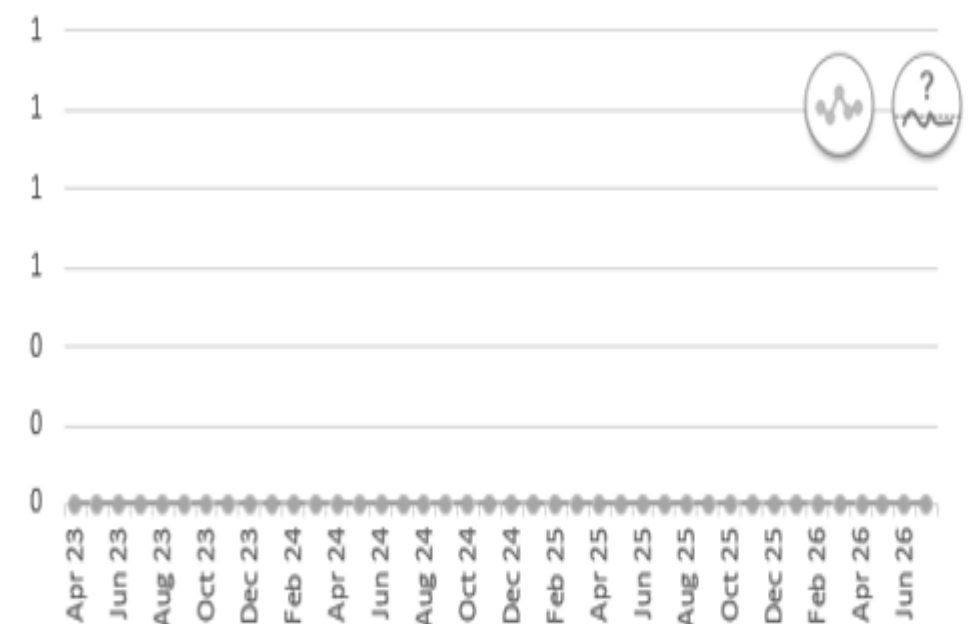


Jul-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events

CQC Domain : Safe

Never events

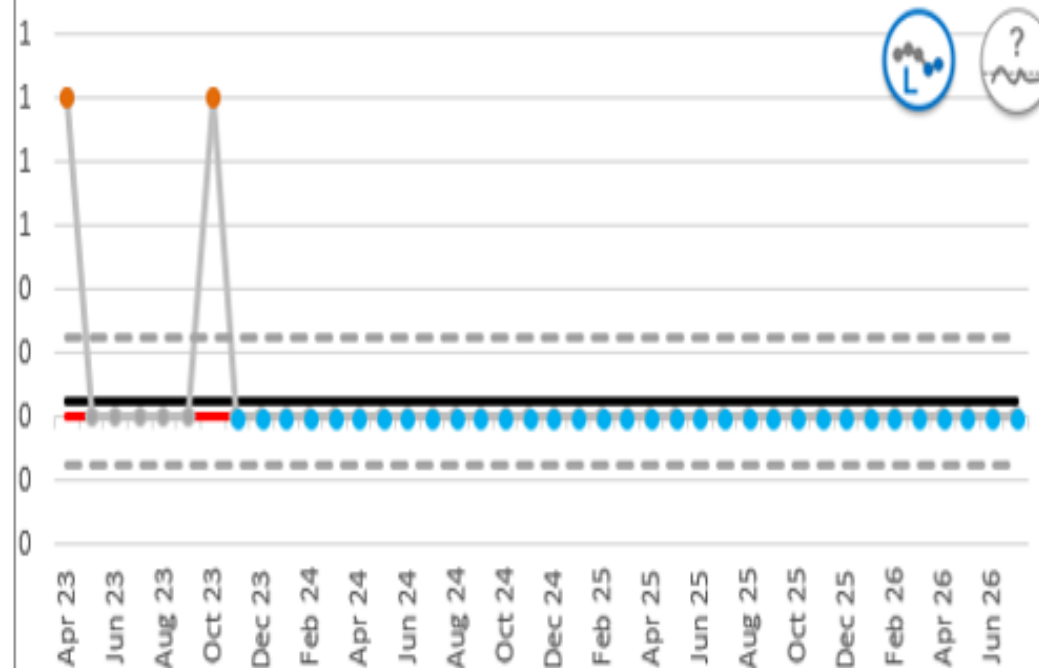


Jul-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Serious untoward incidents – reported via StEIS (IPC Contract)

CQC Domain : Safe

Serious untoward incidents - reported via StEIS (IPC Contract)

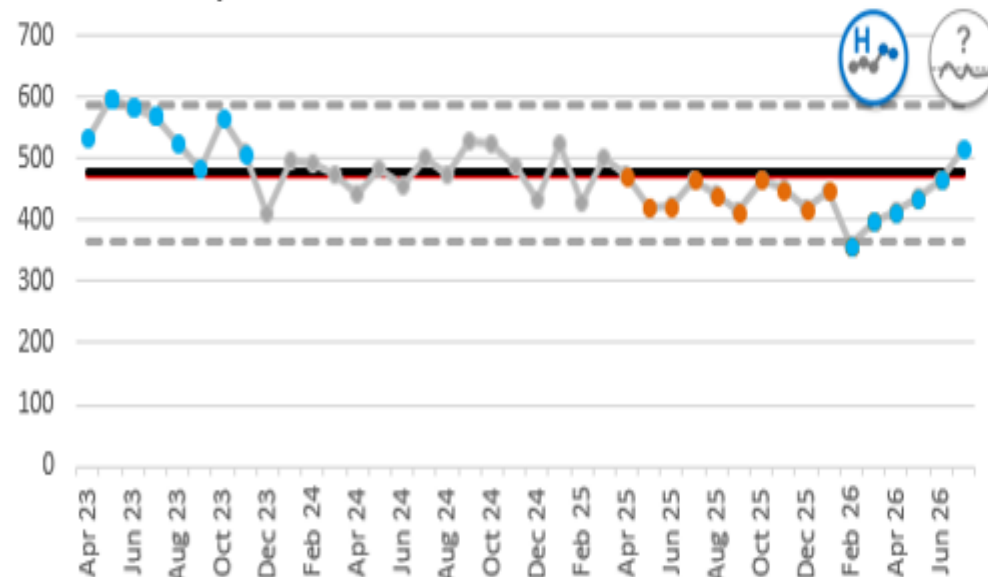


Jul-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Number of Incidents reported

CQC Domain : Safe

No. of Incidents reported

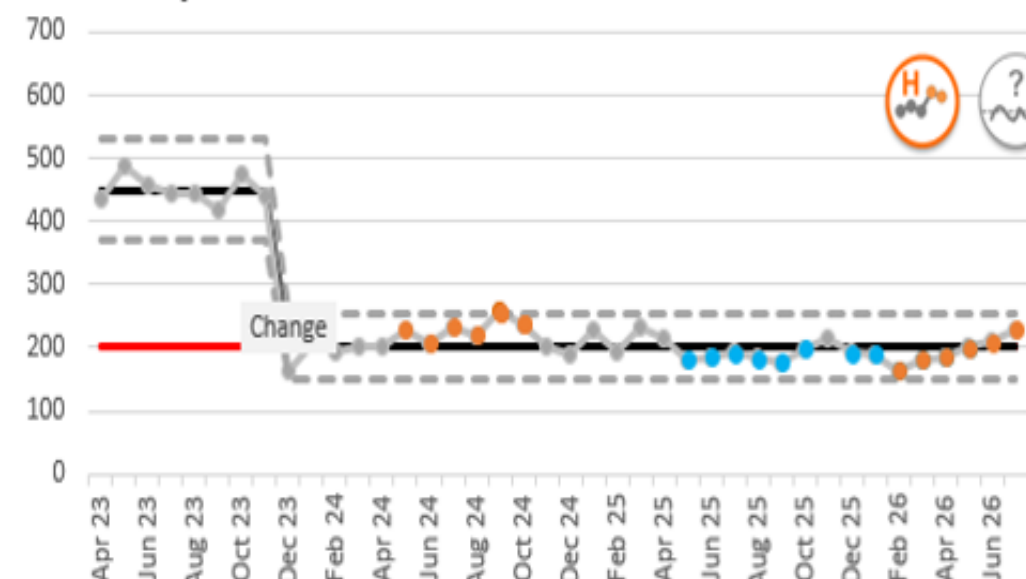


Jul-26
517
Variance Type
Special cause variation - Improving
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

CQC Domain : Safe

Patient Safety Incidents

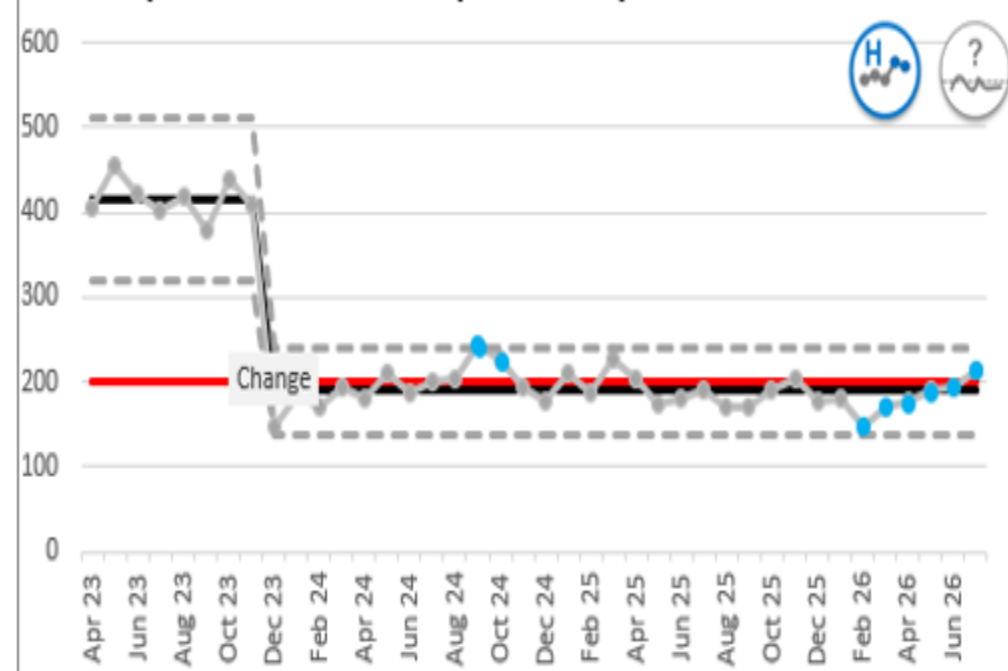


Jul-26
230
Variance Type
Special cause variation - Concerning
Threshold
200
Assurance
Hit & miss target subject to random variation

No. of reported no and low harm patient safety incidents

CQC Domain : Safe

No. of reported no and low harm patient safety incidents

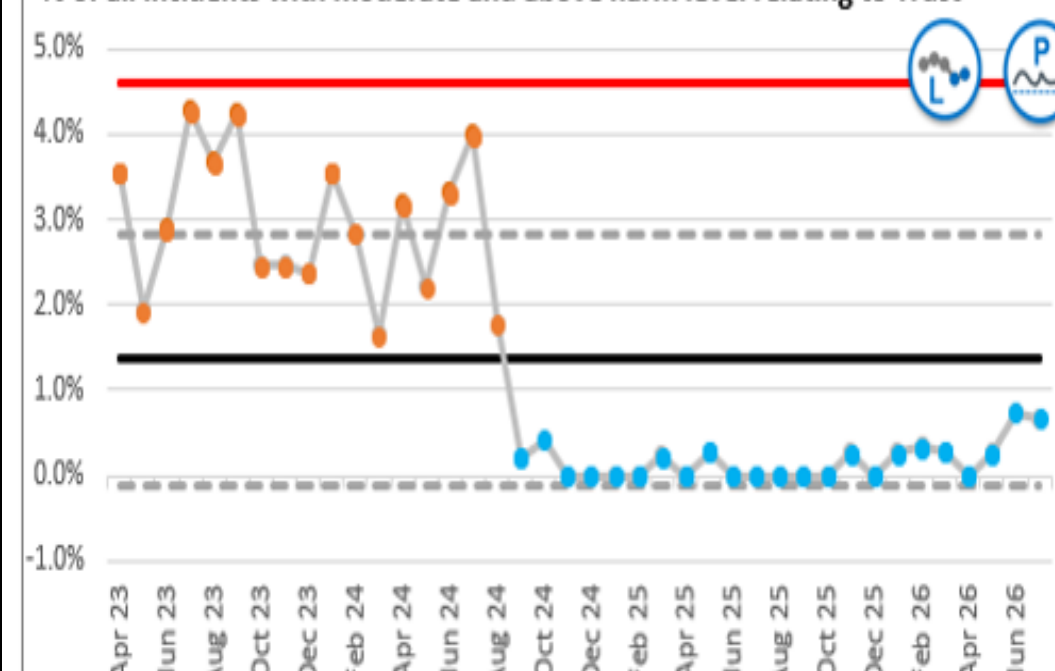


Jul-26
215
Variance Type
Special cause variation - Concerning
Threshold
200
Assurance
Hit & miss target subject to random variation

% 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

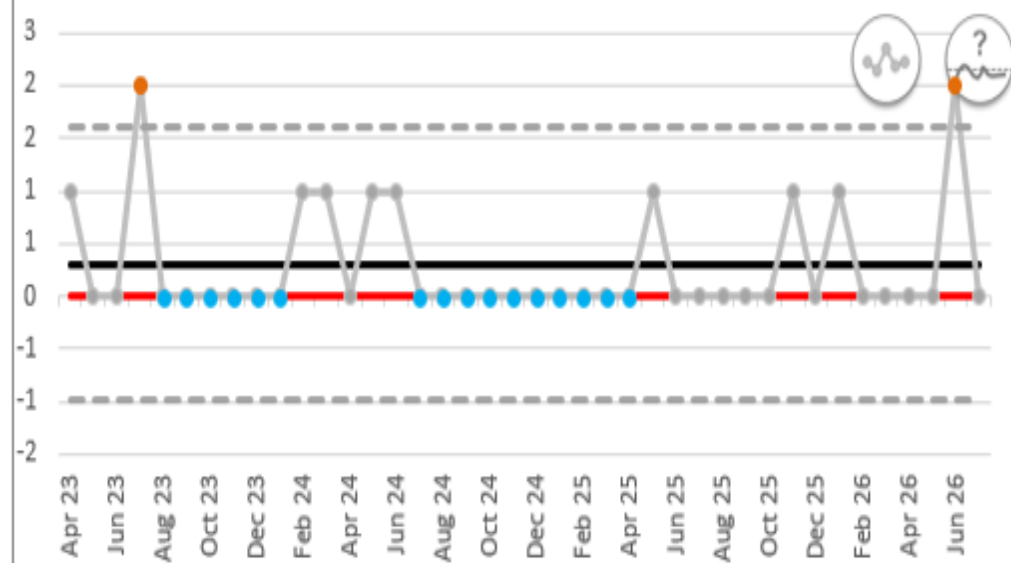


Jul-26
0.7%
Variance Type
Special cause variation - Improving
Threshold
2.2%
Assurance
Consistently hit target

Falls resulting in moderate or above harm

CQC Domain : Safe

Falls resulting in moderate or above harm

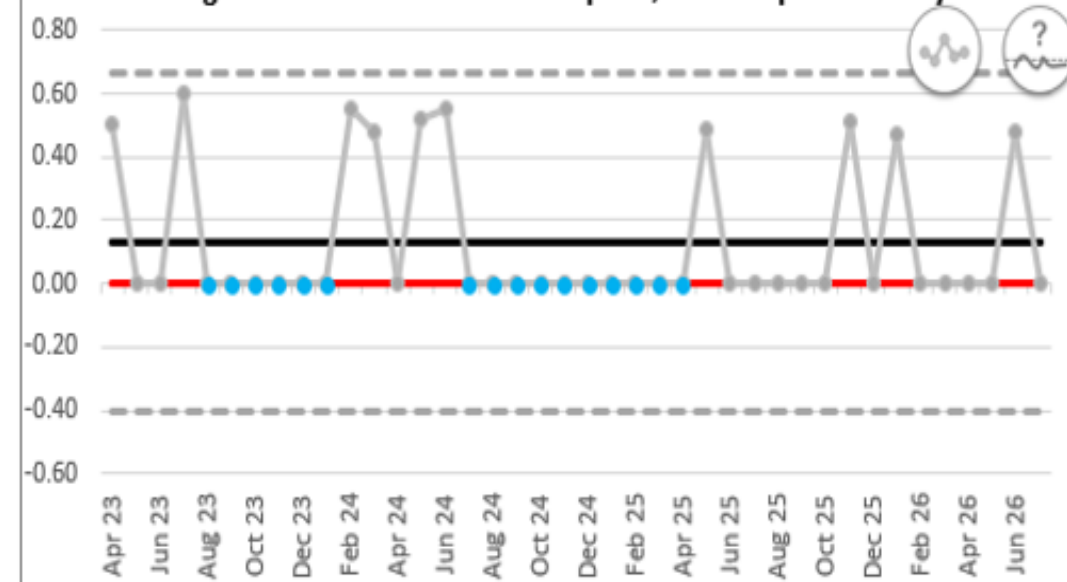


Jul-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Safe

Falls resulting in moderate or above harm per 1,000 Occupied Bed Days

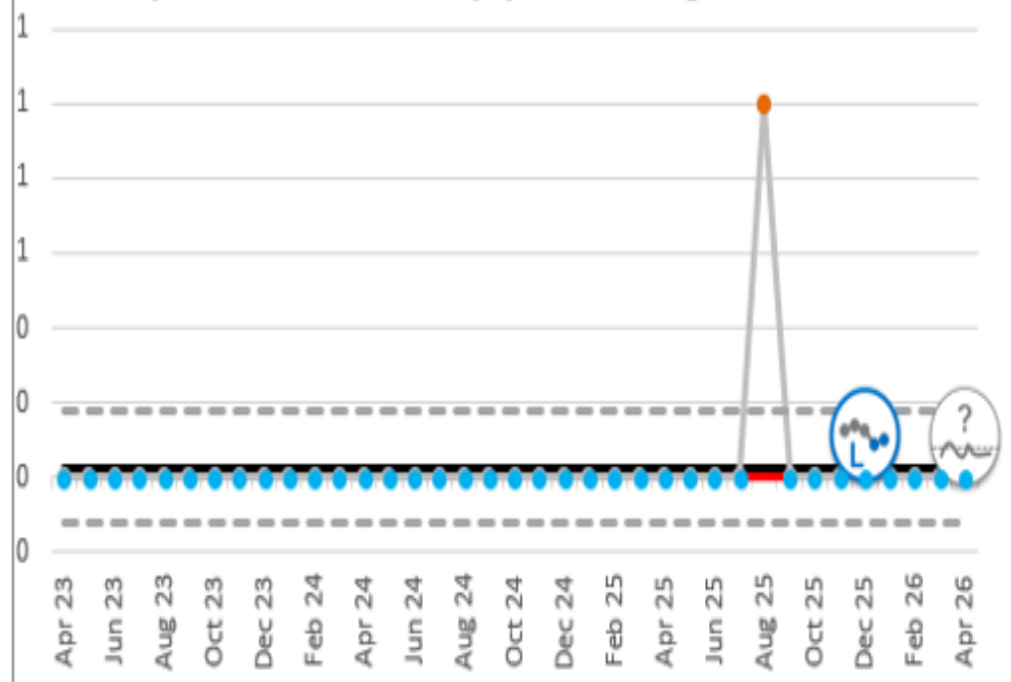


Jul-26
0.00
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Safe

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

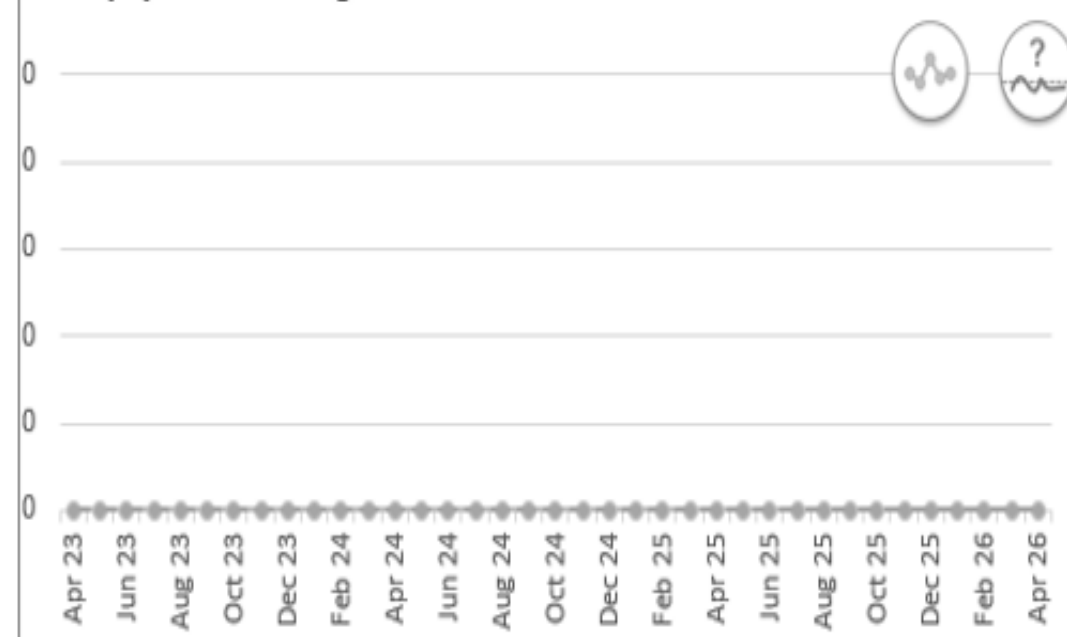


Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Safe

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

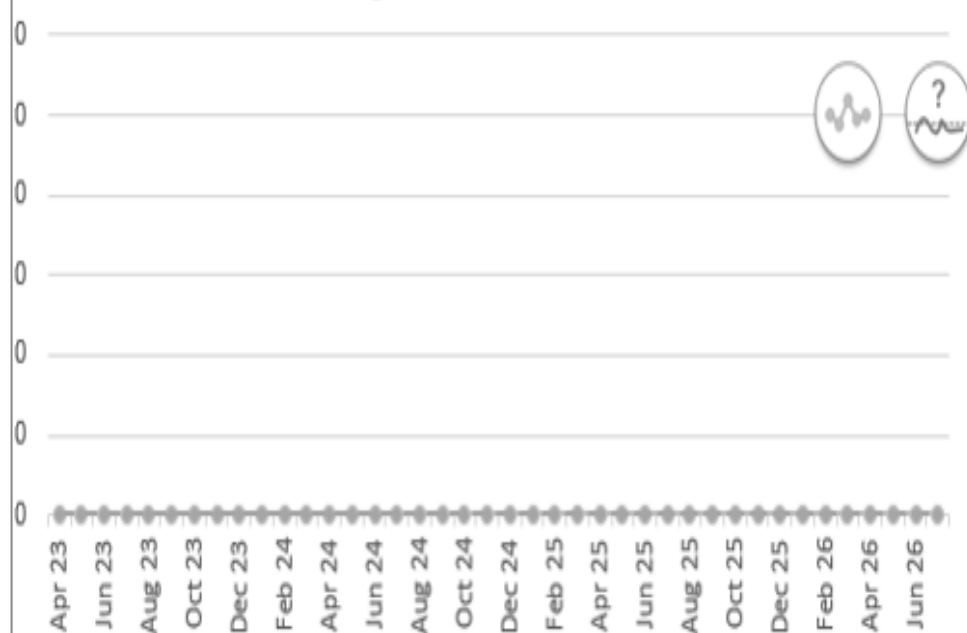


Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

MRSA infections with learning identified for the Trust

CQC Domain : Safe

MRSA infections with learning identified for the Trust



Jul-26

0

Variance Type

Common cause
variation

Threshold

0

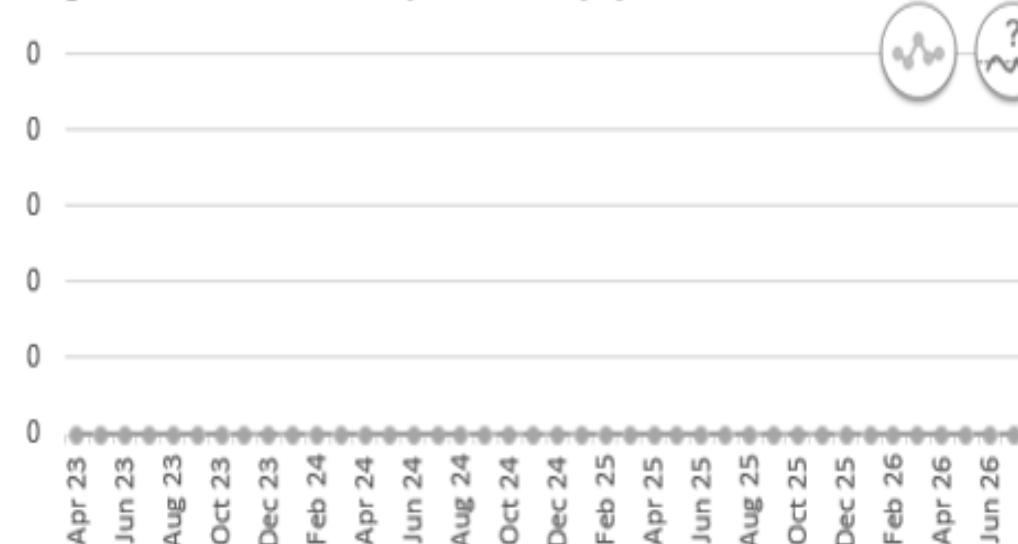
Assurance

Hit & miss target
subject to random
variation

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

CQC Domain : Safe

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



Jul-26

0

Variance Type

Common cause
variation

Threshold

0

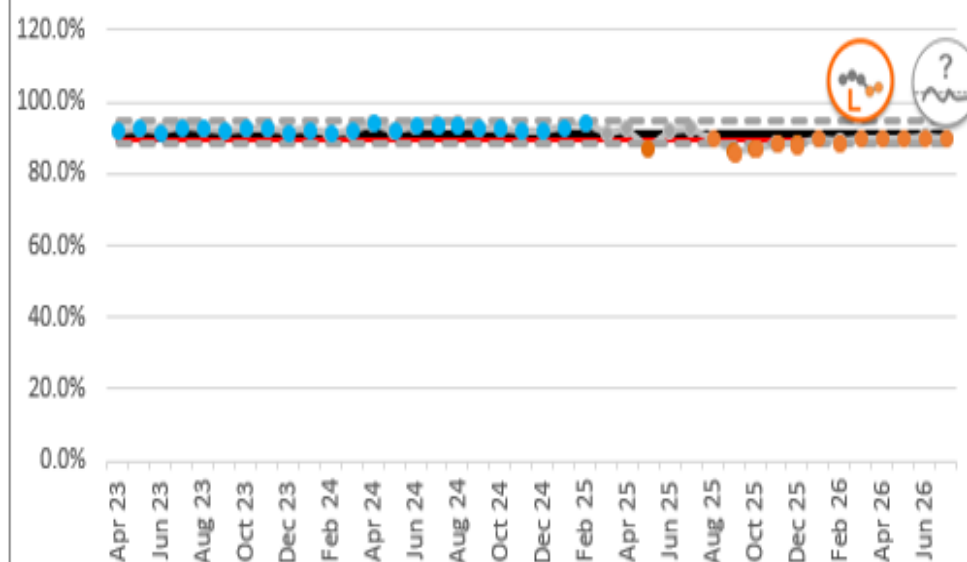
Assurance

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



Jul-26

90.1%

Variance Type

Special cause
variation - Concerning

Threshold

≥90%

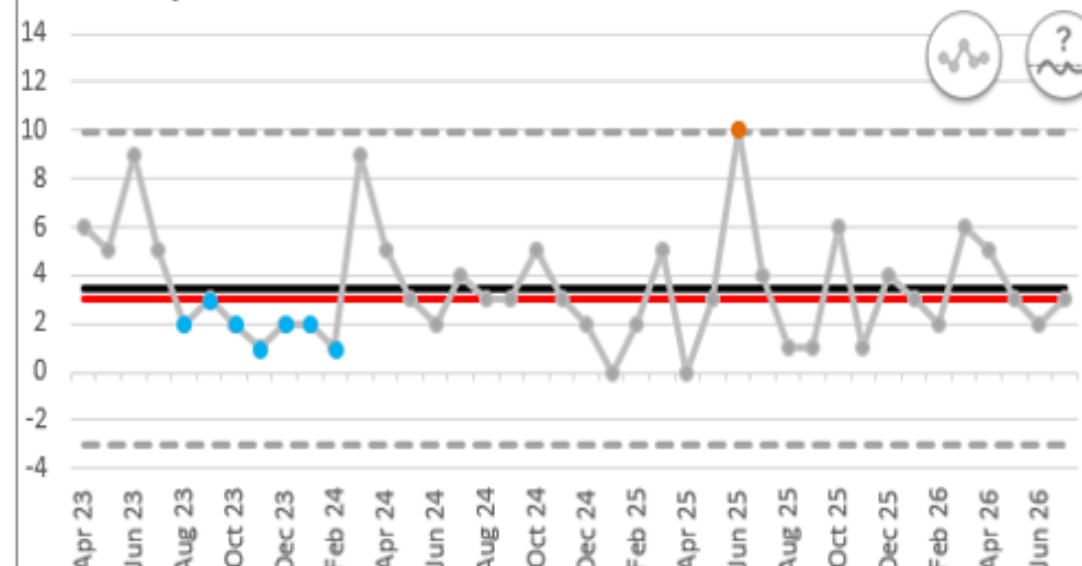
Assurance

Hit & miss target
subject to random
variation

Total Complaints Received

CQC Domain : Responsive

Total Complaints Received



Jul-26

3

Variance Type

Common cause
variation

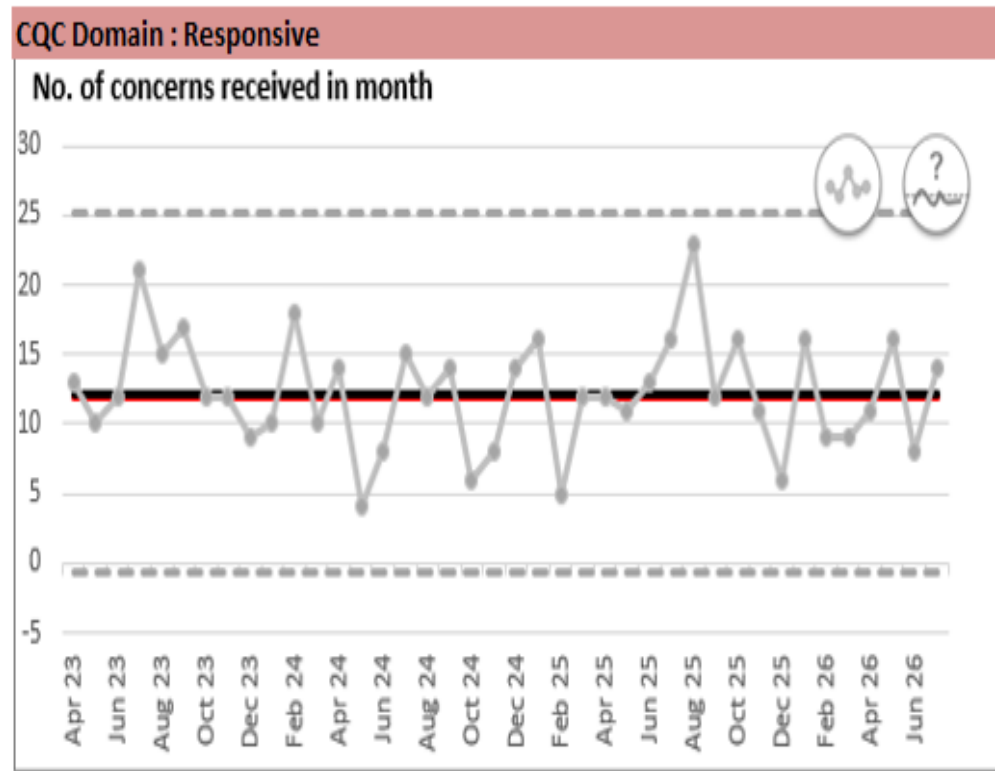
Threshold

3

Assurance

Hit & miss target
subject to random
variation

No. of concerns received in month



Jul-26
14
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)	Jul 26	59.97%	≥58.29%			61.1%
Number of inpatients not meeting the Criteria to Reside	Jul 26	135	≤126.6027			158
Patients waiting longer than 12 hours in ED from a decision to admit	Jul 26	575	≤1584			656
Proportion of patients more than 12 hours in ED from time of arrival	Jul 26	17.52%	≤19.24%			18.3%
Ambulance Handovers: % >15 mins	Jul 26	75.64%	≤74.99%			79.4%
Ambulance Handovers: % > 45 mins	Jul 26	11.09%	≤0%			16.6%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Jul 26	65.22%	≥65.63%			59.6%
Referral to Treatment - total open pathway waiting list	Jul 26	43975	≤45332			45207
Referral to Treatment - cases waiting 65+ wks	Jul 26	0	≤0			9
Referral to Treatment - % of 52+wk waiters	Jul 26	0.70%	≤0.86%			1.95%
Cancer Waits - reduce number waiting 62 days +	Jun 26	66	≤44			130
Cancer - Faster Diagnosis Standard	Jun 26	79.65%	≥79.52%			73.5%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Jun 26	94.20%	≥92.1%			91.5%
Cancer Waits - 62 days to treatment (monthly)	Jun 26	78.04%	≥76.36%			74.8%
Diagnostic Waiters, 6 weeks and over - DM01	Jul 26	94.96%	≥94.5%			93.1%
Long length of stay - number of patients in hospital for 21 or more days	Jul 26	188	≤79			170

Highlights

UEC

- Patients waiting over 12 hours from decision to admit reduced from 735 in June to 575, a reduction of 160 patients (22%)
- Patients waiting over 12 hours from arrival improved from 18.1% to 17.5%. Improvement is expected to continue moving into August with the implementation of the Acute medicine footprint
- 4-hour A&E APH Site performance remains above the revised target at 60.0%, although slightly below the previous position of 62.6%.

RTT

The Trust achieved caseload, and 65-week targets for July 2026.

Cancer 28-day, 31-day and 62-day standards

The Trust achieved all of the key cancer standards in June 2026 (28-day faster diagnosis standard, 31-day standard and 62-day).

Diagnostic performance

The Trust achieved the 6-week diagnostic standard in July 2026.

Areas of Concern

4-hours (Type 1)

Resident doctor out-of-hours staffing remains the key challenge, with gaps partially mitigated by consultant cover. The pressure is resulting in prolonged waits for patients to be seen, resulting in a low compliance to the 4-hour standard at the start of the day.

Ambulance handovers: %>45 mins

Patients experience handover over 45 minutes remain above the 0% target.

Performance has improved over recent months with a focus on out of hours handover times.

RTT

Performance on the percentage of patients waiting 18-weeks or less standard for July 2026, was 65.2% versus a target of 65.6%. Performance for August 2026 is forecast to meet a target of 65.3%, but achievement of September target is at risk with the target increasing to 66.8% without the additional RTT capacity.

Forward Look (Actions)

UEC

Workforce zoning implemented across medical and nursing teams to strengthen local ownership and accountability to improve 4 hour performance. Daily operational performance reviews and MDT huddles in place to proactively manage flow and performance.

Continued focus on effective patient streaming following co-location with the Urgent Treatment Centre (UTC).

Twice weekly EMD executive review of performance with ED leadership team.

Daily breach validation reviews undertaken to ensure accurate and consistent performance reporting. Implementation of Acute Take Co-ordinators from late August to support flow of medical patients throughout ED and SDEC

RTT

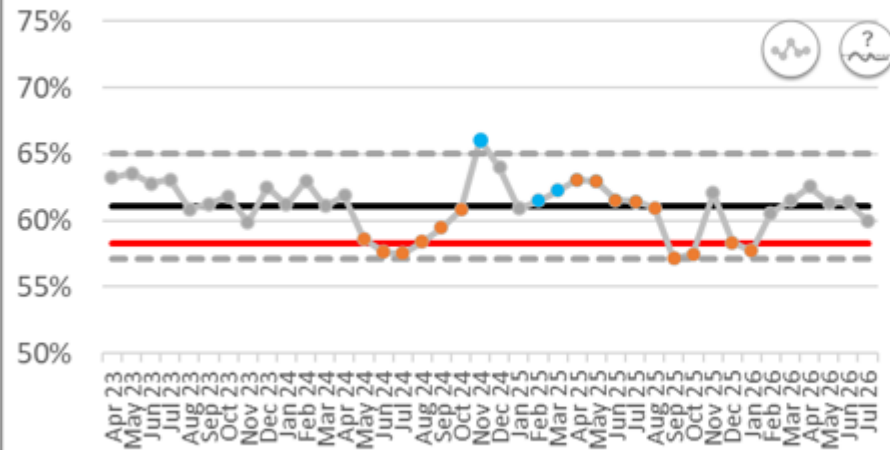
Additional validation support improved performance, but it remained below target. Divisions are reviewing bids for additional RTT funding, which were included in 2026/27 performance plans, without this capacity September performance is at risk.

		Cancer Performance for July, for the 28-day standard is forecast to be below target. This is primarily due to pressures in Skin with an increase referrals, challenges with workforce and ongoing work to optimise the new pathway and digital solution. Additional capacity is being provided via insourcing with weekly recovery meetings in place. Lower GI have also seen performance pressures and have flexed capacity to improve outpatient waiting times. Diagnostic performance Endoscopy performance presents a risk to August performance and is being closely monitored by the operational team.
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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)



Jul-26

60.0%

Variance Type

Common cause variation

Threshold

≥58.29%

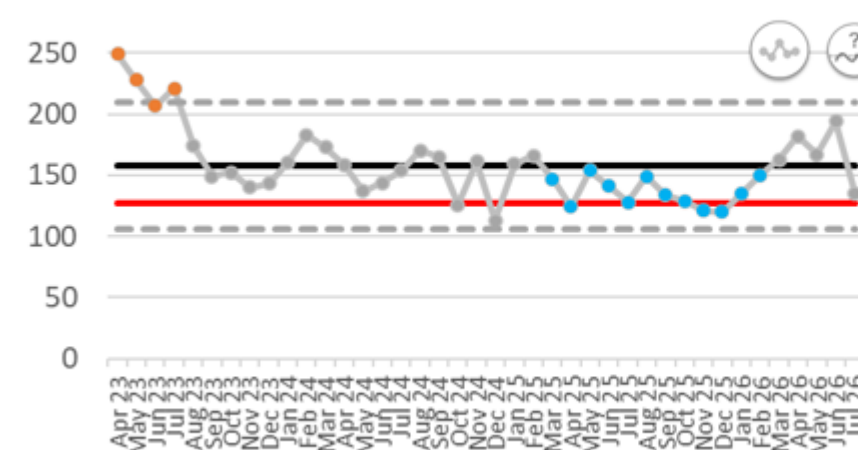
Assurance

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



Jul-26

135

Variance Type

Common cause variation

Threshold

≤126.6027

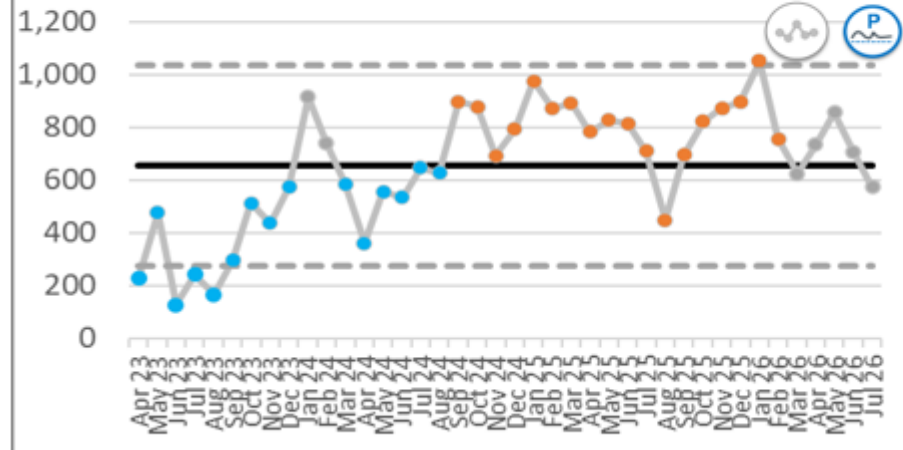
Assurance

Hit and miss target subject to random variation

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

CQC Domain : Responsive

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



Jul-26

575

Variance Type

Common cause variation

Threshold

≤1584

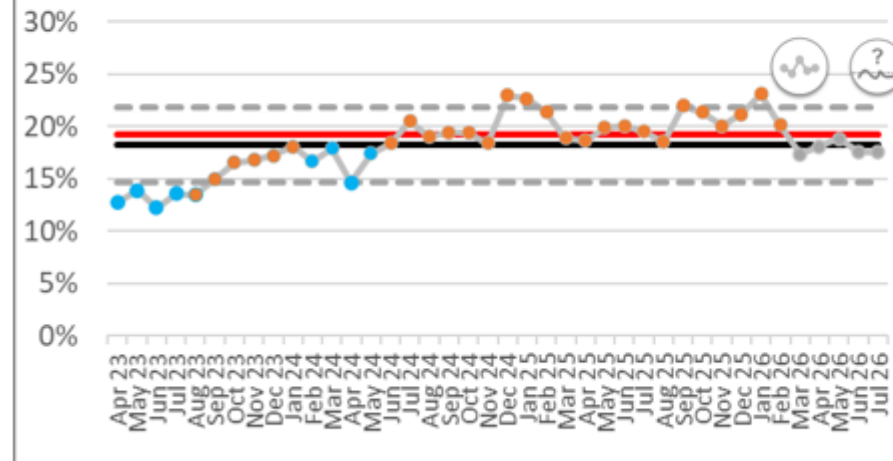
Assurance

Consistently hit 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



Jul-26

17.5%

Variance Type

Common cause variation

Threshold

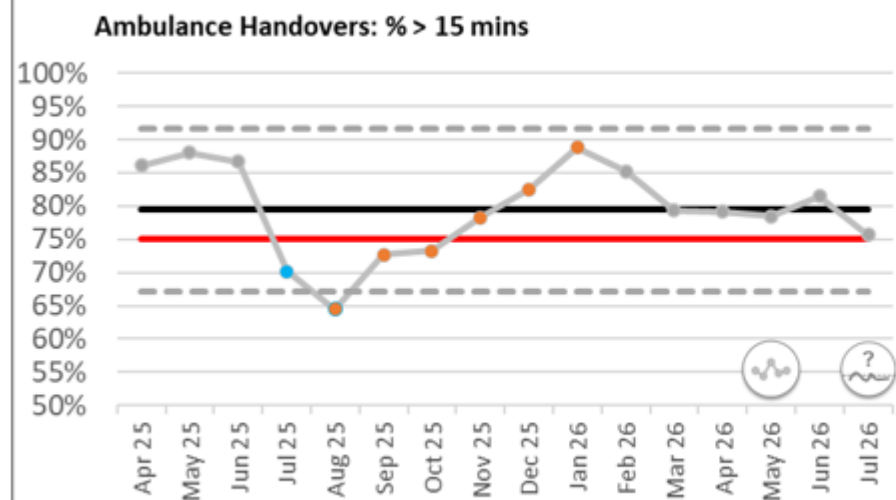
≤19.24%

Assurance

Hit and miss target subject to random variation

Ambulance handover % < 30 minutes

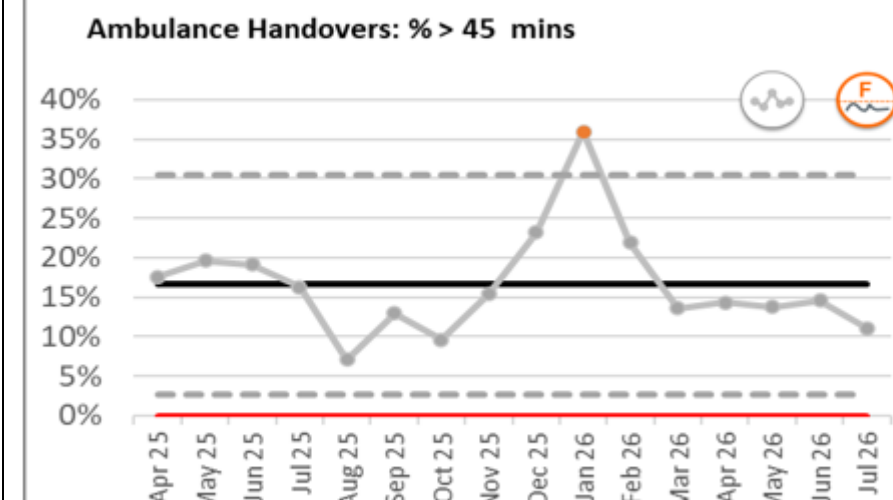
CQC Domain : Responsive



Jul-26
75.6%
Variance Type
Common cause variation
Threshold
≤74.99%
Assurance
Hit and miss target subject to random variation

Ambulance handover % < 45 minutes

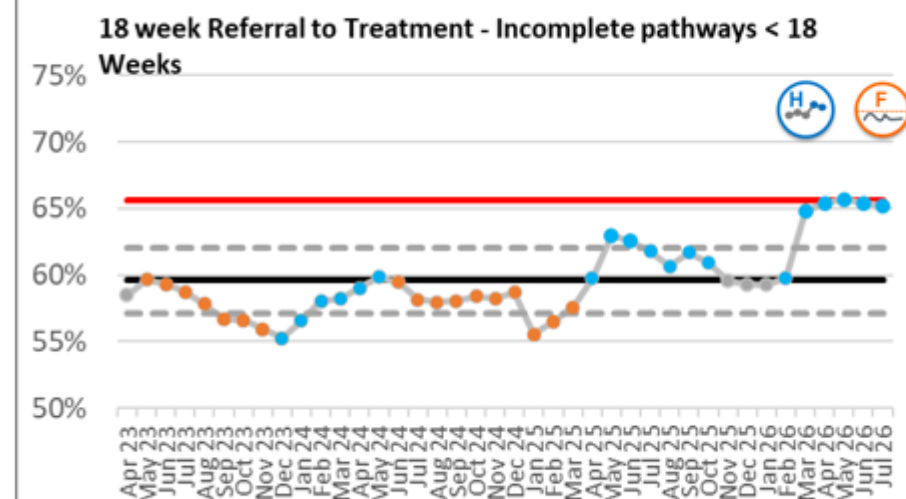
CQC Domain : Responsive



Jul-26
11.1%
Variance Type
Common cause variation
Threshold
≤0%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

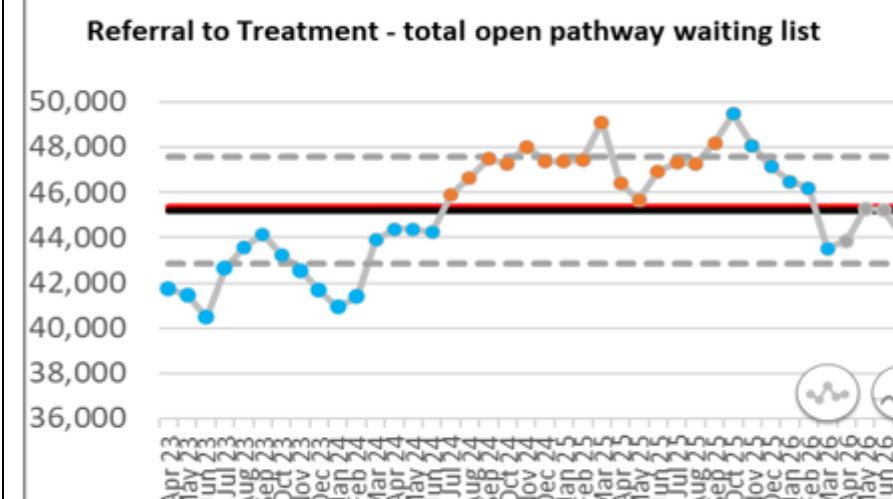
CQC Domain : Responsive



Jul-26
65.2%
Variance Type
Special cause improving variation
Threshold
≥65.63%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive

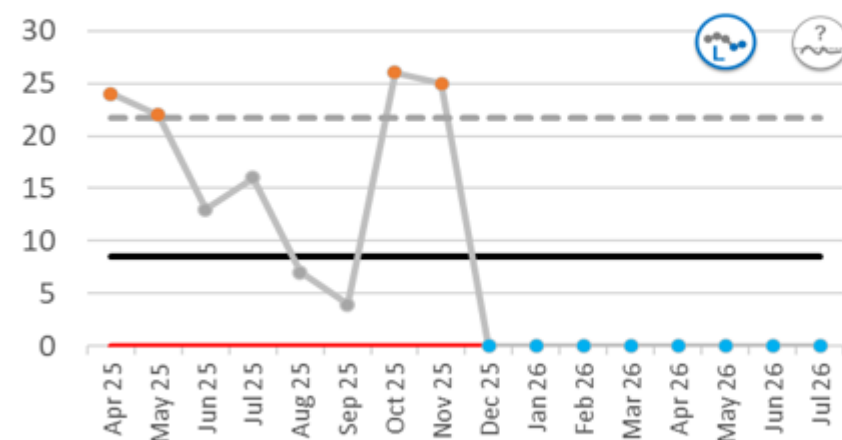


Jul-26
43975
Variance Type
Common cause variation
Threshold
≤45332
Assurance
Hit and miss target subject to random variation

Referral to Treatment – cases exceeding 52 weeks

CQC Domain : Responsive

RTT - cases waiting 65+ wks



Jul-26

0

Variance Type
Special cause
improving variation

Threshold

≤0

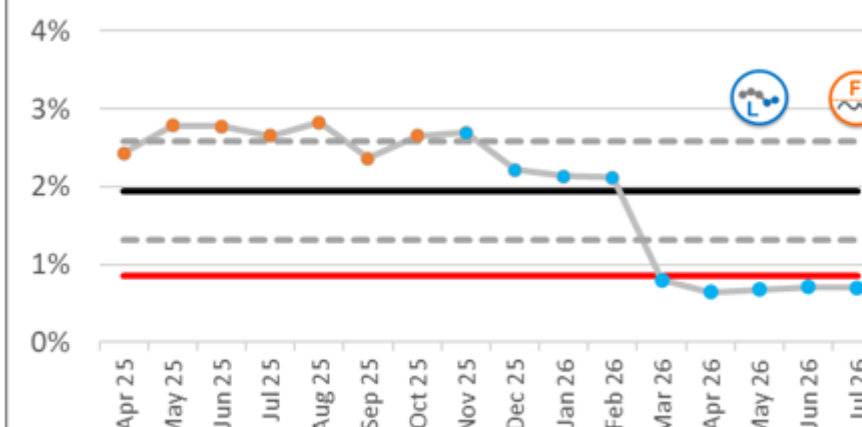
Assurance

Hit and miss target
subject to random
variation

Referral to Treatment – cases waiting 78+ weeks

CQC Domain : Responsive

% of 52+wk waiters



Jul-26

0.70%

Variance Type
Special cause
improving variation

Threshold

≤0.86%

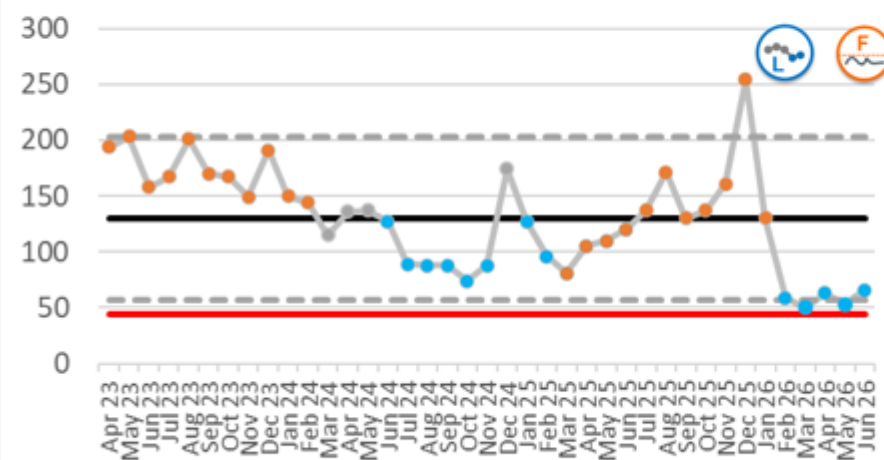
Assurance

Consistently fail target

Cancer Waits – reduce number waiting 62 days +

CQC Domain : Responsive

Cancer Waits - reduce number waiting 62 days +



Jun-26

66

Variance Type
Special cause
improving variation

Threshold

≤44

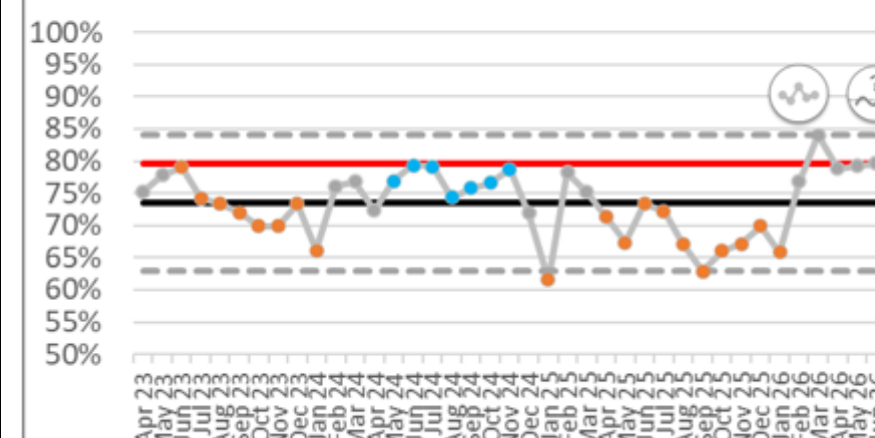
Assurance

Consistently fail target

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive

Cancer - Faster Diagnosis Standard



Jun-26

79.7%

Variance Type
Common cause
variation

Threshold

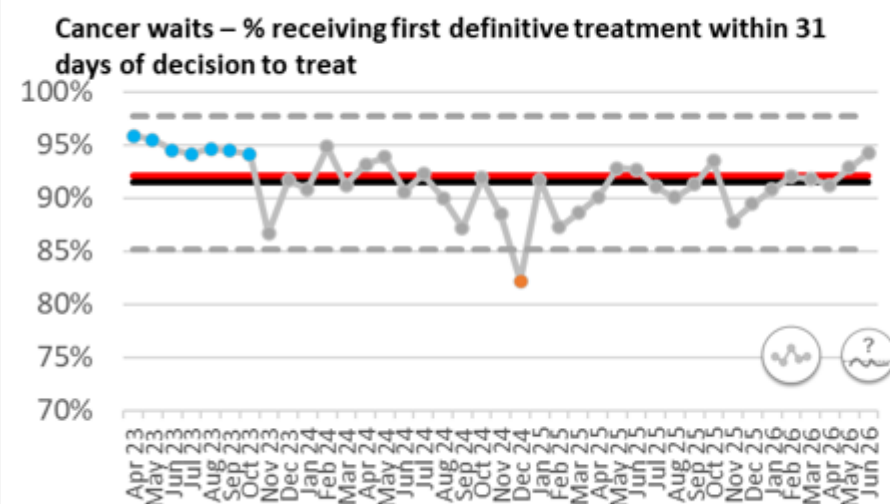
≥79.52%

Assurance

Consistently fail target

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

CQC Domain : Responsive



Jun-26

94.2%

Variance Type

Common cause
variation

Threshold

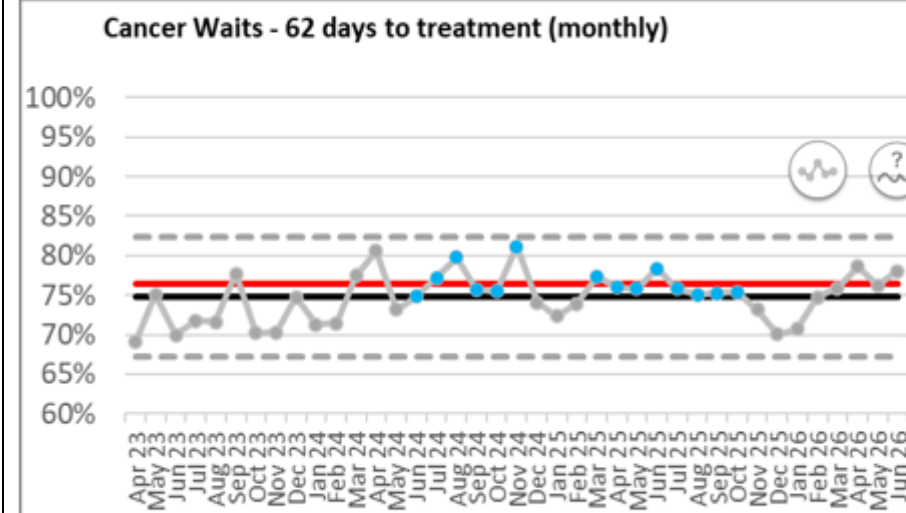
≥92.1%

Assurance

Hit and miss target
subject to random
variation

Cancer waits - 62 days to treatment (monthly)

CQC Domain : Responsive



Jun-26

78.0%

Variance Type

Common cause
variation

Threshold

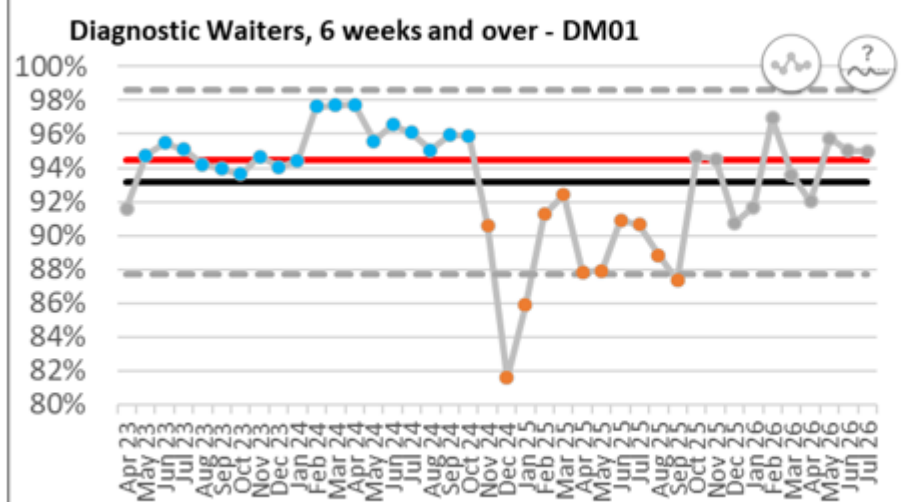
≥76.36%

Assurance

Hit and miss target
subject to random
variation

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



Jul-26

95.0%

Variance Type

Common cause
variation

Threshold

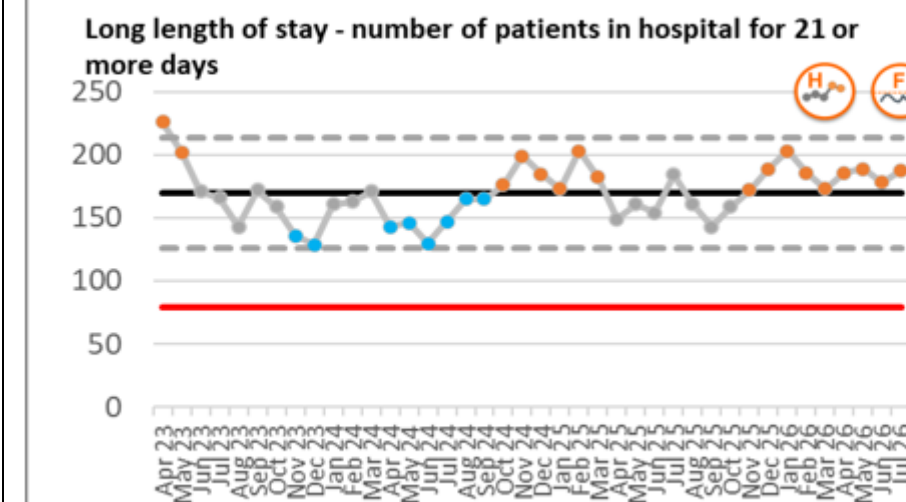
≥94.5%

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



Jul-26

188

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	July 26	96.6%	95.0%			96.10%
CICC Occupancy Rate (Commissioned Beds)	July 26	93.7%	92.0%			95.5%
CICC Median LoS (Active Beds Daily Snapshot)	July 26	15.1	21			18.6
Urgent Community Response - 2 hours	July 26	88.8%	70.0%			87.6%
GPOOH - UCAT Response Times (60 min response)	July 26	99.4%	98.0%			98.8%
GPOOH - UCAT Response Times (15 min response)	July 26	77.1%	65.0%			69.2%
GPOOH - UCAT Response Times (30 min response)	July 26	96.1%	90.0%			93.0%
GPOOH - CAS Response Times (20 min response)	July 26	74.2%	75.0%			69.7%
GPOOH - CAS Response Times (2hr response)	July 26	81.0%	90.0%			70.9%
GPOOH - NHS111 Response Times	July 26	79.7%	75.0%			61.9%
RTT - % of Patients Seen Within 18 Weeks	July 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	July 26	100.0%	99.0%			100.0%
UTC Attendances seen within 4 hrs	July 26	99.1%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	July 26	93.4%	95.0%			94.3%
Eastham Attendances seen within 4 hrs	July 26	97.9%	95.0%			93.9%

Highlights

Operational performance remains strong. The KPI position for M5 26-27 is:

- 81 Green KPIs
- 4 Amber KPIs
- 6 Red KPIs

Highlights by exception:

- Overall urgent care performance remains in a strong position with WIT and UTC continuing to exceed the 95% standard
- CICC Median Length of Stay reduced to 15.1 days, significantly better than the target of 21 days. Utilisation and patient throughput from the acute bed base to CICC continues to flow without delays
- 0-19/25 services – all key metrics across the four regional teams performing above target
- Waiting lists – RTT and DM01 100% and majority of non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times.

Areas of Concern

- **CAS Response Times:** CAS response time performance remained below the required standards during July 2026 for both 20 minute and 2-hour response time. Whilst both measures remain below target, performance continues to compare favourably with the year-to-date average.
Ongoing pressures within GP Out of Hours services, particularly during peak demand periods and overnight shifts, continue to affect the availability of dedicated clinical resource for CAS activity. Clinical teams maintain a risk-based approach to managing cases, prioritising the most urgent patients while ensuring all cases are managed safely. Daily oversight from shift managers and GP coordinators remains in place to monitor caseloads, mitigate risk and support further improvement in response times.
- **VCHC Attendances:** Performance at VCH remains an ongoing challenge but has seen some improvement, which is due to the ongoing pressures within the workforce.
- **Waiting lists:** remedial action plans in place for Community Dental, Cardiology and MSK services. Dental waits are related to volume of patients awaiting paediatric exodontia. Cardiology challenges related to the volume of outstanding resting and 7 day ECGs after significant increases in referral rates. MSK relates to increasing demands on the service and an aim to reduce the volume patients awaiting first appointments ahead of therapies integration programme of work.

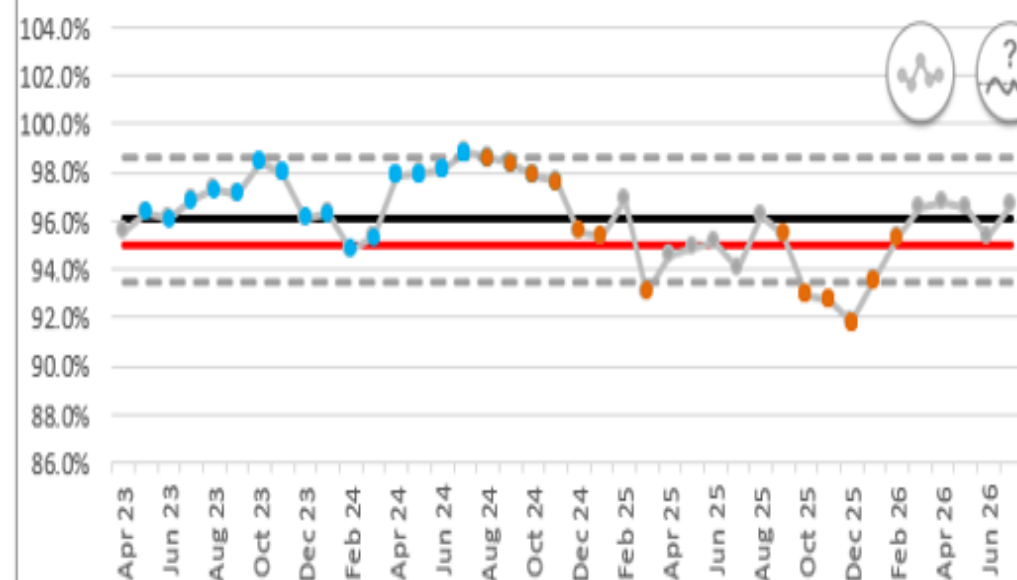
Forward Look (Actions)

- **CAS Response Times** – Continue with workforce model review however this will now be extended to the wider model following the recent contract award of Trust hosting the CAS service for Wirral, Warrington and Cheshire
Proceed with recruitment into vacant posts.
- **VCHC Performance** – continue with recruitment process to increase workforce, providing sustainability within the service.
- **Waiting lists: Dental** – secured additional funding to support additional theatre lists to reduce backlogs. Ongoing collaborative working with WUTH to maximise theatre throughput and additional capacity. Remedial actions, monitoring and validation have resulted in improvements in waiting times and waiting list size. **Cardiology** - joint action plan remains in place with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH. **MSK** – recovery trajectory in place, actions include validation, improvements in productivity and also a bid for additional resource from GIRFT.

WIC & UTC Attendances seen within 4 hrs

CQC Domain : Responsive

WIC & UTC Attendances seen within 4 hrs

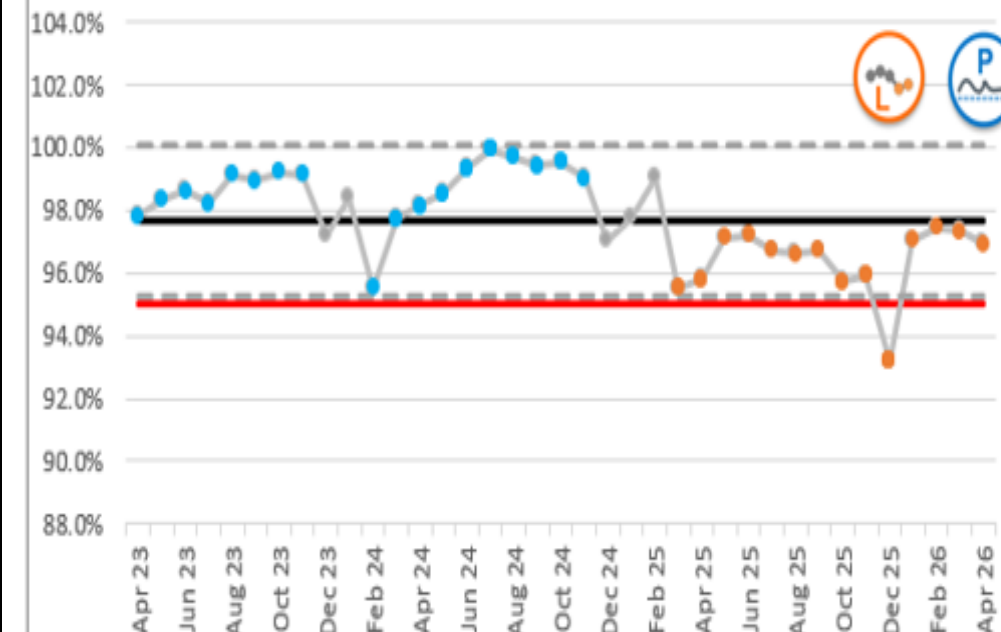


Jul-26
96.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

UTC Attendances seen within 4 hrs

CQC Domain : Responsive

UTC Attendances seen within 4 hrs

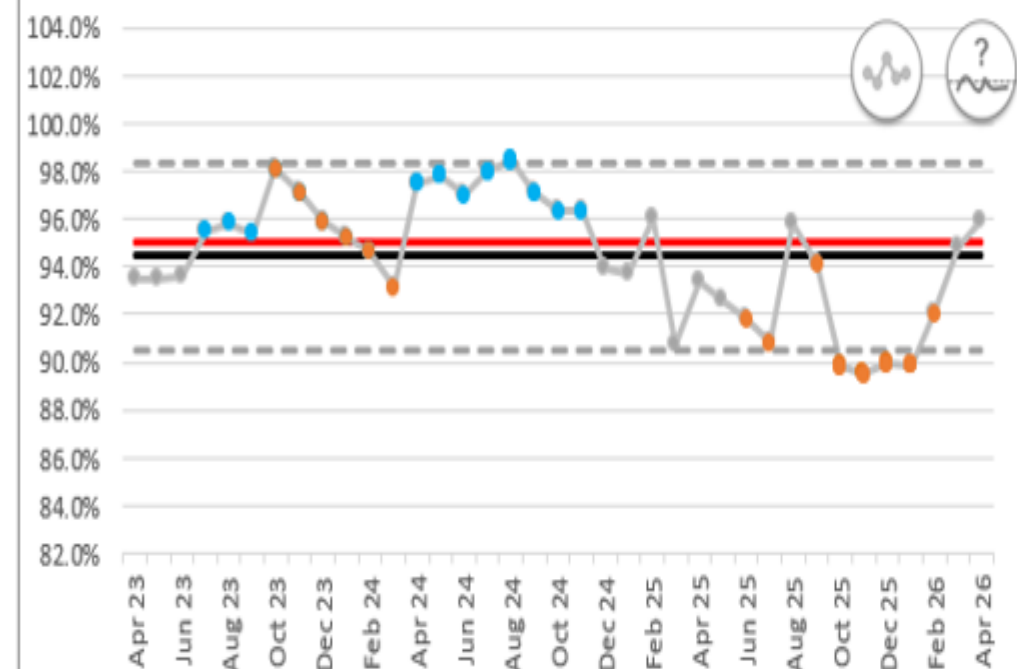


Jul-26
99.1%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Consistently hit target

VCHC Attendances seen within 4 hrs

CQC Domain : Responsive

VCHC Attendances seen within 4 hrs

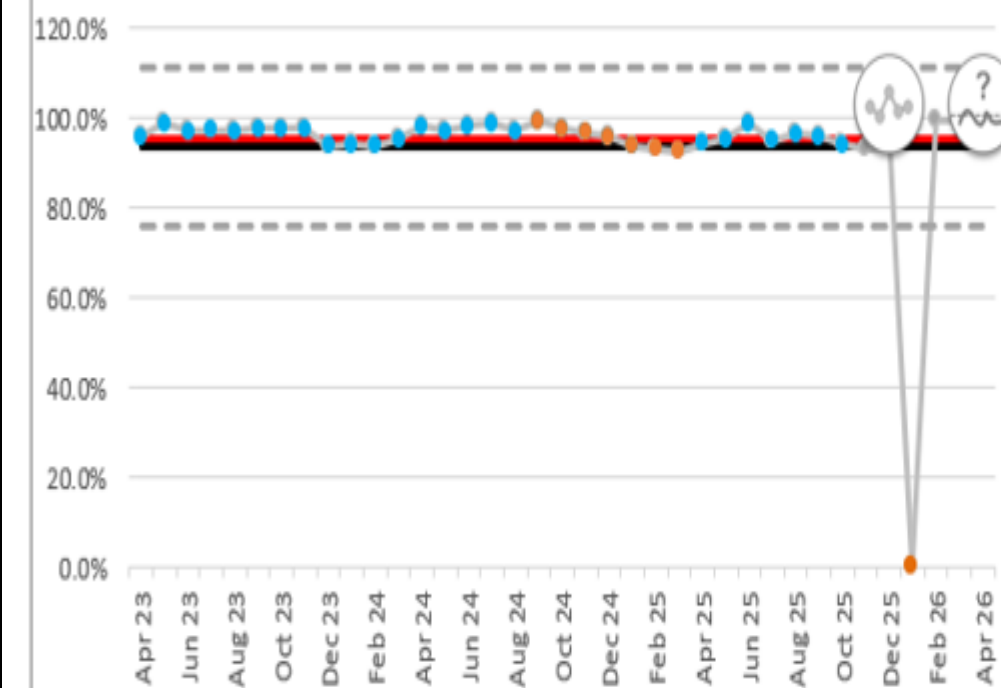


Jul-26
93.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Eastham Attendances seen within 4 hrs

CQC Domain : Responsive

Eastham Attendances seen within 4 hrs

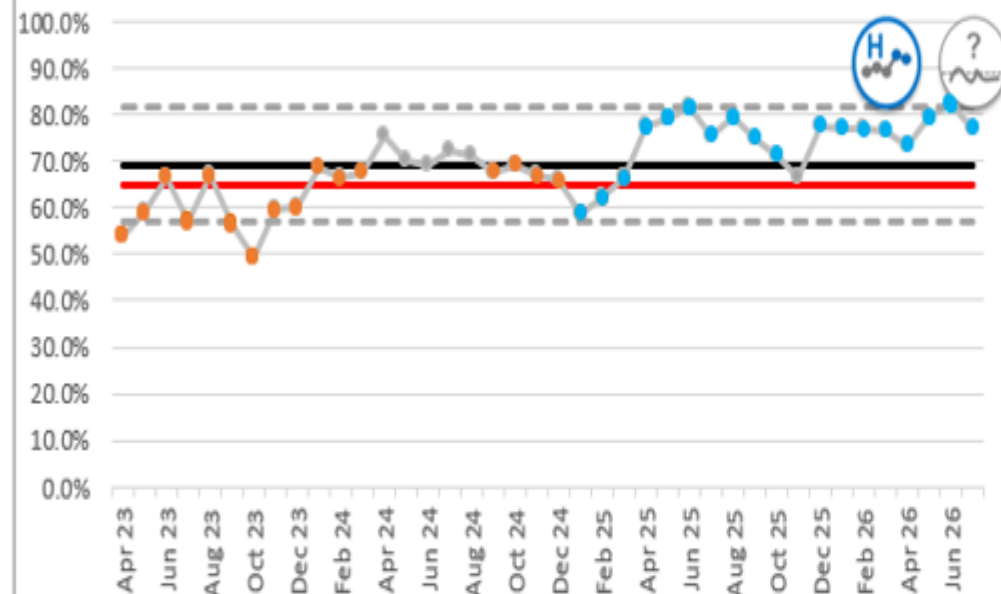


Jul-26
97.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (15 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (15 min response)

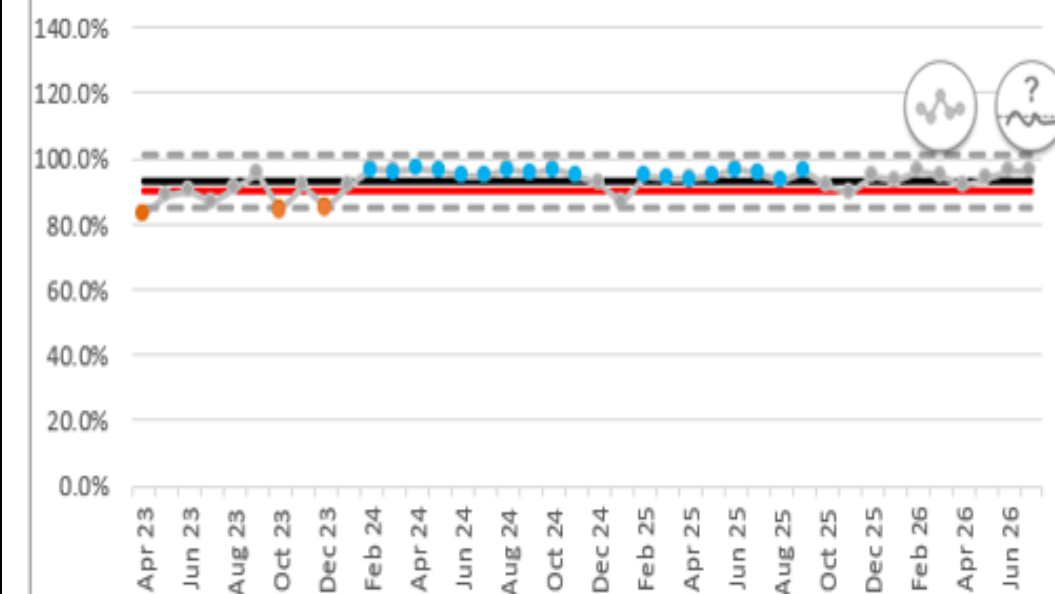


Jul-26
77.1%
Variance Type
Special cause variation - Improving
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (30 min response)

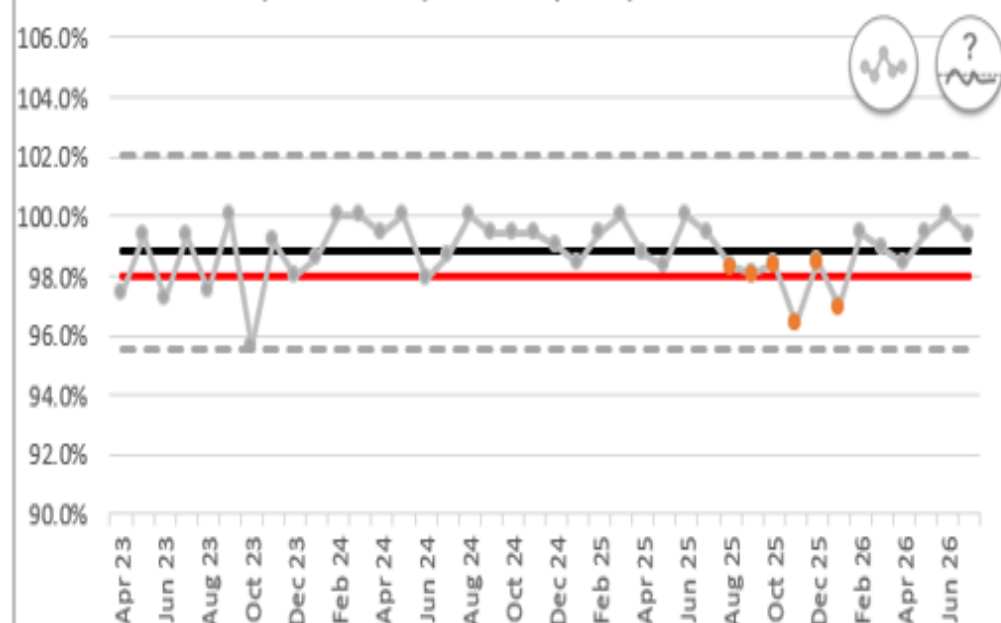


Jul-26
96.1%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

CQC Domain : Responsive

GPOOH - UCAT Response Times (60 min response)

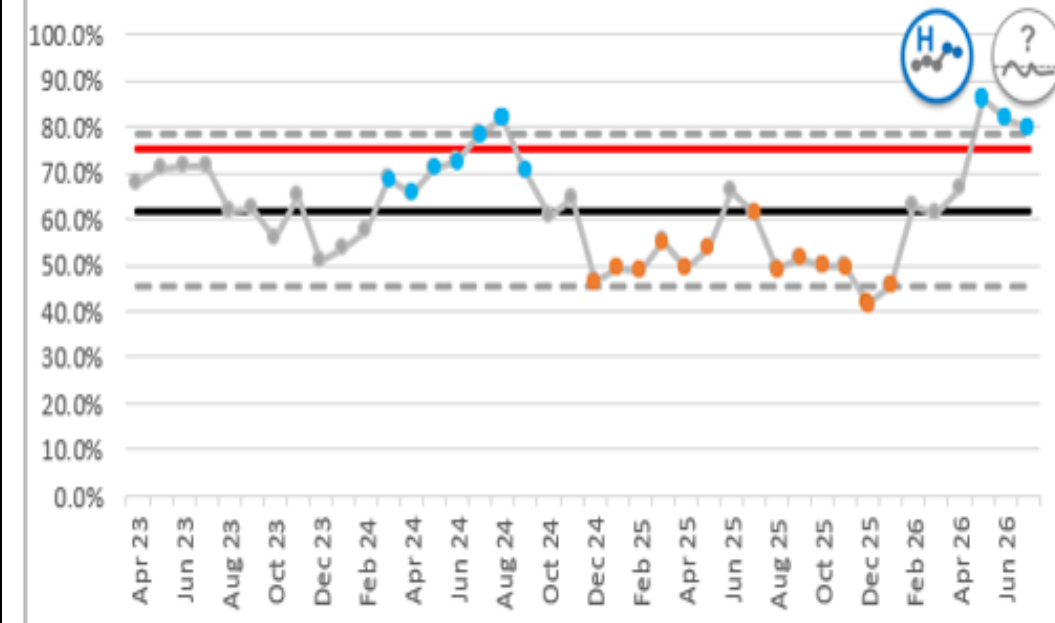


Jul-26
99.4%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH - NHS 111 Response Times

CQC Domain : Responsive

GPOOH - NHS111 Response Times

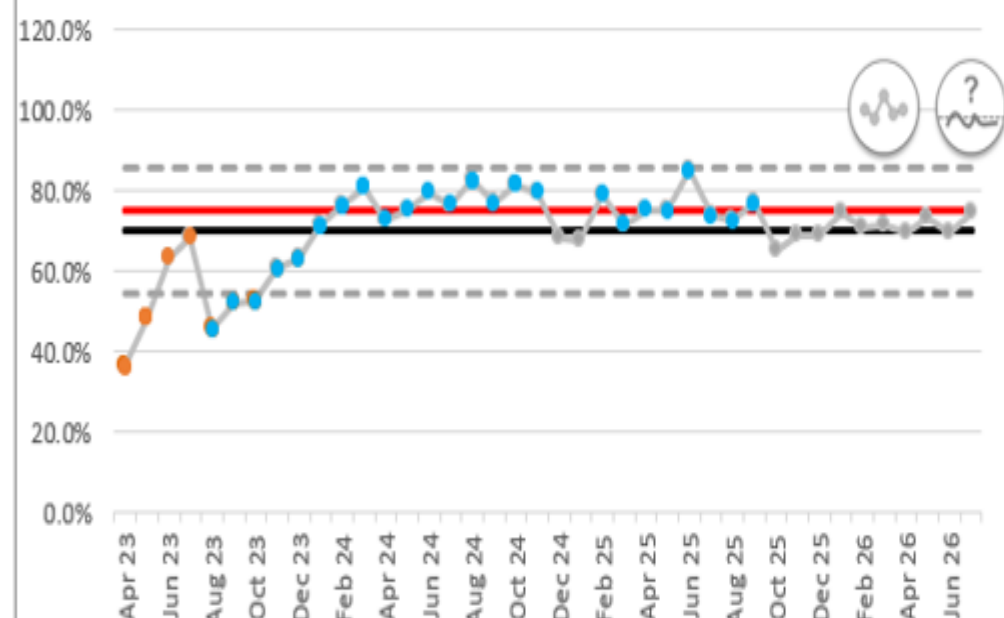


Jul-26
79.7%
Variance Type
Special Cause variation - Improving
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (20 min response)

CQC Domain : Responsive

GPOOH - CAS Response Times (20 min response)

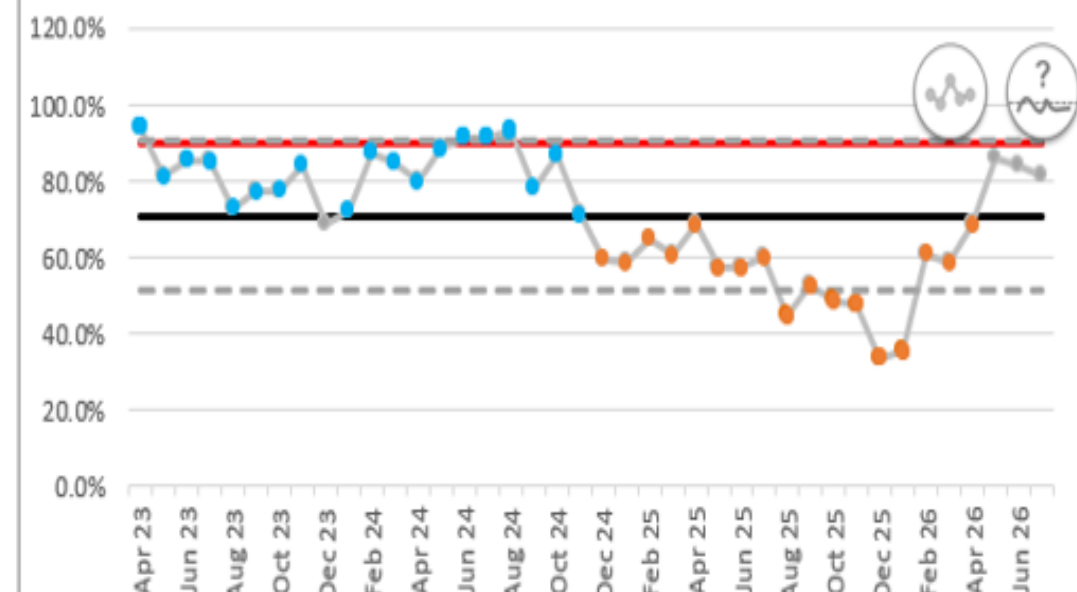


Jul-26
74.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

CQC Domain : Responsive

GPOOH - CAS Response Times (2hr response)

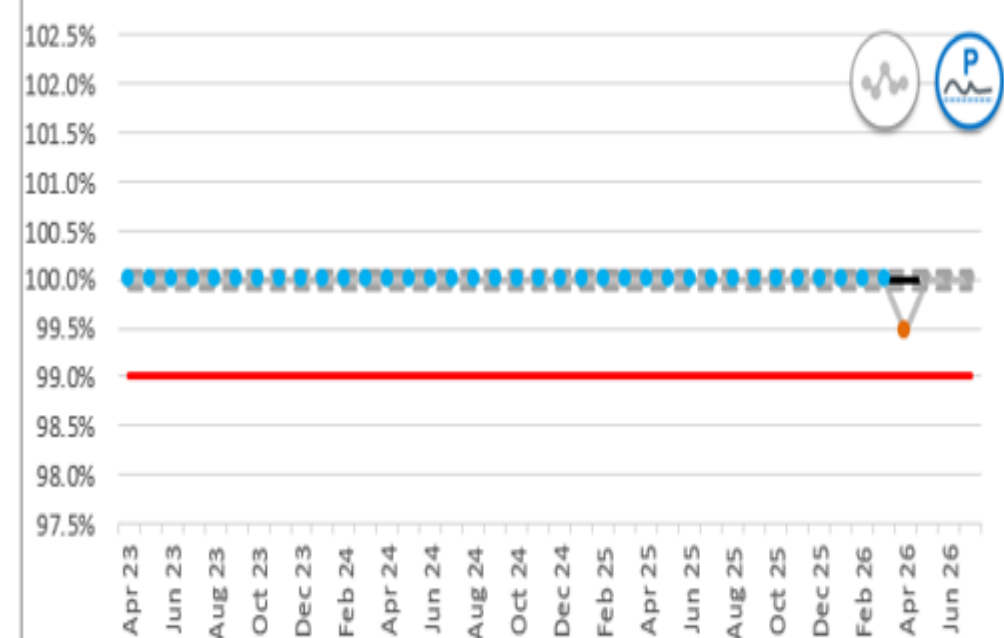


Jul-26
81.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

CQC Domain : Responsive

DM01 - % of Patients Waiting with a Wait Under 6 weeks

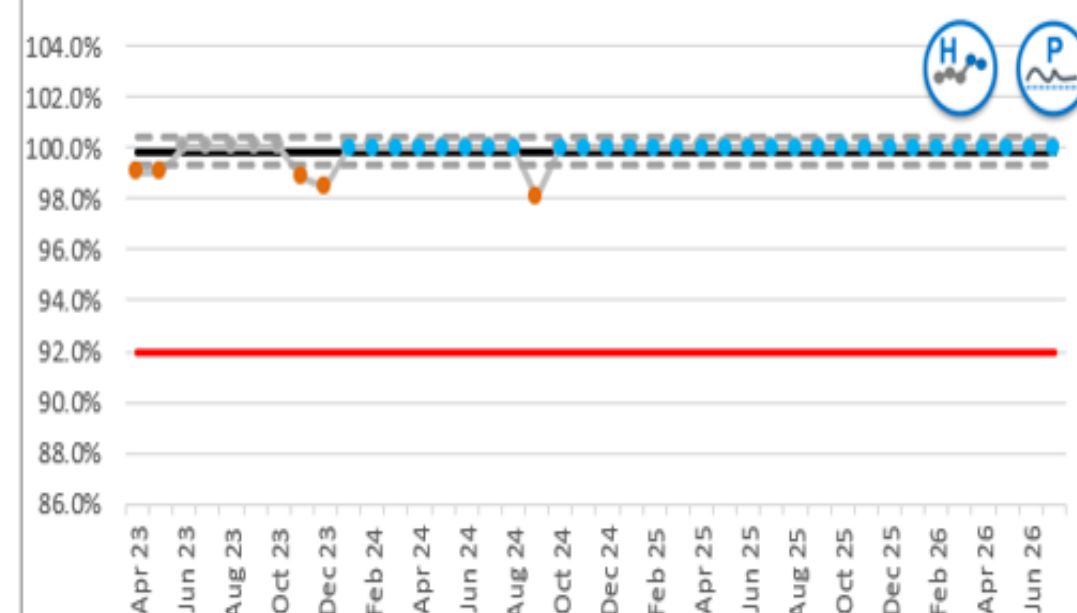


Jul-26
100%
Variance Type
Common cause variation
Threshold
≥99%
Assurance
Performance consistently achieves the target

RTT - % of Patients seen within 18 Weeks

CQC Domain : Responsive

RTT - % of Patients Seen Within 18 Weeks

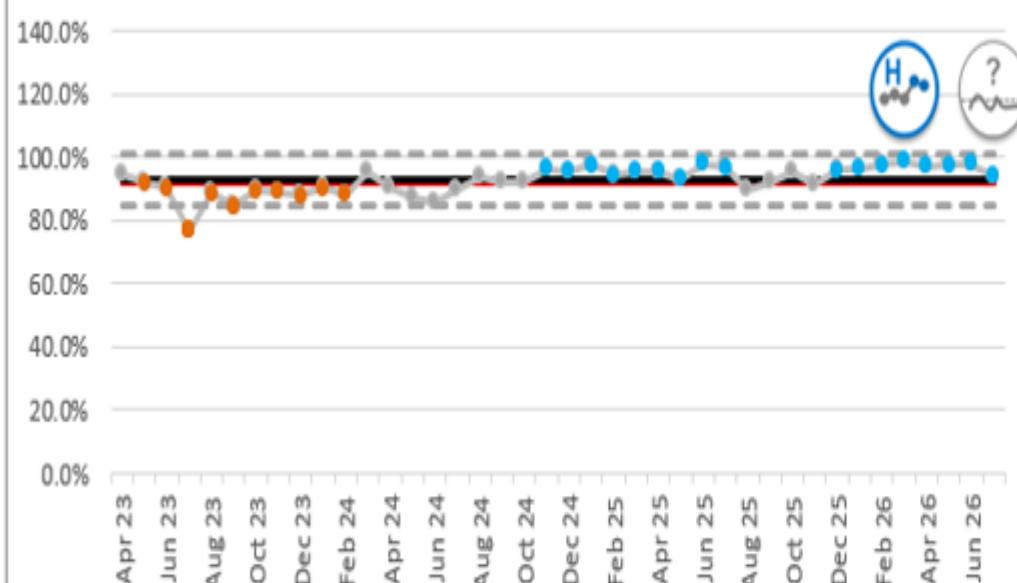


Jul-26
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target

CICC Occupancy Rate (Commissioned Beds)

CQC Domain : Responsive

CICC Occupancy Rate (Commissioned Beds)

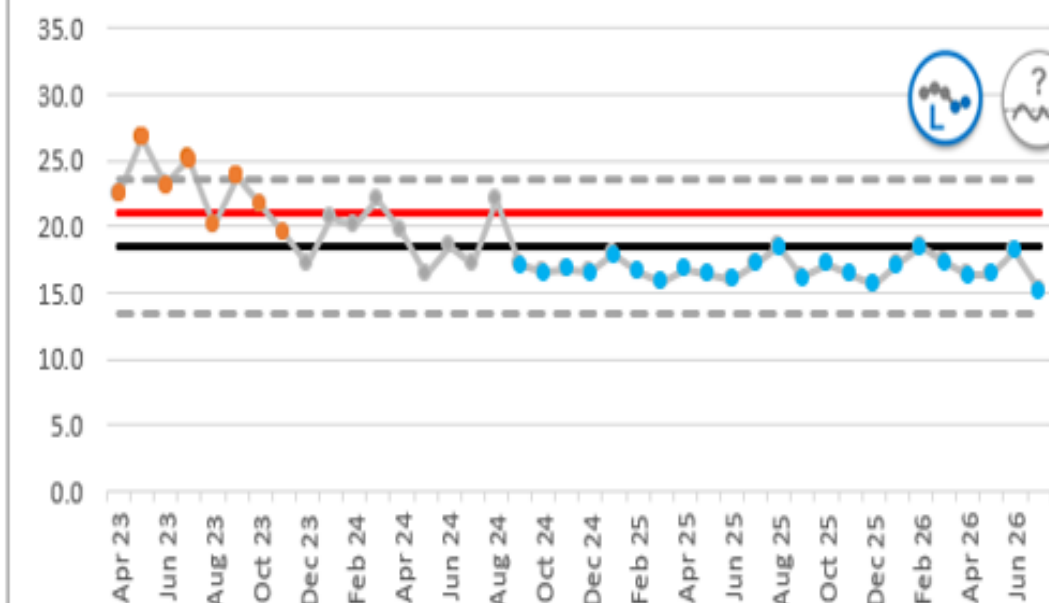


Jul-26
93.7%
Variance Type
Special cause variation - Improving
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

CQC Domain : Responsive

CICC Median LoS (Active Beds Daily Snapshot)

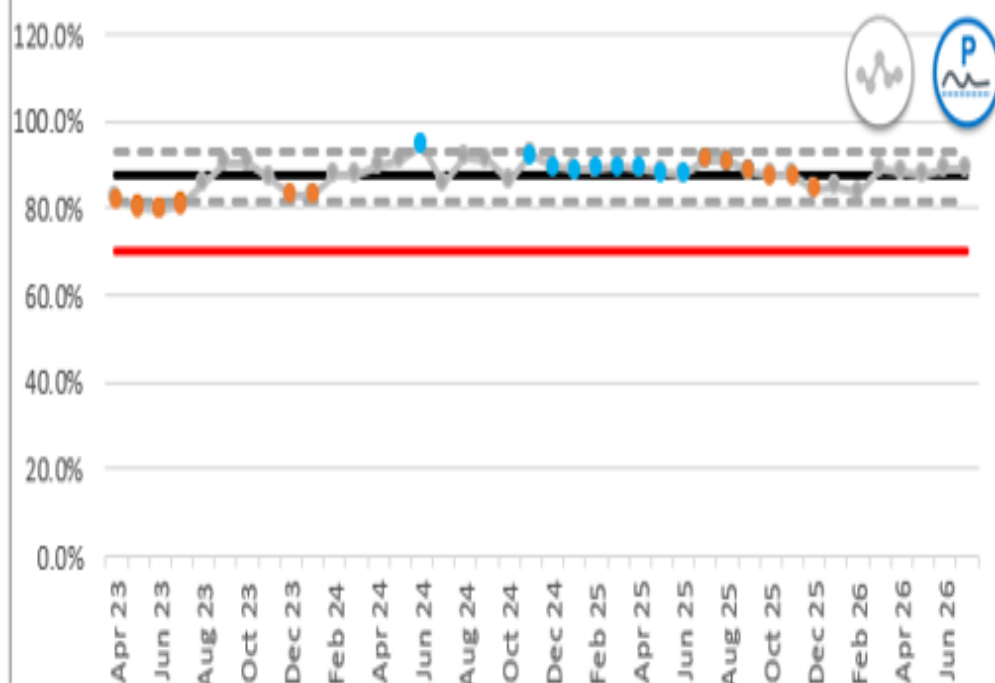


Jul-26
15
Variance Type
Special cause variation - Improving
Threshold
21
Assurance
Hit & miss target subject to random variation

Urgent Community Response - 2 hours

CQC Domain : Responsive

Urgent Community Response - 2 hours



Jul-26
88.8%
Variance Type
Common cause variation
Threshold
≥70%
Assurance
Consistently hit target

Waiting Lists					0-19/25 Performance								
Waiting list movement (since Mth01) - July 2026					0-19/25 Services - July 26								
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting	KPI	East Cheshire		Knowsley		St Helens		Wirral	
						In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Nursing	61% (0%)	94% (-2%)	100% (1%)	642 (68)	Birth visits 14 days	88.3%	88.8%	94.8%	93.2%	94.7%	93.6%	92.3%	93.3%
Specialist Medical	81% (-4%)	98% (-2%)	99% (-1%)	2716 (-286)	12 month reviews	87.9%	88.7%	94.0%	92.6%	95.2%	94.7%	94.9%	94.1%
Specialist Medical - Dental	36% (-9%)	59% (-9%)	78% (-6%)	308 (34)	2.5 year reviews	89.1%	89.2%	82.1%	89.2%	94.5%	94.8%	93.6%	91.5%
Therapies	48% (-4%)	72% (-6%)	85% (-4%)	5303 (612)	Breastfeeding 6-8 weeks	57.9%	60.8%	36.8%	38.5%	43.5%	42.9%	48.1%	46.5%

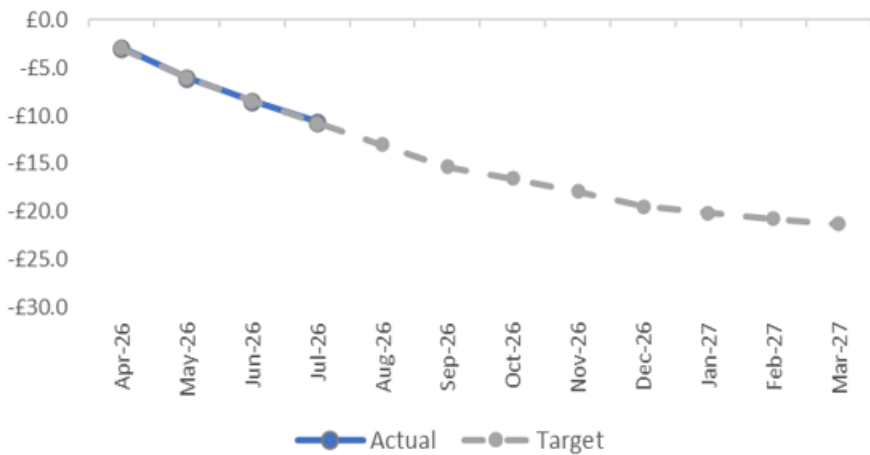
CFO Finance Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Jul 26	1.3%	≤0.8%			
I&E Position	Jul 26	-£10.7m	-£10.8m			
Cumulative CIP	Jul 26	£6.6m	£6.7m			
Capital Expenditure	Jul 26	£3.1m	£3.9m			
Cash Position	Jul 26	£2.6m	£2.7m			

I&E Position

CQC Domain : Use of Resources

I&E Position



Jul-26

-£10.7m

Variance Type

Position meets the plan

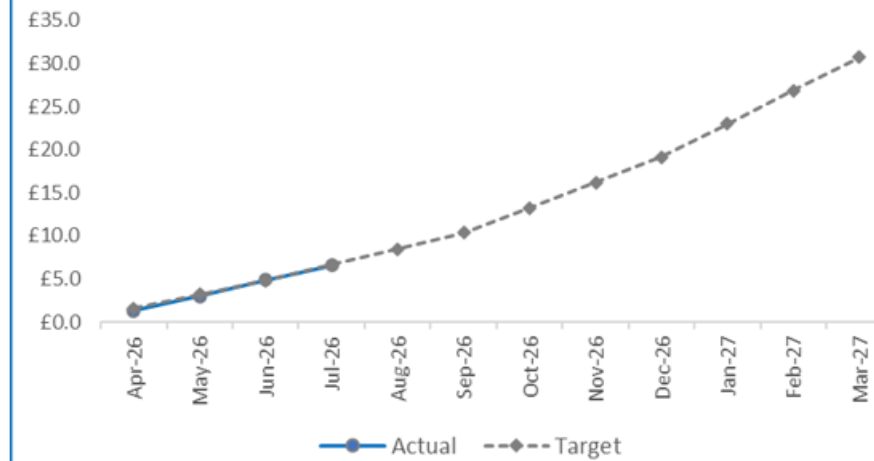
Target

-£10.8m

Cumulative CIP

CQC Domain : Use of Resources

Cumulative CIP



Jul-26

£6.6m

Variance Type

Position does not meet the plan

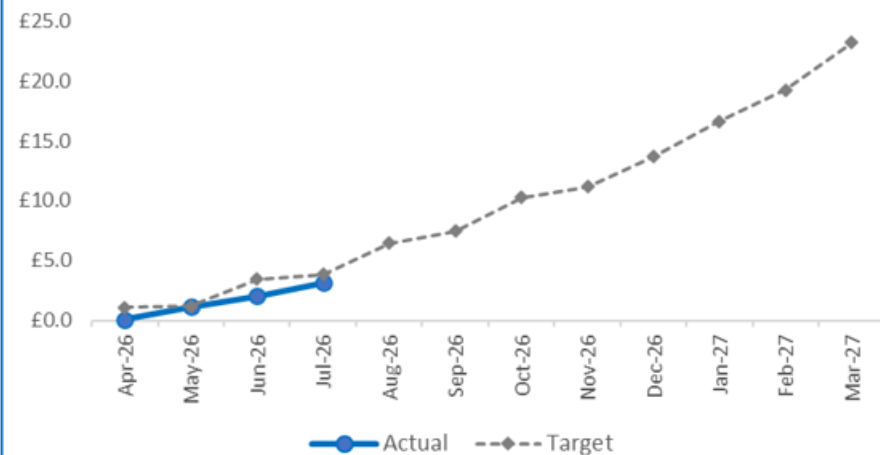
Target

£6.7m

Capital Position

CQC Domain : Use of Resources

Capital Expenditure



Jul-26

£3.1m

Variance Type

Position does not meet the plan

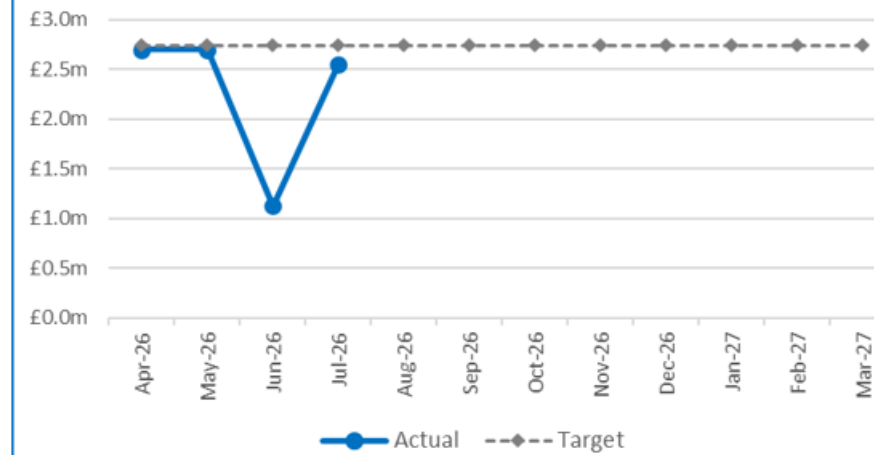
Target

£3.9m

Cash position

CQC Domain : Use of Resources

Cash Position



Jul-26

£2.6m

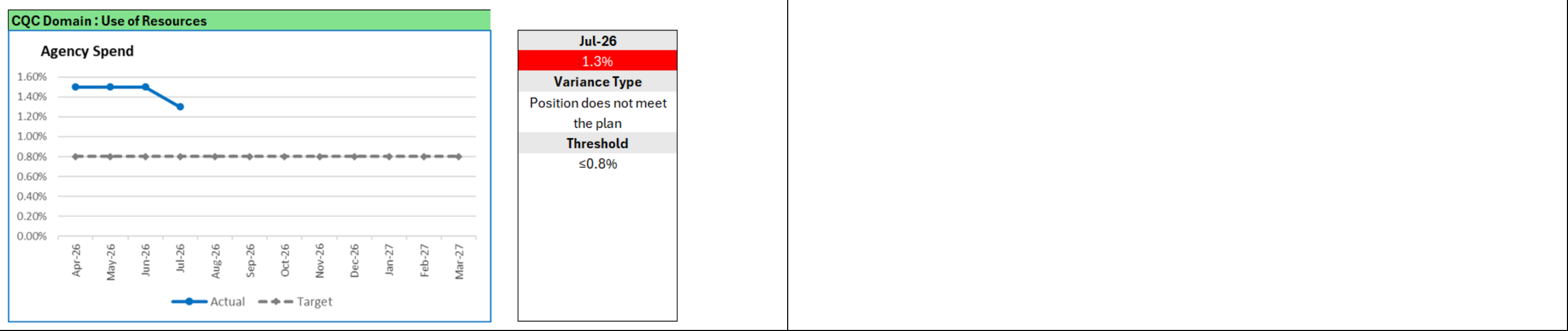
Variance

Position does not meet the plan

Target

£2.7m

Agency spend %



Finance

Executive Summary

At the end of July 2026 (M4), the Trust is reporting a deficit of £10.7m, which is in line with plan.

The Trust identified three key risks within the plan:

- Full CIP Delivery: The primary risk to achieving the 2026/27 financial position is delivery of our CIP target of £30.7m. Of this target £18.6m has been transacted and a further £8.9m is fully developed. Overall the Trust has identified £35.3m against the target which on a risk adjusted basis is £28.4m.
- Activity / Casemix: After accounting for the impact of industrial action, the Trust is £1.0m behind plan at M4. This has been offset by non-recurrent mitigations.
- 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 vacancy controls remaining in effect.

The Trust's revised planned deficit of £21.3m has been accepted by NHSE and, as a result, the Trust has now received Deficit Support Funding for Q1 and Q2. The Trust continues to adhere to the agreed cash mitigation plan as until a sustainable financial position is achieved, this will remain a significant issue.

It is important to note that management of risks against this plan alone do not deliver long-term financial sustainability. The significant improvement required for sustainability will be delivered through the medium-term finance plan (MTFP) for 2026/27 to 2028/29.

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

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Jul 26	1.3%	≤0.8%			
I&E Position	Jul 26	-£10.7m	-£10.8m			
Cumulative CIP	Jul 26	£6.6m	£6.7m			
Capital Expenditure	Jul 26	£3.1m	£3.9m			
Cash Position	Jul 26	£2.6m	£2.7m			

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

The Board is asked to:

- Note the report and that the Trust continues to operate within the NHSE NW Finance Performance and Recovery Meeting (FPRM) process

I&E Position

Narrative:

The table below summarises the M4 position:

Cost Type	Year to Date		
	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£159.4m	£161.7m	£2.3m
Other Operating Income	£16.1m	£16.0m	-£0.1m
Total Income	£175.5m	£177.7m	£2.3m
Employee Expenses	-£134.5m	-£136.3m	-£1.8m
Operating Expenses	-£49.8m	-£50.4m	-£0.5m
Non Operating Expenses	-£2.0m	-£1.8m	£0.2m
CIP	£0.1m	£0.0m	-£0.1m
Total Expenditure	-£186.2m	-£188.4m	-£2.2m
Reported Position	-£10.8m	-£10.7m	£0.1m

Key variances within the YTD position are:

Clinical Income – after adjusting for IA, clinical income is £1.0m off plan which is offset by additional non-recurrent funding, including the Hantavirus response, and income from high cost drugs and devices, which are both reflected in additional costs.

Employee Expenses - £1.8m adverse variance principally driven by higher than planned spend on bank and agency, the Hantavirus response and remaining escalation capacity.

Operating expenses – £0.5m adverse variance mainly driven by high cost drugs and devices.

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

Cumulative CIP

Narrative:

The Trust has delivered £6.6m of recurrent CIP at M4 against a profiled target of £6.7m, a shortfall against plan which is offset by non-recurrent mitigations.

£18.6m has now been transacted and a further £8.9m is fully developed. Overall, the Trust has identified £35.3m, 115% of target which on a risk adjusted basis is £28.4m, 92% of target.

The overall value identified is positive, however the deliverability of the programme requires continued grip through operational and divisional governance routes.

Elective Activity

Narrative:

After accounting for Industrial Action, elective and day case activity is £1.0m below plan at M4. This is driven by reduced activity in Trauma and Orthopaedics driven by consultant sickness and reductions in case mix in respect of Urology.

A recovery plan has been agreed by the Executive Team.

Capital Expenditure

Narrative:

At M4 the Trust has spent £3.1m against a plan of £3.9m:

Scheme	NHSE plan spend	Plan spend M4	Actual spend M4	Variance
Estates and backlog maintenance	£7.209m	£1.000m	£0.879m	-£0.121m
Operational delivery	£9.276m	£1.300m	£0.500m	-£0.800m
IT equipment	£0.900m	£0.050m	£0.610m	£0.560m
Medical education	£0.075m	£0.000m	£0.000m	£0.000m
Transformation	£1.000m	£0.250m	£0.000m	-£0.250m
PDC Commitments	£5.310m	£1.250m	£1.136m	-£0.114m
NHSE TOTAL CAPITAL PLAN 26/27	£23.770m	£3.850m	£3.125m	-£0.725m

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 M4 was £2.6m, just under the minimum cash requirement of £2.7m.

In M4 it was confirmed that the Trust's revised planned deficit of £21.3m was accepted by NHSE. As a result, the Trust received Deficit Support Funding for Q1 and Q2 in M5. The Trust continues to need to adhere to the agreed cash mitigation plan and will do until a sustainable financial position is achieved

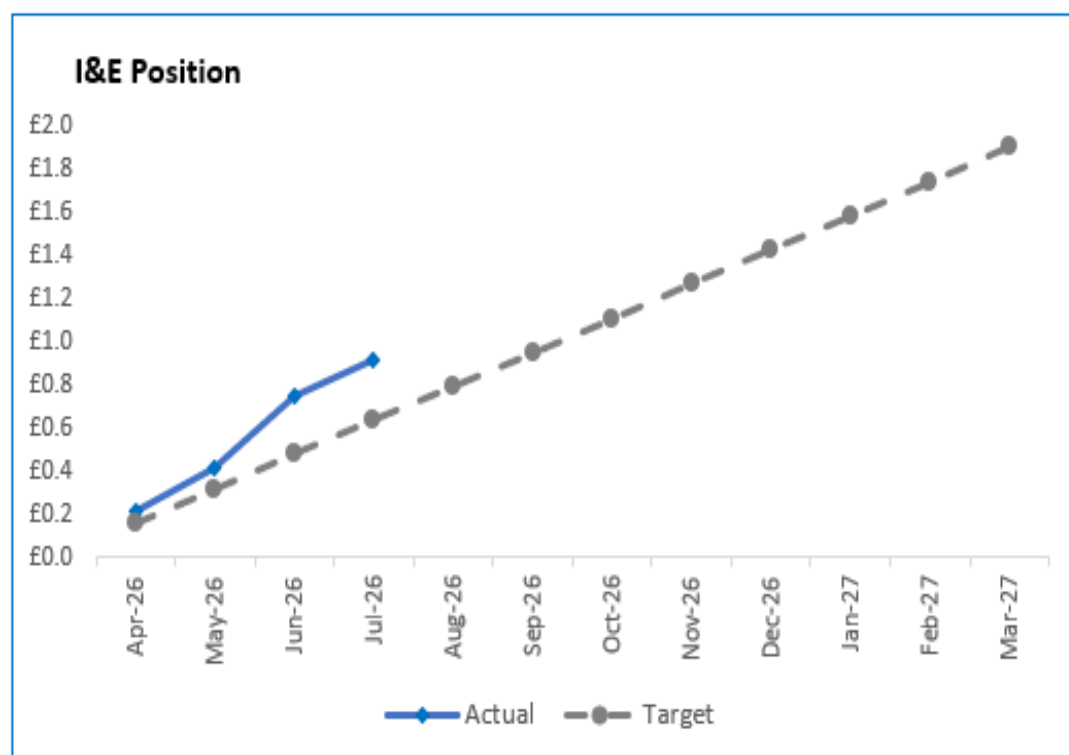
The Trust's cash mitigation actions are consistent with the NHS cash regime. These include:

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

Finance Summary - WCHC

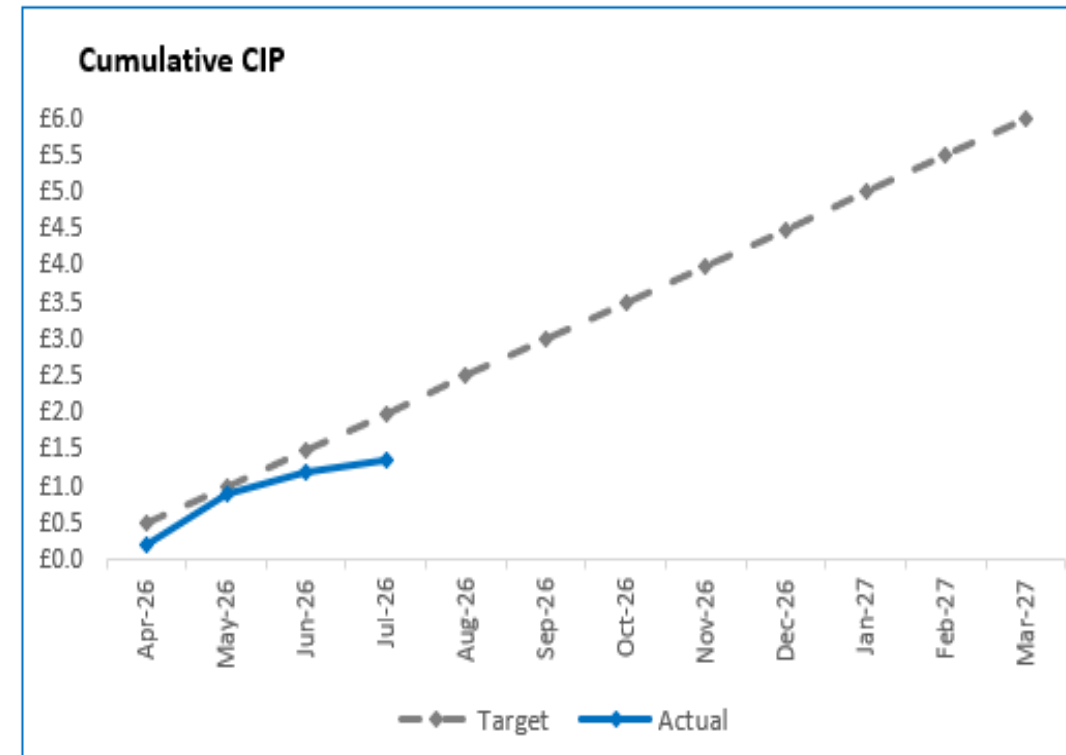
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Jul 26	0.3%	≤0.1%			
I&E position	Jul 26	£0.91m	£0.63m			
Cumulative CIP	Jul 26	£1.34m	£2m			
Capital expenditure	Jul 26	£1.37m	£2.3m			
Cash position	Jul 26	£10.78m	£9m			

I&E Position



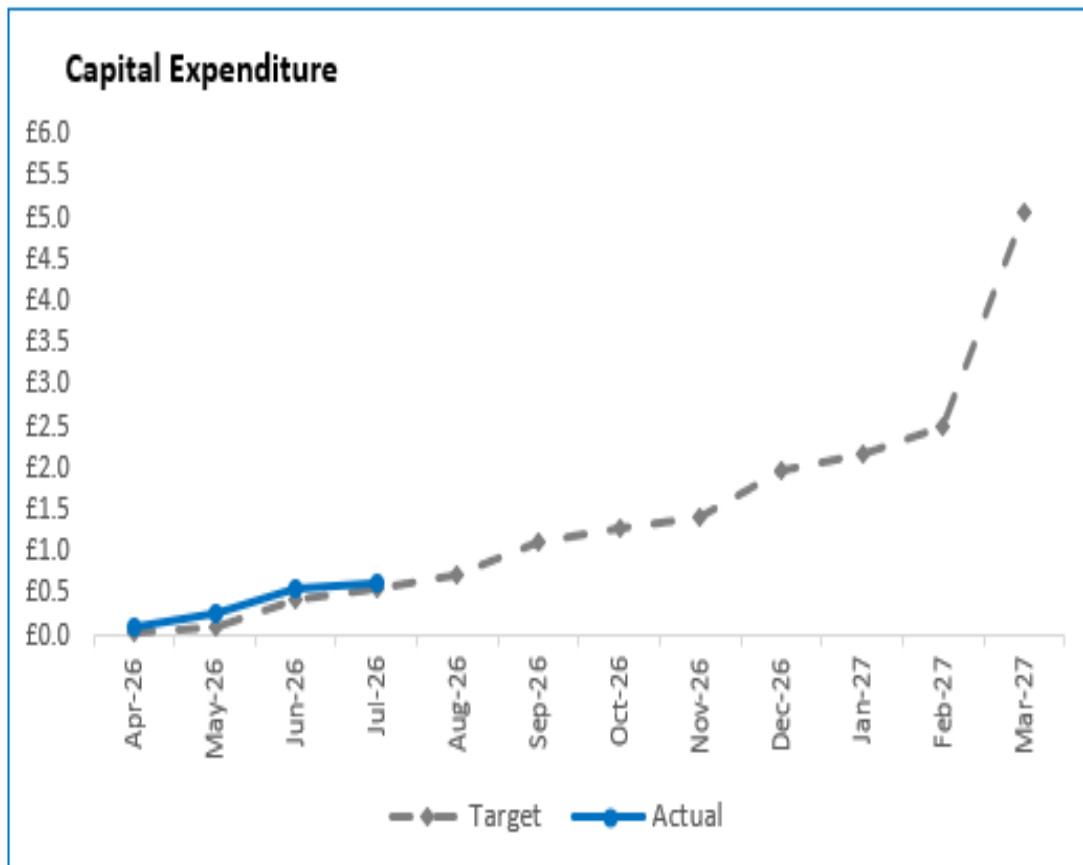
Jul-26
£0.91m
Variance
Position better than plan
Target
£0.63m

Cumulative CIP



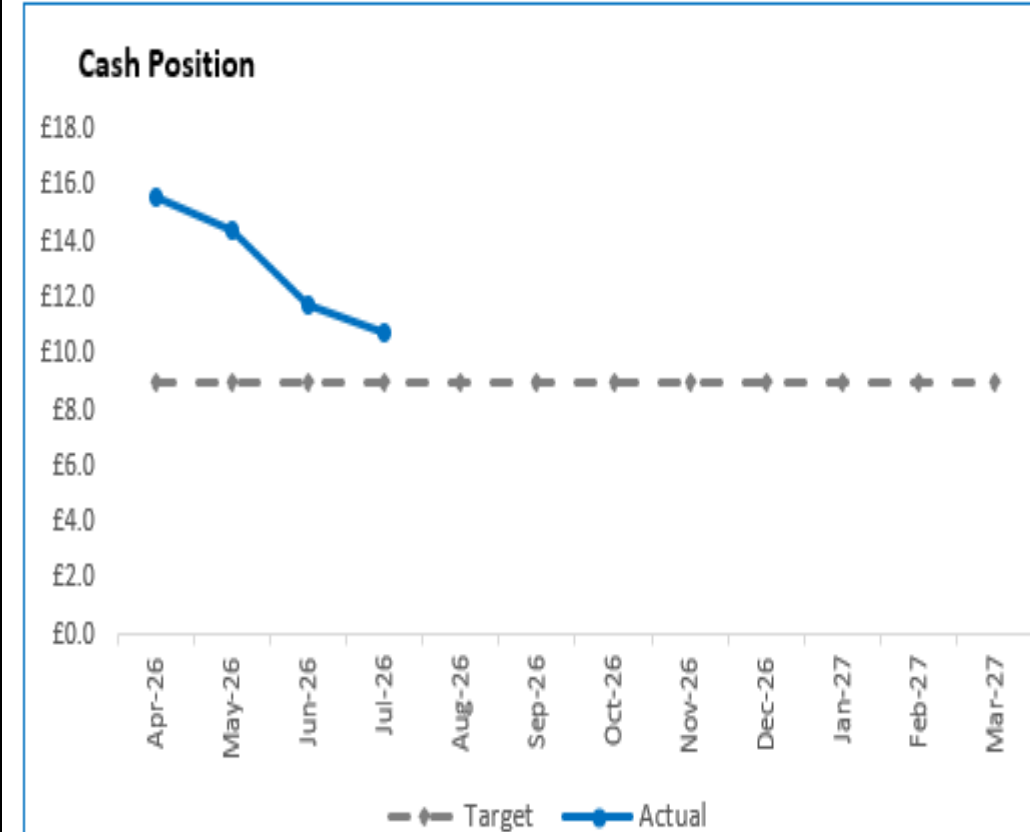
Jul-26
£1.34m
Variance
Position worse than plan
Target
£2m

Capital Expenditure



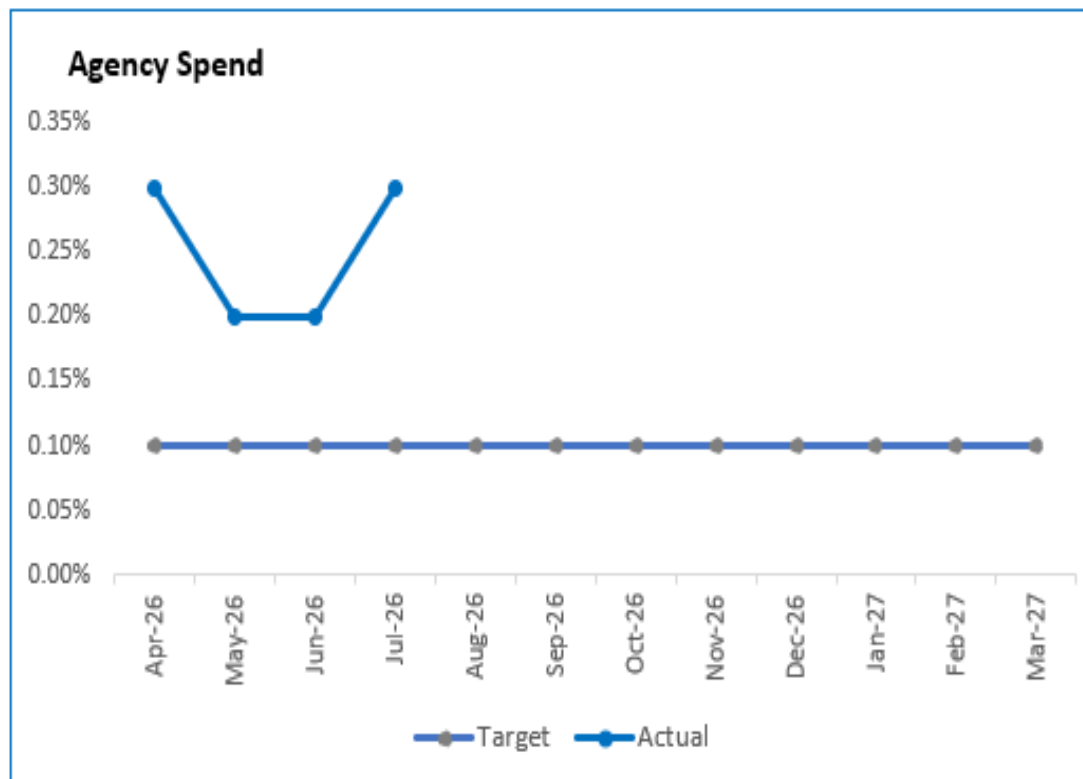
Jul-26
£1.37m
Variance
Position better than plan
Target
£2.3m

Cash Position



Jul-26
£10.78m
Variance
Position better than plan
Target
£9m

Agency Spend



Jul-26
0.3%
Variance
Position worse than plan
Target
≤0.1%

Finance

Executive Summary

At the end of July 2026 (M4), the Trust is reporting a £0.9m surplus, a £0.3m positive variance to plan.

The reported position reflects favourable performance across pay and non-pay expenditure, partially offset by a shortfall in delivery of the Cost Improvement Programme (CIP).

While the reported financial position is positive, the workforce and CIP positions indicate that part of this benefit reflects under-delivery of planned savings rather than fully sustainable underlying improvement. Total WTE is 6.69 above plan, driven by unachieved CIP and higher than planned bank spend.

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

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Jul 26	0.3%	≤0.1%			
I&E position	Jul 26	£0.91m	£0.63m			
Cumulative CIP	Jul 26	£1.34m	£2m			
Capital expenditure	Jul 26	£1.37m	£2.3m			
Cash position	Jul 26	£10.78m	£9m			

The Board is asked to:

- Note the report.

I&E Position

Narrative:

The table below summarises the M4 position:

	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£8.8m	£8.9m	£0.0m	£35.3m	£35.2m	-£0.0m
Other Operating Income	£0.2m	£0.3m	£0.1m	£0.9m	£1.1m	£0.2m
Total Income	£9.0m	£9.1m	£0.1m	£36.1m	£36.3m	£0.2m
Employee Expenses	-£7.0m	-£6.9m	£0.1m	-£27.5m	-£27.1m	£0.3m
Operating Expenses	-£1.6m	-£1.6m	£0.0m	-£5.8m	-£6.2m	-£0.4m
Non Operating Expenses	-£0.6m	-£0.6m	-£0.0m	-£2.2m	-£2.1m	£0.1m
Total Expenditure	-£9.1m	-£9.0m	£0.1m	-£35.5m	-£35.4m	£0.1m
Reported Position	-£0.1m	£0.2m	£0.2m	£0.6m	£0.9m	£0.3m

The Trust is reporting a £0.9m surplus at M4. This is attributable to positive variances in pay and non-pay, partly offset by a shortfall in CIP delivery.

The Trust has received £0.2m income more than plan, most of which relates to additional income received from 0-19 services.

Employee expenses have a £0.3m positive variance, with underspends due to vacancies which are partially offset by increases in bank and agency spend.

Operating expenditure has an adverse variance of £0.4m. This is being driven by overspends in respect of Nursing (continence products and dressings) and Estates (utilities and increased charges for leased estate).

Cumulative CIP

Narrative:

The Trust's CIP target for 2026/27 is 6%, equivalent to £6.0m and 64 WTE. At M4, the target was £2m, with £1.3m achieved.

The Trust has identified £7.1m against its target (118%) and on a risk adjusted basis this is £6.0m (100%). The challenge for the Trust is in delivery and ensuring reductions in run rate from the schemes.

Capital Expenditure

Narrative:

At M4 the Trust has spent £0.6m against a plan of £1.4m:

Scheme	NHSE plan spend	Plan spend M4	Actual spend M4	Variance
Estates and backlog maintenance	£0.340m	£0.110m	£0.062m	-£0.048m
Operational delivery	£2.276m	£0.360m	£0.000m	-£0.360m
IT equipment	£0.560m	£0.110m	£0.402m	£0.292m
Transformation	£0.160m	£0.000m	£0.000m	£0.000m
IFRS16	£1.342m	£0.000m	£0.000m	£0.000m
PDC Commitments	£1.445m	£0.800m	£0.165m	-£0.635m
NHSE TOTAL CAPITAL PLAN 26/27	£6.123m	£1.380m	£0.629m	-£0.751m

Cash Position

Narrative:

The cash balance at the end of M4 was £10.9m.

CPO Workforce Summary – WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Jul 26	5.83%	≤5%			5.91%
Staff turnover % - in-month rate	Jul 26	0.84%	≤1%			87.52%
Mandatory training % compliance	Jul 26	89.56%	≥90%			91.92%
Appraisal % compliance	Jul 26	84.73%	≥88%			0.82%

Highlights

Areas of Concern

Sickness absence levels continue to be above the Trust's 5% target.

Latest performance is 5.83% in-month which is an increase of 0.47% since June (5.36%) but an improved in-month position compared to both July'25 (6.16%) and July'24 (6.42%).

The rolling sickness absence has improved each month and is currently at 5.85%. This is also an improved position on the rolling sickness rate compared to July'25 (6.13%) and July'24 (6.06%).

Long-term absence (>28 days) has risen to 3.69%, and short-term absence (<28 days) has increased to 2.15%.

Women & Children's has the highest sickness rate at 6.92%, Estates, Facilities and Capital 6.33%, Medicine and Urgent Care 6.16%, Surgery 5.93% and Clinical Support Division 5.42%.

All Divisions saw an increase in sickness, and only Corporate Support (3.88%) remains below target.

Anxiety/Stress/Depression continues to be the main reason for absence at 35.05%, followed by Gastro at 10.08%.

The three main staff groups for sickness are: Additional Clinical Services (8.04%), Estates and Ancillary (6.50%) and Nursing and Midwifery (6.01%).

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).

Forward Look (Actions)

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 is £1m contributing to the Trust Cost Improvement Programme broken down into divisional plans with specific targets.

4 Workstreams:

- Workstream 1: Targeted Trust Level Staff Group and (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:

Key initiatives delivered so far this year include:

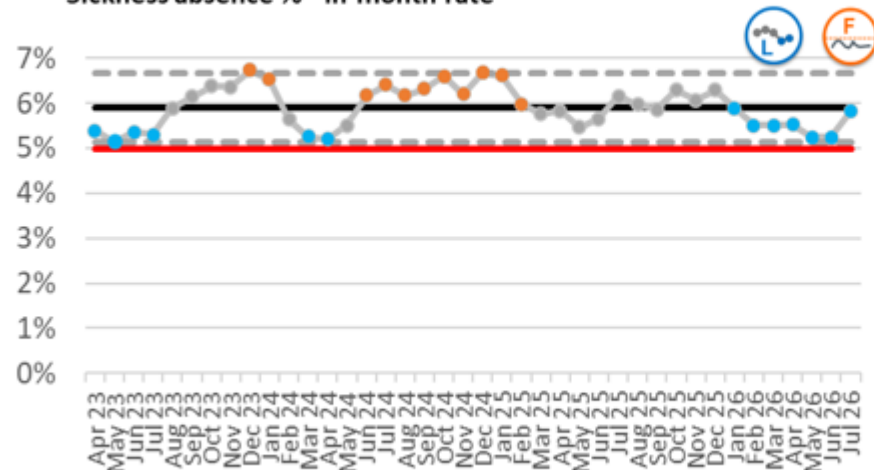
- Targeted psychological support to Divisions with identified wellbeing concerns following traumatic events
- Launched the new 'Well in Work' Programme (6-week CBT course)
- Continued rollout of 'Well Wirral' Return to work programme
- Revised mental health referral triage to ensure faster access to care
- New Workforce population centric health needs assessment and drafted 3-year plan. This includes triangulated data from Wirral Health Inequalities, Staff Groups, Sickness reasons, Staff Postcode and Consultant expertise.
- TRiM bid for funding to introduce across the Trust.
- New psychological intervention process, support and training being designed for managers to help staff post a significant event
- Continued implementation of a calendar of proactive wellbeing initiatives including:
 - On-side cervical health checks in collaboration with the Smear Campaign and Living Well Bus, Alcohol support programme - Shrink in the Drink in partnership with Unite and Smoking cessation clinic for staff
- Psychotherapist led workshops – most recent was Resilience, Wellbeing & Mental Health to WEPP Programme / Nurse Preceptorship
- EAP & Wisdom Wellbeing App increased uptake and continued promotion

	Mandatory Training Mandatory Training Compliance for July 2026 was slightly below its 90% target at 89.56%. All Divisions are above 90% compliance with the exception of Estates, Facilities and Capital who are currently 74.77% compliance. Subjects of below 90% compliance are Data Security at 89.37%, IPC L2 at 87.67%, PVP Levels 1-4 All Levels of Resuscitation Training are below 90% compliance the lowest are Level 3 Pediatric (55.88%), Level 2 Pediatric (58.08%) and Level 3 Adult (58.77%). NOTE: Advances Life Support Resuscitation was moved over from Role Essential Training to Mandatory Training in line with the National Core Skills and Training Framework. This has contributed to the drop in overall compliance. Appraisal Compliance Organisational appraisal compliance for July remains below the 88% KPI, at 84.73%. Data from July demonstrates a decrease in Trust compliance in comparison to June (85.35% vs 84.73%). Corporate Services is the worst performing at 79.80% compliance. Whilst remaining non-compliant the figures for June compared to July have improved slightly in Clinical Support and Surgery. Women & Children's is the only division that remains compliant with 91.54% for July (June 93.16%). The last time organisational appraisal compliance was met was December 2025	Mandatory Training Estates, Facilities and Capital have an improvement plan to increase compliance. A dedicated training room has been established for staff to complete their training. Education Governnace to monitor compliance and work with subject matter experts to develop targeted plans to improve compliance. Divisions to review areas of low Resus compliance to understand the risks of non-compliance to patient care and establish actions plans to mitigate risks. Appraisal Compliance Recent actions taken • New e-Learning package now live and available for completion via ESR. The content is to support staff in engaging and gaining more value from their appraisal and check-in discussions. • Ongoing proactive targeting of appraisal audits based on compliance positions as per the workforce reports. • HRBP's working with their respective divisional leadership teams to drive compliance improvement, with OD support, where required. • Feedback re the new Appraisal and Check In documentation continues to be largely positive, indicating that it's more intuitive. This is also reflected within the appraisal audits. Rather than a further specific review of the paperwork, the appraisal audit responses will be used as indicators of satisfaction. • Continued offering of bespoke OD support to depts. and divisions to help them improve compliance positions and staff experience.
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Sickness absence % in month rate

CQC Domain : Safe

Sickness absence % - in-month rate



Jul-26

5.8%

Variance Type

Special cause
improving variation

Threshold

≤5%

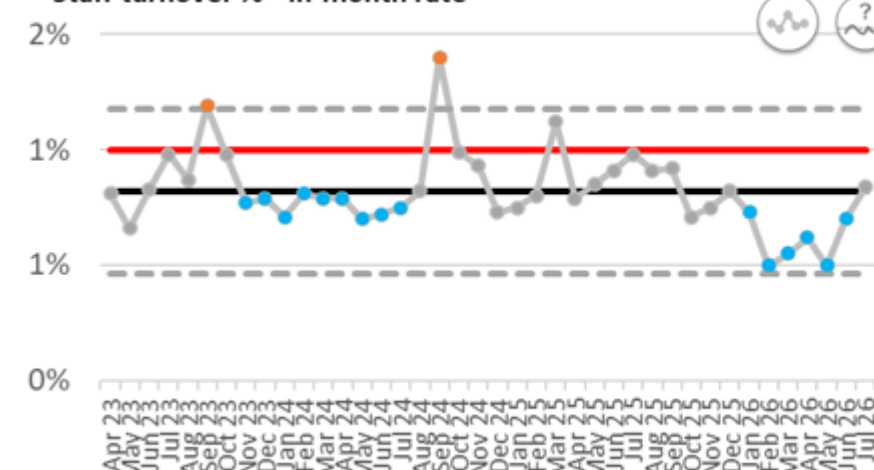
Assurance

Consistently fail target

Staff turnover % in month rate

CQC Domain : Safe

Staff turnover % - in-month rate



Jul-26

0.8%

Variance Type

Common cause
variation

Threshold

≤1%

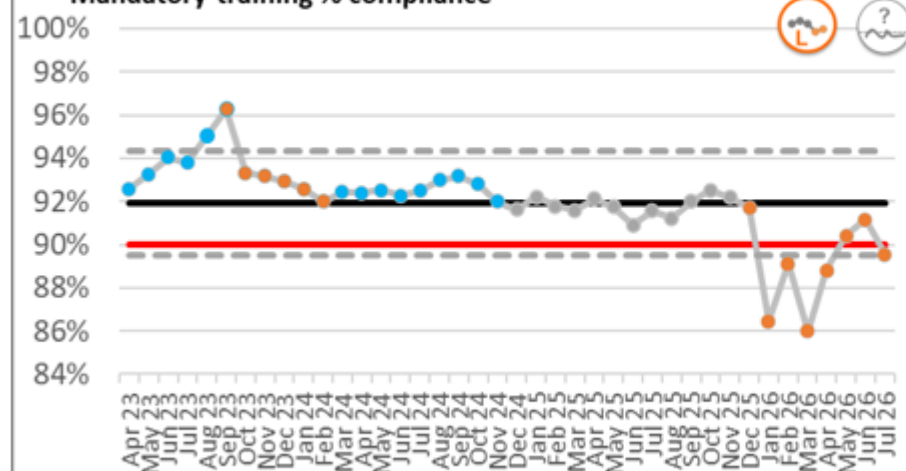
Assurance

Hit and miss target
subject to random
variation

Mandatory training % compliance

CQC Domain : Safe

Mandatory training % compliance



Jul-26

89.6%

Variance Type

Special cause
concerning variation

Threshold

≥90%

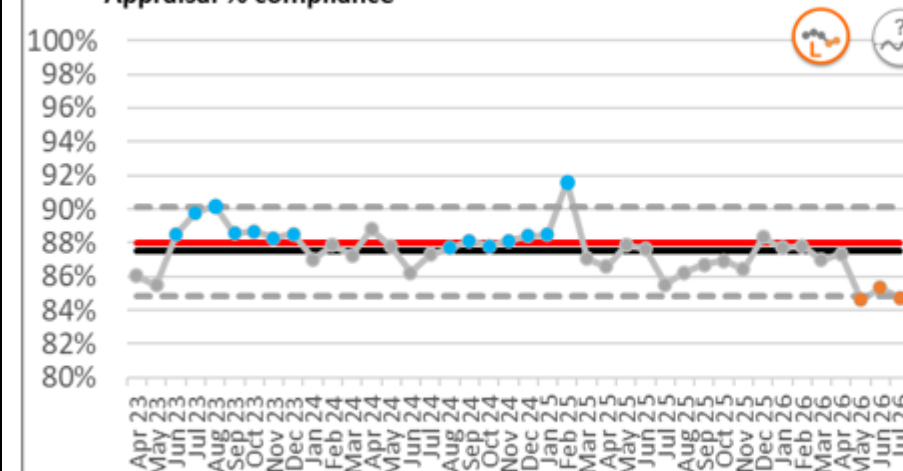
Assurance

Hit and miss target
subject to random
variation

Appraisal % compliance

CQC Domain : Well-led

Appraisal % compliance



Jul-26

84.7%

Variance Type

Special cause
concerning variation

Threshold

≥88%

Assurance

Hit and miss target
subject to random
variation

Workforce Summary – WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	July 26	11.3%	12.0%			12.4%
Mandatory Training Compliance	July 26	94.4%	90.0%			95.0%
Sickness Absence	July 26	6.2%	5.0%			6.5%
Sickness Absence (Short Term)	July 26	2.2%	2.0%			1.6%
Sickness Absence (Long Term)	July 26	4.0%	3.0%			4.9%
Agency usage	July 26	0.5%	1.0%			0.9%
Variance to Agency Cap (£)	July 26	-188433	-			-177197.8
% of Agency Usage against Funded WTE	July 26	0.1%	-			0.6%
% of Bank Usage against Funded WTE	July 26	3.6%	-			3.5%
% of Contracted FTE Vacancies	July 26	4.6%	6.0%			5.0%

Highlights

Areas of Concern

Sickness absence levels continue to be above the Trust's 5% target. WCHC sickness absence has been consistently over 7%, with a significant proportion being long-term absence, the Trust threshold was last achieved in August 2023.

Latest performance is 6.18% in-month which is an increase of 0.46% since June (5.72%). The rolling sickness absence has improved each month and is currently at 6.85%.

Long-term absence (>28 days) has reduced to 4% and short-term absence (<28 days) has increased to 2.2%. YTD short term sickness is within tolerance at 1.6% but LTS is above tolerance at 4.4%.

Specialist Medical has the highest sickness rate at 7.7%, Therapies 7.4%, Nursing 6.3%, 0-19/25 5.7%, Community Response 5.5% and Corporate 4.2%.

Anxiety/Stress/Depression continues to be the main reason for absence at 44.4%, followed by Gastro at 10.04%.

Through last year's Sickness Absence project which commenced in August 2025 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 sickness reducing from 7.62% to 6.18% and a real focus on managing long term sickness cases which has reduced from 6.26% in August'25 to 4.03% in July'26.

Note: The Turnover KPI has increased from 10% to 12.01% in July 2026 to Better align to the Workforce Plan requirements. (This is reflected in table above but not in charts below).

Turnover continues to be monitored through in-month and rolling 12-month measures, alongside early leavers (within 1 year). July's voluntary leaver reasons show the largest categories as Other/Not Known (55.56%) and

Forward Look (Actions)

Sickness Transformation Project currently being planned with Service Directors This will include the following workstreams:

4 Workstreams:

- Workstream 1: Strengthening leadership and management accountability
- Workstream 2: Proactive Wellbeing Support
- Workstream 3: Workforce Specific Targeted Action Plans (with a focus on Eastham walk-in (alongside VCH and APH UTC), 0-19 service, Community Response and Community Nursing using the common approach for Workstream 1 and 2.
- Workstream 4: Strengthening Trust Policy and process to further drive change

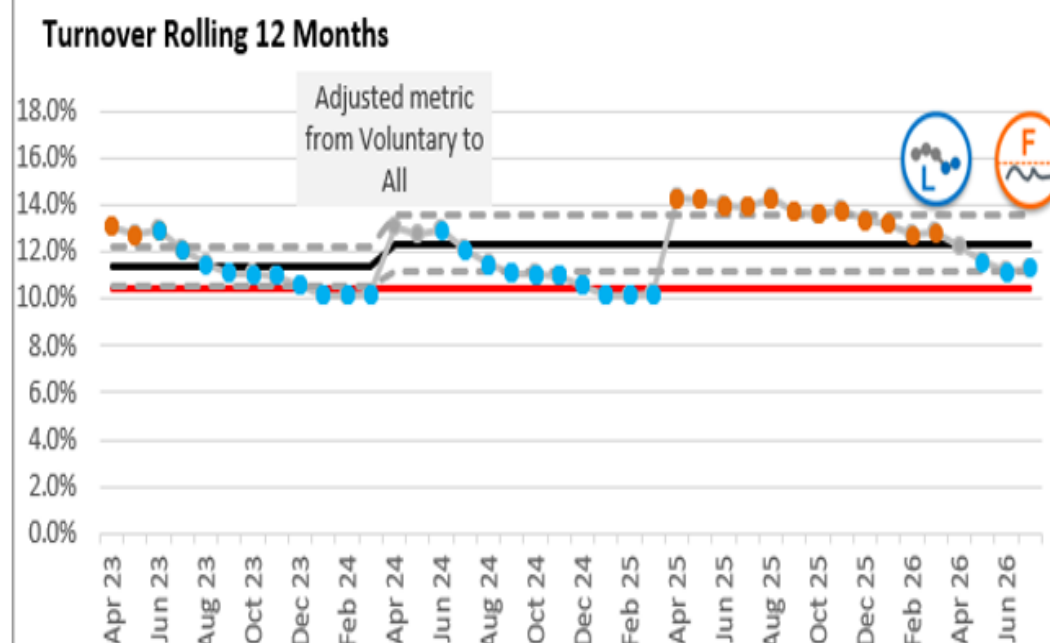
The Service has several initiatives planned to maximise impact including:

- A targeted Communications campaign around reasonable adjustments – what they are and how to implement them, how to add value with a good OH referral and further promotion of the Employee Assistance Programme.
- Promotion of practitioner health for the medical community
- Transfer of OH service provision for WCHC wef 1st November 2026
- Flu staff vaccination programme from October.
- **Continued rollout of the 4-week Return to Work Programme**
- Launch of the Well In Work – CBT Therapy only programme for staff struggling in work with stress and anxiety
- Local audits extended to WCHC and included in PCOG.
- Continuation of sickness absence training.
- Drafting high impact transformational sickness action plans for each Service focused on hot spots.

	Promotion (44.44%). Actions remain focused on strengthening retention conversations, exit insight quality (reducing “other/not known”), and targeted support in areas with higher early leaver impact.	
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Turnover – Rolling 12 Months

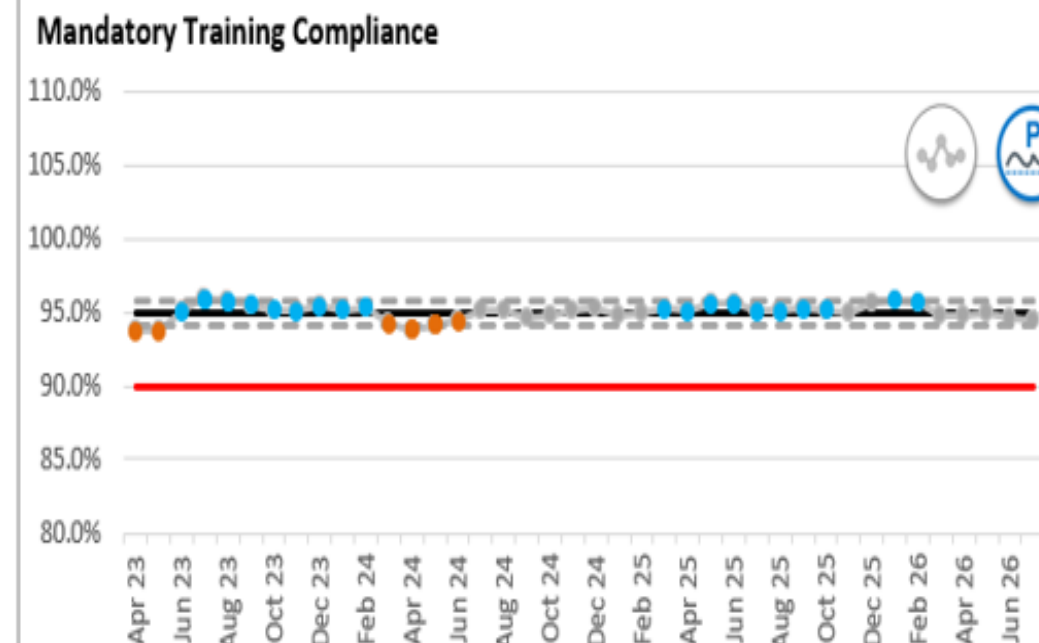
CQC Domain : Safe



Jul-26
11.3%
Variance Type
Special cause variation - Improving
Threshold
≤10.4%
Assurance
Performance consistently fails the target

Mandatory Training Compliance

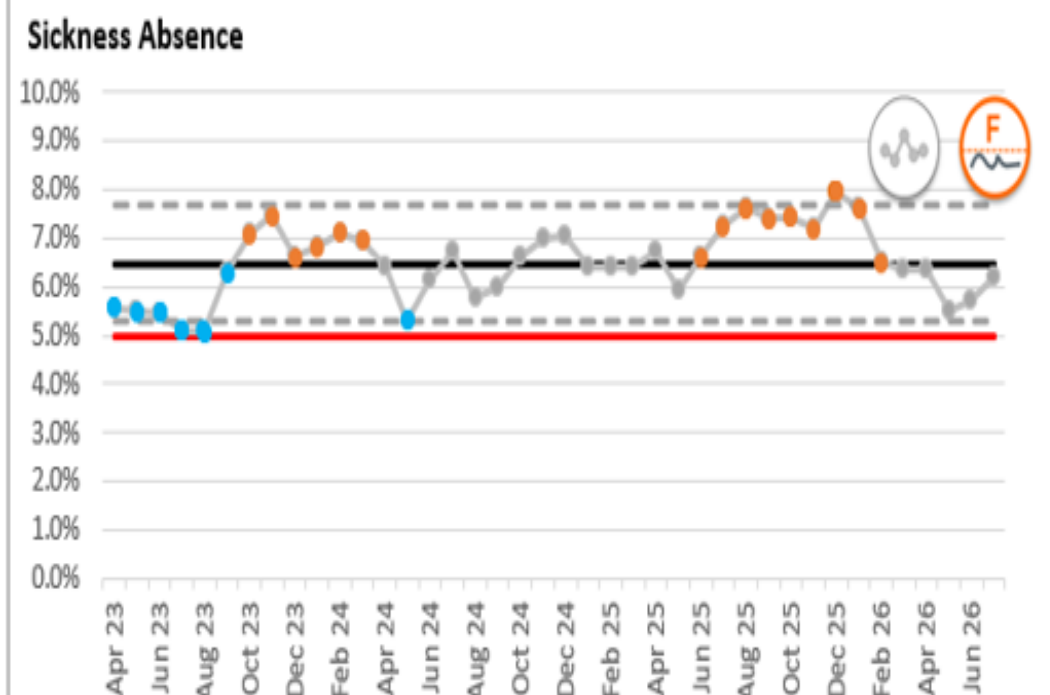
CQC Domain : Safe



Jul-26
94.4%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

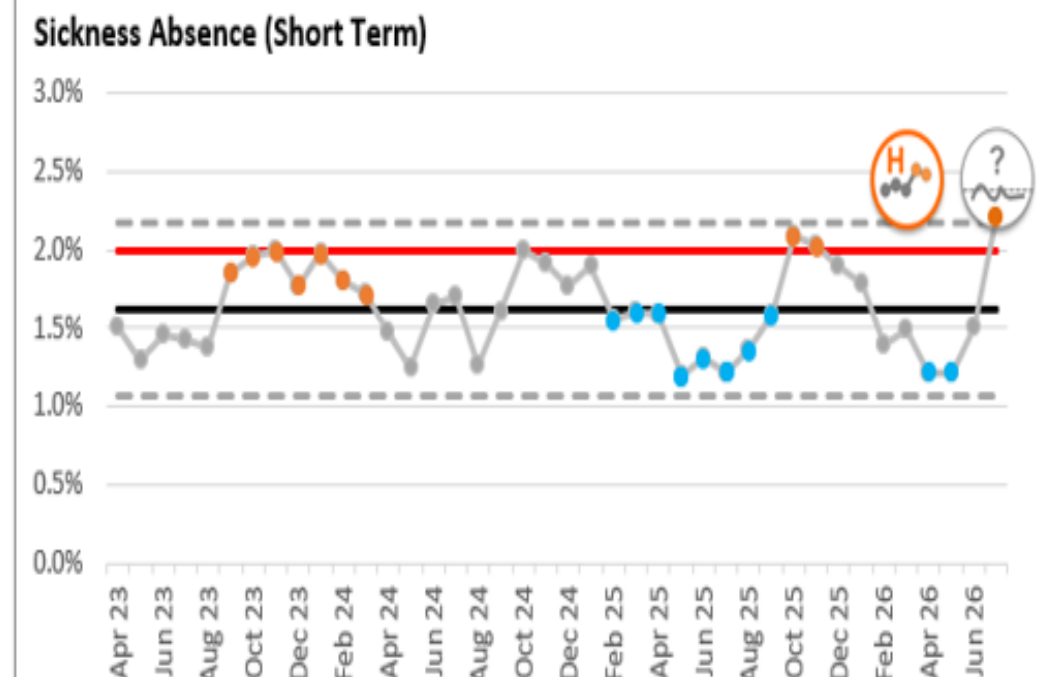
CQC Domain : Safe



Jul-26
6.2%
Variance Type
Common cause variation
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

CQC Domain : Safe

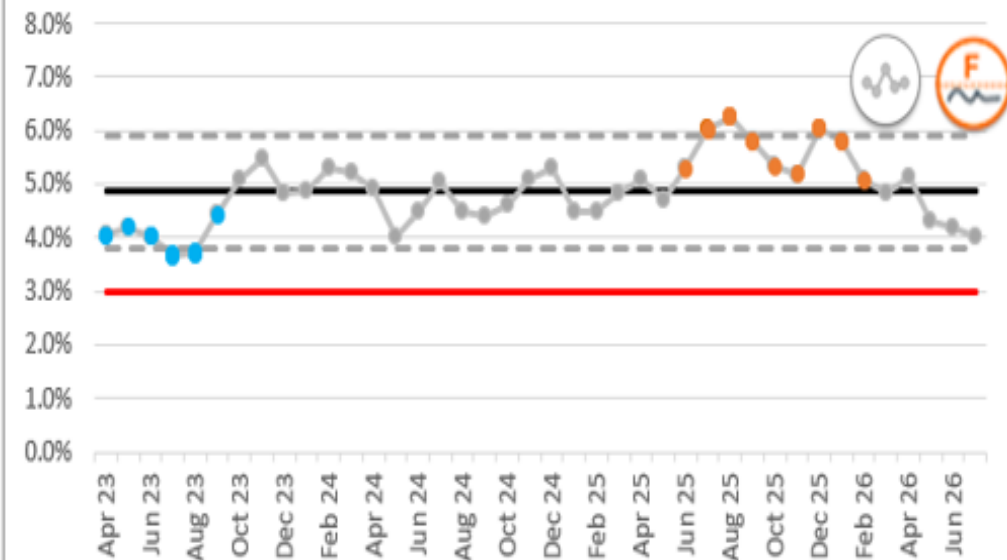


Jul-26
2.2%
Variance Type
Special cause variation - Concerning
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Sickness Absence (Long Term)

CQC Domain : Safe

Sickness Absence (Long Term)

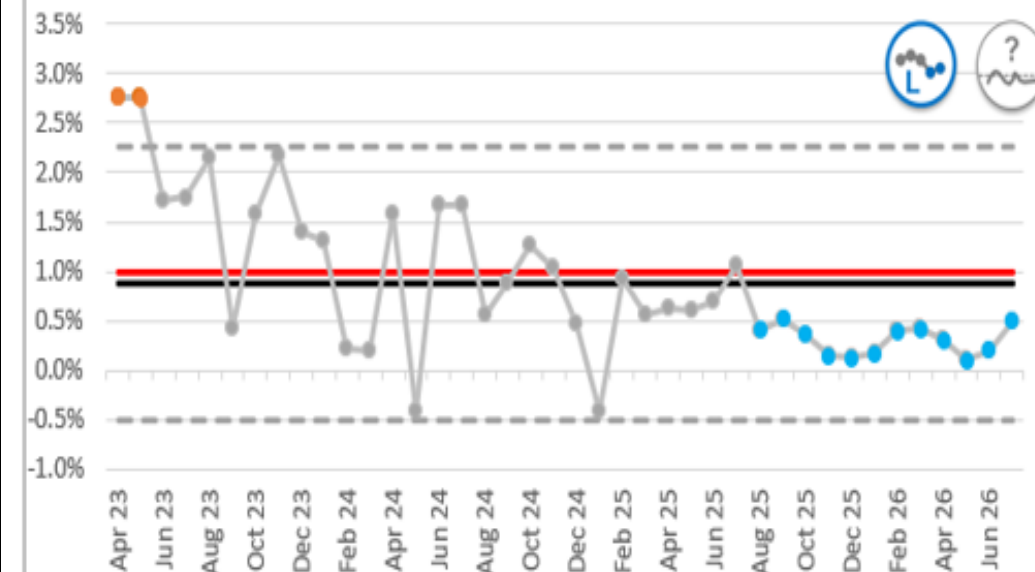


Jul-26
4.0%
Variance Type
Common cause variation
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

CQC Domain : Well-led

Agency usage

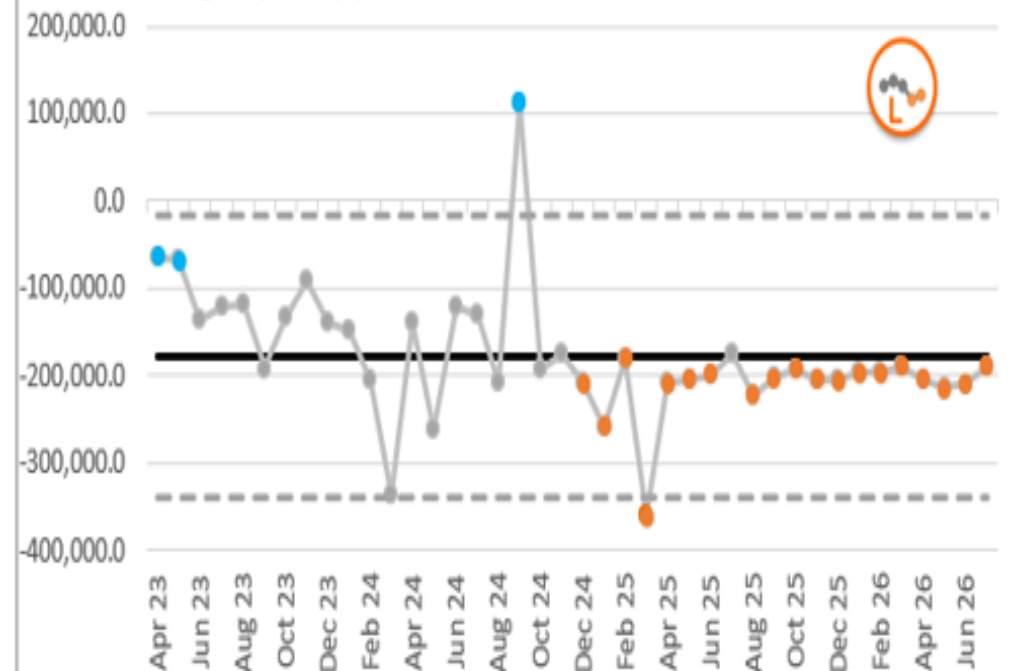


Jul-26
0.5%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

CQC Domain : Well-led

Variance to Agency Cap (£)

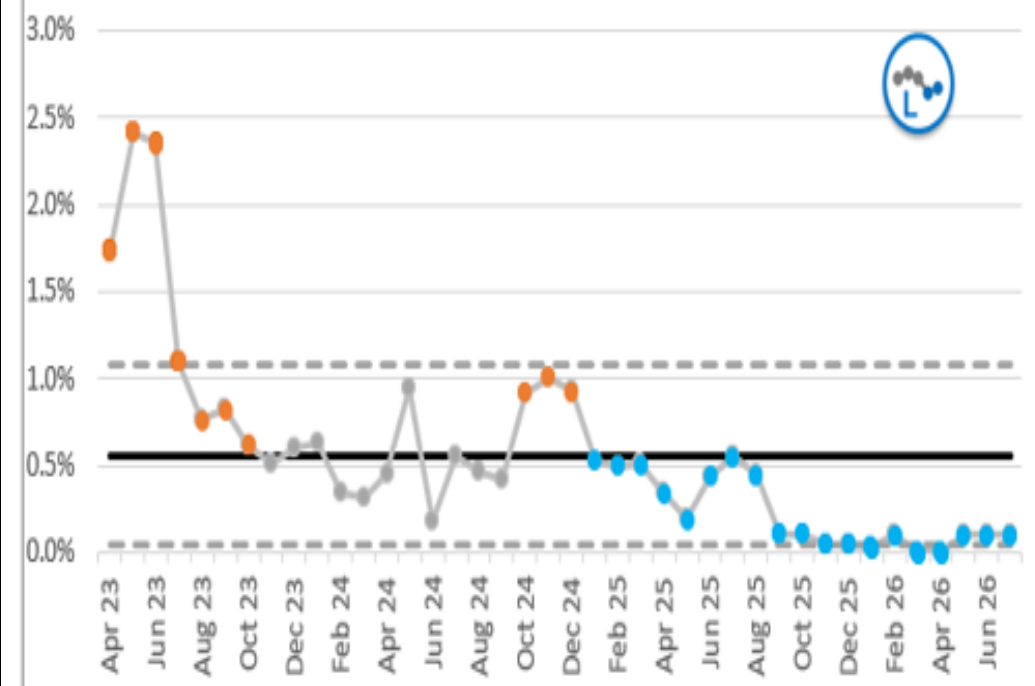


Jul-26
-£188,433.00
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

CQC Domain : Well-led

% of Agency Usage against Funded WTE

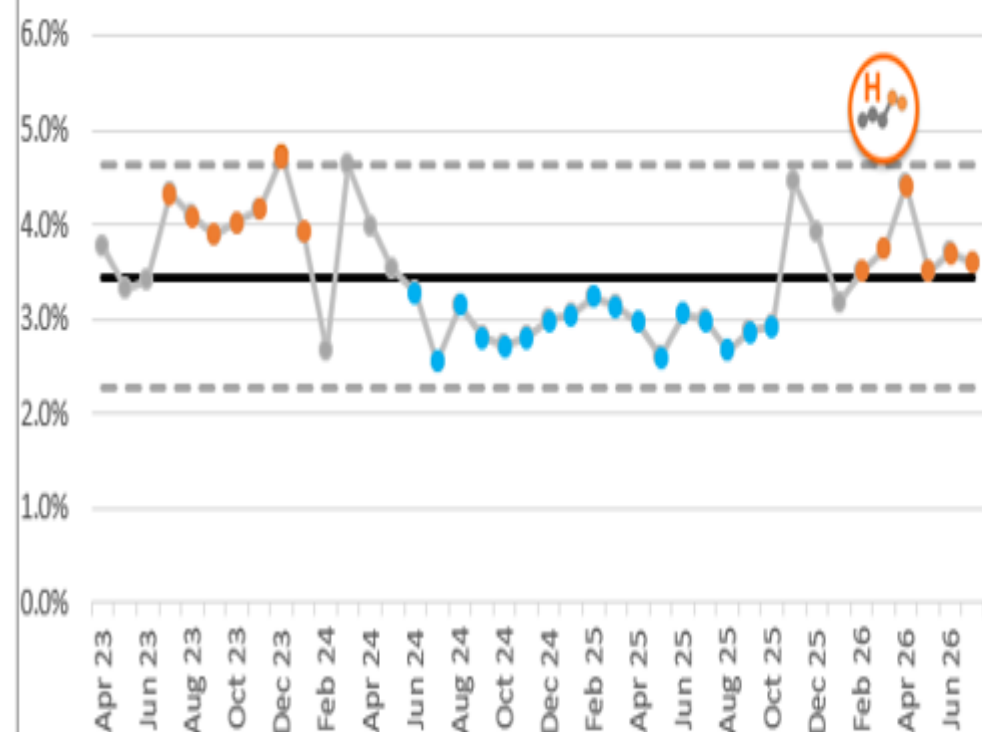


Jul-26
0.1%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Bank Usage against Funded WTE

CQC Domain : Well-led

% of Bank Usage against Funded WTE

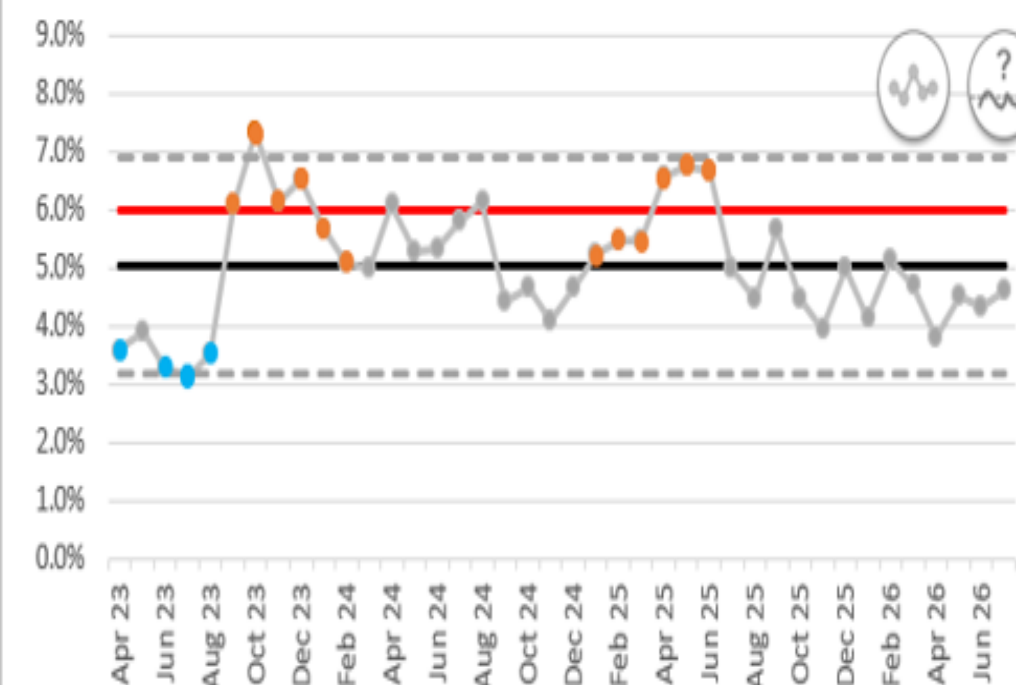


Jul-26
3.6%
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led

% of Contracted FTE Vacancies



Jul-26
4.6%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Group Board of Directors in Public
02 September 2026

Item 9

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 Board of Directors with the new strategic risks in the Board Assurance Framework for review and approval, following work completed by Committees of the Board during June - August 2026. It is recommended that the Group Board: • Approves the recommendation from the Finance & Performance Committee, supported by the Quality Committee to increase the risk rating of ID01 to RR20. • Approves the recommendation from the Quality & Safety Committee that a new strategic risk is included in the BAF related to the patient safety and quality governance framework • Reviews the risk ratings noting that there are 6 high-level strategic risks • Approves the updates for each risk as reported • Notes that further work through the Committees of the Board will continue to monitor each of the strategic 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 implemented and each of the Committees of the Board has maintained oversight of each of the relevant strategic risks. A new strategic risk is recommended to the Board from the Quality & Safety Committee.

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

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

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, 11 have been reviewed by the relevant Committees as described above in the governance journey and since the last meeting of the Group Board. 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. As reported in June 2026, this will have continued oversight through the Audit & Risk Committees for each statutory Board but given the committee schedule these will not meet again until September 2026.
1.3	Of the 11 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 (RR20). 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). The Group Board is asked to approve the proposed increase to ID01 and as described above this has been considered and is recommended by both the Finance & Performance Committee and the Quality Committee given the continued demands on unscheduled care and the consequential impact on the Trust's legal undertakings with NHSE and the Trust's published NOF position.

1.4	At its meeting on 13 August 2026, the Quality Committee considered a proposal following discussion at WUTH Executive Assurance & Risk Committee (EARC) which reflected the quality governance and patient safety framework in place and a recommendation to add a new risk to the BAF to track controls and mitigations in both Trusts. The proposed risk is below and is recommended by the Quality Committee; <i>ID13 - The Trust's quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks.</i> The consequences of failing to fully mitigate this risk would be the inability to obtain robust assurance regarding the quality and safety of services, leading to potential harm to patients, deterioration in quality outcomes, regulatory concerns, reputational damage and failure to deliver the Trust's strategic objectives.
1.5	There are no further proposed changes to risks ratings. The Joint Committees of the Board will continue to oversee the relevant strategic risks and assurance on process and tracking will be provided to each of the Audit & Risk Committees in September 2026.

2	Implications
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 (August 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)	5 x 5 (20)
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	Open	3 x 5 (15)	3 x 3 (9)
10. Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services	IMB	Chief Integration Officer	Seek	3 x 4 (12)	3 x 4 (12)
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)

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

Risk ID

Risk theme

Risk appetite

Link to strategic objectives

Executive lead

Committee oversight

01

Operational Effectiveness

Minimal

Delivering Excellence - We will create the conditions for outstanding care and performance

Chief Medical Officer & Executive Managing Director

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 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 - Financial penalties or loss of income linked to performance breaches - Increased scrutiny and intervention from regulators	4 x 5 (20)	1) Board and Executive oversight of UEC performance	- Weekly UEC report to Execs from UEC oversight group - Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews (WUTH) - Integrated Performance Board (WCHC) - Integrated Performance Report - NOF segmentation tracking - CQC action plans - tracking through Board and Committees - Standing paper to private Board presenting progress to Financial Plan including CIP and legal undertakings - Quality Committee scrutiny of quality and patient safety impacts arising from demand pressures. - Finance & Performance Committee review of operational performance and recovery trajectories	- 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) 5 x 5 (20)	- NOF segment 4 (WUTH) - Exit criteria from legal undertakings re: UEC performance - Implementation of the NHSE NW Performance Accountability Framework	- New engagement arrangements with NHSE – Director of Corporate Affairs - Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – Director of Corporate Affairs - WUTH invited to next national corridor care summit in September 2026	- Regional performance oversight meetings from June / July 2026 - NHSE Director of Intensive Support & System Co-ordination to meet with DCA - August 2026 - in progress.	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 (WUTH) - Integrated Performance Board (WCHC) - EARC oversight (WUTH) & high-level risk reports (WCHC) - Integrated Performance Report - Implementation of continuous flow model to improve egress from ED – new ED facility opened with UTC co-location	- External clinical audits - NHSE oversight (ECIST) - Cheshire and Mersey UEC standardisation programme	- Dependency on short-term escalation measures during sustained pressure - Delays in implementing case for change to align to C&M UEC standardisation programme (WUTH & WCHC)	- Development of longer-term system capacity and pathway transformation plans - Executive Managing Director				

and system partners
- Failure to meet national urgent and emergency care standards (and impact on NOF rating)

3) Enhanced community and intermediate care pathways

- GP streaming at front door with triage to UTC
- Clinical guardrails agreed as part of transformation and CIP programme

- UEC improvement programme
- Integration of WUTH 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
- Cheshire and Mersey UEC standardisation programme

- Delays in implementing case for change to align to C&M UEC standardisation programme (WUTH & WCHC)

4) Early discharge planning and discharge to assess models

- Quality metrics relating to harm, incidents, complaints and patient experience associated with unscheduled care pressures
- 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
- Corridor care metrics
- Internal audit reviews of urgent and emergency care pathways, patient flow and discharge processes

- 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 summit in planning for September 2026
- **CMO/CNO/DCA**

- Corridor care action plan includes key actions to address discharge planning
~~- Wirral Corridor care summit taking place on 29.4.26~~

5) Daily SITREPs and senior clinical oversight

- 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

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

6) Patient experience monitoring and complaints management

- Sickness absence reviews
- EAP
- Clinical and professional supervision
- Rota management
- *See also strategic risk ID03 and ID04*

- NSS findings and action plans

7) Staff wellbeing and support

8) System partnership working

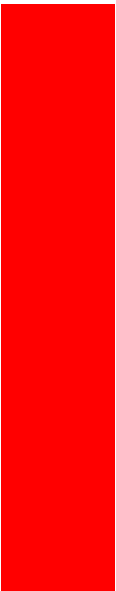
- UEC Programme Board
- Daily, weekly and monthly reporting on demand, capacity, patient flow, length of stay, delayed discharges and escalation levels

- Full engagement in system tiering meetings
- Wirral Provider Alliance
- HWB workshop to define future priorities and working arrangements - August 2026

- Limited influence over capacity and performance within partner organisations.
- Limited assurance regarding impact of



- Quality metrics relating to harm, incidents, complaints and patient experience associated with unscheduled care pressures
 - Drivers of the Deficit UEC programme with actions across WUTH and WCHC
 - Participation in system operational resilience groups.
 - Review of system escalation plans and winter planning arrangements.
 - Monitoring of discharge pathways and community capacity through Place and Provider Collaborative meetings
- Full engagement with ECIST Team
 - Model Hospital and GIRFT reviews
 - Healthwatch engagement for patient voice



community and social care capacity constraints on performance.

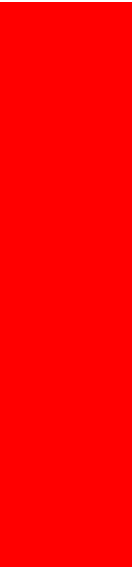


Risk ID	02
Risk theme	Operational Effectiveness
Risk appetite	Minimal
Link to strategic objectives	Delivering Excellence - We will create the conditions for outstanding care and performance
Executive lead	Chief Medical Officer & Executive Managing Director
Committee	Quality and Safety Committee
oversight	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 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	- Weekly planned activity report to Execs - Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews (WUTH) - Integrated Performance Board (WCHC) - Integrated Performance Report - NOF segmentation tracking - CQC action plans (WUTH & WCHC) - tracking through Board and Committees	- CQC inspection report(s) and on-going CQC engagement (WUTH & WCHC) - Contract monitoring arrangements with ICB/NHSE	4 x 4 (16)	- Exit criteria from financial undertakings re: UEC performance - Implementation of the NHSE NW Performance Accountability Framework	- New engagement arrangements with NHSE - Director of Corporate Affairs - Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – Director of Corporate Affairs	- Regional performance oversight meetings from June / July 2026 - In progress with NHSE	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 (WUTH) & high-level risk reports (WCHC) - NOF segmentation tracking	- NOF segmentation publication		- NOF segment 4 (WUTH)				
			3) Robust waiting list management and validation processes	- RTT and waiting list reports - Waiting list validation audits - Waiting List Health Inequalities Tool (WCHC) - NOF segment 1 (WCHC)	- NOF segmentation publication		- NOF segment 4 (WUTH) - Learning from complaints, incidents and patient feedback not consistently embedded	- Strengthen triangulation of quality intelligence - Chief Nursing Officer - Full RTT review - pending - Executive Managing Director			

	4) End-to-end pathway management	- Divisional Performance Reviews		- 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	- NOF segmentation publication	- 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 summit in planning for September 2026 - CMO/CNO/DCA	- Corridor care action plan includes key actions to address discharge planning

5) Outpatient
transformation
programme



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	- Single IPR produced in June 2026, with further updates planned for September 2026 to reflect new NOF metrics	3 x 2 (6)	Q3 26-27
	- Reduced staff morale, engagement and productivity			- Clear reporting and escalation routes through Board and relevant committees (WSB, People)	- Board Assurance Statements		- Single reporting arrangements across both Trusts	- Governance arrangements below committee under review in WUTH and WCHC	- Review of performance against new Workforce NOF metrics		
	- Increased staff turnover			- Workforce metrics reported through Integrated Performance Report			- Analysis of Trusts position against new NOF metrics	- Deliver against each of the strategic and operational priorities for 26/27 - provide assurance to the Committee via regular reports	- BI completing a review of current and anticipated performance against new Workforce NOF metrics		
	- Over-reliance on temporary staffing			- Drivers of the Deficit Governance Structure							
	- Loss of income			- Strategic and operational priorities for 26/27 (aligned to relevant BAF risk)							
	- Loss of confidence from patients, staff, partners and commissioners			- Quality Committee reporting on key quality and patient safety metrics							
	- Reduced system and stakeholder trust in the Trust’s leadership and governance										
	- Reduced staff wellbeing and increased risk of burnout		2) Workforce Planning Processes in place	- Triangulation of workforce plan to financial and activity plans	- Board Assurance Statements		- National shortages in certain roles	- Delivery of the workforce plan through service improvement and workforce transformation			
	- Increased employee relations cases, grievances and conflict			- Divisional Performance Reviews	- Internal audit reports on workforce processes (ESR, data quality)		- Staff turnover rates remain above Trust target	- Corporate Services integration			
	- Negative impact on recruitment reputation and employer brand			- 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	- Clinical Services integration			
	- Reduced patient experience through disengaged workforce			- CPO is SRO for the Sickness Absence Programme (Drivers of the Deficit)	- Model hospital - peer benchmarking						

	3) Staff Experience & Staff Engagement	- People Experience Team working across both WUTH & WCHC - NSS staff engagement score (WUTH & WCHC) tracking - NSS action plans in Divisions (WUTH & WCHC) - Tracking of key workforce metrics including turnover, absence, ER cases (via WSB, PCOG, Committee and IPR) - Quarterly Pulse surveys - Health & Wellbeing Support (inc. psychological support, absence management) - FTSU arrangements & network (reporting to People Committee & Board) - Annual appraisal process (WUTH & WCHC) - 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)	- National staff survey results and benchmarking data (WUTH & WCHC) - CQC inspection findings (WCHC – WIC/UTC; WUTH – Medicine & ED)		- Sickness absence remains above Trusts target (links to drivers of the deficit) (WUTH & WCHC) - Drivers of the Deficit Programme planned actions with identified risks - Impact of corporate services organisational change on employee experience and engagement - Impact of clinical services integration on employee experience and engagement - NSS action plans on staff engagement - Real-time employee experience metrics - Variable staff survey response rates across divisions - Further assurance on the effectiveness, equity and sustainability of recruitment, career progression and promotion pathways to support workforce retention, inclusion and future leadership capacity	- Phase 2 of corporate service organisational change completed - Corporate Services integration - NSS action plan tracking - Deliver sickness absence transformation programme (WUTH & WCHC) - Implementation of medical E-roster (WUTH)	- Phase 3 of corporate service organisational change due to commence		Q3, 2026-27	
	4) Strategic Organisational Development programmes in place	- Leadership development programme (for all levels) aligned to LQF - Mandatory training compliance monitoring - Continuous professional development frameworks	- National staff survey results - Professional regulatory requirements and accreditation standards		- Development of a people & culture dashboard - Management capability programme with a focus on inclusive and compassionate leadership					

		- Talent management and succession planning			
	5) Equality, Diversity & Inclusion (EDI) Strategy in place	- WRES and WDES reports, tracking of key indicators and action plans - Inclusive recruitment practices - Engaged staff networks - Executive sponsors for staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter		- Implementation of recommendations from the Lord Mann Review	
	6) Multi-year Cultural Development Programme	- To be established July - September 2026 (WUTH & WCHC) - Trend analysis of NSS themes, pulse surveys and engagement metrics - FTSU thematic reports (via Quality Committee)		- Development of a people & culture dashboard - Management capability programme with a focus on inclusive and compassionate leadership - Establish culture metrics within Integrated Performance Report - Consolidate WUTH & WCHC employee experience reporting - Undertake annual culture assessment and benchmarking	- To be developed as the multi-year cultural development programme is established (Q3, 26-27)
	7) Leadership visibility programme	- Executive breakfast sessions with Divisions (WUTH & WCHC) - Monthly All Staff Briefings (WUTH & WCHC) - Exec & NED Walkabouts		- Implementation of NHS Leadership & Management Framework (and consider how it aligns with Leadership Quality Framework) - Implementation of new NHS Staff Standards	

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	- Single IPR in development	- Single IPR produced in June 2026, with further updates planned for September 2026 to reflect new NOF metrics		3 x 2 (6)	Q3 26-27
	- Reduced staff morale, engagement and productivity			- Clear reporting and escalation routes through Board and relevant committees (WSB, People)	- Board Assurance Statements		- Single reporting arrangements across both Trusts	- Governance arrangements below committee under review in WUTH and WCHC	- BI completing a review of current and anticipated performance against new Workforce NOF metrics			
	- Increased staff sickness			- Use of culture metrics and KPIs (e.g., engagement scores, FTSU data, turnover, absence) via IPR			- Analysis of Trusts position against new NOF metrics	- Review of performance against new Workforce NOF metrics	- Deliver against each of the strategic and operational priorities for 26/27 - provide assurance to the Committee via regular reports			
	- Increased staff turnover			- Strategic and operational priorities for 26/27 (aligned to relevant BAF risk)								
	- Widening inequalities in staff experience and progression											
	- Poor learning culture											
	- Loss of income											
	- Loss of confidence from patients, staff, partners and commissioners											
	- Reduced system and stakeholder trust in the Trust's leadership and governance											
	- Failure to embed NHS People Plan priorities		2) Staff Experience & Staff Engagement	- People Experience Team working across both WUTH & WCHC	- National staff survey results and benchmarking data (WUTH & WCHC)		- Sickness absence remains above Trusts target (links to drivers of the deficit) (WUTH & WCHC)	- Phase 2 of corporate services organisational change in progress	- Phase 3 of corporate service organisational change due to commence			Q3, 26-27
				- NSS staff engagement score (WUTH & WCHC) tracking	- CQC inspection findings (WCHC - WIC/UTC; WUTH - Medicine & ED)		- Consistent approach to co-production and staff involvement in decision-making	- Delivery of the workforce plan through service improvement and workforce transformation				
				- Strong FTSU arrangements			- Full understanding of the experience of multi-					

		(inc. policy) and Guardian - Structured staff networks influencing policy - New Partnership Agreement launched with Staff Side (WUTH) - Clear and consistent communication on values and behaviours - Employee recognition scheme - Internal communications plan to support Better Together – integration programme - NHSE Staff Experience Assessment Framework implemented - NSS action plans in Divisions (WUTH & WCHC) - Tracking of key workforce metrics including turnover, absence, ER cases (via WSB, PCOG, Committee and IPR) - Quarterly Pulse surveys			- cultural staff across the Trust - NSS action plans on staff engagement - Impact of corporate services organisational change on employee experience and engagement - Impact of clinical services integration on employee experience and engagement - NSS action plans on staff engagement - Real-time employee experience metrics - Variable staff survey response rates across divisions - Further assurance on the effectiveness, equity and sustainability of recruitment, career progression and promotion pathways to support workforce retention, inclusion and future leadership capacity - Implementation of recommendations from the Lord Mann Review	- Corporate Services integration - Clinical Services integration - Review of appraisal process in WUTH to reflect WCHC approach - Q2 26-27 - NSS action plan tracking - Deliver sickness absence transformation programme (WUTH & WCHC)	
	3) Clear commitment to Equality, Diversity & Inclusion	- EDI strategy aligned to WRES, WDES and NHS People Plan - EDI dashboard reviewed at EDI	- EDS completed (jointly) with overall attainment level – Achieving		- Further development of staff networks - Deliver all actions from WRES action plan - Deliver all actions from WDES action plan		

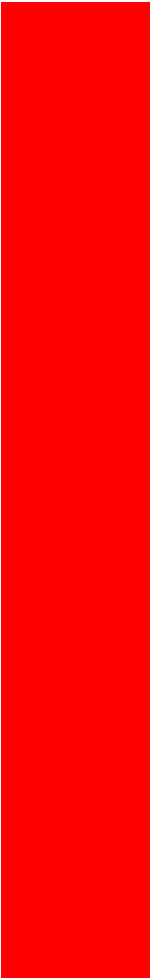
		- Steering Group (via PCOG) - Coaching Hub established - Monitoring of workforce inequalities - EDI mandatory training - Engaged staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter - Executive sponsors for staff networks - Equality Rights briefing to Board seminar		
	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 - FFT scores (demonstrating patient satisfaction)		- Impact of organisational change (corporate & clinical) (integration programme aligned to statutory transaction)
	5) Fair People Management Practices	- 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				
	6) Multi-year Cultural Development Programme	To be established July - September 2026 (WUTH & WCHC) - Trend analysis of NSS themes, pulse surveys and engagement metrics - FTSU thematic reports (via Quality Committee)		- Development of a people & culture dashboard	- Establish culture metrics within Integrated Performance Report - Consolidate WUTH & WCHC employee experience reporting - Undertake annual culture assessment and benchmarking	- To be developed as the multi-year cultural development programme is established (Q3, 26-27)

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 - Standing agenda item (private board) on delivery to plan - Director of Transformation & Turnaround in post - Clear executive accountability - Exec-level SROs for Drivers of the Deficit programmes agreed	- MIAA grip and control review (moderate assurance) - Engagement in FPRM processes (inc. with PWC) - Letter received from NHSE (26.08) confirming MTFP accepted with conditions	5 x 3 (15)	- WUTH in financial undertakings - CIP and financial performance accountability not consistently embedded at divisional and budget-holder level - NHSE approval of revised plan and confirmation re: DSF - Implementation of the NHSE NW Performance Accountability Framework	- Engagement with NHSE to define the metrics to remove all undertakings - DCA / CFO - Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – Director of Corporate Affairs - Regional oversight arrangements to be confirmed - DCA / CFO - Implementation of recommendations from MIAA grip and control review - CFO - Further communication expected from NHSE re: DSF - CFO	- Meeting with NHSE on 22 April 2026 – complete - NHSE performance oversight arrangements emerging – June/July 2026 - NHSE Director of Intensive Support & System Co-ordination to meet with DCA – August 2026 - in progress	5 x 2 (10)	March 2027
			2) Board approved three-year MTFP aligned to system and ICB assumptions / priorities	- M1 & M2 & M3 financial plan delivered (WUTH & WCHC) - M4 (WUTH) reporting in line with plan (10.7m deficit) - M4 (WCHC) reporting a surplus of £0.9m (a £0.3m positive variance to plan). - Resubmitted plans approved by Board (WUTH) - Response to national escalation letter (18.05.26) - Compliant plan agreed (WCHC) - Board Assurance statements confirming triangulation between workforce, finance and operational delivery - Board papers and minutes – standing item with finance, CIP and regulatory oversight updates - Triangulation with workforce, finance and operations	- 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 - Letter received from NHSE (26.08) confirming MTFP accepted with conditions		- Limited ability to influence system decisions that affect long-term affordability - ICB support for decommissioning plans - NHSE support to accelerate statutory transaction - Resubmitted plans have a combined gap to national control totals of £14.9m - Delivery of elective income - financial plan assumes sustained recovery and throughput - Pressures in urgent care impacting on delivery of the financial plan	- Regional oversight arrangements to be confirmed - DCA / CFO - Elective recovery actions – see ID02 - Unplanned care recovery actions – see ID01 - FRPM process supporting national conversations re: statutory transaction timeline – CEO	- NHSE performance oversight arrangements emerging – June/July 2026 – in progress with NHSE		

		- Exec-level SROs for Drivers of the Deficit programmes agreed			
	3) Annual budget setting process aligned to MTFP trajectory	- Consistent budget setting processes across both Trusts			- MiAA costing review (WUTH & WCHC) agreed through internal audit plan - CFO
	4) Annual CIP plan with defined CIP governance	- M1 & M2 CIP delivery on plan (WUTH & WCHC) - Identified CIP = 41.6m (113%) - Risk adjusted CIP = 33.3m (91%) - Productivity Improvement Board monitoring CIP delivery including risks to service (chaired monthly by CEO) - Weekly CIP Assurance Group (chaired by Director of Turnaround & Transformation) - Risk-adjusted CIP plans - Drivers of the Deficit Programme Board reset with agreed business rhythm - Clinical guardrails agreed with Board - Triangulation between finance, quality and operational performance when approving or revising CIPs - People Committee tracking delivery of the workforce plan - Director of Transformation & Turnaround in post - EPCP with enhanced controls in place (chaired by CEO) - CIP SOP developed - Further refinement of the risk-adjusted CIP position	-FPRM process	-CIP schemes not sufficiently developed early in the financial year, reducing deliverability – risks in H2 – higher risk now pushed back to Q4 - 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) - Formal reporting shortfall (at M4) of 3.4m	-(DoD) Programme Board sign-off of current project plans with SROs – May/June 2026 - Financial Recovery Plan in development for Board approval in October 2026 -Further actions in the Finance Recovery Programme will support the under delivery at M4

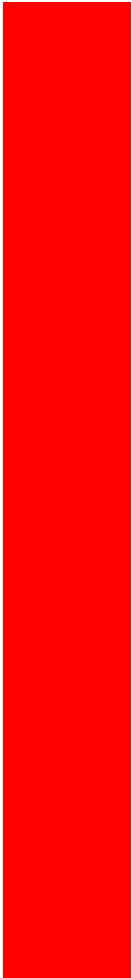


5) Clear financial KPIs with regular oversight

6) Cost pressure mitigations

- Financial governance arrangements in place (see above)
- Monthly IPR reporting to Board (WUTH & WCHC)
- Tracking of NOF metrics via Finance Committee and IPR
- FPG papers shared with FPC for information / wallet items (AAA report)

- NOF metrics



~~Revised scope, chair and membership of Finance Performance Group - CFO~~

New FPG arrangements from June 2026



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		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 across both Trusts - Standing paper to private Board presenting progress to Financial Plan including CIP and legal undertakings	- 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	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 (monthly) - Productivity improvements tracked as transformation benefits	- Full engagement in monthly FPRM process - Internal audit plan					
			3) Financial and benefits realisation controls	- Executive oversight and SRO for all CIP schemes / drivers of the deficit - Weekly CIP Assurance Group (WUTH & WCHC)	- MIAA grip and control review (moderate assurance)		- Implementation of recommendations from MIAA grip and control review - CFO			

	4) Integrated quality and safety controls	- 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 (WUTH & WCHC) - Tracking of NOF metrics - Clinical guardrails in place	- NOF metrics - On-going and proactive engagement with CQC - On-going and proactive engagement 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.	- 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 (WUTH & WCHC)	- 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								
	- 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		- Embedding of Joint committees and Committees in Common approach	- Finalise new governance arrangements (post-transaction)				
				- Audit Committee scrutiny of systems and processes	- External Audit programme		- Establishment of future governance arrangements to statutory transaction	- Review of Risk Management Policies					
				- 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 - 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 - NOF segment 1 (WCHC) including access to services metrics	- 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	- See control 7	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) - Health Inequalities Waiting List Tool in place (WCHC) - Your Voice Group (WCHC) - Councils of Governors	- CQC inspection reports (WCHC and WUTH 2025) - Compliance with AIS		- Completion of all associated actions in CQC action plans (WCHC and WUTH 2025) - Inconsistent community representation from some underserved or seldom-heard groups	- Develop and implement a clear Health Inequalities Improvement Plan aligned to national priorities (e.g. Core20PLUS5) - 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 - Leadership development and staff awareness sessions delivered to increase confidence in interpreting population health and inequalities data			- Lack of staff confidence in accessing and interpreting health inequalities data - Health inequalities and inclusion considerations to be incorporated into service planning and quality improvement methodologies	- Enhance workforce training and leadership capability in population health and inclusion	
	6) System collaboration	- Evolving trusted relationships with system partners (primary care, VCSFE, local authority) to support population health approaches - Chief Integration Officer member of JTEG with local authority - New joint strategy aligns with Cheshire and Merseyside's <i>All Together Fairer: Our</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 - Joint programmes with local authority and primary care partners to address identified inequalities in priority communities	- WPA governance review in progress



7) Data Quality & Insight

- Internal audit reviews of data quality arrangements and reporting processes



- Data quality improvement work across both organisations to increase completeness of demographic data and improve identification of underserved groups.
- Health inequalities metrics routinely reviewed through Quality and Safety Committee and relevant operational groups, with escalation arrangements established

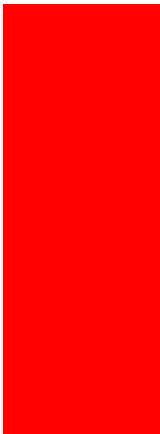
- Further development of population health dashboards to provide segmentation by deprivation, ethnicity, age, disability and other protected characteristics



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 in each Trust - Clear reporting and escalation routes through Board and relevant committees (Audit, Quality and Finance) and relevant sub-groups in each Trust (IGDS and IAG)	- NHSE cyber security guide for executive and non-executive directors	5 x 3 (15)	- Board approved Digital Strategy - Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested.	- Finalise Digital Strategy - Develop report structure based on NHSE guidance (issued June 2026)	- Enabling strategy to be completed in H2, 26-27	5 x 2 (10)	- Q4, 26-27
			2) Cyber Security Controls - implementation of nationally mandated cyber security standards and controls	- Compliance with NHS Data Security and Protection Toolkit (DSPT) requirements via self-assessment in each Trust - Identity, authentication and access controls in place - Role based access controls implemented - Documented vulnerability management process - Regular vulnerability scanning reporting through IT/security governance groups	- Internal audit plan covering cyber security controls, access management and patching compliance for both Trusts - NHS England / national cyber assurance feedback - External penetration testing or cyber maturity assessments		- Assessment against NHSE 7 foundational outcomes that have the greatest impact on organisational cyber resilience	- Complete assessment following NHSE letter (June 2026) - Adopt new and updated NHSE directive cyber policies to be included in the 2027 next DSPT			September 2026

	3) Business continuity and disaster recovery	- Capital programme reporting evidencing investment in resilience and critical infrastructure - Business Continuity and Disaster Recovery plans including backup solutions for key systems - Incident response plan established with defined escalation processes - Records of regular testing and exercising (table-top and live tests) - Post-incident and post-exercise reviews evidencing learning and improvement - Information Asset register (IAR)	- Internal audit review of BCP and disaster recovery arrangements - <i>moderate assurance</i> - DSPT review (MiAA)	- Evidence of regular IAR review	
	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 security and BCP requirements with regular reviews - Suppliers register in place - Supplier assurance documentation (SOC	- System / national assurance of shared or hosted platforms	- Cyber risk assessments to be consistently repeated during contract life cycle	



6) System and external alignment / collaboration

- reports, compliance statements)
- Regular review of critical supplier risk registers
- Procurement oversight processes
- 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
				Internal	External			Planned	Progress update		
Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively	- Reliance on systems that are not fit for purpose impacting on service quality and patient - Reduced level of skills in the workforce - Insecurities within systems present vulnerability to cyber-attacks - Poor staff experience	4 x 4 (16)	1) Executive and Board Oversight of Digital and Information Risk	- Defined accountability through the SIRO, CIO/ CNIO in each Trust - SIRO responsibility included JD - SIRO reports to Board and CIO attends Board - New Joint Digital Committee established to oversee digital delivery and risk - BAF oversight (ID12) by Joint Digital Committee - Digital Governance arrangements established with minutes and action log tracking in each Trust (IGDS and IAG) - Annual Information Governance Annual Report / Statement	- SIRO network and annual training - NHSE cyber security guide for executive and non-executive directors	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)	- Q4, 26-27
			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		- Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested. - Legacy infrastructure increasing security and resilience risk - Assessment against NHSE 7 foundational outcomes that have the greatest impact on organisational cyber resilience	- Develop report structure based on NHSE guidance (issued June 2026) – CIO - Complete assessment following NHSE letter (June 2026) - Implementation of new guidance for staff about unlawfully accessing patient medical history of a campaign in response	- Paper to Digital Committee in September 2026		September 2026

Group Board of Directors in Public
2 September 2026

Item No 11

Report Title	Joint Committee Chairs Reports – Joint Quality and Safety Committee
Date of Meeting	13 August 2026
Author	Dr Steve Ryan, Chair of Joint Quality and Safety Committee

Alert	The Committee wish to alert members of the Group Board that: • Nutrition and hydration remain a key quality focus for us. Despite progress in recruitment to Speech and Language Therapist vacancies, work continues on Percutaneous Endoscopic Gastrostomy provision and on fully stabilising the provision of Total Parental Nutrition. • The Committee was informed of the significant reduction in doctors allocated by the North West Deanery. The Emergency Department and Neonatal Unit are particularly impacted. Mitigation is being developed, which could have budgetary implications. • Emergency Department safety checklists had been identified as an area for improvement. Work is underway to ensure compliance. One potential consequence of lack of compliance is the risk of missing the opportunity to detect tissue ulcers at the earliest time to enable proactive management. • The recent heatwaves have exposed specific challenges in keeping magnetic resonance image scanners cool and prompted a Trust-wide audit of the resilience of heat sensitive equipment. • A never event relating to retained nasal packing post operatively (relating to a prior year) has been identified, with the patient coming to no harm. This will be investigated under the Patient Safety Incident Response Framework (PSIRF). This incident predated improvement work related to the prevention of never events across the Trust over the past year. • Two serious harm incidents, relating to patient fractures following falls have been reported in community services and again will be investigated using PSIRF.
Advise	The Committee wish to advise members of the Group Board that: • Although there has been substantial progress in the WCHC Care Quality Commission (CQC) action plans for Eastham Walk in Centre and the Urgent Treatment Centre, as outlined in the detailed progress update received, there is a need to seek further assurance about the resilience of our plans. In addition there is a significant opportunity with the completion of the Urgent and Emergency Care Update Programme to review our actions in its light. The digital element of the upgrade is one specific example of this. Mersey Internal Audit Agency will undertake a review of the plan and its implementation. • The Chief Medical Officer outlined the challenge of the outpatient service transformation programme. This

	programme is mandated nationally on a scale, at pace and with a high aspiration for the metrics to be achieved in a short timescale. The Programme Improvement Board is hosting a summit in September for Consultant teams to take the work forward. Clearly there will also need to be adaptations to care pathways beyond the Trusts. • Although the WUTH Infection Prevention and Control (IPC) Annual report indicated the wide range of expected leadership, systems and processes to be in place, we had not made sufficient headway in IPC improvement, exceeding our annual <i>Clostridioides difficile</i> trajectory and heading that way this year. We also had more gram-negative infections reported. Hence the need for continued focus on day-to-day controls (Such as isolation and sampling) and for a quality improvement collaborative approach. This is one of our key improvement objectives for 2026/2027. There were some notable positive achievements (Such as PLACE score, dealing with the Sterile Service Department major incident in October 2025 and a reduction in Norovirus outbreaks) and introducing enhanced processes (such as H2O2 vapour disinfection). • It agreed that actions from the MIAA review into WISE accreditation would have a target date of end of Q4 to allow a comprehensive consultation and re-engineering of the system. The current process will remain in place until then and if actions are completed early, this will be recorded.
Assure	The Committee wish to assure members of the Group Board that: • It gained assurance from the WCHC Q4 report for safeguarding governance and delivery against the 2025/2026 Safeguarding Strategy Delivery Plan and approved the Safeguarding Strategy Delivery Plan for 2026/2027. It noted that key risks were being monitored and managed. It was pleasing to note an increase in the use of care leaver passports by young people on the Wirral following improvement work. The Committee also received a case study which demonstrated the holistic use of trauma-informed care in helping a young person navigate care. • In receiving the WCHC Quality and Patient Experience Report for April and May 2026, it was assured by WCHC's risk and governance framework to ensure the delivery of safe and effective care. • The Committee received a detailed report to consider WUTH's response to the NHS England letter of 26th June, setting out their requirements for key actions required following the Nottingham maternity review and aligned with actions required following the Fuller Enquiry. The Committee noted the Trust's Assurance Statement (submitted previously by 31st July), covering letter and supporting evidence. The Committee was familiar with biannual and annual mortuary service reports, but received new evidence including access audits to the

	mortuary. Noting the findings and requirements of the Nottingham/Fuller reviews, The Committee approved the Board Assurance Statements and recommended them to the Board. • Noted that, in its interrogation of the Infection Prevention and Control (IPC) Q1 report for WCHC, it was assured that against the IPC Board Assurance Framework of the 10 elements, 6 were fully compliant, with 3 of the remaining compliant at end of Q2, the last by end of Q3. These time scales were agreed to be appropriate. IPC outcomes for the Trust remain satisfactory. • The WUTH Accountable Officer for Controlled Drugs report gave good assurance that effective controls were in place, with the Trust benchmarking appropriately with other organisations across the North West. The Committee approved the recommendations contained within the report. • Noted that in receiving the separate Trust Learning from Deaths reports that effective oversight of scrutiny of all deaths is in place as is monitoring of mortality rates. Evidence of deep dives where data suggests it is seen as well as learning and dissemination.
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. • The Committee supported the introduction of a new BAF risk (ID13) relating to the Trust's quality governance and safety and assurance arrangements. • The Committee reviewed the High Level Risk report for Community Trust. Although the risk rating had reduced from 15 to 12, the Committee questioned what the level of clinical risk was for patients because of high referral rates of patients for Electrocardiograms at St Catherine's Hospital. Routine wait times are 3 weeks and 2-3 days for urgent referrals. For the latter and for emergency referrals, pathways are available via Arrowe Park unscheduled pathways. The Committee were assured that the service remained safe and responsive, despite the pressures.
Other comments from the Chair	• The Committee agreed to receive the WCHC Integrated Performance Board briefing as an AAA report in future as opposed to a verbal report (in addition to receiving the minutes of its meetings) • The Chief Medical Officer noted that as policies are due for renewal, we should be mindful that in a few months, as the merger progresses, we will be required to merge all our policies. To avoid unnecessary work, it was agreed to take a risk-based approach and hold over unnecessary updated pending the merger.

	• Asks the Audit and Risk Committee to note the agreed extension to the WISE accreditation internal audit actions.
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Group Board of Directors in Public
2 September 2026

Item No 11

Report Title	Joint Committee Chairs Reports – Joint Quality and Safety Committee: Maternity and Neonatal Report (WUTH)
Date of Meeting	13 August 2026
Author	Dr Steve Ryan, Chair of Joint Quality and Safety Committee

Alert	The Committee wish to alert members of the Group Board that: • This separate AAA report is provided to the Board, recognising enhanced requirements for visibility of Board oversight of Maternity and Neonatal services. This follows recommendations from national reports. • Internal monitoring mechanisms had noted an increase in the number of neonatal deaths in the first half of 2026. This did not trigger the national surveillance system (“MOSS”), and it was noted that this could fall within the statistically expected range (especially for a level 3 unit providing care to the sickest babies). Despite this, it was agreed to undertake a review of these deaths. It was also agreed to review those that happened in 2025. The review for 2025 has not identified any thematic issues of concern, nor has the analysis for 2026 at this point. Neonatal deaths are subject to external scrutiny through the Perinatal Mortality Review Tool (PMRT) and reported through the national Maternity and Newborn Safety Investigations System. However, it was agreed that the internal rapid review process following a neonatal death should be strengthened and this has been enacted. No issues for escalation have been identified at this point. Further updates will be given as the local re-review is completed. • Neonatal Intensive Care provision is a high complexity and high intensity activity which has the potential to create issues with team working at times. Having identified evidence of some issues with interactions between team members and organisational development diagnostic analysis was carried out. The findings have been shared with the team who have accepted the findings and agreed to a programme of work to improve team functioning and culture. This is now underway. The Committee noted and supported this 3-phase programme. • The Group Board will be required to continue to monitor maternity triage. Known risks around the service include the physical environment, and the timeliness of access to medical advice (given the medics in question have other contemporaneous duties). There is also a need for a more robust informatics system for tracking and reporting. There will be an opportunity to discuss this further at the September Board meeting.
Advise	The Committee wish to advise members of the Group Board that:

	The Committee had sight of the Ockenden Nottingham Maternity report, the Amos National report and gained an understanding of the key findings and key actions which will be added to ongoing actions for the CQC national maternity survey 2026, Maternity Incentive Scheme action plan and the Three-Year Delivery Plan (The latter now fully completed).
Assure	The Committee wish to assure members of the Group Board that: - The service was required to undertake a “drill” in response to a hypothetical alert by the national MOSS surveillance system. This is akin to a mock serious incident exercise. This was undertaken and showed that the drill objectives were met, indicating we have effective leadership, systems and processes in place if we ever receive such an alert. - The Trust received a certificate from the Royal College of Obstetricians and Gynaecologists highly commending our approach to the professional development of our resident obstetricians and gynaecologists. - In hearing a patient story about maternity and neonatal care it noted the high degree of professionalism and service user-centredness in place to support women and birthing partners navigating the delivery of their baby. - Run rates for adverse outcomes and benchmarking were scrutinised and other than the neonatal deaths reported in the alert section, no causes for concern were detected. - The assurance for mortuary services is noted in the main AAA report to the Group Board from QSC. - Recent summaries of PMRT reviews as well as a summary of these for 2025/2026 were presented, showing where learning has been identified and actions taken. No thematic issues of concern have been identified. - Training compliance remains good and further evidence for the assurance of this will be obtained during an external developmental review of this for the Maternity Incentive Scheme scheduled for 25th August 2026. - The training touchpoint was declared as August 2026 and full compliance was achieved with the overall compliance to be 30th November 2026. The committee has reviewed and discussed the trajectory to achieve remains on target. - It received a comprehensive report from the Director of Midwifery and is assured appropriate systems of care, culture, learning and curiosity are in place and relevant designated actions have been completed or are scheduled to be. Risk assessments where issues are identified have been undertaken and best mitigations are in place and the Board can be assured that continued oversight is in place and highly visible to the Board. - The triage specification tool has been received along with the 10-point plan which will be presented at the next Group Board meeting.

	• The maternity and neonatal assurance board is a forum where the agenda is discussed in depth ensuring an additional level of assurance and scrutiny to the Board of Directors.
Review of Risks	• There were no new risks to escalate to the Group Board
Other comments from the Chair	• The complexity and overlap of reporting requirements could risk the masking of important signals in any organisation. The divisional local quality assurance arrangements, the input of the Maternity and Neonatal Voices Partnership and the visibility of the Maternity & Neonatal Safety Champions (now clearly documenting the dual role of the Executive Champions) will help us mitigate this risk. • Thanks to the Director of Midwifery and her team for producing such concise reporting documentation.

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2 September 2026

Item No 12

Report Title	Joint Committee Chairs Report – Digital Committee
Date of Meeting	June 2026
Author	Haris Sultan, Chair of Joint Digital Committee

Alert	- The Joint Digital Committee wish to alert members of the Board of Directors that: FOI and Subject Access Requests: The Committee received a further update on recovery progress. Early performance against the recovery trajectories has been positive, with SAR processing capacity increased through temporary staffing and clinical coding also improving via a managed service. However, WUTH remains non-compliant with the statutory response timescales. The Committee has requested the SIRO to update the Trust Board directly on compliance, the resourced improvement plan, and anticipated timescales. Cyber Security: NHS England wrote to Trusts on 10 June setting out board-level expectations for cyber risk assurance, requesting organisation-wide governance and executive accountability to ensure effective cyber risk management aligned with national standards. This includes completion of the DSPT, new directive cyber policies from September, and a named Executive Director with accountability for cyber security. The Committee will now receive a standing item on Trust cyber security risk to maintain oversight. Digital Portfolio Delivery Risk: A small number of projects within the 45-project Digital Portfolio are experiencing delay. These do not currently change the portfolio's strategic direction but are placing pressure on specialist technical resource and may affect sequencing of dependent projects if not actively managed.
Advise	- The Joint Digital Committee wish to advise members of the Board of Directors that: WCHC Digital Maturity Assessment: The Committee received the outputs of WCHC's Digital Maturity Assessment. WCHC performs above the national average in 3 of 7 "What Good Looks Like" pillars (Well Led, Safe Practice, Healthy Populations) and ranks 6th among regional Community peers overall, with Empowering People and Improving Care identified as priority areas. The Committee notes the merger presents an opportunity to scale existing strengths across the combined organisation. Digital KPI Suite Approved: The Committee approved an initial suite of board-level Digital KPIs covering Access to Information, Clinical Coding, Staffing, Service Desk and Cyber Security. The Committee noted these KPIs are currently weighted toward IT delivery, and that digital KPIs reflecting the

	organisation's operational and clinical digital benefits also need to be tracked. This is a proportionate first step and will be reviewed and refined as reporting maturity develops. ○ Copilot Rollout and Frontline Productivity Funding: NHS England has provided WUTH with 1,000 Microsoft Copilot licences free of charge; WCHC's allocation is still awaited. Findings from the local pilot were consistent with the wider NHS experience. Separately, Frontline Productivity Funding outcomes for Cheshire and Merseyside is expected in September or October, but the region is materially oversubscribed, demand is estimated at around 2.5 times the available allocation, and EPR funding requirements sit within the same overall discussion. This will require significant prioritisation across the system, and the Committee will keep the Board updated as outcomes are confirmed.
Assure	• The Joint Digital Committees wish to assure members of the Board of Directors that: ○ Cheshire and Merseyside Digital Strategy and Plans: The Committee received a presentation from John Llywelyn, Chief Digital & Information Officer at NHS Cheshire & Merseyside ICB, setting out the proposed strategic approach to digital, data and technology across the system. This noted the changing provider landscape requires stronger system-wide integration, common architecture and shared responsibility for cyber security. It was agreed that the CDIO will keep the Committee informed of ICB-level work on a regular basis to ensure alignment. ○ AI Safety and Ethics: The Committee received assurance on the safety and ethical measures currently in place. A clinical safety function is established, comprising CIOs and CNIOs, supported by a clinical safety policy including hazard logs and mitigation processes. The Patient Safety and Quality Board receives bi-annual reports from the CNIOs, closing the governance loop. The Committee acknowledged the need for a clearer governance pathway for new digital innovations and opportunities, noting that AI ethics activity remains limited, with a policy under development and governance arrangements still being established. This was recognised as consistent with the position across most NHS trusts, and the Committee looks forward to seeing this develop.
Review of Risks	• BAF Risk ID12 - No change to the rating was proposed this meeting. The Committee agreed the risk description should be broadened beyond financial and productivity considerations to also reflect clinical transformation and clinical improvement outcomes delivered through the Digital Healthcare Team. • BAF Risk ID11 - No change to the rating was proposed this meeting, though the updates since April shown in red in the BAF reflect the points raised in NHS England's letter on board and executive cyber assurance.

Other comments from the Chair	• This was a positive second Digital Committee meeting, there is a clear sense that the Committee now has oversight of both organisations. • Next stage of progress will be to move beyond reporting primarily on IT delivery and towards tracking the operational and medical digital benefits being realised, so the Board can see the organisational impact of digital improvement rather than just system performance. • The Committee's visibility of the WCHC digital position also continues to improve but remains less developed than for WUTH-led services; members suggested that hearing directly from clinicians would add further value to future meetings.
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Group Board of Directors in Public
2 September 2026

Item No 13

Report Title	Joint Committee Chairs Reports – Joint People Committee
Date of Meeting	July 2026
Author	Lesley Davies, Chair of Joint People Committee

Alert	The Committee wish to alert members of the Group Board that: WUTH and WCHC Workforce Performance Report - WUTH substantive and bank FTE are now under plan. Agency FTE is over plan, which is attributed to demand from the Emergency Department and Theatres. The Trust is focusing on these areas, and the situation is being managed. Sickness stands at 5.25%, remaining above the 5% target. It has risen 0.01% month on month and continues to present a workforce risk. Turnover is now below target at 9.96% a fall of 0.22%, and in-month. Appraisal compliance is at 85.35%, below the 88% target, although compliance has improved by 0.72%. The Trust is monitoring these areas of performance and continue to implement return to work and performance management strategies and focusing on staff well-being and support - WCHC overall workforce WTE continues a gradual downward trajectory across the year and is just above plan. Bank usage remains variable with an increase in usage month on month and remains above plan in June. Sickness absence has increased from 5.51% in May and remains above Trust target at 5.69% with anxiety/stress/depression continuing to be the primary driver and long-term absence stands at 3.57%. Turnover remains above target, with voluntary leavers most frequently citing Other/Not Known and Promotion. Mandatory training remains above target overall, with some divisional variation; role specific compliance remains more variable and requires continued focus. - The Committee queried Time to Hire which has increased. In some areas, particularly Therapies, Medical Staffing and SSD services, delays in recruitment are contributing to agency expenditure, creating a need to backfill vacancies through agency staff. The Committee was advised that recruitment timelines will continue to be challenging. Processes are in place to identify recruitment pinch points and additional HR resource has been deployed to reduce time-to-hire.
	The Committee wish to advise members of the Group Board that: NHS England has published the NHS Staff Standards and Leadership and Management Framework. The framework comprises three elements: a code of practice, standards, and

	competencies for both clinical and non-clinical leaders, and a self-assessment tool. The NHS Staff - Standards set out expected behaviours for all staff and have been mapped against the NHS Staff Survey. A presentation on the NHS Staff Standards and Leadership and Management Framework will be brought to the next Committee meeting. - The Committee was advised that the Cheshire and Merseyside Provider Collaborative has identified a number of priorities for the year ahead and is considering the workforce implications associated with delivery. Areas currently being prioritised include achieving greater consistency in job planning for medical staff and senior nurses, exploring shared service opportunities, and developing consistent Band 5 and Band 6 nursing role profiles. CIP Update - The planned staff reductions as set out in the Cost Improvement Plan is integral to the planned savings of £36.7m. Whilst delivery of the savings target continues to be closely monitored, the Committee was advised that there is some flexibility around the precise WTE reduction required. - At Month 2 workforce reductions are 5.63 WTE behind plan. This remained within tolerance and does not currently adversely affect delivery of the financial plan. It was agreed to review future reporting arrangements to ensure People & Culture Committee discussions focus on the key workforce and people-related issues arising from the CIP programme as other aspects of the plans are reported to other committees Divisional Culture Update – Surgery - The Committee had requested an update on the cultural concerns raised within the Surgery Division. A verbal update was provided, and it was acknowledged that the Division was not yet where it had hoped to be with the cultural change programme. Recent changes in leadership at Associate Medical Director and Divisional Director level were noted as part of the improvement journey. Work continues to progress, and a full update, including impact and outcomes will be provided to the Committee at its next meeting. As part of the Safe Staffing Report, CSW sickness absence was also noted within the Surgery Department. WUTH Freedom to Speak Up Annual Report 2025/26 (including Q4 2025/26) - The 2025 NHS Staff Survey revealed a decline in staff confidence regarding speaking up and belief that concerns would be addressed, falling below national averages. - The Committee was advised that the number of individuals speaking up remained steady at 79 for both 2024/25 and 2025/26, with an increase noted in the last two quarters and
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	early 2026/27. The Trust has provided enhanced visibility of the FTSU process, training and promotion to support improvements in reporting and staff confidence in the process. • Of the concerns raised, attitudes and behaviours accounted for over 44% of concerns, consistent with the previous year. Bullying and harassment concerns decreased from 40 to 28 cases. • The Committee noted that patient safety-related concerns decreased from eight to two in 2025/26, reflecting a national downward trend and indicating effective use of incident reporting mechanisms. Joint WUTH and WCHC Fit and Proper Person Policy • The Committee APPROVED this policy for submission to staff consultation and subsequently to September Board.
Assure	The Committee wish to assure members of the Group Board that: Strategic Priorities 2026/27 • The Committee took good assurance from the approach and focus on the 2026/27 priorities. Key priorities include cultural and leadership development, organisational integration, workforce planning, digital rostering, recruitment, staff experience and expanded occupational health services. Given the scale of the transformational change underway the approach of the Trust is to focus on a smaller number of priorities capable of delivering the greatest impact. These priorities have been considered through the Committee and other forums and are aligned to the Trusts strategic objectives and priorities. WUTH Job Planning Consistency Panels 2026/27 • The Committee was assured by the work being undertaken regarding the Trust's job planning process, noting that the panels have been implemented to ensure medical job plans are fair, contractually compliant, and aligned with service delivery, workforce capacity, and financial constraints. Whilst there are some outstanding areas before final sign-off, Trauma & Orthopaedics and Obstetrics and Gynaecology/Breast have been completed and signed off. Completion of all divisions are planned for the end of July 2026. The process commenced earlier this year in line with the activity and financial plan. WCHC Freedom to Speak Up Annual Report 2025/26 (including Q4 2025/26) • The Trust's staff were supported by 115 FTSU Champions who promote a speak-up culture within teams and staff networks. • Community Nursing accounted for the highest proportion of concerns reported (31%), with 63% of concerns raised either

	openly or confidentially through the FTSU Guardian, reflecting staff confidence in the process. • 87% of the Community Nursing concerns relate to the process of re-banding specific job roles. • The Committee was ASSURED that FTSU systems and processes continue to be robustly implemented throughout WCHC; and APPROVED the submission of the WCHC 2025/26 Annual FTSU report to the Board of Directors in accordance with the Trust's governance framework
Review of Risks	WUTH Risks ID03 and ID04 • The Committee discussed both the impact and likelihood and whether it judged the current risk level identified as appropriate. After due discussion, members acknowledged the impact and likelihood score was 3 x 4 initiating it was significant and agreed this was appropriate. WCHC Risks • The Committee discussed and noted the three key risks being escalated to Committee; these relate to unresolved job evaluation outcomes, high sickness absence exceeding 5% tolerance, and reduced clinical dental workforce due to unallocated training posts. • The Committee was ASSURED of the processes in place to monitor the high-level organisational risks as per the Trust's Risk Policy, including oversight by the sub-committees of the Board
Other comments from the Chair	• No other comments.

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2 September 2026

Item No 14

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

Alert	- The FPC wish to alert members of the Board of Directors that: - The WUTH Financial Plan for 2026/27 has not yet been approved and is still being discussed with NHSE. The WCHC plan has been approved. - The CIP target of 6% is £30.7m for WUTH and £6m for WCHC - The CIP includes 305 WTE (WUTH) and 64 WTE (WCHC) reduction with a 51 FTE shortfall currently identified. - Both Trusts are working up a CIP to 120% of the value needed in order to mitigate the risk of under achieving in areas. At the time of reporting, 105% has already been identified. - Cash remains the most important risk and requires close and robust management at WUTH and the Trust will need NHSE cash deficit support. - Detailed discussions with the ICB and NHSE are continuing in order to reach an agreed and accepted financial plan for 26/27 and good progress is being made.
Advise	- The FPC wish to advise members of the Board of Directors that: - At WUTH, despite the impact of industrial action, at month one, the Trust reported a £2.9 deficit which is on plan and in line with budget. - A cash support application for WUTH for June has been submitted to the NHSE. - The WCHC is reporting a £0.1m surplus and no variance to the plan overall position. However, the planned workforce and CIP positions for 26/27 are not yet fully realised and the Trust has not yet delivered the full sustainable underlying improvement plan. - For both Trusts the capacity and stretch challenge for teams was recognised with appropriate resources being considered to support delivery. - Detailed reports on the delivery of the financial plan and the CIP including the drivers of the deficit are received from the CFO and the Turnaround and Transformation Director on a monthly basis and are thoroughly scrutinised by FPC - A schedule of Deep Dive presentations has been programmed with the first from the Diagnostic and Clinical Support Division presented at this meeting. These are to focus on clinical and financial performance including improvement plans where necessary and CIP delivery
Assure	The FPC wish to assure members of the Board of Directors that:

	○ Principles of the estate utilisation strategy to ensure both Trusts use of the assets are cost effective and efficient and align with the NHS ten year plan were received. ○ The focus, scrutiny and triangulation of financial and clinical performance undertaken by the committee has been enhanced by a refresh of the membership and through monthly face to face meetings. ○ Reports received are prioritised on the delivery of the financial plan, CIP and WTE reductions necessary with robust discussion and challenge. ○ The appointment of the Turnaround and Transformational Director has added capacity and focus.
Review of Risks	• All five of the strategic risks the committee is responsible for are scoring as high risks and these are constantly being monitored by the Exec and reviewed by the committee.
Other comments from the Chair	• Both Trusts are fully focused on delivering the financial plan as well as driving improvements where necessary in the achievement of clinical targets with the previously approved clinical guardrails in place

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2 September 2026

Item No 14

Report Title	Joint Committee Chairs Reports – Finance and Performance Committee
Date of Meeting	24 June 2026
Author	Meredydd David, Chair of Finance and Performance Committee

Alert	- The Committee wish to alert members of the Group Board that: - the Financial Plan for WUTH has been resubmitted to NHSE as requested although formal confirmation is still awaited. - identified CIP schemes across both Trusts totalled £41.7m (113% of target), and when adjusted for implementation risk, the forecast is £31.9m (87% of target), showing £4.8m remaining to be mitigated which is an improved position. - planned workforce reduction is 369 WTE, with a current forecast impact of 326 WTE, representing a 43 WTE shortfall that has improved by 8 WTE from M1 with further improvements in development - the Trust had a cash balance of £2.7m at the end of the period, this was only enabled due to access to revenue support funding and will continue to rely upon cash support until deficit support funding is secured. Managing cash is a significant focus and challenge in particular managing the risk of increased creditor balances and the potential impact on supplier relationships.
Advise	- The Committee wish to advise members of the Group Board that: - WUTH report at the end of May 2026 (M2), a deficit of £6m, which is in line with plan. The Trust has submitted a revised planned deficit of £21.3m for 26/27 which it is anticipated will be accepted by NHSE. - the M2 WTE position was in line with plan. Further reductions in WTE are forecast from M6, aligned to the delivery of CIP schemes. Agency expenditure remained above plan and there was concern should this position continue. - each WUTH Division is required to present on a monthly basis summaries covering CIP delivery, activity, and finance performance, together with their own assessment of associated risks. - the Deep Dive presentation into the Surgery Division was well received but highlighted that currently the delivery of the financial plan represented a high risk at M2, although the position was expected to be mitigated over time. - WCHC at the end of May 2026 (M2), the Trust is reporting a surplus of £0.4m, which is in line with plan. The Trust is currently 5.65 behind (worse than) plan on WTEs but this is a positive movement from M2 - the costing plans for WUTH and WCHC and supporting information provided relating to the National Cost Collection pre submission report to ensure that they meet the expected

	requirements in line with the Approved Costing Guidance was received and approved. ○ urgent care improvements were not yet being sustained performance against both the 4-hour and 12-hour standards had improved, but the step change required had not yet been achieved. ○ 12-hour performance remained in the bottom quartile and that patient flow from the Emergency Department continued to be a concern. A programme of work to address medical intake was being developed. ○ WCHC continues to deliver well against targets in the majority of areas however CAS response times remain below the expected standard and continue to require close operational oversight. NHS 111 response times also continue to be impacted by the ongoing focus on emergency department streaming and increasing face-to-face capacity within UTC/GPOOH ○ an overview of the proposed estate strategy with clinical service relocations to support the Trusts left-shift strategic aims in line with the NHS 10 Year Health Plan was received. The proposals had also been clinically validated and senior clinical leaders were supportive. ○ two contract awards were considered and approved – provision of outsourced radiology sourcing and provision of cardiac pacemakers and capital purchase of remote monitoring. ○ Committee received the final Urgent Emergency Care Upgrade Programme update and were pleased to hear the new facility was planned to be fully operational for late July. A presentation was also given on the proposed clinical service relocations to support the Trusts left-shift strategic aims in line with the NHS 10 Year Health Plan. Good progress continues with key areas identified and further clinical engagement planned.
Assure	• The Committee wish to assure members of the Group Board that: ○ the risk of failing to deliver the WCHC financial plan was considered low, with there being a greater opportunity to exceed or outperform the planned position. ○ WUTH met monthly trajectories in May for all of the key RTT standards; caseload, % 18 weeks, % of 52-week waiters and 65-week waiters. ○ for cancer, performance for April was above target for the 28-day faster diagnosis (FDS) and 62-day treatment standards but remains below trajectory for the 31-day treatment cancer standard.
Review of Risks	• For WUTH it was agreed that for ID01 Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience the risk rating should be increased to 20 • For ID02 Failure to effectively manage planned/scheduled care, adversely impacting on quality of care and patient experience

	this would reduce to 12 following completion of the full referral to treatment review. • For WCHC there were four high level risks escalated to the Committee. These related to inhalation sedation machines in community dental services with ongoing capital business case work; reduced clinical assessment staffing for complex dysphagia referrals with interim support challenges; bladder and bowel service issues concerning portable bladder scanners; and payment delays for subcontracted GP LARC providers in Sexual Health Wirral. • The committee was ASSURED of the processes in place to monitor high-level organisational risks as per the Trust's Risk Policy, including oversight by the sub-committees of the Board
Other comments from the Chair	• It is acknowledged that the scale and pace of the CIP programme remains challenging with the key risks relating to delivery and organisational capacity. The importance of ensuring that clinical guardrails remained central to decision-making was reinforced. The next two to three months will be critical in providing greater assurance on delivery of the planned trajectory and financial plans. It was pleasing to note the improvement in WUTH delivery performance with a number of indicators now green.

Group Board of Directors in Public
2 September 2026

Item No 14

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

Alert	- The Committee wish to advise members of the Group Board that: - WUTH has submitted a revised planned deficit of £21.3m for 26/27 which we expect to be accepted by NHSE, but this has not been approved in writing yet. - WUTH is 33 WTE ahead of plan at M3 but there is a £1.6m adverse variance in respect of staff costs. This is due to higher WLI costs than plan, pay enhancements due to additional bank holidays, the Hantavirus response and continued premium rate pay. Improvement will require stronger controls and delivery of CIP schemes. - WUTH had a cash balance of £1.1m at the end of the period and will continue to rely upon cash support until deficit support funding is secured. - Full delivery of the CIP plans and productivity gains in medicine, Surgery and DCS remained a high risk particularly as the quantum of saving in the plan increases significantly for Q3 and Q4. - CIP schemes for Q3 and Q4 were well developed, however achievement of the anticipated cost savings remain a key risk and is dependent on operational realisation of the anticipated benefits. - the risk profile is shifting from CIP delivery to embedding grip and control. While a number of Divisions are on track, the run rate is not reducing as expected, creating an ongoing and increasing risk. This increases pressure on delivering grip and control risk.
Advise	- The Committee wish to advise members of the Group Board that: - the total identified CIP schemes was now £42.5 million (113% of target), with a risk-adjusted value of £34.2 million (93% of target), indicating a £2.5 million shortfall that has improved by £2.3 million since the previous report. - noted that verbal confirmation has been received that deficit support funding will be supported by NHSE. - at the end of June 2026 (month 3), the Trust is reporting a deficit of £8.5m, which is in line with our plan. - that the national direction of travel is to reduce follow-up appointments in hospital settings. It was advised that a summit with clinical leads had been arranged to ensure how the changes could be implemented and delivered. - For WCHC at the end of May (month 3), the Trust is reporting a surplus of £0.8m, which is £0.3m variance to plan. The Trust is

	currently 5.31 behind plan on WTEs but this is a positive movement from M2. ○ For WUTH planned cash flow and revenue support requests in month 3 month 4 had been received.
Assure	• The Committee wish to assure members of the Group Board that: ○ WUTH BPPC performance had improved over recent months, largely due to a more stable cash position and improved reporting mechanisms for NHS payments. ○ The Executive have discussed management of the consequences of major incidents with NHSE NW with agreement as to the role of partners individually and collectively. ○ A progress update on the Cheshire & Merseyside Future Procurement Operating Model Business Case Programme was discussed and will be shared with the Board once work completes at a regional level
Review of Risks	• The detail shared in relation to risk ID01, ID02, ID05, ID06 and ID11 and proposes any further controls, assurances and gaps were reviewed and the current risk rating in the context of the current controls and assurances and agreed risk appetite were considered appropriate
Other comments from the Chair	• Good progress was recognised but it was also noted that the next phase will be more challenging, with a need to accelerate delivery and recover delayed schemes. A step change in performance will be required for Q3 and Q4

WUTH Board of Directors in Public
2 September 2026

Item No 15

Report Title	Committee Chairs Report – WUTH Charitable Funds Committee
Date of Meeting	9 July 2026
Author	Lesley Davies, Chair of WUTH Charitable Funds Committee

Alert	The Committee wish to alert members of the Board that: The Committee was advised that several charity-specific policies are currently overdue for review and update. Assurance was provided that there is no immediate compliance or regulatory breach. Policies will be updated and brought to the next Committee meeting
Advise	The Committee wish to advise members of the Board that: - The Committee was advised that, at present, there are no formal forecasting arrangements for major fundraising events. It was agreed that this activity would form part of the reporting in future to enable the Charity to assess expected income from key events, anticipate costs of delivery and identify trends in fundraising performance over time. - The Committee approved the further development of the business case for the Critical Care Garden Appeal. Members received assurance that significant preparatory work is underway on future fundraising priorities. - The proposed Critical Care Garden Appeal has a clear charitable purpose focused on improving patient experience, wellbeing, and recovery through access to outdoor space and natural light. - A dedicated Bereavement Restricted Fund was approved, providing a mechanism to support future investment in bereavement environments, services, and support for patients, families, and staff. - Both initiatives align closely with patient experience and wellbeing objectives, providing confidence that future fundraising will deliver tangible benefits to service users
Assure	The Committee wish to assure members of the Board that: - The Committee reviewed the Terms of Reference and were assured that they remain fit for purpose - The Committee also was assured that although a new strategy was yet to be developed, a broad range of fundraising activity remains active, including: community fundraising events, individual donations, grant applications, legacy giving - The Committee requested details of the Smeed and Ford legacy notification service which the Charity uses. The Committee noted that using an organisation to search for legacy commitments represents standard sector practice and helps ensure legacy income opportunities are not lost and that Smeed

	and Ford have a long history in the charity sector for this type of service • The Committee was also assured that restricted and designated funds are being actively reviewed and plans are in place to release and utilise certain grant-related funds where eligibility periods have ended, allowing charitable resources to be directed towards delivering benefits. • The Committee received assurance that the Charity remains in a healthy financial position: ◦ Income of £53k had been received by the end of May. ◦ Expenditure totalled £26k. ◦ Funds increased overall by £28k during the reporting period. • Reporting arrangements have been strengthened following external audit recommendations, with improved visibility of restricted and designated funds. • Charity cash balances continue to generate interest income while maintaining appropriate accessibility to funds.
Review of Risks	• The Charity has now established a formal framework for identifying and managing its principal risks. • Current risks have been identified and relate to: ◦ Financial sustainability ◦ Workforce capacity ◦ Reputation ◦ Compliance • The Committee reviewed and approved these risks for inclusion in the Charity Risk Register, demonstrating active oversight of potential threats to the Charity's objectives. • Members recognised that risk controls and mitigations will continue to mature, providing increasing assurance over time. The Committee acknowledged the impact pressure of work and resourcing was having on the Charity's ability to develop and execute its proposed activities; these considerations will be discussed at future Committee meetings
Other comments from the Chair	• No comments

Group Board of Directors in Public
02 September 2026

Item 16

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Chris Douglas, Chief Nurse Nikki Stevenson, Chief Medical Officer
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')

Purpose of the Report and Recommendation	
Report For	Discussion
The last update on Maternity and Neonatal Services was reported to the Board of Directors in July 2026, and the quarterly report was also submitted to the Board of Directors in June 2026. An extended monthly report was submitted to the Quality Committee meeting held in August 2026. Included within this paper is the monthly Perinatal Quality Oversight Model (PQOM) Assurance Report, which provides an overview of the latest key quality and safety metrics for July 2026, together with the current position regarding patient safety incidents. The report has been revised in line with NHS England recommendations and provides comprehensive oversight and assurance of maternity and neonatal service performance. The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH). It includes progress updates relating to the AMOS Report and the Ockenden Report actions, Maternity Incentive Scheme (MIS) Year 8 compliance, and the annual Perinatal Mortality Review Tool (PMRT) reports for both maternity and neonatal services. Together with the monthly Perinatal Quality Oversight Model (PQOM) Assurance Report, this paper provides comprehensive assurance regarding service quality, safety, performance, and improvement activity across maternity and neonatal care.	

Key Points to Note
Recommendations The Trust Board is asked to note: - • No maternity or neonatal Patient Safety Incident Investigations (PSIIs) were declared during July 2026. • MIS Year 8 delivery remains on track, with successful achievement of the Training Compliance Touch Point and continued progress towards final submission in March 2027. • Compliance has been maintained with Saving Babies' Lives Care Bundle Version 3 and consultant obstetric attendance standards. • Planned Caesarean Birth Capacity Mapping confirms capacity remains sufficient to meet demand, supported by two additional elective Caesarean section sessions introduced during 2025.

- The Homebirth Service Safety and Quality Review confirmed that WUTH continues to provide a safe, sustainable, and well-governed homebirth service.
- Neonatal workforce standards remain non-compliant; a three-year workforce improvement plan requires Board approval.
- Progress continues across the Maternal Care Bundle, Perinatal Equity and Anti-Discrimination Programme (PEADP), maternity triage improvements, organisational development programme, and workforce initiatives.
- The Trust has reviewed the findings of the Nottingham Ockenden Review and the AMOS Review and has established action plans to address identified recommendations.
- PMRT reviews have identified learning opportunities, with strengthened multidisciplinary review processes now in place for all neonatal deaths.

Key Risks

This report relates to these key risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):

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

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
September 2026	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For discussion and approval
September 2026	Maternity and Neonatal Assurance Meeting	Quarterly Maternity and Neonatal Services Report	For discussion and approval

1	Perinatal Quality Oversight Model (PQOM) Assurance Report
1.1	The Perinatal Quality Oversight Model (PQOM) is reported at Appendix 1 and provides the latest July 2026 quality and safety metrics for maternity and neonatal services. The model forms a core component of the Trust's governance and assurance framework, supporting the Trust Board in maintaining effective oversight of performance, risk, quality, safety, and improvement activity across the perinatal pathway. For this reporting cycle, information is presented in a revised slide-pack format aligned with NHS England's recommended reporting approach for maternity and neonatal services. This format has been developed to enhance clarity, improve the visual interpretation of key information, and provide comprehensive oversight of quality and safety metrics, including patient safety incidents, clinical outcomes, harms, workforce measures, patient experience, and improvement activity. The revised presentation is intended to support more focused discussion, strengthen assurance processes, and improve the accessibility of information for Trust Board members. The presentation will consistently be presented as Appendix 1 and will serve as a high-level summary of the full Board report and any supporting appendices. This approach enables Board members to quickly identify key issues, assurances, risks, and decisions, while retaining access to detailed narrative, analysis, and supporting evidence contained within the accompanying report and appendices. The slide-pack provides a summary of: • Performance against national, regional, and local expectations. • Areas demonstrating sustained improvement and good practice. • Emerging concerns and areas requiring escalation or focused intervention. • Key risks, mitigating actions, and improvement plans. • Trends and themes across patient safety incidents, clinical outcomes, workforce indicators, and patient experience measures. • Progress against key maternity and neonatal improvement programmes, including AMOS, Ockenden actions, Maternity Incentive Scheme (MIS) Year 8 requirements, and recommendations arising from Perinatal Mortality Review Tool (PMRT) reviews. The revised reporting format has been developed to improve clarity, enhance the visual presentation of data, and support more focused Board discussion and decision-making. It also ensures full visibility of the quality and safety metrics recommended by NHS England, while providing a structured and accessible summary of the detailed information contained within the full Board report and supporting appendices.
2	Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)
2.1	Patient Safety Incident Investigations (PSIIs) continue to be reported monthly via the regional maternity safety dashboard by all maternity providers across Cheshire and Merseyside and Lancashire and South Cumbria (Northwest Coast). This reporting arrangement supports regional oversight, benchmarking, and the identification of shared themes and learning across maternity services.

	There were no Patient Safety Incident Investigations (PSIIs) declared within maternity services during July 2026. All relevant cases arising during the reporting period have been appropriately assessed and referred to the Maternity and Newborn Safety Investigations (MNSI) Programme in line with national requirements and the Trust's internal governance processes. There were no MNSI referrals in July 2026, and there are currently no active MNSI investigations. The only outstanding MNSI report relates to a historic case from 2022, for which a draft report has now been received and is progressing through the approval process. There were also no Patient Safety Incident Investigations (PSIIs) declared within neonatal services during July 2026. <i>The Board of Directors is requested to note the position.</i>
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3	Maternity Incentive Scheme (MIS) Year 8
3.1	The Trust is progressing towards compliance with all six revised MIS Safety Action Standards for 2026, supported by strengthened governance, enhanced clinical oversight, and monthly assurance reporting. Board oversight remains essential to secure the CNST contribution refund and any associated incentive payment. 1. Overview of the Scheme The Maternity Incentive Scheme (MIS) is a national NHS Resolution programme designed to improve maternity and neonatal safety by linking financial incentives to the delivery of defined safety actions. Now in its eighth year, the scheme: • Rewards Trusts that meet six updated safety standards. • Provides a refund of the additional maternity contribution to CNST. • Offers an incentive payment where applicable. • Reinforces national expectations for robust governance, high-quality clinical practice, and effective learning systems. 2. Current Trust Position Monthly monitoring via the Maternity and Neonatal Quality Assurance Meeting continues to track progress against each Safety Action Standard. Key points: • A refreshed gap analysis at Appendix 2 reflects the 2026 scheme updates. • Evidence collection and validation processes have been strengthened. • Early indicators show steady progress, with targeted actions underway in areas requiring improvement. • Cross-Divisional collaboration between Maternity, Neonatal, Governance, and Quality teams is supporting delivery. 3. Assurance and Governance The Trust has implemented: • Enhanced evidence-tracking mechanisms to ensure audit-ready documentation. • Strengthened clinical governance oversight, including escalation routes for emerging risks.

- Regular reporting to the Quality and Safety Trust Board and Board of Directors.
- Clear accountability for each safety action, with named leads and defined timelines.

These measures ensure the Board receives timely, accurate assurance to support the annual self-declaration.

4. Board Responsibilities

Board oversight is a mandatory requirement of the MIS. The Board must:

- Review progress against all six Safety Action Standards.
- Confirm that evidence is complete, accurate, and triangulated.
- Approve the Trust's self-declaration to NHS Resolution.
- Ensure that any identified risks are mitigated through appropriate governance and resourcing.

Successful compliance will secure the financial refund and maintain the Trust's position as a provider of safe, high-quality maternity and neonatal care.

5. Forward Look

Over the coming months, the Trust will focus on:

- Closing remaining gaps identified in **Appendix 2**.
- Strengthening data quality and audit trails.
- Ensuring staff training, incident learning, and clinical documentation meet national standards.
- Preparing for internal and external scrutiny of evidence.

As part of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 8 requirements, the Trust has been undertaking work to ensure compliance with all safety actions. Although the scheme remains a self-declaration process and there is no routine external review of all submitted evidence, Wirral University Teaching Hospital was selected by the NHS England review team for a validation review of Safety Action B: Training, which took place on 25 August 2026.

During the review, the Trust delivered a comprehensive presentation outlining its approach to meeting the requirements of Safety Action B. Initial feedback from the review team was highly positive, with particular recognition given to the collaborative, multidisciplinary approach demonstrated across maternity services. Formal feedback will be provided through the review rubric; however, the NHS Resolution review team welcomed the strong team-based approach and the commitment shown to embedding the training requirements within practice. The review has provided additional assurance regarding the Trust's compliance with the requirements of this safety action

A key change to the MIS Year 8 processes this year is the introduction of two formal reporting touchpoints. The first declaration and progress update was submitted to the Quality Committee on 13th August 2026, providing assurance that the Trust had achieved compliance with the applicable safety actions outlined in **Appendix 3**.

The final Trust submission is due by 2 March 2027, at which point full compliance with all applicable safety actions must be formally declared and evidenced.

	The Trust remains on track with its MIS Year 8 programme and will continue to provide updates through the established governance structure to ensure ongoing oversight and assurance. <i>The Board of Directors is requested to note the current position in relation to the Maternity Incentive Scheme (MIS) Year 8 programme, including achievement of the Training Compliance Touch Point (Safety Action B), receive assurance regarding progress towards compliance with all applicable Safety Action Standards, and note that the Trust remains on track to submit its final declaration to NHS Resolution by 2 March 2027.</i>
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4	Workforce (Safety Action A)
4.1	Appendix 4 provides assurance that the Trust is compliant with Safety Action A1 of the NHS Resolution Maternity Incentive Scheme in relation to consultant obstetric attendance on the labour ward. The evidence demonstrates that consultant attendance arrangements are aligned with RCOG guidance, escalation processes are embedded within clinical practice, and compliance is routinely monitored through audit and maternity governance oversight. Note the assurance provided regarding compliance with Safety Action A1 of the NHS Resolution Maternity Incentive Scheme. Appendix 5 provides assurance to the Board regarding compliance with maternity workforce requirements, previously presented in June 2026. Since the original submission, there have been no material changes to the assessment of compliance. The only updates are the availability of funding of £10,000 per appointment to support the recruitment and retention of newly qualified midwives, and an Early Years funding opportunity which will support the addition of one midwife and one maternity support worker to further strengthen the maternity workforce. Appendix 6 provides an update on the Trust's compliance with neonatal workforce requirements. As previously reported to the Board in June 2026, the Trust is not currently compliant with the relevant workforce standards. There have been no material changes to the position since the previous report. Appendix 7 sets out the proposed three-year neonatal workforce improvement plan, detailing the actions, milestones and trajectories required to achieve compliance. Board approval of the workforce plan is required to meet the requirements of Safety Action A of the NHS Resolution Maternity Incentive Scheme. <i>The Board is asked to note the assurance provided in relation to compliance with Safety Action A regarding consultant obstetric attendance on the labour ward and the current position in respect of maternity and neonatal workforce requirements. The Board is further asked to note that, whilst there have been no material changes to the previously reported neonatal workforce position, the Trust remains non-compliant with the relevant neonatal workforce standards, and to approve the proposed three-year neonatal workforce improvement plan set out in Appendix 7 to support achievement of compliance with the requirements of Safety Action A of the NHS Resolution Maternity Incentive Scheme.</i>

5	Planned Caesarean Birth Capacity Mapping and Home Birth Service
5.1	A summary of the Planned Caesarean Birth Capacity Mapping review is provided in Appendix 8. The review confirms that planned Caesarean birth capacity remains sufficient to meet demand across the full patient pathway. The Trust has also completed the Homebirth Service Safety and Quality Review in response to the request from the Chief Midwifery Officer for England. The review confirmed that WUTH continues to provide a safe, sustainable, and well-governed homebirth service, with no significant safety concerns identified. <i>The Board of Directors is asked to note the findings of the Homebirth Service Safety and Quality Review and the assurance provided regarding the continued safe delivery of homebirth services at WUTH.</i>

6	Quarterly Thematic Report on Learning including MOSS Clinical Safety Checks
6.1	Appendix 9 presents the Quarterly Learning Report, providing an overview of learning arising from MNSI and NHS Resolution Early Notification investigations, PMRT reviews, PSIRF investigations, NHS Resolution claims scorecards and relevant national reports. The report identifies recurring themes, outlines actions taken in response, demonstrates progress against improvement plans, and evidence how learning has been shared across the maternity service and incorporated into multidisciplinary training where appropriate. Appendix 10 presents the quarterly Maternity Oversight and Safety System (MOSS) Clinical Safety Checks report. The report provides assurance on compliance with national maternity safety standards, highlights areas of good practice and identifies any risks, concerns or themes requiring further action. The findings support ongoing maternity safety surveillance and inform quality improvement activity through established governance processes. <i>The Board is asked to note the assurance provided through the Quarterly Learning Report (Appendix 9) and the MOSS Clinical Safety Checks Report (Appendix 10). These reports demonstrate progress in addressing identified themes, embedding learning from reviews and investigations, and monitoring the effectiveness of safety and quality improvement actions, providing assurance of compliance with Safety Action C6 of the NHS Resolution Maternity Incentive Scheme.</i>

7	Maternity Care Bundle Implementation Plan
7.1	Included at Appendix 11 sets out the Trust's Maternal Care Bundle Implementation Plan, developed in collaboration with relevant services and stakeholders. The Trust is currently 50% compliant with the requirements of the Maternal Care Bundle and has established a programme of work to achieve full implementation by March 2027. Meetings have been arranged with the Local Maternity and Neonatal System (LMNS) and NHS England to identify and secure the support required to deliver the remaining elements of the programme. Progress against the implementation plan will be monitored through established governance arrangements and reported quarterly to provide assurance of delivery and compliance.

	<i>The Board is asked to note the current compliance position and approve the Maternal Care Bundle Implementation Plan, supporting the actions required to achieve full compliance by March 2027.</i>
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8	Saving Babies Lives
8.1	Appendix 12 provides assurance that the Trust has maintained 100% compliance with all six elements of the Saving Babies' Lives Care Bundle Version 3. Compliance continues to be monitored through established maternity governance arrangements and will be reported through future Board assurance reports and the NHS Resolution Maternity Incentive Scheme process. <i>The Board is asked to note the continued 100% compliance with the Saving Babies' Lives Care Bundle Version 3.</i>

9	Perinatal Culture Improvement Plan
9.1	Appendix 13 provides an update on the Perinatal Equity and Anti-Discrimination Programme (PEADP), which serves as the Trust's strategic framework for coordinating national equity programmes, maternity improvement initiatives and recommendations arising from external reviews and investigations. In line with the requirements of MIS Safety Action F4, the programme supports the delivery of safe, equitable and inclusive maternity and neonatal care through a structured improvement approach focused on reducing inequalities, strengthening organisational culture, and improving outcomes and experiences for women, babies, families and staff. An accompanying improvement plan is included at Appendix 1 to support delivery of the programme objectives. <i>The Board is asked to note the assurance provided through the PEADP programme and the associated improvement plan detailed at Appendix 1 of the report.</i>

10	Organisational Development Support Programme
10.1	Following identification of cultural, leadership and team-working challenges, an Organisational Development (OD) support programme has been established using a phased approach designed to stabilise, rebuild and embed sustainable improvements in team functioning and culture. Phase 1 – Stabilisation focuses on immediate interventions to support individuals and teams, including targeted coaching, mediation of key professional relationships, clarification of behavioural expectations and the establishment of clear communication arrangements. This phase aims to create a stable foundation from which improvements can be progressed. Phase 2 – Rebuilding centres on restoring effective team working through facilitated workshops, development of team charters and working agreements, rebuilding trust and psychological safety, and establishing a shared understanding of purpose, roles and expectations across the multidisciplinary team. Phase 3 – Embedding focuses on sustaining improvement through regular reflective team forums, development of a constructive feedback culture and ongoing team review and support mechanisms. The objective is to ensure that positive cultural and

	behavioural changes become embedded within day-to-day practice and governance arrangements. The programme will be monitored through existing governance structures, with progress reported through the appropriate clinical governance and leadership forums to provide assurance that improvements in culture, communication and multidisciplinary working are being sustained. A full report is included at Appendix 14. Expected Outcomes • Improved communication and working relationships. • Increased psychological safety and staff engagement. • Clear behavioural expectations and accountability. • Stronger multidisciplinary team working. • Sustainable cultural improvement embedded within the service. • Enhanced patient safety through effective collaboration and teamwork.
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11	Ockenden 2026
11.1	The Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust was published 24 June 2026. The full report is included in Appendix 15 with a summary at Appendix 16. 1. Overview • Nationally significant independent review led by Donna Ockenden into maternity and neonatal services. • Examined care across 2012–2025, involving 2,500+ family cases and extensive staff input. • Identified hundreds of cases of avoidable harm, including maternal and neonatal deaths and injuries. 2. Headline Findings • Systemic failure across multiple domains The report concludes that poor outcomes were not isolated incidents but the result of: • Weak leadership, governance and organisational culture • Failure to investigate incidents effectively • Failure to learn and implement improvements consistently Recurrent themes contributing to harm • Failure to listen to women and families • Poor multidisciplinary working and communication • Inadequate staffing and workforce planning • Lack of access to, or completion of, mandatory training • Failure to escalate clinical concerns appropriately 3. Culture and Patient Experience • Persistent culture where women’s concerns were dismissed or minimised. • Families described lack of compassion, honesty and involvement in decision-making. • A closed culture inhibited speaking up and learning from harm. 4. Workforce and Capacity

	• Significant staffing shortages across maternity and neonatal services. • Workforce models not aligned to acuity or complexity of patient population. • Limited protected time for training, supervision and development. 5. Clinical Safety and Governance Failures • Inconsistent risk assessment, monitoring and escalation. • Poor incident investigation quality, leading to missed learning. • Lack of robust governance oversight at Board level. • Failure to implement national standards and guidelines reliably. 6. Key Recommendations / Actions The report sets out 18 Immediate and Essential Actions (IEAs) for national adoption, including: Patient-centred care • Ensure clear, consistent information to support informed choice. • Strengthen shared decision-making and consent processes. Workforce • Introduce a national perinatal workforce planning model reflecting complexity. • Standardise and strengthen key roles (e.g. labour ward coordinators). Safety systems • Improve mandatory training compliance and quality. • Strengthen incident reporting, investigation and learning systems. • Establish effective clinical escalation frameworks. Leadership and governance • Boards must have clear oversight of maternity safety data and risks. • Strengthen accountability, transparency and assurance processes A gap analysis for Wirral University Teaching Hospital is included at Appendix 17 for noting and discussion. Since the publication of the Ockenden Report, the Trust has undergone an unannounced inspection by the Human Tissue Authority (HTA). While the full inspection report is not yet available, the review included maternity services, with particular focus on the human tissue storage facilities and the perinatal post-mortem process. Initial feedback was positive, with only minor recommendations relating to fridge monitoring. These changes have been implemented immediately to ensure continued compliance and best practice.
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12	AMOS
12.1	The AMOS review has provided assurance regarding the progress made within maternity services while also identifying a few areas requiring further development to strengthen governance, safety, and compliance with national recommendations. Overall, the review recognised the commitment of staff and the progress achieved since the publication of the Ockenden Report. However, continued focus is required to ensure that improvements are embedded, sustained, and demonstrably effective. The full report is included in Appendix 18 with a summary at Appendix 19.

The Trust has considered the findings and recommendations and has developed an action plan to address the areas identified. Progress against these actions will be monitored through the Maternity and Neonatal Safety Improvement Programme governance structure, with regular reporting to the Women's and Children's Care Group and Trust Boards.

Recommended Actions: -

- Strengthen maternity governance arrangements to ensure clear oversight, accountability, and escalation of risks.
- Improve the quality and timeliness of incident reporting and investigation, ensuring learning is shared across services.
- Enhance multidisciplinary learning and review processes, including Perinatal Mortality Review Tool (PMRT) and patient safety incident reviews.
- Develop and embed a robust workforce plan to address staffing pressures and ensure safe maternity staffing levels.
- Increase compliance with mandatory training and emergency skills drills across all maternity staff groups.
- Strengthen fetal surveillance processes, including training, competency assessment, and audit of practice.
- Improve the consistency of risk assessment, documentation, and care planning throughout the maternity pathway.
- Enhance service user engagement and the mechanisms for capturing and responding to feedback from women and families.
- Strengthen audit, assurance, and quality improvement programmes to demonstrate the effectiveness of implemented changes.
- Ensure continued oversight and delivery of the Ockenden and Saving Babies' Lives recommendations, with regular reporting on progress and outcomes.

A series of national actions have been identified to strengthen maternity and neonatal safety, improve leadership accountability, address inequalities, and enhance the experience of women, babies and families. These actions build on learning from national reviews, including Ockenden, East Kent and Amos, and are expected to form part of local provider assurance arrangements during 2026/27.

Key National Actions and the ten national priorities are: -

1. **Roll out Martha's Rule** across all maternity and neonatal services, including antenatal, intrapartum, postnatal, triage and neonatal care settings.
2. **Strengthen the use of real-time patient experience and outcome data** through a monthly cycle of data collection and review at public Board meetings, including Friends and Family Test (FFT), Patient Reported Experience Measures (PREMs) and Maternity and Neonatal Voices Partnership (MNVP) feedback, alongside renewed focus on clinical audit.
3. **Establish dual Board-level accountability** between the Medical Director and Chief Nurse, ensuring equal representation and accountability across obstetric, midwifery, neonatal and operational leadership structures.
4. **Participate in the national "Amos into Action" staff listening exercise** to support cultural improvement, staff engagement and implementation of the Amos and Ockenden recommendations.

5. **Address inequalities in maternity and neonatal outcomes** through implementation of the Perinatal Equity and Anti-Discrimination Programme, active use of inequalities dashboards and delivery of the Maternal Care Bundle by March 2027.
6. **Ensure safe and responsive 24/7 services** through Board assurance of safe staffing levels, workforce responsiveness and effective escalation arrangements across all key professional groups.
7. **Complete and review homebirth service safety and quality assessments**, ensuring findings are reported to the Board and that any identified concerns are addressed promptly.
8. **Promote a culture of openness, compassion and candour** by reviewing how incidents, complaints and concerns are managed, ensuring responses are trauma-informed and family-centred.
9. **Deliver safe and effective maternity triage services** through completion of a Board-level triage audit, implementation of identified improvements, dedicated staffing arrangements and robust escalation processes.
10. **Implement recommendations relating to post-death care and bereavement services**, including actions arising from the Fuller and Nottingham University Hospitals reviews, ensuring all deceased patients are treated with dignity and respect.

Implications for the Trust: -

The actions align with the Trust's existing maternity and neonatal quality and safety priorities, including:

- Safety culture and learning.
- Perinatal equity and reducing health inequalities.
- Workforce sustainability and safe staffing.
- Family-centred and compassionate care.
- Effective governance and Board oversight.
- Patient engagement and co-production through service user feedback mechanisms.

Several actions are already partially embedded within current governance arrangements, including review of patient experience data, maternity safety reporting, incident learning processes and workforce assurance.

Current Position

At this stage, detailed national implementation guidance, performance metrics and assurance requirements have not yet been issued for all workstreams.

The Trust will:

- Continue monitoring national communications and NHS England guidance.
- Undertake a gap analysis against current arrangements once detailed requirements are published.
- Identify any resource, workforce or governance implications.
- Report progress and compliance through existing maternity governance structures and Board assurance processes.

Risks

	Potential risks include: - • Additional workforce and training requirements. • Changes to assurance and reporting arrangements. • Resource implications associated with implementation of new national standards. • Requirement for accelerated improvement plans where gaps are identified. These risks will be assessed further once national guidance is available. Recommendation The Trust Board is asked to: • Note the ten national maternity and neonatal safety priorities for 2026/27. • Acknowledge that further national guidance and implementation requirements are awaited. Trust Board and Board Assurance An action plan is being developed against all ten recommendations and with a summary included in the PQOM (Appendix 1), with executive oversight in place. Progress will be reported through established governance routes, and assurance will be provided to the Trust Board and Board of Directors on completion of actions and evidence of sustained improvement. <i>The Board of Directors is asked to note the findings of the AMOS Review, the associated improvement actions and the ten national maternity and neonatal safety priorities for 2026/27 and receive assurance that progress will continue to be monitored and reported through established governance and Board assurance processes.</i>
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13	Perinatal Mortality Review Tool Annual Reports (PMRT) Annual Reports
13.1	The Trust Board is asked to review and discuss the attached Perinatal Mortality Review Tool (PMRT) Annual Reports for Maternity and Neonatal Services at Appendix 20 and 21 noting the themes, learning, recommendations and actions arising from the reviews undertaken during the reporting period. The reports provide assurance regarding the Trust's approach to the systematic review of perinatal deaths, identification of contributory factors, quality of care assessment and opportunities for learning and improvement. The Board is invited to consider the findings alongside local and national maternity and neonatal safety priorities, seek assurance that identified actions are being implemented and monitored through established governance processes, and note any emerging risks, trends or areas requiring further oversight to support the delivery of safe, effective and equitable care for women, babies and families. A thematic review of neonatal deaths has been undertaken to identify recurrent themes, contributory factors and opportunities for improvement in the quality and safety of care. The findings have been reviewed through the Trust's established Clinical Governance processes, with actions monitored through the Maternity and Neonatal

	Governance Framework to ensure learning is embedded and improvements are sustained. As part of this work, changes have been implemented to strengthen the local review process. Prior to submission to PMRT, all neonatal deaths now undergo a comprehensive multidisciplinary internal review involving relevant obstetric, neonatal, midwifery and specialist teams, as appropriate. This enhanced approach ensures that care is thoroughly scrutinised, contributory factors are identified at the earliest opportunity and learning is acted upon promptly. The strengthened review process has improved the quality of information submitted to PMRT, enhanced organisational learning and provided greater assurance that opportunities for improvement are identified and addressed through existing governance arrangements. <i>The Board of Directors is asked to review and note the PMRT Annual Reports for Maternity and Neonatal Services (Appendices 20 and 21). The Board is also asked to note the learning identified, the actions implemented to strengthen review processes and governance oversight, and the arrangements in place to support continued improvement in maternity and neonatal outcomes.</i>
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14	10 Point Plan and Triage Specification Tool
14.1	Appendices 22 and 23 provide the Trust's response to the national maternity 10 Point Plan and the Board-level Maternity Triage Specification and Audit Tool. The audit has been completed in line with national requirements and provides assurance regarding the safety, effectiveness and responsiveness of maternity triage services. The review has considered staffing, capacity, escalation arrangements, waiting times, assessment timeframes, redeployment, outcomes and compliance with recognised triage standards. The findings have informed a local improvement plan to ensure alignment with forthcoming NHS England maternity triage guidance and support the delivery of consistent, high-quality triage services for women and families. <i>The Board of Directors is asked to note the national 10 Point Plan, review the findings of the Maternity Triage Specification and Audit Tool, and approve the associated improvement actions. This will provide assurance that the Trust is meeting national expectations for maternity triage services and has appropriate oversight of quality, safety, performance and ongoing compliance with emerging national requirements.</i>

15	Conclusion
15.1	The Trust Board can be assured that: • Robust governance arrangements are in place to oversee maternity and neonatal quality, safety and performance. • There were no maternity or neonatal Patient Safety Incident Investigations (PSIIs) declared during July 2026. • Progress against the Maternity Incentive Scheme (MIS) Year 8 requirements remains on track, with achievement of the Training Compliance Touch Point and continued progress towards final declaration requirements. • Compliance has been maintained with the Saving Babies' Lives Care Bundle Version 3 and consultant obstetric attendance standards.

	• Learning from PMRT reviews, national investigations, Ockenden, Nottingham and AMOS recommendations continue to be embedded through established governance arrangements. • A strengthened multidisciplinary review process for neonatal deaths has been implemented to enhance organisational learning and quality assurance. • The Trust has completed the Homebirth Service Safety and Quality Review, which confirmed WUTH's homebirth service as a safe, sustainable and well-governed service that supports women's choice and personalised care. • Progress continues across key improvement programmes, including the Maternal Care Bundle, Perinatal Equity and Anti-Discrimination Programme (PEADP), workforce improvement plans, organisational development initiatives and maternity triage improvement work. • Action plans are in place to address areas of non-compliance, including neonatal workforce standards and implementation of the Maternal Care Bundle by March 2027. • Arrangements are in place to respond to the ten national maternity and neonatal safety priorities for 2026/27, with executive oversight and Board assurance processes established. Overall Assurance Rating: Significant Assurance, with continued Board oversight required to support delivery of national improvement priorities, achievement of neonatal workforce compliance, implementation of the Maternal Care Bundle and successful completion of MIS Year 8 requirements. Final Board Recommendation <i>The Board of Directors is asked to note the assurances provided within this report and supporting appendices, approve the Neonatal Workforce Improvement Plan (Appendix 7), approve the Maternal Care Bundle Implementation Plan (Appendix 11), approve the Maternity Triage Improvement Actions arising from the Triage Specification Audit (Appendices 22 and 23), and support staff release to participate in the Perinatal Equity and Anti-Discrimination Programme (PEADP) in line with MIS Safety Action F.</i>
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16	Implications
16.1	Patients • The appendices demonstrate the standards, performance measures and governance arrangements in place to support the delivery of safe, effective and high-quality maternity and neonatal services. • The Perinatal Quality Oversight Model (PQOM), PMRT reviews, patient safety reporting and quality metrics provide assurance regarding patient safety, clinical outcomes and continuous improvement. • Learning from Ockenden, AMOS, PMRT reviews and national maternity safety initiatives continues to be embedded to improve outcomes and experience for women, babies and families. • The introduction of enhanced multidisciplinary reviews for neonatal deaths strengthens organisational learning and supports improvements in patient care. • The recent Human Tissue Authority inspection provided positive assurance regarding the quality and safety of maternity services, with only minor recommendations identified and addressed immediately.
16.2	People

	• The Trust continues to progress delivery of the Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards, supported by strengthened governance, training oversight and evidence assurance processes. • Strong partnership working with the Maternity and Neonatal Voices Partnership (MNVP) continues to support co-production, service user engagement and the incorporation of patient feedback into service improvement. • The Trust remains committed to implementing recommendations arising from the Ockenden, AMOS and Nottingham reviews, alongside the newly published national maternity and neonatal priorities. • An Organisational Development support programme has commenced to strengthen leadership, multidisciplinary working, psychological safety and team culture across maternity services. • Progress continues across key improvement programmes, including Saving Babies' Lives Care Bundle Version 3, Perinatal Equity initiatives, workforce development and patient safety programmes. • Monthly governance and assurance processes continue to support staff engagement, learning from incidents and the delivery of safe, personalised and equitable care.
16.3	Finance • Continued investment is required to support maternity and neonatal service delivery, workforce sustainability, training requirements, quality improvement programmes and implementation of national safety priorities. • Financial commitment will be required to support delivery of MIS Year 8 requirements, Ockenden and AMOS recommendations, Organisational Development interventions, and future NHS England maternity and neonatal safety initiatives. • Effective governance and assurance arrangements help mitigate financial risk associated with CNST compliance and support the Trust's ability to secure the associated financial reimbursement.
16.4	Compliance • This report supports assurance against several statutory, regulatory and national requirements, including: • NHS England Perinatal Quality Oversight Model reporting. • Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards. • Ockenden recommendations and national maternity safety requirements. • AMOS review recommendations. • Saving Babies' Lives Care Bundle Version 3. • Perinatal Mortality Review Tool (PMRT) requirements. • Maternity and Newborn Safety Investigation requirements. • NHS England maternity and neonatal quality governance standards. The report provides assurance to the Trust Board and Board regarding oversight, compliance, risk management and continuous improvement across maternity and neonatal services.

Group Board of Directors in Public
02 September 2026

Item 17

Title	Director of Infection Prevention and Control Annual Report 2025-26
Area Lead	Chris Douglas, Joint Chief Nursing Officer / Director of Infection Prevention & Control
Author	Lorraine Young, IPC Matron

Purpose of the Report and Recommendation	
Report For	Assurance
The purpose of this annual report is to provide assurance to the Quality and Safety Committee regarding activity in relation to Infection Prevention and Control (IPC) for the reporting period 01 April 2025 – 31 March 2026. It is recommended that the Board: Be assured that IPC systems and processes continue to be robustly implemented to effectively evidence compliance with The Code of Practice on the Prevention and Control of Infections, Care Quality Commission Health and Social Care Act 2008, Regulation 12.	

Key Points to Note
This report demonstrates compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and demonstrate compliance with the ten-criterion outlined in the Act and to provide assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards. The report recognises the hard work of all staff working across clinical and support services in ensuring patient safety within our organisation. Whilst the Trust exceeded the NHS threshold for <i>Clostridioides difficile</i> infection (CDI) in 2025/26, we did report 16 fewer cases than the previous year.

Key Risks
This report relates to the following BAF risks: - Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. - Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience. - 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	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	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
13 August 2026	Joint Quality & Safety Committee	Director of Infection Prevention and Control Annual Report 01 April 2025 – 31 March 2026	For assurance.
6 August 2026	Patient Safety Quality Board	Director of Infection Prevention and Control Annual Report 01 April 2025 – 31 March 2026	

1	Narrative
1.1	The Director of Infection Prevention & Control Annual Report provides an overview of the significant achievements made to assure trust standards in relation to IPC practice and associated regulatory compliance. This report is testimony to the hard work of all the teams in WUTH and although we have exceeded the Healthcare Associated Infections (HCAI) thresholds set by NHSE, there has been a significant amount of work to improve standards across the Trust. Whilst the Trust exceeded the NHS threshold for <i>Clostridioides difficile</i> infection (CDI) in 2025/26, we did report 16 fewer cases than the previous year. We now need to build on this reduction, and the quality improvement work that has been done in previous years, to prevent patients acquiring CDI and strive to not exceed the threshold that will be set for 2026-27. An IPC improvement plan will be developed to support targeted improvement work throughout 2026/27.

	There have been significant changes in IPC leadership during 2025/26, but as we move into 2026/27 it is anticipated that a more stable structure will help to bring IPC to the forefront of every decision made in WUTH to ensure we keep our patients and staff safe.
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2	Implications
2.1	Patients • Infection prevention and control (IPC) is essential in practice to safeguard patient health and reduce healthcare-associated infections • A collaborative approach to IPC can significantly improve infection control outcomes and enhance patient safety and quality of care
2.2	People • Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services
2.3	Finance • Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action
2.4	Compliance • This report demonstrates compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and demonstrate compliance with the ten-criterion outlined in the Act and to provide assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards



**Wirral University
Teaching Hospital**
NHS Foundation Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2025/2026

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2 Executive Summary

Good management and organisational processes are crucial to ensure that high standards of IPC, including cleanliness, are developed and maintained. The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

IPC risk assessments are responsively implemented by the Trust to effectively manage and mitigate risk of harm to patients. During 2025/26 the IPC team supported the wards and divisions in managing 25 outbreaks of Norovirus, 9 periods of increased incidences of *Clostridioides difficile*, 4 periods of increased incidence of CPE, 13 outbreaks of COVID and 6 outbreaks of Influenza; this was alongside their daily audit and surveillance activities.

Whilst the Trust exceeded the NHS threshold for *Clostridioides difficile* infection (CDI) in 2025/26, 16 fewer cases were reported than the previous year. The Trust are committed to building on this reduction, utilising proven quality improvement methodology, to prevent patients acquiring CDI, striving to not exceed the threshold that will be set for 2026/27. The Executive team remain committed to ensuring that the Trust is equipped with the resources to effectively deliver the identified quality improvements and fully support the implementation of the fundamentals that have been identified locally as proven reduction strategies for CDI.

During 2025/26, the Trust also exceeded the threshold for gram negative bacteraemia. It is anticipated that implementation of the CDI quality improvement plan will positively impact on the prevention of all health care associated infections within the organisation. This will continue to be robustly tracked to respond to emerging themes and trends within the data, to assure patient safety.

Whilst promoting a zero-tolerance approach to MRSA bacteraemia the Trust reported two MRSA bacteraemia in 2025/26 which is an increase of one from the previous year.

In regard to MSSA bacteraemia infections, whilst there are no national objectives set, it is positive to note that the Trust is an outlier within the north-west for reporting low annual numbers. This may be a result of the continued investment in the use of antimicrobial body wash for all people admitted to the Trust.

The Trust continues to report mandatory surveillance of SSI following Orthopaedic surgery and has seen a reduction in incidence during the 2025/26 annual period, with three infections being reported following 415 surgeries.

This report is testimony to the hard work of all the teams in WUTH, and although the Trust has exceeded national thresholds set by NHSE, there has been a significant amount of work to improve standards across the Trust.

Over the next 12 months IPC will remain a Trust priority, with a refresh on the fundamental principles of IPC supported by a quality improvement programme, with the aim of delivering high-quality, safe care to our patients. Robust tracking of HCAI thresholds during 2026/27 will continue through the Trusts' governance framework, evidencing clear outcomes to drive a cycle of continuous improvement.

In conclusion, I would like to acknowledge the hard work of the IPC Team, the divisions they support and all the support services across the Trust. Working as a unified team, they have shown continued commitment to the delivery of infection prevention practices by responsive management of the Trust's infection risks in a dynamic, caring manner.

Chris Douglas

Joint Chief Nursing Officer / Director of Infection and Prevention and Control

3 Description of Infection Prevention

3.1 Nursing Team

The role of the Director of Infection Prevention and Control is held by the Joint Chief Nursing Officer. The Deputy Director/Lead Infection Prevention and Control Nurse, left the Trust at the end of October 2025. Supported by our integration ambitions, since November 2025 the Head of Infection Prevention and Control at Wirral Community Health & Care NHS Foundation Trust (WCHC) has supported the team as joint lead for WCHC and WUTH. The Deputy Chief Nurse at WCHC has also supported as joint Deputy DIPC for both organisations.

The Infection Prevention & Control Matron has managerial responsibility for the Infection Prevention & control team.

There have been other changes to the IPC nursing team during 2025-2026:

- at the end of June 2025 1x Band 6 returned to a clinical role within the Trust
- at the end of July 2025 1x Band 7 left the Trust for a promotion
- a Band 6 IPCN was successfully recruited to the vacant Band 7 post and started in September 2025
- at the end of December 1x Band 6 left the Trust for a promotion

There has been a delay in recruiting to the vacancies that has impacted on the IPC service and has been added to the risk register.

The IPC Team is budgeted for:

- 1x band 8a (1 WTE) Infection Prevention and Control Matron
- 3 x band 7 (2.8 WTE) Senior Infection Prevention Specialist Nurses.
- 2 x band 6 (2.0 WTE) Infection Prevention Specialist Nurses – vacancies
- 1 x band 4 (1.0 WTE) Secretary

Following the recruitment process, the band 6 posts will be filled at the end of April 2026.

3.2 Microbiology Clinical Team

The IPC team is supported by a Microbiology Team consisting of:

- 2 x WTE Consultant Microbiologists
- 2 x WTE Speciality Doctors
- 1.8 WTE Clinical Scientist

This is a reduction of 1 x WTE Consultant Microbiology (current vacancy) and 0.2 x WTE Clinical Scientist support. Temporary cover to fill this gap was provided by a 0.8 WTE Clinical Fellow.

Infection Control Doctor responsibilities were transferred to the 1 x WTE Clinical Scientist in June 2025.

Microbiology On-call Service

The out-of-hours consultant microbiologist service is shared between three Trusts, defined by an SLA, (with Chester and Warrington). This support is available on call from 5pm – 9am, and weekends and bank Holidays for Microbiology.

The on-call Consultant Microbiologist service does not provide standalone IPC advice unless related to aspects of care related to Microbiology advice.

3.3 The Infection Prevention and Control Team

The IPC Team was led by the Deputy DIPC up to October 2025, the Head of IPC for WCHC has supported since November 2025, and the Principal Clinical Scientist – Microbiology / Clinical Lead for Infection Prevention & Control provide the Infection Prevention & Control service to the Trust. The Deputy DIPC, with support from the IPC Matron and Head of IPC, is responsible for delivering the annual infection prevention & control plan including the annual audit programme. This is delegated responsibility from the DIPC, who reports to the Trust Board on behalf of the Infection Prevention and Control group.

3.4 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is an offsite Medical Microbiology Laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is based in Bromborough, Wirral. It provides a microbiology diagnostic service for WUTH, including a 24/7 out-of-hours service for urgent clinical samples. The service also provides screening for IPC organisms of interest including, MRSA (Meticillin resistant *Staphylococcus aureus*), VRE (Vancomycin resistant *Enterococci*) and CPE (Carbapenem producing *Enterobacterales*) either as part of WUTH screening strategy or in response to increased incidence and contact screening or outbreaks.

In addition, the Point of Care Testing (POCT) Team provides a diagnostic service for respiratory viruses such as Influenza and COVID-19 in the admission areas.

Off-site serological confirmatory and viral testing is also referred to Manchester Foundation Trust (MFT) as part of a Service level Agreement (SLA) or to UKHSA laboratories according to the National UKHSA network.

3.5 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**.

3.6 The Infection Prevention and Control Group

This group continues to meet monthly, and each Division provides appropriate representation. The group is chaired by the DIPC; the deputy chair is the Deputy DIPC. Its purpose is to provide assurance and escalation to the Trust Board via the Patient Safety and Quality Board (PSQB). The IPCG is authorised to approve IPC policies and to formulate recommendations for Infection Prevention and Control reporting these to PSQB via a monthly chairs report.

The Trust Infection Prevention & Control Group Terms of Reference can be found in **Appendix 2**. These are reviewed annually.

3.7 Departmental/Divisional Infection Prevention and Control groups

The following Divisions/Specialties meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG):

- Medicine/Acute Care
- General Surgery
- Perioperative Medicine (POM)
- Women's and Children's
- Diagnostics and Clinical Support

4 Reports to the Trust - Summary

Reports written and/or coordinated by the Deputy DIPC/ IPC Matron include:

- daily IPC update including outbreak and surveillance summary for the patient flow team, senior management, the nursing teams, and facilities detailing all patients with alert organisms including any areas under increased surveillance due to an increase in prevalence of any specific organism
- monthly IPC data summary of activities for the IPC divisional meetings and the IPCG
- monthly IPC chairs reports and updates for the PSQB
- annual Director of Infection Prevention & Control Report
- ad hoc updates in relation to the IPC Board Assurance Framework
- weekly Executive Team update for DIPC
- continence steering group chairs report to IPCG
- monthly integrated performance report
- quarterly CDT and Gram-negative report to IPCG
- monthly WISE IPC Audit Report

5 Budget Allocation to Infection Prevention

5.1 Microbiology and Laboratory Services

The medical microbiologists and the Laboratory are funded from the Pathology Division, which is within the Division of Diagnostics and Clinical Support.

5.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

5.3 The Infection Prevention and Control Nursing Team (IPT)

The IPC Team is funded from the Corporate Nursing budget and funds the nursing team along with any infection prevention initiatives identified during the year. This includes infection prevention signage, posters, study days and campaigns.

5.4 Investments in Infection Prevention at WUTH

In the year 2025-26 the Trust continued in its investment of:

- MRSA screening for all emergency admissions
- CPE and VRE screening for all Critical Care patients and patients admitted to the Trusts Haematology ward
- Hydrogen Peroxide Vapor (HPV) 'fogging' following incidences of CDI, COVID, VRE, CPE when capacity/patient flow allows
- reactive HPV programme when bed capacity/essential maintenance works allow
- EvaluClean – A simple system utilised by the IPC team that uses a UV marker which is invisible to the human eye to mark objects, following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process
- Adenosine Triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) by way of swabbing certain objects to determine if organic matter is detected to measure the effectiveness of cleaning
- increased cleaning in addition to the base line clean to support the increase in *C.difficile* infection

- disposable curtains throughout the Trust
- deployment of Air purifiers in collaboration with Facilities for patients diagnosed with COVID
- daily cleanliness monitoring checklists completed on Tendable by the cleanliness supervisory team
- use of skin disinfectant washes for all adult patients for the first 5 days of admission

6 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridioides difficile* (*C. difficile*) and in recent times COVID-19.

HCAIs pose a serious risk to patients, staff, and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS.

7 Surveillance/ Mandatory reporting

UK Health Security Agency's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections.

The monthly quality check of the mandatory data introduced in 2019 continues. The data is first quality checked by the IPC analyst and the IPC matron and then 'signed off' by the Deputy DIPC on behalf of the Chief Executive on the UKHSA data base.

Each individual alert organism has a senior review and lessons identified reported to the appropriate steering group, this is to ensure that annual plans include the identified themes and trends to ensure education and training promote improvement.

Carbapenemase producing *Enterobacteriaceae* (CPE), Vancomycin resistant Enterococci (VRE) COVID-19, Influenza, Norovirus and many other organisms are reported locally throughout the year.

7.1 *Staphylococcus aureus*

Staphylococcus aureus (Staph) is a type of bacterium (germ) commonly found on the skin and in the nose of about 30% of people. Most of the time staph does not cause us any harm, but it can sometimes cause infections. Staph infections can look like pimples, boils or other skin conditions. In healthcare settings Staph infections can be serious or fatal, leading to:

- blood stream infections or sepsis when bacteria get in the bloodstream
- pneumonia, which most often effects people with underlying lung disease, including those on mechanical ventilators
- endocarditis (infection of the heart valves) which can lead to heart failure or stroke
- osteomyelitis (bone infection) caused by Staph bacteria travelling in the blood stream or put there by contact such as trauma (puncture wound of the foot)

In healthcare, the risk of Staph infection is higher for patients:

- in intensive care units
- who have undergone certain types of surgeries
- with medical devices inserted into their bodies
- with weakened immunity

To reduce the risk patients can avoid sharing items that contact skin, such as towels, razors, toothbrushes and needles. Healthcare staff can reduce the risk by washing their hands, maintaining good environmental hygiene in and around the patient area and, if equipment is shared between patients, decontaminating it effectively in between uses.

Most Staph infections can be treated with antibiotics, however some Staph infections are resistant to certain antibiotics, for example Meticillin Resistant *Staphylococcus aureus* (MRSA).

7.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

Meticillin-resistant *Staphylococcus aureus* (MRSA) infections remain a serious cause of healthcare-associated infection globally. While the incidence is decreasing, this remains an important concern for IPC professionals.

The WUTH guidelines were reviewed in 2024 against national guidelines, and the decision was made to continue to complete screening for MRSA as per existing local policy, which was universal screening, and not to adopt targeted screening, using a risk assessment approach.

All patients who require an overnight stay regardless of their MRSA status are given a small bottle of the approved antiseptic skin wash and asked to wash/shower daily for the first 5 days of their admission, or until the bottle is finished, which must be used in accordance with the manufacturer's instructions. If MRSA screening results are reported as positive, they continue to use the skin wash until discharge, or at least for a minimum of 5 days after diagnosis.

Changes were implemented in CERNER so ward staff can record the daily skin washes to provide assurance that patients are receiving the wash for the first five days of the admission and as part of the decolonisation treatment.

7.3 Reporting and monitoring arrangements for MRSA bacteraemia

All laboratory reported incidences are entered into the UKHSA data capture system (HCAI DCS) and a Post Infection Review (PIR) is completed by the MDT. There is no longer a mandatory requirement to enter these PIR reports into the DCS reporting system unless requested by UKHSA if deemed to be a high outlier.

Completed PIR reports are available to be shared with the Integrated Care Board and discussed at their quality meetings.

Following a laboratory confirmed MRSA bacteraemia a multi-disciplinary team, ideally the patient's clinician, Microbiologist, Deputy DIPC/IPC Matron, Ward Matron, Ward Manager and Pharmacist meet to complete the investigation to determine the causative factors of the MRSA bacteraemia and identify any learning to support the development of a local action plan, it is the responsibility of the division to achieve the action plan.

7.4 The incidence of MRSA bacteraemia

In 2025/26 we have reported 2 MRSA bacteraemia (1 HOHA and 1 COHA), this is the same as the previous year.

SPC Chart 1 below provides a breakdown of **MRSA bacteraemia** by month.

SPC Chart 1

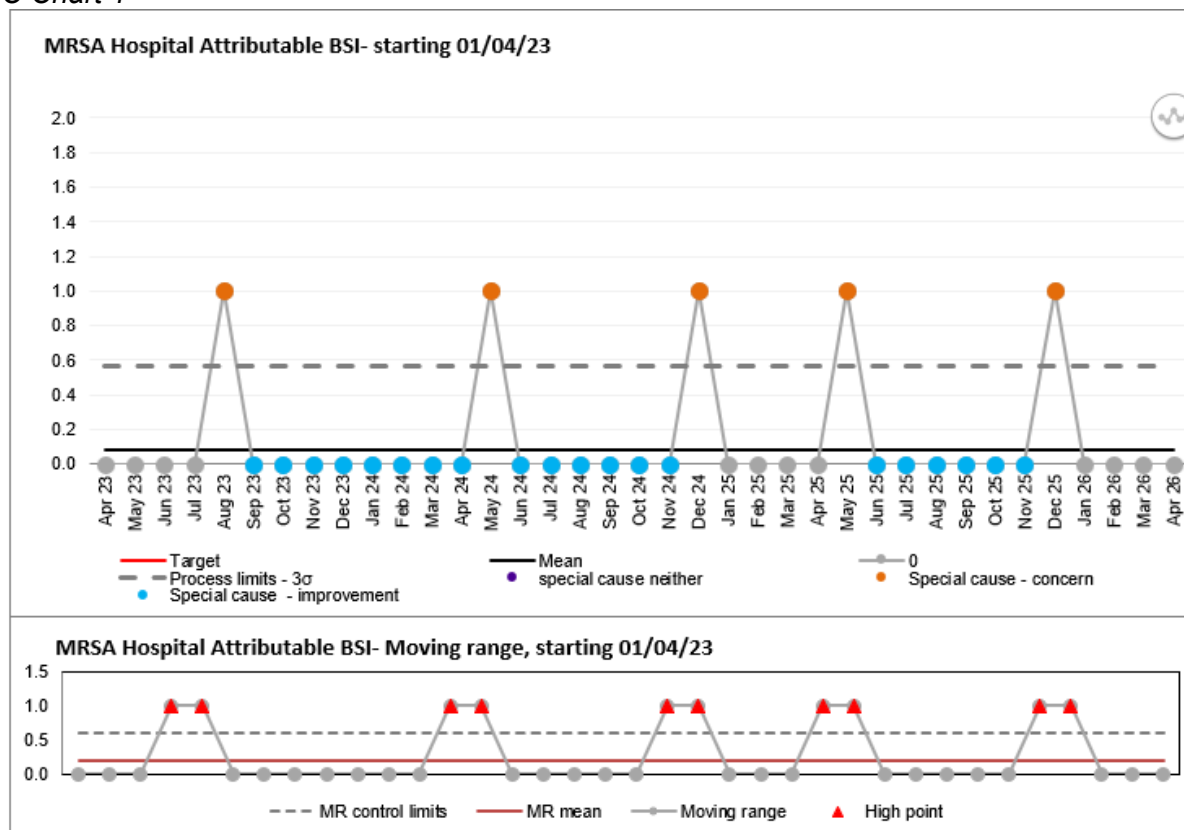


Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15.

Table 1

The incidence of MRSA Bacteraemia since 2020/21						
	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
CO-CA	0	3	0	2	1	3
CO-HA	0	0	1	0	1	1
HO-HA	2	2	2	1	1	1
Sub-ICB	2	5	3	3	3	5

Table 2 below provides a breakdown of Hospital Onset Healthcare Associated (HO-HA) and Community Onset Healthcare Associated (CO-HA) and Community Associated **MRSA bacteraemia** by month.

Table 2

Breakdown of MRSA cases in 2025/26													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HO-HA	0	0	0	0	0	0	0	0	1	0	0	0	1
CO-HA	0	1	0	0	0	0	0	0	0	0	0	0	1
Community Associated	0	0	1	1	0	0	0	1	0	0	0	0	3

7.5 Themes from Post Infection Review

The first MRSA bacteraemia was reported in May 2025, this was classed as Community Onset Healthcare Associated. The patient was known to have a history of MRSA and had attended the dialysis unit for an emergency renal line. The line was misplaced in the azygos vein and attempts to pull back were unsuccessful. The patient had an overnight stay in hospital and attended Interventional Radiology the following day for manipulation and was discharged home. Three days later the patient presented with an MRSA bloodstream infection. The source of the infection was deemed to be the renal line. The main learning was that the patient's MRSA status was not checked at the time of the line insertion, therefore prophylaxis was not considered. The renal LOCSSIP form has now been amended to include infection status.

The second MRSA bacteraemia was reported in December 2025, this was classed as Hospital Onset Healthcare Associated. The patient was admitted following a fall and was known to have a history of MRSA but was negative for MRSA on admission screening. They had multiple comorbidities and were initially treated for pneumonia and during the admission had haematuria, hyponatremia and bowel obstruction. Following investigation infective endocarditis and discitis were excluded, and the source of the bacteraemia remained unknown. The learning identified from the review included:

- skin washes not recorded for the first 5 days of admission
- MRSA alert not considered when starting antimicrobial treatment
- urinary catheter not changed when patient was diagnosed with a catheter associated urinary tract infection

Reviews were also undertaken for the three Community Onset Community Associated (COCA) MRSA bacteraemia reported in 2025-26 with WCHC IPC Team. Learning identified for WUTH, although did not contribute to the bacteraemia, were common to all three reviews, included:

- delay in blood culture collection
- missing MRSA alert
- delay in prescribing decolonisation treatment
- cannula insertion and removal not documented

7.6 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

MSSA affects people of all ages and has been known to cause outbreaks among sports teams, families, prison inmates and people who live and work in close quarters, such as military recruits. Treatment for these infections generally require antibiotics.

All laboratory reported incidences of MSSA bacteraemia are entered into the UKHSA data capture system (HCAI DCS) and a review is completed by the MDT.

There are no national or local objectives set against these at present and many are related to skin and soft tissue infections. WUTH remain a low outlier in the statistics table for 2025/26, this may be because all patients are given the antiseptic body wash on arrival into the trust which will help to eradicate Staph on the skin.

In 2025-26 we have reported 26 MSSA bacteraemia, this is an increase of 2 infections when compared to 2024-25.

Table 3 below provides a breakdown of **MSSA bacteraemia** by year and month since 2016/17.

Table 3

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18
2021/22	1	2	2	0	0	0	4	0	3	5	4	4	25
2022/23	2	1	4	2	5	2	4	2	1	2	2	5	32
2023/24	5	5	0	0	4	2	3	4	1	5	2	1	32
2024/25	3	2	0	1	3	2	1	2	3	0	5	2	24
2025/26	1	2	1	2	2	3	3	1	0	3	2	6	26

SPC Chart 2 below provides a breakdown of **MSSA bacteraemia** by month.

Chart 2

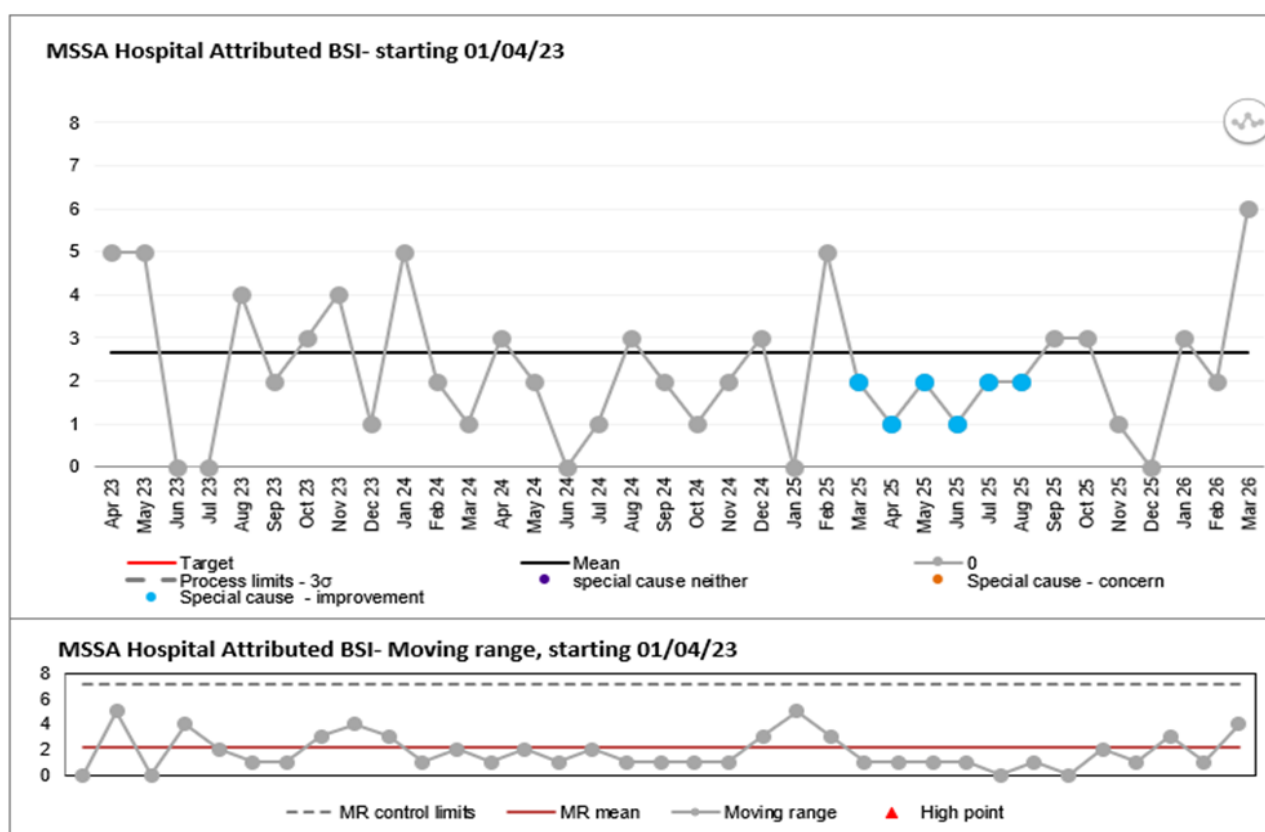


Table 4 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated **MSSA bacteraemia** by month.

Table 4

Breakdown of MSSA cases in 2025/26													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HO-HA	1	2	1	2	1	0	2	0	0	3	0	5	17
CO-HA	0	0	0	0	1	3	1	1	0	0	2	1	9
Community Associated	3	0	6	1	4	1	9	3	3	5	4	3	42

The source of the 17-hospital onset MSSA BSIs were identified as:

- 10 – vascular access
- 2 – unknown source
- 1 – infective endocarditis
- 1 – spinal abscess
- 1 – catheter associated
- 1 – underlying oral cancer
- 1 – skin

Themes identified from the rapid reviews included:

- cannula insertion and ongoing care is not always documented in CERNER
- no evidence of PICC line dressing change
- when lines are thought to be the source of the infection the line tips are not always sent to the lab to confirm line infection
- patients required multiple cannulas or had problems with poor access
- it was unknown if patients received antiseptic skin washes for the first 5 days of admission, as per Trust policy
- no evidence of daily review of urinary catheter
- aseptic Non-Touch Technique competencies unknown for staff inserting invasive devices or collecting blood cultures
- a peripheral set of blood cultures not collected when taken from a line, as per policy

7.7 *Clostridioides difficile* Infection (CDI)

Clostridioides difficile (*C.difficile*) is a bacterium found in the intestine. It can be present in healthy people and cause no symptoms; however, antibiotics can cause an imbalance of bacteria within the gut resulting in a proliferation of harmful bacteria and *C.difficile* infection. *Clostridioides difficile* infection (CDI) is highly infectious and will spread through contact with a contaminated environment or person and is estimated to cause 20 to 30% of antibiotic-associated diarrhoea. As a significant healthcare associated infection, multiple infection control measures and treatment modalities have been explored, and this remains an evolving field. Crucially, the management of severe CDI should be considered a medical emergency and urgently assessed and reviewed regularly to ensure that patients receive prompt and optimised care.

Prevention of CDI is based on the following principles:

- suspect that a patient may be infective if there is no clear alternative cause for diarrhoea
- prompt isolation in a single room, preferably with ensuite facilities
- wear gloves and apron for contact with the patient and their environment
- wash hands with soap and water, complying with bare below the elbows to ensure effective hand hygiene
- send a sample immediately to test for CDI and if positive start treatment
- keep the environment clean and clutter free

7.8 Reporting and Surveillance of *Clostridioides difficile*

Trusts are required under the NHS standard contract 2025-26 to minimise *C.difficile* infections so that they are no higher than the threshold levels set by NHS England. There were some key changes from the 2024-25 thresholds for 2025-26:

- in addition to trust thresholds, publication of thresholds at sub-ICB are included (previously published at ICB level)
- due to the increasing trends, the approach for each trust and sub-ICB is, their 2025-26 thresholds are the lower of:
 - their 2024-25 threshold; OR

- 10% decrease on 2024 calendar year cases a more ambitious threshold (for most trusts) of a 5% reduction for *C. difficile* (compared to one case count historically). This also improves the alignment between trust and ICB thresholds

i.e. whichever of the above options leads to threshold which reflects the largest reduction from their 2024 calendar year cases.

NHS acute providers use the case assignment definitions for healthcare associated infections:

- **hospital onset healthcare associated:** (HOHA) Specimen date is ≥ 3 days after the current admission date* (where day of admission is day 1)
- **community onset healthcare associated:** (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

* admission date refers to the date of admission to the reporting acute Trust, or where the patient was admitted via A&E (of the same reporting Trust), the decision to admit date.

Since April 2024 the date of admission has been classed as the date of the 'decision to admit', also patients on Virtual Wards are classed as the same as being an inpatient at the reporting Trust.

7.9 Local reporting for CDI in 2025-26

The national objective set for WUTH for healthcare associated *Clostridioides difficile* infections (CDI) this year was 103, which proved to be very challenging, having reported 141 infections, 38 over our objective, although this was 26 infections less than the previous year.

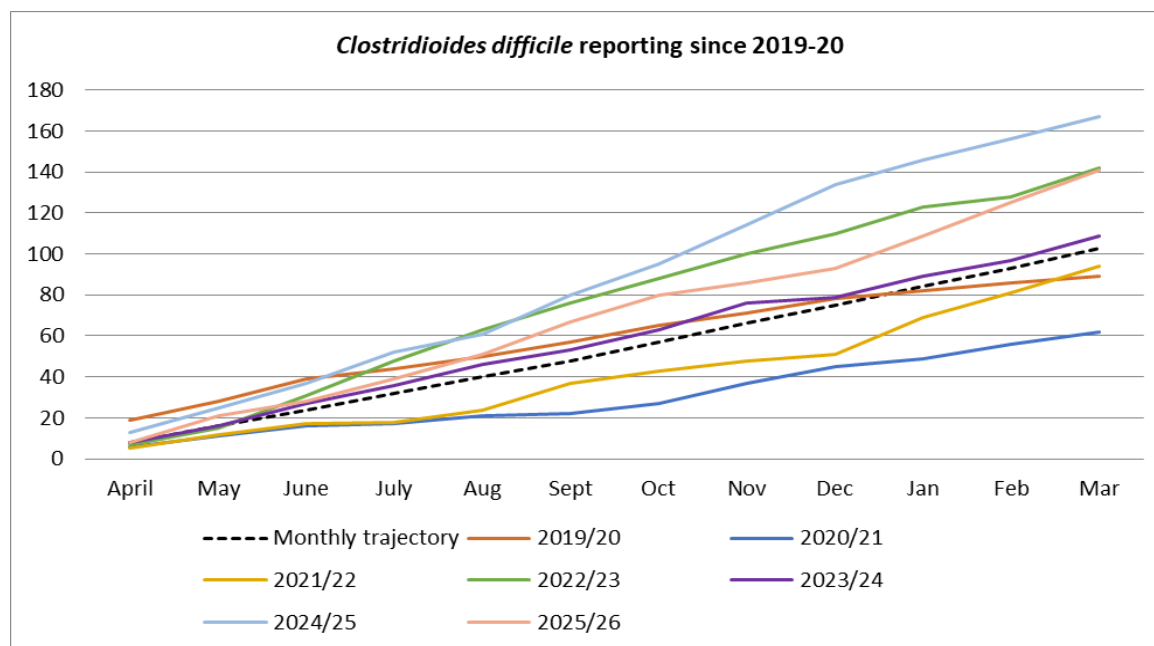
Table 5 below provides a breakdown of *Clostridioides difficile* by year and month.

Table 5

The incidence of <i>Clostridioides difficile</i> since 2019/20													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94
2022/23	7	8	16	17	15	13	12	12	10	13	5	14	142
2023/24	8	8	11	9	10	7	10	13	3	10	8	12	109
2024/25	13	12	12	15	9	19	15	19	20	12	10	11	167
2025/26	8	13	7	11	12	16	13	6	7	16	16	16	141

Graph 1 below provides *Clostridioides difficile* reported infections since 2019-20 and annual trajectory.

Graph 1



SPC Chart 3 below provides a breakdown of ***Clostridioides difficile* infections (CDI)** by month.

Chart 3

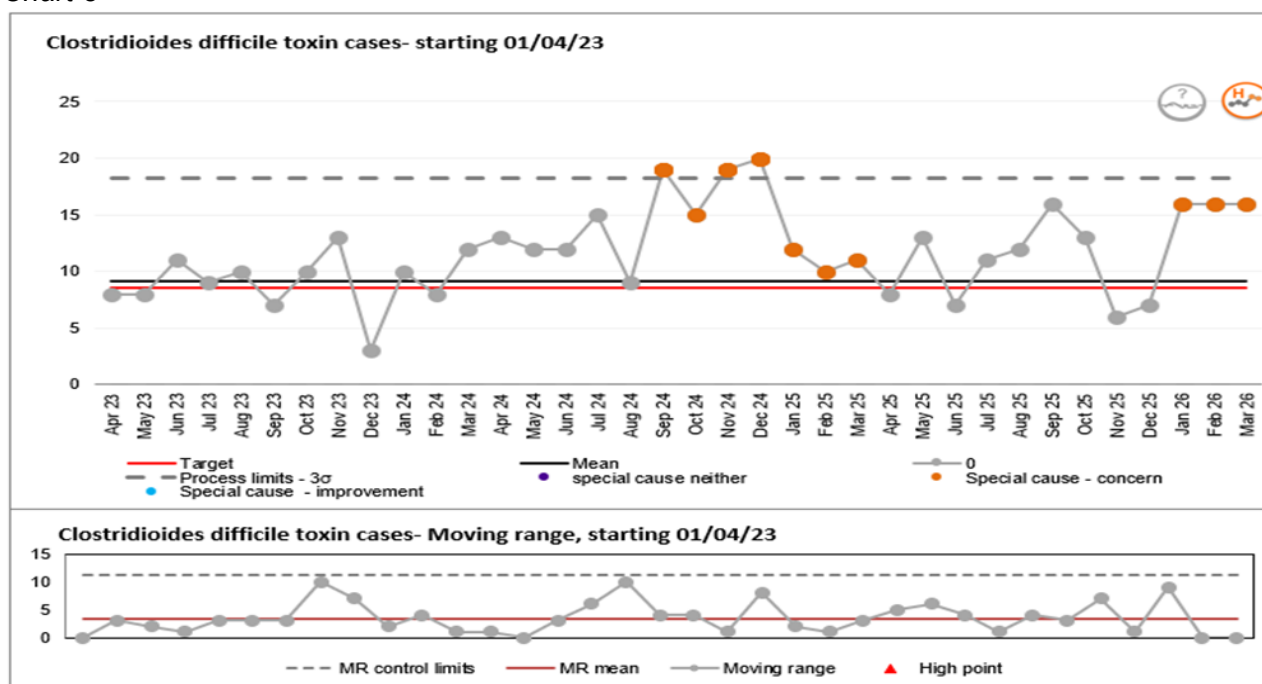


Table 6 below provides a breakdown of Hospital Onset Healthcare Associated (HO-HA), Community Onset Healthcare Associated (CO-HA), Community Onset Indeterminate Association (CO-IA), Community Onset Community Associated (CO-CA), *Clostridioides difficile* infections (CDI) by month.

Table 6

Breakdown of <i>Clostridioides difficile</i> cases in 2025/26													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HO-HA	5	11	3	8	7	6	9	5	5	14	14	10	97
CO-HA	3	2	4	3	5	10	4	1	2	2	2	6	44
CO-IA	3	3	1	4	1	1	1	2	0	1	2	0	19
CO-CA	0	3	2	3	0	1	6	7	2	2	5	6	37

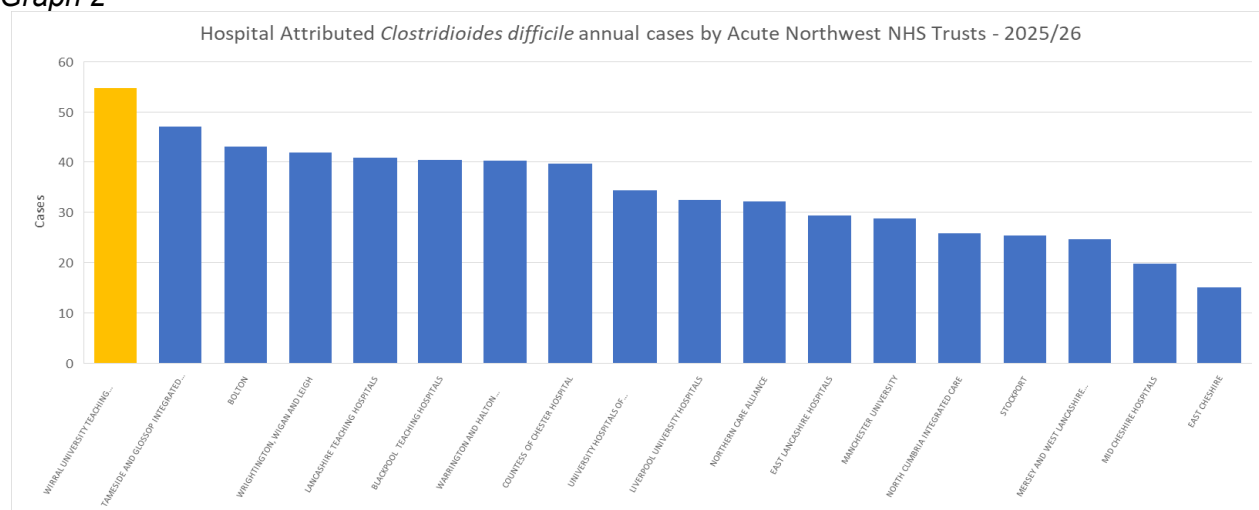
Table 7 below shows *C.difficile* by Trust for Cheshire and Merseyside: Quarterly counts and rates . Healthcare associated cases (Hospital onset and community onset).

Table 7

Organisation Name	Counts				Rate per 100,000 bed days			
	Apr-Jun 2025	Jul-Sep 2025	Oct-Dec 2025	Jan-Mar 2026	Apr-Jun 2025	Jul-Sep 2025	Oct-Dec 2025	Jan-Mar 2026
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10	8	1	0	73.8	56.8	7.4	0.0
COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	17	13	19	18	40.3	31.0	45.2	42.8
EAST CHESHIRE NHS TRUST	8	3	4	1	29.8	11.5	15.2	3.8
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0	4	0	0.0	0.0	31.5	0.0
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	44	52	34	46	32.1	38.7	25.4	34.3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	1	0	1	0.0	15.3	0.0	14.7
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	27	31	25	26	24.5	28.0	22.6	23.5
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	13	10	5	6	31.0	23.5	11.5	13.8
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	7	7	2	36.6	91.7	91.7	26.2
THE WALTON CENTRE NHS FOUNDATION TRUST	6	2	5	3	46.1	17.5	46.9	28.1
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	19	25	13	24	37.8	52.2	25.4	46.9
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	28	39	26	48	44.0	60.3	40.3	74.4
Cheshire & Merseyside	175	191	143	175	33.2	36.6	27.3	33.4

Graph 2 below shows hospital attributed *Clostridioides difficile* rates per 100,00 bed days by Acute Northwest NHS Trusts. The yellow bar illustrates WUTH data.

Graph 2



7.10 Incidence of *Clostridioides difficile* Toxin (CDT) and Equivocal Cases

The diagnosis of CDI is based on a combination of laboratory and clinical findings. It is defined by the presence of diarrhoea (with no other underlying cause), together with the direct detection of either *C.difficile* toxin or detection of the *C.difficile* toxin gene (by PCR), through laboratory testing of the stool. Samples in which the *C.difficile* toxin gene only is detected are categorised as 'Equivocal', whereas samples in which direct *C.difficile* toxin is detected are described as 'toxin positive'. Table 8 below shows the total number of Equivocal and Toxin positive cases.

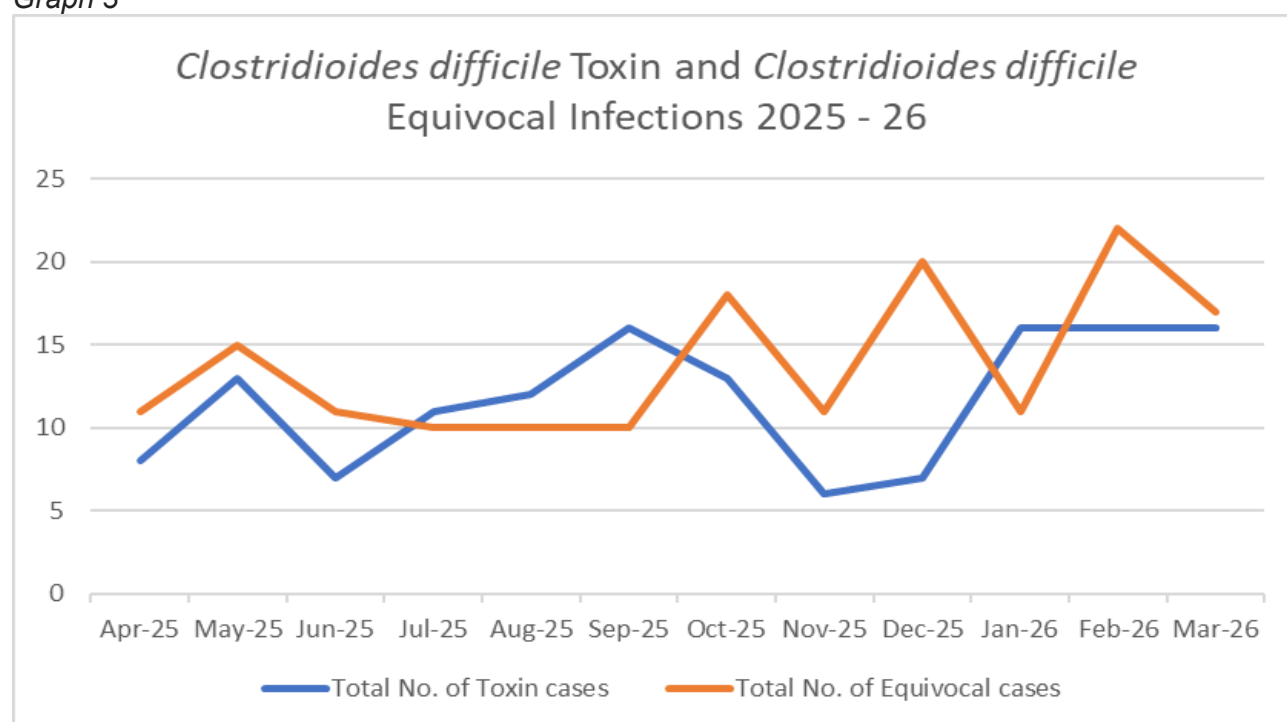
Table 8

Month 2025/26	Total No. of Toxin cases	Total No. of Equivocal cases	Total No. of Toxin and Equivocal
Apr-25	8	11	19
May-25	13	15	28
Jun-25	7	11	18
Jul-25	11	10	21
Aug-25	12	10	22
Sep-25	16	10	26
Oct-25	13	18	31
Nov-25	6	11	17
Dec-25	7	20	27
Jan-26	16	11	27
Feb-26	16	22	38
Mar-26	16	17	33
Total	141	166	307

It is important to understand that both 'equivocal' and 'toxin positive' cases contribute to the bioburden of *C.difficile* spores contaminating the healthcare environment. These may be transmitted from patient to patient through shared equipment and facilities or by healthcare workers' hands. Symptomatic patients with either equivocal or toxin positive results are managed the same with patient isolation, antimicrobial treatment and enhanced environmental cleaning.

Graph 3 shows Toxin versus Equivocal results.

Graph 3



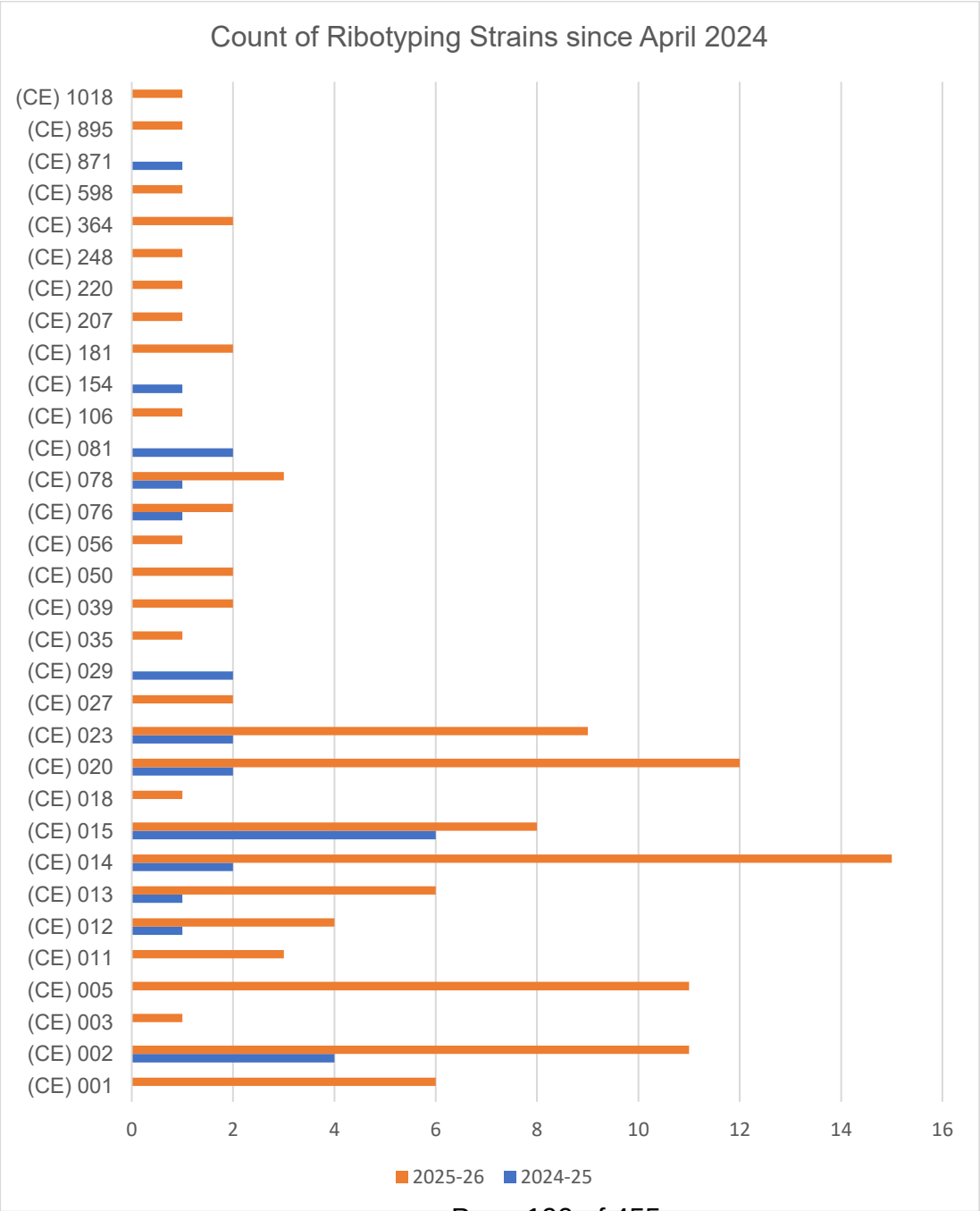
7.11 Molecular typing

Molecular typing is an important infection control tool to monitor the prevalence of certain strains within a healthcare institution or to investigate if a cluster of infections are unrelated or part of an outbreak. Currently, if *C.difficile* clusters are identified by the IPC team, samples are selected for ribotyping through the *C.difficile* Ribotyping Network (CDRN).

Since April 2025 the *C.difficile* Ribotyping Network (CDRN) have been developing a Whole Genome Sequencing (WGS) program for *C.difficile* which provides more detailed distinction between different organisms and helps monitor transmission and inter hospital spread. WUTH were selected as a sentinel site and are participating by submitting the first 10 toxin positive samples each month and this runs alongside routine requests for ribotyping.

Graph 4 below provides a comparison of *C.difficile* ribotyping results between 2024-25 and 2025-26, showing a broad distribution of ribotypes in both years. It must be noted that as 'ribotype' is also included in the new scheme, this is reflected in the greater numbers of ribotypes reported for 2025-26. The WGS data is not included in this report, however when the full years data is received, this will enable deeper analysis with more granular details allowing identification of possible clusters or outbreaks of CDI.

Graph 4



The Whole Genome Sequence data received from UKHSA is due to be reviewed to provide more granular details of possible clusters or outbreaks of CDI.

7.12 Themes from CDI patient safety investigations

Of the completed reviews in 2025-26 whilst no two patients' journeys are the same, some common themes continued to emerge, including:

- missed opportunities to obtain a sample
- overlap of care with other patient(s) diagnosed with CDT or CDE
- broad spectrum antimicrobial usage, particularly Co-amoxiclav
- previously known CDT/CDE
- delay in isolating people, with only a fifth of patients being isolated in a single room with ensuite facilities

7.13 Gram-negative bloodstream infections (BSIs)

Gram-negative bloodstream infections (GNBSIs) are serious infections resulting from bacterial dissemination into the bloodstream and are associated with an increased risk of sepsis and mortality.

In 2011 it was mandatory for all Acute NHS trusts to report all incidence of *Escherichia coli* bacteraemia onto the Data Capture System (DCS) and in 2017 it became mandatory to also report *Klebsiella spp.* and *Pseudomonas aeruginosa* bacteraemia.

Under the NHS Standard Contract 2025-26 Trusts are required to minimise rates of GNBSIs so that they are no higher than the threshold levels set by NHS England.

Due to the increasing trends, the approach for each Trust is, the 2025-26 thresholds are the lower of:

- the Trust's 2024-25 thresholds

OR

- 10% decrease on 2024 calendar year cases

i.e. whichever of the above options leads to a threshold which reflects the largest reduction from their 2024 calendar year cases.

NHS acute providers use the case assignment definitions for healthcare associated infections:

- **hospital onset healthcare associated:** (HOHA) Specimen date is ≥ 3 days after the current admission date* (where day of admission is day 1)
- **community onset healthcare associated:** (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

* admission date refers to the date of admission to the reporting acute Trust, or where the patient was admitted via A&E (of the same reporting Trust), the decision to admit date.

Since April 2024 the date of admission has been classed as the date of the 'decision to admit', also patients on Virtual Wards are classed as the same as being an inpatient at the reporting Trust.

E.coli

Escherichia coli (*E.coli*) bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E.coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. *E.coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E.coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

Community associated *E.coli* bacteraemia are most frequently the result of urinary tract infections in older adults, while hospitalised patients are more likely to develop bacteraemia because of lower respiratory tract infection, UTI or surgical site infections. *Escherichia coli* causes more than one-third of the bacteraemia cases in England each year, and the incidence of these infections is increasing.

Table 9 below provides a breakdown of hospital associated ***E.coli* bacteraemia** by month against the trajectory.

Table 9

<i>E.coli</i> bacteraemia													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Threshold 2025/26	85												
2025/26	9	9	7	6	11	10	7	6	13	13	8	10	109
2024/25	4	12	6	7	10	10	12	7	11	5	3	9	96
2023/24	8	5	6	8	13	7	6	4	5	13	7	8	90
2022/23	8	4	9	12	10	6	5	5	11	5	6	8	89
2021/22	4	4	7	3	3	5	4	4	6	5	6	8	59

In 2025/26 we have reported 109 *E.coli* bacteraemia which is 24 infections over our annual threshold. This is also an increase of 13 infections when compared to 2024/25.

Graph 5 below provides ***E.coli* bacteraemia** reported infections by month against the trajectory, showing comparison with previous years.

Graph 5

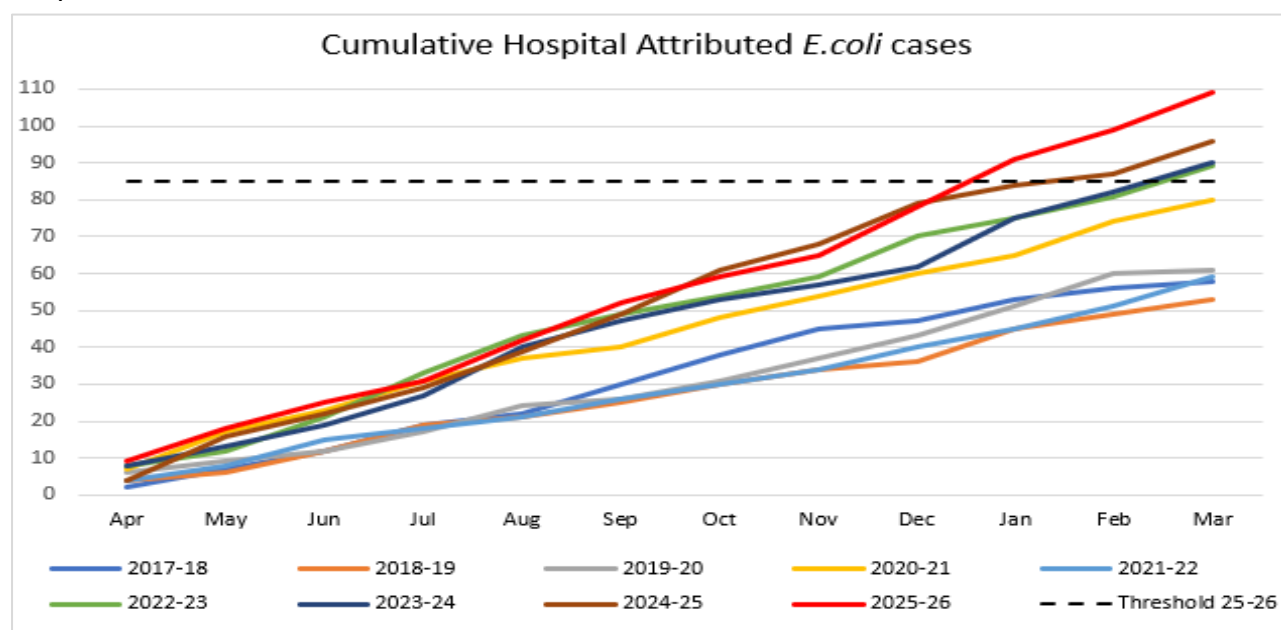


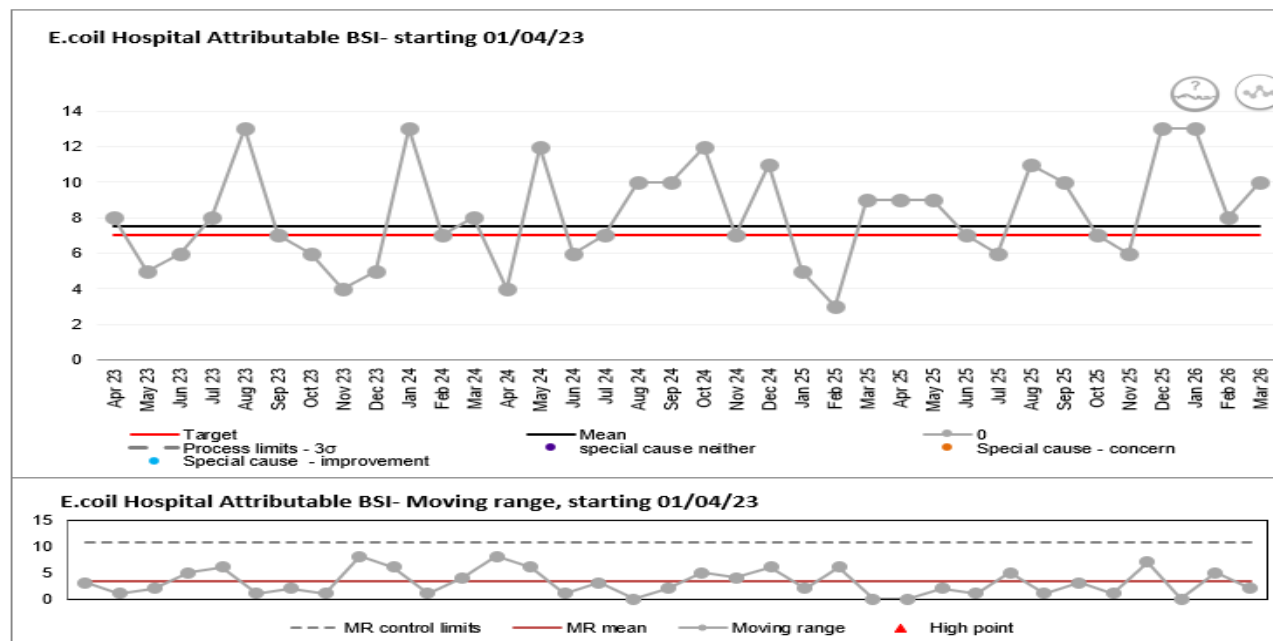
Table 10 below table provides a breakdown of Hospital Onset Healthcare Associated, Community onset Healthcare Associated and Community Associated ***E.coli* bacteraemia** by month.

Table 10

Breakdown of E.coli cases in 2025/26													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HO-HA	4	4	2	4	9	5	0	4	7	5	6	2	52
CO-HA	5	5	5	2	2	5	7	2	6	8	2	8	57
Community Associated	11	19	15	15	23	13	13	18	6	11	14	10	168

SPC chart 4 below provides a breakdown of *E.coli* bacteraemia by month.

Chart 4



Suspected source of hospital onset *E.coli* BSIs:

- 13 – Catheter Associated Urinary Tract Infections (CAUTI)
- 18 – hepatobiliary / intraabdominal
- 8 – UTI, not catheter related
- 4 – unknown source
- 3 – Pyelonephritis
- 2 – wounds / abscesses
- 1 – Nephrostomy
- 2 – Respiratory
- 1 – post-op procedures

Klebsiella

Klebsiella bacteria are normally found in the human intestines and faeces (where they do not cause disease). In healthcare settings, *Klebsiella* infections commonly occur among sick patients who are receiving treatment for other conditions. Patients whose care require devices like ventilators (breathing machines) or intravenous (vein) catheters, and patients who are taking long courses of certain antibiotics are most at risk for *Klebsiella* infections. Healthy people do not usually get *Klebsiella* infections.

Table 11 below provides a breakdown of healthcare associated ***Klebsiella* bacteraemia** by month against the trajectory.

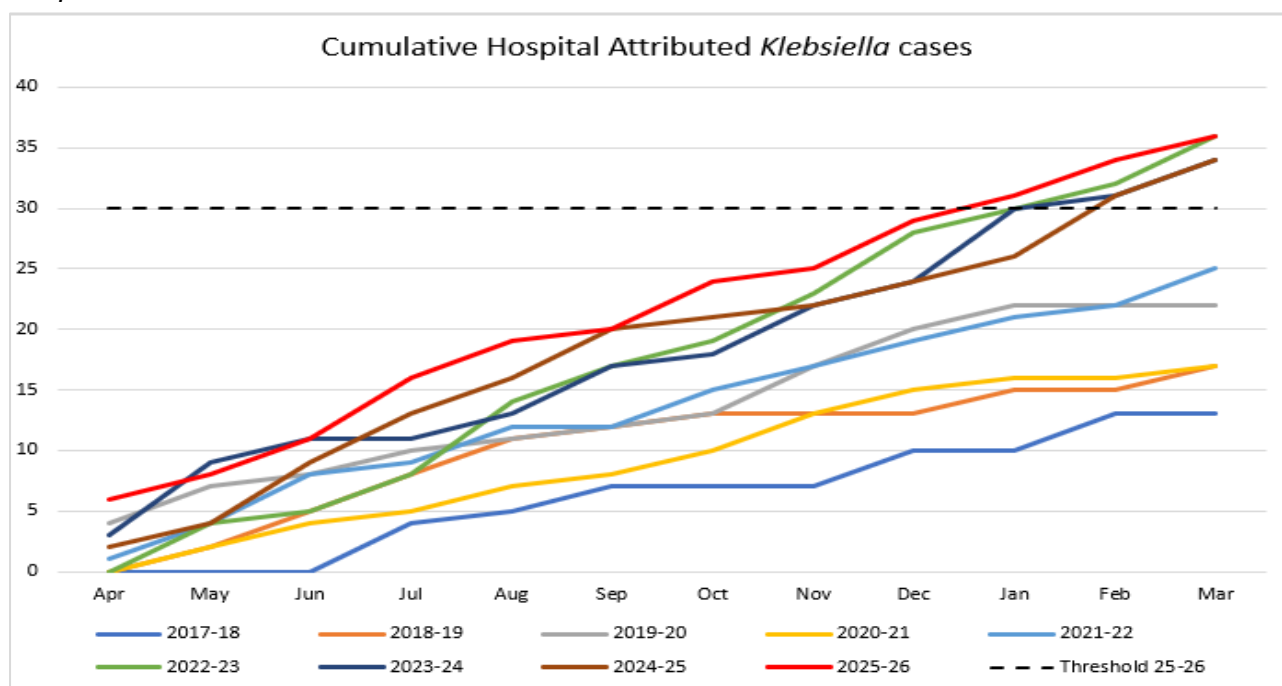
Table 11

<i>Klebsiella</i> bacteraemia													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Threshold 2025/26	30												
2025/26	6	2	3	5	3	1	4	1	4	2	3	2	36
2024/25	2	2	5	4	3	4	1	1	2	2	5	3	34
2023/24	3	6	2	0	2	4	1	4	2	6	1	3	34
2022/23	0	4	1	3	6	3	2	4	5	2	2	4	36
2021/22	1	3	4	1	3	0	3	2	2	2	1	3	25

In 2025-26 we have reported 36 *Klebsiella* bacteraemia, which is 6 infections over our annual threshold. This is also an increase of 2 infections when compared to 2024-25.

Graph 6 below provides ***Klebsiella* bacteraemia** reported infections by month against the trajectory.

Graph 6



SPC chart 5 below provides a breakdown of ***Klebsiella* bacteraemia** by month.

Chart 5

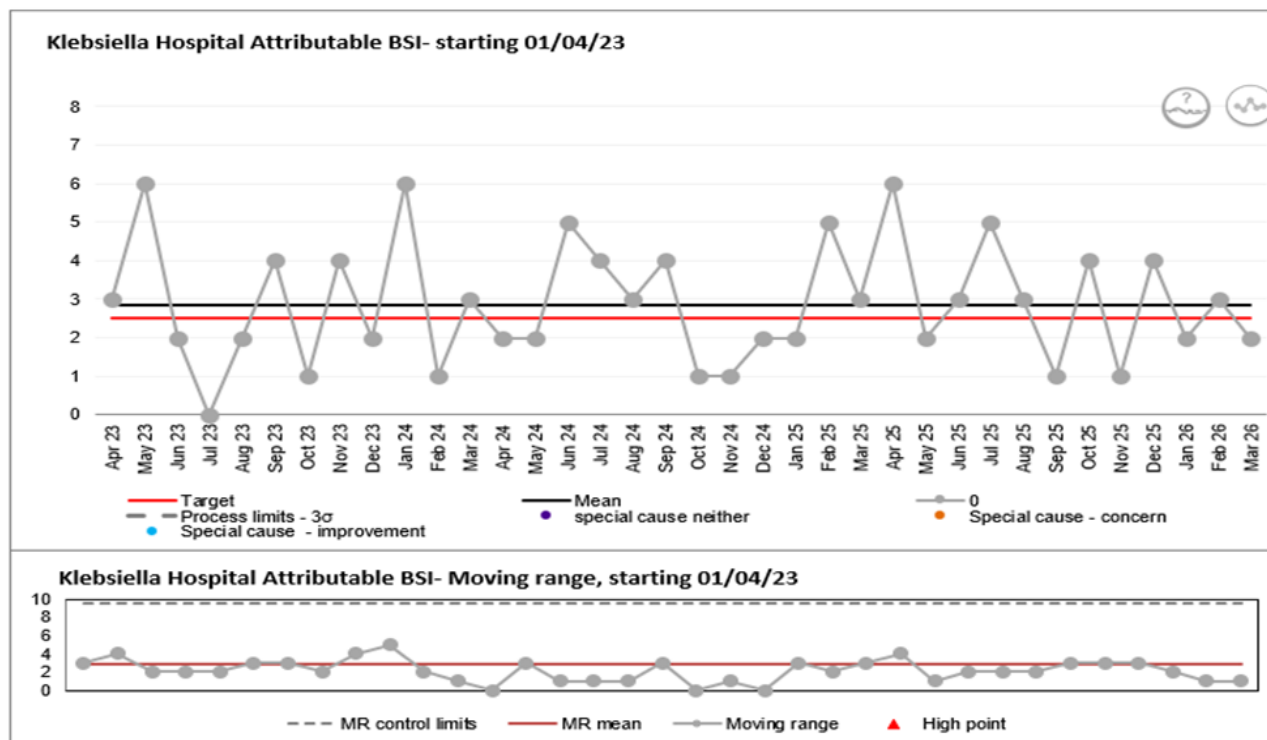


Table 12 below provides a breakdown of Hospital-onset healthcare associated, Community-onset healthcare associated and Community associated *Klebsiella bacteraemia* by month.

Table 12

Breakdown of Klebsiella cases in 2025/26													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HO-HA	5	0	2	4	3	0	1	1	2	0	3	0	21
CO-HA	1	2	1	1	0	1	3	0	2	2	0	2	15
Community Associated	2	7	5	2	4	3	3	4	3	6	2	1	42

Suspected Source of Hospital onset *Klebsiella* BSIs:

- 10 – hepatobiliary / intra-abdominal
- 6 – CAUTI
- 2 – Vascular access devices
- 2 – unknown source
- 1 – UTI, not catheter related

Pseudomonas

Pseudomonas aeruginosa is a bacterium commonly found in the environment, particularly in moist areas and water sources. It can also be found in soil and on plants and vegetables. While it is widespread, it rarely causes illness in healthy individuals. However, it is an opportunistic pathogen and can cause infections in people with weakened immune systems such as those in hospital or with conditions like cystic fibrosis. Resistant strains of the germ can also spread in healthcare settings from one person to another through contaminated hands, equipment, or surfaces.

Table 13 below provides a breakdown of hospital associated *Pseudomonas bacteraemia* by month against the trajectory.

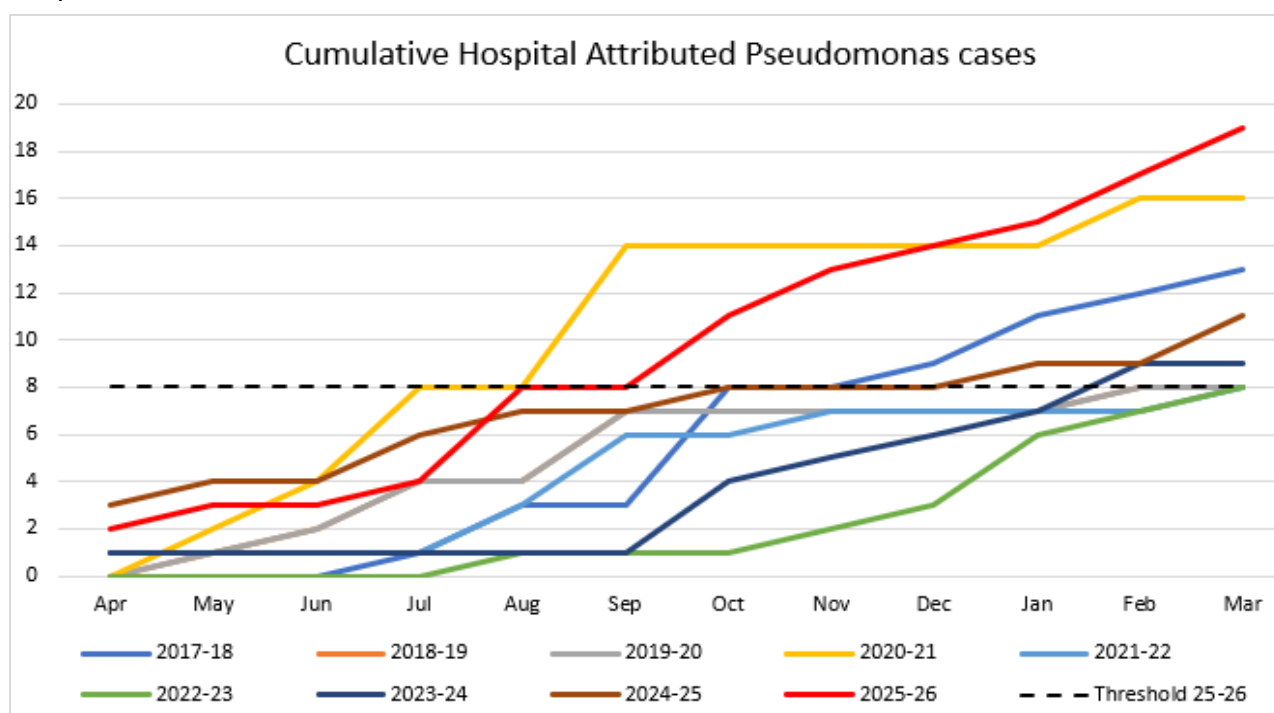
Table 13

<i>Pseudomonas bacteraemia</i>													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Threshold 2025/26	8												
2025/26	2	1	0	1	4	0	3	2	1	1	2	2	19
2024/25	3	1	0	2	1	0	1	0	0	1	0	2	11
2023/24	1	0	0	0	0	0	3	1	1	1	2	0	9
2022/23	0	0	0	0	1	0	0	1	1	3	1	1	8
2021/22	1	0	0	0	2	3	0	1	0	0	0	1	8

In 2025/26 we have reported 19 *Pseudomonas bacteraemia* by month end March which is 11 infections over annual threshold. This is also an increase of 8 infection when compared to 2024/25.

Graph 7 below provides *Pseudomonas bacteraemia* reported infections by month against the trajectory.

Graph 7



SPC chart 6 below provides a breakdown of ***Pseudomonas bacteraemia*** by month.

Chart 6

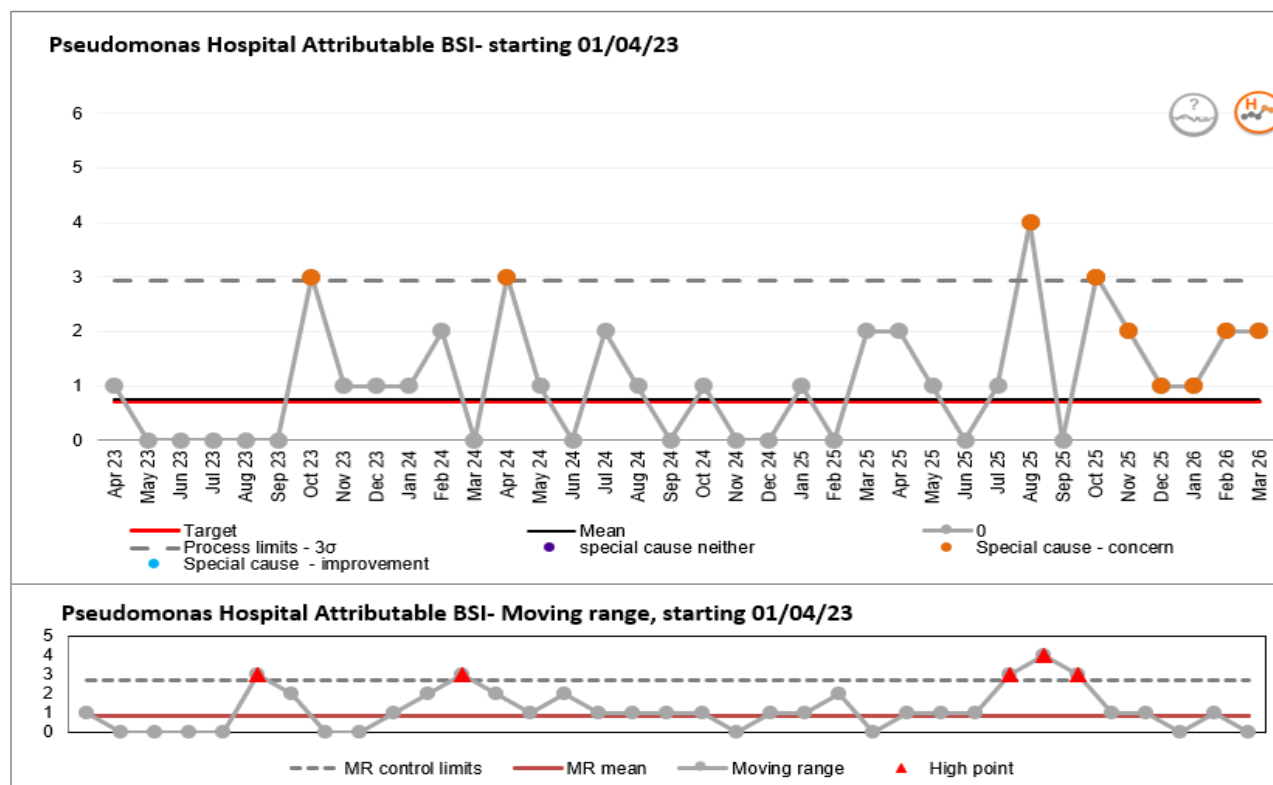


Table 14 below provides a breakdown of Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA) and Community associated *Pseudomonas* bacteraemia by month.

Table 14

Breakdown of Pseudomonas cases in 2025/26													
Incidence	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
HO-HA	1	0	0	1	2	0	1	1	0	0	0	2	8
CO-HA	1	1	0	0	2	0	2	1	1	1	2	0	11
Community Associated	1	0	4	0	2	0	0	0	1	0	1	1	10

Suspected Source of Hospital onset *Pseudomonas* BSIs:

- 5 – CAUTI
- 2 – intra-abdominal
- 1 – unknown

7.14 Themes from gram negative blood stream infections (GNBSIs) reviews

An initial rapid review of all hospital onset gram negative BSIs is undertaken by IPC and Microbiology to determine an initial source and if it requires further investigation, as often these bacteraemia are unavoidable due to the complexities of the patient. A review is recommended if the source is considered to be linked to either urinary catheter, intravascular device, chronic wounds, surgical or tracheostomy site infection, ventilator associated pneumonia, or if focus of infection is unknown.

A quarterly report is provided to IPCG to provide an update on GNBSI figures, how we compare regionally and what themes have been identified.

Of the completed reviews in 2025-26 whilst no two patients' journeys are the same, some common themes continued to emerge, including:

- insertion and ongoing care of invasive devices not clearly documented
- appropriate samples not collected when infection suspected, including urine samples
- previous specimen sensitivities not considered when prescribing antimicrobials
- hydration of patients not being considered, especially in patients who are prone to UTIs

7.15 Carbapenemase-producing *Enterobacteriaceae* (CPE)

The spread of antibiotic resistance in gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are responsible for some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

Table 15 below provides a breakdown of all hospital associated CPE **bacteraemia** by year and month. There were no reported CPE bacteraemia in 2025-26.

Table 15

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1
2021/22	0	0	0	0	0	0	0	1	0	0	0	0	1
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0
2024/25	0	0	0	0	0	0	0	0	0	0	0	0	0
2025/26	0	0	0	0	0	0	0	0	0	0	0	0	0

In April 2025 a gap analysis of the UKHSA guidance – Actions to contain CPE (2023), was undertaken by the WUTH ICD and IPCT which identified that screening of all admissions who have had a previous admission to any hospital (UK or abroad) in the last 12 months has not been implemented, as recommended in the guidance. This remains a gap and will be escalated in 2026-27.

Routine screening for CPE is only routinely undertaken on Ward 30 (Haematology) and Critical Care, on admission to the area and weekly. In other areas only patients with a CPE alert or have been identified as current contact of a CPE positive patient, are screened for CPE.

There is currently no data collected for patients who have tested positive for CPE from clinical sites.

Further review of the Trust CPE Guidance is required in 2026-27.

7.16 Mandatory Glycopeptide resistant *Enterococci* (VRE) bacteraemia

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.

There has been no incidence of VRE bacteraemia reported at WUTH during the period 2025-26. Unlike other organisms under mandatory surveillance, UKHSA employs a reporting year which runs

from October–September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

Table 16 below provides a breakdown of all hospital associated VRE **bacteremia** by month.

Table 16

The incidence of VRE bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	1	0	1	0	1	1	0	0	1	0	5
2020/21	1	0	0	0	0	0	0	0	0	0	0	0	1
2021/22	0	2	0	0	0	1	0	1	0	0	0	0	4
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0
2024/25	0	0	0	0	0	0	0	0	0	0	0	0	0
2025/26	0	0	0	0	0	0	0	0	0	0	0	0	0

7.17 Quarterly Mandatory Laboratory Reporting (QMLR)

It is mandatory to submit 'Quarterly Mandatory Laboratory Reporting' data via the UKHSA Health Care Associated Infection (HCAI) Data Capture System. This has been completed throughout the year by the Clinical Microbiology Team.

This data includes:

- total number of blood culture sets examined
- total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- total number of positive blood culture sets
- total number of *S. aureus* positive blood culture sets
- total number of *Clostridioides difficile* toxin positive reports in people aged 2 - 64 years.
- total number of *Clostridioides difficile* toxin positive reports results in people aged ≥ 65 years
- total number of stool specimens tested for diagnosis of *C. difficile* infection
- total number of stool specimens examined
- total number of faecal specimens and rectal swabs taken for Carbapenemase-producing *Enterobacteriaceae* (CPE) screening

Table 17 below provides the annual figures submitted for the previous 2 years:

Table 17

QMLR Category reported	2024-25	2025-26
Total BC examined	12452	12120
Total VRE positive blood cultures	4	3
Total positive blood cultures	1301	1328
Total <i>St. aureus</i> positive blood cultures	85	78
Total <i>C. difficile</i> reports 2-64 yrs (de-duplicate if <28 days apart)	51	41
Total <i>C. difficile</i> reports >65yrs (de-duplicate if <28 days apart)	146	106
Total stool samples tested for <i>C. difficile</i>	6333	5999
Total stool samples examined	12899	12205
Total screens for CPE	4891	5082

7.18 SARS-CoV-2 (COVID-19)

The Government's aim throughout the COVID-19 pandemic was to protect the lives and livelihoods of citizens across the United Kingdom (UK).

The emergence of new variants has been a significant factor in determining the path of the virus as new variants of COVID-19 continue to emerge. Living with and managing the virus like any other respiratory virus will maintain the population's wall of protection, continuing to communicate safer behaviors that the public can follow will also help to manage the risks. There remained a steady influx of patients identified with COVID-19 throughout the year with most as can be seen in table 18 below being detected shortly after admission.

Table 18

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month	1-2 days	3-7 days	8-14 days	15+ days	
Apr-25	19	0	4	9	32
May-25	19	4	3	5	31
Jun-25	23	2	6	13	44
Jul-25	19	2	2	0	23
Aug-25	35	1	1	1	38
Sep-25	55	6	3	11	75
Oct-25	41	4	5	4	54
Nov-25	20	4	2	8	34
Dec-25	23	3	1	1	28
Jan-26	13	2	10	20	45
Feb-26	13	0	2	0	15
Mar-26	14	3	2	3	22
Total	294	31	41	75	441

Graph 8 below shows the incidence of patient COVID-19 results in 2025-2026.

Graph 8

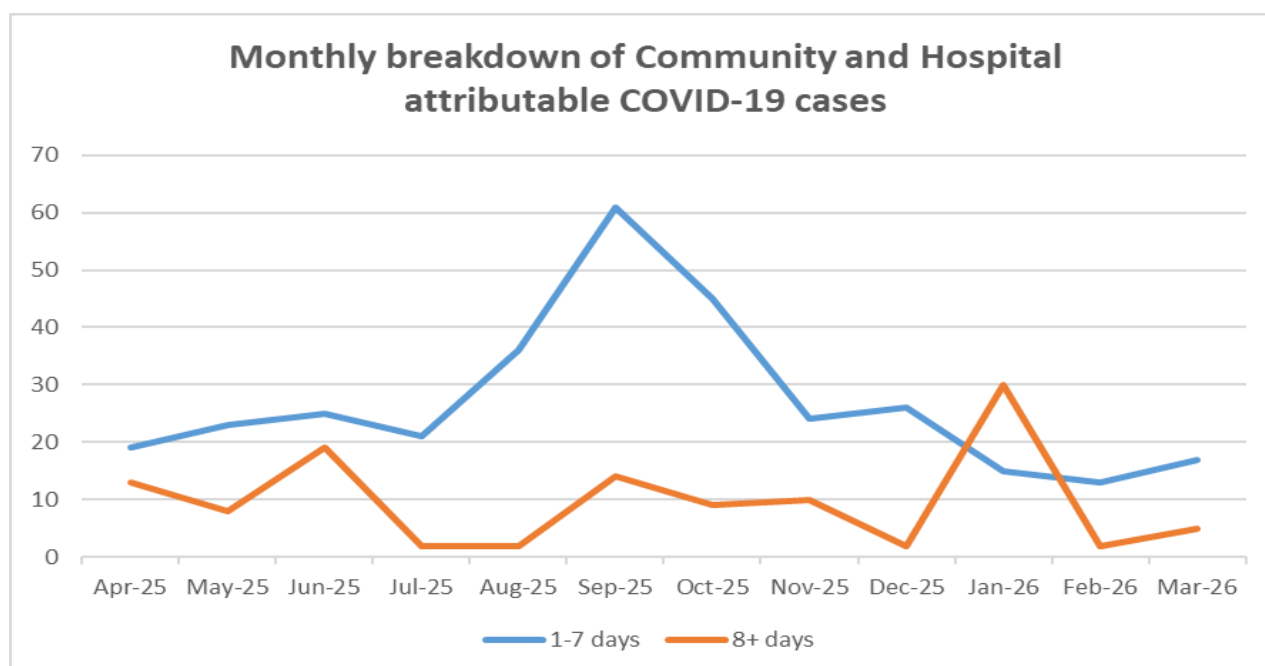
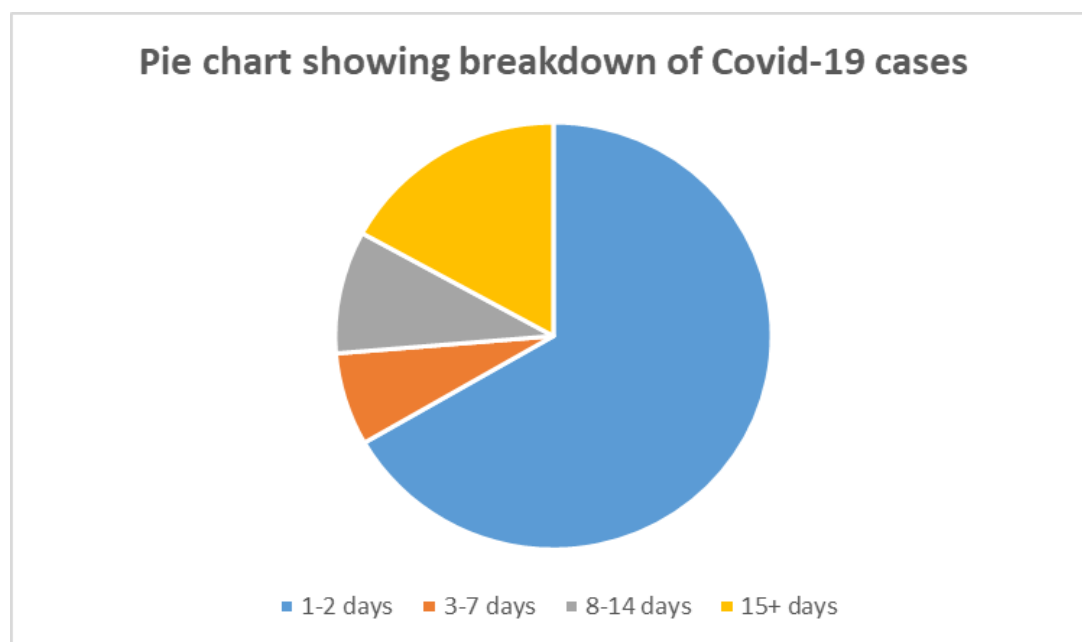


Chart 7 below provides a breakdown of COVID-19 in 2025-2026.

Chart 7



7.19 Seasonal Influenza

WUTH participates in the Unify2 influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU). Table 19 below shows the summary of Influenza Cases in Augmented care areas reported through Unify2 Surveillance Scheme since 2019-2020.

Table 19

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
2019/20	3	4	3	0	0
2020/21	0	0	0	0	0
2021/22	0	0	0	0	0
2022/23	2	2	12	0	0
2023/24	1	5	4	0	0
2024/25	3	0	5	1	0
2025/26	0	1	4	0	0

Throughout the rest of the Trust there were 358 positive flu patients admitted in 2025/26, compared with 493 the previous year. There were 352 Flu A positives, 1 Flu A & B, and 5 Flu B positives. Some cases were an incidental finding due to the type of test that was performed for COVID-19; as can be seen above 5 patients required level two and level three care settings (ICU and HDU).

7.20 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to UKHSA comprising of at least one quarter per year for one orthopaedic category as a minimum. Throughout the year the Trust has been completing and submitting results of ongoing mandatory surveillance every quarter for:

Orthopaedic

- *hip replacement* - Replacement of the hip joint including resurfacing of the joint, acetabulum replacement and revision of previous replacement and conversion from a previous hemiarthroplasty or bone fixation.

Throughout the year the Trust has been completing local surveillance, not reported externally, for:

Colorectal

- *large bowel* - Incision, excision, or anastomosis of the large bowel, including procedures which involve anastomosis of small to large bowel.

Table 20 below identifies the number of SSI reported.

Table 20

Category	Apr-Jun 25		Jul-Sept 25		Oct-Dec 25		Jan-Mar 26	
	Total operations	SSI reported	Total operations	SSI reported	Total operations	SSI reported	Total operations	SSI reported
MANDATORY Hip replacement	115	0	130	3	41	0	129	0
LOCAL Large Bowel	48	4	52	4	55	6	59	3

All suspected SSIs are reviewed by the weekly multidisciplinary team, comprising of IPC, Microbiology, SSI nurse, Clinician and Matron to agree if it is a confirmed SSI and identify learning and agree local action plans.

The RCAs and action plans are shared with the ward/Theatre areas and clinicians for comments and learning. Action plans developed with the ward areas are being reviewed regularly to monitor progress. This is fed into divisional IPC for assurance. SSI has also been added to Division clinical governance meetings, and any issues are being escalated via divisional quality board (DQB).

Learning identified from the RCA's have been reported at monthly IPCG meetings and action plans developed to address learning.

In February 2026 a letter was received from UKHSA Surgical Site Infection Surveillance Service (SSISS) to report that the Trust had been identified as a high outlier among participating hospitals for the surveillance period July-September 2025 with an SSI rate of 1.5%. This was investigated; however no clear links have been identified to date.

8 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of outbreaks which enables control measures to be instigated early to avoid escalation. An outbreak, as defined in the National Infection Prevention manual is:

- two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified period

Or

- a higher-than-expected number of cases of HAI in each healthcare area over a specified time

Once an outbreak has been identified, the IPC Team complete an incident form and arrange an initial outbreak meeting with the divisional teams to give support and advice. A risk assessment is then undertaken to determine if additional meetings are required, however the IPC team visit the outbreak areas daily to provide ongoing support until the outbreak is determined to be closed.

8.1 Norovirus

Between 1st April 2025 and 31st March 2026 there were 25 confirmed Norovirus outbreaks, across 16 wards with 7 wards experiencing more than one outbreak of Norovirus. This is a decrease of 8 outbreaks when compared to the previous year.

The length of outbreaks ranged from 2 days up to 26 days, with an average of 11 days. 3 of the outbreaks only lasted for 1 to 3 days as all patients were either isolated or discharged from the affected bay.

In total, 396 patients experienced diarrhoea and/or vomiting symptoms, of these 135 patients were confirmed to have Norovirus. When Norovirus is confirmed on a ward it is presumed that any further patients on the ward with symptoms are likely to have Norovirus, so not all patients are sampled. There were 51 staff who also reported symptoms during these outbreaks, however 8 outbreaks had no staff affected.

N.B. It is rare to receive samples from staff in the Lab for testing.

8.2 *Clostridioides difficile*

There were 9 wards that were identified as having a period of increased incidence of *C.difficile*, during 2025-26, compared with 15 the previous year.

Once a period of increased incidence (PII) is declared all wards are required to implement the Trust *C.difficile* improvement plan, enhanced cleaning is initiated and increased attention to outstanding Estates issues addressed. The PII improvement plan is monitored for a minimum of 4 weeks and may be extended if there are more patients diagnosed with *C.difficile* that are deemed to be linked. A plan is developed to ensure that all areas of the ward are HPV cleaned.

8.3 COVID-19

Although there was no longer a requirement to report COVID-19 outbreaks to the NHSE, COVID-19 outbreaks continued to be declared internally with initial outbreak meetings held to review the outbreak situation and monitor mitigating actions, this was supported with regular visits by the IPCT to the outbreak wards.

Between April 2025 and March 2026 there were 13 COVID-19 outbreaks declared, which was a significant reduction from the previous year when 23 outbreaks were declared, in total 69 patients tested positive for COVID-19.

Only 13 staff tested positive as part of 5 of the outbreaks, however the true figure of affected staff is unknown as there is no longer a requirement for staff to routinely test for COVID-19.

The number of outbreaks peaked earlier in 2025-26 when June 2025 saw 4 outbreaks declared followed by January 2026 when 3 outbreaks were declared.

8.4 Influenza

Between April 2025 and March 2026 there were 6 Influenza A outbreaks declared, this was the same number recorded as the previous year. In total 4 wards were implicated with ward 33 experiencing 3 outbreaks in close succession in December and January, in total 32 patients tested positive for Influenza.

Only 4 staff tested positive as part of 3 of the outbreaks, however the true figure of affected staff is unknown as staff testing for influenza is not undertaken.

Outbreaks of Influenza were contained to the winter months between November and February.

Initial outbreak meetings were held to ensure that all mitigating actions were implemented. The outbreak was monitored until 5 full days after the last positive patient was tested.

8.5 Carbapenemase-producing *Enterobacteriaceae* (CPE)

There was an increase in CPE outbreaks / PIs reported in 2025-26 with 4 declared, compared to only one in the previous year.

9 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff have been exposed to a specific infection e.g., scabies, Group A *Streptococcus*, identified by either the IPCT or PHE which results in the need for either staff and patient screening / treatment or both. When these situations have been identified the IPC team support the ward teams to complete contact tracing and screening, if exposed patients / staff are identified immunisation records are checked by the patient's clinician and occupational health for verification of immunity and vaccination offered as required.

9.1 Group A *Streptococcus*

Group A *Streptococcus* (also known as GAS, group A strep, strep A, and *Streptococcus pyogenes*) is a bacterium which can colonise the throat, skin and genital tract. Strep A infections are more common in children, but adults can also get them. Most strep A infections are not serious and can be treated with antibiotics. But rarely, the infection can cause serious problems, this is called invasive group A strep (iGAS) It is spread by close contact between individuals, through respiratory particles and direct skin contact. It can also be transmitted environmentally, for example through contact with contaminated objects, such as towels or bedding, or ingestion of food prepared by someone with the infection.

During 2025-26, 8 patients had an iGAS identified from blood cultures or other samples collected on admission, which is a decrease of 7 from the previous year. As this is sometimes only diagnosed post admission, 'warn and inform' letters were regularly issued to staff who may have been exposed, prior to confirmed diagnosis. There were no cases of healthcare workers who acquired GAS reported by Occupational Health or transmission to other patients identified.

9.2 Mpox

Mpox (previously known as monkeypox) is an infectious disease that is caused by the MPXV virus and was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research. The first human case was recorded in 1970 in the Democratic Republic of Congo (DRC), and since then the infection has been reported in several African countries and, more recently, has spread to multiple countries around the world, including the UK. There are 2 major types of MPXV, called clades, and are known as clade I and clade II, these are also sub-types of each clade.

Since May 2022, cases of human mpox have been reported in multiple countries that do not usually have mpox virus in animal or human populations, this ongoing outbreak is mostly caused by clade IIb and is mostly spread by sexual contact.

Since August 2024, clade I MPXV has also been reported from multiple countries outside of the African region that had not previously reported it, including in the UK. This is mostly caused by clade Ib MPXV and is mostly spread through close physical contact (including both sexual and non-sexual contact).

Mpox was initially considered to be a high consequence infectious disease (HCID), however in January 2023, ACDP advised that clade II no longer met the criteria due to the low case fatality rate,

and mild to moderate illness. Later in February 2025, Clade I Mpox, which was previously considered more infectious, also had its HCID status revoked.

Up to 31 March 2026, 45 cases of Mpox clade 1b have been reported in the UK; 39 in England, 3 in Scotland and 2 in Wales.

Although there have been no confirmed mpox cases admitted to WUTH during 2025-26, there was a patient who was admitted to the Trusts Acute Medical Assessment Unit, where Mpox was suspected as a differential diagnosis, but subsequent testing was negative.

9.3 Tuberculosis

Tuberculosis (TB) is an infectious disease caused by the organism *Mycobacterium tuberculosis* (MTB). TB usually presents as a chronic disease of the respiratory tract but may also affect other organ systems. TB is spread by inhalation of infectious droplets, which may be coughed or sneezed by a patient with respiratory TB. People with TB in organs other than the respiratory tract or with latent TB are rarely infectious to others.

During 2025-26 there was only one TB incident that required a multi-disciplinary approach, this included staff from IPC, Microbiology, Occupational Health, and the TB Specialist Team.

In June 2025, an inpatient was confirmed to have respiratory TB post admission, due to a delay in reporting the result. Contact tracing was undertaken which identified a number of patient and staff contacts who had potentially been exposed. A risk assessment of the level of contact was undertaken as per the guidance and relevant patient contacts were followed up by the TB specialist nursing team, with Occupational Health following up staff contacts.

9.4 Measles

Measles is caused by a morbillivirus of the paramyxovirus family. Early symptoms include the onset of fever, malaise (aches and pains), coryza (head cold), conjunctivitis (red eyes) and cough. The most common complications of measles include pneumonia, ear infection, diarrhoea and convulsions. Rarely, measles can and does cause encephalitis and death.

Measles case numbers started to increase in April 2025 with outbreaks particularly affecting London and the North West. In July 2025 UKHSA declared a national incident response to co-ordinate multi-agency input with the aim of limiting further spread.

Trust Measles preparedness meetings were facilitated by IPC, to ensure admission areas had processes in place to identify suspected measles cases promptly. To support staff, the Measles intranet page was updated, and a quick reference guide was developed.

Wirral Public Health also facilitated Wirral System Measles meetings to review measles epidemiology within Wirral identify system learning from recent cases and agree multi-agency actions.

During 2025-26 there were 7 suspected measles who were seen at WUTH with only 2 patients confirmed positive from PCR testing.

9.5 Hepatitis A

Hepatitis A virus infection causes a range of illness from mild, like nonspecific nausea and vomiting, through to hepatitis (liver inflammation, jaundice, or icterus) and rarely liver failure. It is normally spread by the faecal-oral route but can also be spread occasionally through blood. Good hygiene along with safe drinking water, safe handling of food and good handwashing practice prevents infection.

In August 2025 a patient was admitted with jaundice and generally unwell. A review of the patient's journey and contact tracing was undertaken to determine if there was any risk of ongoing transmission or potential serious complications due to exposure. There were 15 patients who were identified as contacts, however following an incident review meeting no further action was deemed to be necessary.

10 Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable soon and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad-spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

10.1 Antibiotic Stewardship Team (AST)

The Antimicrobial Stewardship Team develops and supports the implementation of policies, procedures and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners junior doctors and the Deputy Director of IPC / IPC Matron. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care and Respiratory Consultant. Wider attendance remains a challenge however the team engages directly with specific teams when required for certain pieces of work.

The AMS Team has the following strategies to improve AMS at WUTH:

- prescriber education training program
- maintaining an evidence-based antimicrobial formulary and AMS policies & guidelines
- audit program to monitor antimicrobial prescribing, consumption and identify areas for improvement
- ward-based AMS Team
 - the ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers
- areas which are high-users of broad-spectrum antibiotics and areas with patients with complex infections requiring long-courses of treatment have been identified by point prevalence audits and prioritised for visitation by the ward focused AMS Team
- service improvements to improve antimicrobial prescribing (new treatments and diagnostic tests, developments to the e-prescribing system, etc)

10.2 Ward-focused Antimicrobial Stewardship Team

The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions but also provision of case-based teaching directly to prescribers. Areas which are high users of broad-spectrum antibiotics or high incidence of *C.difficile* infections have been identified by point prevalence audits and prioritised for visitation in addition to areas with critical or complex infections requiring long courses of treatment.

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues.

10.3 AMS Priorities for 2025-26

In the absence of specific antimicrobial CQUIN targets for the 2025/26 financial year, antimicrobial stewardship priorities were aligned with national contractual and strategic drivers. The NHS Standard Contract service condition SC21.3 requires providers to use all reasonable endeavors, consistent with good practice, to minimise broad-spectrum antibiotic use in line with the UK National Action Plan (NAP) for Antimicrobial Resistance. In response, the Trust's antimicrobial stewardship programme for 2025/26 focused on supporting delivery of the UK 5-year National Action Plan 2024–2029 (NAP), which sets out key ambitions to reduce antimicrobial use and resistance. The following priorities were identified for the 25/26 financial year:

Priority 1: Reduce total antibiotic consumption to support overall NAP target

Target: Reduce total consumption of antibiotics by 1.5% by March 2026 compared with last financial year 24/25, measured in DDDs per 1000 admissions (NAP).

Priority 2: Reduce unnecessary broad spectrum antibiotic use

Target: Reduce broad spectrum antibiotics (Watch & Reserve antibiotics) by 1% compared to last financial year 24/25, measured in DDDs per 1000 admissions (NAP).

Priority 3: Reduce unnecessary IV antibiotics

Target: Reduce IV antibiotics, measured in DDDs per 1000 admissions, by 1% compared to last financial year 24/25 (Local priority).

Priority 4: Assurance of compliance with best practice AMS principles outlined by 'Start Smart Then Focus'

Target: To achieve >95% compliance with all indicators from the Antibiotic Safe Prescribing Indicators Report' (ASPIRE).

Priority 5: Assurance of appropriateness of prescribing restricted antibiotics

Target: To achieve >95% compliance with formulary or otherwise appropriate.

Table 21 below shows the Trusts assurance position at the end of 2025-26.

Table 21

Assurance position		Data source	Target	Q1	Q2	Q3	Q4	Total
1	Reduce total antibiotic consumption compared to last financial year (DDDs/1000 admissions). Baseline: 4083	Define	1.5% reduction (<4021)	11% decrease (3625)*	6% decrease (3846)	7.5% decrease (3719)	6% decrease (3783)	7.6% decrease YTD
2	Reduce usage of broad-spectrum antibiotics (Watch & Reserve) compared to	Define	1% reduction (<2122)	8% decrease (1978)*	8.7% decrease (1966)	7.7% decrease (1958)	7.4% decrease (1966)	8% decrease YTD

	last financial year (DDDs/1000 admissions). Baseline: 2144							
3	Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly). Baseline: 1178	Define	1% reduction (<1166)	4% increase (1226)*	3.5% decrease (1137)	3% decrease (1129)	3.6% decrease (1124)	1.5% decrease YTD
4	Antibiotic Safe Prescribing Indicators Report' (ASPIRE) Quality indicators: Local audit							
4.1	Compliance with antibiotic formulary	Local audit	≥95% compliance	98%	98%	96%	97%	97%
4.2	Documentation of indication for antibiotics on prescription	Local audit	≥95% compliance	96%	96%	95%	95%	95.5%
4.3	Stop / review date on antibiotic prescription	Local audit	≥95% compliance	100%	100%	100%	99%	99.75%
4.4	Antibiotic clinical review undertaken within 72 hours of initiation	Local audit	≥95% compliance	96%	96%	98%	97%	97%
5	Assurance of appropriateness of prescribing of restricted antibiotics	Local audit	≥95% compliance	97%	97%	98%	99%	98%

*Using proxy June admissions data

Further information related to antimicrobial Stewardship can be found in the Antimicrobial Stewardship Annual Report 2025-26.

10.4 AMS and *Clostridioides difficile*

While reducing *Clostridioides difficile* infection rates is not identified as a 'named' priority in the context of this report, it remains an important area of focus for the antimicrobial stewardship (AMS) team, given the significant impact on patient experience and the associated morbidity and mortality. Our overarching aim continues to be the improvement of AMS practices across the Trust, which would then minimise the potential for avoidable cases of *C. difficile*. Key priorities to underpin this include reduction of broad-spectrum antibiotic use, optimisation of IV antibiotic prescribing, and

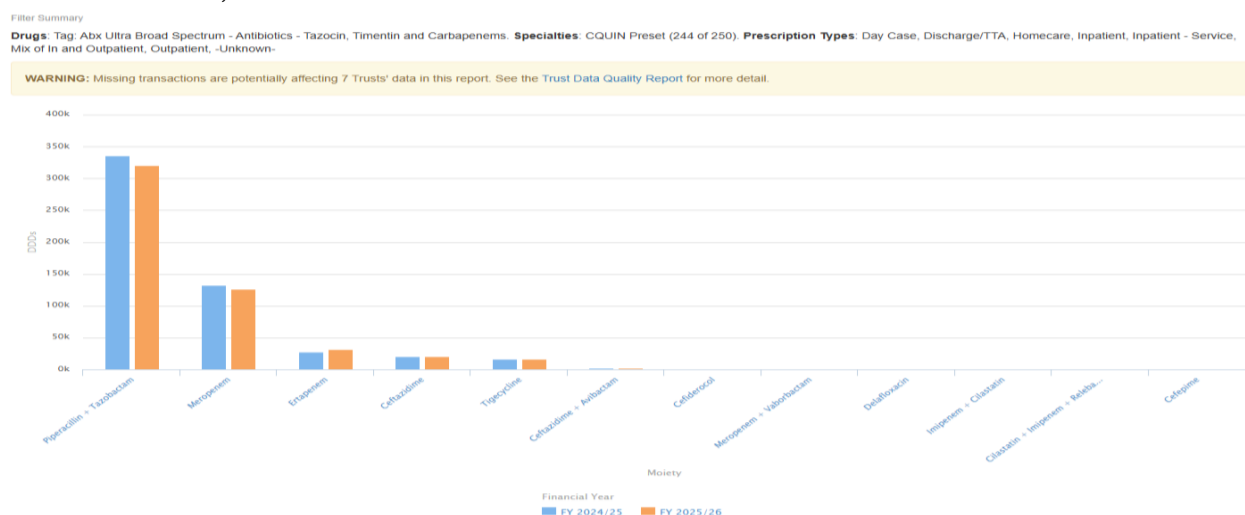
maintaining compliance with 'Start Smart Then Focus' principles. To support this, the AMS team has continued to focus on several key areas, including review of high antibiotic use clinical areas, implementation of targeted audits, ongoing review and update of antimicrobial formularies, delivery of education, and continuation of AMS ward rounds.

Actions supporting a reduction in *C. difficile* risk, while aligning with wider Trust priorities, include:

- introduction of smaller 3-day antibiotic pre-packs in ED for prophylaxis following human and animal bites
- ongoing review of antimicrobial formulary chapters to ensure alignment with current evidence and stewardship principles
- continued monitoring of ASPIRE compliance to support adherence to 'Start Smart Then Focus' principles
- ongoing review of restricted antibiotic use to ensure appropriate prescribing and minimise unnecessary exposure to high-risk agents

The AMS team will continue to build on this work and encourages ongoing engagement across the Trust to support improvements in antimicrobial use. Reassuringly, there is a continued downward trend in the use of antibiotics associated with a higher risk of *C. difficile*, as demonstrated in Graph 14 showing ultra broad-spectrum antibiotics use in DDDs per 1000 admission comparing 2024-25 and 2025-26.

Graph 14. WUTH ultra broad-spectrum antibiotic use in DDDs per 1000 admissions, comparing 24/25 and 25/26, data from DEFINE software.



In November 2025 a letter was received from NHS England to 'Act Now: protect our present secure our future'. In order to meet the targets laid out in the National Action Plan NHSE asked for prescribers and clinicians to work together. A joint IPC and AMS presentation is due to go to Board to provide information on the Trust's current performance against AMR targets, benchmarking using the Model Health System and identifying key concerns. 3 priority areas will then be agreed and published to achieve AMR improvement.

10.5 AMS Compliance with IPC Board Assurance Framework

There are two areas where the Trust is declaring non-compliance. The first is: "Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay."

The microbiology laboratory has been without the capacity to help extract data to monitor trends or organisms and resistances. The post is to be advertised/filled in near future which should address monitoring infective organisms. While the ASPIRE audits address, as far as is reasonable, the early accurate diagnosis, the outcomes and length of stays aspect is extremely challenging to deliver.

Early, accurate diagnosis is somewhat subjective as a measure and then marrying this up to outcomes and length of stay which are often affected by several different factors, would be very difficult to deliver in a robust and meaningful way.

The second is: "Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- total antimicrobial prescribing
- broad-spectrum prescribing
- intravenous route prescribing
- treatment course length"

While the Trust is compliant with most of this section, measuring adherence to the recommended course length has proved challenging, both from a technological perspective and in terms of manual data collection required to generate robust evidence. The Trust has a well-established clinical pharmacy service that actively monitors antimicrobial prescribing, supporting regular review of antibiotic use with the aim of ensuring timely discontinuation or optimisation of therapy.

To address this gap, a pilot audit of antibiotic course length was undertaken on selected wards in Q1 2025/26 to provide baseline insight into prescribing practices and assess the feasibility of routine data collection. The audit identified suboptimal adherence to recommended treatment durations, with evidence of prolonged courses and poor documentation of stop or review dates.

11 Decontamination

11.1 Decontamination Arrangements

Effective decontamination of reusable medical devices and equipment (including surgical instruments) is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection, and sterilisation) to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.

The Trust Decontamination Lead is currently working to strengthen decontamination processes across the organisation, including both automated systems and manual procedures for instruments that cannot be processed through decontamination units.

All such devices should follow stringent protocols following Manufacturer's 'Instructions for use' to ensure efficacy, compliance, and the prevention of HCAI's following procedures.

WUTH supports a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment is directed to the Trust Decontamination Lead.

The Decontamination Group meet monthly, chaired by the Decontamination Lead to discuss all areas of decontamination and agree possible actions/resolutions with the support of the Deputy DIPC/Lead – Infection Prevention & Control, the Trust Principle Clinical Scientist, Authorising Engineer for Decontamination (AED), and other key group members. Actions remaining unresolved are escalated to the Infection Prevention and Control Group (IPCG) via the Decontamination chairs report.

Improvement plans are in place to support areas where semi-critical devices requiring High-level disinfection are unable to be processed through the Central Sterilising Unit.

11.2 Sterile Services

Sterile Services sits within the Division of Perioperative Medicine and is situated at the APH site. The unit provides decontamination services to both Wirral University Teaching Hospital NHS Foundation Trust and to other NHS trusts. The services include washing, decontamination, assembly packing and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items.

In addition, the service operates an Endoscopy Decontamination Unit at the Clatterbridge General Hospital (CGH) site, supporting on-site procedures by providing decontamination of flexible endoscopes through automated high-level disinfection, including cystoscopes and ureteroscopes.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external, on behalf of the organisation. It operates in compliance with the Quality Management System Standard BS EN ISO 13485:2016, through the effective implementation of the departments procedures.

The unit manager is supported in all activities by the Trust Decontamination Lead.

The unit regularly updates and reviews their protocols to support continuous improvements in quality and customer service, and their effectiveness is monitored through quarterly internal audits, reported incidents and non-conformities. Assurance is provided to the Division of Perioperative Medicine Infection Control Group, IPCG and other Safety & Quality Boards.

In March 2025, a refurbishment of the department commenced and is scheduled for completion in November 2026. The project is being carried out in two phases to allow the department to remain operational with minimal disruption. As part of the refurbishment, the department will receive new washer/disinfectors and sterilisers, a replacement reverse osmosis (RO) plant, and upgrades to ceilings, walls and doors.

Two of the new washer/disinfectors will be multi-chamber units, and the new sterilisers will be pass-through machines loading straight from the pack room. These enhancements are expected to significantly improve production efficiently and reduce processing times.

In October 2025 the Trust declared a critical incident after mass staining occurred on surgical instrument sets following a full decontamination process. This started with a backlog following a ventilation failure in the packing area where all instrument sets had to be removed and reprocessed, adding to the already pressured shortness of staff and working machinery. Management of the incident involved a full investigation of the events leading up to the incident and resulted in replacement of aged instruments and refurbishment of instrument sets.

12 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a 'Healthcare Cleaning Professional' Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement, and review of cleanliness services in hospitals and our cleanliness standards are governed by the following:

- National Standards of Healthcare Cleanliness 2025 which replaced the National Specification for Cleanliness in the NHS 2007

12.1 Management arrangements

The Trust continues to align with the National Standards of Healthcare Cleanliness, promoting a culture based on collaboration, transparency, assurance, infection prevention, and continuous improvement.

A multidisciplinary approach remains central to the delivery of cleanliness standards, with engagement across clinical teams, Facilities, Infection Prevention and Control (IPC), and patient representatives. This ensures that cleanliness is recognised as a shared responsibility and embedded within patient safety priorities.

The Facilities Department provides a comprehensive cleaning service, including routine daily cleaning and rapid response infection control cleans, aligned to national standards and IPC requirements. All cleaning activity is subject to robust auditing and governance processes to ensure compliance and continuous improvement.

There is a strong emphasis on transparency, with audit outcomes displayed within clinical areas and reported through formal governance structures, providing assurance to patients, staff, and regulators that high standards of cleanliness are consistently achieved and maintained.

12.2 Cleaning Programme

The Healthcare Cleaning Professional Team delivers a comprehensive and responsive cleaning programme to support the Trust's IPC agenda.

This includes:

- rapid response cleaning
- enhanced and outbreak cleaning
- terminal cleaning
- advanced disinfection technologies

A key development during 2025/26 has been the introduction and widespread adoption of Metis Health misting using hypochlorous acid solution as the primary method of enhanced disinfection. This has largely replaced traditional Hydrogen Peroxide Vapour (HPV) processes across the majority of infection-related cleans.

The misting technology is deployed in:

- areas with known infectious patients
- outbreak situations
- terminal cleans and decant areas

The implementation of this system has delivered significant benefits:

- substantially reduced turnaround times, enabling quicker reopening of clinical areas
- improved patient flow through reduced bed downtime
- increased staff efficiency and service responsiveness
- reduced cost compared to HPV methods
- enhanced environmental sustainability, with hypochlorous acid representing a safer and less harmful alternative to traditional chemical-based systems

The service has remained resilient and adaptable in response to operational pressures, including winter demand and estate challenges, while maintaining a focus on quality and IPC compliance.

12.3 Performance Monitoring

The Trust maintains a robust and transparent framework for monitoring cleanliness standards, aligned with the National Standards of Healthcare Cleanliness.

Cleaning performance is assessed through a combination of:



- technical cleanliness audits
- efficacy audits
- routine supervisory monitoring

Auditing is undertaken using recognised digital audit systems, supporting real-time data capture, visibility, and escalation where required. Daily cleanliness monitoring is now embedded across clinical areas, providing additional assurance and supporting continuous quality improvement.

Efficacy audits continue to be undertaken on a rolling programme, with multidisciplinary involvement to ensure a comprehensive assessment of cleaning standards and practices.

Audit outcomes are:

- displayed publicly within ward and department entrances, in line with national transparency requirements
- reported through formal governance structures, including the monthly Infection Prevention and Control Group (IPCG)

This approach ensures clear oversight, accountability, and the ability to respond proactively to any identified risks or areas for improvement.

12.4 Patient-Led Inspection Programme (PLACE)

The Trust continues to actively participate in the national Patient-Led Assessment of the Care Environment (PLACE) programme.

During the 2025-26 assessment cycle, inspections were completed at:

- Arrowe Park Hospital on 15 October 2025
- Clatterbridge Hospital on 22 October 2025

Following a previous cleanliness score of 93.10%, the Trust has demonstrated significant improvement, achieving a PLACE cleanliness score of 97.55%.

This improvement reflects a focused and coordinated programme of work, including:

- enhanced training and awareness for staff
- increased visibility and frequency of auditing
- strengthened leadership and accountability at ward and departmental level
- environmental and process improvements
- greater collaboration across multidisciplinary teams

The improved score demonstrates the Trust's commitment to continuous improvement and provides assurance that high standards of cleanliness are being delivered across the organisation.

12.5 The Decontamination Unit (Central Equipment Library)

The Decontamination Unit has moved management responsibility from the Facilities department to the EBME department (still under the Facilities and Support Services Directorate). This move is to improve oversight and control of clinical equipment. The service model is currently unchanged, and the department continues to provide a centralised service for the cleaning and processing of non-invasive medical devices across Arrowe Park and Clatterbridge sites.

These improvements have strengthened IPC assurance, reduced the risk of cross-contamination, and improved the overall quality and consistency of the decontamination process.

12.6 Continued Initiatives

The Trust continues to embed and optimise the use of the Otex Decontamination Laundry System, which provides a validated ozone-based disinfection process compliant with HTM 01-04.

The system remains effective against a range of microorganisms, including MRSA, E. coli, and C. difficile spores, and continues to deliver:

- verified disinfection performance for each wash cycle
- reduced water and energy consumption
- contribution to the Trust's carbon reduction and sustainability objectives

This technology supports both IPC outcomes and environmental sustainability commitments.

12.7 Service Improvements

A range of service improvements have been implemented to strengthen IPC assurance and operational efficiency within the Facilities and Support Services directorate, including:

- implementation of Metis Health misting to increase turnaround times and operational efficiencies
- appointed an Authorised Person for waste and clear waste strategies in place to minimise cross contamination of waste streams
- introduced offensive waste collection within bays and side rooms within wards
- implemented a new Trust-wide fleet of air mattresses and cleaning protocol, replacing a very aged fleet of mattresses
- improved medical equipment tracking, with the rolling implementation of medical equipment tracking to improve clinical efficiencies and traceability of equipment

These initiatives support a proactive approach to infection prevention, ensuring that equipment and environments meet the required standards for safe patient care.

12.8 Water Safety Group (WSG)

Key elements of water safety in hospitals include robust planned and reactive maintenance protocols, regular water quality assessments, advanced filtration systems, and staff training. Additionally, implementing standard operating procedures and emergency preparedness plans, using point-of-use filters, and adhering to regulatory standards are crucial. A Water Safety Plan (WSP) and a Water Safety Group (WSG) are essential for managing and minimising risks related to waterborne pathogens.

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology, Infection Prevention, Clinical Governance and an external Authorising Engineer continue to meet monthly. The Legionella risk assessment and Water safety plan (WSP) is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections related to water systems. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The legionella risk assessment and WSP encompasses all areas of potential risk associated with water supply (*Pseudomonas aeruginosa* and Legionella); this includes potable water, hot and cold-water systems, endoscopy waters (AER final rinse waters), hydrotherapy pool, birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continues to give advice on remedial action when required where water systems or outlets are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extraordinary meetings to troubleshoot and instigate remedial actions to reduce risks to patients and staff.

The Water Safety Group is accountable to the Board of Directors (BOD). The Group reports to BOD via the Health and Safety Management Committee (HSMC) and Infection Prevention and Control Group (IPCG).

12.9 Ventilation

Ventilation is used extensively in all types of healthcare premises to provide a safe and comfortable environment for patients and staff and control temperature and odour. More specialised ventilation is provided to help reduce airborne infection risks in areas such as operating departments, critical care facilities, isolation rooms, and primary patient treatment areas.

The Health and Social Care Act 2008 places a duty of care on healthcare providers. Increased health risks for patients will occur if ventilation systems do not achieve and maintain the required standards. The link between surgical site infection and theatre air quality has been well established. If the ventilation plant has been installed to dilute or contain harmful substances, its failure may expose people to unacceptable levels of risk.

Ventilation is also installed across the Trust's premises to ensure compliance with the quality assurance requirements of items processed in pharmacies and sterile services departments, and to protect patients and staff from airborne microorganisms and toxic substances (for example, in surgical theatres, laboratories, and anaesthetic rooms). Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves to contain, control, and reduce hazards to patients and staff from airborne contaminants.

Good indoor ventilation can reduce the risk of airborne transmission of respiratory infections. CO₂ air monitoring can be used as a proxy to indicate areas of poor ventilation. It can give an effectiveness of ventilation in a multi-occupancy setting by monitoring levels of CO₂ that can build up through exhaled air. It does not provide a direct measure of infection risk, or a direct measurement of ventilation rates. CO₂ rates were first measured back in 2021 and to mitigate risk a number of air purifiers were purchased. These air purifiers purchased use HEPA filters which can reduce the number of potentially infectious particles in the air, thereby reducing the risk of transmission of infection. It must be noted that this intervention does not reduce transmission via close range aerosols and droplets or via fomites.

These air purifiers are now used when a patient who is nursed in a bay is diagnosed with COVID-19 or Influenza, this helps to clean the air within the bay to reduce the risk to others in the bay. When the patient gets isolated, the air purifier remains in the bay as that is where the risk remains. The devices are held and distributed via the Central Equipment Library and SOPs are in place to support their use.

Fig 1. Air purifier (AIRVIA AERO 100)



12.10 The Ventilation Safety Group (VSG)

The management of the ventilation systems of a healthcare provider is overseen by a Ventilation Safety Group (VSG). The group is multidisciplinary comprising of Estates & Facilities, Microbiology, Infection Prevention, clinical governance, and external Authorising Engineer and meets monthly to

discuss the legal and mandatory requirements of ventilation systems in healthcare premises. The group makes decisions on the design, maintenance, and the operation of ventilation systems. This group reports to the Health and Safety Management Committee and the Infection Prevention and Control Group.

The WSG and VSG promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes 1) Systems to manage and monitor the prevention and control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. It also Operates under the strict technical guidance of HTM 03-01 (Specialised ventilation for healthcare premises), the VSG monitors the aerodynamic safety of our clinical spaces. It validates air change rates (ACRs), pressure cascades, and HEPA filtration efficiencies across critical areas like ultra-clean operating theatres, intensive care units, protective isolation suites and other areas in the hospital environment in regard to air quality. The VSG also enforces strict asset containment zones during refurbishment works to prevent the aerosolisation of construction dust and opportunistic fungal spores like *Aspergillus*.

12.11 Waste Management

Each year, NHS providers continue to produce approximately 156,000 tonnes of clinical waste that is either sent to high temperature incineration (HTI) or for alternative treatment (AT), with operating rooms responsible for over 30% of a facility's total waste and 60% of specially regulated medical waste.

The NHS Clinical Waste Strategy has set a target for all NHS organisations to achieve a 20:20:60 split (20% HTI: 20% AT: 60% Offensive waste sent to municipal incineration and Waste to Energy) for their clinical waste streams. During 2025-26 we have achieved a clinical waste stream split of 20:06:74 and continue to strive to do better.

High Temperature Incineration and Alternative Treatment processes for waste have significant environmental impact and are associated with high running costs and carbon emissions. Through improved processes, education and guidance we continue to improve waste segregation, reducing costs and lessening the impact on the environment.

The Trust Waste Management Safety Group continues to meet monthly to address waste issues ensuring we remain compliant and efficient with all waste relating matters.

Thicker orange bags have been procured for the capture of infectious waste ensuring the waste is safely contained and doesn't spill out contaminating other streams and surfaces.

Waste handler training has been rolled out to Healthcare Cleaning Professionals within Facilities ensuring waste is disposed of safely, stored safely and waste bags are securely tied and have the ward/department and date of production displayed prior to disposal.

Secure waste storage areas have been constructed at the Clatterbridge site, allowing for effective segregation of waste and preventing unwanted access to potentially hazardous waste streams, with the main waste compounds at both sites having increased security measures introduced.

During 2025-26 the Trust Policy 071 Safe Management of Healthcare Waste has been reviewed. A healthcare waste training package provided for e-Learning for Health is available on ESR. Several waste related risks have been identified, and where appropriately placed on the Trust risk register, these are being closely managed and regularly monitored.

13 Infection in the Built Environment

Infection in the built environment refers to the transmission and acquisition of pathogens derived directly from the physical design, infrastructure, utility systems, and fabric of healthcare facilities. In acute NHS Trusts, the hospital infrastructure serves as a secondary environmental reservoir for

hazardous, often antimicrobial-resistant (AMR) organisms, threatening vulnerable and immunocompromised patient cohorts.

13.1 National Awareness and Technical Regulatory Frameworks

National awareness surrounding the risks of the healthcare-built environment has escalated significantly, transitioning from traditional reactive estates management to proactive, design-led infection prevention.

Clinical Guidance vs Technical Frameworks: In England, while the National Infection Prevention and Control Manual (NIPCM) provide standard clinical operational instructions, it does not explicitly govern physical infrastructure. Instead, healthcare engineering, design, and structural parameters in NHS England are heavily dictated by the Health Technical Memoranda (HTM) and Health Building Notes (HBN) series. Compliance with these technical documents is the core mechanism for mitigating infrastructure-associated infections. Conversely, NHS Scotland's framework explicitly merges these areas via its NIPCM Chapter 4 (Infection Control in the Built Environment and Decontamination), setting an integrated national regulatory example.

Specialised Working Groups: Driving this shifting landscape includes expert working groups. In particular, the Healthcare Infection Society (HIS) has created the Built Environment Infection Prevention Initiative (BEIPI), which actively bridges the gap between clinical IPC and NHS capital/estates teams to embed IPC principles and anti-microbial resistance (AMR) mitigation into building life cycles. Alongside it, the Wastewater and AMR Special Interest Collaborative (SPARC) focus specifically on addressing secondary environmental reservoirs and biofilm dissemination pathways within wastewater plumbing systems. Staff from WUTH are active members in these groups.

13.2 Specialist Infrastructure and Risk Governance

To manage technical compliance and structural safety, our Trust operates specialised multi-disciplinary advisory Sub-Groups that report directly to the Infection Prevention and Control Group (IPCG). All the WUTH specialist groups are multi-disciplinary comprising of local Estates Engineering Experts (including authorised person (AP)), a Microbiologist, IPC Team representation, Clinical Stakeholders, Health & Safety/governance representation and respective external Authorising Engineers for the specialty.

13.3 Ward Design and Patient Placement

Optimising ward geometry and spatial design is critical for breaking environmental transmission pathways before patients occupy space. Guided by **HBN 04-01 (Adult In-patient Facilities)** and **HBN 00-09 (Infection Control in the Built Environment)**, ward design focuses on engineering controls that isolate pathogens and streamline clinical safety.

14 Training Activities

IPC education was delivered across the Trust via a planned programme throughout the year and also add hoc in response to areas with increased infection, none compliance and observations of clinical practice that required further education to promote good practice. The IPCT have delivered education sessions across the two hospital sites in a variety of settings to include clinical and non clinical areas.

The IPCT continue to support specific education programmes coordinated by clinical skills to include; Clinical Champions, Wirral Enhanced Preceptorship Programme (WEPP) and the Care Support Worker Programme.

14.1 Infection Prevention Link Practitioners

The IPC Link Practitioner Programme continued during 2025-26. For each IPC Link Nurse topic, there are two separate sessions provided, to provide staff with adequate opportunity to attend. The primary purpose of the IPC link practitioner sessions is to educate staff, and to provide IPC link staff with resources and information, to promote and monitor IPC Practices within their workplace. The IPC Link Nurse Sessions also include allocated time for discussions and the sharing of good practices amongst colleagues.

In June 2025 the theme was CAUTI prevention. The results and learning from the 2025 CAUTI audit were shared as well as the key principles for optimum catheter care and introduction to the new Nurse Led Catheter Removal Protocol.

In October 2025 the theme was *C.difficile* prevention and management, when the 5 key priorities of cleaning, environment, isolation, sampling and bare below the elbows.

A session on winter illnesses was planned for January 2026, however due to operational pressures, increased outbreaks of infection and reduced staffing within the IPC team, this unfortunately needed to be cancelled. The IPCT delivered key messages on winter illness at the Trust wide All Staff Briefing;

Attendees of the IPC Link Practitioner meetings have continued to evaluate the sessions well and positive feedback has been received.

14.2 Student Nurse Training

The IPCT have supported Student Inductions arranged by the Practice Educator Facilitators. These sessions provide a basic IPC overview, in addition to knowledge gained in the University setting. These sessions are arranged on an ad hoc basis. In the last twelve months IPC have provided nine first year student induction sessions. Second and third year Student Nurses have also continued to shadow the IPC Team on an ad hoc basis.

14.3 Mandatory Training for Trust Staff

As part of the work to align all mandatory training courses to the National Core Skills Training Framework (NCSTF) programme, the frequency of Level 2 IPC mandatory training was changed from 18 months to every 12 months. The frequency of the IPC Level 1 Mandatory Training remains at 3 yearly. The content of the e-learning modules has been refreshed; however, Level 1 training is no longer included in Level 2 training. Therefore, all staff who are required to complete IPC Level 2 Mandatory Training must also complete IPC Level 1 Mandatory Training, to be compliant with both. As a result, compliance has inevitably reduced but is anticipated to return to pre-change compliance in June/July 2026.

14.4 Trust Induction Training

The IPC Team continues to attend and participate in the bi-monthly Trust Induction. IPC provided a 5-minute presentation on the basic principles of IPC and were available to answer questions as part of the Market Place following the formal presentations. Since December 2025 there is no longer a formal presentation, however a member of IPC team attends the Market Place to provide an updated IPC Induction Newsletter and engage with new starters.

14.5 Wirral Enhanced Preceptorship Programme (WEPP)

The Wirral Enhanced Preceptorship Programme (WEPP) is a 2-day Development Programme, held monthly, for all newly qualified staff. IPC provide one 2-hour IPC Session, which covers the Chain of Infection, Standard IPC Precautions, and Alert Organisms. During 2025-2026, the IPC Team provided 8 WEPP sessions.

14.6 Care Support Worker (CSW) Training

The IPC Team deliver a 1.5 hour IPC Session for CSWs, as part of the CSW Core Skills Course. The CSW Core Skills Course is a monthly 2-day programme, as part of the National Care Certificate. The IPC Session covers the basic IPC practices, hand hygiene, diarrhea management, swab/sample collection and essential mattress checks. The IPCT also supports Competency Assessment sign-off for mattress & commode Checking. IPC have provided 20 CSW Core Skills Sessions during 2025-26.

14.7 Resident Doctor Induction Training

Twice a year the IPC Team participate in the Resident Doctor Induction Programme. This is beneficial in recognising the vital role Doctors play in infection prevention. This IPC Session, as part of the Resident Doctor Induction Programme, provides an overview of standard IPC precautions, accessing IPC Alerts in CERNER, alert organisms, and the role of doctors in preventing infections. Further Resident Doctor Training is also undertaken within the Trauma and Orthopedics, to highlight expected IPC standards and familiarise Resident Doctors with relevant IPC guidance.

14.8 Specific Training

The IPC Team regularly provides ad hoc training when visiting wards and departments as required. IPC have also supported regular bespoke training for other departments throughout the year including:

- facilities Supervisor Training – providing underpinning knowledge on the risks associated with certain organisms from the environment and the different types of cleaning required
- medical Division Impact Training – held monthly by the Medical Division, IPC facilitate a 1 hour session. This is a practical session for CSWs covering cleaning of commodes / equipment, mattress checks, PPE donning and doffing, use of ChlorClean, and the importance of Stool Charts. The RGNs sessions are also provided with detailed information on organisms and routes of transmission. IPC have provided 3 Impact Training Sessions during 2025-26

14.9 Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a framework for safe and effective aseptic practice, especially during clinical procedures, focusing on preventing contamination by identifying and protecting "key parts" and "key sites". It is a standardised approach to aseptic technique, internationally recognised and adopted, and helps reduce healthcare-associated infections. ANTT training equips healthcare workers with the knowledge and skills to minimise infection risks during procedures by understanding and applying these principles.

Training is provided by Clinical Skills and Divisional Clinical Educators.

ANTT assessments are updated annually, and all Junior Doctors receive an ANTT assessment during their first year, as part of their Induction Programme.

ANTT Train-the-Trainer Facilitators receive Clinical Skills Training, which is refreshed every three years to maintain their competency, and ensure compliance with the Competency Assessment Framework.

Table 22 below shows the ANTT compliance data up to the end of March 2026 as recorded in the Core Mandatory Compliance Report.

Table 22

Division	Hand Hygiene		Standard ANTT		Surgical ANTT	
	#	%	#	%	#	%
Clinical Support Div	905	97.52%	239	62.08%	136	59.13%

Corporate Support Div	438	97.33%	12	41.38%	11	37.93%
Emergency Div	29	100.00%	201	79.13%	189	78.10%
Estates, Facilities & Capital Div	487	57.50%	1	100%	1	100%
Medicine Div	190	96.45%	1025	82.93%	705	64.86%
Surgery Div	211	98.60%	827	82.70%	657	77.02%
Women and Children's Div	125	96.90%	397	75.76%	348	78.38%
Overall Total	2385	85.36%	2702	78.80%	2047	70.93%

During 2025-26 the ANTT Policy was reviewed by Clinical Skills to revert back to Standard and Surgical ANTT to support an application for the Trust to be accredited for ANTT.

14.10 IPC Newsletters

During 2025-26 the IPC Team continued to develop IPC Newsletters. Each IPC Newsletter focuses on a different theme, providing accessible and relevant information to all WUTH staff, and is circulated as part of the Trust Bulletin.

6 Newsletters were developed during 2025-2026:

- **World Hand Hygiene Day – May 2025**

To celebrate and raise awareness for World Hand Hygiene Day, May's Newsletter promoted the '5 Moments of Hand Hygiene' and detailed the 'Gloves are Off' approach. This Newsletter outlined the appropriate use of gloves in the clinical environment, being bare below the elbow, and the correct use of alcohol handrub.

- **Peripheral Vascular Access Devices – July 2025**

The IPC Team focused on Invasive Devices for July's Newsletter, which explained the risks to patient safety related to cannulas and IV access. The importance of not only inserting invasive devices correctly, but also the maintenance of those devices once in situ was promoted.

- **C. difficile Refresher – July 2025**

Following an increase in *C.difficile* infections, a refresher of the 5 key principles to prevent CDI was created to remind staff about the importance of cleaning, environment, isolation, sampling and bare below the elbows.

- **Preventing CAUTI Related UTIs – August 2025**

In line with the Trust's annual CAUTI Audit, this issue relayed important information on catheter care and continence. This newsletter prompted staff to consider the principles of 'HOUDINI' and the Nurse-led Catheter Removal Protocol.

- **Bowel Management – October 2025**

In addition to Bowel Management problems and it's connection to *C. difficile* infection, the October IPC Newsletter focused on the other key areas of bowel continence and management. The importance of the Bristol Stool Chart, rapid recognition of symptoms and the impact of medications such as laxatives. This was created in collaboration with the Continence Steering Group.

- **Infection Prevention Control Induction – November 2025**

The IPC Induction Newsletter covers the basic principles of Infection Prevention, as

Fig 2.



well as signposting where staff can find all IPC related policies and guidance. This issue is typically given out to new starters as part of their WUTH Induction Training.

Figure 2 illustrates the newsletters that have been published.

14.11 IPC Campaigns

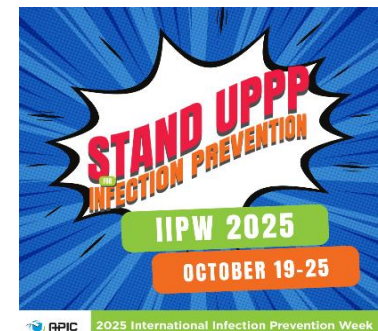
World Hand Hygiene Day was celebrated on 5th May 2025. The IPC Team had a promotional stand in the main entrance at APH, providing useful information for staff, patients and visitors. There were lots of freebies, a hand hygiene quiz for staff and the UV light box was used to assess how well people cleaned their hands.



Infection Prevention Week

October saw the International Infection Control Prevention Week being showcased at WUTH. This year the IPC team promoted the service and promoted the theme **Stand UPPP** for Infection Prevention, reminding us to:

- **Unite** – Infection prevention is a team effort with every role making a difference
- **Prevent** – Taking action today saves lives tomorrow
- **Protect** – Reinforce practices that safeguard patients, staff and the public
- **Prevail** – Stay resilient and adaptable through strong IPC practices



Throughout the week, IPC product suppliers GAMA Healthcare, Daniels Healthcare, Vernacare and Tristel visited the wards and departments to share key messages and answer queries.

The IPC team were in the front entrance and firtrees restaurant with IPC freebies such as individual alcohol handrub dispensers, hand wipes, moisturizing hand cream, notepads and pens. Staff also had the opportunity to enter a competition to spot the 12 IPC risks, with winners winning a voucher or hamper.

Photographs showing the winners of the competition



15 Audit

15.1 Audit programme for 2025-26

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015).

15.2 IPC Environmental audit

The IPC Environmental Audit programme is aligned with the Wirral Individualised Safe Care Every time (WISE) Accreditation Plan for inpatient wards. However other departments and outpatient areas are also audited at least annually.

During 2025-26, 86 wards and departments had an IPC Environmental Audit undertaken, this is a slight decrease of 5 from last year. Of the 86 wards and departments audited 32 areas were reaudited more than once during the year, which is an increase of 10 from the previous year. A monthly report is provided to IPCG with audits and scores completed by IPC.

Due to a period of reduced staffing within the IPC team, there were 9 areas that were not audited during 2025-26 and will be prioritised for the forthcoming year:

If a ward scores below 70% (red) a re-audit is undertaken within 3 months, if a ward scores between 70% and 89% (amber) a re-audit is undertaken within 6 months if capacity / workload permits. Areas that score Red on 2 consecutive occasions will not routinely be re-audited again within the financial year. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC Divisional meeting. The Senior Nurses within the Divisions also undertake regular audits to ensure there is improvement, and when a green score is achieved, this is maintained. A monthly report is provided to IPCG with audit scores completed by IPC. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC Divisional meeting.

Table 23 below is a breakdown of the ward category scores by Division for 2025-26, with the most recent audit score taken into account.

Table 23

Division	Green	Amber	Red
Medicine	9	17	1
Acute	3	3	4
Surgery	14	2	1
Women's & Children	1	8	1
Clinical Support	0	18	3
Facilities	0	0	1
Total	27	48	11

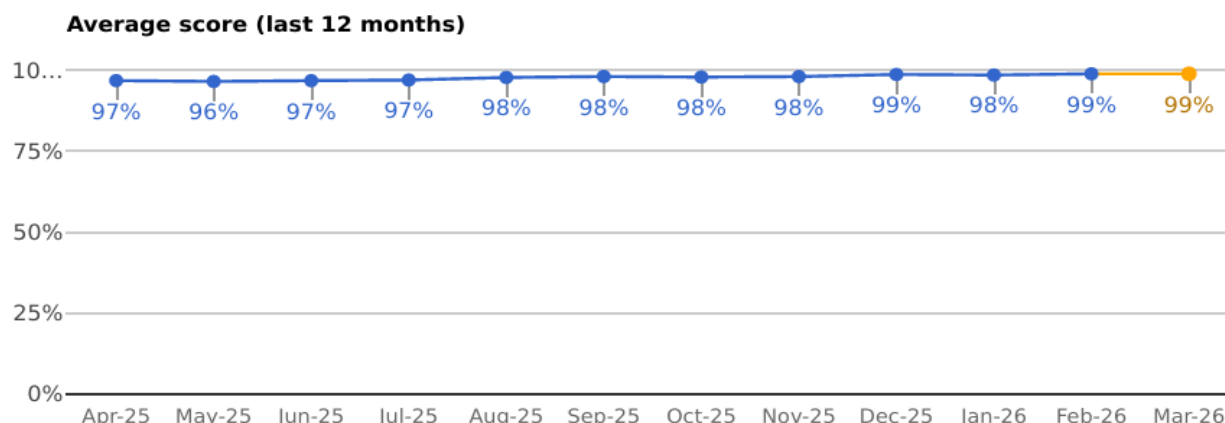
15.3 Hand Hygiene Audit

All wards / clinical departments are expected to undertake weekly hand hygiene audits using the Tendable hand Hygiene Audit, which are increased to daily during an outbreak or increased incidence of infection. A monthly report is submitted to IPCG for assurance purposes.

The IPCT have provided additional support to the auditors to ensure the correct process for auditing is undertaken.

Figure 3 shows the average monthly hand hygiene scores for 2025-26.

Fig. 3

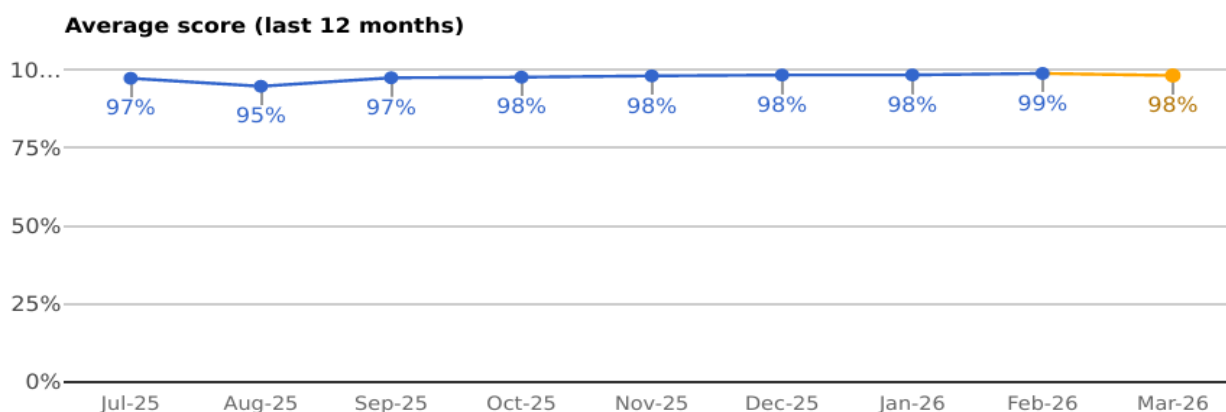


15.4 Commode audit

A Monthly audit of commodes on all the wards was completed by the IPC team up to June 2025 when the Commode audit tool was added to Tendable for all wards to complete. Ad hoc audits are also completed IPC following increased incidence of infection.

Figure 4 shows the average monthly commode scores since July 2025.

Fig. 4



15.5 Sharps audit

A Sharps Audit was undertaken by WUTH sharps bin supplier in February 2026. In total 396 sharps containers were audited across 81 areas within the Trust. No bins were found to have protruding sharps, and all were at the correct height, which is consistent from the previous audits. Overall, the following non-compliance was identified:

- 13 (3.28%) containers were not assembled correctly, an increase from 0.77% last year
- 1 (0.25%) container had mismatched lid and label, similar to last year
- 1 (0.25%) container overfilled, this is an increase from zero last year
- 9 (2.27%) containers were not signed or dated after being assembled, similar to last year
- 5 (1.26%) containers had inappropriate contents, an increase from 0.77% last year

- 17 (4.29%) containers did not have the temporary closure in place when left unattended, similar to last year

Of the 81 areas audited, 60 areas (74%) were fully compliant, 16 areas (20%) scored 95-100%, 5 areas (6%) scored 85-94% and no areas scored below 85%.

The audit findings have been shared with the Divisions to action, and with the Health & Safety team.

15.6 Catheter associated urinary tract infection (CAUTI) Audit

A CAUTI audit is a process used to assess and improve practices related to urinary catheter use, with the goal of reducing the incidence of Catheter-Associated Urinary Tract Infections (CAUTIs). These audits involve reviewing catheter insertion and maintenance procedures, identifying potential risk factors, and ensuring adherence to established guidelines and care bundles.

A Trust wide catheter associated urinary tract infection (CAUTI) audit, instigated by the Continence Steering Group was undertaken in March 2026 by IPC with support from the Divisions. Although the audit has previously been undertaken across the system, this is the first year a joint audit report has been produced.

Within WUTH all patients with an indwelling urinary and suprapubic catheters were audited within the Trust over 4 days. From the wider system a sample of adult patients from community settings or caseloads, as well as patients residing in their own home or care homes were also audited by community colleagues.

Initial results indicate that prevalence of urinary catheters in WUTH was 12% with 8% of these patients being diagnosed with a CAUTI within the previous 7 days of the audit. This is a slight increase from 7% in the previous year.

The final audit report is due to be agreed at the Continence Steering Group and will then be presented at IPCG. Divisions will also be asked to disseminate the findings to their teams and use the outcomes to support continuous quality improvement, strengthen compliance with best practice. The recommendations from the audit will also be incorporated into the Continence Steering Group Annual Plan.

15.7 Other Audits via Tendable app

The following audits are undertaken by the staff on the wards and departments via the Tendable App:

- personal protective equipment
- daily first impression audit
- high impact interventions for:
 - central venous catheter insertion
 - central venous catheter ongoing care
 - peripheral vascular insertion
 - peripheral vascular ongoing care
 - surgical site infection preoperative/perioperative
 - ventilator associated pneumonia ongoing care
 - *Clostridioides difficile*
 - ANTT
- care bundles
 - urinary catheter insertion
 - urinary catheter ongoing care

16 Working Groups

16.1 Contenance Steering Group

The Contenance Steering Group was established to support the understanding of areas for improvement regarding continence and to support the delivery of organisation wide improvement. This meeting had been chaired by the Deputy DIPC, and since November 2025 has been chaired by the Infection Prevention and Control Matron. This is a collaborative group which is supported by WCHC Bladder and Bowel Service. The work of the Contenance Steering Group is in line with the group's Annual Plan which is informed from learning identified in BSI reviews and other continence related incidents and patient feedback.

During 2025-26 the following work was completed:

- coordinated the system wide annual CAUTI audit
- developed a CAUTI awareness campaign
- created a bowel management newsletter
- developed and launched a nurse led catheter removal protocol
- reviewed and updated the Tendabale elimination audit question set
- developed a discharge flowchart for patients being discharged with a urinary catheter
- created a dedicated continence page
- bowel management questions in CERNER have been reviewed and updated

16.2 Fit Testing Group

In September 2024 the Deputy DIPC created a Fit testing Group for all Trust Fit testers to attend to ensure that there is sufficient Fit Testing resilience across all Divisions. This included monitoring the calibration of the portacount machines and progress with fit testing within the Divisions. In November 2025 the IPC Matron took over as chair and escalated issues to IPCG via a chair's report. Further work is required to create a robust fit testing service for the trust.

17 External Assurance Assessments

During 2025-26 MIAA performed an IPC audit. The overall objective of the audit was to provide assurance of the operational effectiveness of the arrangements in place for the management of IPC at the Trust with a specific focus on *C.difficile*. The audit report provided overall moderate assurance, and provided the following recommendations:

- the IPC BAF should be subject to review by PSQB as a standing item. There should be triangulation between the IPC BAF and the Trust's Board Assurance Framework
Progress: The IPC BAF is an agenda item on IPCG and is reported to PSQB
- the control measures and action plans outlined in the IPC risk register should be subject to formal review to ensure relevant action is taken to address and mitigate the risks.
Progress: The IPC risks are reviewed monthly and reported to IPCG quarterly
- the Trust should ensure that all medical staff follow policies surrounding infection prevention and control, particularly around hand hygiene, uniform and use of PPE and other equipment/facilities
Progress: Basic principles of IPC are promoted and all staff are empowered to challenge any non-compliance
- requirement for each directorate team to undertake a review of IPC BAF compliance prior to each IPCG meeting and report updated position, should be re-enforced and performance monitored and reported to the Trust Board
Progress: The IPC BAF has been shared with Divisions to report updated position
- the Trust should review its IPC training offered and compare to the requirements of the IPC Education Framework
Progress: The Learning and Development team have led a review of the Trust's IPC training to ensure it is fully aligned to the CSTF. A wider piece of workforce planning will be undertaken once the Trusts have fully merged

- the planned Decontamination Policy should be completed and the updated policy agreed at IPCG
Progress: The Decontamination Policy has been approved by IPCG in May 2026

18 Policy Development

WUTH follows the National Infection Prevention and Control Manual (NIPCM) for England, which is a comprehensive, evidence-based guide for infection prevention and control (IPC) practices in all health and social care settings. It provides standard infection control precautions (SICPs) and transmission-based precautions (TBPs) to help reduce the risk of healthcare-associated infections (HCAs). The NIPCM aims to standardise and optimise IPC practices across England, ensuring the safety of patients, staff, and visitors. A link to the National IPC Manual for England is available on the WUTH Intranet which ensures that the most up to date version is available for staff to access.

The following local policies have been reviewed and updated in 2025-26:

- pol 189 Mattress Policy
- pol 191 Norovirus Outbreak policy
- pol 137 MRSA Infection Prevention and Control Policy

IPC Guidance

The following guidance was also produced in 2025-26:

- CPE Guidance: Screening and IPC Measures
- Mpox Quick Reference Guide
- Immediate Action for Patients Presenting with Suspected Measles
- Measles – Quick Reference Guide for Clinicians
- Middle East Respiratory Syndrome coronavirus (MERS-CoV) Guidance

19 Infection Prevention & Control Board Assurance Framework

NHSE published the first version of the Infection Prevention and Control Board Assurance Framework in 2020. Since this time there have been several versions published that are updated and refined to reflect the current challenges. The purpose of the Framework is to provide an assurance structure for boards against which they can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual, the Health and Safety Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). The framework is structured around the existing 10 criteria set out in the Code of Practice (2008) as listed in Table 24.

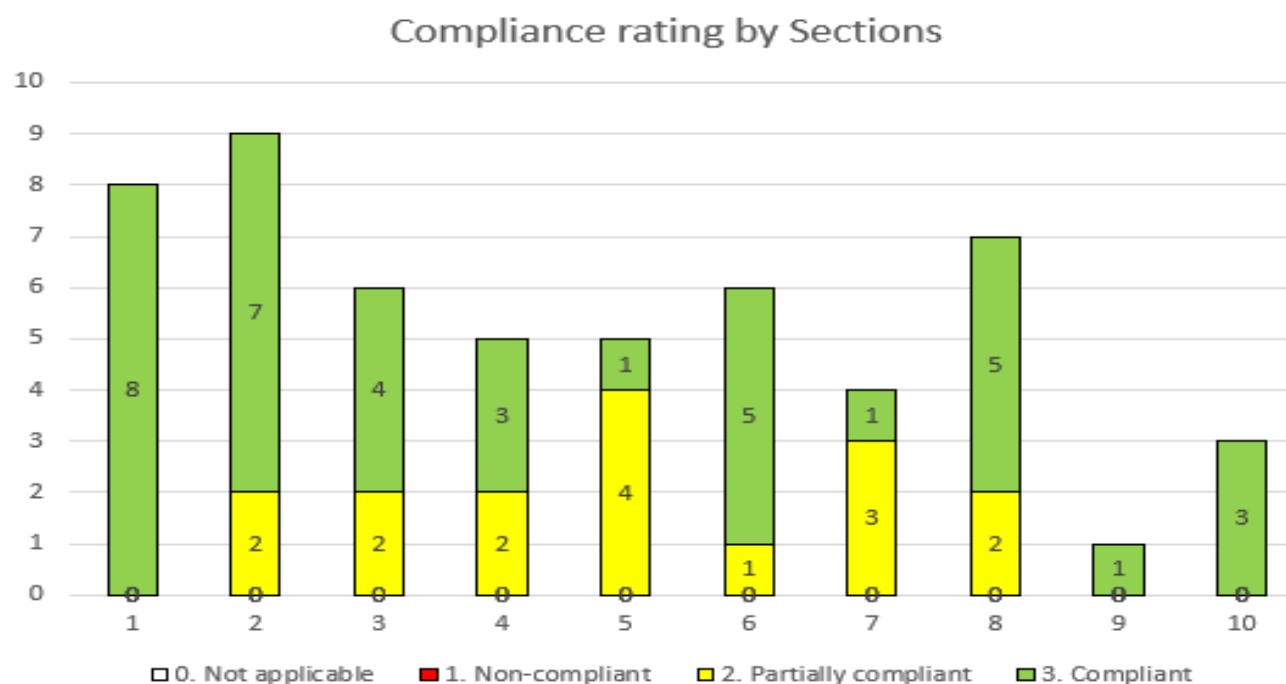
Table 24

IPC BAF Standards	
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion.

5	Ensure prompt identification of individuals who are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation precautions and facilities.
8	Provide secure and adequate access to laboratory/diagnostic support as appropriate.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Trust's current compliance with each standard of the IPC BAF is shown in Graph 15 below.

Graph 15



The IPC BAF will continue to be monitored through IPCG with actions identified to improve compliance.

20 Conclusion

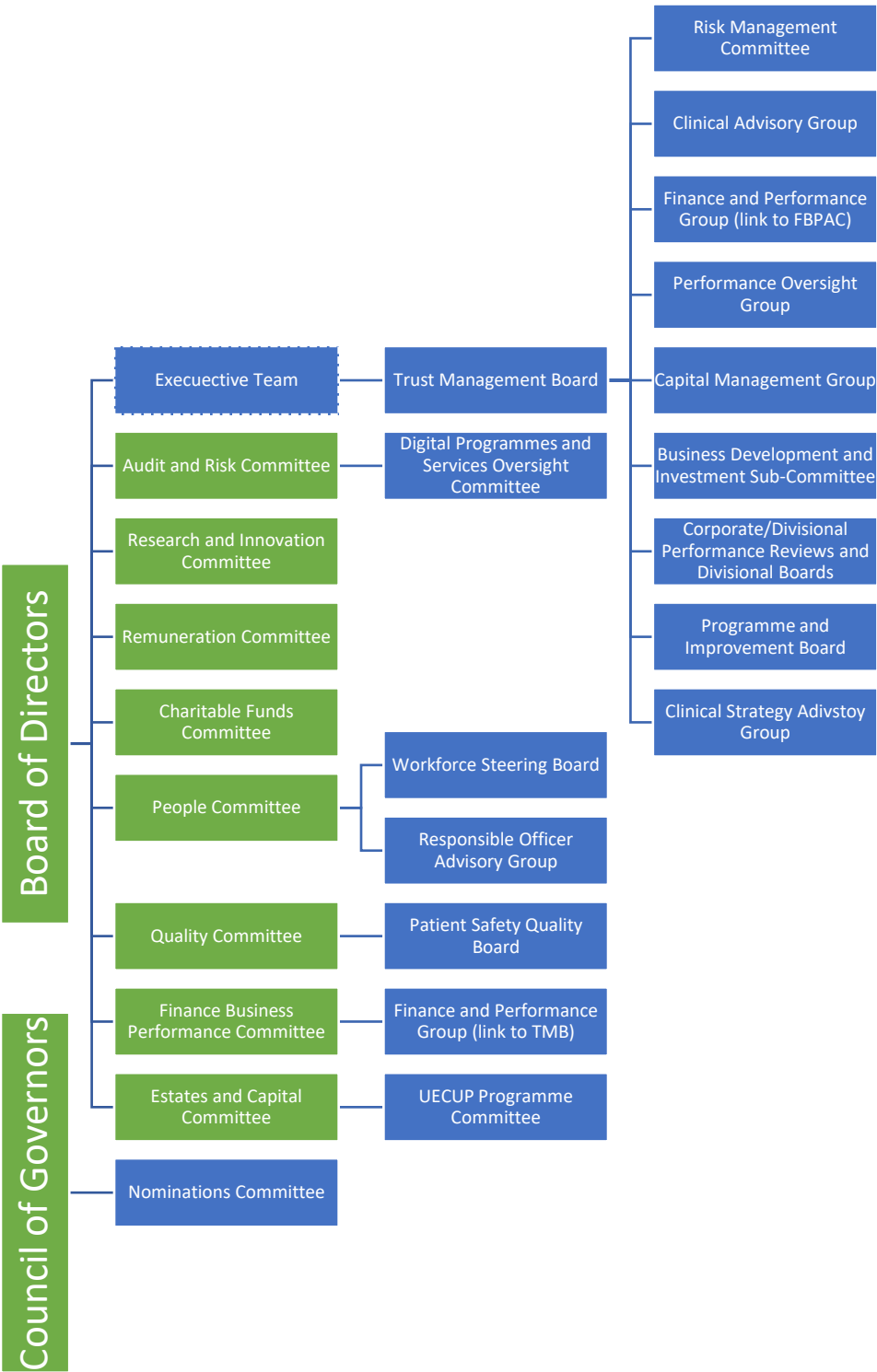
The above report details the annual infection prevention & control activities in 2025-26 as reported to the monthly IPCG. It has been a challenging year, with significant changes to the leadership within the IPC Team. Nonetheless the IPC team have continued to support all staff across the Trust to provide safe care for our patients. This report also demonstrates the collaborative work undertaken across the organisation between teams and departments to improve standards.

It is essential that there is continued support from Board to ensure that processes are in place to enable staff to make the right choices when caring for our patients and keeping them free from avoidable Infections.

In keeping with our Trust values, we also need to continue to promote and recognise the hard work that the teams deliver daily to help to keep our patients safe to sustain and maintain the improvements.

Lorraine Young
Infection and Prevention and Control Matron

21 APPENDIX 1 Governance Structure





22 APPENDIX 2 Infection Prevention and Control Group Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Deputy DIPC and/or the Deputy Chief nurse.

2. MONTHLY CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (DIPC) (Chair)
- Deputy Director of Infection Prevention & Control
- Consultant Microbiologist/Infection Control Doctor
- Principal Clinical Scientist – Microbiology/ Infection Prevention and Control
- Occupational Health representative
- Antimicrobial Pharmacist
- Associate Director of Estates, Engineering and Capital Delivery
- Associate Director of Estates, Facilities and Capital Governance and Sustainability
- Head of Soft FM
- UKSHA Consultant for Cheshire and Merseyside
- Divisional Directors of Nursing
- Divisional Governance Leads

CLINICAL LEADS/MEDICAL REPRESENTATION FROM DIVISIONS ON A QUARTERLY BASIS

- Surgery
- Women & Children
- Medicine
- Acute
- Diagnostics and Clinical support

Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary perspectives and have considered the impact across all the Divisions and departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

3. QUORUM

For decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 8 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor, the Associate Director of Nursing Infection Prevention and Control (or nominated deputy) , and 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month.

6. OVERVIEW

The Infection Control Group is a subcommittee of the Patient Safety and Quality Board (PSQB) and monitors the Infection Prevention and Control strategic objectives. The 3-year IPC Strategy is agreed by the Trust Board and is based on WUTH organisational priorities. The Trust IPCG oversee and monitor the annual IPC plan in meeting the 3-year Strategy.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive and trust board with relevant information and advice.

Approve the Strategic plan and interpret and advise on the National Infection Prevention and Control manual.

Provide assurance that the Code of Practice on the prevention and control of infection NHS core standards and Department of Health recommendations on infection prevention and control are implemented.

Receive assurance and escalations that monthly infection surveillance data and performance, including Outbreaks relating to MRSA Blood-Stream Infections, *Clostridioides difficile* Infections, *Klebsiella* Bacteraemia, *Pseudomonas* bacteraemia and *E.coli* bacteraemia are monitored with learning from a review of these cases with appropriate actions being taken within the divisions to prevent further incidence.

Approve Infection prevention and control policies and guidelines that enable implementation of the National Infection Prevention and Control manual.

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control inclusive of the decontamination of medical and surgical devices equipment, e.g., Health Act 2008 and receive assurance as such from the Divisions.

Receive assurance from the divisions that training and supervision systems regarding Infection Prevention and Control is in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams

Have regard to NICE guideline NG15 (Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use)

Have regard to the Antimicrobial Stewardship Toolkit for English Hospitals.

Support the development of local plans to identify further actions required to meet the requirements of the National IPC Board assurance framework.

Approve the annual infection prevention and control plan and monitor and review progress on a quarterly basis.

8. ORGANISATION

Administration support is provided by the Deputy Director of Infection Prevention and Control's Secretary who organises the meetings and provides minutes.

The Deputy Director of Infection Prevention and Control will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A chairs report will be submitted to the PSQB monthly prepared by the Deputy DIPC.

A chairs report will be presented from the Decontamination group, Antimicrobial Stewardship group, the Ventilation safety group, Water safety group, the WIVAT group and Monthly Divisional IP&C meetings be exception.

The Terms of Reference for the group will be reviewed every 2 years.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	
V1.2	November 2022	Reviewed the membership and clarified reporting mechanisms.
V1.3	July 2023	Updated titles of core membership
V1.4	June 2024	To reflect requirements in the NHS standard contract 2024/25

11. DOCUMENT OWNER

Infection Prevention and Control Secretary/Team Administrator.

Group Board of Directors in Public
02 September 2026

Item 18

Title	WCHC Freedom To Speak Up Annual Report 01 April 2025 – 31 March 2026
Area Lead	Chris Douglas, Joint Chief Nursing Officer / Director of Infection Prevention & Control
Author	Alison Jones, Freedom To Speak Up Guardian

Purpose of the Report and Recommendation	
Report For	Assurance
The purpose of this report is to provide assurance to the Joint People Committee in relation to the established Freedom to Speak Up (FTSU) systems and processes in place across Wirral Community Health and Care NHS Foundation Trust (WCHC) and annual activity for the 2025/26 reporting period. It is recommended that the Committee: Be assured that FTSU systems and processes continue to be robustly implemented throughout WCHC	

Key Points to Note
- There are 115 FTSU Champions across the Trust promoting a speak up culture in their teams and in all staff network groups - The highest number of concerns reported were from Community Nursing (31% of overall concerns) 30 of the concerns reported (63%) were either reported openly by staff members or confidentially via the FTSU Guardian

Key Risks
This report relates to key Quality and Safety Board Assurance Framework Risks in addition to the following People Committee BAF risk: ID04 – Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing and morale are supported

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

Governance journey			
Date	Forum	Report Title	Purpose/Decision
16 July 2026	Joint People Committee	Freedom To Speak Up Annual Report 2025/26	For assurance and approval.

1	Narrative
1.1	This annual report provides an overview of Freedom to Speak Up (FTSU) activity during 2025/26 and covers the following key areas: • Governance • Concerns Reported by Service • Predominant Themes identified • Our People - Confidence in the FTSU process - Feedback from Satisfaction Questionnaires - Monitoring information • Key priorities for 2026/27
1.2	30 of the concerns reported (63%) were either reported openly by staff members or confidentially via the FTSU Guardian

2	Implications
2.1	Quality/Inclusion • This is an assurance report detailing Freedom To Speak Up concerns reported in the last financial year. The Speaking Up policy, which supports the governance and process of speaking up, contains the Quality & Equality Impact Assessment.
2.2	People • The Trust encourages all staff to speak openly and freely ensuring compliance with equality and diversity standards for all
2.3	Finance • None identified

2.4	Compliance • Freedom to speak up is a fundamental element of CQC well-led key inspections
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Freedom To Speak Up Annual Report

April 2025 – March 2026

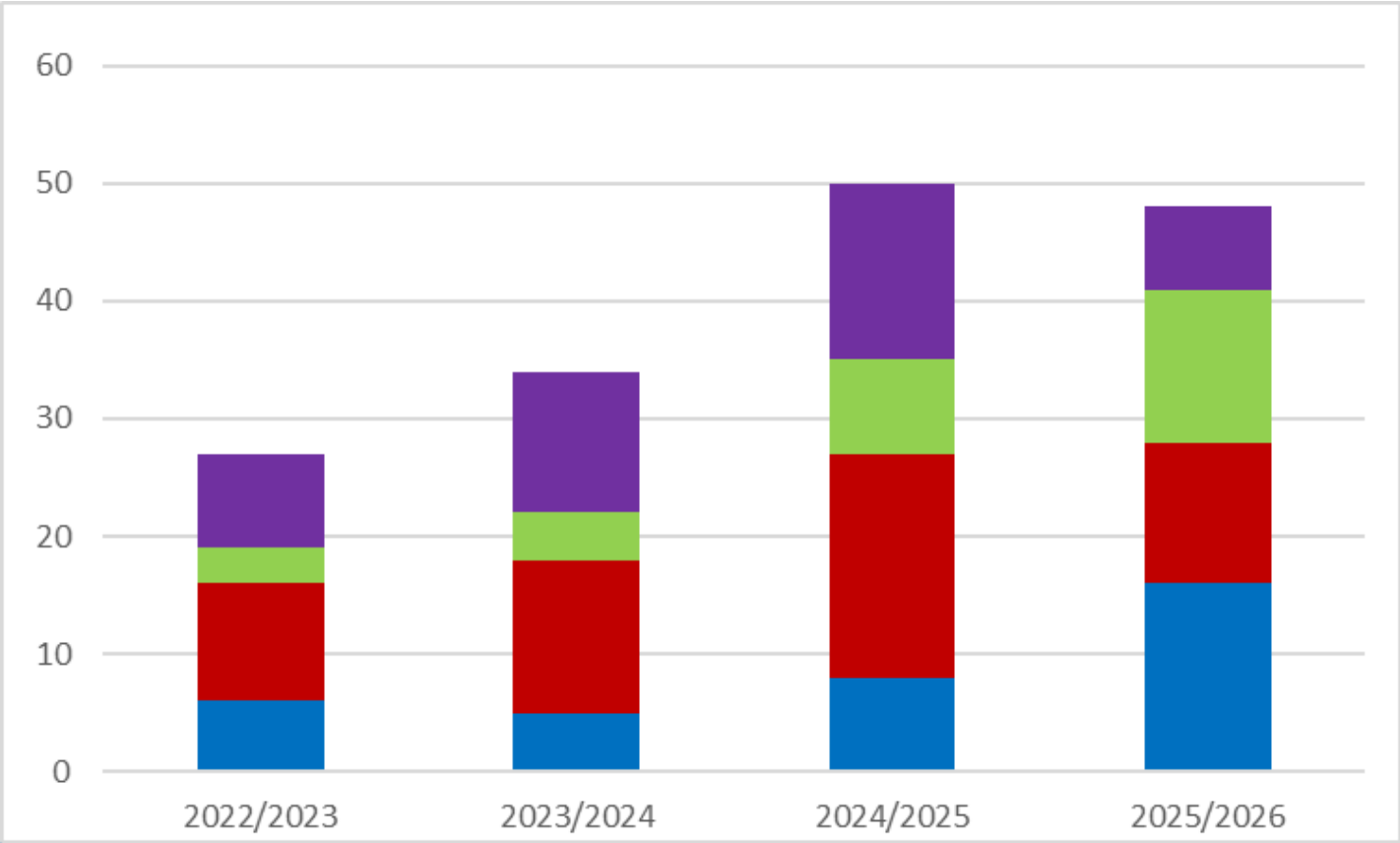
Alison Jones: FTSU Guardian

Date: 02 September 2026

Governance - How FTSU is monitored and supported

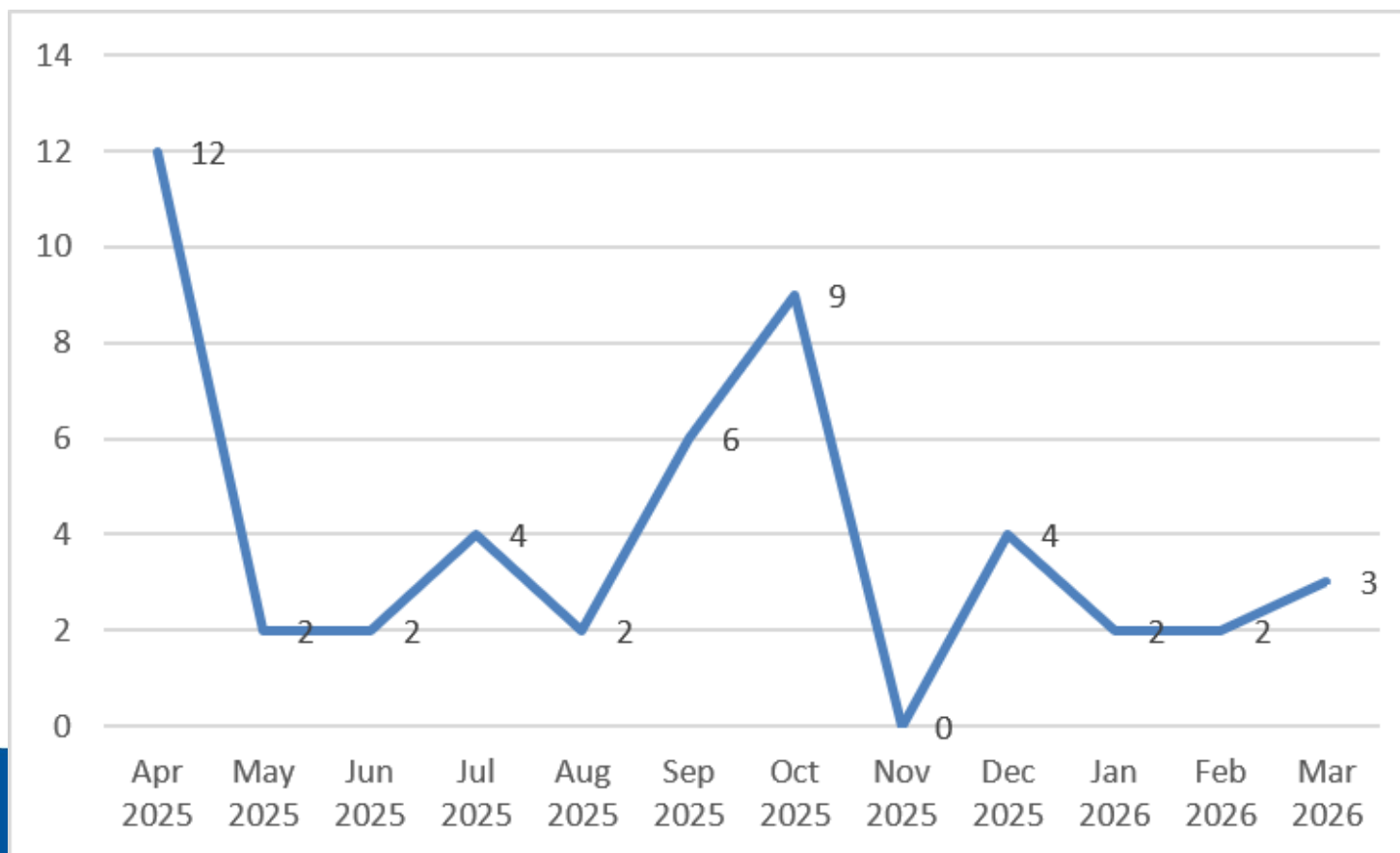
- The Trust has an established governance framework embedded across the organisation to effectively deliver a robust Freedom to Speak Up (FTSU) system
- The FTSU Guardian supports staff who raise concerns and promotes a culture of open reporting
- There are 115 FTSU Champions across the Trust promoting a speak up culture in their teams and in all staff network groups
- The Trust's Speak Up policy aligns to the recommendations from the National Guardians Office
- The FTSU Guardian is supported by both an Executive and Non-Executive Board member
- A quarterly FTSU Steering Group monitors themes and learning as well as effective triangulation with other data sources
- Senior leaders from Nursing, Human Resources and Operations meet bi-weekly with the FTSU Guardian to discuss progress and learning from concerns and to triangulate information from all areas

Comparison of FTSU Concerns Reported

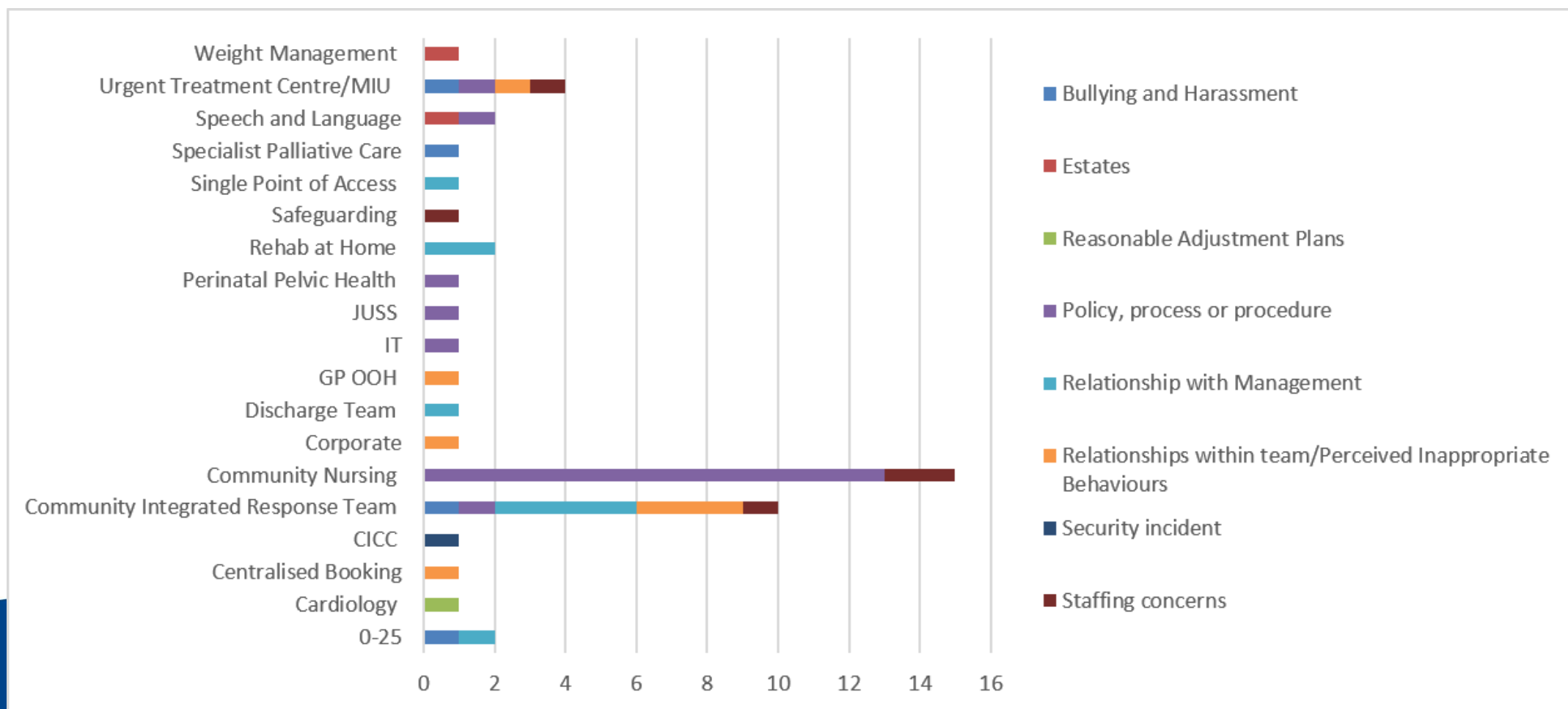


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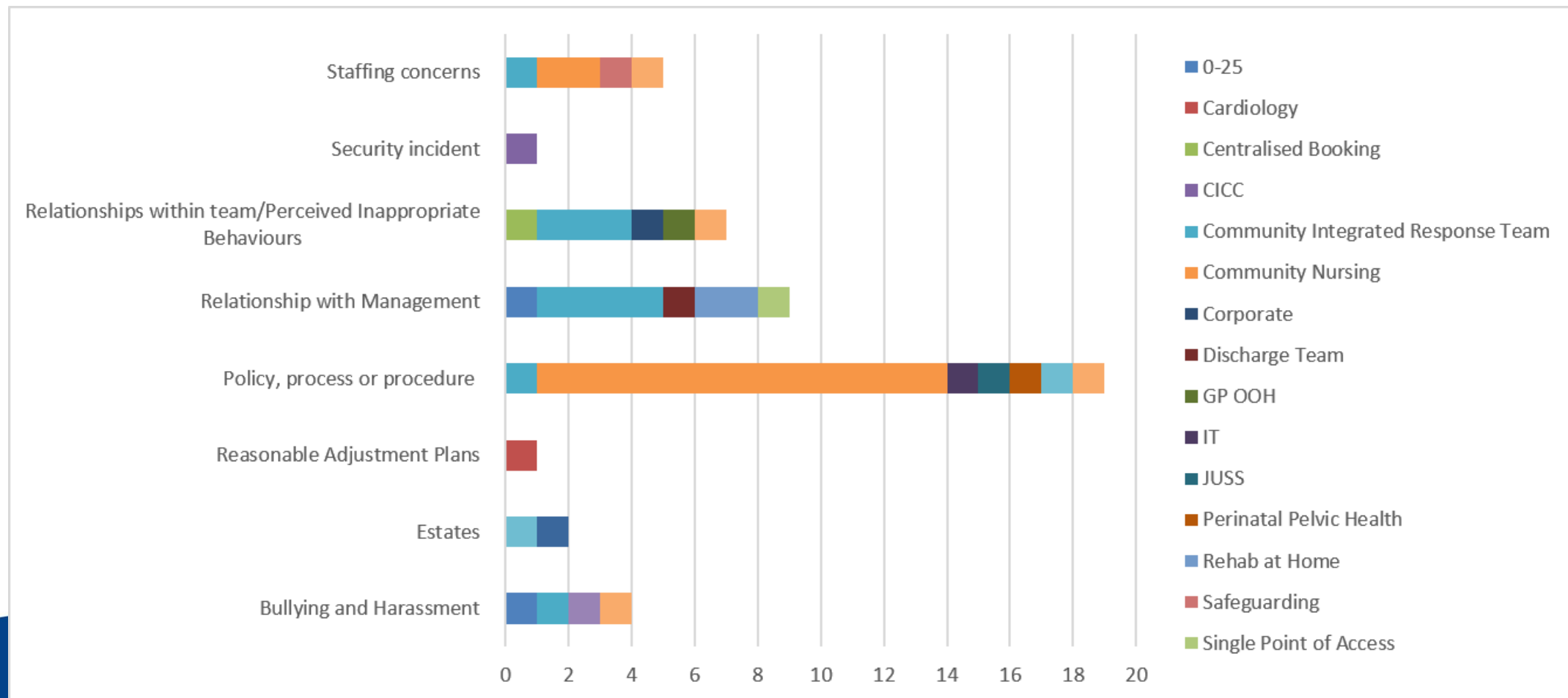
2025/26 Concerns Reported per Month



Concerns Reported – by Team and Theme



Concerns Reported – by Theme and Team



Summary and Themes of Concerns Reported

- 48 concerns were reported to the FTSU Guardian in 2025/26
- The highest number of concerns reported were from Community Nursing (31% of overall concerns)
- 87% of the Community Nursing concerns relate to the process of re-banding specific job roles. The concerns reported were escalated to the HR Team who conducted a review through the correct formal policies/processes and there are ongoing actions being taken in response to the concerns raised
- 35% of the overall concerns related to relationships with management and colleagues or perceived inappropriate behaviours. The Team who reported the majority of these concerns is the Community Integrated Response Team (CIRT)

Confidence in FTSU Process

- 30 of the concerns reported (63%) were either reported openly by staff members or confidentially via the FTSU Guardian
- 18 of the concerns reported (37%) were reported anonymously
- In 1 case (2%) the reported sighted fear of detriment in an interview process if it was known they had spoken up. The case was reported anonymously. Following a thorough investigation of the recruitment process, it was confirmed that Trust policy had been followed, and no areas of improvement were identified

What Our People Tell US

Feedback from satisfaction questionnaires

It was a straightforward process and I was glad to have raised the issue that was dealt with promptly.

My query was dealt with quickly, professionally and with an empathetic tone

I felt supported to share the issue at hand and felt confident that it was being explored/reviewed once reported. regular updates were given throughout the process. I think that being kept informed was the key to feeling well supported during this process

I found the whole experience very straight forward and very helpful

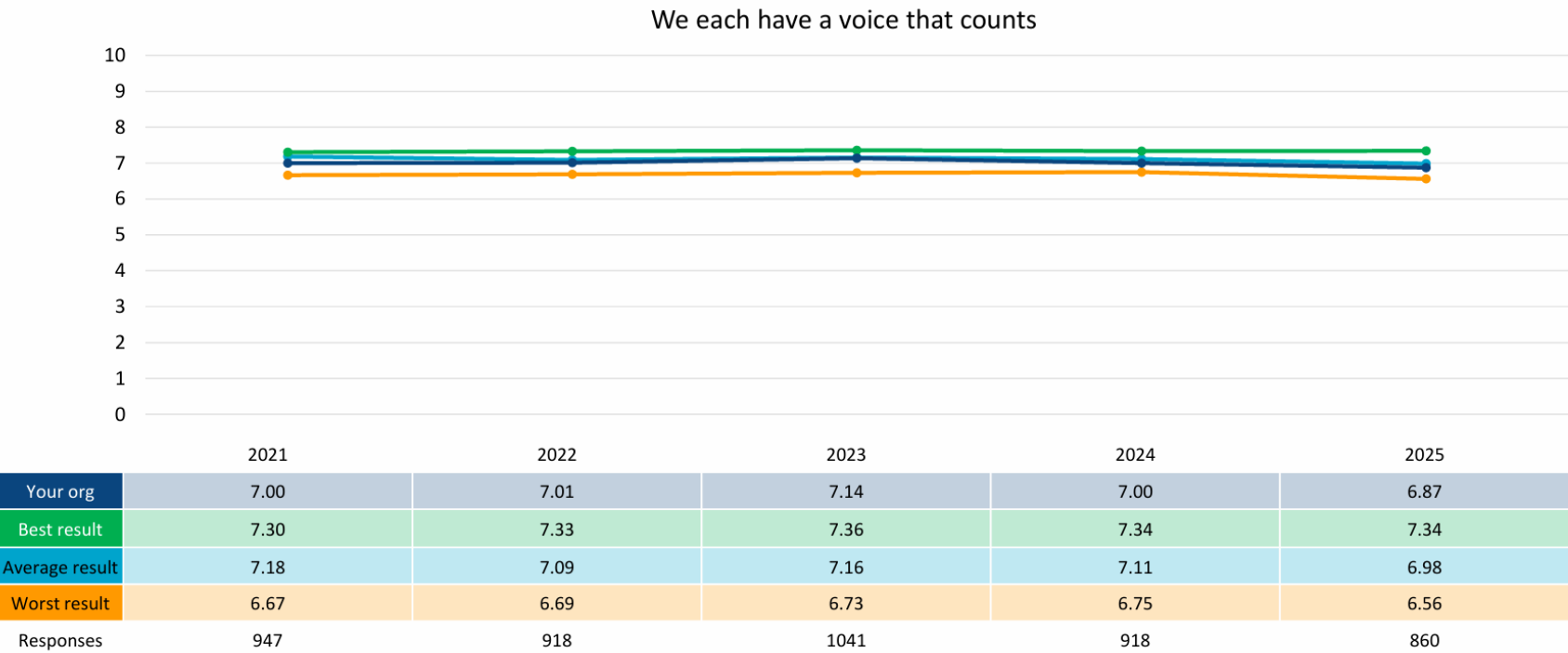
I felt well supported and that my concern was dealt with promptly and taken seriously

Guardian handled everything with privacy and sensitivity. Would only move forward with my consent

I feel like, while my issue was dealt with and addressed appropriately from the Freedom to Speak up team, the resolution was disappointing. While I appreciate the role of the Freedom to Speak Up officer and team I just think that ultimately it ends up in a lip service response from the higher ups and issues just won't ever be resolved.

Staff Survey 2025

 Promise element 3: We each have a voice that counts



- All Teams had the opportunity to review their staff survey results
- In areas where results were lower than the previous year, action plans were created with a view to Teams highlighting areas where improvements could be made with effective monitoring mechanisms in place

A celebration of Speaking Up and raising awareness



Report Summary

- The Trust has a robust Freedom To Speak Up governance framework to support staff in effectively raising their concerns
- The FTSU process is supported by an accessible electronic reporting system, supporting staff to report concerns either openly or anonymously
- Senior Leaders discuss and share Speak Up data regularly for learning and support and effectively triangulate this with other sources of data to assure safety
- The Trust has a high number of FTSU Champions who are committed to supporting their teams by signposting and promoting Speaking Up
- The feedback received from reporters is primarily positive with reporters advising that they would speak up again in future should they need to

Aims and Objectives for 2026/27

- The Speaking Up policy is currently under review with a view to aligning to the Wirral University Teaching Hospital (WUTH) policy, reflecting the National Guardian Office policy. This will ensure a consistent approach across both organisations, support our integration journey
- The function of the National Guardians Office (NGO) has now been incorporated into NHS England (NHSE). The aim is to work along side NHSE, as well as National and Regional Guardians, to ensure Speaking Up remains a key priority and any changes in practice or data collection from the NGO to NHSE are fully supported
- During 2026/27 the Guardians at WUTH and WCHC will continue to work in collaboration to further enhance the profile of FTSU across both organisations

Group Board of Directors in Public
02 September 2026

Item 19

Title	WUTH Freedom to Speak Up Annual Report 2025/26 (including Q4 2025/26)
Area Lead	Deb Smith – Chief People Officer / Executive Lead for FTSU
Author	Tracey Nolan FTSU Guardian/People Experience Lead

Purpose of the Report and Recommendation	
Report For	Assurance
It is recommended that the Board: Note the report	

Key Points to Note
National Guardians Office (NGO) guidance ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should be on a bi-annual basis. The purpose of this report is to ensure Trust Board are sighted on the FTSU themes and to provide assurance that concerns raised via the FTSU Guardian are listened to and resolved via the correct channels. Where themes / trends are identified this report outlines action taken to escalate themes for further review / action. The report includes data for 2025/26 reporting periods.

Key Risks
This report relates to key Board Assurance Framework (BAF) Risks: BAF 5: Failure to have the right culture, staff experience, and organisational conditions to delivery our priorities for our patients and service users.
NOTE: Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary.

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	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	No
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
July 2026	Joint People Committee	As above	As above

1	Narrative
1.1	Revised NGO guidance for 2022 (“Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services” 2022) highlights that reporting activity should now be on a bi-annual basis and therefore this report seeks to meet those requirements and outline FTSU activity for 2025/26. This report provides an overview of activity data for 12 months 2025/26 and work undertaken to progress the agenda in line with national policy and best practice guidance. Data is presented in a way that maintains the confidentiality of individuals who speak up. The National Guardians Office (NGO) issued new requirements for recruiting and embedding FTSU Guardians in a new framework published in May 2025. From 1 July 2026, following a recommendation in July 2025 by the Dash review of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian’s Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements. Last year the National Lead for Guardian Support and Policy (Bethany Carter) issued supporting narrative that highlights that the FTSU Guardian role has become an integral part of building healthy, safe, and inclusive cultures across our health and care systems with Guardians creating space for speaking up and listening well. However, it was felt that as the role has grown, so too did the need for greater consistency and clarity in how it is understood, supported, and implemented. A Gap analysis was undertaken this year to align with the 5 core principles recommended by NGO. (Appendix 1) • Championing a supportive environment • Identifying and overcoming barriers • Providing timely feedback and follow-up • Driving organisational learning and improvement • Ensuring robust governance and assurance

1.2

Staff Survey and FTSU

The NHS Staff Survey provides crucial insight into whether staff feel confident that their voices will be heard.

Since 2020 the staff survey has included a question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year's survey along with the follow-up question: 'If I spoke up about something that concerned me, and I am confident my organisation would address my concern.'

Staff Survey 2025 feedback

Freedom to Speak up:

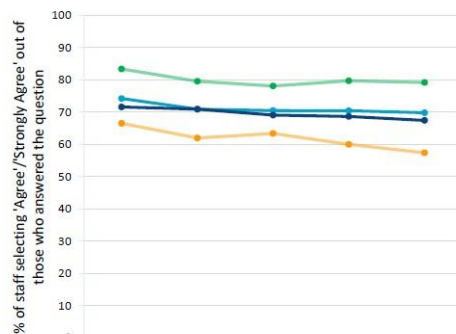
- There are several questions which cover the subject of raising concerns
- Some of these are linked into the people promise score of *we each have a voice that counts: raising concerns* and some are additional questions that are not linked
- The data can be seen at a trust level which compares the answers to those of all NHS acute trusts (hospitals)
- Data can be broken down by divisions and directorates, protected characteristics and staff groups.



People Promise elements and theme results – We each have a voice that counts: Raising concerns

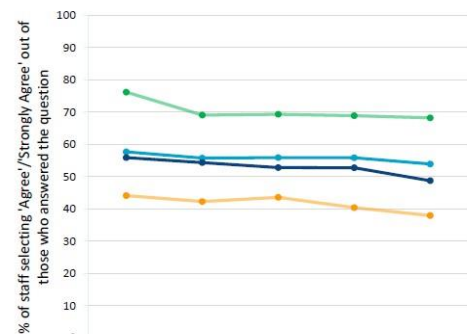


Q20a I would feel secure raising concerns about unsafe clinical practice.



	2021	2022	2023	2024	2025
Your org	71.60%	70.95%	69.08%	68.65%	67.44%
Best result	83.36%	79.55%	78.09%	79.72%	79.16%
Average result	74.22%	70.95%	70.47%	70.44%	69.82%
Worst result	66.54%	61.98%	63.38%	60.04%	57.41%
Responses	2878	3115	2433	3108	2791

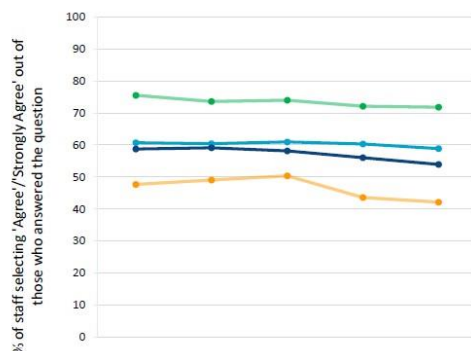
Q20b I am confident that my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	55.91%	54.37%	52.84%	52.76%	48.75%
Best result	76.20%	69.10%	69.34%	68.88%	68.23%
Average result	57.69%	55.78%	55.93%	55.88%	53.94%
Worst result	44.15%	42.28%	43.60%	40.40%	37.97%
Responses	2870	3115	2440	3100	2787

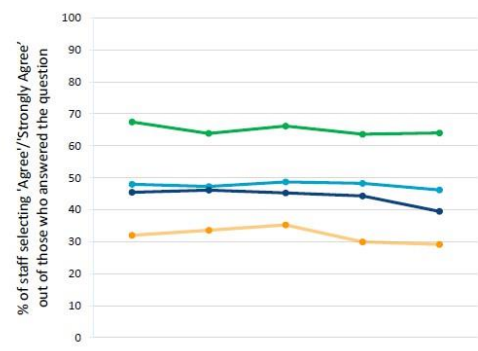


Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2021	2022	2023	2024	2025
Your org	58.74%	59.11%	58.13%	56.01%	53.90%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%
Responses	2872	3105	2438	3101	2784

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	45.43%	46.11%	45.24%	44.33%	39.47%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%
Responses	2863	3103	2435	3095	2783

Wirral University Teaching Hospital NHS Foundation Trust Benchmark report

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Findings

Results unfortunately show a decline in staff experience in this area and fall below the national average for comparator Trusts.

Trust results are comparable to national findings, identified by the National Guardians office and indicate “a plateau in confidence” again. The National Guardians office is calling for the role of the Freedom to Speak Up Guardian to be strengthened and standardised with greater accountability for leaders and organisations, and the embedding of a culture of listening and action across the entire NHS.

The same approach was adopted in reviewing the staff survey results, with FTSU Champions involved in a workshop event held to review results and support identification of priority areas for 2026/27.

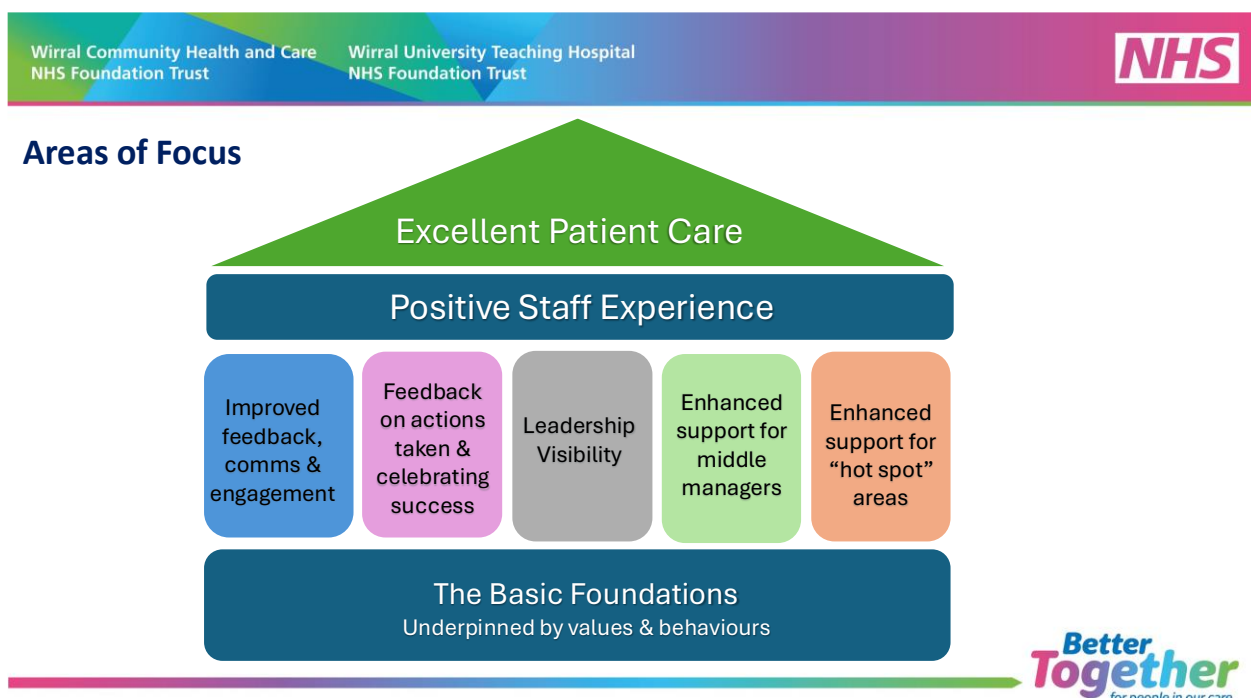
As a result of the feedback from staff, WUTH has identified that a “Back to Basics” focus is required to ensure that literature is visible around workplace areas and staff know how to raise concerns as an area of focus for 2026/27, with actions included in the FTSU action plan for 2026/27.

The divisions with the lowest confidence will also form part of the action plan this year to target in terms of building trust with staff.

Following the staff survey results an area of focus for Freedom To Speak Up will be ensuring staff are fed back to following concerns being raised – the aim being to build trust and confidence in the Speaking Up process.

Work has already commenced with Divisional feedback opportunities underway and priority actions identified which include supporting staff to speak up and ensuring feedback is provided on actions taken.

Work is also underway with the governance support team who are adding to feedback sent to staff who have raised incident forms, that whilst necessary actions have been taken, detailed outcomes can be obtained from local management.



1.3 FTSU Activity

Number of People Speaking Up

Data is submitted to the National Guardians Office (NGO) on a quarterly basis and although previously we have been able to provide a comparison between the overall number of people speaking up against regional and national Trusts of similar size this is now not possible due to The Guardians Office closing imminently.

The number of people speaking up to FTSU Guardians has remained the same over the past year with 79 people speaking out in 24/25 and 79 staff speaking up in 25/26.

Although numbers were the same for both financial years Q3 and Q4 demonstrate a significant increase in numbers of staff speaking up and this has continued into Q1 26/27.

23/24				24/25				25/26			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
24	24	27	29	37	13	12	17	12	12	28	27
21	25	36	46	34	41	31	32	34			
31	35	40	44	39	43	40	37	43			

Increased visibility around the hospital, bespoke training and attendance at team meetings, promoting the service within induction as well as all managers training events has already seen a rise in concerns raised in the coming year, although staff when spoken to this year have said that they feel able to raise concerns with their line manager themselves, this is positive and suggests that staff feel they are working within a psychologically safe environment.

Nationally the raising concerns sub-score, which reflects how confident staff feel about speaking up and whether they believe their organisation will act, has fallen to 6.37.

Between 2021 and 2024, this score was stable. This year, it has dropped marking the sharpest single year fall the survey has recorded. The underlying indicators point to the same shift in confidence:

- Just six in ten staff now feel safe to speak up about anything that concerns them.
- On clinical safety concerns, confidence in raising them has fallen to 71.1% compared to the previous year 71.56%.
- Clinical Safety - Staff confidence in raising clinical safety issues has been on a slow, multi-year decline from its peak of 75.17% in 2021. The current score of 71.10% is officially the lowest recorded since this benchmark was created. Crucially, fewer than half (47.6%) believe their organisation would act on a general concern, and 55.5% believe it would act on a clinical safety concern. Taken together, these results suggest that NHS staff feel less able to speak up and less confident it will lead to action.
- This year's survey was carried out against a backdrop of sustained financial pressure, structural reorganisation and the impact of industrial action.

We need to build the confidence of staff in the speaking up process. Our action plans this year include targeting the lower scoring areas from the staff survey as well as going back to basics and ensuring that staff know how to raise concerns.

Concerns Raised by Theme

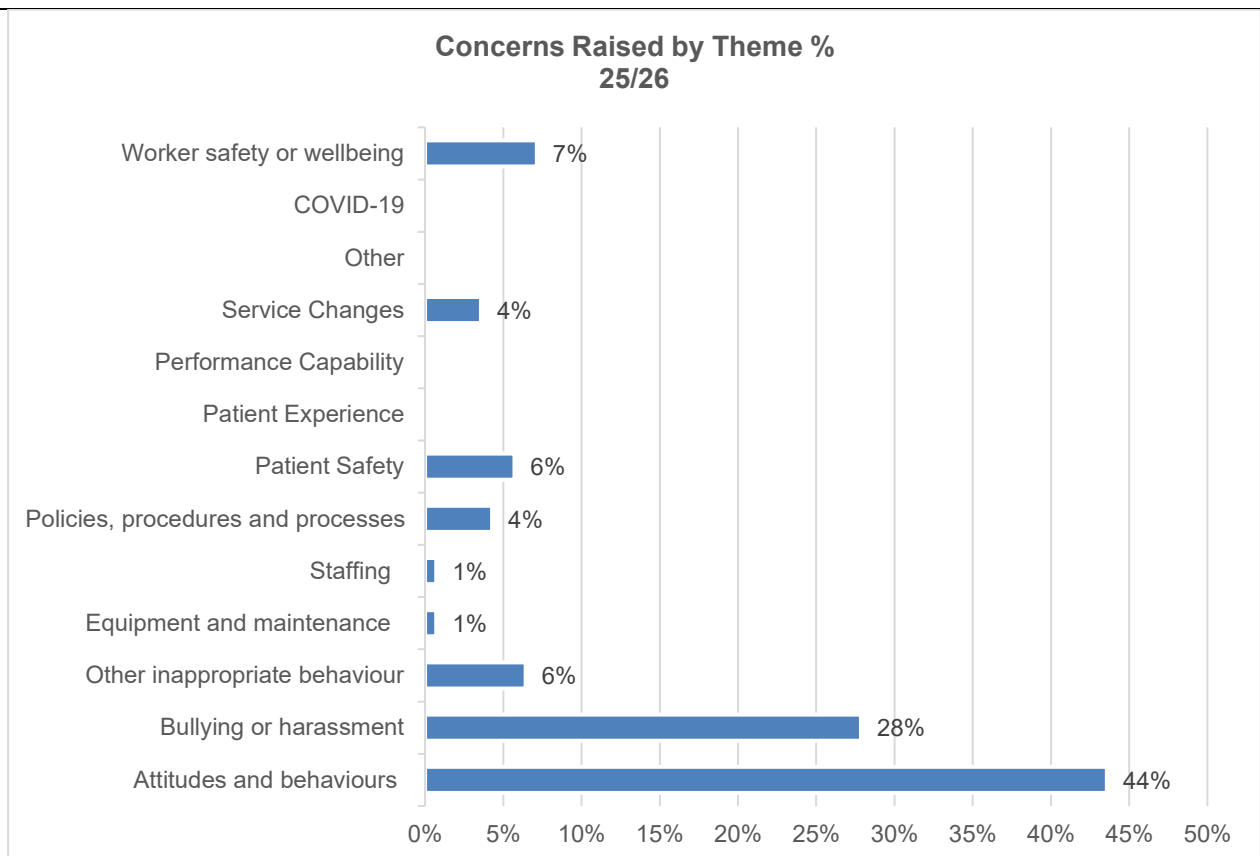
The table below sets out the concerns raised during 25/26 by theme. This 12 month period has witnessed a surge in concerns raised about Attitudes and behaviours, accounting for over 44% of all concerns raised during the year. When comparing this to last year the figure was the same.

Bespoke training has been delivered to some areas with a emphasis on kindness and respect at work. Acknowledging that pressure can elevate poor behaviour and discussing the importance of our own responsibilities coming to work has been positively received. The focus on kindness in teams and apologising will endeavor to tackle attitudes and behaviour within areas.

Bullying and harrasment has decreased from last year with 28 concerns raised over the year in comparison to 40 concerns raised the year before. Moving forward data on bullying and harrasment will be split between manager to staff and peer to peer to give a greater insight into concerns raised.

During the financial year there was a total of 79 FTSU cases (individuals), these 79 staff members between them raised 92 concerns. These concerns were then grouped into the national guidance reporting themes (13 themes). Of the 92 concerns raised, 28 related to bullying and harassment – this accounts for 30.4% of all 92 concerns raised.

It is important to note that as per the NGO guidance, “bullying or harassment” is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case.



By breaking down broad categories like "bullying and harassment," we can gain the possible ability to identify specific cultural trends and systemic issues that a generic term may not provide. Moving forward into the new year changes have been made to recording themes. When looking at Bullying and harassment these will be split into Manager and Peer categories.

Splitting these cases into Manager vs. Peer categories provides a clear distinction and when triangulated with divisions this aims to provide a clearer picture of the divisional differences. Knowledge of manager or peer is also important in the management and training when we know where the bullying and harassment may be coming from

- The intervention required for a peer-to-peer conflict (often mediation or team building) is vastly different from an abuse of power by a manager (which may require HR formal action or leadership training).
- This allows the Trust to see if there is a "middle-management" issue or a general poor behaviour/hostility issue within specific departments.

Sexual Safety as a Standalone Category

Moving sexual safety out of the general "harassment" or "other inappropriate behaviour" umbrella is an important move to ensure that we meet our obligations under The Sexual Safety Charter and manage these concerns in an appropriate way.

Recording sexual safety concerns separately also ensures that our recording mechanisms are in line with the sexual safety charter and will enable us to provide data for annual reporting.

1.4

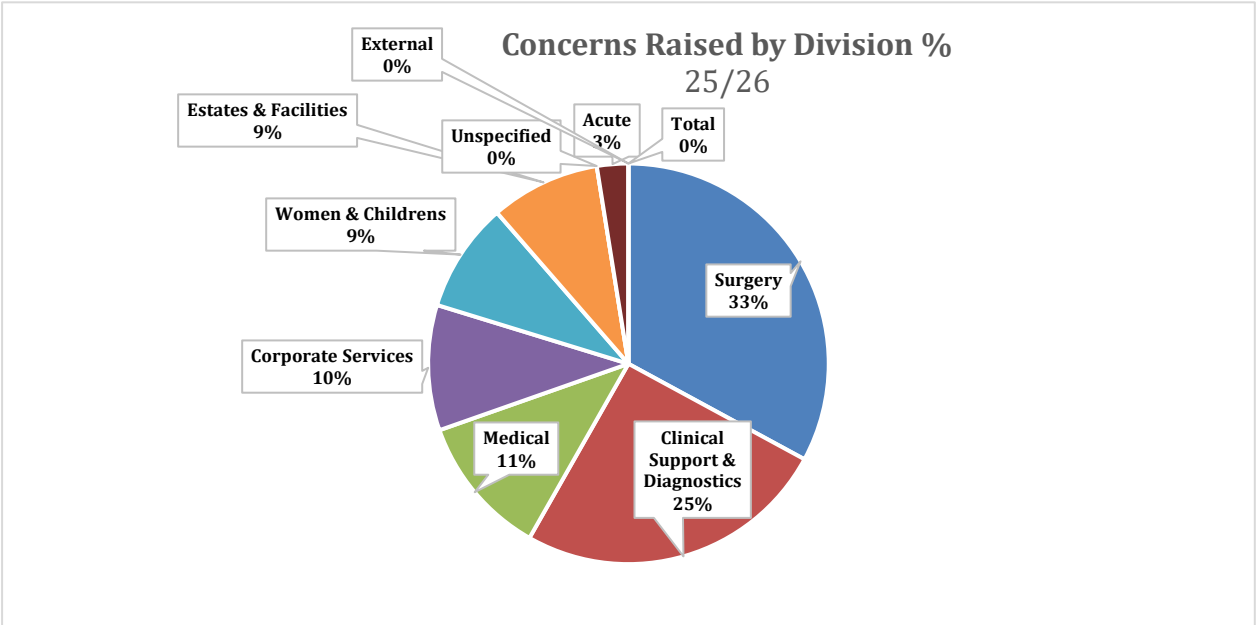
FTSU Patient Safety Data

Patient safety concerns have decreased this year compared to last with only 2 concerns raised 25/26 compared to 8 concerns raised in the previous year.

The average concerns raised nationally relating to **patient safety or quality** comprised 18% of all National cases in 2024/25, a decrease from 19% in 2022/23 and sustaining a downward trajectory.

Staff will automatically use the incident reporting mechanism to raise patient safety concerns and many staff would not view FTSU as the usual platform to report patient safety concerns

Concerns raised by Division



Divisional info

Surgery Division Concerns are the highest again for 25/26, though the numbers are moving in a positive direction and are lower than the previous year.

The change in numbers suggests that the targeted interventions previously implemented within the Surgery Division maybe yielding results.

Why Surgery ?

It is common for Surgery Divisions to account for a higher percentage of concerns due to several structural factors:

1. **High-Stakes Environment:** The clinical risks associated with surgical procedures often lead to a more vigilant "safety culture" where staff are trained to spot and report even minor deviations.
2. **Operational Pressure:** Issues involving theatre throughput, equipment availability, and staffing levels are frequent triggers for staff feedback.

3. **Complex Multi-Disciplinary Teams:** Surgery involves coordination between surgeons, anaesthetists, nursing, and ODPs, which can sometimes lead to communication friction that requires mediation. (British Journal of Anaesthesia)

Staff survey Divisional breakdown – Response to Speaking Up questions

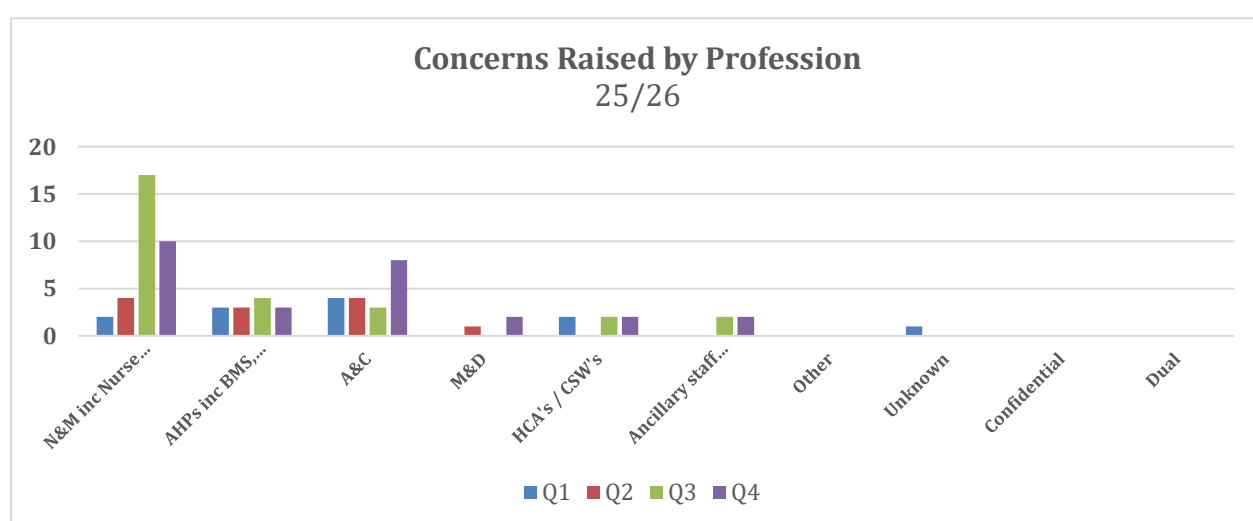
Q	Description	Comparator (Organisation Overall) n = 2825	Clinical Support Div n = 722	Corporate Support Div n = 357	Emergency Div n = 63	Estates, Facilities & Capital Div n = 430	Medicine Div n = 477	Surgery Div n = 450	Women and Children's Div n = 326
q20a	Would feel secure raising concerns about unsafe clinical practice	66.6%	70.2%	55.9%	66.7%	60.8%	70.6%	60.7%	79.4%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	48.9%	50.7%	43.5%	45.2%	50.9%	49.3%	39.6%	61.1%
care provided by organisation									
q25e	Feel safe to speak up about anything that concerns me in this organisation	54.3%	59.4%	53.7%	54.0%	54.0%	49.7%	42.8%	66.9%
q25f	Feel organisation would address any concerns I raised	39.9%	41.1%	40.2%	38.1%	41.7%	37.7%	30.6%	51.2%

Surgery response to speaking up is the lowest division in terms of confidence in the Speaking Up process along with the number of staff speaking up from this division being lower than the previous year.

There has been a number of targeted interventions within surgery, and this has continued in the form of proactive wellbeing support for staff. It has been two years since the Working Party on Sexual Misconduct in Surgery (WPSMS) published the [Breaking the Silence: Addressing Sexual Misconduct in Healthcare report](#), which provided the first comprehensive analysis of sexual misconduct in the surgical workforce. WUTH have since signed the Sexual Safety Charter, mandated sexual safety training and remains committed to encouraging staff to speak out about inappropriate behaviour.

1.5 Concerns Raised by Professional Group

The following table highlights the concerns raised by professional group.



The highest staff group raising concerns across the 12-month period are from Registered Nurses/Midwives accounting for 41% of all concerns raised. Clerical roles account for 36% of concerns raised (29 staff) across the year.

Staff Groups and Speaking Up

Staff group		Comparator (Organisation Overall)	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Q	Description	n = 2825	n = 127	n = 379	n = 700	n = 256	n = 420	n = 65	n = 210	n = 668
q20a	Would feel secure raising concerns about unsafe clinical practice	66.6%	70.6%	70.6%	56.0%	70.7%	61.5%	69.2%	74.3%	73.4%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	48.9%	57.6%	56.5%	46.1%	40.0%	51.5%	40.0%	46.7%	49.2%
q25e	Feel safe to speak up about anything that concerns me in this organisation	54.3%	59.5%	56.2%	51.9%	60.4%	54.0%	58.5%	56.2%	51.6%
q25f	Feel organisation would address any concerns I raised	39.9%	46.8%	45.1%	39.0%	34.4%	40.9%	32.3%	40.0%	38.8%

Q25e - Would feel safe to speak up about anything that concerns me in the organisation. The lowest group was Nurses/Midwives yet this has been the group of staff who have spoken up more than any other group.

Q25f – Feel organisation would address any concerns raised – there is a significant difference between the 2 questions which suggests that staff feel able to speak up however there then appears to be little faith in the organization then addressing the concerns.

Demographics

79 staff raised concerns.

5% of staff were Black, Asian and Ethnic Minority (BAME) staff; no staff raised concerns around racism

6% of staff were neurodiverse and every concern raised was around lack of understanding and appreciation of neurodiversity in the workplace.

Disadvantageous or Demeaning Treatment as Result of Speaking Up

None were reported across the 12-month period.

Lessons Learned

The 2025 staff survey highlights a decrease in staff feeling their immediate managers care about their concerns, less staff feel safe to speak up about anything that concerns them in the organisation and are less confident that the organisation would address their concerns.

It is vital that the Trust through its leaders continue to promote a positive speak up culture to build staff confidence in knowing that when they do speak up that they will be listened to, and action will be taken.

Work continues to further improve the timeliness of responses from managers once a concern has been raised, with FTSU Guardians setting expectations of managers when concerns are raised. A new monitoring and escalation process has also been implemented with Executive, Non-Executive and Senior Trust leaders to review themes and trends and ensure timely progress and actions are taken. It is vital that lessons are also learnt as a result of raising concerns and solutions are not the only focus but looking back over the concern and learning from what went wrong.

Themes throughout the year have demonstrated that the way we talk to each other is important and the way that we ask people for help or to change can impact people significantly, both positively and negatively. Kindness can make a huge difference to people and can have a significant impact on individuals and divisions. Kindness can create a more positive and supportive environment.

Anonymous Concerns

Two anonymous concerns were received throughout the year, both of which were related to bullying. Anonymous reporting continues to remain low, which is a positive indicator. Staff are encouraged to discuss any concerns with their line manager in the first instance, where possible.

Progressing the FTSU Agenda

The national infrastructure is currently undergoing a significant transition:

- **Integration into NHS England:** As part of broader NHS structural reviews (such as the Dash Review) and the 10-Year Health Plan, the standalone National Guardian's Office is scheduled to close by the end of June 2026.
- **Transfer of Functions:** The vital functions of the NGO are being transferred directly into NHS England, the Care Quality Commission (CQC), and the Department of Health and Social Care (DHSC).
- **Continued Commitment:** Despite the structural change at the national executive level, the NHS remains fully committed to the FTSU agenda. The network of local Freedom to Speak Up Guardians will continue to operate and be a mandatory requirement for healthcare providers, with an aim to streamline processes and better integrate staff voice data into wider NHS improvement systems.

We will aim to develop a FTSU development plan that not only ensures that the Trust remains aligned to national FTSU requirements but also continues to improve and provide a quality FTSU service at WUTH as well as consider the "well led" domain within CQC guidance.

There have been some highlights throughout the year:

Looking at training compliance earlier in the year we recognised that Estates and Facilities were low across the board in all mandatory training. A low training compliance often masks deeper cultural issues, leading to low "speaking up" numbers. When staff don't feel they have time for mandatory training, they often don't feel they have the "permission" or psychological safety to flag safety risks or operational concerns. This is evident within the division and may explain the low numbers of staff who speak up from Estates and Facilities.

A commitment to offer a "trio of training" to include 3 behavioural packages of training was agreed.

- Respect at Work
- Freedom to Speak Up training
- Sexual Safety training

	10 sessions at Arrowe were offered and Oliver McGowan along with Fire Safety was included so staff could attend for any sessions that they needed to do in the hope that compliance would increase. • Drop ins in the Estates and Facilities areas have been offered and staff have raised concerns whilst there. • We have increased the number of FTSU Champions throughout the hospital • We have undertaken targeted walk abouts with CSWs during rebanding consultations • We have spent time in ED building trust and understanding staff experiences. • We have supported Wirral Community NHS with Freedom to Speak Up whilst their Guardian is not in work, with a workforce sharing agreement in place for WUTH's FTSU Guardian. Ensure the Trust is up to date with national and local guidance, policy and best practice – The National Guardian framework has been published with recommendations made for NHS Trusts. Merseyside Internal Audit Agency have assessed the National Guardians Freedom to Speak Up policy and asked for extra information to be added - completed 1. Increase FTSU capacity – Increase champion network to ensure that all divisions have champions within them – we will continue to engage new champions, currently we have 43 trained champions throughout the divisions – champions are able to thanks, promote and signpost staff. – we will continue to increase the Champions network 2. Staff survey – we will use the staff survey to identify areas of strength and areas for development 3. As of May 2026 89.23%, staff have completed their level 1 speak up training. We are delighted to report that level 2 has increased to 93.26% this last 12 months. Level 2 training consists of line managers and supervisors which is a core group of staff Compliance continues to be high when compared with regional Trusts and seeks to promote awareness and support to all staff. Level 3 training which is the “follow up” remains at 100% - there are plans in place to roll this down to the triumvirates in the coming year. 4. Identify groups potentially facing barriers to speaking up and work towards addressing those barriers – This objective seeks to engage staff from minority groups who are potentially less likely to speak up. Within the last 12 months FTSU champions are present within all the staff networks. The work of the FTSU champions is particularly important to promote the FTSU agenda and to further champion the agenda amongst staff with protected characteristics. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. 5. Work has commenced to complete the Freedom to Speak Up: Reflection and Planning tool. This improvement tool is designed to help us identify strengths in the Leadership team and identify any gaps that need work. The tool will be tabled for September Board for discussion.
1.6	Conclusion

	The number of people speaking up to FTSU Guardians has remained the same over the 12-month period. Considerable work has continued during the year to implement national FTSU policy and guidance the development of an annual action plan Work continues to enhance reporting and provide board assurance of the FTSU agenda. The FTSU guardian/staff experience Lead continues to build and develop the role, promoting the service, regular walkabouts to ensure visibility and membership within key groups such as close links with governance and FTSU agenda continues to be heard, and the promotion of this significant role continues to be raised.
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2	Implications
2.1	Patients Whilst the FTSU service is aimed at supporting staff to speak up, a healthy speak up culture undoubtedly will improve the care delivered by our staff and the experiences of our patients and service users. Less patient safety concerns have been raised this year which can be an indicator that other reporting processes are working, as staff experiences have continued to decline in this area, further work is needed to review speak up processes and how feedback is given to staff following concerns raised.
2.2	People Staff experience metrics within the last staff survey (2025) have declined, with staff less satisfied in a number of areas including less confident that concerns will be addressed. Whilst the staff survey does not specifically show this is the FTSU service, data is concerning for the organisation and additional efforts placed on trying to build staff confidence to speak up.
2.3	Finance Findings from the national review and associated gap analysis undertaken (appendix 1) indicates resource implications for the FTSU Guardian / service. These should be considered as part of impending organisational change structure reviews.
2.4	Compliance Biannual reporting and presented by the FTSU Guardian continues to be in line with national guidance.

Freedom to Speak Up Arrangements - Gap Analysis

NGO			WUTH	
No.	NGO Area for Review	Recommendation	WUTH Current Position	Action Needed / Recommendation
1	Work of FTSU Guardians to be aligned to 5 core principles: i) Championing a supportive environment ii) Identifying and overcoming barriers iii) Providing timely feedback and follow-up iv) Driving organisational learning and improvement v) Ensuring robust governance and assurance	FTSU Guardian work to be aligned with these core principles	The principles are contained within the FTSU Guardian JD and associated activities, however not explicitly laid out. 2026/27 Action plan now aligned to the core principles.	Review of FTSU JD to explicitly highlight these principles. Future FTSU reports to be aligned to the core principles.
2	Ensuring FTSU Guardians have the key competencies for the role, with support provided to develop where necessary.	FTSU Guardians to undertake a self-assessment of their competencies contained within the FTSU development guide	FTSU Guardian currently completing.	FTSU Guardian to complete review.
3	Support for FTSU Guardians	That each organisation has a minimum of one full-time equivalent FTSU Guardian is in place, aligned with the core role requirements. Cover for absences: i) <4 weeks internal cover ii) >4 weeks Exec Lead to ensure access to another FTSU Guardian, alongside established FTSU routes, in line with Starting Out, Stepping Down FTSU Guardian must be recruited into stand-alone roles or where an organisation has an existing model of “dual roles”, enough time must be given to complete all aspects and tasks required i.e. in line with the NGO development guide. Lack of support could lead to non-	WUTH has 22.5 hours dedicated to FTSU, with the postholder working full-time hours however to also cover People Experience. Reciprocal agreement with WCHC FTSU to offer FTSU Guardian support as necessary. WUTH FTSU Guardian provided support for WCHC during recent episode of absence. Organisational change process due to commence July/August and resources to be reviewed as part of the organisational change process.	Minimum of one full-time equivalent FTSU Guardian to be in place aligned with the core role requirements.

Freedom to Speak Up Arrangements - Gap Analysis

		compliance and removal from the guardian register.		
		All FTSU Guardians to be fully trained and registered and connected with NGO network	Lead FTSU Guardian is compliant with NGO training.	No further action required unless additional FTSU Guardian(s) are appointed.
4	Access to FTSU Guardians – deemed not an urgent response service	24-hour FTSU Guardian cover is not essential, but all workers should be aware of how to contact their named Guardian at any time.	In line with recommendations, with email signature and out of office messages used to promote availability.	Email signatures and out of office messages to include when next in along with signposting information.
5	FTSU Board and leadership responsibilities	Organisations to have adopted the national FTSU Policy	Policy adopted and in place and updated June 2026.	No further action
		Exec and Non-Exec leads in place	In place. New Non-Exec lead commenced for 2026 and new Exec lead to take over August 2026.	New Exec lead to commence August 2026 and Trustwide promotion of Exec and Non-Exec lead to take place via Trustwide comms.
		NGO planning and reflection tool to be completed at least every 2 years	Completed in 2024.	Further review of the tool to take place this year with new Non-Exec and Exec Lead in post.
		FTSU Guardians to be recruited via an open and transparent recruitment process	Completed	No further action
		Responsible for ensuring adequate FTSU resource i.e. minimum one full-time FTSU Guardian and proportionate to the size and complexity of the organisation	See section 3	
		FTSU Guardians must have direct access to an FTSU Executive lead, who they regularly meet with	Exec and Non-exec leads in place, with quarterly meetings established and an open door policy in place.	To be re-established with new CPO following commencement.
		FTSU Guardians must attend Board meetings at a minimum six-monthly intervals and expected to present FTSU report	In place	No further action
		FTSU Guardians to be involved in discussions about culture, worker safety and experience	In place. FTSU Guardian is the lead for Sexual safety, is also a people experience lead and is linked in to a variety of agendas	No further action
6	Data reporting and recording	FTSU Guardians not to discuss cases with other FTSU Guardians or colleagues unless explicit consent to do so.	In place	No further action

Freedom to Speak Up Arrangements - Gap Analysis

		FTSU Guardians to record cases and reporting data in line with NGO guidance	In place	No further action
7	Independence of the FTSU Guardian role	FTSU Guardians must be supported to act with impartiality, maintain their professional independence, and carry out their role without undue influence	Reviewed on regular occasions due to national concerns that FTSU Guardians sitting under HR may be deemed a barrier. This however hasn't been highlighted at WUTH	No further action currently – however ongoing review of role to ensure independence and consideration given to changing line management structure if deemed conflicting.
8	FTSU Guardian Line Management	FTSU Guardians to report to designated Exec lead for FTSU, however general management responsibilities to sit with a different senior manager for purposes of signing off annual leave and appraisals.	In place	No further action
		Strongly advice that FTSU Guardians should not line manage other FTSU Guardians	This does not occur at WUTH. Supervision and support on case work is however in place.	No further action
9	NHS Banding	For organisations with a lead/deputy guardian model the Band 7 should be considered a minimum band for the deputy and the Band 8a a minimum standard for the lead.	WUTH currently has a band 7 as the FTSU Lead.	A review of the JD and banding for the role is recommended, in line with NGO sample JD's and will be implemented as part of impending organisational change processes within Corporate Services.

Appendix 2 Speak Up @ WUTH Action Plan 2026 - 2027

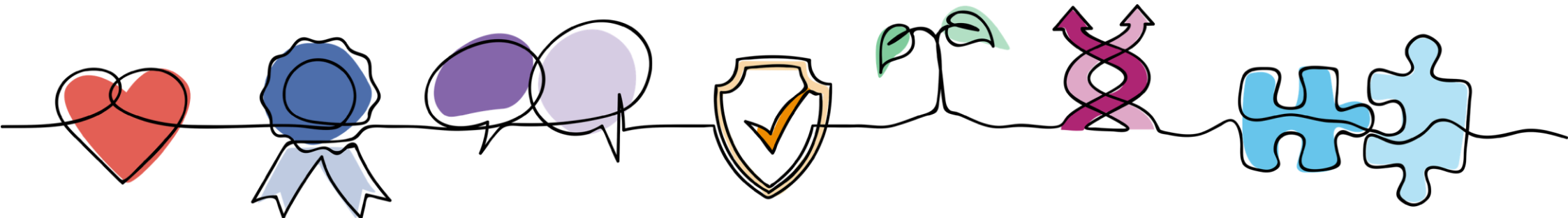
Overview –This action plan takes into consideration National Guardian’s Office (NGO) Guidance, Care Quality Commission Requirements, internal review findings and recommendations and learning from NGO case reviews.

	Objective	Action	Ownership	Deadline	BRAG	Comments
1	Championing a supportive environment	1.1 Increased awareness raising of FTSU and support available to staff	Lead FTSU Guardian	31/10/27	Green	FTSU Guardian to continue to be part of induction. Drop-in sessions held within Estates, Facilities and Capital Planning and face to face sessions developed to reach more staff. Work to continue and new ways identified to reach staff due to low uptake. FTSU Guardian has dedicated session on manager essentials, leadership for all programmes, doctors in training and student nurse programmes.
2	Identifying and overcoming barriers	2.1 Review access to the FTSU service to ensure staff are aware of when and how to speak up	Lead FTSU Guardian / FTSU Champions	30/09/27	Green	Back to basics review to be completed ensuring posters, Trust comms and website information is up to date and staff are aware. Ensure contact methods are effective and accessible, with clear information and signposting is available when FTSU Guardian is unavailable.
		2.2 identify and develop more FTSU Champions from within staff networks, with a particular focus on LGBT+ and multicultural networks	Lead FTSU Guardian	31/03/27	Green	FTSU Guardian linked with all networks and attending wherever possible.
		2.3 Regular walkabouts to cover all Trust areas, including out of hours staff e.g. nights and weekends	Lead FTSU Guardian / FTSU Champions	31/03/27	Green	
		2.4 Targeting of areas of low satisfaction with 'raising concerns' in the 2025 staff survey to understand potential reasons and actions that may support improvements	Lead FTSU Guardian / FTSU Champions	30/09/27	Green	Review of staff survey undertaken with workshop held for FTSU Champions.
		2.5 Revised reporting for bullying and harassment concerns, with data to be split to show whether B&H is from colleague(s) or manager(s)	Lead FTSU Guardian	30/09/27	Complete	Changes made to database and for reporting in the next biannual report.
		2.6 Work with EDI lead and multicultural staff network co-chairs to understand staff experiences and reducing barriers to speak up.	Lead FTSU Guardian	31/03/27	Green	Links in place and FTSU Guardian supported Trust drop in sessions following recent local protests. Links made with staff member and staff story captured and to be shared at People Committee and Board and drop-in sessions held in areas deemed hard to reach.

3	Providing timely feedback and follow-up	3.1 Monitoring of length of time cases open for, to be included in future biannual reports.	Lead FTSU Guardian	31/03/27	Green	Further consideration and review is required to ensure effective monitoring.
		3.2 New senior oversight meetings to monitor time cases open for and to understand and remove barriers as necessary.	Lead FTSU Guardian / Exec and Non-exec Leads	31/10/27	Green	To be re-established with new CPO following commencement.
		3.3 Feedback sought from users of the FTSU service via short survey on closure of a concern.	Lead FTSU Guardian	31/10/27	Green	Survey previously offered to staff however uptake low. Survey monkey no longer supported due to Trust finances and alternative mechanism via MS Forms to be introduced.
4	Driving organisational learning and improvement	4.1 Maintaining Trust compliance levels of 90% for national FTSU eLearning programmes (levels 1,2 &3)	Lead FTSU Guardian / Divisional Triumvirates	31/03/27	Amber	Pilot programme developed for Estates, Facilities and Capital Planning staff to deliver series of bespoke face to face sessions for staff. However, numbers of staff in attendance were only small and therefore compliance levels within EF&C still non-compliant. Targeted work to continue with alternative approaches to be considered by EF&C management team.
		4.2 Roll out of level 3 FTSU elearning programme to Divisional Triumvirates	FTSU Lead / Divisional Triumvirates	31/03/27	Green	Plan to be shared for approval at next Education Governance Group
		4.3 Feedback sought from users of the FTSU service via short survey on closure of a concern.	Lead FTSU Guardian	31/10/27	Green	Survey previously offered to staff however uptake low. Survey monkey no longer supported due to Trust finances and alternative mechanism via MS Forms to be introduced.
		4.4 Learning from cases to be shared as part of biannual reports; new senior oversight group and as part of Trust communications where possible and through governance reporting.	FTSU Lead / Senior leaders	31/03/27	Green	
5	Ensuring robust governance and assurance	5.1 Biannual reporting through workforce governance structure, presented by the FTSU Guardian.	Lead FTSU Guardian	31/03/27	Complete and ongoing	Biannual reporting cycle in place and ongoing. Report goes to People Committee and to the Board of Directors for review.
		5.2 Monthly meetings with Deputy Chief Operating Officer and Head of HR	Lead FTSU Guardian / DCPO / Head of HR	30/09/26	Green	Meetings took place however delayed due to org change processes. Meetings to be rescheduled.
		5.3 Quarterly senior oversight group	Lead FTSU Guardian / Exec Lead	30/09/26	Green	To be re-established with new CPO following commencement.
		5.4 Complete NGO Board Reflection Tool	Exec Lead / Non-Exec Lead	31/03/27	Green	Initial discussion held with new Non-Exec Lead and to be completed with new CPO when in post.

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: [A guide for leaders in the NHS and organisations delivering NHS services](#), which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.fts-u-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks

2 = concern or risk which warrants discussion to evaluate and consider options

3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I have led a review of our speaking-up arrangements at least every two years	
I am assured that our guardian(s) was recruited through fair and open competition	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am regularly briefed by our guardian(s)	
I provide effective support to our guardian(s)	
Enter summarised commentary to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	
We regularly and clearly articulate our vision for speaking up	
We can evidence how we demonstrate that we welcome speaking up	
We can evidence how we have communicated that we will not accept detriment	
We are confident that we have clear processes for identifying and addressing detriment	
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	
We regular discuss speaking-up matters in detail	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	
We support our guardian(s) to make effective links with our staff networks	
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian’s Office guidance and universal job description and to attend network events	
We have reviewed the ringfenced time our Guardian has in light of any significant events	
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	
We can evidence that our staff know how to find the speaking-up policy	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	
We have an annual plan to raise the profile of Freedom to Speak Up	
We tell positive stories about speaking up and the changes it can bring	
We measure the effectiveness of our communications strategy for Freedom to Speak Up	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	
Our HR and OD teams measure the impact of speaking-up training	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	
All managers and senior leaders have received training on Freedom to Speak Up	
We have enabled managers to respond to speaking-up matters in a timely way	
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	
We use triangulated data to inform our overall cultural and safety improvement programmes	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	
We use this information to add to our Freedom to Speak Up improvement plan	
We share the good practice we have generated both internally and externally to enable others to learn	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	
Our guardian(s) has been trained and registered with the National Guardian Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	
Our guardian(s) has access to a confidential source of emotional support or supervision	
There is an effective plan in place to cover the guardian's absence	
Our guardian(s) provides data quarterly to the National Guardian's Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	
We are assured that confidentiality is maintained effectively	
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	
We know who isn't speaking up and why	
We are confident that our Freedom to Speak Up champions are clear on their role	
We have evaluated the impact of actions taken to reduce barriers?	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	
We monitor whether workers feel they have suffered detriment after they have spoken up	
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	
Our improvement plan is up to date and on track	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	
Our speaking-up arrangements have been evaluated within the last two years	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	
We have we evaluated the content of our guardian report against the suggestions in the guide	
Our guardian(s) provides us with a report in person at least twice a year	
We receive a variety of assurance that relates to speaking up	
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Group Board of Directors in Public
02 September 2026

Item 20

Title	WUTH Learning from Deaths Report (Q4 2025-2026)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Trust Medical Director

Purpose of the Report and Recommendation	
Report For	Information
The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q4 2024-2025. It is recommended that the Board: Note the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.	

Key Points to Note
- The medical examiners continue to provide independent scrutiny of all deaths. - The Trust SHMI for the 12 months to June 2025 is 1.01 (within expected range) - The HSMR rolling 12-month figure remains in the “above expected” range at 111. Review of this has highlighted the impact of coding backlogs during 2025. - The monthly HSMR has shown a decrease in the latest 2-month reporting period. - The Mortality review group (MRG) is a multidisciplinary group that meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner. - MRG continues to review Telstra Health data to benchmark nationally and highlight areas of concern. - Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and via the Divisional Quality Boards. Specific learning points are also fed back to relevant Trust wide steering groups.

Key Risks
This report relates to these key risks: BAF Risk 2 – Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.

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
August 2026	Joint Quality and Safety Committee	As above	As above
July 2026	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospital NHS Foundation Trust during Quarter 4 of 2025–26. It aims to identify key learning, themes, and areas for improvement to strengthen patient safety, improve quality of care, and ensure compliance with the national Learning from Deaths framework. Wirral University Teaching Hospital is committed to the principles set out in the National Quality Board (NQB) Learning from Deaths guidance, including systematic case record review, organisational learning, and transparent reporting. The Trust's mortality governance processes are designed to ensure that deaths are reviewed in a structured, proportionate, and timely manner, with a clear focus on identifying where care may not have met expected standards and where improvements are required. The Trust undertakes mortality reviews to assess the quality of care provided to patients who have died. These reviews focus on identifying both good practice and opportunities for improvement, including whether any problems in care were present and whether these may have contributed to the patient's death. This approach supports delivery against the NHS Outcomes Framework, particularly: • Preventing people from dying prematurely • Treating and caring for people in a safe environment and protecting them from avoidable harm

In line with national guidance, the Trust triangulates multiple sources of information to develop a comprehensive understanding of mortality, including:

- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) benchmarking data
- Structured judgement review findings
- Medical Examiner scrutiny outcomes
- Incident reporting and patient safety investigations
- Feedback from bereaved families and carers where available

While HSMR and SHMI are not direct measures of care quality, they are used as screening tools, as recommended nationally, to identify potential areas of concern that may warrant further detailed review.

All deaths within WUTH are subject to independent scrutiny by the Medical Examiner service, in accordance with national policy. Cases where concerns are identified are escalated for further review through the Trust's Mortality Review Group. In addition, a representative sample of deaths (approximately 5% per quarter) is reviewed for quality assurance purposes, ensuring that the Trust maintains oversight of care quality across all deaths, not solely those flagged for concern.

Key learning from mortality reviews is thematically analysed and shared across the organisation through established governance routes, including the Mortality Review Group and Divisional Quality Boards.

Patient demographics

There was a total of 471 deaths in Q4 25-26.

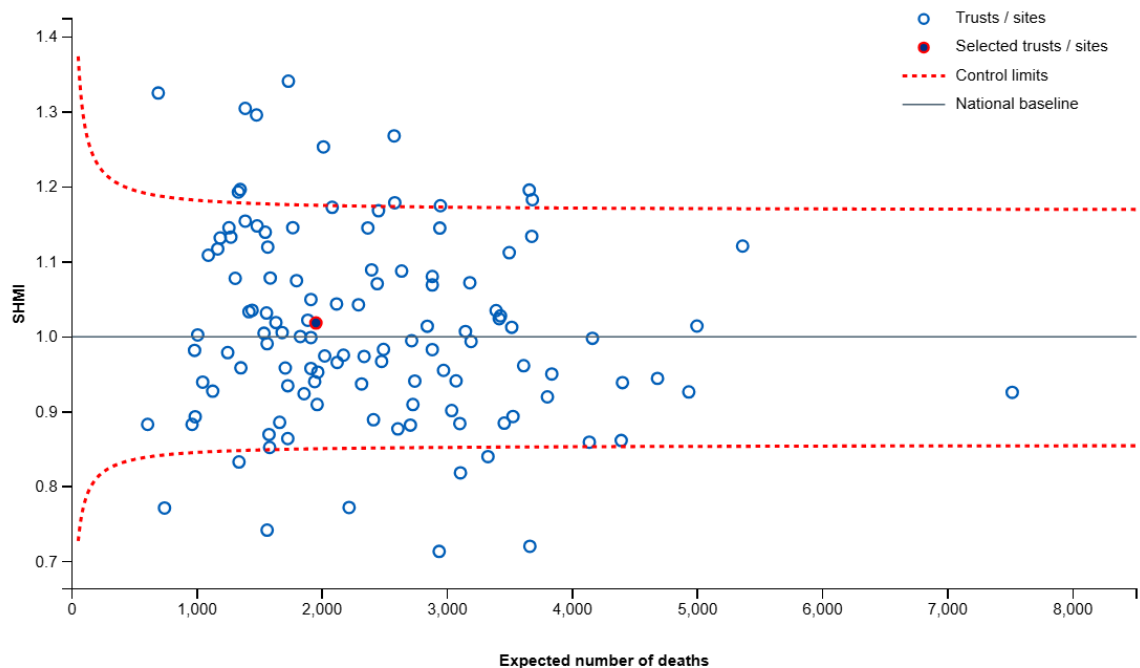
Age and ethnic profile are in keeping with previous reports, with the majority of deaths in the over 70 age group and "White British" ethnic group

Mortality Comparators

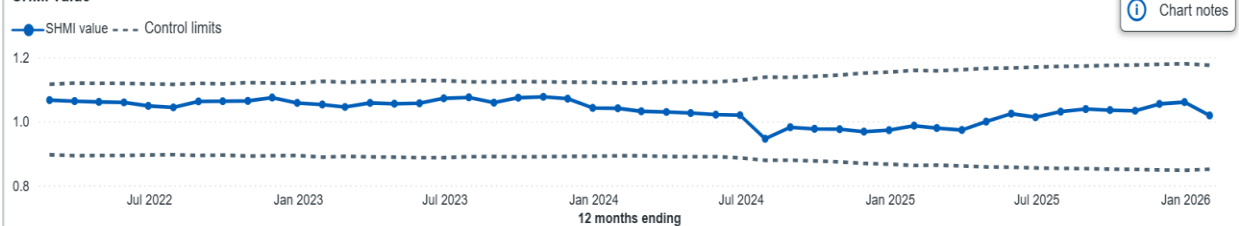
Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to Jan 2026) is 1.01 which is within the "as expected" range. SHIMI for WUTH has been relatively stable in the "expected" range for several quarters now.

SHMI funnel plot

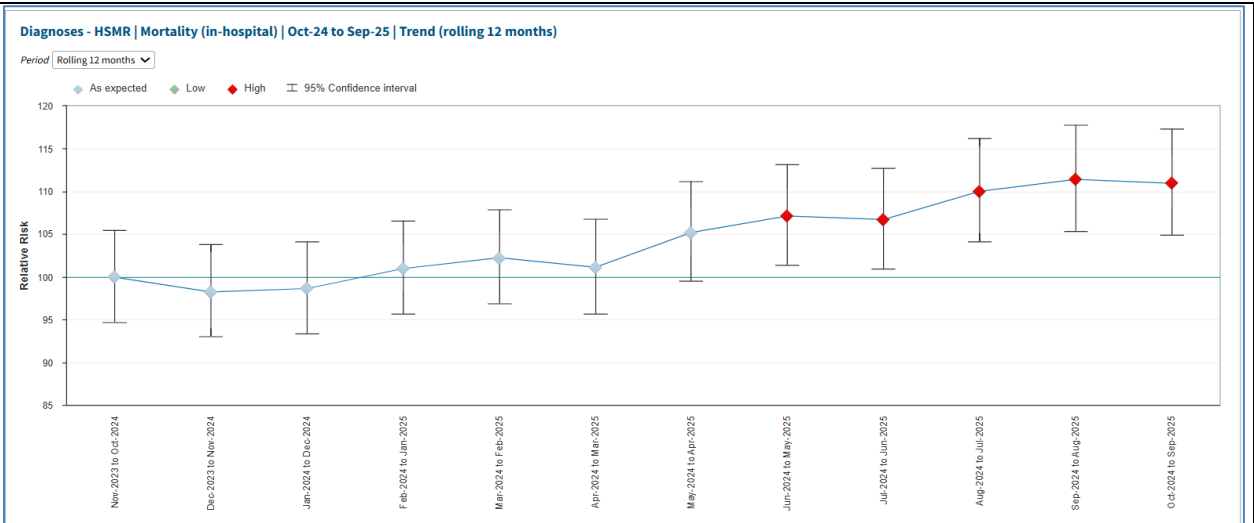


SHMI value

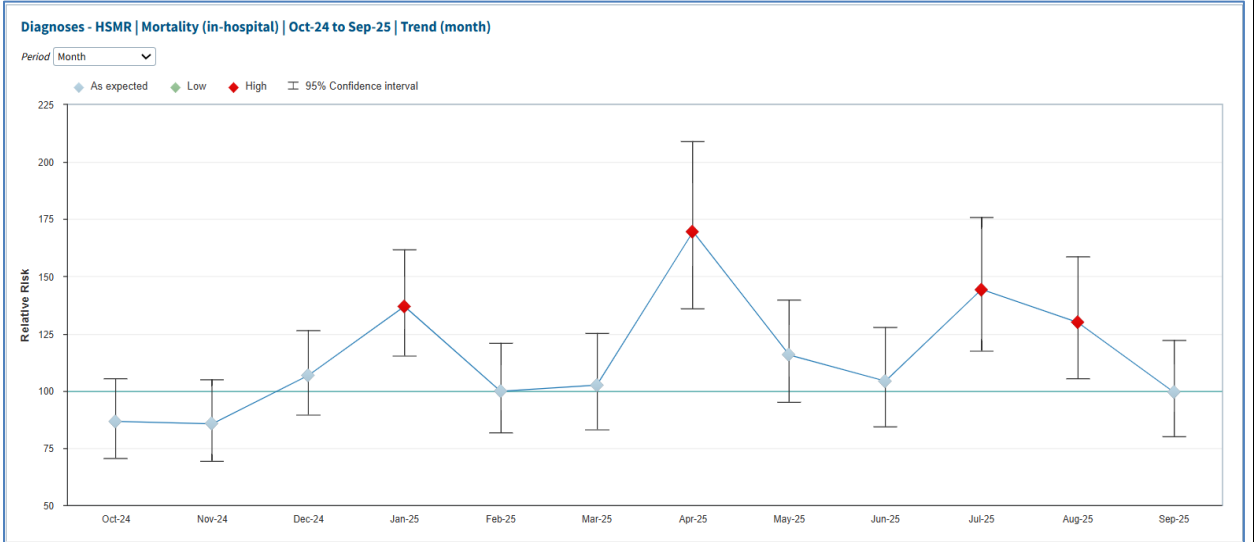


Hospital Standardised Mortality Ratio (HSMR)

The HSMR on the latest 12 months rolling trend continues to be in the “above expected” range at 111. This is due to the issues with uncoded care episodes from April 2025 to Sept 2025.



The monthly HSMR has shown a decrease in the last two months of avialable data



Mortality Dashboard

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

19 cases escalated by the ME service during Q4 have been allocated for review using our Mortality Review form. 9 of these cases were in deaths in patients with a recorded Learning Disability.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 40 deaths were allocated for review in Q4 (8%) using the PMR template.

Summary of all Adult in patient deaths and case reviews					
	Total Adult In-patient Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q1 (25-26)	430	100%	15	28	43
Q2 (25-26)	412	100%	20	30	50
Q3 (25-26)	441	100%	19	39	58
Q4 (25-26)	471	100%	22	40	66

Grading of Adult Care and avoidability following review in Q4 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, affected outcome
Escalated review	7	7	11	2
QA review	27	7	1	0

During Q4 62 reviews were discussed at MRG and graded as above.

During Q4 there were 9 deaths reported for patients with a recognised learning disability. All 9 will be reviewed through MRG as well as being referred to the national LeDeR programme.

Learning Disability Mortality Reviews			
	Total No. of LD Deaths	Reviews Opened	Referred to National LeDeR Programme
Q1 (25-26)	6	4	6
Q2 (25-26)	5	5	5
Q3 (25-26)	2	2	2
Q4 (25-26)	9	9	9

Perinatal and Neonatal deaths

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

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q1 (25-26)	1	2	4	3
Q2 (25-26)	5	3	3	8
Q3 (25-26)	2	0	5	2
Q4 (25-26)	2	2	2	4

All neonatal deaths and stillbirths are reviewed using the PMRT process. Both paediatric deaths were expected deaths.

Outcome from PMRT reviews finalised in Q4

Stillbirth (n=3)	Care of mum & baby up until death	Care of mum after death of baby
A - no care issues	1	1
B - care issues which made no difference	2	1
C - care issues which MAY have made a difference	0	1
D - care issues which were LIKELY to have made a difference	0	0

Neonatal death (n=2)	Care of mum & baby up until birth	Care of baby from birth until death	Care of mum after death of baby
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A - no care issues	0	0	1
B - care issues which made no difference	2	1	0
C - care issues which MAY have made a difference	0	1	0
D - care issues which were LIKELY to have made a difference	0	0	1

C and D gradings for care of mum after death of baby related to poor experience of bereavement care due to gaps within the team due to sickness at the time. The bereavement team have since recruited a second bereavement midwife as well as a bereavement support worker to cover the service Monday to Friday.

Neonatal care of baby graded C (care issues which MAY have made a difference to the outcome) - this relates to care provided by another Trust before the baby was transferred to WUTH.

No themes in relation to B gradings - reasons included follow up of DNA, communication and guidelines not followed.

Learning identified through review of mortality reviews during Q4.

Learning for mortality is derived from 3 main sources.

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

General learning themes from mortality reviews are collated on a learning tracker and shared across Divisions for learning . The following themes were identified in quarter 4:

- Issue with feeding/ diet
- Delayed senior review of patients in some cases that led to poor patient experience
- Medication errors not causing harm

The above themes are fed back to Divisions through the relevant mortality leads and picked up through relevant trust wide groups (Eg Medicines Safety and optimisation group). Additionally, if mortality reviews identify individual learning points rather than themes these are fed back to the relevant teams.

External Benchmarking Data

Telstra Health Data

The Telstar Health (formerly Dr Foster) dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality. During Q4 Deaths due to aspiration pneumonia have been flagged as requiring further review. An audit of these deaths is underway and will be reported back through MRG

	In Q3 deaths due to sepsis and respiratory failure were flagged for review. A case note audit of deaths has been undertaken for both groups and has not shown any gaps in care. In the Sepsis group there was a theme of frail elderly patients who were expected deaths. One death has been flagged for further review (not related to sepsis) In the respiratory failure group, the case note audit did not flag any issues with care and coding was felt to be an issue. None of the deaths in either group were escalated by the Medical Examiner for further review.
	<u>Conclusion</u> • SHIMI remains in the “as expected” category. • HSMR has risen to the “above expected” range. Analysis has shown this to be due to coding backlog issues. • Deaths due to Aspiration pneumonia failure are being reviewed to gain assurance that they are not related to coding issues • Reviews of deaths due to sepsis and respiratory failure have not shown issues with care or concerning themes • MRG continues to meet every 2 weeks to scrutinise and review mortality across the Trust • The Medical examiner service continues to provide 100% scrutiny of all inpatient and Emergency Department deaths

2 Implications	
2.1	Patients • The report supports patient safety and experience by providing assurance that all inpatient and Emergency Department deaths receive Medical Examiner scrutiny, with cases of concern escalated to the Mortality Review Group for further review and learning. • The report identifies and monitors deaths involving patients with a recorded learning disability, ensuring referral to the national LeDeR programme and review through local mortality governance processes to support equitable care and learning.
2.2	People • There are ongoing requirements for clinical, Medical Examiner, coding and governance teams to support mortality review, thematic analysis and timely feedback of learning through divisional and Trust-wide governance routes. • The focus on learning disability deaths, bereavement care and clinical themes supports inclusive, person-centred improvement and helps identify whether particular patient groups require additional attention or support. • Relevant stakeholders include clinical divisions, the Medical Examiner service, Mortality Review Group, Divisional Quality Boards, bereaved families and carers, and external review programmes such as LeDeR and PMRT.
2.3	Finance • There are no direct financial implications arising from this report.

2.4	Compliance • The report supports compliance with the national Learning from Deaths framework, Medical Examiner requirements, LeDeR review expectations, PMRT processes and the Trust's internal mortality governance arrangements.
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Group Board of Directors in Public
02 September 2026

Item 21

Title	WCHC Learning from Deaths Report (Q4 2025-2026)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Trust Medical Director

Purpose of the Report and Recommendation	
Report For	Assurance
The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. It is recommended that the Board: • Be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy; and • Be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.	

Key Points to Note
• During Q4 there were a total of 4 deaths reviewed through the mortality group structure at WHCT. This includes a 1 neonatal death, which will also be reviewed through the PMRT process. • The neonatal death had not received any care from services provided through WHCT • During Q4 there were 0 deaths which met the criteria for StEIS reporting. • Each death investigated during Q4 has been analysed to identify if any care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system. • Of the total deaths reported in Q4, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Learning was identified as a result of safety systems review; this was discussed and shared at service level and reported to Clinical Risk Management and Mortality Review Groups, with any learning shared wider as appropriate

Key Risks
This report relates to these key risks: • BAF Risk 2 – Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.

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
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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
August 2026	Joint Quality and Safety Committee	As above	As above
July 2026	SOG	As above	As above

1	Narrative
1.1	<u>Background</u> Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users. The National Quality Board (NQB) Learning from Deaths framework (2017) exists with the specific aim to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people. The key findings of the CQC report were as follows: • Families and carers are not treated consistently well when someone they care about dies. • There is variation and inconsistency in the way that system partners become aware of deaths in their care. • Trusts are inconsistent in the approach they use to determine when to investigate deaths. • The quality of investigations into deaths is variable and generally poor. • There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

Since 2017 the focus on learning from preventable deaths and unexpected deaths has continued to strengthen and the NHSE developed the Patient Safety Strategy in 2019 which describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

The National Safety Strategy has been pivotal introducing a Patient Safety syllabus, Patient Safety Specialists, and Patient Safety Partners. All of which have been embedded within the governance of the Trust.

Patient Safety and Incident Reporting Framework (PSIRF) is embedded within our Trust. It sets out the NHS approach for effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is embedded within our Clinical Risk Management group and Mortality Review group.

Learning From Patient Safety Events (LFPSE) is designed to capture events where:

- A patient was harmed or could have been harmed
- there has been a poor outcome, but it is not yet clear whether an incident contributed or not
- risks to patient safety in the future have been identified
- good care has been delivered that could be learned from to improve patient safety.

WCHC Learning from deaths governance framework

Policies

Learning from Deaths Policy (GP58); It provides a framework for how the Trust will evaluate those deaths that form part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

Incident Management Policy (GP08). This cross-references the Learning from Deaths Policy, ensuring a consistent approach to implementation, and includes the process to follow in the event of an unexpected death of a patient.

The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths.

Process

All reported deaths which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Safety Incident Review Group (SIRG) and the fortnightly Clinical Risk Management Group (CRMG). Further investigations are commissioned based on the events surrounding the death and the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

The Mortality Screening Tool considers whether a variety of factors were present. Examples include:

- Receipt of an End-of-Life advance care plan (PACA)

- Presence of a DNACPR form
- Association with failed visits
- Association with rescheduled visits
- Concerns raised by any party regarding the care provided prior to death
- The involvement of other services involved prior to death
- Medical Cause of death (if known)

Commissioned investigations are monitored at CRMG against progress and timelines. Any investigation reports and associated action plans are approved at CRMG. This includes cases which are under investigation by the coroner.

Thematic learning from Learning from Deaths cases is reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director and who is responsible for the Learning from Deaths agenda.

Minutes from the Mortality Review Group are submitted to the Quality and Safety Committee and to the Board by exception.

A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers. This includes working with the UK Health Security Agency and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease.

The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

Child Deaths

Given the extensive geography that WCHC delivers Children and Young People's services, there are now robust processes in place which enable every unexpected child death to be identified within all the localities we deliver care. This includes Wirral, East Cheshire, St Helens & Knowsley.

The membership of the Mortality Review Group includes the Trust's Child Death Overview Panel (CDOP) representative and the Trust's Head of Safeguarding enabling, the visibility of any thematic learning across the whole of Cheshire and Mersey. The membership is regularly reviewed to ensure it contains a variety of skills and knowledge to maximise the identification of learning.

The Trust has links with each Place-based Child Death governance structures, which facilitates the identification of themes over a large geography and then uses this data to

reflect on how WCHC can continuously improve the delivery of its Children and Young People services. Services.

The Trusts Named CDOP representative is an active participant of the multi-agency Place-based Sudden Unexpected Death in Childhood (SUDIC) meetings and feeds any intelligence and learning into the Mortality Review Group. When our representative has any concerns then these are escalated and raised with system partners.

The Mortality Review Group will receive the Child Deaths Annual reports when they become available.

Bereaved Families

Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison.

Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations.

National Medical Examiners

Medical Examiner officers at hospital trusts now provide independent scrutiny of almost all non-coronial deaths occurring in hospitals. All deaths in England and Wales are independently reviewed either by a Medical Examiner or a coroner. Medical Examiners provide an important safeguard.

The Department for Health and Social Care (DHSC) published details of the death certification reforms and are now in place since April 2024. Primary legislation was commenced on 1 October 2023. The new death certification process requires all deaths in England and Wales to be independently reviewed either by a medical examiner or a coroner.

Our local NHS host trust for this function is Wirral University Teaching Hospital NHS Trust. We have created agile and secure access for medical records to allow the Medical Examiner to fulfil their role.

Q4 25-26 WCHC Reported deaths (Datix incident reporting)

During Q4 there were a total of 4 deaths reviewed, including 1 neonatal death.

During Q4 there were 0 deaths which met the criteria for StEIS reporting.

During Q4 no deaths have been reported to the coroner service.

Structured Judgement Reviews:

Total Number of Deaths in scope	4
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There are no outstanding cases from the previous quarter (Q3)

Total Number of Deaths considered to have more than 50% chance of being avoidable	0
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LeDeR reviews: - Please note that these are undertaken by the mental health trust

Total Number of Deaths in scope	0
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Total Deaths reviewed through LeDeR methodology	0
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Total Number of deaths considered to have been potentially avoidable	0
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SUDIC reviews:

Total Number of Child (Neonatal) Deaths	1
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Total Deaths reviewed through SUDIC methodology	0
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Summary of thematic / other Learning for Q4

Each death reported during Q4 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

Of the total deaths reported in Q4, after investigation, one is being investigated through the AAR process as there is potential for further learning across the Wirral system. On review of the 4 deaths there were no gaps in care identified by services provided at WHCT. Each death was reviewed at service level and via the Clinical Risk Management Group (CRMG), and Mortality Review Group.

Specific learning identified during Q4 have been fed back to relevant service and wider healthcare partners across the NHS. These include

- Need to share DNACPR status across NHS services as this isn't always visible to external care providers

2	Implications
2.1	Patients • No deaths reviewed in Q4 were found to have been caused by gaps or omissions in care provided by the Trust; however, identified learning, particularly

	around visibility and sharing of DNACPR status across NHS services, should support safer, more coordinated care for patients.
2.2	People Staff should continue to apply the Learning from Deaths framework, PSIRF principles and local mortality review processes consistently, ensuring timely escalation, family engagement and dissemination of learning through service-level governance, CRMG and Mortality Review Group.
2.3	Finance There are no immediate financial implications arising from this report. Existing governance and review processes are being managed within current resources, with any future resource requirements to be considered through established operational and governance routes.
2.4	Compliance The report supports compliance with the National Quality Board Learning from Deaths framework, Trust Learning from Deaths Policy, Incident Management Policy, PSIRF, Duty of Candour requirements and statutory expectations for quarterly reporting and publication.

Group Board of Directors in Public
02 September 2026

Item 22

Title	WUTH Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26
Area Lead	Hayley Kendall, Joint Executive Managing Director and Accountable Emergency Officer
Author	Steve Povey, Head of EPRR / Emergency Planning Officer

Purpose of the Report and Recommendation	
Report For	Assurance
This report provides an overview of the Trust's Emergency Preparedness, Resilience and Response arrangements during 2025/26 and outlines progress made against statutory and regulatory requirements. It is recommended that the Board: • Notes the contents of the EPRR Annual Report 2025/26 • Takes assurance regarding the Trust's emergency preparedness arrangements and compliance activities. • Notes the priorities and work programme for the forthcoming year.	

Key Points to Note
The Trust continues to meet its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004), with all mandated emergency plans in place and maintained. Robust governance arrangements remain established through the Accountable Emergency Officer, Emergency Planning Officer, Local Health Resilience Partnership engagement and a 24/7 on-call structure. During 2025/26, the Trust responded to a range of incidents and operational challenges, delivered statutory exercises and communication tests, and completed its annual self-assessment against NHS England Core Standards. The Trust achieved a rating of Substantial Compliance, representing an improvement from Partial Compliance in 2024/25. An independent MIAA audit provided Moderate Assurance and identified a few areas of good practice alongside recommendations that have informed ongoing improvement activity.

Key Risks
This report relates to these key risks: • Failure to maintain effective emergency preparedness and business continuity arrangements could impact on the Trust's ability to respond to major incidents and maintain essential services. • Incomplete implementation of business continuity planning and assurance processes

- may affect organisational resilience.
- Ongoing action is required to achieve full compliance with all NHS England EPRR Core Standards.

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

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

Governance journey			
Date	Forum	Report Title	Purpose/Decision
August 2026	Joint Finance and Performance Committee	As above	As above

1	Narrative
1.1	Overview and Assurance The annual report outlines the Trust's arrangements for emergency preparedness, resilience and response during 2025/26. The Civil Contingencies Act (2004) requires the Trust, as a Category 1 responder, to maintain plans and arrangements that ensure services can continue during emergencies and major disruptions. The Trust has maintained appropriate governance arrangements, including the appointment of an Accountable Emergency Officer and Emergency Planning Officer, active participation in Local Health Resilience Partnership meetings and operation of 24/7 on-call arrangements. During the year, the Trust supported responses to a number of incidents and delivered its statutory programme of exercises, training and communication testing.
1.2	Compliance and Improvement The Trust completed its annual NHS England EPRR Core Standards self-assessment and achieved a rating of Substantial Compliance, demonstrating improvement from the

	previous year. A supporting action plan remains in place to address areas requiring further development. An MIAA audit of business continuity arrangements completed during 2025/26 provided Moderate Assurance and identified several areas of good practice. Recommendations focused on business continuity planning, risk management, policy alignment, training requirements and annual work planning. Actions have been developed and implemented to address the findings.
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2	Implications
2.1	Patients Effective EPRR arrangements support patient safety and continuity of care during major incidents, emergencies and service disruptions.
2.2	People The report highlights ongoing training, exercising and support arrangements for on-call managers, directors and relevant staff to ensure organisational preparedness.
2.3	Finance No significant direct financial implications are identified within this report. However, effective preparedness and business continuity arrangements mitigate financial risks associated with service disruption.
2.4	Compliance The report supports compliance with the Civil Contingencies Act (2004), NHS Act 2006 requirements relating to the Accountable Emergency Officer role and NHS England EPRR Core Standards.

**Emergency Preparedness Resilience and Response
(EPRR)**

Annual Report 2025/26

Report date: July 2026

Author: Steve Povey, Head of EPRR / EPO

Sponsor: Hayley Kendall, Joint Executive Managing Director and Accountable Emergency Officer



WUTHstaff

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Executive Summary

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

The Trust has the required Accountable Emergency Officer (AEO), supported by the Emergency Preparedness Officer (EPO) along with the appropriate representation at Local Health Resilience Partnership (LHRP) meetings.

All of the mandated emergency plans to respond to a major incident are in place and published on the Trust emergency planning intranet page.

Introduction

The NHS needs to be able to plan for, and respond to, a wide range of incidents that could impact on health or patient care. These could be anything from extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A business continuity/critical incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority.

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with such incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of its services in the event of a disruption.

Purpose

The purpose of this annual report is to:

- Provide an overview of the emergency preparedness arrangements within Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
- Describe the Trust's responses to incidents that have occurred during 2025-26
- Outline the work that has been undertaken in this field during the past 12 months
- Summarise the planned workstreams and priorities for the year ahead

Emergency Preparedness Structure

Lead Officers

Accountable Emergency Officer (AEO)

The NHS Act 2006 (as amended) places a duty on providers to appoint an individual to be responsible for EPRR matters. This individual is known as the AEO. For the period covered in this report, the AEO was:

Hayley Kendall, Joint Executive Managing Director	01/04/24 – 31/03/25
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Emergency Planning Officer

The AEO is supported in this role with the role of Emergency Planning Officer (EPO). For the period covered in this report, the Head of EPRR acting as the EPO was:

Steve Povey, Head of EPRR	01/04/25 – 31/03/26
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Meeting Structure

In order to discharge the Trust's responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the Trust's operational structure.

Trust wide ad-hoc planning meetings are initiated for any required emergency planning such as large scale community events, planned IT downtime planning, bank holiday planning, service/ward change or other operational pressure where services may be affected. Section 9 details the events that have been formally planned for during this period.

EPRR meeting structure:

- The Local Health Resilience Partnership (LHRP) meetings provide a forum to ensure that planning is not conducted in isolation by a single organisation, but is undertaken in partnership with other local responders and commissioners. There are 2 levels of LHRP meetings; Strategic and Tactical.
- The AEO, or their representative, attends the Strategic LHRP meetings for Cheshire & Mersey. These meetings are held twice a year at Strategic Level.
- A Deputy Executive Director, Director of Operations or the EPO attends the Cheshire & Mersey LHRP Strategic meetings on behalf of the AEO should they be unavailable.
- The EPO attends the Cheshire & Mersey LHRP Tactical level meeting.
- During the course of the report both the Strategic and Tactical Level LHRPs meetings were regularly attended by a WUTH representative.
- Attendance of at least 75% of these meetings is required to comply with NHS Core Standards for EPRR.

Out of Hours Arrangements

On-call rota

The Trust operates an on-call rota which is on a 24/7/365 basis and ensures that 1st On Call Managers and 2nd On Call Directors are contactable at all times and are able to respond quickly to business continuity, critical or major incidents at any given time. This structure is supported by specific clinical and departmental on-call rotas which are designed to respond to local service-related operational issues. There is central coordination of these rotas via switchboard.

On-call booklet

The Hospital Manager/Executive On-call booklet is regularly reviewed and updated to ensure that current information is to hand for any operational issue and risk assessment forms for major incidents.

On-call training

Induction meetings are in place for members of the on-call director and manager rota, this includes major incident training. The on-call managers hold quarterly on-call forums where on-call issues, new guidance, updates and major incident refresher training is held. In December 2025 the trust introduced an updated training package containing in depth information to improve initial training.

NHS England and the Cheshire and Mersey ICB host Principles of Health Command Training throughout the year. Attendance on this course is mandatory for all oncall managers and directors with compliance measurable and part of the NHS England Core Standards for EPRR.

Risk Register (Local Resilience Forums)

Both Cheshire & Merseyside Local Resilience Forums maintain a register of risks which are likely to present a threat to the wider community. Representation at these forums for Trusts is done by Cheshire & Merseyside ICB with any updates given at the LHRP quarterly meetings. These provide the basis for setting the planning agenda and establishing emergency preparedness work plans for the Cheshire & Merseyside regions.

Exercises and Training

The Civil Contingencies Act (2004) outlines the organisational responsibility to exercise plans. Under the Act, all NHS organisations are required to undertake:

- Live exercises (or incident) every three years
- Table top exercises annually
- Communications exercises every 6 months

Exercises, incidents and projects with EPRR support

During the year the Trust experienced a number of incidents which involved an EPRR response, these included live responses as well as full EPRR command and control be stood up to deal with Trust responses to known events.

Incident	Overview	Declared Date	Stepped Down Date
Water Street	Major Incident Standby – vehicle driving into crowds	26 th May 2025	26 th May 2025
Oracle Millennium access	Log in issues – some staff unable to access system	8 th July 2025	8 th July 2025
SSD BC & Critical incident (BC Inc 16-21/10) (Critical 21/10 – 7/11) BC Inc 7/11 – 8/12)	Failure of sterile services equipment resulting in a backlog of instruments and an unidentified residue on some instruments.	16 th October 2025	8 th December 2025
Main generator failure	Air circuit breaker fault during monthly test – temporary solution followed by permanent resolution	15 th January 2026	16 th January 2026
Cherry Tree House power failure	Supply cable failure – generator supplied while new cable installed.	14 th January 2026	14 th January 2026 (temp solution)
Bone cement shortage	Global supply issue due to packaging fault. Alternative supply identified via NHSE.	18 th February 2026	23 rd February 2026
Stryker cyber attack	Cyber attack on US based supplier resulting in the inability to place orders for orthopaedic implants.	12 th March 2026	27 th March 2026
Exercise Aura	Pandemic Outbreak exercise (joint exercise with WCHC)	19 th March 2026	N/A

Live Tabletop Exercises

In addition to the communications exercises mentioned below the Trust also undertook a live tabletop exercise, Exercise Aura, which was a pandemic/outbreak exercise and was used to feed into a regional response for a system exercise with NHS England.

Exercise Aura was a joint exercise with Wirral Community Health and Care Foundation Trust (WCHC) with an observer present from NHS Cheshire and Merseyside ICB. The exercise consisted of an advanced background pre-read followed by 4 sessions in which a pandemic outbreak played, worsening for sessions 1 to 3 before showing signs of a downturn in session 4 to promote recovery conversations.

The exercise was fully documented with lesson plans, facilitator material, handouts for each inject, advance pre-read information and tabletop reference documentation. A full debrief was undertaken with a formal debrief report available from Trust EPRR.

Communications Exercises

The major incident contact list for in and out of hours was successfully tested during 2025/26 as outlined in the table below:

Type of test	Overview	Date
Out of hours	Exercise Gabriel (with ICB)	25/02/2026
In hours	Trust exercise	09/04/26*

* Note: Delayed from scheduled March date

External Review

NHS England Assurance for EPRR (Core Standards)

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust self-assessed against these standards between July and October 2025. Following assessment, the organisation self-assessed as demonstrating **substantial compliance** level.

This is an improvement on the 'partial compliance' level in 2024/25. This followed improvements to the trust preparedness identified by the 2024/25 standards action plan.

Core Standards Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

A copy of this assessment along with the declaration of the level of compliance achieved was taken to the Public Board of Directors on the 5th November 2025.

Core Standards Action Plan

The Core Standards Action plan which gives details of the standards not met and their associated actions is within Appendix 4 of this report.

Reports to Committee and Public Board

EPRR Reports to Board/Committee were presented on the following dates:

Item	EARC	Public Board of Directors
EPRR Annual Report 2025/26	September 2025	5/11/26
EPRR Core Standards 2025/26 Compliance Report	September 2025	
Quarterly EPRR Report to Risk Management Committee	April 2025	
Quarterly EPRR Report to Risk Management Committee	August 2025	
Quarterly EPRR Report to EARC	November 2025	
Quarterly EPRR Report to EARC	March 2026	

Event Planning

During 2025/26 planning meetings supported by EPRR have taken place to ensure that safe robust plans were in place for the following events:

Event	Summary
Half Term/Bank Holiday Planning Easter, early and late May, August, October Half-term, Christmas/New Year period, February Half-term	Trust wide plans are developed to outline the arrangements that are put in place in the Trust and within key partner organisations in preparation for the Bank Holiday and selected Half Term periods. They provide assurance to the Wirral system and describe initiatives that have been put in place to maintain safe patient flow during a period of known increased demand. They provide robust plans for internal oncall teams to follow through the oncall structure. Daily System calls continue through all bank holiday dates with the exception of Christmas Day and Boxing Day.
Trust wide Wirral Millennium planned upgrades/downtime:	Planned Wirral Millennium 'downtime' and system upgrades requires trust wide planning to ensure that issues/risk and actions have been identified and that staff in all areas are aware of the formal downtime process to follow to maintain patient safety. The EPO coordinates all such responses with leads from the specialty area. The EPO agrees all potential disruption plans with the AEO.
Multiple estates planning events: Projects supported during this period included the Trust	Planned Estates projects that affect the Trust operationally require careful planning with key stakeholders to ensure that risk is identified and mitigation put in place to ensure patient and staff safety. The EPO is involved in the planning of all

Event	Summary
UECUP programme surveys, planned power outages at APH and CBH.	such events and approves the progression of such events with the AEO.

MIAA Audit

Core Standard 51 requires the Trust to 'conduct audits at planned intervals to confirm they are conforming with its own business continuity programme'. This was achieved by an audit by MIAA in August 2025 which looked at the Trust policy, its implementation and the business continuity plans produced by divisions and departments. The full report has been presented to the Audit Committee and is available from EPRR upon request.

The report rated the Trust with moderate assurance and made a number of recommendations. At the time of the audit the Trust had completed the introduction of a new Trust policy based on the NHS England business continuity toolkit. This had introduced a replacement business continuity plan template for users and along with this another template was in use by some areas.

The report identified a number of areas of good practice, these were:

- The Trust business continuity policy has been updated onto the formal Trust policy template to ensure approval, ratification and document control assist in the ongoing management of the policy.
- Roles and responsibilities are clearly defined within the policy and critical functions identified.
- A major incident plan is in place for the Trust to respond effectively to incidents that could disrupt delivery of service.
- An Emergency Preparedness, Resilience & response (EPRR) policy is in place which details the arrangements in place to ensure delivery of care to patients.
- A review of five business continuity plans (BCP's) found that each contained a clear risk assessment, including how to maintain continuity in services and actions for each identified risk.
- Following a refresh of the business continuity approach, training and support sessions were made available along with continuing ad hoc training within divisions and departments. This includes increasing the number of areas requiring specific BCP's (recommendation 1).
- The business continuity policy contains plans to co-ordinate plans to arrange exercises to test response (see also recommendation 5 in Appendix 5).
- A significant risk report is reviewed by the trust Executive Assurance & Risk Committee (EARC) at each of its meetings along with a quarterly EPRR report containing a BCP status report.

MIAA report findings and recommendations

The report findings and recommendations are available in Appendix 5.

Work undertaken in 2025-26

The following work-streams were completed during the year under review:

- Provided assurance for NHS England Core Standards for EPRR
- Facilitated internal communication exercises, that tested alerting procedures as part of incident response preparedness.
- Delivered major incident training to new on-call managers and directors
- Developed Trust wide plans for planned events such as IT planned downtime, Bank Holiday/Half Term periods and multiple estate projects

Progress with work programme for 2025-26

All actions are complete as detailed in appendix 2, these were the improvement actions from the 2024/25 plan.

Work programme for 2025-26

Work streams have been developed using recommendations from the Local Health Resilience Partnership. They were undertaken during the 2025/26 financial year. Please refer to the plan in appendix 3.

EPRR Statement of Compliance

Wirral University Teaching Hospital, NHS Foundation Trust has a duty to protect the health of our community. This duty extends to times of emergency.

The purpose of the Major Incident Plan along with other associated Emergency Preparedness, Resilience and Response Plans is to outline how we will respond in the event of an emergency, to meet our responsibilities as a Category 1 Responder and comply with relevant guidance and legislation.

The Major Incident Plan is built on the principles of risk assessment, co-operation with partners, emergency planning, communication and information sharing. It is essential that we are prepared to look beyond a major incident, and put in place business continuity management arrangements, to secure the day to day running of the organisation.

The Management Team within Wirral University Teaching Hospital NHS Foundation Trust has an important role in ensuring we respond professionally to an emergency whilst maintaining vital services. It is essential that you are familiar with how the Trust will operate during such an event, what role you may play and the role of the other organisations we will be working with.

A Major Incident can take place at any time day or night and it may be necessary for staff to work in unfamiliar environments for flexible / extended periods. The plan will be subject to an annual test and three yearly tabletop exercise.

This Plan includes the provision of action cards for the different roles that may be involved.

Janelle Holmes

Chief Executive

Wirral University Teaching Hospital



WUTHstaff

wuth.nhs.uk

Appendix 2

Progress with 2025/2026 Plan

Lead: Steve Povey, Head of EPRR

Recommendation /Issue (in line with EPPR Framework)	By end of Quarter 2025-26	Progress
Produce an annual report on Emergency Preparedness 2025/26 to Executive Assurance and Risk Committee September 2025	Q2	Complete
Undertake the self-assessment for the 2025/26 EPRR assurance process	Q3	Complete
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject – Note: No deep dive subject nominated in 2025/26	Q3	N/A
Ensure RMC and the Public Board of Directors (BoD) has sight on the level of compliance against the 2024/25 revised process for the revised EPRR assurance	Q3	Complete
Carry out a Communication Exercise at a 6-month interval	Q3 & Q4	Complete
Carry out the 3-yearly review of all relevant emergency plans and note at BoD – Some policies updated in line with Core Standards Action Plan and new policy for incident response.	Q4	Complete
Develop and deliver strategic refresher Major Incident Training to on-call Hospital Managers, Hospital Clinical Coordinators and Executives	Q4	Complete
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire & Merseyside LHRP	Q4	Complete

Recommendation /Issue (in line with EPPR Framework)	By end of 2025/26
Undertake a table top exercise – Exercise Aura March 2026	Complete
Produce an annual report on Emergency Preparedness 2025/26 to Executive Assurance and Risk Committee (EAR) September 2026 and ensure noted at the Public Board Meeting	Complete
Undertake the self-assessment for the 2025/26 EPRR assurance process	Complete
Undertake a ‘Deep Dive’ into the preparedness of the Trust for the specified subject - Note: No deep dive subject nominated in 2025/26	Complete
Carry out a communication exercise at a 6-month interval	Complete
Ensure the Board of Directors (BoD) has sight on the core standards level of compliance achieved, the results of the 2025/26 self-assessment (N/A) and the improvement plan for the forthcoming period	Complete
Carry out the 3-yearly review of all relevant emergency plans and note at BoD, where required	Complete
Update and deliver strategic refresher major incident training to on-call hospital managers, hospital clinical coordinators and executives, review On Call Training and re-publish On Call handbook.	Complete, pending handbook issue
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire and Merseyside LHRP	Complete
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Complete

Appendix 3

2025/26 Work Plan

Activity	Review Date due	Progress
EPRR Annual Report to EARC	September 2025	Complete
NHSE Core Standards to EARC/BoD	September 2026	To Board meeting September 2026
Core standards update report to NHS C&M	From May 2026	Complete
Plans		
Adverse Weather Plan	March 2026	In Consultation following updated UKHSA plan
Pan Flu Plan	December 2026	In Progress
Evacuation Plan	March 2026	In progress, Ward pairings being clinically assessed
Major Incident Plan & Action Cards	March 2026	Plan complete, action cards ongoing
Power Failure Action Cards	March 2026	Power resilience plans being reviewed after new W&C and ED generators on line.
Business Continuity Plans	September 2026	In progress & ongoing
Fuel Plan	September 2026	To EARC August 2026
Out of hours Comms Test	February 2026	Complete
In Hours Comms Test	March 2026	Complete (April)

Training & Exercising		
On-Call Training 1:1	At induction	Refer to on-call spreadsheet
On Call Competencies Portfolios	Ongoing 3 yearly cycle	Ongoing
Tabletop Exercise – Pandemic/outbreak	March 2026	Complete
Tabletop Exercise – Lockdown	October 2025	Complete
Exercise Pegasus	October & November 2025	Regional Teams only, Trust involvement downgraded
Meetings		
LHRP Strategic	May, July, Nov	Reported in Annual Report
LHRP Tactical	April/July/Nov/Jan	
CBRN training		
CBRN Train the trainer	2026	NWAS Course dates released, WUTH have multiple trainers
PRPS Training for ED Staff	Course programme via ED	Ongoing

Appendix 4

Core Standards Action Plan

Standard	Target Date	Action	Status
CS9 - Collaborative Planning	April 2025	The trust will be consulting with partners and making the trust policies available on a Resilience Direct Landing page to ensure all policy contents are available	Complete.
CS14 – Countermeasures	April 2025	Distribution of counter measures to be considered as part of trust Exercise Aura.	Complete.
CS15 – Mass Casualty	March 2025	Review numbers of mass casualty patients that can be received by the trust as part of a regional response .	Complete. Exercise Creta (Trust) and Forma (Region) tested and review the trust ability to respond and fed into the mass casualty framework update.
CS16 – Evacuation & Shelter	Awaiting ICB & LA	Trusts are awaiting updated evacuation and shelter guidance from local authorities. Trust plans being linked with Wirral Borough Council	Discussions ongoing
CS17 – Lockdown	April 2025	Lockdown policy requires updating with additional elements	Complete. Updated Lockdown Policy approved and in place.
CS25 – Staff Awareness & Training	March 2025	Trust to introduce EPRR awareness training to all staff	Ongoing proceeding through Education Governance Committee ahead of sign off and introduction

CS37 – LHRP Engagement	Sept 2025	LHRP Meetings to be attended or appropriate deputy sent. Complete.	Complete. 2024/5 meetings have met with the attendance requirement
CS47 – Business Continuity Plans	August 2025	Adoption of new NHSE toolkit for business continuity. All BC plans being transferred to new template for consistency as part of the adoption of the NHSE toolkit.	Policy and template in place, divisions have updated plans and plans are subject to update and analysis
CS51 – BC Audit	August 2025	MIAA audit of trust business continuity process This is a separate item in this report.	Full compliance will be achieved as the new policy is fully implemented with plans in place, available to test and audit.
CS53 – Assurance of commissioned providers	April 2025	Review procurement process for non centralised suppliers to ensure resilience.	Ongoing

MIAA Audit Findings & Recommendations

1. Business Continuity Plans		Risk Rating: High
Operating Effectiveness		
Key Finding – An assessment of areas requiring BCPs had been undertaken by the Trust in April 2025. However, audit review noted that this did not include Corporate services (e.g. Finance, Facilities, Communications, Procurement and Information Governance). In addition, BCPs were not available for all of the areas identified by the Trust as requiring a BCP in their assessment. Audit review of a sample of Business Continuity Plans found that different templates had been used, not all BCPs had been fully completed and version history was not available for all of the sample.	Specific Risk – Business Continuity Planning may not provide adequate consideration for all departments within the Trust.	Recommendation – The Trust should ensure that all areas are considered for requirement of a BCP and that those deemed requiring a BCP have one in place. The Trust should ensure that there is a consistent approach to Business Continuity Plans across the Trust, which are subject to regular review, tested and updated on a regular basis. Action Taken – The trust policy has been further updated with a revised BCP template incorporating all MIAA recommendations e.g. version history, security classification.
2. Risk Review		Risk Rating: Medium
Operating Effectiveness		
Key Finding – Audit review of a sample of BCPs identified that 3 risks had been scored at 15, however these were not visible on the significant	Specific Risk – Risks identified from BCPs are not reported and effectively managed.	Recommendation – A review should be undertaken of all risks raised on Business Continuity Plans to ensure that, where relevant, these have been captured on an

risks report. Upon further review it was identified that these 3 risks should not have been scored at 15. In addition, we were unable to confirm whether risks raised in BCPs had been reported or triangulated to divisional / corporate risk registers.		appropriate risk register and been subject to regular review. Action Taken – The BCP template has been updated to include trust risk reference to ensure consistency and all BCP identified risks are entered onto the trust risk register.
3. Business Continuity Policy		Risk Rating: Medium
Operating Effectiveness		
Key Finding – The Trust has a Business Continuity Policy in place. However, some elements of the recommended NHS England Business Continuity template had not been included.	Specific Risk – Non-standard processes may be in place which do not provide adequate assurance that an agreed BCP is in place.	Recommendation – The Trust should review the Business Continuity Policy to ensure that it is in line with the recommended NHS England template. Action Taken – The updated version 1.1 of the trust policy includes all NHSE recommended areas.
4. Training Requirements		Risk Rating: Medium
Operating Effectiveness		
Key Finding – Audit review of the BCP Policy identified that ‘all plans should contain information on training requirements’, however audit testing of a sample of individual BCPs found that they did not capture training requirements.	Specific Risk – Staff may not have received sufficient training to adequately ensure BCP process is in place.	Recommendation – The Trust should ensure that BCPs contain training requirements in line with Trust Policy and that these are collated and training provided for all relevant staff. Action Taken – The updated BCP template in policy version 1.1 has a specifically identified section for required training.
5. Annual Work Plan		Risk Rating: Medium
Control Design		

Key Finding – An annual work plan was in place which included BCPs, however this did not include reference to specific BCP training and exercises identified from review of individual BCPs.	Specific Risk – There may be no formalised and structures approach to exercises identified from BCPs. Exercises may not be undertaken which hinders early identification (and reporting and implementation of improvements) of any lessons to learn.	Recommendation – An annual work programme should be compiled based on the risks identified within individual BCPs. Action Taken – The annual EPRR work plan has been adapted to include training and exercising rather than this be a separate document.
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Group Board of Directors in Public
02 September 2026

Item 23

Title	WCHC Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26
Area Lead	Hayley Kendall, Executive Managing Director
Author	Mick Blease, LSMS/EPRR Lead
Report for	Approval

Executive Summary and Report Recommendations
The attached EPRR report identifies work undertaken to ensure that the Trust is compliant with statutory requirements placed upon it as a Category 1 Responder under the Civil Contingencies Act (CCA) 2004 by showing that the Trust can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. The purpose of this paper is to provide assurance to the Trust Board that the Trust is ready to respond to threats and hazards and major disruptive events that may impact on the delivery of its services to ensure business continuity The papers include the recently reviewed Trust Major Incident Plan. There is a requirement that the Major Incident Plan is reviewed on an annual basis. The report includes an annual exercising and training plan for the year 2025/65 which is designed to enhance the Trusts response to emergencies and business continuity incidents. It is recommended that the Board/Committee: • be assured by the Annual EPRR report for the year 2025/26 that the Trust has plans and processes in place in order to react to incidents to ensure services, that the Trust is commissioned to deliver continue. • Approve the annually reviewed Major Incident Plan (MIP)

Key Risks
No Risks have been identified

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:
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Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	No
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	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
August 2026	Joint Finance and Performance Committee	As above	As above

1	Narrative
1.1	Background The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are minimum requirements for NHS-funded organizations to ensure they can respond to emergencies, such as major incidents or pandemics, while maintaining critical services. These standards ensure compliance with the Civil Contingencies Act 2004 and the Health and Care Act 2022. Standards 3 and 4 dictate; - - The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements - The organisation has an annual EPRR work programme, informed by: - current guidance and good practice - lessons identified from incidents and exercises - identified risks - outcomes of any assurance and audit processes
1.2	Report Purpose and content The annual report outlines the work conducted and The purpose of the annual report is to provide an overview of: The Trust's state of readiness to respond to the challenges, threats, hazards and major disruptive events that may impact on the delivery of its services or require a wider community response.

	• Describe our response to recent incidents • Outline the work that has been undertaken in the last 12 months The report is sectioned as follows: 1. Planning 2. Training and Exercising 3. Response 4. Partnership Working 5. Assurance 6. Priorities for 2025/26 The report evidences compliance across a number of EPRR Core Standards but specifically Standard 3: <i>The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.</i> <i>The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements</i>
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2	Implications
2.1	Patients • NA
2.2	People • NA
2.3	Finance • There is no financial impact identified by this report.
2.4	Compliance The report evidences compliance across a number of EPRR Core Standards as referenced in the following legislation and guidance, The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. Core Standard 3 states: <i>The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements</i>

Annual Emergency Preparedness, Resilience and Response (EPRR) Report for 2025/26

Introduction

This is the Annual Report relating to Emergency Preparedness, Resilience and Response (EPRR) for the year 2025/26 for Wirral Community Health and Care NHS Foundation Trust. (WCHC)

The report identifies the work undertaken to ensure that Wirral Community Health & Care NHS Foundation Trust is compliant with the statutory requirements placed upon it by:

- The Civil Contingencies Act (CCA) 2004
- Terms and conditions of the NHS Standard Contract for Emergency Planning
- NHS England core standards for Emergency Preparedness Resilience and Response (EPRR)
- NHS EPRR Framework (July 2022)

The purpose of the annual report is to provide an overview of:

- The Trust's state of readiness to respond to the challenges, threats, hazards and major disruptive events that may impact on the delivery of its services or require a wider community response.
- Describe our response to recent incidents
- Outline the work that has been undertaken in the last 12 months

The report is sectioned as follows:

1. Planning
2. Training and Exercising
3. Response
4. Partnership Working
5. Assurance
6. Priorities for 2025/26

1.0 Planning

1.1 Accountable Emergency Officer /Emergency Preparedness Officer

Under the EPRR framework, the Trust is required to be represented at the Local Health Resilience Partnership (LHRP) for Cheshire and Merseyside by the Accountable Emergency Officer (AEO).

The role of AEO is currently held by Hayley Kendall the Executive Managing Director.

Mick Blease is the Trust Emergency Preparedness Officer and represents the Trust at the regional LHRP practitioner meetings. The Trust has been compliant with attendance at both the Strategic and Practitioner meetings throughout 2025/26.

1.2 Major Incident Plan

In line with the requirements of the Civil Contingencies Act 2004, the EPRR framework (July 2022) and Standard NHS contract, as a Category 1 Responder, the Trust must have emergency plans that make explicit how the organisation will respond in the event of an emergency or major incident.

The Major Incident Plan (MIP) has been subject to a regular annual review. Changes made during this year's review include Accountable Emergency Officer and contact details for the EPRR teams at NHS England and the ICB. It also includes clarification on roles and responsibilities within the [EPRR Policy ~~major incident policy~~](#).

The plan is attached as separate document for approval as part of this EPRR annual submission. All changes to the previous MIP have been added in red. (Appendix A)

1.3 Business Continuity Planning

WCHC has a legal and contractual duty to develop robust business continuity arrangements which set out how the Trust will maintain critical functions if there is a major emergency or disruption.

Business Continuity Plans are in place at service level to provide a consistent methodology and format across the Trust, a Business Continuity Policy aligned to ISO22301 (International standard for Business Continuity Management) has been developed.

The Trust BCP arrangements are underpinned by the Business Continuity Policy (GP62). This Policy was developed in 2024 and approved by the Quality and Safety Committee. The Policy is due to be reviewed March ~~2027,2027~~; however the Policy is currently undergoing a review to reference the requirement for services to identify minimum staffing levels.

The Trust BCP template was developed in 2024 and was accompanied with a BCP development training session. Services continue to utilise these templates for their annual BCP review process. In 2025 all services were compliant with the BCP review process which was reported in the Trust annual core standard self-assessment assurance process in October 2025. The 2026 annual review process has now commenced with compliance being monitored by the EPRR lead and HSSR Group.

MIAA conducted a full review of WCHC EPRR arrangements and "Business Continuity ~~Planning~~ **inPlanning**" in February 2025. The overall assurance opinion showed a substantial rating and the statement "There is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently."

Business Continuity plans have been subject to an annual review. That latest internal audit, conducted in December 2024, resulted in one action:

- EPRR Lead to liaise with HR to review Induction Toolkit with a view to referencing Business Continuity Plans.

This action has been completed.

Business Continuity plans have been utilised on several occasions during 2025/26. The main reason for activation has been staff shortages particularly within the Walk in and Urgent care settings.

1.4 Health Safety Security Resilience Group (HSSR)

The HSSR Group has met on a quarterly basis throughout 2025/26. It is chaired by the EPRR lead. The group includes representation from services across the organisation and Staff Side representatives.

EPRR plans and Policies travel through this group prior to implementation. The group is also consulted on new and reviewed EPRR related policies.

During 2025/26 the group have reviewed the EPRR Policy GP52 (February 2026). The group have also assisted in the review of the following EPRR related plans.

- Major Incident Plan (April 2025)
- CBRN Plan (June 2025)
- Adverse Weather Health Plan (June 2025)
- Pandemic Plan (August 2025)
- ICC Development Plan (April 2025)

In addition, the group have monitored compliance with regards to the completion of service level business continuity plans.

Administration Support for this group is provided by the Senior Assistant & Quality Improvement Champion, Corporate Affairs.

The HSSR reports into the Quality and Safety Committee.

1.5 On Call Manager Process

WCHC operates a two-tier On Call rota system. The Trust utilises a Tactical level as its first level of On Call. This level consists of service directors and deputy directors, which currently has 9 named individuals performing this role.

The tactical level consists of managers performing the role daily. This system requires the transfer of the On Call phone to the individual's phone and is managed by the Centralised Booking Service who operate seven days a week.

The second level of On Call is the Strategic level referred to locally as the escalation level. This level is made up of Chief officers and Directors. The rota has 12 named individuals. The escalation level also operates on a day about basis.

Rotas are managed by the EPRR lead and are produced two months in advance taking cognisance of dates where managers have indicated that they would be unavailable to perform the role.

The process is continually subject to review by the EPRR Lead and members of the rota. On Call incident logs are completed on Datix, allowing for more effective management of incidents. Reporting and analysis of On Call incidents takes place at the HSSR and within On Call Manager training.

1.6 Counter Terrorism

There are five levels of threat from Terrorism:

- low - an attack is highly unlikely
- moderate - an attack is possible but not likely
- substantial - an attack is likely
- severe - an attack is highly likely
- critical - an attack is highly likely in the near future

The level is set by the Joint Terrorism Analysis Centre and the Security Service (MI5).

The current threat level in relation to international terrorism in the UK is "Substantial" an attack is likely and was last changed on the 9th February 2022. The previous rating of Severe had been in place since November 2021 following the attack outside the Liverpool Women's hospital.

Nationally, there were 3034 arrests for terrorism-related activity in the year ending 31 December 2025, representing a 1,114% rise on the previous year however this can be attributed to actions taken against supporters of the newly formed Palestine Action group. There had been an increase of non-Palestine Action related arrests with 255 arrests on the previous 12-month period (an increase of 2%).

The EPRR lead continues to maintain close links with counter terrorism policing and attends regional training and exercise events. The trust is also signed up to the periodical counter terrorism circulation UK Protect. Key messages to staff concerning preparedness and security are communicated in Staff Bulletin, StaffZone and training sessions. The Trust is also able to access the Action Counters Terrorism e-learning training package.

Trust representation at the monthly Wirral, St Helens, Knowsley and Cheshire East Channel Panels have transferred from the EPRR lead to the Trust Safeguarding team. The Panel collectively assesses the risk to an individual and decides whether an intervention is necessary. Referrals to the panel are made via the Prevent programme. If a Channel intervention is required, the panel works with local partners to develop an appropriate tailored support package. Nationally there has been a 27% increase in referrals to the Prevent program (8,778 in the year to March 2025), with a sharp rise (240%) in cases linked to a "fascination with extreme violence" in the first quarter of 2025.

1.7 Terrorism Protection of Premises Act 2025 (Martyn's Law)

The Terrorism (Protection of Premises) Act 2025 also ~~referred~~referred to as Martyn's Law, is named in tribute to Martyn Hett, one of the 22 victims of the horrific Manchester arena attack in 2017.

The Act comes into effect 1st April 2027.

The guidance sets out clear steps for businesses and service providers. This includes smaller premises like shops, restaurants and health centres where 200-799 people may be present, to ensure evacuation routes are in place, staff know how to swiftly implement a lockdown in their building, and staff know how to quickly communicate with their customers where an attack occurs.

The Trust has developed a Lockdown plan for its premises. This was last successfully tested at the Trusts largest site, ~~SCHC, in~~SCHC, in December 2025 and no additional actions were identified.

Larger premises where 800 or more people will be present, will be required to take further steps to reduce their vulnerability to acts of terrorism – such as having CCTV, bag search policies, or vehicle checks where appropriate.

WCHC does not operate any premises where 800 or more persons would be present.

1.8 Plan Development

The following table provides an up-to-date position regarding plans that support the EPRR programme.

Two new plans have been developed during the past year in response to feedback received relating to our core standard submission in October 2023. These plans relate to the set up of an Incident Coordination Centre and site lock down procedures. Previously these arrangements were included in the EPRR policy and the Security Management policy respectively.

Emergency Planning Documents.				
	Title	Last Updated	Review Due	Comments
1	Major Incident Plan	Apr-25	Apr-26	Included in papers for Q&S approval.
2	CBRN Plan	Jun-25	Jun-26	Reviewed Annually
3	Adverse Weather Health Plan	Jun-25	Jun-26	Reviewed Annually
4	Pandemic Plan	Aug-25	Aug-28	Amalgamated Flu and Community Outbreak Plan.
5	Fuel Plan	Apr-24	Apr-27	
6	Industrial Action Plan	Jan-25	Jan-28	
7	Lock down Plan	Dec-24	Dec-27	
8	ICC Development Plan	Apr-25	Apr-27	

1.9 EPRR Resourcing

The Trust continues to assess the resources in place to fully discharge its EPRR duties.

The Trust employs an EPRR lead/Local Security Management Specialist on a full time basis. 50% of this role is dedicated to EPRR.

The EPRR Lead utilises the services of the Estates Senior Administrator on an ad hoc basis to assist with EPRR related matters including supporting the Health Safety Security Resilience Group meeting.

Other financial support is provided from central budgets to support the EPRR programme. This includes an annual payment to the Integrated Care Board that supports additional EPRR training and other EPRR support. During the year 2025/26 the Learning and Organisational Development department has supported our Fit Testing Training programme.

Individual services will utilise their own budgets in order to support the EPRR programme. Services purchase their required PPE including Masks, Gowns and Gloves. The two "Walk-in-Centre's" also purchase the required CBRN(e) response equipment from their own budgets.

2.0 Training and Exercising

2.1 Training

The Trust has actively invested in the knowledge and skills of its Emergency Planning Lead and ongoing training of other key staff.

2.1.1 On Call training

On-call Manager (Strategic and Tactical) training programme has been developed and delivered to individuals who have been recruited on to the respective on call rotas. The training has been delivered by the EPRR lead. The training is scenario based. Numerous real events are utilised to provide the individual with sufficient knowledge to perform the role of an on-call manager. The on-call mechanisms are fully described and the systems available to support individuals performing the role.

The EPRR lead maintains a close working relationship with all on-call Managers and has regular debriefs to continue to understand the issues that are being raised and the resolutions utilised to resolve them. This information is utilised to refresh the on-call training packages. Integration with WUTH has resulted in an increased number of Strategic on-call managers for the WCHC rota that also provide Strategic cover for WUTH. These individuals have received relevant localised WCHC on-call induction training from the EPRR lead.

On-call Managers are also required to complete the Principles of Health Command training developed and delivered by NHS England EPRR team. Separate packages are delivered to members of the Strategic and Tactical on call rotas. During 2025/26 all Trust On Call Managers have continued to maintain compliance with this requirement. One new member to the Tactical on-call rota will receive their training in April 2026 alongside the EPRR lead.

In addition all on call managers and EPRR lead have received an accredited input addressing the legal awareness of performing the role an incident commander and the decision making process involved. The training focused on the potential pitfalls that may be encountered. References were made to the inquiry that followed the Manchester Arena attack in 2017. All those attendees thoroughly enjoyed the training recognised its relevance and agreed it would assist them when making decisions.

2.1.2 Fit Test Training

Staff performing certain functions such as “Aerosol Generated Procedures” are required to wear an FFP3 face mask to enhance the safety of themselves and the patient with regards to passing on of infections. Once a member of staff has been identified as being required to wear such a mask they should be “Fit Tested” for each mask type. The person performing the “Fit Test” should be trained in the procedure.

In order to further enhance the “Fit Testing” capability of the Trust additional training was provided in August 2025. This training focused on the individual services most reliant on the use of FFP3 masks. Additional “Fit Testing” kits were also acquired making those services fully self-sufficient in this area.

In addition to this the trust utilises a portacount device that provides a Quantitative testing method which negates the requirement for the subject to taste as a test of secure fitting.

Currently there are 26 individuals who are trained in the “Fit Testing” process. These details have been added to the ESR databases and are available to search.

Exercise Aura, discussed later in this report, was a joint integrated exercise between WUTH and WCHC to respond to a pandemic. The use of FFP3 masks was discussed. The Trust IPC lead

informed the exercise that the use of FFP3 would be reviewed to ensure that this type of PPE would only be used where necessary. The findings of that review were discussed at IPC Group April 2026. The group agreed with that there is no assurance that fit testing results are being recorded. It was agreed that the risk associated with Fit Testing would sit with the Specialist Medical Services Directorate who have been identified as the main users of FFP3 masks. Further discussion needs to take place to identify a clinical lead to ensure a suitable process is in place when wider deployment of FFP3 would be required such as a Covid19 incident.

2.1.3 Loggist Training

A full loggist refresher training session was conducted in July 2025. A total of 7 members of staff attended the training. The session built on the Exercise Coborn CBRN scenario that had been previously delivered to On Call managers on 30th June 2025. The EPRR lead performed the role of facilitator and devised several actions for staff to document and record. Feedback from the session was extremely positive.

An action for the for the 2026/27 workplan will be to work with the WUTH EPRR lead to review the number of trained loggists across both organisations as the integration journey develops.

2.1.4 Debrief Training

The EPRR lead attended an accredited EPRR Incident Debrief Training course that had been arranged by the ICB EPRR team. The qualification attained identifies the EPRR lead as being able to debrief EPRR incidents in any single organisation or region.

2.2 Tests and Exercises

The trust is required to ensure response plans have been appropriately tested, conducting:

- A live exercise/Incident every 3 years
- A tabletop exercise annually
- Communications test every 6 months

The tables below advise on the exercises and training that have taken place involving the Trust during the past three years.

Date	Type	Topic	Attendees
Internal Exercises			
05/12/2023	Table Top Exercise	Exercise Niveous. Testing the effectiveness of the Adverse Weather Health Plan.	Facilitated by the EPRR Lead. Service Leads and On Call Managers.
29/12/2024	Live Exercise	SCHC Lockdown Exercise. Testing the effectiveness of the Lockdown Plan.	Facilitated by the EPRR Lead. On Call Strategic. Security and Estates staff.
30/06/2025	Tabletop Exercise	Exercise Coborn. A CBRN exercise that focused on a scenario of a CBRN incident at a	Facilitated by the EPRR Lead. Service Directors Service Leads

		busy Walk In centre.	On Call Managers
10-14/06/2025	Communication exercise	Exercise Alexander a Trust led communication exercise testing all Trust On Call mechanisms	Facilitated by EPRR Lead who, out of hours, contacted all on call staff including On Call Strategic and Tactical managers.
16-23/12/2025	Communication Exercise	Exercise Alexander a Trust led communication exercise testing all Trust On Call mechanisms	Facilitated by EPRR Lead who, out of hours, contacted all on call staff including On Call Strategic and Tactical managers.
29/12/2025	Live Exercise	Lockdown Exercise at SCHC testing ability of Trust to secure the building. Process was successful and no additional actions necessary.	All building occupiers. Facilitated by EPRR Lead.
19/03/2026	Tabletop Exercise	Exercise Aura. Pandemic exercise. Joint exercise between WUTH and WCHC	Facilitated by WUTH and WCHC EPRR Leads. Service leads from across both organisations.
External Exercises (previous 3 Years)			
29/08/2024	Live exercise	Exercise Calliope – ICB led communication exercise leading to the establishment of an Incident Management Team. WCHC Trust response facilitated by EPRR lead	EPRR Lead On Call Managers. IMT members
03/12/2024	Tabletop Exercise	Exercise Nexus - Community Outbreak Exercise based in an asylum seeker setting.	EPRRLead and IPC Staff
08/07/2025	Exercise Australis	An ICB Regional Business Continuity exercise to focus on a National Power Outage. Including Debrief	EPRR Lead and On Call Managers
20/03/2025	Tabletop Exercise	Cyber attack Incident exercise	IT Staff
External			

Debriefs/Debriefings (3Years)			
10/05/2023	Briefing	Adverse Weather Delivered by UKHSA	EPRR Lead
11/05/23 & 5/06/23	Briefing	Summer Preparedness Webinar and Workshop delivered by UKHSA	EPRR Lead
03/11/2023	Briefing	Counter Terrorism Security Agency (CTSA) Event	EPRR/LSMS
22/02/2024	Briefing	National presentation relating to Martyns Law and security requirements following mass gatherings.	EPRR Lead
10/04/2025	Briefing	UKHSA Warm weather health webinar	EPRR lead
24/09/2025	Briefing	UKHSA Cold Weather Webinar	EPRR Lead
10/11/2025	Briefing	Martyns Law Webinar.	EPRR Lead
11/12/2025	Briefing	UKHSA Annual adverse weather planning webinar.	EPRR Lead
27/12/2025			
Internal Training			
Various dates	E Learning	Action Counters Terrorism input.	Accessed by relevant staff Receptions etc)
Various dates	Face to Face	On call Manager training	Delivered to new recruits of the On call Manager rotas.
30/07/2025	Face to Face	Loggist Training	Delivered to five volunteers by EPRR Lead.
25/08/2025	Face to Face	AEO Training – ICB Training package	Delivered by EPRR lead to AEO and Dep COO
External Training			
05/08/2025	Face to Face	Fit Test Training	Provided by Face 2 Fit . 8 members of staff.
Various dates	Teams	Principles of health command	Various Strategic and Tactical On Call managers.
21/07/25	Face to Face	Action Counters Terrorism awareness	EPRR/LSMS Training.

2.2.1 Training and Exercise programme

The trust is required to complete a live exercise within a three-year period that can test elements of the emergency planning measures in place. The occurrence of an incident that has tested the effectiveness of elements of the plans in that period may also show compliance in this area.

Listed below are the Incidents and exercises that have occurred during the past three years and evidence of compliance with this standard. These are in addition to the training/exercises that have already been documented above.

Date	Exercise/ Incident	Details
12/08/2023	Incident	Refurbishment work being completed at the communications room located at the VCHC Walk In Centre. During these works there was a failure of a BT circuit that adversely affected the ability to communicate via telephony and internet at various locations throughout the Trust. Some initial mitigation was put in place utilising the 4G network, but additional work was required in order to facilitate printing. Full normal service was achieved with-in 36 hours. Lessons learnt included the need to establish a full risk assessment with stakeholders that could be affected by such works. Full testing of network connections to include a number of checkpoints at each stage to ensure expected outcomes are met.
03/01/2024	Incidents	VCH IT and Telephony Circuit failure affecting many services throughout the organisation through loss of IT and telephony. This occurred following a decision made by BT to terminate an incorrect line. Full recovery took a number of days and required the assistance of other providers including WUTH who provided support by affording access to their systems. This temporary measure is still in place as BT have not yet provided the new line that could be tested. A new “failover” system has been introduced which is tested weekly and provides additional mitigation. This measure is a permanent measure that enhances Trust resilience in this area. Weekly contact is made with the BT account manager to ensure the matter is rectified as soon as possible. An Incident Management Team was established that was led by the Deputy Chief Operations Officer. The team met several times each day until the situation reached a satisfactory conclusion. This delay in the provision of the new line is also affecting the ability of the IT service to adequately assess any lessons identified from this IT failure.
10/01/2024	Incidents	Primary domain controller failure at SCHC causing IT issues for users. Staff were unable to log on to computers as the controller that had failed would verify all log on details. Recovery was to utilise a secondary server at VCHC to verify accounts. This mitigation did not recover all systems including Mail Central and Datix. A new primary domain controller was installed and cleared the known errors but introduced a new error around the Always On Virtual Private Network (AOVPN) which was not syncing. Additional work took place to rectify, and all systems were fully operational 72 hours after the incident commenced. Lessons identified are still being assessed as the Trust IT works closely with one of its partners to ensure that automatic updates of domain controllers is managed safely.
26/01/2024	Incident	In response to national measles outbreaks and the publication of revised NHSE guidance, the Infection Prevention Control Service completed a risk assessment and developed an action plan in order to ensure that WCHC was in the strongest position to deal with a Measles

		outbreak locally. An internal measles preparedness meeting group was established with relevant services and the EPRR Lead to progress actions. Action plan and risk assessment were continually monitored by trusts <u>by trusts</u> Clinical Assurance Group with oversight provided by the Infection Prevention and Control Group Walkthroughs were completed within the Urgent Treatment Centre and VCH Walk in Centre to support preparedness plans in relation to measles. This helped to identify learning to improve the patient journey and any associated actions have been implemented by the service.

2.2.2 Incident Coordination Centre (ICC)

The Trust is required to maintain appropriate incident control centre facilities to control and co-ordinate the response to an emergency. Incident Control Centres are established at St Catherine's Health Centre and a backup facility at the Albert Lodge training wing located at VCHC.

ICC Equipment and connectivity is checked and tested on a monthly basis.

3.0 Response

3.1 Incident – Industrial Action

Resident Doctors have continued to call various periods of industrial action throughout the year. The Trust has contributed with preindustrial action assessments and situation reports to the ICB but Trust services had not been disrupted by any of the periods due to the non-employment of resident doctors.

3.2 IT Incidents

The Trust has experienced a number of Information Technology incidents that have adversely affected the business continuity of a number of services during the past year. The incidents are highlighted at section 2.2.1 above where three separate incidents are discussed. Although there were three separate causes with different outcomes the one common thread of all three was the swift and excellent response from the IT services in order to mitigate the causes affecting business continuity. In addition to the initial responses an Incident Management Team was convened, and meeting structure and battle rhythm established.

In all cases, once business as usual had been established, a full after-action review was commenced in order to identify any lessons for future learning. In two of the three cases that learning process is ongoing as the IT Team work closely with stakeholders and providers. Full Situations, Background, Assessment, Recommendations (SBAR's) were completed.

3.3 Closure of Eastham Walk In Centre

Eastham Walk In Centre routinely operates between 12:00 hours and 20:00rs seven days a week and provides healthcare and advice on a non-appointment basis and is one of three bases that the Trust operates this service from. In December 2025 the team that staffing is resourced from sustained a period of significant staff absence due to sickness, In order to maximise the services

the Trust was able to deliver the decision was made to close the Walk In Centre service operated from Eastham Clinic. The situation remained under constant review. Signage and communications ensured that significant messages were cascaded to the communities affected by the closure. The centre was eventually opened on the 9th February 2026

3.3 Lessons Identified and learning from Incidents and Exercises.

Following any EPRR exercise or EPRR related incident a full after-action review will take place. That review will be supported by a debrief of all involved in the event. The review will be led by the EPRR lead who will document the findings and develop an action plan where necessary.

During 2025/26 the following is provided as examples of the lessons have been identified:-

Exercise Coborn - 30th June 2026

The exercise firstly involved a hazardous material type incident at a Wirral Walk In Centre addressing the Remove, Remove, Remove element of the response plan. The second part of the exercise included the deliberate deployment of an unknown white powder over a crowded waiting area in the centre. Finally, the participants were asked to consider the discovery of a suspicious suitcase left by the person deploying the powder.

A full debrief took place and the following lessons were identified to be considered in future planning.

- Lesson Identified – Plan to include “where safely possible” deploy runner to other buildings to remain indoors in order to minimise casualties.
- Lessons identified – Develop/identify a process for OCM’s to access service staffing at any time. In the absence of an operational command point.
- Lessons Identified – All On Call Managers to download JESIP phone application.

Exercise Aura - 19th March 2026

Exercise Aura was a joint exercise between Wirral Community Health and Care and Wirral University Teaching Hospital and was facilitated by the two trust leads for Emergency preparedness, Resilience & Response. This exercise focused on the response to a Covid 19 type pandemic. The exercise included a number of injects that commenced with the horizon scanning of an outbreak that may affect the UK. The exercise progressed to the planning for the outbreak and dealing with the same. The final inject concentrated on the recovery phase from the outbreak.

A total of eight lessons were identified that have resulted in the following recommendations;

1	Trust EPRR to liaise with partners at LHRP to investigate further sharing of plans.
2	Pandemic/outbreak plan to be updated with latest guidance in line with the annual check for EPRR Core Standards.
3	To repeat the exercise to a larger group including partner agencies utilising the Teams platform.

4.0 Partnership Working

The trust actively participates in the following multi-agency groups to ensure a proactive and co-ordinated approach to informing and sharing best practice:

- Local Health Resilience Partnership (LHRP Strategic), attended by Accountable Emergency Officer and led by ICB EPRR
- LHRP Practitioners Group – Working group for both Merseyside and Cheshire attended by Emergency Planning Lead and led by ICB EPRR
- Wirral Emergency Planning Group – Multi-agency working group attended by both industry, category 1 and 2 responders to review resilience arrangements and public events across Wirral
- WUTH Emergency Planning Team Meeting
- CWP Emergency Planning Team
- Local Resilience Forum (Merseyside) via ICB representation
- C&M Community and Mental Health Core Standard Working Group.
- C&C ICB Core Standards Task and Finish Group.

5.0 Assurance

Under the CCA 2004, the trust has legal responsibilities in six specific areas:

- Co-operating with other responder organisations
- Risk assessment
- Emergency planning
- Communicating with the public
- Sharing information with local responder organisations
- Business continuity plans to ensure that services can continue to deliver their functions in the event of an emergency so far as its reasonably practicable

Compliance against the EPRR requirements of the CCA 2004 is monitored via an annual self-assessment exercise the results of which are required to be submitted to trust board for approval before submission to NHS England.

Organisations are expected to state an overall assurance rating as to whether they are fully, substantially, partially, or non-compliant with the NHS EPRR Core Standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

5.1 Core Standards Self-assessment.

The self-assessment process for 2025 was completed by the EPRR lead. The initial self-assessment was subject of a check and challenge process conducted by the Cheshire and Merseyside ICB EPRR Team prior to submission to NHS England.

As a result of the self-assessment submitted and the associated evidence provided, the ICB agreed that WCHC has an overall assessment of "Substantially Compliant" and an overall compliance percentage of 97%.

The below table outlines the self-assessed compliance status of the 58 core standards that are applicable to a community trust and which domain the standard belongs.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	10	10	0	0
Total	58	56	2	0

There were two standards that have been assessed as “**Partially Compliant**”.

Standard 33 relates to Warning and Informing and specifically to identify how the Trust will provide 24-hour communication and support to On Call managers.

This is a standard that many providers are unable to evidence full compliance with as it requires on on-call mechanism for communication staff. Work will continue with other providers to ascertain if something can be done on a system based footing to provide that 24-7 support that the standard dictates.

Standard 49 states that the Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

MIAA has conducted its annual assessment of the Trust to certify the toolkit. The assessment identified a small amount of improvement required to achieve full compliance. An action plan has been developed to address these areas in order to achieve full compliance at the next assessment which will take place in June 2026.

No additional action plan is required to address these two standards.

6.0 Workplan for 2025/26

A full EPRR work plan has been developed for the year 2026/27. This work plan can be found at **Appendix B** of this report.

Mick Blease

Emergency Planning Lead
21st April 2026

EPRR

Training and Exercise

Programme

2025/26

Introduction

This document outlines Wirral Community Health and Care NHS Foundation Trust (WCHC) training and exercise programme covering Emergency Preparedness, Resilience and Response (EPRR), both internally and externally for 2024/25.

The EPRR programme set both statutory and non-statutory training as outlined from the Civil Contingencies Act (2004) and EPRR Framework 2022 stating:

- *Require a plan to include provision for the carrying out of exercises.*
- *Require a plan to include provision for the training of staff or other persons*
(Reference. CCA 2004)
- *The NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically.*
All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.
(Reference. EPRR Framework 2022 Section 8.3)

National Occupational Standards (NOS)

Standards for NHS incident training are contained within the Skills for Justice National Occupational Standards (NOS) framework and should be referred to when identifying staff training needs; please see

[NHS EPRR National Occupational standards](#)

Emergency Planning Officer

The Emergency Planning Officer role is to ensure the EPRR Training and Exercise programme is maintained and reviewed on an annual basis.

Teaching Plan

Teaching and learning plan will breakdown in detail each training or exercise programme set out within the overall EPRR annual programme, outlining all the teaching and learning activities, with allocated timings, assessment activities and resources required.

All material provided is adjusted dependent on type of training and exercise carried out ensuring that individual needs are met.

Multi-Agency Training

This plan is focused on internal training for WCHC but recognises the ongoing training and exercising with multi-agency partners in meeting the statutory responsibilities set out within CCA 2004.

The ICB represents the system at the local Merseyside Local Resilience Forum and will advise the Emergency Planning Officer on any Multi-Agency training opportunities.

CPD / PDR

Currently training carried out by the Emergency Planning Officer is not accredited. Records of training delivered will be maintained by the Emergency Planning Officer with support from the Learning and Organisational Development Team.

Core Standards

WCHC EPRR Training and Exercise programme provides assurance and evidence to the following NHS Core Standards question under Domain 5.

22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in

			accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.

The core standards also identifies the following training requirements under the headings of Hazardous Materials and Chemical Biological Radiological and Nuclear (CBRN) incidents.

63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented

Training Programme	Aim	Objectives		NOS
On Call	To analyse and construct the theory and practical processes of being an on call manager/Director for external and internal incidents including Gold/Silver command or support for MKUH.	- Summarise the legislation and guidance associated with civil protection. - Describe how this guidance applies to their organisation and the role of on-call. 3. Explain the responsibilities of their organisation in preparing for and responding to emergencies and major incidents. - Discuss the types of 'emergencies and potential threats they may encounter. - Describe the environment where a Loggist may be utilised during an 'Emergency'. - State the importance of the legal aspects and requirements in relation to logs, records and documentation. - Understand MKUH ICC 'Tactical' and 'Strategic' set-up and process. - To be assessed through on-call competency programme		CC AA1 CC AA2 CC AA3 CC AB1 CC AC1 CC AE2 CC AE3 CC AF1 CC AF2 CCAG1 CCAG2 CCAG3 CCAG4 CC AH1 CC AH2
Hazmat/CBRN		- Summarise the legislation and guidance associated with CBRN /HAZMAT - Describe how this guidance applies to WCHC and identify the services that may be affected. - Explain the responsibilities of their organisation in preparing for and responding to CBRN / HAZMAT incidents. - Discuss the types CBRN / HAZMAT and potential threats they may encounter in a Community Trust setting. - Demonstrate the skills and methods as underpinned by IOR and its principles.		CC AA2 CC AA3 CC AF1 CC AA1
Loggist Training	To analyse and construct the legal, and practical	Summarise the legislation and guidance associated with civil		CC AA1 CC AA2

	processes for record keeping during an incident and how loggists play a key role	protection. - Describe how this guidance applies to their organisation and the role of the loggist. - Explain the responsibilities of their organisation in preparing for and responding to emergencies and major incidents. - Discuss the types of 'emergencies and potential threats they may encounter. - Describe the environment where a Loggist may be utilised during an 'Emergency'. - State the importance of the legal aspects and requirements in relation to logs, records and documentation. - Demonstrate the skills and methods of decision logging.		CC AA3
Business Continuity Exercise	The exercise aims to develop an overview of Business Continuity Management System (BCMS) as underpinned by statutory requirements, and the applications in activating BCP in response	- To outline what BCMS is and why WCHC requires business continuity. - To describe the process in how BCMS is developed. - To apply BCMS development in the Trust and role of the Business Continuity Lead - To test current BCPs in accordance with national guidance and best practice		

Annual WCHC Exercise Programme

Provider Exercise	Aim	Objectives
Communication Exercise NB: Every 6 months	To test all internal on-call cascade process.	- To test WCHC cascade system for OOH - To test on-call arrangements for the Organisation and its ability to respond to an incident.

IOR / Dry Decon NB: Annually	To test WCHC process to carry out a Dry Decontamination following self-presenters in line with IOR guidance.	- To test WCHC capabilities in carrying out a Dry Decontamination. - To test WCHC planning arrangements concerning Dry Decontamination - To test staff on the Dry Decontamination process and its application
Business Continuity NB: Annually	To test WCHC application in response to a internal 'critical incident' requiring business continuity response	- To test WCHC capabilities in carrying out a business continuity response, In and Out-of-Hours - To test WCHC planning arrangements concerning business continuity. - To test key staff on the business continuity process and its application
Table Top Exercise NB: Annually	To test and assess WCHC planning arrangements against specific incident. within a tabletop environment .	To be developed dependent on type of tabletop exercise outlined
Live Exercise NB: <3 years	To test and assess WCHC planning arrangements against specific incident within a live exercise environment.	To be developed dependent on type of tabletop exercise Outlined. NB If the Trust has had to respond to a real time EPRR Incident then this can be utilised as evidence and comply with the requirement to have a live event every three years.

Proposed Training for 2025/2026.

Training Exercise	Dates	Summary	Attendees
On Call Manager Training	September 2026	Capture identified Learning from recent On Call manager incidents and other scenarios.	On Call Managers
Lockdown Exercise (SCHC)	December 2026	The Exercise will test the newly developed Lockdown Plan for the Trust.	Security Personal/Estates staff On call Manager(s)
Joint WUTH and WCHC and Partner Agencies Pandemic Tabletop Exercise	October 2026	This Exercise will test both Trusts Pandemic Plans and the effectiveness of Service Business Continuity Plans and knowledge of ICC set up for On Call Managers.	Service leads On Call Managers
Cyber Tabletop	May 2026	Provide knowledge to service	IT Staff

Exercise		nominated individuals who are responsible for the development of Business Continuity Plans.	On Call Manager
Joint WUTH and WCHC Loggist Training	November 2026	This training will enhance both Trust resilience with regards to its Major Incident Loggist ability and take into account roles post integration.	Volunteer Loggists
Communication Exercise (6 Monthly)	June and December 2026	Test the ON Call response times of key EP roles including On Call managers, Loggists, Estates and IT.	On Call staff and Loggists
Evacuation Exercise. CICC	July 2026	Test the effectiveness of the Trust Evacuation Plan of the CICC wards	CICC Ward Managers and other CICC staff.

External training opportunities:-

Via NHS England:

- Principles of Health Command (NHSE dates available) Tactical and Strategic On Call Managers.

Via the ICB:

- Resilience Direct Training (ICB supplied)

Additional Training can be added on an Ad Hoc basis that is relevant to incidents or events as they occur in order to prepare for or capture lessons from.

MAJOR INCIDENT PLAN

Document Title	Wirral Community NHS Foundation Trust Major Incident Plan
Authorising Manager	Hayley Kendall
Job Title	Executive Managing Director
Plan Author	Mick Blease
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Version Control:

Version History:		
V1	Development of Major Incident Plan to reflect organisational change	April 2011
V2	Amendments to update information	April 2012
V3	Amendments to include update in line with NHS commission Board Structures and Emergency Preparedness, Resilience and Response (EPRR) arrangements	April 2013
V4	Amendments to update information	October 2014
V5	Review of information and addition of escalation pathways	October 2015
V6	Update of ICC details Update of phone contact details	September 2016
V7	Amendments to Authorising Manager and Plan Author Rest Centre process	September 2017
V8	Amendments made to the trust On Call arrangements section 4.3	August 2018
V9	Amendments made in relation to the Trust name.	August 2019

	Executive pack included which provides summary of the MIP for On Call managers.	
V10	Amendments to Action cards to include requirement to Tenants of WCHC controlled buildings, Amendments to Authorising Manager	September 2020
V11	Reference to Integrated Care systems and updates relating to communication links	September 2021
V12	Change of reference from CCG to ICB including relevant contact details. Change reference of Divisional Managers to Service Directors.	S 2022
V13	Removal of reference to Rest Centre Management.	August 2023
V14	Removal of out-of-date terminology. Include reference to the NHS Emergency Preparedness Resilience Response Framework July 2022. Cognisance taken from NHSE Core Standards feedback 2023. Inclusion of Countermeasures (CBRN)	August 2024
V15	Changes to ICB and NHSE EPRR Contact details. New NHSE/ICB Incident Reporting process included at 4.8	April 2025.
V16	Annual Review – ICB Contact Details Updated. Reference how to access mutual aid.	April 2026

Further information about this document:

Document Name	Major Incident Plan
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Distribution

The plan will be made available to all staff via the StaffZone

Hard copies are also available in both ICC rooms

The plan is included in the On Call Managers pack

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Major Incident Plan Overview

SECTION 1: Introduction

1.1 Background

The NHS needs to plan for, respond to and recover from a wide range of incidents, emergencies or disruptive challenges that could impact on health or patient care. These range from extreme weather conditions to an outbreak of an infectious disease, or a major transport incident. The Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 and the Health and Care Act 2022 require NHS England and NHS-funded organisations to demonstrate that they can deal with such incidents while maintaining services to patients. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR).

During times of pressure and in response to incidents, NHS-funded organisations require a structured approach to support effective decision-making. This structure provides a clear leadership pathway with accountable decision-making in response to information about the incident. This approach to leadership is commonly known as 'command and control'.

In compiling this plan reference is made to the NHS Emergency Preparedness Resilience Response Framework July 2022.

The Framework describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (EPRR), to help all NHS funded Organisations in England meet the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

This Framework reflects the changes introduced from the Health and Care Act 2022 and the formation of Integrated Care Boards (ICBs).

1.2 Purpose

The Major Incident Plan (MIP) plan acts as a reference and signposting document to provide appropriate guidance in planning and response and recognises that the NHS follows the principles of subsidiarity in that an incident should be managed at the level closest to the people affected so far as is reasonably practicable.

NHS-funded organisations are required to fulfil the requirements as Category 1 or Category 2 responders, as appropriate, under the CCA 2004, the NHS Act 2006 and the Health and Care Act 2022, as well as the NHS EPRR Framework, and to apply the principles of integrated emergency management (IEM) in their preparation for and response to incidents and emergencies.

This MIP outlines how the Wirral Community Health and Care NHS Foundation Trust (WCHC) will Respond in the event of a major emergency and is structured around the recognised phases of a response.

- Alerting
- Activation
- Operation
- Escalation and de-escalation
- Stand down

The Major Incident Plan is a generic plan and can be applied to all major incidents and significant internal incidents.

1.3 Who is the Plan for?

All staff within the organisation should be aware of the existence and purpose of the MIP and their individual contributions to the success of the Plan.

All such staff should know and understand their specific role in the overall plan. Service Directors, Heads and Service Leads have a duty to ensure their Business Continuity Plans are in place to support the MIP.

Staff likely to be involved in a major incident response should ensure they have the appropriate training, equipment and knowledge to be able to respond safely and effectively to an emergency. In the event of a major incident, it is likely that several organisations will respond.

1.4 Consultation and Distribution of the Major Incident Plan

This plan will be reviewed annually by the EPRR lead. The Health Safety Security Resilience Group (HSSR) will be consulted on the reviewed plan prior to submission to the Quality and Safety Committee for approval prior to distribution.

The plan is made available as follows:

- Electronically on StaffZone
- A hard copy in the major Incident rooms.
- External partner agencies will receive a copy electronically

When a revised plan is issued recipients will be expected to destroy previous versions.

1.5 Incident Types

1.5.1 Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels. This would require special arrangements to be put in place until services can

return to an acceptable level. This could be a surge in demand requiring resources to be temporarily redeployed within the organisation.

1.5.2 Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to services.

1.5.3 Major Incident

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally.

The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

Each will impact on service delivery within the NHS, and this may undermine public confidence and require contingency plans to be implemented. When making the decision to declare an incident the person making the decision should be clear on what the declaration of an incident will achieve. NHS organisations and NHS-funded organisations should be confident in judging the severity of an incident and determining if declaration is warranted.

1.5.4 Classification of types of Major Incidents

The following list provides commonly used classifications for types of Major Incidents. This list is not exhaustive and other classifications may be used as appropriate to describe the nature of the incident.

- **Rapid onset** – develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g. a serious transport accident, explosion or series of smaller incidents.
- **Rising tide** – a developing infectious disease epidemic or a capacity/staffing crisis or industrial action.
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action.
- **Headline news** - public or media alarm about an impending situation, significant reputation management issues, e.g. an unpopular patient treatment plan which gathers significant publicity.
- **Chemical, biological, radiological, nuclear and explosives** – CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.
- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials.
- **Cyber security incident** – a breach of a system's security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.
- **Mass casualty** – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage

1.5.6 Levels of Incidents

As an incident evolves it may be described, in terms of its level, as identified in the table below.

NHS England Incident Levels	
1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans.
2	An incident that requires the response of a number of NHS-funded organisations within an integrated care system (ICS) and NHS co-ordination by the integrated care board (ICB) in liaison with the relevant NHS England region.
3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to co-ordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).

4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to co-ordinate the NHS response at the strategic level. NHS England (Region) to co-ordinate the NHS response, in collaboration with the ICB, at the tactical level.
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1.6 Review and Audit

The MIP will be reviewed and updated (where necessary) at least annually and, where required, following exercises or after an incident has occurred.

Audit

The MIP will be subject to annual review and as a minimum tested through an annual desktop exercise. Lessons learnt will be captured, incorporated into the MIP where relevant and shared with the wider NHS.

The Foundation Trust's approach to emergency preparedness will be assessed every twelve months either by means of external audit or via self-assessment and assurance provided to the Local Health Resilience partnerships

1.6.1 Training Schedule

Regular training will be provided for Wirral Community Health and Care NHS Foundation Trust (WCHC) staff to ensure they fully understand their role in the event of a major incident. In addition, the Foundation Trust will undertake the following:

- A communications cascade test every six months
- A table top exercise every year
- A live exercise every three years
- Refresher and awareness training for individuals undertaking information handling roles
- Familiarisation of Incident Coordination Centre (ICC) awareness sessions

1.6.2 Other Related Plans

The following plans have been developed to response to specific hazard and threats

- Business Continuity Plans
- Chemical, biological, radiological and nuclear (CBRN) Plan
- Pandemic Plan
- Community Outbreak Plan
- Fuel Plan
- Escalation and Surge Plan
- Adverse Weather Health Plan
- Industrial Action Plan

1.6.3 Underpinning Principles for the NHS EPRR

These underpinning principles apply to all commissioners and NHS-funded organisations.

a) **Preparedness and anticipation** – the NHS needs to anticipate and manage the consequences of incidents and emergencies by identifying risks and understanding direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared. This includes having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) **Continuity** – the response to incidents should be grounded within organisations' existing functions and their familiar ways of working. Actions will need to be faster, on a larger scale and in more testing circumstances during a response to an incident.

c) **Subsidiarity** – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building blocks of response for an incident of any scale.

d) **Communication** – good two-way communication is critical to any effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) **Cooperation and integration** – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. This includes active mutual aid across organisations, within the UK and across international boundaries as appropriate (see Section 8.7).

f) **Direction** - clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident

Trust EPRR policies and plans support these underpinning principles.

1.6.4 Mutual Aid Arrangements.

The successful response to incidents has demonstrated that joint working can resolve very difficult problems which fall across organisational boundaries. Mutual aid arrangements should exist between NHS-funded organisations, and between NHS-funded organisations and partner organisations. These should be regularly reviewed and updated. –

Requesting Mutual Aid from System Partners

Formal requests for mutual aid are to be:

- Made by the Strategic Commander, or Director of the affected Trust
- Made in writing using the Mutual Aid Request Form (Appendix 3).
- Sent to the supporting Trust(s) and NHS Cheshire and Merseyside.

Requests can be made in response to:

- A declared major incident.
- A declared critical incident.

Before a mutual aid request is made, the requesting Trust must have exhausted all other internal options. It would be expected by this point that an incident has been declared, and an Incident Coordination Centre (ICC) along with an Incident Management Team (IMT) has been stood-up.

There will be instances whereby mutual aid needs to be requested urgently, and other times whereby the request is less urgent.

For urgent requests that require a time critical response, an informal request for mutual aid may be made via the telephone to another Trust who may be able to provide support.

The requesting Trust must:

- Inform NHS Cheshire and Merseyside via the On-Call Tactical Commander within 30 minutes of the initial informal request.
- Once mutual aid has been confirmed, complete the Mutual Aid Request Form and submit it to NHS Cheshire and Merseyside via ICC@cheshireandmerseyside.nhs.uk.

Instances of mutual aid needing a less urgent response, the initial request must be made formally using the Mutual Aid Request Form in collaboration with the NHS Cheshire and Merseyside On-Call Tactical Commander.

The full Cheshire and Mersey Mutual Aid agreement and associated request forms can be accessed here:- [Mutual Aid agreement](#)

In the event of NHS Cheshire and Merseyside requiring mutual aid to support the incident response or recovery arrangements, these can be requested by the NHS Cheshire and Merseyside Commander through NHS England or the relevant TCG / SCG. Mutual aid could include staffing, equipment, services, or supplies.

Requests for Military Aid to the Civil Authorities (MACA) can be made when the NHS capacity has been exceeded or the NHS does not have the specific capability to deliver; in these cases the military may be required to augment responses. MACA support is not guaranteed and may incur a charge for its provision unless it is in response to an immediate threat to life. MACA support would be requested via the ICB/NHSE

Clinical networks will retain a key role in coordinating their specialist capacity.

SECTION 2: COMMAND AND CONTROL

2.1 Command, Control and Co-ordination

For the NHS to be able to respond to a wide range of incidents and emergencies that could affect health or patient care, the appropriate alerting processes need to be in place to inform those responsible for co-ordinating the applicable response.

Under the framework, the management of the response to major incidents will normally be undertaken at one or more of three levels – Strategic, Tactical and Operational. The degree of management and co-ordination required will depend on the nature and scale of the emergency.

2.2 Multi-Agency Command

If a significant incident or emergency is large or widespread, it may be necessary to co-ordinate the response of several organisations. This may be at tactical level or at both tactical and strategic level.

2.3 Multi-Strategic Co-ordinating Group (SCG)

Most emergencies are dealt with by local responders at a local level through SCG. A Multi-SCG Co-ordinating Group may be convened where the local response has been or may be overwhelmed and wider support is required, or where an emergency affects a number of neighbouring organisations.

2.4 Strategic Co-ordinating Group

Multi-agency strategic co-ordination is undertaken through an SCG. Any agency that feels a strategic multi-agency approach is necessary can request that an SCG is convened (e.g. pandemic influenza).

The geographical responsibility of an SCG follows that of the Local Resilience Forum (LRF) and in turn with the local Police service boundary. The NHS is usually represented at the SCG by an NHS England area team and Ambulance Service senior manager.

The SCG is a fast moving, information sharing and strategic decision making group. Its role is to allow organisations responding to the incident to share information and co-ordinate their response options.

2.5 Tactical Co-ordinating Group (TCG)

A multi-agency TCG may be called to deal with local emergencies that do not warrant the activation of an SCG. A TCG may also be established to support an SCG, dependent upon the scale/severity of the incident. In these circumstances, the NHS Tactical (Silver) Commander may deploy to the TCG if required.

2.6 Roles and Responsibilities

2.6.1 NHS Strategic Commander

Role: The role of the NHS Strategic Commander is to direct and command the response of all NHS resources.

Responsibilities: The NHS Strategic Commander attends the multi-agency SCG on behalf of NHS organisations locally and is responsible for:

- Declaring a local emergency or major incident
- Representing the NHS at SCG meetings
- Advising the Police Commander
- Co-ordinating the local NHS response to a local emergency (major incident)
- Implementing public health advice as directed by SCG
- Liaising directly with NHS England Merseyside Area Team Tactical (Silver) Commander, ICB's, UKHSA and Foundation Trusts' incident management rooms
- Mobilising primary (including ICB's) and community care resources to support acute and non-acute Foundation Trust
- Acting as the health focal point with other agencies and organisations and fulfil the requirements as a Category 1 Responder as detailed within the CCA 2004

The initial activation of the Merseyside NHS Strategic (Gold) Commander (Merseyside Area Team 2nd on call) is via the North West Ambulance Service Health Control Desk (01772 867640) who holds a copy of the on call rota.

2.6.2 NHS Tactical Commander

Role: The role of the NHS Tactical Commander is to initially assess the information received upon initial activation, co-ordinate the response of local NHS resources, or escalating to the NHS Strategic Commander whilst focusing upon the tactical management of NHS resources

Responsibilities:

- Declare a local emergency (major incident)
- Work closely with any location suffering a business continuity interruption
- Work closely with Clinical Commissioning Groups during a business interruption/local emergency
- Work closely with the NHS Staff Officer during a business interruption/local emergency out of hours
- Co-ordinate the local NHS response to a local emergency (major incident)
- Mobilise primary and community care resources to support the response
- Manage demands on resources
- Communicate regularly and systematically with the NHS Strategic Commander
- Compile situation reports for the NHS Strategic Commander

- Contact the NHS Strategic Commander when resources are required
- Represent the NHS at the multi-agency TCG
- Act as the health focal point for other agencies and organisations, e.g. Public Health
- Work closely with the North West Ambulance Service Silver Commander
- Inform the NHS North of England Director on call via the Health Control Desk (if appropriate)
- Ensure communication networks are set up
- Support the distribution of the public and media communications messages agreed by multi-agency partners; and
- Fulfil the responsibilities of a Category 1 Responder as detailed within the Civil Contingencies Act 2004.

2.6.3 WCHC Strategic/Tactical On call Manager

Role: NHS Foundation Trusts or key partners responding to a multi-agency incident would become Operational command and will be required to co-operate with the NHS Tactical Commander and NHS Strategic Commander requests.

Individual organisations remain in command of their own resources and staff but each one must liaise and co-ordinate with all the other agencies.

The role of the WCHC Tactical On-call Manager/Strategic Commander is to respond to the local emergency (significant incident), either in isolation or as part of a wider NHS response.

Responsibilities:

- Implement internal command and control structures to manage and support the wider response
- Provide regular information to NHS Tactical Command/NHS Strategic Commander using recognised methods and established report formats as required within specified timescales; and
- Contribute to the debrief process and recovery phase.

2.7 Integrated Care Boards

Wirral Community Health and Care NHS Foundation Trust forms part of the Cheshire and Merseyside Integrated Care Board. Integrated Care Boards support NHS England, Merseyside Area Team in discharging its EPRR functions and duties locally.

The ICB will chair the Local Health Resilience Partnership (LHRP) forum. The ICB provides a 24/7 escalation route for providers should they fail to maintain necessary EPRR capacity and capability.

The EPRR role of the ICB is to:

- Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
- Support the NHS England in discharging its EPRR functions and duties locally
- Provide a route of escalation for the LHRP should a provider fail to maintain necessary EPRR capacity and capability
- Fulfil the responsibilities as a Category 1 Responder under the CCA including maintaining business continuity plans for their own organisation
- Chair the LHRP; and
- Seek assurance provider organisations are delivering their contractual obligation.

2.8 Local Authority

Each LA manages a civil contingency planning function. The principal concern of the LA in the immediate aftermath of an emergency is to provide support for the people in their area. Generally, they do so by co-operating with the emergency services in the overall response. The LA will also activate and co-ordinate voluntary sector support.

The health EPRR role of the Local Authority, via their Director of Public Health (DPH) is to:

- Provide leadership for the public health system within their LA
- Ensure that plans are in place to protect the health of their populations and escalate any concerns or issues to the relevant organisations or the Local Health Resilience Partnership as appropriate (LHRP).
- Provide initial leadership with UKHSA for the response to public health incidents and emergencies within their LA area. The DPH will maintain oversight of population health and ensure effective communication with local communities. UKHSA will deliver and manage the specialist health protection services.

2.9 UK Health Security Agency (UKHSA)

UKHSA combines public health and scientific knowledge, research and EPRR within one organisation and works at international, national, regional and local levels.

In terms of EPRR UKHSA will:

- Work with the NHS at all levels
- Support and advise other organisations that play a part in protecting health
- Be responsible for leading the mobilisation of UKHSA in the event of an emergency or incident
- Deliver public health services including, but not limited to, surveillance, intelligence gathering, risk assessment, scientific and technical advice and

microbiology service to emergency responders, Government and the public during emergencies at all levels

- Undertake, at all levels, its responsibilities on behalf of the Secretary of State for Health as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA).

2.9.1 UKHSA – Nationally

The EPRR role of UKHSA nationally is to:

- Provide support to DH to fulfil its role in the UK central Government's National Risk Assessment (NRA) process
- Participate in national multi-agency planning processes including risk assessment, exercising and assurance
- Provide leadership and co-ordination of UKHSA and national information on behalf of the UKHSA during periods of national emergencies
- Support the response to incidents that affect two or more UKHSA regions.

2.10 Scientific and Technical Advice Cell (STAC)

The STAC will access comprehensive and authoritative advice from a wide range of sources, including NHS England and Public Health England and other key scientific and technical sources to support and advise the SCG in directing the response to an incident. The nature of the incident will determine the range of relevant specialist and needed to form a STAC and membership of the STAC will be determined by the type of incident.

SECTION3: Reception Centres

Role the WCHC in supporting Rest Centres

Reception centre is the generic name given to all forms of centres which give shelter.

There are four main types:

- Rest Centres
- Survivor/Evacuee Reception Centres
- Friends and Relatives Reception Centres
- Mass Holding Centres

The Local Authority will determine the requirement for a Rest Centre and determine a suitable location.

If requested WCHC will provide appropriate staff at rest centres to support the needs of patients in the community. Requests for such services will come via the rest centre manager to the On Call Manager, either in hours or out of hours or via tactical command.

Typically, Community Nurses will be required to attend and assess non-urgent nursing care needs of any people in the designated rest centre, and if appropriate to provide relevant care, for example, providing dressings to a patient. A record of any treatment will be recorded in the rest centre treatment log Appendix 5 and medications recorded in the prescriptions record sheet Appendix 3

If *emergency* oxygen is required liaise with local surgeries to understand who may have stocks in surgeries or the Ambulance service. Replacement Cylinders for patients for longer term can be arranged via GPs completing a Home Oxygen Order Form for the suppliers Appendix 4

Community Nurses are equipped with bags containing a range of equipment to support delivery of care and a range of dressings are available from community nurse bases. In addition, there are specific rest centre bags the contents of which are checked on a monthly basis Appendix 6. Bags are located at each base.

SECTION 4: Alert and Activation

4.1 When a Major Incident is declared by an agency or other health provider, the WCHC will:

- Assess the impact on the Trust and if required activate the major incident procedure including the setting up of the Incident Coordination Centre (ICC)
- Mobilise community resources in response to the incident
- Support the Local Health economy by taking steps to relieve pressure in the system

Responding to and Managing Major Emergencies

4.2 Activation of the Plan and Declaring Incident Over

The Trust can be formally informed of a major incident from a variety of sources including

- other Category 1 and 2 Responders
- through the NHS Strategic and or Tactical Command activation process

However to prevent inappropriate activation of the Plan there will always be an assessment phase prior to activation.

The Executive Managing Director, or the on call director out of hours, has the overall responsibility for activating the MIP and is required to declare a major incident. They will also be responsible for declaring the incident closed and instructing the Incident Team to 'Stand Down' utilising the NHS England proformas.

4.3 WCHC On-Call arrangements

WCHC has a 24hrs a day/7 days per week/365 days a year on-call rota. This rota consists of two levels including Tactical and Strategic levels. The Tactical Level consists of service directors and deputy directors. There are currently eight (8) managers rostered to perform the role of Tactical on call and will complete a day on call at a time.

There are twelve (12) directors rostered to perform the role of Strategic on call manager and will complete a day on call at a time. Following the declaration of a Major Incident affecting WCHC the AEO will form the role of Strategic Commander for the Trust in hours and the oncall director will be the Strategic Commander out of hours.

The Trust Tactical on call manager will be the first point of contact for any calls relating to incidents, whether internal or external in hours or out of hours and relating to minor or significant incidents. The Tactical on call manager will contact the Strategic commander and escalate any incidents they deem necessary.

The Tactical on call manager can be contacted on the 07810 754 138. This number is widely publicised across the Trust and included in Business Continuity Plans.

The EPRR Lead is responsible for maintaining the two individual rotas and published a month in advance. Rotas are shared with all individual managers and also included in the On Call section of the Team drive that all managers have access to.

If the Trust On call manager decides to escalate to the NHS England Area Team they will need to follow the steps below and consider the following:

- Will or has the incident the potential to affect the wider health economy?
- Will or has the incident the potential to affect multi-agency partners?
- Will additional support from NHS England Team be required?

This must be agreed with the strategic oncall director first and clearly documented.

4.4 Criteria for Activation of the Major Incident Plan

The Trust will need to consider the activation of its incident response plan in a number of different circumstances See Appendix 7

- An incident which cannot be managed by normal business continuity management e.g. the closure or evacuation of one or more health care premises, serious staffing issues
- An incident causes serious disruption to one or more of the services provided and requires special arrangements to be put in place
- An incident that causes or could cause implications for partner organisations
- An incident occurs which represents a threat to public health or well-being or involves serious concern or alarm and is within the scope of the services offered

- Information received from NHS England, Cheshire and Merseyside ICB, NWAS, Multi Agency Partners, Media or the public.

In all of these circumstances the Tactical On Call manager will need to assess the information. The information received will need to be assessed utilising a risk assessment, and a decision made as to whether to activate this plan. This will be discussed with the strategic oncall director who will be the decision maker and enact the major incident plan as required.

4.5 Joint Decision Model

Commanders should use the Joint Emergency Services Interoperability Principles (JESIP) Joint Decision Making (JDM) Model to help bring together the available information, reconcile objectives and make effective decisions. The JDM centres around three primary considerations; working together, saving lives, and reducing



harm.

4.6 METHANE Model

Standard messaging should be utilised when relaying information to other organisations. The METHANE model is an established reporting framework from the Joint Emergency Services Interoperability Principles (JESIP), which provides a common structure for responders and their Incident Coordination Centre's to share incident information. It is recommended that M/ETHANE is used for all incidents.

M	MAJOR INCIDENT	Has a major incident been declared? (Yes/No – If 'No', then complete ETHANE message)	Include the date and time of any declaration.
E	EXACT LOCATION	What is the exact location or geographical area of the incident?	Be as precise as possible, using a system that will be understood by all responders.
T	TYPE OF INCIDENT	What kind of incident is it?	For example, flooding, fire, utility failure or disease outbreak.
H	HAZARDS	What hazards or potential hazards can be identified?	Consider the likelihood of a hazard and the potential severity of any impact.
A	ACCESS	What are the best routes for access and egress?	Include information on inaccessible routes and rendezvous points (RVPs). Remember that services need to be able to leave the scene as well as access it.
N	NUMBER OF CASUALTIES	How many casualties are there, and what condition are they in?	Use an agreed classification system such as P1; P2; P3 and dead.
E	EMERGENCY SERVICES	Which, and how many, emergency responder assets and personnel are required or are already on-scene?	Consider whether the assets of wider emergency responders, such as local authorities or the voluntary sector, may be required.

A M/ETHANE Reporting Template is available at Appendix 3

4.7. Contact Arrangements

4.7.1 ICB Contact Arrangements

Note: In the event that the Trust declares an emergency the ICB must be contacted

On Call ICB Contact Numbers

For **Cheshire and Merseyside ICB** the following number will be used:

- 0151 247 5050
 - Option 1 – Tactical Commander
 - Option 2– Strategic Commander
- Incident Response 01323 690830

Communications

In hours (Monday to Friday, 0900-1700)

- Primary contact - 07870 619073
- If unanswered - 07984 875078

Out of hours: *(informal arrangement and subject to availability):*

- Primary contact - 07870 619073
- If unanswered - 07984 875078

- The ICB can also be contacted via email
- General - EPRR@Cheshireandmerseyside.nhs.uk
- Incident Control Centre – ICC@Cheshireandmerseyside.nhs.uk
- System Control Centre – SCC@Cheshireandmerseyside.nhs.uk

NHSE North West Regional Operations Centre (NW ROC)

- 0345 113 0099
- NHSE Email - england.eprrnw@nhs.net

4.8 NHS England Northwest SBAR Reporting

When WCHC declares a Business Continuity or Critical Incident (including implementation of Business Continuity arrangements) it must notify the Cheshire and Merseyside ICB within 15 minutes of declaration – and **within a maximum of 1 hour** of invocation/declaration, this notification must be utilised the SBAR template by email. The document will be emailed to ICC@Cheshireandmerseyside.nhs.uk. The initial notification and associated SBAR will be completed by the Tactical On Call manager. **During in hours the SBAR should be agreed by the AEO and out of hours it will be agreed by the Strategic on-call director. Ongoing incidents requiring daily updates will be** the responsibility of the Incident Commander to ensure completion. The SBAR template is included at Appendix 10.

SECTION 5: INCIDENT COORDINATION CENTRE (ICC)

5.6.1 Staff Recall

In the event of a major incident, staff are expected to respond outside their contracted hours, subject to their personal availability. This may include the introduction of shift working and will involve duties which are different from their normal role. The numbers and type of staff required will be co-ordinated by the On-call manager liaising with the oncall director to agree what is required. Staff may be contacted through the business continuity arrangements outside of normal working hours and will be asked to bring their staff ID card with them, if possible, particularly if they have patient facing roles.

5.6.2 Establishment of WCHC ICC

Responsibility for making the decision to establish the ICC on behalf of the Trust lies with the Trust AEO in hours and the director oncall out of normal working hours.

Following the decision to establish, the Incident Management Team will be convened at the main ICC. Details on how to access the facility out of hours are contained in Part 2 of this plan.

5.6.3 Staffing of the ICC

During working hours the ICC will require the redeployment of appropriate staff to work as required. Outside normal working hours, staff will be asked to support an incident should they be able to do so.

The Incident Management team will include all of the following roles

- Strategic Commander (On Call Strategic)
- Tactical On Call Manager
- Operational Support (Emergency Planning lead or Senior Manager)
- Loggist
- Admin support x 2
- Communications representative
- Clinical lead as appropriate to the incident

Other staff may be asked to support the incident management team by invitation, for example, HR, Estates or IT staff, and Service Directors/Service Leads The staff identified to support the incident management team will be determined by the type and size of the incident.

Roles and responsibilities of the incident management team are outlined in the action cards in section 11

5.6.4 Management of a Major Incident

When a Major Incident is declared the Incident Management Team (IMT) takes over responsibility for management of the organisation in order to optimise the effectiveness of its response, where appropriate liaising with the Executive Team. All normal management arrangements are over-ruled for the duration of the incident. To create capacity to deal with the incident, the IMT may in line with Business Continuity Plans

- Utilise resources (e.g. staff) from any area of the Trust
- Scale down any business
- Suspend any area of business

The organisation has a duty to respond to a major incident and also to maintain its normal business activities during the major incident as far as is reasonably practicable. This may involve making difficult decisions which seek to balance differing priorities. The IMT will be assisted in these decisions by emergency plans developed to deal with specific types of incidents and by the Trusts Business Continuity Plan(s).

5.6.5 Alerting and mobilising staff

It may be necessary to reduce or suspend non-essential work in accordance with internal business continuity arrangements in order to create resources needed to support the overall response.

Where it is clear that staff will need to be mobilised in our response to a significant incident, the response will be delegated from the Incident Management Team.

Staff who work in either a senior management role or a community role are provided with a mobile telephone, this would be the first method of contact to staff where there is an urgent need to mobilise staff resources. Alternative methods for contacting staff would be telephone, SMS, text message or email. All relevant contact details should be included in service level Business Continuity Plans.

5.6.6 Shift Patterns

Shift patterns will need to be considered from the very beginning of the response. If there is the potential for the response and recovery to be prolonged, then appropriate replacements must be identified and stood down from normal duties if necessary, in order to allow them to come onto shift in a condition to be effective. Shift patterns should ideally marry up with the other Responders' changeovers. All records will be stored and used within briefing meetings in the control room.

5.6.7 Battle Rhythm

The frequency of meetings and timescales for collation of requested information or 'battle rhythm' must be established at the earliest opportunity by the AEO or strategic oncall director out of hours. This will drive the process to enable the timely receipt of information to be collated and considered so that the Strategic Commander can develop the response in support of the incident.

5.7 Record Keeping

As an operational responder the Trust will record all its actions utilising designated Log books and forms held within the Incident Coordination Centre (ICC)

Decision Log Books must be clear, intelligible, accurate and follow best practice, which is no 'ELBOW':

- No Erasures
- No Leaves torn out
- No Blank Spaces
- No Overwriting
- No Writing between lines

Commanders are responsible for recording all decisions, actions and rationale that they make in relation to the incident within a Decision Log Book, which are stored in the ICC's.

Record keeping is necessary to:

- Provide information to people newly arrived at the control room (e.g. when a new shift comes on duty) about what has already been done and what has not been done
- Provide evidence after the event to help us respond better to future incidents
- Provide evidence, if required, for internal or public reviews of the incident

During a major incident accurate records must be kept of every message received, action taken or instruction given. All records should be dated, timed, initialled and written in black ink. Pages should be numbered. As such the following system of logging messages and decisions has been developed.

5.7.1 Role of the Loggist

The role of the Loggist includes the following:-

- To capture decisions and rationale during an incident or emergency' following 'best practice'
- To aid with response to the incident or emergency'
- To support any future inquiries which may occur.

In order to achieve these aims the Loggist will work with the Strategic Commander and ensure that all decisions are included in a contemporaneous log that accurately reflects the decisions made and the rationale behind them. At the conclusion of a command meeting the Loggist and the Strategic Commander will review the log, amend if necessary and sign, time and date the entry to that point.

Individuals will receive the necessary training in order to perform the role of a Loggist.

Contact details of all Trained Loggists is be included in the telephone directory of the On Call folder.

The Loggist should refer to Action card 4

Please note: until the Loggist arrives, the Strategic Commander is responsible for maintaining their own Decision Log Book. Failure to keep a Decision Log could legally jeopardise the organisation's ability to justify its actions in response to the incident.

5.7.2 Message Records Sheets

These are used to record all incoming and outgoing information, which includes reference to all phone calls, emails and faxes. Once a message is taken, this will go

to the Strategic Commander, then either delegated or given to the Message Records Handler for recording and then filing. A copy of the message records sheet can be found in Appendix 3.

5.7.3 Decision Log

These are to record significant complex decisions. These must be passed to the Strategic Commander who will decide on a decision or delegate to another decision maker within the team i.e., Operations Manager.

Decisions will be recorded by the Strategic Commander Decision Loggist. All active decision logs should be used as a basis for the situation reports and should reflect the key issues on the whiteboard. A copy of the Emergency Logbook is held centrally within the Major Incident Room.

5.7.4 Personal Logs

It is vital that all messages are logged accordingly. Occasionally members of the Major Incident Team may record their own log i.e. time arrived, breaks taken, notes. This should be recorded in their own pocket note books. All notes are to be submitted to the Strategic Commander after the incident and will form part of the Foundation Trusts incident records.

Tactical Commanders will inform Operational Command of their requests for information.

5.7.5 Summary Report of Major Incident

The Strategic Commander is responsible for compiling a report of the major incident and presenting it to the Senior Management Team

5.7.6 Specific Emergency Plans

The Trust –has developed a range of specific plans (e.g. Pandemic Flu, Heatwave) to deal with certain kinds of incidents which have been assessed either locally or nationally as significant risks. The plans are available From StaffZone or the On Call folder [T:\On Call](#)

5.8 Briefings

WECHC (?) must relay the decisions and actions required in a structured way. This ensures it is understood by those who are tasked with completing actions as part of the handover to another Commander.

There are two briefing tools which can be used: SBAR and IIMARCH. SBAR which covers Situation, Background, Assessment and Recommendation is a structured method for communicating critical information that requires immediate action contributing to effective, escalated, and increased patient safety (Appendix 6).

For handovers, Commanders should utilise IIMARCH covering Information, Intent, Method, Administration, Risk Assessment, Communications and Humanitarian Issues as it is a more detailed briefing tool (Appendix 5).

When using IIMARCH, it is helpful to consider the following:

- Brevity is important - if it is not relevant, leave it out
- Communicate using unambiguous language free from jargon and in terms people will understand
- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used

5.9 Health and Safety

A major incident may involve staff working in areas they do not normally work.

The Trust is committed to providing and maintaining a healthy and safe working environment for all staff, patients, visitors and contractors.

The Trust recognises the benefits of ensuring safe systems of work, continuous improvement in Health and Safety and compliance with the relevant Health and Safety legislation.

During the response to an incident, members of staff will not be expected to compromise their personal health and safety and the Trust policies will continue to apply.

As all staff carries some degree of responsibility for health and safety, staff will undertake those same responsibilities during the response to an incident.

5.10 Vulnerable Groups

During a significant incident or emergency, the NHS has a specific requirement, in conjunction with other agencies, to ensure at risk groups are specifically catered for. The guidance relating to the CCA 2004, Emergency Preparedness sets out the responsibilities placed on category 1 responders to plan and meet the needs of those who may be vulnerable in emergency situations

Examples of vulnerable groups are:

- Those already ill, either acutely or with chronic health problems
- People dependant on medicines
- People with mental health problems
- People with learning disabilities
- Parents with babies or young children or pregnant women
- The elderly
- People with physical disabilities

In addition, there may be other groups who are vulnerable because of shared or individual equality characteristic such as people who do not read or understand English.

5.11 Countermeasures (CBRN)

Countermeasures, within the NHS scope are a group of medications developed to enable the protection and treatment of the public in Hazardous Materials (HAZMAT) or chemical, Biological, Radiological or Nuclear (CBRN) incidents.

The United Kingdom Health Security Agency (UKHSA) store the national stock of countermeasures. When requested these can be distributed between two to five hours. This will be dependant on the type of countermeasure and the holding location required. NHS England acts as the conduit between the requesting provider and UKHSA.

The providers should liaise directly with NHS England Regional First On Call via 0345 113 0099. Please see process below.

NHS Providers	NHS Regional On Call	NHS England National Duty Officer
On identification of the need for countermeasures	Regional first On Call confirms genuine request, postal address , and contact details	Confirms locations and incidents requiring countermeasures
On Call Strategic, With Medical Director approval calls NHS England First on Call	Regional on-call requests stock from either : NHS Blood and Transport (chemical) NHS National Duty Officer (BRN)	Contacts UKHSA Duty Officer and confirms countermeasures request (if BRN Stocks confirm delivery location to UKHSA)
GIVE Cause of request, Affected population Name and Quantity of countermeasure being requested. Full postal address of receiving location . Name and Contact Number of person designated to receive countermeasure.	Regional first on-call contacts National EPRR duty Officer (if request made to NHS BT) Regional First on-call informs Regional second on-call.	Contact Second on-call and brief on situation. DHSC Duty Officer

A CBRN incident requiring the deployment of countermeasures would automatically trigger a level 3 incident, resulting in the incident being led by the NHS England Regional Team.

SECTION 6: GUIDANCE FOR STAFF

6.1 Staff working away from their office base

When a major incident occurs, many staff may be away from their office base, working at a remote site, working in the community or off duty. All staff must contact their office base as soon as they are made aware of a major incident. This is so they can:

- Assure their manager of their personal safety
- Inform their manager of their location
- Receive instructions from their manager about any changes to their duties arising from the incident
- During a major incident, staff may be directed to work at locations other than their usual workplace.

It is essential that during a major incident line managers are kept informed of their staff's whereabouts at all times.

Trust Staff should not speak to the media – if they are approached, they should direct enquiries to the On Call manager who should agree the rules of engagement with the strategic director oncall out of hours. In hours this should be the AEO.

Staff Welfare

An emergency situation can be a stressful time. Staff may be called in unexpectedly from home, asked to work in unfamiliar environments and for extended periods. When called to assist in an emergency there are a number of key actions staff should take before and during their response:

Notify your family, partner or significant other:

- Staff should not work for longer than eight hours without going off duty. Please ensure regular breaks are taken
- Staff will be reimbursed and insured for any activities carried out during a major incident, whether at their normal place of work or otherwise

6.2 Approach for Trust Staff Located at Trust Premises

Many Trust staff work on sites managed by other Trusts, e.g. Wirral University Teaching Hospital NHS Foundation Trust, or on other organisations' sites. The organisation which manages the premises is responsible for responding to a major incident occurring on those premises. The employing organisation for staff has responsibility for utilising staff resource.

6.3 Counselling Services

Anyone involved in a major incident may suffer from stress and trauma, therefore counselling and support needs to be planned for individuals, including carers, siblings, relatives and staff.

Access to psychological and counselling support will be co-ordinated by general practitioners. Patients requiring such support will be directed to the most appropriate provider(s). Staff impacted should access the occupational health services for support as required.

SECTION 7: BUSINESS CONTINUITY

7.1 Maintaining Business Continuity

7.1.1 Overview of Business Continuity

The CCA requires category 1 responders to put in place arrangements to ensure that they continue their functions in the event of an emergency. This requires the NHS to ensure that those organisations delivering services on their behalf e.g. contracted out services, which underpin service provision e.g. information technology and telecommunications providers can deliver in the event of an emergency.

7.1.2 WCHC Business Continuity Arrangements

Business Continuity Planning complements the MIP and also addresses potentially serious disruptions in the services provided by the Foundation Trust that *may not* be of sufficiently high risk to trigger the MIP.

The central co-ordination of a planned response to such events whose impact could not be handled within routine service arrangements and could require the implementation of *special planning procedures by the Trust* to respond to it, rests with the AEO and out of hours the strategic oncall director.

Significant incidents likely to cause serious disruption of the continuity of the Trusts business may warrant activation of the MIP. Minor business interruptions are dealt with using routine management intervention and service level business continuity plans *or escalation plans where appropriate*.

Service Directors, and Service Leads are responsible for developing, maintaining, communicating and operating their own service level business continuity procedures to mitigate the impact of any incident affecting the normal delivery of services. Service level continuity plans are prepared within an overarching Foundation Trust continuity framework.

The Trust Business Continuity Policy (GP62) provides additional information relating to Business Continuity.

7.2 Hazard, Risk Assessment and identified Risks

7.2.1 Hazard and Risk Assessment

A vital component in the plan preparation process is the identification of potential hazards and threats and applying the risk assessment process.

The Merseyside Community Risk Register has been created for two reasons. Firstly, to reassure the people and communities of Merseyside that an assessment of potential hazards and threats has been made or considered. Secondly, to satisfy the requirements outlined in the CCA and its statutory guidance (Emergency Preparedness), the **Community Risk Register** and is available online at Merseyside Fire and Rescue Service's website at www.merseyfire.gov.uk and click on the icon 'Merseyside Community Risk Register'

The hazards and threats which may affect the Foundation Trust (?WCHC) fall into the following categories and form the basis of the development of this plan and the individual Service continuity plans:

The number of risks is not exhaustive but could include

Risk	Reason
Loss of workplace/ premises	Fire Flood Act of terrorism Unsafe building Extreme weather conditions
Loss of staff	Industrial action Pandemic Flu or other communicable disease Extreme weather causing transport difficulties
Loss of IT computer	Loss of server access Loss of Power Theft/crime Loss of information Cyber attack
Loss of communications	Power failure affecting phone exchange server Loss of service due to supplier issues Industrial action Severe weather
Loss of utilities	Loss of supply on site Loss of supply off site
Loss of supplies	Supplier in receivership Fuel shortage Product recall

7.5 Departmental Business Continuity Plans

Further information on dealing with a wide range of events can be found in Departmental Business Continuity Plans. These plans can be located within the on-call pages on the Team drive. [Service Level Business Continuity Plans](#).

7.6 Mutual Aid

Mutual Aid is an agreement to lend assistance across neighbouring boundaries and partner organisations. This may occur due to a major incident response that exceeds local resources, such as a significant disaster. It can involve offering resources to help support partners e.g. man hours, materials

SECTION 8: COMMUNICATIONS

8.1 Communications and the Media

The overall aim for communications in a major incident will be to provide effective, accurate and timely communications to the public, staff and other stakeholders.

8.2 Internal Communications

The following systems are in place for communications during a major incident

- Internal communications system for notifying all the Trusts staff of any change in major incident status
- The use of the Central Alert System will receive external health alerts for internal cascade, via Service Directors and service leads
- List of contact numbers of key staff and individuals
- Site addresses for all services

The AEO is responsible in hours for agreeing and approving communications, out of hours this is the strategic director oncall.

Services are responsible for maintaining a register of the current contact details for their staff for use during major incidents and other emergencies.

A central register of current contact details of all Trust staff will be maintained by Human Resources via Electronic Staff Record (ESR)

8.2.1 Situation Reports

A Situation Report (SITREP) is a form of status reporting that provides decision-makers/ Strategic Commander of a quick understanding of the current situation. It provides a clear, concise understanding of the situation.

During any major Incident the Business Operations Support team will develop a situation Report template that will be relevant to the specific incident being

experienced. An example of a Situation Report is included at Appendix 4 of this plan. – can you change this as we must utilise the NHS England template and it should be the responsibility of the EPRR function with the AEO to populate these

The template will contain all relevant fields that will require responses from service leads in order to provide up to date information to the Incident Coordination Centre.

The specific submission times of Situation reports will be decided by the Strategic Commander at the commencement of an incident. – this is driven by NHSE so can you include the ICB and NHSE timescales please along with a sign off process via the AEO, also where do we want them storing?

In addition to internal situation reports there it is likely there will be the requirement for external situation reports, regionally and nationally. Requests for these reports will be sent to the Trust Major Incident email account. The Trust EPRR Lead and the Business Intelligence team will support this process with sign off from the AEO in hours and strategic director out of hours.

Just a note on the above – can you ensure I have access to the email account please.

8.2.2 Key Internal Audiences

- Directly employed staff/staff representatives
- Trust Board members
- Cross-organisational Services

8.2.3 Key Communication Channels

- Telephone
- Global email
- Group emails
- Social Media
- Regular bulletins/briefings
- Cascade systems via Service Directors and service leads
- Dedicated information phone help lines

8.2.4 Lost Communications

In the event of not being able to establish, or a loss of communications the following alternative methods are to be considered for the passage of information:

- Mobile phones/SMS text messages/WhatsApp
- Alternative Analogue/digital phone lines in the ICC
- Email 4G connectivity
- Fax Runner

8.2.5 Briefings to Staff

Regular staff briefings will be issued according to the severity and type of incident to ensure staff are aware of what is happening, what they can do to play their part and what to advise their patients. All communications to staff will also be posted onto the staff intranet.

8.2.6 Guidance for Staff

It is essential that during a major incident line managers are kept always informed of their staff's whereabouts whilst at work.

WCHC staff should not speak to the media – if they are approached.

All media enquiries during normal office hours 9.00 am to 5.00 pm Monday to Friday must be directed to Communications and Marketing Team wcnt.communications@nhs.net or 0151 514 6365. Outside these hours media relations will be the responsibility of the on-call Duty Manager to manage and agree responses with the strategic director oncall.

- Do not disclose personal or confidential details of either patients or staff
- Do not confirm or deny that an incident has occurred
- Do not speculate on the cause of the incident
- Do not discuss the incident
- Do not criticise any organisation or individual
- Do not comment on the presence of suspects, VIPs or any other person on NHS premises

8.2.6 Working with the media

The media will be a key means of communicating with the public. The Communications lead will co-ordinate in partnership with Tactical/Strategic Communications Cell to produce timely briefings to be given to the media at regular intervals if required.

8.3 External Communications

8.3.1 Key audiences

- Trust Development Authority / Monitor
- Patients
- Wider public including vulnerable groups
- Integrated Care Systems.
- NHS England area team
- Members
- WUTH
- Neighbouring Foundation Trusts
- Wirral Council/Social Care (adults and children)
- Stakeholders
- Local Media

8.3.2 Key communication channels - external communications will be disseminated via:

- Media (Press releases, Advertorials, Radio interviews etc.) - supervised by the Communication Team
- NHS Direct (health advice where appropriate)
- Existing/newly created dedicated information phone help lines/call centre
- Public Website

8.3.3 Vulnerable Groups

Within the CCA the particular needs of vulnerable persons are recognised. The general definition of vulnerable persons is: people present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies.

Vulnerable groups include:

- Black & Minority Ethnic communities
- People with mental health problems
- People with physical or learning difficulties
- Older people
- Children and young people

Communication channels may include:

- Social Inclusion Team
- Community Health Link Works
- NHS England, Merseyside
- Integrated Care Systems
- Wirral Borough Council

NHS offer a text service for the deaf/hard of hearing –

<https://www.nhs.uk/services/service-directory/text-relay/N10499195>

Access to interpreters can be arranged by contacting Language Line

<https://staff.wirralct.nhs.uk/services-support/interpretation-translation-and-accessibility/>

8.4 Incident Communication Plan

A separate Incident Communication Plan is available in order to support the communications team.

8.5 Information Sharing

WCHC, as a Category 1 responder under the Civil Contingencies Act (2004) have a duty to share information with other local responders to enhance coordination.

SECTION 9: STAND DOWN AND RECOVERY

9.1 Incident Stand Down

In the event of a significant major incident NHS England Area Team Strategic Commander or Tactical Commander will inform all organisations when a significant incident is closed.

The on Trust Strategic Commander, following consultation with key personnel and relevant stakeholders will have the responsibility of formally making the decision for the Trust to stand down. In hours this will be the responsibility of the AEO. The following matters will be taken into account in reaching this decision.

- The incident has been controlled
- The immediate needs of the affected people and the community have been met

9.2 Debrief

Immediately after a Major Incident STAND DOWN AEO will hold a 'hot' debrief with staff.

All staff will be given the opportunity to give more detailed, anonymous feedback to a scheduled full de-brief process.

9.3 Post Incident Considerations

It is vital that a senior manager be appointed to assume responsibility for the debriefing and recording process – I think this should be the EPRR lead

- Evaluation of a response to the incident (including nominated staff to attend a multi-agency evaluation). How was the incident handled? What problems were there? What needs to change to ensure a better response time if appropriate?
- Assessing the continued health needs of those affected by the incident including psychological needs and the identification and referral route of any support services needed for staff, patients, and relatives involved in the major incident.
- Consideration of the effect of the incident on KPIs and services
- Ensuring all relevant documents are collected and a major incident report prepared. Patient confidentiality must be respected at all times
- Careful secure storage of all records relating to the incident. This should include all papers, logs and notes made during and related to the incident response. These may be requested by the agencies or other investigative body. The records associated with an incident should be archived in line with The Corporate Records Policy

9.4 Post Incident Report

The AEO is responsible for ensuring that a full internal report and action plan specific to the incident will be prepared and submitted to the Executive Meeting Forum within 1 month from the date of the incident.

If appropriate any lessons learnt from the incident should be shared with the appropriate NHS England Area Team, ICB's and other key stakeholder's partners. Following the debrief and preparation of the internal report and associated action plan, the MIP and any other relevant plans will be reviewed and amended as required.

9.5 Incident Recovery

After a major incident the IMT will meet to assess the disruption to functions caused by the incident, including any long-term implications. This assessment will include:

- Effects on staffing (e.g. loss of staff through injury or sickness, impact of overtime worked by staff during the incident on staffing levels)
- Support needs of staff affected by the incident (including trauma support)
- Development of recovery plan supporting Business Continuity
- Disruption caused to patient care
- Disruption caused to other functions
- Damage inflicted to buildings
- Financial losses
- Future provision of services in the short, medium, and long-term

It is important to work with partners as appropriate to facilitate the post incident recovery.

SECTION 10: MAJOR INCIDENT PACK INCLUDING ACTION CARDS

10.1 Foundation Trust Incident Control Team – Roles and Responsibilities

10.1.1 Background

This section outlines the roles and responsibilities of the Major Incident Team and should be used in a major incident.

During a major Incident any member of staff may be asked to perform a key role on behalf of the organisation. These roles may not be closely related to their usual responsibilities and Action Cards have been developed to support staff in these situations.

The Strategic Commander will allocate roles as appropriate. A copy of Action Cards must be kept with you at all times, and includes contact details for the emergency alert system, and the control room.

All on-call staff should be familiar with the contents of their Action Card and should use it from the moment they are contacted about an incident.

Actions Cards are ROLE specific and are not designed for designated individuals.

Action Cards may only be passed to another person once a full briefing and handover has been given, in writing, on the actions taken to-date and outstanding issues.

10.1.2 Responsibilities

By using the Action Cards, your role will be clearly outlined. If there are any queries, please discuss with the Strategic Commander and confirm in writing any alterations to the Action Cards.

During a handover of roles, i.e. starting a shift or finishing a shift, a full briefing must be given as to the process taken and decisions made. The Information Handling Manager will conduct the handover.

10.1.3 Action Card Summary

- Must be used by all members of the Incident Management Team
- Remove the need to consult large or complex plans during an incident
- Are role specific and provide all essential information needed to perform the specific role
- Help people focus on their role and provide guidance
- Prevent important tasks being forgotten or delayed

Action Card 1: Strategic Commander

Role

Escalation On Call Manager

Responsibilities

- Identify whether an Internal incident is responded to as a Major Incident, or
Provide advice to, and operate under the instruction of, any command and control structures in place for an Externally identified Major Incident
- Assemble and direct the Incident Response Team, with effective workload distribution
- Ensure clear aims and objectives for response to the incident
- Ensure effective co-ordination of resources.
- Ensure robust communication links with NHS England Local Area Team and other partners including Tenants of SCHC and Trust Controlled premises.
- Ensure that all records and data are captured and stored in a readily retrievable manner
- Ensure all records are archived accurately post incident and stored securely briefing or outgoing/incoming shift staff

Checklist

- ☐ If a major incident has been declared inform all relevant staff including Exec Team and NHS England Local area team
- ☐ Contact, inform and assemble all incident response team members
- ☐ Brief the Incident Response Team with aims and objectives for WCHC's response to the incident
- ☐ Determine priorities – safety of staff, patients, service users –any groups particularly at risk?
- ☐ Safety and security of buildings, equipment and information
- ☐ Business continuity: services and locations – which services and buildings are required to implement BC plans
- ☐ Ability to communicate with staff and service users, partners and public; messages to be provided (who, what, when, how and how often)
- ☐ Sitrep reporting structure internally and to external partners (who, what, when, how and how often)

Action Card 1: Strategic Commander

- ☐ Briefing structure with key staff (who, what, when, how and how often)
- ☐ Mobilise additional, appropriate staff if necessary
- ☐ Keep a record of your own tasks including telephone calls that you make
- ☐ Produce effective handover notes for incoming shift

Incident Stand Down

- ☐ Following confirmation of 'Stand Down' by NHSE or after taking the Trust decision to 'Stand Down' for an internally declared incident, ensure all relevant staff or agencies are notified of the stand down
- ☐ Ensure all records are forwarded to Emergency Planning Lead
- ☐ Ensure effective post-incident debriefing sessions

Action Card 2: Operational Support

Function specification

Emergency Planning Lead and/or Operational On Call Manager

Responsibilities

Provide additional operational management support to Strategic Commander

Depending on circumstances, this may include the tasks identified for Service Director (Action Card 3), Communications Lead (Action Card 6) and Admin Support (Action Card 9).

Checklist

- ☐ Assist the Strategic Commander in assembling the Incident Response Team
- ☐ Support the setting up of the Incident Response Team
- ☐ Set up and maintain plan and record of tasks and events (as distinct from decision log)
- ☐ Distribute action cards
- ☐ Support the Strategic Commander in coordinating the resources to support the incident
- ☐ Assess which WCHC operations will be affected by the incident and inform them of the situation. If any action is required ensure this is fed back to the Strategic Commander
- ☐ Attend meetings and teleconferences and update the Strategic Commander
- ☐ Maintain an overview of incoming emails, faxes and phone calls
- ☐ Assist with briefings and debriefings
- ☐ Keep a record of your own tasks including telephone calls that you make
- ☐ Produce handover notes for incoming shift.

Incident Stand Down

- ☐ Ensure stand down message is communicated
- ☐ Inform all agencies that the team has been dealing with that WCHC has stood down
- ☐ Ensure all records are forwarded to Emergency Planning Lead
- ☐ Contribute to post-incident debriefing sessions

Action Card 3: Service Director

Function specification

In Hours: Service Director identified deputy

Out of Hours: Operational On Call Manager

Responsibilities

At the direction of, manage all service resources to support the major incident

Checklist

- ☐ Determine service priorities – safety of staff, patients, service users –any groups particularly at risk and consider safety and security of buildings, equipment and information.
- ☐ Implement Business Continuity Plans for the division as appropriate
- ☐ Review staffing levels and rotas for current day and next 24/48 hours at affected locations
- ☐ Provide regular updates as required by the Strategic Commander
- ☐ Appropriate communication with staff and service users, partners and public; messages to be provided (who, what, when, how and how often)
- ☐ Keep a record of your own tasks including telephone calls that you make
- ☐ Produce handover notes for the incoming shift.

Incident Stand Down

- ☐ Receive incident Stand Down, communicate as appropriate
- ☐ Contribute to post-incident debriefing sessions
- ☐ Ensure all records are forwarded to Emergency Planning Lead

Action Card 4: Decision Loggist

Function specification

WCHC trained loggist

Responsibilities

Maintain a complete record of key decisions made by Strategic Commander

Checklist

- ☐ Meet with Strategic Commander to clarify role and responsibility during major incident
- ☐ Retrieve Green Emergency Log Book
- ☐ Detail key attendees and clarify their initials, name and role
- ☐ Record key decisions the Strategic Commander makes
- ☐ Ensure that all key times are included, such as the start time, when the log was started and each entry is timed

Incident Stand Down

- ☐ Contribute to post-incident debriefing sessions
- ☐ Ensure all records are forwarded to Emergency Planning Lead

Notes for loggists:

- Entries must be chronological
- Begin each entry on a new line but ensure there are no complete line gaps between entries
- Record stand down from the major incident and sign the log book
- Unused space at the end of the series of entries must be ruled through (with a 'Z') then signed in full, dated and timed
- All entries made must be written in black ink

- At the end of the incident ensure each entry is agreed by Strategic Commander
- Do not include any assumptions/comment/opinion
- Do not erase large portions of text so what was underneath is then illegible
- Do not tear out pages from the book
- Do not write in the margins
- Do initial any crossings out or mistakes you make
- If you make a mistake whilst compiling your note, score through the mistake with a single line, initial it and insert the correct word after the error
- If you see a mistake after an entry was made you must bring this to the attention of the person for whom you are compiling the log. The mistake should be cross-referenced (in red ink and using alphabet notation) to the corrected entry which should appear on the next available page or if there is sufficient space at the foot of the page for the entry. You and the other person must sign, date and time this.

Action Card 5: Estates and Facilities Support

Function Specification

Staff member with knowledge of estates infrastructure and utilities

Responsibilities

Provide advice and assistance in respect of estates and facilities

Checklist

- ☐ Identify impact on estates and facilities
- ☐ Identify what additional facilities are available to support the response to the incident if required
- ☐ Advise on availability of/access to additional premises as necessary and provide guidance on health and safety issues
- ☐ Where appropriate confirm availability from Landlord/Provider if not WCT site/facility
- ☐ Ensure that any problems with facilities e.g. heating, water, electricity, etc. are appropriately managed and promptly resolved
- ☐ Provide/arrange for specialist support and assistance as necessary
- ☐ Keep a record of your own tasks including telephone calls that you make

Incident Stand Down

- ☐ Produce handover notes for the incoming shift
- ☐ Contribute to post incident debriefing sessions
- ☐ Ensure all relevant documents are forwarded to the EPRR lead.

Action Card 6: Communications Lead

Function Specification

In Hours: Head of Communications and Marketing

Out of Hours: Operational On Call Manager

Responsibilities

Provision of communication co-ordination, advice and support to the Strategic Commander

Checklist

- ☐ Establish contact with local NHSE (**0345 113 0099**) and Cheshire and Merseyside ICB Communications Team (**0847 124 9802**) as appropriate.
- ☐ Manage the media response to a major incident by liaising with the Strategic Commander regarding Press arrangements
- ☐ Ensure that media and staff know that all media enquiries are directed to the Incident Communication Lead
- ☐ Respond to Press enquiries
- ☐ In conjunction with the Chief Executive, Strategic Commander and NHSE, prepare Press briefings as appropriate
- ☐ Communicate briefings and updates to all WCT staff so that they are aware of the incident and the response the WCT is providing
- ☐ Make sure that all briefings/press releases are signed off by the Strategic Commander
- ☐ Press briefings, once approved, to be placed on suitable media channels including social media
- ☐ Keep records of your own tasks together with telephone calls made
- ☐ Produce handover notes or the incoming shift

Incident Stand Down

- ☐ Ensure that all records, notes and documents associated with the incident are collated and archived
- ☐ Contribute to post-incident debriefing sessions

Useful Telephone numbers.

British Red Cross	0300 023 0700
Royal Voluntary Service	02476 681369
Salvation Army	0300 123 8028
RSPCA	0300 123 8028

Action Card 8: Rest Centre Clinical Support

Function specification

Community Nurses and/or GP Out of Hours and/or Trust Pharmacist.

Responsibilities

Assess and treat any person placed in rest centres, coordinating additional care as needed

Checklist

Incident declared

- ☐ Collect documentation (Patient Treatment Record and Prescription Record Sheet) and relevant medical equipment.
- ☐ Attend the rest centre as directed by the Strategic Commander /Service Director.
- ☐ Confirm contact details to Service Director Strategic Commander /.
- ☐ On arrival report to Rest Centre Manager and clarify if there are any clinical needs already identified and confirm resources within rest centre (space/equipment etc)
- ☐ Assess health needs of evacuated persons. Any major health needs identified should be prioritised until arrival of ambulance.
- ☐ Provide immediate first aid interventions to patients.
- ☐ Maintain health records of all people for whom care has been provided.
- ☐ Provide regular updates to the Incident Coordination Centre/Service Director and request any additional support needed.
- ☐ Confirm shift times in plenty of time to enable replacement providing relevant handover information to those replacements.

Incident Stand Down

- ☐ Gather all records and make arrangements for these records to and liaise with Service Director to ensure that these are uploaded to electronic patient records where applicable.
- ☐ Contribute to post-incident debriefing sessions.

Action Card 9: Admin Support

Functional specification

In Hours: Corporate Secretariat

Out of Hours: Operational On Call Manager

Responsibilities

To provide administrative support to the Strategic Commander including set up and running Incident Coordination Centre, responding to messages etc

Checklist

- ☐ Setting up Incident Coordination Centre according to the instructions in the Major Incident Plan including:
 - Opening Major Incident cupboards
 - Connecting phones to appropriate phone sockets
- ☐ Completing the board with details of those persons who are in attendance and their responsibilities, e.g. loggist
- ☐ Checking the Major Incident email account and informing the Strategic Commander of incoming emails
- ☐ Responding to phones within the Incident Coordination Centre and relaying information.
- ☐ Responding to emails on the instruction of the Strategic Commander

Incident Stand Down

- ☐ On being informed of incident stand down support Strategic Commander Operational Manager in recording of debrief information
- ☐ Restore room to pre-incident set up
- ☐ Contribute to post-incident debriefing sessions.

APPENDIX 1A: Contact Details of Incident Coordination Centres Rooms

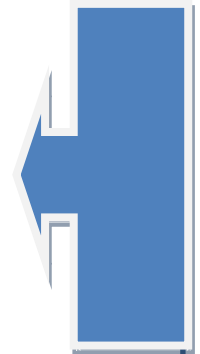
Incident Coordination Centre

Name:	St Catherine's Incident Coordination Centre
Address:	Training Room 1 & 2 St Catherine's Health Centre Derby Road Birkenhead Wirral CH43 0LQ
Normal Access:	7.00 am – 9.30 pm, 7 days per week
Out of Hours Access:	Contact Arrowe Security: 0151 609 0909
Incident Coordination Centre Numbers	0151 514 2177 Ext 592177 0151 514 2178 Ext 592178 0151 514 2179 Wxt 592179 0151 652 6468 (Analogue)
Fax Numbers:	0151 652 1569
Email Address:	WCNT.MajorIncident@nhs.net
Cabinet Padlocks:	9999

APPENDIX 1B: Backup Major Incident Coordination Room

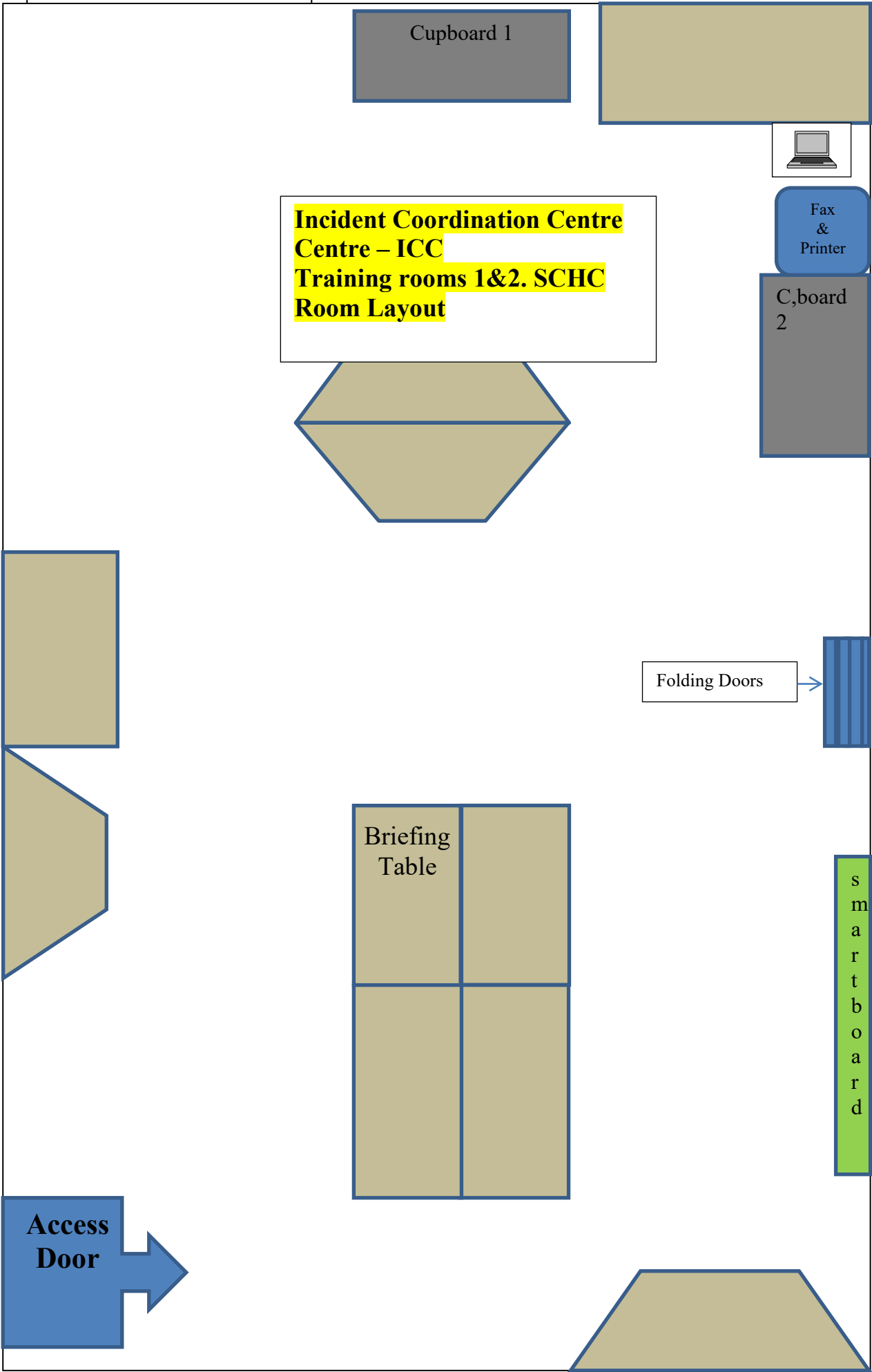
Name:	VCHC, Albert Lodge
Address:	Hot Desk Room Albert Lodge Victoria Central Health Centre Mill Lane Wirral CH44 5UF
Normal Access:	8.00am – 10.00pm, 7 days per week.
Out of Hours Access:	Contact Arrowe Security: 0151 609 0909
Incident Coordination Centre Numbers	Main Telephone numbers 0151 514 2674 ext 592674 0151 514 2673 ext 592673
Fax Numbers:	No Fax Machine
Email Address:	WCNT.MajorIncident@nhs.net
Cabinet Padlocks:	9999. The ICC Storage tambour unit is located in the store area in Entrance number 1 to the building. In addition to the Hot desk room. Training rooms 1 and 2 can utilised in order to use screens to facilitate meetings etc.

Appendix 1C



Incident Coordination Centre –
ICC
Hot Desk Room
Albert Lodge
VCHC

Appendix 1D



Appendix 2: Telephone Message Form

The Major Incident Telephone Message Form is used to record all incoming and outgoing messages relating to the major incident. These pads are located with in the Major Incident Store cupboards.

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Incident:

Date:

Location:

Log completed by:

Time	To / From*	Name of Contact	Name of Org	Contact details	
	(*Delete as appropriate)				
Outline of message					
Decision Made/Action To Be Taken/Advice Given and Reasons				By Who	By When

Appendix 3: M/ETHANE Template



JESIP

Time	Date
Organisation	
Name of Caller	Tel No

M	Major Incident	Has a Major Incident been declared? (Yes/No - If 'No', then complete ETHANE message)	
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E	Exact Location	What is the exact location or geographical area of incident?	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/personnel are required or are already on-scene?	

Restricted once complete

Signature

Appendix 4: Situation Report Template

Please ensure all completed Situation Report Templates are sent to WCNT.majorincident@nhs.net

Organisation:		Date:	
Name (completed by):		Time:	
Telephone number:			
Email address:			
Authorised for release by (name & title):			

Type of Incident (Name)	
Organisations reporting <u>serious</u> operational difficulties	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	
Mitigating actions for the above impacts	

Impact of business continuity arrangements	
Media interest expected/received	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
WCHC Incident Coordination Centre contact details Name: Telephone number: Email:	

Appendix 5: IIMARCH Briefing Tool Template



Element	Key questions and considerations	Action
I	Information What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported using M/ETHANE	
I	Intent Why are we here, what are we trying to achieve? Strategic aim and objectives, joint working strategy	
M	Method How are we going to do it? Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans.	
A	Administration What is required for effective, efficient, and safe implementation? Identification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics.	

Element	Key questions and considerations	Action
R	Risk assessment What are the relevant risks, and what measures are required to mitigate them? Risk assessments (dynamic and analytical) should be shared to establish a joint understanding of risk. Risks should be reduced to the lowest reasonably practicable level by taking preventative measures, in order of priority. Consider the hierarchy of controls. Consider Decision Controls.	
C	Communications How are we going to initiate and maintain communications with all partners and interested parties? Radio call signs, other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy	
H	Humanitarian issues What humanitarian assistance and human rights issues arise or may arise from this event and the response to it? Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights	

Appendix 6: SBAR Briefing Tool Template

SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals and organisations.

S	Situation: A concise statement of the problem
B	Background: Pertinent and brief information related to the situation
A	Assessment: Analysis and considerations of options
R	Recommendation: Action requested / recommendation
Completed By: Date: Signed:	

Appendix 7: Rest Centre – Prescription Record Sheet.

Prescriptions Record Sheet to be completed for each patient requiring medicines

Record details of prescriptions issued to patients at reception centres. This form does not replace the usual FP10 prescription

Name of Patient:

Date of Birth:

Address of Patient:

GP Name:

Practice:

Details of Medication Prescribed:

Name of Drug	Strength	Dose	Frequency	Quantity

Signature of DOCTOR:

Date:

Appendix 8: Rest Centre – Record Of Treatment.

MAJOR INCIDENT REST CENTRE PATIENT RECORD OF TREATMENT

DATE OF INCIDENT:

First Name:		Last Name:	
DOB:		Known Allergies:	
Address:		NOK Details:	
Postcode:		Name:	
Tel no:		Relationship:	
GP Name:		Contact No:	
		Surgery Address:	
Medical History:		Medications:	
Summary of Treatment/Intervention (use continuation sheet if required)			
Ongoing Treatment Referral (Specify Service)			
Consent to share information gained: (tick as appropriate)		YES	NO
Print Name:	Signature:	Destination:	

Appendix 9: Incident Severity Rating

The information within the table below and the descriptors contained therein are not exhaustive. Each incident should be assessed against the impact experienced.

Incident	One or more of the following apply	
Localised Disruption / incident	The incident is not serious or widespread and is unlikely to affect business operations to a significant degree No significant impact on patient or staff safety No significant impact on performance or finance The incident can be dealt with and closed by relevant managers No significant media or political interest	Incident managed within the affected areas Where the initial impact assessment grades the situation as a localised minor incident, the affected management team should deal with this using localised contingency arrangements. Where this incident has the potential to impact on clinical delivery the service lead must be notified. Where this incident has the potential to spill over into the evening / weekend the On call manager should be notified and informed of the contingency arrangements in place.
Minor Disruption / Incident	Limited impact on patient and staff safety Incident expected to be fully resolved and closed within 24 hours Limited but some impact on service delivery in critical	Incident managed using local contingency arrangements Where the initial impact assessment grades the situation as a minor disruption, the incident should be managed by the Service Director/Deputy These Service Directors will escalate where necessary and inform the relevant Managers as appropriate. Where this incident has the potential to impact on clinical delivery the service lead

	areas One or a number of local contingency plans activated Incident still expected to be managed through localised contingency arrangements Limited financial / performance impact Limited Governance issues Possible public/media/political interest	must be notified. Where this incident has the potential to spill over into the evening / weekend the On-call manager should be notified and informed of the contingency arrangements in place.
Significant Disruption / Incident	Disruption to a number of critical services likely to last for more than 1 working day Significant impact on patients and staff Access to one or more sites denied where critical services are carried out for more than 24 hours Suspension of a number of services required Access to systems denied and incident expected to last more than 1 working	Numerous contingency plans activated thus requiring effective management by calling together of a specific multi directorate team Where the initial impact assessment grades the situation as significant the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The on call manager should consider how best to manage the incident and if activation of the Foundation Trust major Incident plan is required. It may also be necessary to inform the NHS Merseyside First on Call.

	day and therefore impacting on operational service delivery A number of critical services seeking to activate service level contingency plans thus requiring overall management Significant impacts on finances and performance Significant Governance issues Possible public/media/political interest	
Major Disruption / Incident	Incident expected to impact on critical services for more than 48 hours Wide spread disruption, loss of a major or multi-occupancy site Major impact on patient and staff safety Wide-scale incident in a geographical area affecting multiple critical services Significant disruption to business activities Local contingency	Widespread incident requiring overall strategic management – Possible Major Incident Where the Initial impact assessment grades the situation as major disruption the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The AEO, following Liaison with the on Call managers, Executive members and other Senior Managers agree the composition of a n Incident Management Team A decision may be made to declare a Major Incident in line with agreed protocols contained within the Foundation Trust Major Incident Plan. Consideration should be given to informing the ICB and other Health Economy Partners – this will be determined by the Senior Manager in charge of the Foundation Trust response. NB: The term Major Incident should not be used lightly or confused with a Major Incident that sets out the Foundation Trusts response to an external Trauma type mass casualty incident¹. However, the

	plans inadequate to deal with incident Response requires strategic coordination and assistance from other health economy partners	Command and Control principles adopted by the Foundation Trust for both types of incident are the same.
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Significant Incident/serious disruption to services – requiring command and control, but not requiring strategic co-ordination and special arrangements from other health economy partners

Major Incident/major disruption to services – an event whose impact cannot be handled within routine service arrangements and requires the implementation of special arrangements, by one or more of the emergency services, the NHS or local authorities, to respond to it.

Appendix 10 – NW Incident Notification SBAR

North West SBAR Reporting Template V1.0 (2025)

Any NHS organisation declaring a Business Continuity or Critical Incident (including implementation of Business Continuity arrangements) must notify their ICB within 15 minutes of declaration – and **within a maximum of 1 hour** of invocation/declaration, this notification must be followed up with an SBAR by email.

ICB colleagues are required to notify NHS England Regional on call within the same time periods and followed up with an SBAR by email to england.eprnw@nhs.net with additional commentary around what supportive actions the ICB is taking to mitigate any system level or service level risks within their community.

Organisation name					
Site(s) affected					
Date of report			Time of report		Report number
Type of incident declared					
Date declared			Time declared		
Completed by (name, role)					
Point of Contact (name and email)					
Exec Sign off by (name, role)					
Signature					
Element	Prompts	Description			
S	<u>Situation</u> Clearly and briefly describe the current situation.				
B	<u>Background</u> Provide clear, relevant background information on the incident including: • Timings • Media				

	Exact situation	
A	<u>Assessment</u> State your assessment of the situation based on the situation and background. Include impacts to the Trust and service delivery	
R	<u>Recommendations</u> Explain the actions being taken by the organisation to standdown from the incident/situation alongside any support required of partner agencies, ICB or NHS England	

Provider only		
ICB notified at:	(Date & Time)	
	(name)	(role)
SBAR sent to ICB at:	(Date & Time)	

Stakeholders Informed	Organisation	Date & Time
Ambulance Trust		
Neighbouring Trusts		
Other		

Next update to be available/provided at:	(Date & Time)
--	---------------

Integrated Care Board only	
Additional system commentary e.g. Does the SBAR content reflect the operational situation and the actions being taken?	
ICB actions taken	

ICB actions required				
ICB Colleagues Briefed	Tactical Commander	(time)	Communications & Media team	
	Strategic Commander		System Coordination Centre	
Level of incident coordination	Level 1 (Provider)		Level 3 (NHSE Region)	
	Level 2 (ICB)		Level 4 (NHSE National)	
Sign off	(name)		(role)	
Signature				
NHS England notified at:	(Date & Time)			
	(name)		(role)	
SBAR sent to NHSE at:	(Date & Time)			

NHS England Region only				
Additional regional commentary e.g. Does the SBAR content reflect the operational situation and the actions being taken?				
Regional actions taken				
Regional actions required				
Regional Colleagues Briefed	Tactical On Call	(time)	Regional Communications team	
	Strategic On Call		Regional Operations Centre	
Level of incident coordination	Level 1 (provider)		Level 3 (NHSE Region)	
	Level 2 (ICB)		Level 4 (NHSE National)	

Sign off	(name)	(role)
Signature		
NHS Resilience notified at:	(Date & Time)	
	(name)	(role)
SBAR sent to NHS Resilience at:	(Date & Time)	

Group Board of Directors in Public
02 September 2026

Item 24

Title	WUTH Mortuary Board Assurance Statements
Area Lead	Dr Nikki Stevenson, Chief Medical Officer/Deputy CEO
Author	Dr Nikki Stevenson, Chief Medical Officer/Deputy CEO

Purpose of the Report and Recommendation	
Report For	Assurance
This report summarises the NHS England letter dated 26 June 2026 on strengthening mortuary oversight and seeks Board approval for the statements requested within that letter. The report and associated statements have been reviewed and approved by the Quality and Safety Committee, and are recommended for approval to the Board. It is recommended that the Board: - Notes the findings and requirements arising from the Nottingham maternity review, the Human Tissue Authority report and the Fuller Inquiry (appendix 1); - Approves the Board Assurance Statements at Appendix 2, following recommendation to the Board by the Quality and Safety Committee.	

Key Points to Note
On 26 June 2026, NHS England wrote to NHS trusts and integrated care boards following findings from Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust and the Human Tissue Authority's report on that trust. The letter requires renewed Board attention to the dignity, security and care of deceased people and should be considered alongside the Fuller Inquiry Phase 2 report. Board Assurance Statements are required for submission to NHSE to confirm compliance.

Key Risks
This report relates to the following key risks: - BAF Risk 2 – Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience. - 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	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	No
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
13 th August 2026	Quality and Safety Committee	WUTH Mortuary Board Assurance Statement	Approval and recommendation to the Board

1	Narrative
1.1	Background and National Context On 26 June 2026, NHS England wrote to NHS trusts and integrated care boards following findings from Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust and the Human Tissue Authority's report on that trust. The letter requires renewed Board attention to the dignity, security and care of deceased people and should be considered alongside the Fuller Inquiry Phase 2 report. The Fuller Inquiry made 75 recommendations to strengthen protection, security and dignity after death, including 29 immediately relevant to the NHS. NHS England states that Boards are responsible for clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for.
1.2	Required assurance and action The reports set out a number of actions, including • Confirm that roles and responsibilities across estates, safeguarding, pathology, bereavement, mortuary and corporate services are clear, understood and regularly tested. • Review progress against the 29 NHS-relevant Fuller Inquiry recommendations and maintain a time-limited action plan for any gaps. • Confirm clear executive leadership for safeguarding people after death. • Maintain an effective oversight plan covering mortuaries, related storage and wider facilities, supported by appropriate information and governance. • Review HTA reportable incident records for 2015-2026 in line with the evidential compliance audit requirements and report any missing incidents retrospectively. • Complete the latest NHS Premises Assurance Model self-assessment

1	Narrative
	• Cascade the national letter to relevant services and Freedom to Speak Up Guardians. All actions are either completed or in progress within the requirements of the letter.
1.3	Board Assurance Statements Annex 3 of the letter requires that Trusts return a set of Board assurance statements to NHSE by the 31st July 2026. In agreement with the Chair of the Board and the CEO, confirmation has been provisionally sent to NHSE to meet the deadline but with the caveat that both Quality and Safety Committee and the Board must sign off on these statements. NHSE has acknowledged this, and no questions have been received as of the time of writing this report. The Quality and Safety Committee met on the 13th August and reviewed the Board Assurance Statements along with associated evidence. This is highlighted in that Committee's Chairs report, included at Agenda Item 11. The Committee approved the report, and recommend that the Board approve the statements at this meeting. Following this approval, a confirmatory email with signed statements will be forwarded to NHSE.

2	Implications
2.1	Patients • Robust oversight supports dignity, respect, security and compassionate care after death, and reduces avoidable harm to bereaved families.
2.2	People • No direct workforce related implications, however training and other support mechanisms may be required for those staff in relevant teams.
2.3	Finance • No direct financial implications.
2.4	Compliance • The report supports compliance with Human Tissue Authority requirements and guidance, the NHS Safeguarding Accountability and Assurance Framework, the NHS Premises Assurance Model, and Health Building Note 16-01.

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's [Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust \(NUH\)](#), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, [published in July 2025](#). The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

[The NHS Premises Assurance Model \(PAM\)](#) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

[Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services](#) was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the [insightful provider board guide](#) is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the [Code of governance for NHS provider trusts](#) (March 2026) and [Guidance on good governance and collaboration](#) (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. Assessing provider capability: guidance for NHS Trust Boards (August 2025)

[Assessing provider capability: guidance for NHS trust boards](#) provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

5. Advanced Foundation Trust Programme (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the [Advanced Foundation Trust Programme](#) requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

6. NHS Safeguarding accountability and assurance framework (April 2026)

The [NHS Safeguarding Accountability and Assurance Framework](#) (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) [Codes of Practice](#) provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published [good practice guidance for those responsible for the dignity and care of the deceased](#). This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

[Hospice UK](#) have several resources to support clinical and non-clinical staff in a hospice role. Their [Care After Death](#) guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.264-265).

Supporting guidance

NHS Premises Assurance Model (see entry 1 in Annex 1).

Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).

Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.265).

Supporting guidance

Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

The Insightful provider board guide (see entry 3 in Annex 1).

Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).

Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the [Phase 2 Report](#) (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis. The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps. In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Evidence: Audits, Safeguarding Assurance Group, Safeguarding Action Plans
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	Evidence: Mortuary Assurance Report to QSC and Board Mortuary Annual Report to QSC and Board
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Evidence: As above

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Evidence: As above
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	The trust has completed its self assessment against the latest version of the NHS premises Assurance Model (PAM). The assessment is scheduled for Board review and approval in September 2026. No outstanding actions have been identified through the process.

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date
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Group Board of Directors in Public

Item 25

02 September 2026

Title	WCHC Policy Update – Managing Conflicts of Interest
Area Lead	Ali Hughes, Joint Director of Corporate Affairs & Communications
Author	Cate Herbert, Company Secretary
Report for	Information

Purpose of the Report and Recommendation	
Report For	Approval
It is recommended that the Board: Approves the extension of the policy to the end of December 2026.	

Key Points to Note
The WCHC Policy for Policy Management requires that relevant committees of the Board undertake the detailed scrutiny of new and revised policy documents and approve them in accordance with the Policy Schedule. One policy, the Managing Conflicts of Interest Policy, is retained by the Board for review and an extension is requested to allow review to incorporate the recently completed audit recommendations.

Key Risks
This report relates to these key risks: Risks relating to individual policies will be recorded on the Trust's risk register as required. There are currently no risks identified relating to the review of policies.

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
This is the first report to the Group Board on this topic.			

1	Narrative
1.1	The WCHC Policy for Policy Management requires that Committees of the Board oversee the Trust-wide policies, retaining both review and scrutiny responsibilities. One policy, the Managing Conflicts of Interest Policy, is retained by the Board. This policy is currently due to expire on the 30th September 2026. An internal audit from MIAA has recently been completed and identified some areas for clarification and improvement. It is therefore requested that the policy is extended to the end of December 2026 to allow for these elements to be added to the policy and for the policy to then travel through the ratification process.

2	Implications
2.1	Patients Implications for patients will be outlined in individual policies if applicable.
2.2	People Implications for staff will be outlined in individual policies if applicable.
2.3	Finance Financial implications will be outlined in individual policies if applicable.
2.4	Compliance This report supports compliance with the WCHC Policy for Policy Management.

WUTH Board of Directors

Item 26

02 September 2026

Title	WUTH Accountable Officer Controlled Drugs Report
Area Lead	Chris Green, Director of Pharmacy and Medicines Optimisation
Author	Amy Janvier, Lead Pharmacist Procurement and Medicines Supply

Purpose of the Report and Recommendation

Report For	Information
It is recommended that the Board: • Note the report; and • Approve the recommendations	

Key Points to Note

This report provides an overview of Controlled Drug (CD) activity during 2025/26. It is a national requirement for Trusts to employ a Controlled Drugs Accountable Officer (CDAO) and that the CDAO provides assurance around CD management to Trust Boards or their delegated committee. The Trust CDAO is the Director of Pharmacy and Medicines Optimisation.

CD incidents are monitored in the Trust on a daily basis and incidents of note and trends are escalated to the CDAO. In addition, it is a legal requirement that Wirral University Teaching Hospital NHS Foundation Trust (WUTH) report any incidents, concerns or individuals of concern regarding the management of controlled drugs within the organisation to the CD Local Intelligence Network (CDLIN) every quarter or as appropriate. 381 reports of issues involving CDs were submitted in 2025-26. 74 (19%) of the reports were actual incidents where patients received an incorrect medicine, an incorrect dose, a medicine via an incorrect route or an expired medicine; 307 (81%) reports were classed as near misses. 7 incidents caused 'low harm' to patients while all other reports were 'no harm'. The Trust is noted by the regional CDLIN to be a high number, low harm reporter indicative of an open reporting culture.

Audits of controlled drugs were undertaken in all quarters during 2025/26. The standards audited relate to CD legislation reflected in the Trust CD policy. Compliance was very good across all areas.

The recommendations from the report will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion.

Key Risks

This report relates to these key risks:	
- Controlled drugs are potentially harmful medicines if they are not used in a safe and controlled manner. - Controlled drugs are highly susceptible to the risk of diversion as they are potentially abusable, and because of this they also present an opportunity for illicit sale and distribution.	

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

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	No

Governance journey			
Date	Forum	Report Title	Purpose/Decision
August 2026	Joint Quality and Safety Committee	As above	As above
June 2026	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	Introduction In accordance with the Controlled Drugs (CDs) Regulations 2013, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) has an Accountable Officer (AO) for controlled drugs who has responsibility for the safe use and management of controlled drugs. The CDAO is the Director of Pharmacy and Medicines Optimisation. It is the CDAO's responsibility to report CD incidents and near misses, and, individuals of concern to the Regional CD Local Intelligence Network (CDLIN). The CDAO must also produce an annual report for the Board of Directors or its delegated committee to provide assurance around the management of CDs within WUTH.

During 2025/26, WUTH had 3 areas within the Pharmacy Department holding a wide range of CDs: the Pharmacy Dispensary and Aseptic Unit on the Arrowe Park Hospital site and Central Pharmacy Stores at Clatterbridge. In addition, the pharmacy satellite dispensaries stock gabapentin, pregabalin and tramadol which are schedule 3 CDs. These CDs are to be ordered in a CD order book, have additional prescription requirements but are not required to be stored in a CD cupboard. The pharmacy satellites do not stock schedule 2 CDs. CDs are supplied to over 80 wards and departments within WUTH.

The Trust holds two Home Office Controlled Drug Licences which permit the supply of CDs to external organisations such as Wirral Hospice St Johns. There is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs. These standards are applied across all Trust CD activity and their attainment gives additional, external assurance that CD processes are tightly controlled.

1.2

Monitoring of CD Incidents and Usage Trends

All incidents are monitored on a daily basis by the Trust Medicines Safety Officer (MSO) and incidents of note and trends including CDs are escalated to the CDAO. In addition, incident numbers are submitted to the CDLIN on a quarterly basis and incidents of note are submitted in real time for review by the CDLIN.

There were 381 incidents involving CDs reported across WUTH between April 2025 and March 2026 compared to 320 reported the previous year. CD incident reports continue to show an upward trend (Table 1).

Table 1: CD Incidents Reported April 2015 – March 2026

Financial Year	Number of incidents	Percentage increase on previous year
2025-26	381	↑19%
2024-25	320	↑7%
2023-24	298	↑41%
2022-23	211	↑5%
2021-22	201	↑24%
2020-21	161	↓4%
2019-20	169	↑1%
2018-19	167	↑9%
2017-18	153	↑82%
2016-17	84	↑30%
2015-16	65	-

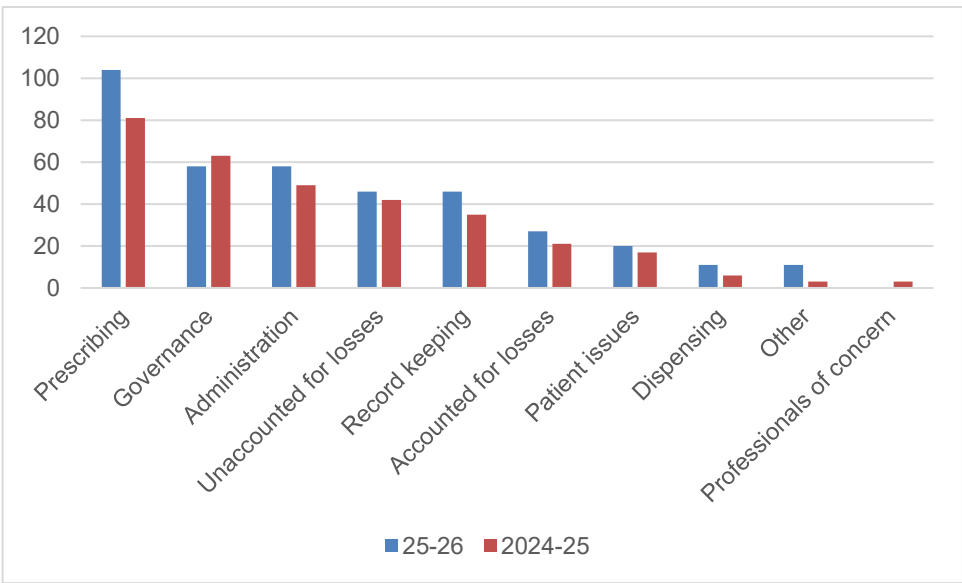
Due to the continuing and concerning increase in CD incident numbers a paper was written and submitted to the Quality Committee in October 2025. In evaluating the increase in numbers of reports and benchmarking ourselves against other Trusts, data supplied by NHS England's NW CD Local Intelligence Network (CD LIN) was compared to the Trust's CD incident data. For NW acute trusts, incident numbers increased by 275% 20-21 compared to 24-25 which is significantly more than WUTH's

corresponding increase of 190%. The CD LIN supports that the increase in reporting figures is seen as a positive development.

As identified in the review, the Emergency Department was the area with the highest number of reported incidents, 84. This is partly a reflection of the pressure the area has faced with patients receiving corridor care, staying in the department for extended periods of time and the volume of new prescribing on admission.

From the 2025-26 WUTH CD incidents 74 of the reports were actual incidents where patients reportedly missed a dose, received an incorrect medicine, incorrect dose or a medicine via an incorrect route; 307 reports were classed as near misses. 7 incidents caused 'low harm' to patients while all other reports were 'no harm'. The number of reports is small in the context of the number of CD transactions carried out across the Trust on an annual basis with an estimate of over 200,000 doses of CDs administered at WUTH each year. WUTH is noted to be a 'high number, low harm reporter' (in line with National Reporting and Learning System evidence) and it is considered to be good practice to submit all incidents reported rather than simply those of concern. Figure 1 shows the break down in type of incident reported in CDLIN categories for the year 2025-26 compared to 2024-25.

Figure 1: Categories of CD Incidents Reported



Prescribing incidents (n=104) was the most common incident type reported. In 84 of the prescribing incidents patients did not receive any incorrect medicines.

21 incidents were related to the prescribing of buprenorphine or methadone for substance misuse, reduced from 30 the year before. Most of these incidents are occurring outside of normal working hours when confirming a patient's dose and last collection from their usual community pharmacy is difficult. Work is continuing to review the guideline for management of these patients on admission to ensure patients receive the correct medicine at the correct dose, and the guideline is practical to follow in the context of a busy ED.

17 incidents were reported about theatre specific opiate prescriptions not being discontinued from patients' active prescription lists upon transfer to general wards. In

all cases the prescriptions were discontinued without the patients receiving any incorrect doses.

Other repeated incidents included incorrect doses prescribed on admission (underdose and overdose), medicines missed when prescribing patient's medicines on admission and medicines not being discontinued prior to new medicines being prescribed leaving duplicate medicines on patients' active prescriptions.

Governance incidents (n=58) include all incidents that have occurred because Trust policy relating to the safe and secure handling of medicines has not been followed. Policies and procedures relating to the management of CDs from delivery into the Trust until they are used, disposed of or given to patients on discharge are more extensive than those for other medicines. This is because there is additional legislation that covers CDs and CDs are considered high risk medicines both in terms of clinical use and for risk of diversion. Examples of governance incidents include, CDs not locked away in a CD cupboard, CD deliveries not dealt with immediately, leaving CDs in the transport bag, patient's own CDs found in bedside lockers, expired CDs not removed from ward / department and CD stock checks not completed correctly. The incidents were all scored as no harm and spread across a range of wards/departments.

Administration incidents (n=58) included patients being given the wrong drug, wrong formulation, incorrect doses in particular volumes of liquids or injectable controlled drugs and patients receiving doses of expired liquids. CD administration errors are identified more frequently than administration errors with other medicines due to the requirement to record doses given both on Cerner and within controlled drug registers. Discrepancies between quantities recorded in CD registers and the physical quantities in the CD cupboards are often traced to an administration error. As in previous years morphine and oxycodone continue to be the drugs most commonly involved in the administration errors reported.

9 incidents were associated with the incorrect administration of oxazepam or chlordiazepoxide against the alcohol detoxification regime on the paper prescription form. This pathway is on the list to be transferred to Cerner when a safe electronic prescribing solution is identified.

Nurses involved in administration errors are asked to reflect on any errors made to gain learning for mitigation strategies and were deemed necessary, attend further training.

A contributing factor for administration errors has been identified in the AO report since 2016, which is that Cerner does not always fully display the prescription without needing to 'hover over' the medicine which means that all of the details are not 'face up' and available without this added step. This was a risk register entry at Cerner go live as it conflicts with national guidance requiring electronic prescribing and medicines administration record to have 'face up' medicines description. To date, Cerner have not committed to providing a fix for this direct patient safety issue and therefore this remains as a residual risk.

Unaccounted for losses incidents (n=46) have seen an increase in incidents since 2024-25. Incidents which are originally reported as discrepancies (accounted for or unaccounted for losses) are investigated promptly by pharmacy staff.

12 of the unaccounted for losses were oxycodone liquid discrepancies. The trust is still having to buy the Wockhardt brand of oxycodone liquid which the trust reported to the MHRA in 2023-24 due to bottles being slightly underfilled. Oxycodone doses are often small volumes 1.25 – 2.5ml and every time a dose is given a small amount of liquid can be lost, which across a 250ml bottle can add up to significant discrepancy.

11 of the unaccounted for losses were morphine 10mg/5ml liquid from the Omnicell cupboards in the Emergency Departments. Following repeated reports of the levels of morphine 10mg/5ml liquid being incorrect in the cabinets the decision was made to treat this liquid as a 'full CD' requiring 2 members of staff to be at the cabinet to remove each dose. It was thought that bottles were being removed from the cabinets to be used as stock in the contingency areas such as the corridors. Since morphine 10mg/5ml liquid has been treated as a 'full CD' the number of incidents has reduced and the volumes of the discrepancies being reported has reduced, for example, a 10ml discrepancy between the register and physical stock compared to 1 x 100ml bottle being missing.

Incident reports of individual tablets or ampoules missing are likely to have been dropped or disposed of by mistake, but this cannot be definitively proven. Where losses cannot be accounted for, there are no trends or repeat areas and losses tend to be of a single tablet, capsule or ampoule.

Record keeping incidents (n=47) include entries on incorrect pages of the CD record books, CDs not written out of the record books when given to patients on discharge and doses administered not recorded correctly either in the CD record book or on Wirral Millennium. This particular issue is commonly identified as an issue during the quarterly CD audits conducted by Pharmacy.

Accounted for losses (n=27) include breakages or spillages and when the missing CDs have been found and are accounted for following an initial report of a discrepancy.

Patient issues (n=20) were patients who have inappropriately taken controlled drugs or been administered them by relatives. The majority of incidents (n=19) were patients who took their own supply of controlled drugs on trust premises without trust staff being informed. The supplies were a combination of medicines prescribed for patients in community that patients did not disclose to staff, controlled drugs sourced illegally by the patients or patients taking inappropriate doses of the medicines they have been given at discharge. 4 of these incidents resulted in low harm, and patients needed reversal agents and increased treatment. The incidents happened across a variety of wards.

Dispensing incidents (n=11) have increased from 24/25 (n=6) but were lower 2023-24 (n=21). Incidents included out of date medicines being supplied, incorrect concentration of an injection, wrong drug and controlled drug items not dispensed from a prescription. All dispensing errors are investigated and actions identified and put in place if possible. Dispensing incidents are discussed with the pharmacy staff involved, who are also required to complete a reflection exercise, and learning is communicated across the pharmacy department.

	Monitoring CD Usage Trends The 'Abusable Drug Investigational Software' (ADIoS) is used to monitor usage trends of CDs across the Trust including prescribing on FP10 community dispensed prescriptions. Abnormal usage trends are reviewed, investigated by the Lead Pharmacist Procurement and Medicines Supply and any areas of concern are escalated to the CDAO. There have again been numerous movements and re-naming of wards and departments throughout the Trust over the last year. Throughout each move/opening/closure the audit trail and security of CDs and CD stationery has been maintained, however it is noteworthy that the moves and changes in specialty / area location makes the monitoring of usage trends in a given area much more difficult. This is particularly relevant in cases where clinical practice and prescribing patterns have changed with a change of specialty. FP10 prescriptions written by trust prescribers pulls through onto ADIoS and as a result of this, 2 prescriptions were recalled from the NHSBSA due to concerns over inappropriate controlled drug prescribing. 1 prescription identified that a Consultant from Clatterbridge Cancer Centre used a WUTH FP10 prescription pad during an outpatient clinic carried out at WUTH. The other prescription indicated that a community pharmacist may have dispensed an inappropriate medicine form against the prescription. No harm came to either patient. Misappropriation of CDs by Trust Staff During 2025/6 2 ongoing investigations into misappropriation of CDs were closed. Investigations into dihydrocodeine, codeine and morphine 10mg/5ml liquid usage on one ward area involved the twice daily counting of stock, installation of a CCTV camera with appropriate signage and installation of electronic door access to the medicine room. No untoward behaviour was identified so the investigation was closed in December. January and February saw significant reduction in stock of these medicines issued to the area but issues have increased in March so investigations have been recommenced. The other investigation was related to a specific member of staff and potential misappropriation of morphine 10mg/5ml liquid. The staff member was removed from the clinical area and monitoring of the issues of morphine 10mg/5ml liquid continued, to provide assurance that appropriate amounts of morphine 10mg/5ml liquid were being issued as stock compared to doses given to patients.
1.3	Assurance Audits Quarterly Ward/Department CD Stock Checks by Pharmacy Staff It is a requirement of the Department of Health Safer Management of CDs Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. The quarterly pharmacy CD audits are in addition to the monthly CD audits matrons complete using the Tendable app. As well as a stock check the pharmacy quarterly ward / department CD checks cover the following areas of practice which are also subject to regulation: • Security of CDs e.g., management of keys and controlled stationary, ensuring daily CD counts have been completed

- Correct documentation in terms of entries and corrections

Results of the audits are presented quarterly at MSOP. Across all quarters the audits found

- Management and security, of controlled drug keys and stationery was excellent.
- Compliance with daily checks was very good, with only a few areas missing one or two records that a daily check had been carried out
- Record keeping and governance was again, very positive in most areas.
- All Patients Own Controlled Drugs (POCDs) had correct running balances.
- Availability of rescue medicines (naloxone for opioids and flumazenil for midazolam), was generally excellent with only one area not holding the required product (flumazenil in quarter 3 and 4)
- Storage of high strength products in the 'pink bags' was excellent

The audits highlighted that a number of issues require closer attention:

- Trust policy for CD keys is that they must be held on their own bunch and lanyard and, not mixed with more general use keys on the same bunch. There is no specific legal requirement around this, however, the nurse in charge of the unit, who is responsible for the CD keys, cannot be fully assured that they are not being used inappropriately if they are attached to keys that are in common use. This clearly requires more reinforcement with CD holding wards and particularly the Children's Ward and Emergency Department areas where persistent non-compliance has been identified.
- Attention to detail in recording individual transactions would improve record keeping, particularly around witnessing transactions. This appears to be a problem that is more commonly encountered in theatres and ED. While the practicalities of clinical workflow in these areas are recognised, these areas offer significant opportunity for diversion where CD use is high and part doses are often given.
- In several areas, staff need to be aware of the correct procedures in amending a CD register, in the event of an error that requires correction.

Quarterly CD Stock Checks in the Pharmacy Department

The WUTH Pharmacy Department is also subject to quarterly CD checks in all stockholding areas by a member of pharmacy staff who work in a different area of the department. These were all completed for 2025/26 without any stock discrepancies being noted. Although not a legal requirement, full CD stock checks are being carried out in Arrowe Park dispensary each month in line with the recommendation made by General Pharmaceutical Council Inspector in 2016. In addition, CD stock levels are checked each time a CD is dispensed, or a delivery is received into the pharmacy department which ensures stock levels are managed in real time.

In addition to the quarterly CD checks other drugs with abuse potential e.g. codeine, zopiclone are counted on a weekly basis and any trends in discrepancies noted and investigated.

	Expired stock schedule 2 controlled drugs are destroyed in pharmacy with a member of staff who works elsewhere in the Trust delegated by the Accountable Officer in accordance with CD regulations. Arrowe Park and Clatterbridge Pharmacy Departments both hold an Environment Agency T28 (Sorting and denaturing of controlled drugs for disposal) Waste Exemption which allows the Trust to dispose of these medicines in accordance with Waste Legislation. Gabapentinoid audit An audit was completed on gabapentinoid prescribing on discharge in patients at risk of falls. These results suggested that due to the high incidence of patients admitted on a gabapentinoid with minimal dose changes during admission, more could be done to identify patients at risk of falls and review the need for the medication. There is currently work ongoing to adapt the medicines reconciliation form template to include a section to identify medication which may increase a patient's falls risk. This information should be used in conjunction with discussing the need, risks and benefits with the patient to make an informed clinical decision on whether to continue the medication or deprescribe. Due to the likelihood of initiated gabapentinoids being continued in primary care, there should also be clear communication to primary care on discharge to ensure ongoing review of the medication.
1.4	Controlled Drug Home Office Licence CD Home Office Licences are required to allow the Pharmacy Aseptic Unit and Pharmacy Stores at Clatterbridge to supply CDs to external customers. The licence renewal application for Clatterbridge was submitted in January 2026. Due to the refurbishment of the aseptic unit the renewal for this licence will not be submitted until the building works are nearing completion. The Home Office CD Annual Returns were completed and submitted in January 2026.
1.5	CQC Annual Report The 2024 report was published in July 2025. There was 1 recommendation for Healthcare providers and 1 recommendation for Healthcare workers included within the report applicable to WUTH: - Designated bodies: ensure you provide effective resource for your controlled drugs accountable officer. For healthcare professionals - Work within your scope of practice These recommendations are already embedded within WUTH.
1.6	LIN activity and working across boundaries Following the Shipman report the Cheshire and Merseyside LIN was established and is led by the NHS England Area Team Accountable Officer, Dr Devina Halsall. The LIN met virtually four times in 2025/26 and shared information and learning about the prescribing and management of CDs in the local geographical area.

	The CDAO has a statutory duty to submit quarterly occurrence reports to the LIN with information about any issues identified regarding prescribing or abuse of CDs. Incident occurrence reports were submitted in line with LIN guidance throughout 2025/26 and the annual Designated Body Declaration was also completed. The alert developed on Cerner to add to patients with potential drug seeking behaviour has been added to 2 patient records following information received from the LIN or colleagues in primary care. WUTH has representatives that attend the Wirral Community of Practice (CoP) on Opioid and Drugs of Dependence group. These representatives include WUTH Medicines Safety Officer, Chronic Pain Pharmacist and Chronic Pain Doctors. Wirral has been identified nationally as an area with high prescribing of opiates, gabapentinoids and benzodiazepines. The CoP hopes to share good practice and develop pathways to identify, support and manage patients on high doses or combinations of these medicines to ensure all prescriptions are clinically appropriate and not causing patient's harm.
1.7	Training The medicines management induction and mandatory training sessions contain information on opiates as they are a high-risk class of medicines and information on medicine diversion. Induction sessions are attended by all staff starting work at WUTH. Opiate and controlled drug training continues to be provided to F1s and non-medical prescribers. Training is also provided to ward and pharmacy staff.
1.8	Lessons learned Actions taken 2025/26 to improve controlled drug management and safety: Use of the 'Drug seeking behaviour' SmartZone alert on Cerner. • Attendance and participation in the Wirral Place Community of Practice – Opioid and Drugs of Dependence group. • Increased controls on morphine 10mg/5ml liquid in the Emergency Department following a number of unaccounted for losses. • Installation of overt CCTV with electronic door access in a clinical area where potential diversion of medicines was occurring. • Use of electronic Omnicell cabinets for CD storage in one additional area in ED. Actions identified and progressing: • Completion of actions identified by the thematic review into opiates completed in 2025. • Review of the management and guideline for patients admitted taking methadone or buprenorphine for substance misuse.

	• Medicines reconciliation form to be amended to prompt pharmacists to complete falls reviews and consider if prescriptions for opiates, gabapentinoids and benzodiazepines are still appropriate for the patients. • Explore electronic options on Cerner to see if amendments to prescribing screens for opiates could help support correct opiate prescribing. • Explore development of a chronic pain pharmacy MDT as part of the polypharmacy project secondment to reduce inappropriate prescribing and improve clinician confidence in deprescribing pain medications. • Review dosing of liquid morphine dosing schedules to enable simpler calculation of liquid doses.
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2	Conclusion
2.1	The management of CDs continues to be monitored by the Trust AO via incidents reported through the Trust incident reporting system and the ADIoS software. The recommendations will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion: • CD incidents review and trend analysis will continue with actions to prevent further incidents being implemented and any learning from incidents shared • Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of nursing will be held accountable for improved performance via MSOP. • WUTH will work with Wirral Place to support the safe prescribing and management of CDs across all areas of Healthcare on Wirral • CCTV cameras will be installed across all medicine rooms to discourage diversion of medicines and allow for easier investigation should areas of potential diversion be identified.

2	Implications
2.1	Patients • The report supports patient safety by maintaining oversight of controlled drug incidents, near misses and usage trends, enabling learning and targeted action where risks are identified. • Continued monitoring, audit and staff awareness will help reduce avoidable harm, improve patient experience and support equitable access to safe medicines management across all wards and departments.
2.2	People

	• There are ongoing implications for clinical, pharmacy and governance teams in maintaining incident reporting, audit activity, medicines safety training and local improvement actions. • The report reinforces the need for clear responsibilities, consistent practice and continued engagement with wards and departments, particularly where repeated non-compliance or higher-risk controlled drug activity is identified. • Engagement with internal teams and external partners, including the Local Intelligence Network and Wirral Place groups, supports shared learning and system-wide improvement.
2.3	Finance • There are no direct financial implications arising from this report. Existing monitoring, audit and governance arrangements will continue to be managed within current resources, although any future improvement actions may require local prioritisation.
2.4	Compliance • The report supports statutory and regulatory compliance by providing assurance on the safe management of controlled drugs, quarterly reporting to the Controlled Drugs Local Intelligence Network, Home Office licence requirements and Trust policy compliance.