Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

5 October 2022

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 October 2022
Time	09:00 – 11:00
Location	Boardroom, Education Centre, Arrowe Park Hospital

Agenda Item		Lead	Presenter
1.	Welcome and Apologies for Absence	Sir David Henshaw	
2.	Declarations of Interest	Sir David Henshaw	
3.	Minutes of Previous Meeting	Sir David Henshaw	
4.	Action Log	Sir David Henshaw	
5.	Patient Story	Tracy Fennell	
Operational Oversight and Assurance			
6.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw	
7.	Chief Executive Officer's Report	Janelle Holmes	
8.	Chief Operating Officer's Report	Hayley Kendall	Stephen Bailey
9.	Board Assurance Reports		
	9.1 Quality and Performance Dashboard	Executive Directors	
	9.2 Month 5 Finance Report	Mark Chidgey	
	9.3 Quarterly Maternity Report	Tracy Fennell	
	9.4 Digital Healthcare Update	Chris Mason	
	9.5 Cost Improvement Programme (CIP)	Matthew Swanborough	
	9.6 Guardian of Safe Working Quarterly Report	Nikki Stevenson	Helen Kerrs
	9.7 Learning from Deaths Report (Q1 2022-23)	Nikki Stevenson	Ranjeev Mehra
10.	Safeguarding Annual Report	Tracy Fennell	
11.	Emergency Preparedness, Resilience and Response (EPRR) Core Standards	Hayley Kendall	

12.	CQC Inspection Preparedness	David McGovern	

Items for Decision

13.	ICB and Place Update - (CMAST) Joint Working Agreement and Committee in Common	David McGovern	
14.	Policy Update Report (Managing Conflicts of Interest)	David McGovern	Cate Herbert
15.	Committee Terms of Reference	David McGovern	Cate Herbert
16.	Standing Financial Instructions	Mark Chidgey	

Wallet Items for Information

17.	Communications and Engagement	Sally Sykes	
18.	Committee Chairs Reports	Committee Chairs	

18.1) People Committee
18.2) Audit and Risk Committee
18.3) Capital Committee – **Verbal**
18.4) Quality Committee – **Verbal**

Closing Business

19.	Questions from the Public	Sir David Henshaw	
20.	Any other Business	Sir David Henshaw	

Date and Time of Next Meeting

Wednesday 2 November 2022, 9:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 31 August 2022
Location	Boardroom, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Vice Chair
SR	Steve Ryan (from 09:30)	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MS	Matthew Swanborough	Chief Strategy Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
SS	Sally Sykes	Director of Communications and Engagement
SH	Shelia Hillhouse	Lead Public Governor
EH	Eileen Hume	Deputy Lead Public Governor
AT	Ann Taylor	Staff Governor
AM	Alan Morris	Public Governor
CD	Chris Davies	Local Authority Governor

Apologies:

SL	Sue Lorimer	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies were received from SL.	

2	**Declarations of Interest** SS declared an interest in relation Picker, who led the National Cancer Patient Experience Survey, commissioned by NHSE/I as outlined in the Communications and Engagement Report. No other 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 were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of the experience of a patient who had caught COVID-19 this year following vaccination. The patient described the symptoms he experienced and upon arriving at Arrowe Park Hospital an x-ray was provided and a range of tests. The patient expressed his thanks for the prompt, professional and excellent care provided. The Board **NOTED** the patient story.	
6	**Chair's Business and Strategic Issues** DH updated the Board of Directors on recent matters and explained the current focus of the new Cheshire and Merseyside Integrated Care Board (ICB). DH also highlighted the Cheshire and Merseyside Chairs Group continued to meet regularly and was being used a forum to generate ideas and set an example. JH commented that the Executive Team had been supporting the Wirral Place Director to ensure adequate governance arrangements were in place and was working regularly with the Wirral Community Health and Care Trust. DH acknowledged there was a positive atmosphere at Clatterbridge due to the new elective hub and continued investment. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH highlighted there had been a small decrease in the number of patients with COVID (approx. 30 patients in hospital). These were predominantly patients where respiratory COVID was not the primary cause of admission and thus an incidental finding. The	

	Clatterbridge Vaccination Centre was preparing to support the COVID Autumn Booster programme. The Trust has seen a small number of monkeypox cases and are handled them in line with guidance. JH reported the Trust declared 4 serious incidents in July, a decrease of 1 on the previous month. Three of the incidents declared were related to falls and one a missed diagnosis. There were two incidents in July that were reported to the Health & Safety Executive (HSE) in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. JH highlighted WUTH Charity was recently presented with a cheque for £12,000 from the Mayor of Wirral resulting from his year's fundraising activities. The Charity was also expected to receive a location fee donation from ITV for the filming of season two of "The Tower". JH explained a designated insight team visit was undertaken by NHSE/I Regional Maternity team and the Local Maternity & Neonatal System (LMNS) visited Wirral Women and Children's Hospital on 16 August. The purpose of the visit was to assess the implementation of the 7 immediate and essential actions from Ockenden Part 1 and an opportunity to visit the Maternity & Neonatal Unit. Following the visit, feedback was overwhelmingly positive with good examples evidenced in improvement and innovation. JH highlighted phase one of the Cheshire and Merseyside Surgical Centre at Clatterbridge was nearing completion with the first patients being operated on 3 October. Phase two was due to commence in October pending national approval on the 2 September. DH sought an update on the ambition and plans to extend the Clatterbridge site. MS confirmed the Trust had submitted an £8m bid to extend the Clatterbridge site, as well as develop wards further and integrate with the vacant Clatterbridge Cancer Centre following the move to Liverpool. MS also highlighted members of the Executive Team met with the local Member of Parliament who was keen and supportive of the Trust's plans. CC suggested a future meeting or walkabout could be held at Clatterbridge. The Board **NOTED** the report.	Cate Herbert
8	**Chief Operating Officer's Report**	

	HK highlighted in July the Trust attained 92.82% elective activity against a plan of 100.60%. For elective admissions 80.68% of activity was delivered against a target of 106.60%. HK acknowledged there had been significant challenges restoring elective services to pre-pandemic levels across Endoscopy and Theatres. To ensure monthly activity plans continued to be delivered, two focussed workstreams had commenced across these areas with weekly monitoring of delivery led by HK. HK reported there was risk associated with the national position from the British Medical Association on recommended rates of pay for additional work over job plan, with a risk of reduced levels of uptake for additional elective work. This would directly impact the Trust's recovery plans and patient waiting times if it was enacted locally. HK highlighted unscheduled care performance against the four-hour standard for type 1 attendances had decreased from 51.67% in June to 48.53% in July. 69 patients waited longer than 12 hours in the Emergency Department from a decision to admit in July. The Trust continues to experience significantly high levels of bed occupancy, with occupancy running at 99%. The high level of bed occupancy causes significant impact on flow out of the department for those patients requiring a bed. 220 patients do not have a criteria to reside, 150 patients more than the Trust accommodated pre-COVID. DH queried the Trust's Home First approach and when this would be rolled out to the community, as well as the winter planning readiness and preparedness. HK confirmed the Home First approach would begin to be rolled out in October and winter planning readiness and preparedness would be discussed at the Executive Team meeting on Tuesday (6 September). HK agreed to provide the Board of Directors with an update on winter readiness and preparedness at the October Board of Directors in Private meeting. JH commented the Trust had received a call from the NHSE/I National Lead for Discharge to ensure the Trust was correctly reporting the number of patients who did not have a criteria to residue in light of the national focus on the issue. DH commented it was important the Trust was able to sufficiently articulate a narrative externally regarding the reasoning and implications for the high levels of bed occupancy and winter readiness and preparedness, to ensure the Trust was seen to be doing everything it could do. DH also suggested the Trust consider a regular briefing for local Members of Parliament as a mechanism to ensure the Trust was articulating a narrative externally.	Hayley Kendall

	SS agreed to consider and implement a regular briefing for local Members of Parliament. The Board **NOTED** the report.	Sally Sykes
9	**Board Assurance Reports** **9.1 Approach to Integrated Care Across Wirral and Cheshire and Merseyside** MS reported the Cheshire and Merseyside Integrated Care Board (ICB) was established as a statutory organisation on the 1 July 2022. The new Integrated Care Board was finalising its operating model and governance structure. DM highlighted that the Board of Directors would receive a regular report each meeting outlining the work of the ICB and associated bodies. SI queried if there had been any discussion regarding a review of integrating services or a desire to start developing stronger integration. DH commented that as the ICB had only been established on 1 July and was continuing to recruit, therefore it will require time to bed in and articulate a vison for Cheshire and Merseyside. The Board **NOTED** the report. **9.2 Quality and Performance Dashboard** The Executive Directors briefed the Board of Directors on metrics in the dashboard. It was noted that of the 49 indicators that were currently reported against thresholds (excluding Use of Resources), 35 were off-target or failing to meet performance thresholds and 14 are on-target. NS highlighted the number of complaints received increased for July from June. The main themes were delays in access to treatment and communication. The number of complaints was expected to increase going into the winter. There had also been a fall in the number of patients recruited to NIHR studies and this was due to research projects being qualitative. TF reported the number of falls resulting in moderate/severe harm had increased but there was no consistent trend to cause a concern. C difficile remained a challenge for the Trust and TF had met with the Chief Nurse at the Cheshire and Merseyside Integrated Care Board to review actions that are in place to reduce incidence of C difficile. There was one category 3 pressure ulcer in July that deteriorated further while in hospital.	

DS explained sickness absence was 7% in July in comparison to 6.50% in June. DS highlighted that there had been an overall improvement following a peak in January 2022 and confirmed that the increase in the last 2 months was anticipated due to short term sickness absence relating to COVID. Turnover remained above 14% against a 10% target. DS highlighted that retention continues to be an area of concern. DS confirmed certain Divisions that had a lower turnover had been sharing best practice and learning and Workforce Directorate Team have commenced a retention work stream, under the People Strategy. Appraisal compliance had improved further and was 86% in July against a target of 88%. Mandatory Training compliance showed an overall improvement trend since April 2022 but had dipped to 89% in July. DS confirmed the face-to-face induction programme had restarted.

SR queried if retirement was causing a higher level of turnover.

DS confirmed retirement was a factor and the age profile of the Trust broadly reflected other Trusts.

SI commented on the upcoming NHS pension changes and acknowledged an annual increase above inflation could push individuals above the pension lifetime allowance.

DH suggested the Trust could consider a self-employed option for those staff who have retired and may wish to return to work.

DS confirmed certain staff groups were more informed about their pension options. However, the Trust could not offer tax or pension advice and does commission an external provider to deliver sessions and advice. The Trust also had a range of options and policies available, such as pension recycling.

The Board **NOTED** the report.

9.3 Board Assurance Framework

DM presented the updated Board Assurance Framework and highlighted the changes made since the previous version reported in June.

DM also highlighted an updated Risk Management Strategy and Risk Management Policy would be presented to the Board of Directors in November for approval. The Board Assurance Framework would also be subject to a MIAA review and presented to a future Audit and Risk Committee.

CC commented that the mitigating actions to improve the risk score did not include due dates and suggested this would be useful.

	DM agreed to include the due dates against the mitigating actions on the Board Assurance Framework. SI commented that it should be expected to see a number of risks remaining red, as they were often dependent on a system approach and could not be mitigated alone by the Trust. The Board **NOTED** the current BAF. The Board **NOTED** and **APPROVED** the proposed amendments to the BAF. The Board **NOTED** the proposals for the annual refreshment and updating of the BAF. **9.4 Month 4 Finance Report** MC reported the Trust was reporting a deficit of £1.980m, which was an adverse variance against budget of £2.395m. The Trust continued to forecast a break-even position; however, the achievement of this position should be considered as at risk. MC confirmed the variance was largely attributed to overspends on employee costs, driven by underperformance in respect of recurrent Cost Improvement Programme (CIP) and the continued use of escalation wards staffed at premium rates. MC highlighted he and JH would meet with the Cheshire and Merseyside ICB to present the Trust's financial position, risks, and mitigating actions. MC also highlighted that capital expenditure was behind trajectory currently but forecasted an overspend by the end of 2022/23 financial year. SI commented that it would be beneficial for the Board of Directors to understand the end of year forecast position throughout the remainder of the year. MC agreed to circulate the M4 forecast position by email. MC also agreed to provide a quarterly update to the Board of Directors. DH queried the commissioning contracts issue. MC confirmed the Trust operated on a block contract for all services other than those covered by the national elective recovery target (Elective procedures and Out Patient attendances). At the end of M4 the Trust was below targeted activity levels and therefore there is a risk that income could be reduced. The Trust has a plan in place to work to the targeted levels from M5.	David McGovern Mark Chidgey

	The Board **NOTED** the report. **9.5 Monthly Maternity Report, including Oversight of Monthly Parental Surveillance Tool** TF provided the key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard, which are linked to the quality and safety of Maternity Services at the Trust. TF also provided the Perinatal Clinical Surveillance Quality Assurance report, providing an overview of the July key quality and safety metrics. TF confirmed there were no areas of concern to raise this month. The Board **NOTED** the report. **9.6 Digital Healthcare Update** CM provided a progress update on the development and agreement of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months. CM confirmed of the 42 projects within those projects – 31 were green, 10 amber and 1 red. CM noted that some Trusts had been affected by a cyber-attack on a supplier, and that while WUTH does not use that particular supplier, the incident highlights the impact and importance of cyber security. CM also highlighted that the upgrade to Wirral Cerner Millilumen was successful and had improved operational performance. DH sought an update following his previous comment regarding the Trust's telephony. MS confirmed the telephone directory had been updated to reduce the number of unused extension numbers, thus reducing the number of unanswered calls. The waiting message had been reviewed. DH requested if an update could be provided in the Chief Executive Officer's Report for the next meeting. SR queried if the Trust was prepared for any future electricity blackout given the current energy crisis. MS confirmed the Trust would continue to receive uninterrupted energy supplies as it was classed as critical infrastructure. MS also confirmed National Grid had reviewed energy capacity to the Clatterbridge Hospital campus to ensure continuation of supply,	Matthew Swanborough

	with the expansion of services on the campus including modular theatres and diagnostic centre. The Board **NOTED** the report.	
10	**Chief Nurse 6 Month Safe Staffing Report** TF presented the report and provided assurance on compliance with NHSE/I developing Workforce Safeguards and Care Quality Commission Fundamental Standards. The guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time. TF highlighted the Trust had made an improvement to the registered nurse vacancy position, reducing from 16% to 6%. The improvement was predicted to continue with proactive local recruitment and the International Nurse Recruitment Campaign. TF also highlighted that in May 2022 Clinical Support Worker vacancy rate increased from 0.9% to 4.9%. A review was undertaken, and actions put in place to support the reduction in vacancies. TF explained that following the Establishment Review outcomes the Chief Nurse and Chief Finance Officer approved the increase of staffing in 6 wards and a reduction in 2. TF confirmed the Emergency Department and Urgent Medical Assessment Centre would conclude its Establishment Review in Q4 and will be reported to the Board of Directors shortly after. The Board **NOTED** the report and **APPROVED** the recommendation to return to the pre pandemic cycle for establishment reviews, thus will receive the next Safe staffing report in June 2023.	
11	**Infection, Prevention and Control Annual Report** TF presented the annual report and provided assurance on compliance with the Health & Social Care Act and the Code of Practice on the Prevention and Control of Infections and Related Guidance. TF highlighted that during 2021/22 the Infection Prevention and Control (IPC) Team along with the wards and departments worked tirelessly to promote the health, safety, and well-being of patients and visitors but also staff in order to deliver clean, safe, and effective care. TF also highlighted there had been a reduction in gram negative bacteraemia, with all reportable organisms being under the Trust's annual objectives set by NHSE/I.	

	NS acknowledged that IPC had been a challenge during COVID and highlighted the positive feedback from NHS England following their recent visited the Trust. NHSE/I considered the Trust had built on the experience of receiving the first cohort of patients from Wuhan, which gave the Trust an early advantage in developing and implementing relevant processes and procedures. DH commented that it was a testament to the Trust for improvements made in IPC and thanked all the staff in involved in IPC. The Board **NOTED** the report.	
12	**2021-2022 Annual Submission to NHS England North West: Appraisal and Revalidation** NS highlighted the Annual Organisational Audit had been stood down again for 2021/22 and a refreshed approach was planned for 2022/23. It still remained a requirement for each Designated Body to provide assurance to the Board. NS explained the governance arrangements in place in relation to the appraisal, revalidation, and approach to managing concerns of senior medical staff at the Trust. The Trust has a process in place for the appraisal of senior medical staff, which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHSE/I. NS confirmed the completed document would be submitted to NHS England North West by the end of September. SR queried if the information required for appraisals was easy to export from the relevant systems and input into individual records for appraisals. NS explained that the necessary information had already been uploaded to the individuals record and no duplication was involved. A new online platform was used and had made the overall process easier. The Board **RATIFED** the report.	
13	**Governance and Committee Membership Update** DM provided a set of governance documents to strengthen the governance arrangements in place at the Trust, and to propose new membership for the Board Assurance Committees and new Board Champions, following the retirement of John Sullivan, and the appointment of LD and RM.	

	The Board **NOTED** the Governor role profile and **APPROVED** the remaining role profiles. The Board **NOTED** the Terms of Reference. The Board **APPROVED** the revised membership of Committees and Board champions.	
14	**Communications and Engagement** SS provided an update on Trust's communications and engagement activities in July/August. The Board **NOTED** the report.	
15	**Committee Chairs Reports** **15.1 Workforce Assurance Committee** LD provided a report on recent proceedings of the meeting held on 18 July. The Committee received a People Strategy update and acknowledged continued progress across a range of areas identified as a priority in year 1. The Committee also received and discussed Workforce Performance Report, which detailed key workforce metrics. A good level of assurance was provided that Divisions had an improvement trajectory in place. LD confirmed the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data had been agreed and submitted before the deadline. The Board **NOTED** the report. **15.2 Charitable Funds Committee** The Board **NOTED** the report. **15.3 Council of Governors** DH provided a verbal report on recent proceedings of the meeting held on 25 July. The Council of Governors received the Quality and Performance Dashboard with Executive Directors highlighting any emerging issues and mitigating actions. The Council of Governors also received a WUTH Strategy 2021/26 Update and approved the Lead and Deputy Lead Governor Role Profiles. The Board **NOTED** the update.	

	15.4 Quality Committee SR provided a report on recent proceedings of the meeting held on 29 July. The Committee received the Quality and Patient Safety Intelligence Report, Serious Incidents Panel Chairs Report and Complaints Report. The Committee also received the Infection Prevention and Control Annual Report whereby it was noted NHSE/I acknowledged the Trust's positive infection control culture. The Committee also noted the Mental Health Key Priorities and the priority areas of focus for the Trust. The Board **NOTED** the report. **15.5 Finance Business Performance and Assurance Committee** SR provided a verbal report on recent proceedings of the meeting held on 24 August. The Committee received the Month 4 Finance Report and a Cost Improvement Programme Update. The Committee discussed High-Cost Drugs and were assured the necessary controls where in place along and acknowledged the cost of drugs continued to increase. LD queried if drugs that had not been used while a patient was in hospital were collected and recycled. NS confirmed this already happened. The Board **NOTED** the report.	
16	**Questions from the Public** No questions from the public were raised.	
17	**Any other Business** No other business was raised.	

(The meeting closed at 11:00)

Action Log
Board of Directors in Public
5 October 2022

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	4 May 2022	7	To ensure the Audit Committee are provided with assurance that actions following a RIDDOR were completed	Cate Herbert	Complete. Completed for the Audit and Risk Committee in September. A further update will come to the Committee at a future meeting.	September 2022
2.	31 August 2022	7	To consider holding a future meeting or walkabout at Clatterbridge	Cate Herbert	In progress. A visit to Clatterbridge is being planned for November.	November 2022
3.	31 August 2022	8	HK agreed to provide the Board of Directors with an update on winter readiness and preparedness at the October Board of Directors Private meeting	Hayley Kendall	Complete. Included on the October meeting agenda.	October 2022
4.	31 August 2022	8	SS agreed to consider and implement a regular briefing for local Members of Parliament	Sally Sykes	Complete.	October 2022
5.	31 August 2022	9.3	DM agreed to include the due dates against the mitigating actions on the Board Assurance Framework	David McGovern	In progress. Due dates will be included on the BAF in time for the next bimonthly update in November.	November 2022
6.	31 August 2022	9.4	MC to circulate the M4 forecast position by email	Mark Chidgey	Complete. Circulated by email on 29 September.	September 2022
7.	31 August 2022	9.4	MC agreed to provide a quarterly forecast position to the Board	Mark Chidgey	In progress. The next quarterly update will be provided in November. This has been added to the cycle of business.	November 2022
8.	31 August 2022	9.6	MS to provide an update in the Chief Executive Officer's Report for the next meeting regarding the Trust's telephony	Matthew Swanborough	Complete. Update provided in the Chief Executive Officer's Report.	October 2022

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 7**
5 October 2022

Title	Chief Executive Officers' Report
Area Lead	Janelle Holmes, Chief Executive
Author	Janelle Holmes, Chief Executive
Report for	Information

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in September. It is recommended that the Board: • Note the report; and • Ratify the electronic approval taken during September in relation to Capital Expenditure.

Key Risks
N/A

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

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

1	**Narrative**
1.1	**Infection, Prevention and Control (IPC) Update** The Chief Medical Officers of the UK nations and the national Medical Director of NHS England have jointly recommended that the COVID-19 alert level be moved down from level 3 amid falling cases. As a result, the UK's COVID-19 alert level has been downgraded to level 2, meaning the virus is in "general circulation" and COVID

	healthcare pressures and transmission are "declining or stable". In line with the reduced alert level, new COVID management guidance was released on the 26 August advising on a further reduction of protective measures. In line with new guidance admission swabbing has now ceased across our hospitals (with the exception of symptomatic patients, immunosuppressed patients, or on admission to the Intensive Care Unit). Only elective surgical patients who are immunocompromised will be swabbed. Patients will test themselves by LFD 24 hours prior to the surgery and routine isolation is no longer required before the operation. The emphasis on social distancing has also reduced with a greater importance on good ventilation, effective cleaning, and local risk assessment. This has enabled meeting room practices, use of learning environments and capacity in the lecture theatre to go back to pre-pandemic arrangements. Visiting has now also been modified to allow 2 visitors to attend for 1 hour between 2-7pm on our adult wards without the requirement to prebook. Additional arrangements are in place to allow flexibility for sibling visiting in our women's and children's departments. In line with national guidance there is no longer a requirement to wear a fluid repellent surgical mask (FRSM) in any area of the Trust. This is with the exception of staff who are in close interaction for prolonged periods with patients who are known COVID positive or in an area with a known COVID outbreak.
1.2	**Autumn Booster Vaccination Programme** The Trust commenced the Autumn Booster Vaccination Programme at the Clatterbridge Vaccination Hub from September 12, 2022. Frontline health and care workers, immunosuppressed people, and people aged over 65, are now able to book in for the first ever variant-targeted vaccine via the national booking system. The Flu vaccine programme is due to commence at the end of September 2022.
1.3	**Cheshire and Merseyside Health and Care Partnership Integrated Care Systems (ICS) Operating Plan 2022/23** The Trust received a letter from Richard Barker, NHS Regional Director (North West) acknowledging receipt of the Cheshire and Merseyside Health and Care Partnership ICS operating plan for 2022/23 and next steps. The letter can be read in appendix 1.
1.4	**Provisional Notification of Positive Outlier Status for National Neonatal Audit Programme (NNAP) 2021 Measures** The Trust received notice from the Royal College of Paediatricians and Child health following the 2021 National Neonatal Audit Programme that Wirral University Teaching Hospitals have been identified as "Outstanding" for the audit measure Antenatal Magnesium Sulphate. This will be reported in the NNAP Annual Report due for publication on 10 November 2022.
1.5	**Trust's telephony** Over the past six months, the Trust's Facilities Department has been working with the Digital Healthcare Team to improve our communication services across the hospital campuses, making best use of our Cisco telephony system. To date this has included realignment of Trust telephone directories, aligning to ESR information; updating of phones; reduction of telephone numbers and improving call answering and directing processes by the Switchboard Team. This has helped reduce unanswered calls on ward and clinical areas by 8%, over the last six months.

	Over the coming months, the Facilities Department will continue with the telephony and switchboard improvements, focussing on use of the Cisco technology and automation in call answering and directing.
1.6	**Modular Theatres Phase 2 Approval** In mid-September 2022, the Trust was awarded £14.9m for the development of two additional modular operating theatres and internal theatre complex refurbishment at Clatterbridge Hospital, as part of the NHS England Targeted Investment Fund (TIF) for 2022/23. This bring a total TIF funding for the theatres redevelopment at Clatterbridge Hospital to £29.5m, and significantly enhances our theatre capacity on the campus. Importantly, this funding also supports the establishment of the South Mersey Elective Hub, with neighbouring hospital Trusts able to start to utilise the new facilities, from November 2022, helping to reduce elective surgical waiting times across Cheshire and Merseyside.
1.7	**Serious Incidents** The Trust declared 5 serious incidents (SI) in the month of August 2022; this is the same as the previous month. The Serious Incident Panel report and investigate under the “Serious Incident Framework” so that learning can be identified. There were no new themes or areas identified from the 5 reported incidents, which spanned areas of the trust, including the Surgical Services (1) Medicine (3) and Women and Children’s (1). The Trust reported 0 Never Events in the month of August. Duty of Candour has been commenced in line with legislation and national guidance. **RIDDOR** There have been four incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in August 2022. All RIDDOR reported events are subject to a local Review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.8	**Ratification of Electronic Resolution – Capital Expenditure** In May 2022 the Board approved an initial budget for Capital Expenditure of £9.765m, and this budget was set at the Trust’s approved CDEL (Capital Department Resource Limit). Since this point, the Trust received ICB approval for urgent maintenance work with an associated increase in CDEL of £2.132m. At the August Board, it was noted that variations to the capital expenditure budget would be required to accommodate this, and an electronic resolution was circulated on the 8 September 2022 to agree this. The recommendations within that report were approved by all Board members, and the Board are asked to ratify this approval.
1.9	**North West Ambulance Service (NWAS) Strategy 2022-25** NWAS have published their new strategic plan for 2022-25. The strategy sets out three core aims and objectives to achieve their vision of delivering the right care, at the right time, in the right, place; every time. The new strategy can be accessed on their website.
1.10	**Cheshire and Merseyside Activity and Recovery Summary (August)** General and acute bed occupancy remains very high, on average 96% or greater for Cheshire and Merseyside. Trusts continue to report high numbers of long lengths of stay patients and patients no longer meeting the criteria to reside.

	79% of patients have been waiting 6 weeks or less for a diagnostic. Cheshire and Merseyside are delivering more activity than before the pandemic for CT, MRI, colonoscopy tests. The number of patients waiting over 13 weeks has reduced by 202, there are still 5,699 people waiting more than 13 weeks for a test The number of patients waiting for cancer surgery increased and now stands at 815. There are 114 patients at P2 level who have waited over four weeks for cancer surgery. The over 62-day backlog increased from 1,689 to 1,720.
1.11	**Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Briefing** **COVID Booster Vaccine Roll-out Announced for Autumn** People living in Cheshire and Merseyside will soon be among the first in the world to receive the new COVID-19 vaccine, when the autumn booster programme begins this month. **COVID Testing** Patient-facing healthcare staff who have no symptoms of a respiratory infection are no longer required to test for COVID-19 on a regular basis. **Virtual Wards** Cheshire and Merseyside are leading the way in the development of virtual wards – to support people who would otherwise be in hospital to receive the care and treatment they need in their own home. Support delivered through Virtual Wards is clinically supervised and can include remote monitoring using apps, technology platforms, wearables, and medical devices such as pulse oximeters. **Increasing Capacity this Winter** Investment of over £13m has been agreed to support several schemes across Cheshire and Merseyside which will see an expansion of the hospital, community, and care home bed-base this winter, totalling more than 200 additional beds. **Waiting List Backlog** Achieved a zero-capacity breach position at the end of July, which mean no 104 week waits at that time. Agreed exceptions related to patients that had opted to wait longer for their treatment (patient choice), and some very complex cases that were excluded from that national target. The next focus is on eliminating over 78 week waits by end of March 2023. We currently have 3252. **Theatre Productivity** A formal programme of work has been launched for theatre productivity to identify and address opportunities for improving the throughput and utilisation of our theatres. Cheshire and Merseyside are currently performing well against the national picture, but there are still opportunities. **Urgent and Emergency Care** Acute Trusts remain pressured in terms of continued high occupancy. C&M G&A occupancy average for July was 96% (range 93%-100%), with majority of Trusts consistently over 95%. **Finance**

	The financial position to July, month 4 sees CMAST reporting a £44m deficit compared to a plan of £36m deficit with 8 organisations requiring improvement in their run rates to return to plan by the year end.

3	**Conclusion**
3.1	The Board are asked to note and receive this report.

Report Author	Janelle Holmes, Chief Executive
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Ref RB HH 2022-08-23

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23 August 2022

Graham Urwin
Chief Executive
Cheshire and Mersey ICB

graham.urwin@nhs.net

By email

Dear Graham

I am writing to acknowledge receipt of the Cheshire and Merseyside Health and Care Partnership Integrated Care Systems (ICS) final operating plan for 2022/23 and set out next steps.

The objectives set out in 2022/23 priorities and operational planning guidance were based on COVID-19 returning to a low level. Your plan has been developed in the context of a changing external environment as a result of new COVID-19 variants and the impact of wider economic factors on the costs of delivery. Although it is inevitable that the ongoing level of healthcare demand from COVID-19 will impact on systems' ability to fully deliver on some of these objectives, we must continue to build on the progress made to date and target recovery of activity as COVID-19 infection rates fall.

As set out in the recent letter to Chief Executives and Finance Directors, systems and providers will be funded for the pay award. However, as the pay award is above the level the Government funded in the NHS settlement last year, it means that we must now re-prioritise resources nationally. We will do this alongside providing investment to maintain safe services, including the creation of additional bed capacity.

NHS England has reviewed your submission in this context, and we have set out below some key elements of your plan that require further review and follow up action. Please could you share this letter with your full Board for consideration. In addition to the elements of your plan described below there are some technical issues that require follow up action, these items will be picked up in detailed feedback from the appropriate NHS England lead.

Elective and cancer care

Systems should continue to focus on meeting the ambitions to reduce long waits for elective care and the cancer backlog over the rest of this year.

The plans submitted by your system included ambitious trajectories for the recovery of elective care and diagnostic activity from quarter one onwards when compared to recent activity levels and the focus by the system now needs to be on the implementation of actions

to deliver the trajectories and maintain this over the coming winter period to ensure the delivery of the trajectories for 78 week waits, 52 week waits and the reduction of the cancer.

It is acknowledged that the system is planning to achieve the 78 week target, but this will require focused attention during the remainder of the year to ensure delivery.

Although the 62 cancer backlog target is planned to be achieved in plans, Tier 1 and Tier 2 meetings are now being established to monitor this process with particular providers of concern for both 78ww and 62 day cancer backlog patients. A continued focus with these providers is needed to support, momentum, and delivery.

There needs to be further work undertaken by the system to reduce the number of follow up Outpatient appointments and Patient Initiated Follow Up appointments to achieve the national ambition.

In relation to diagnostic recovery the system needs to do further work to achieve the national target

Emergency care and system resilience

Systems should continue to focus on meeting the ambitions to reduce long waits for elective care and the cancer backlog over the rest of this year.

At the same time, it is acknowledged that unrelenting non-elective pressures persist, and this is having an impact not just on patient flow but also delivery of services in the round.

Throughout July, most acute trusts across Cheshire & Merseyside were operating at 92%+ G&A bed occupancy. And as of 24 July, there were just over 1,000 patients in hospital beds across C&M with no criteria to reside but who had not yet been discharged. This figure equates to just under 23% of C&M's acute hospital bed base.

All of which is contributing to increased patient safety risks within emergency departments that are routinely being forced to accommodate more patients than normal capacity would allow. Over the course of the end of June/beginning of July, 13.7% of all patients who presented to an emergency department across C&M spent longer than 12 hours from time of arrival in ED. Similarly 5.2% of all ambulances arriving at a hospital across C&M were delayed for over 60 waiting to hand over their patient to the ED team.

Recognising the current set of demands on systems, it is critical that we continue to increase capacity in and out of hospitals to support performance and patient flow, particularly in emergency services. NHS England will continue to work with you on plans to increase capacity to reduce ambulance delays and long waits in Emergency Departments as part of the current operational response and ahead of winter. We will confirm funding and plans to support these goals including the funding for virtual wards over the coming weeks.

Mental health and Learning Disability and Autism

- Mental health
    - MHIS achievement – The MHIS is the minimum investment expected within the Mental Health Operational Plan. Cheshire and Merseyside reported a planned over-delivery of £3.1m which was identified as an error due to incorrect inflation assumptions in Warrington and Halton Place. The revised and expected forecast outturn the ICS will report in-year will be £0.95m over-delivery due inflationary

increase assumptions in Prescribing and Continuing Health Care. Further to discussion in the regional July 22 Triangulation meetings, the ICS is requested to consider the reported higher than average planned spend on Prescribing and complex placements.

- Cumulative growth against Long Term Plan (LTP) trajectories, highlighting areas where systems are investing below 85% of LTP analytical tool expected growth (investment in ambulance response and perinatal investment is particularly low across a large number of systems) – Cheshire and Merseyside report investment below 85% of the LTP analytical tool expected growth in three categories: Ambulance Response, IAPT and CYP Eating Disorders. It is noted that a significant increase in investment levels in Ambulance Response is anticipated in 2023/24, following the announcement of the Capital Funding for additional Mental Health Response Vehicles and current indication reflect that a total of three vehicles are to be requested for Cheshire and Merseyside. Feedback from the system regarding challenges in separating out levels of investment across the CYP and CYP Eating Disorder categories is also noted, including that the CYP category reflects an investment level of 144% of LTP analytical tool expected growth. It is also noted that investment in IAPT is subject to confirmation of trainee numbers and that this will be reviewed and updated by the system. ICB's wishing to request rebasing to correct any material MHIS errors will have an opportunity in September 22 (5-16) with regional review/assurance 19-23rd. Further details on this will be provided by the Regional Finance team.
- Activity Metric Performance – In particular highlighting the importance of (1) CYP access if plan is below trajectory as we have seen an increase demand for services across the country and (2) SMI physical health checks which were heavily affected by the pandemic. Cheshire and Merseyside plans to achieve 9 out of 13 of the MH LTP activity targets in 2022/23. Recovery action plans have been developed for those LTP activity targets unlikely to be met which include Perinatal Mental Health Access, Access to Psychological Therapies, Zero Inappropriate Out of Area Placements and Individual Placement and Support access. Recovery plans will be assured through the Regional Triangulation meetings and quarterly "Deep Dive" meetings with the National Team.
- Overall Workforce growth and take up of new roles for example Psychological Wellbeing Practitioner as there are more new roles being trained than take up in system plans – The National team have recognised that systems will configure their workforce models in line with local need, and the analysis provided for systems to compare their workforce growth to the LTP analytical tool's workforce growth is intended to be highly indicative for this reason. Cheshire and Merseyside are reporting lower than expected levels of workforce growth in Perinatal, IAPT, Community Mental Health, Adult Community Crisis and a reduction in Acute Inpatient all of which require review to ensure the planned workforce growth will enable the achievement of the MH LTP Activity set out in the operational plan. Workforce growth in Children and Young People is reported to be 271% of indicative growth in the LTP Analytical Tool, it is recommended that this is reviewed in terms of achievability.

- Learning disability and autism
  - Adult inpatient trajectories

Finance

Delivering system-level financial balance remains a key requirement for all ICBs. We are pleased to see that you have submitted a balanced plan, noting the £30m deficit related to LUHFT's hospital move in September 2022.

The additional funding provided to systems during the planning round was provided on the basis that the following ongoing conditions are adhered to:

- Commit to recurrent delivery of efficiency schemes from quarter 3 to achieve a full year effect in 2023/24 to compensate for any non-recurrent measures required to achieve 22/23 plans.
- Fully engage in national pay and non-pay savings initiatives which we plan to launch in the coming months, in particular around national agreements for medicines and other non-pay purchasing.
- Monitoring of agency usage by providers, and compliance with usage and rate limits.
- Compliance with a similar set of conditions in relation to bank staff
- Any consultancy spend above £50,000 and any non-clinical agency usage require prior approval from the NHS England regional team.
- Internal audit to be commissioned to produce a report covering the Healthcare Financial Management Association (HFMA) publication - Improving NHS financial sustainability: are you getting the basics right?
- Systematically review excess inflation figures in plans. Further details of this process will be issued in due course.
- and
- Ongoing review of additional costs associated with LUHFT's hospital move.

Workforce

- Planning a total Acute, Ambulance, Community, Mental and Specialist health workforce increase of +2% (+1,477 WTE). Within this, substantive staff are planned to increase by +3.2% (+2,195 WTE), and bank and agency use are planned to decrease by -11.4% and -10.2% respectively (-551 WTE and -167 WTE).
- Within the substantive plans, registered nursing, midwifery, and health visiting staff are showing a planned increase of +5.1% (+1,035 WTE), which would result in a vacancy rate of 4.9% at end March 2023. Allied health professionals are planned to increase by +4.7% (+225 WTE), support to clinical staff by +3.5% (+618 WTE) and medical and dental staff by +3.1% (+193 WTE).
- In Primary Care, the total workforce is planned to increase by +4.5% (+305 WTE). There is growth in all staff groups, but Direct Patient Care roles (Additional Roles Reimbursement Scheme funded) have been particularly prioritised with an increase of +8.9% (+57 WTE).
- Nursing and midwifery – Adult, Mental Health and Learning Disability will prove challenging in 22/23, with higher growth forecasts than we are likely to see based on current projections for net supply (using observed behaviour, supplemented with latest intel including retention, changes in training numbers etc). Midwives and child expansions may be possible. It is difficult to comment on the remaining Nursing & Midwifery staff groups, but they are likely to be challenging, as they will inevitably

recruit from the rest of the Nursing & Midwifery workforce, plus will require appropriate training to develop the workforce (especially for the Intensive Care Unit expansions and in community nursing).
    - Therapeutic radiography is likely to prove challenging.
    - For medical and dental - acute internal medicine and medical oncology will prove most challenging for the expansion identified.
    - For healthcare science \ technical staff there is a planned increase of +5% (250) across the North West, this would appear consistent with additional activity, but there is no detail on which staff groups that would include. As such it is difficult to provide assessment of the supply \ demand equation.
- For other staff groups, it is more difficult to provide comment as they either haven't been 'split out' at appropriate staff group level (i.e., Health Care Science staff groupings) and from which to be able to do a supply \ demand assessment, or the workforce is dependent on factors which are not influenced by education and training, i.e., Administrative & Clerical or managerial roles.
- 2-hour urgent community response for Cheshire & Merseyside +82%.
- Workforce Supply remains the most significant risk. Workforce gaps are being driven by national and international shortages of some roles. Competition from local employers for talent in non- clinical roles is growing, particularly in the retail and hospitality sector where pay is often above NHS rates of pay (specifically at B2/3).

ICBs should monitor delivery against their workforce plans and work with colleagues at all levels to consider whether actions to improve substantive recruitment, retention and staff health and wellbeing are sufficient to meet workforce demand.

Triangulation

Delivery of plans should continue to be monitored and reviewed regularly with regards to the triangulation of Finance, Workforce, and Productivity.

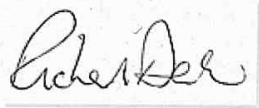
Next Steps

We will continue to work with you to address the issues highlighted above and ensure you are able to access the necessary development support to strengthen the system' capability and capacity for delivery.

We will review progress in context of the changing external environment through our regular monitoring meetings.

If you wish to discuss the above or any related issues further, please let me know.

Yours sincerely



Richard Barker

Regional Director (North West)

cc

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 8**
5 October 2022

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Bailey, Deputy Chief Operating Officer Nicola Cundle-Carr, Head of Business Improvement
Report for	Information

Report Purpose and Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year.

For unscheduled care, the report details performance and highlights the ongoing challenges with long length of stay patients and the impact this has on Urgent and Emergency Care (UEC) performance. The report also highlights the number of patients who remain in the department for longer than 12 hours since arrival and the key performance metrics for the Emergency Department (ED) and the hospital occupancy challenges given the very high volumes of patients in the acute bed base that do not have a criteria to reside.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to clear the backlog of patients awaiting their elective care pathway. Patients are prioritised in line with the nationally mandated clinical prioritisation of patients, with a focus on those prioritised as clinically urgent and very long waiters irrespective of their priority status. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Through the pandemic unscheduled care performance was extremely challenged and this continues with the high bed occupancy levels within the Trust which in turn impacts on the elective recovery programme.

2	Planned Care
2.1	**Elective Activity** For FYE 2022/23 the elective activity has been profiled against the corresponding periods in 2019/20. In August 2022, the Trust attained 111.2% against a plan of 106.7% for Outpatients. For elective admissions 106.5% of activity was delivered against a target of 106.5%. **Outpatient activity by POD** **Elective activity by POD** There continues to be significant challenges with restoring elective services to pre-pandemic levels across Endoscopy and Theatres. To ensure the monthly activity plans are delivered two focussed workstreams have commenced over the next 12 weeks with weekly monitoring of delivery led by the Chief Operating Officer. These schemes will also be monitored via the Trust's Programme Board.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for August with the final position over reporting 93 P2 breaches against a month end plan of 42. However, with increased use against the C2Ai tool which eliminates subjectivity, the numbers of P2 patients are not rising, and this is of particular focus in Urology.

	Target	Actual
New	108.3%	103.7%
F/UP	106.0%	114.2%
Combined	106.7%	111.2%

	Target	Actual
Day Case	108.1%	106.8%
Inpatients	97.5%	104.6%
Combined	106.5%	106.5%

2.3	**Referral to Treatment** The national standard is to have no patients waiting over 104 weeks by August 2022 and to eliminate routine elective waits of over 78 weeks by April 2023 and 52 week waits by March 2025. • 104+ Week Wait Performance - as at the end of August the Trust continued to have no patients waiting longer than 104 weeks. • 78+ Week Wait Performance - 62 patients • 52+ Week Wait Performance- 1122 patients Waiting List Size In August 2022 there were 35,742 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,250 (local C&M target). The loss of six theatres for the first two months of the financial year has significantly impacted on the 52 week and waiting list size positions as approximately 300 cases each month the theatres were unavailable were lost. The Divisions are focussed on recovering the lost activity and performance, but this continues to be challenging given the volume of activity that was lost and the ongoing pressures with workforce in theatres.
2.4	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date: • 2 Week Waits - sustained increase of 2WW referrals meaning increased demand on the system which shows no sign of reduction (currently 20% increase across the Trust). Positive Jul 22 performance with achievement of the standard. The continuous referral increases in Breast remains concerning and will lead to the Trust not achieving the 2 week wait performance in August and September, with planned recovery during October • Faster Diagnosis Standard - continued achievement of the 28-day target (patients being informed they do or do not have cancer within 28 days of referral) • All other targets - all targets for the quarter are predicted to be red apart from 31-day subsequent drug in line with the recovery trajectory. Recovery plans are in place to recover Trust aggregate performance back to pre-COVID from February 2023. Challenged tumour sites include Urology and Colorectal and was a theme pre-Covid.
2.5	**DM01 Performance – 95% Standard** In August 85.28% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01 cohort. This is against the new national standard of 95%. All modalities achieved the 95% compliance target with the exceptions of Endoscopy and Urology Services. Endoscopy performance is achieving against the internal recovery trajectory, and work is ongoing with Urology to secure additional capacity to treat the significant backlog of patients awaiting a cystoscopy. It should be noted that the cystoscopy backlog includes planned patients exceeding six weeks from their target scope date. This is a change in year as previously planned patients were not on an active waiting list (standard across the NHS).
2.6	**Risks to recovery and mitigations** The Trust has robust systems in place to monitor and review elective performance which continues to be monitored weekly at executive level.

	The clinical divisions are progressing through their plans outlined in the previous updates including insourcing, outsourcing and the exciting progress made with the Cheshire and Merseyside Surgical Centre (Clatterbridge) providing much needed additional theatre capacity, due to go live at the end of October 2022 (a one month delay from the revised opening date). There is a very recent risk associated with the national position from the British Medical Association (BMA) on recommended rates of pay for additional work over job plan, with a risk of reduced levels of uptake for additional elective work unless the BMA rate card value is matched by the Trust. This has and will continue to directly impact the Trust recovery plans and patient waiting times. The Chief Operating Officer will meet with all specialities where this has been enacted to understand what mitigations and changes to service provision are required to ensure patient waiting times are not extended. Governance structures are in place across all divisional teams, feeding into the executive led Performance Oversight Group weekly with full participation in regional recovery initiatives. Task and finish groups have also been established in August for those areas remaining most challenged.

3.0	**Unscheduled Care**
3.1	**Performance** **Type 1 performance:** Performance against the **four-hour standard** for type 1 attendances has increased from 48.53% in July to 50.55 % in August. **Type 1 ED attendances:** • 8,195 in July • 7,713 in August • 6.1% decrease **Type 3 ED attendances:** • 3,176 in July • 2,883 in August • 9.2% increase Attendances to the department decreased in August from the previous month as seen in previous years however remained above 2019/20 attendance numbers. In August the Trust reported 155 patients (5 outstanding validation) exceeding the 12-hour DTA target, the highest position year to date. The Trust continued to see significant pressures with flow across all Divisions with occupancy continuing to be running at 99% and over. A full review of each 12-hour breach is completed by the Acute operational team and although a proportion can be related to delays with mental health waits, the majority related to flow from ED to the ward areas. The challenge continues to be the number of patients in the acute bed base who do not have a criteria to reside with August having approximately 35% of the Trust beds occupied by this cohort of patients (220 patients) and all available beds in the Trust staffed and open (64 escalation beds open from April and higher than any number of beds previously opened for winter pressures). In response the wider health and social system is looking at what additional support and resource can be provided to ensure timely discharge for patients that require additional support when deemed medically fit.

The Trust are also working through other admission avoidance schemes such as Same Day Emergency Care (SDEC), admission avoidance at the front door (virtual wards) and closer working with primary care.

Arrowe Park Site ED Type 1 Attendances vs 2019

Month	2022/23	2019/20	YoY Variance	% Var	% of 19/20
April	7,707	7,585	122	1.6%	101.6%
May	8,407	7,696	711	9.2%	109.2%
June	7,891	7,455	436	5.8%	105.8%
July	8,185	7,813	372	4.8%	104.8%
August	7,713	7,407	306	4.1%	104.1%

3.2 Risks and mitigations to improving performance

- Physical environment in ED is challenging during peaks in demand impacting on ability to delivered the timed pathways and there is regular overcrowding. The Trust has plans to mitigate a good proportion of this risk with the development of a dedicated ambulance triage area, previously occupied by the UTC, who are being re-located within the Trust. This is due to open during November and will provide much needed space to receive and triage patients brought to the hospital via ambulance

- Continued increase in walk in attendances to ED is a risk to recovering the UEC performance and there is ongoing work with UTC colleagues to maximise streaming to more appropriate services

- Delivery of the LLOS and criteria to reside system wide recovery trajectory is at risk due to community capacity constraints for complex discharge pathways 1,2,3. This is regularly discussed with Wirral system partners and the significant delays in securing alternative care settings for the patients that do not require care in an acute hospital bed.

- Boarding time in department increased due to bed pressures and the risk of increasing 12 hour DTAs

- Increasing mental health activity and significant increases of attendances under S136 leading to the Mental Health Unit being regularly over 100% and patients being cared for in the ED Initial Assessment Area. Availability of mental health inpatient beds resulting in 12 hour breaches for mental health patients and excessive LOS in the ED.

4.0 Conclusion

The Trust had a significantly challenged month in relation to non-elective performance that has also impacted on the ability to deliver the full elective recovery programme, mainly related to bed occupancy and availability.

The Board of Directors should note that with 35% of the total bed base occupied by patients that require another care setting there is a significant risk of not improving performance across the UEC pathways and the elective programme. Given that this risk is so high in the summer months there is a real risk approaching and planning for Winter if the system position remains the same. The Chief Operating Officer along with the Clinical Divisions is leading the planning process for winter with this in mind and exploring all opportunities to deliver services differently.

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Board of Directors in Public
5 October 2022

Item No 9.1

Title	Quality and Performance Dashboard
Area Lead	Executive Team
Author	John Halliday - Assistant Director of Information
Report for	Information

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of August 2022.

It is recommended that the Board:

- notes performance to the end of August 2022

Key Risks

This report relates to the key Risks of:

- Quality and safety of care
- Patient flow management during periods of high demand

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
This is standing report to Board			

1	Narrative
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 34 are off-target or failing to meet performance thresholds - 15 are on-target

	Following the recent discussions with the Executive Team and the Board as part of the Performance Management Framework Review, the metrics included in the Quality & Performance dashboard have been assessed for continued inclusion, alongside the relevant thresholds. Some thresholds only apply from April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is continuing to clarify the precise definitions and thresholds on a small number of metrics. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

2	Implications
2.1	The issues and actions undertaken for those metrics that are not meeting the required standards are included in the additional exception reports or covered within the Chief Operating Officers Report.

3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Quality and Performance Dashboard, and weekly at the operational meetings with the Clinical Divisions.

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Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.10	0.10	0.05	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.09	0.33	0.17	0.18	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.3%	96.6%	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	1	0	1	0	0	0	0	0	0	0	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	6	13	6	5	3	18	12	13	7	8	16	17	15	63	
	Gram negative bacteraemia : e-coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	-	-	-	8	4	9	12	10	43	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	-	-	-	0	4	1	3	6	14	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	-	-	-	0	0	0	0	1	1	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	0	0	0	1	1	1	4	0	0	1	0	5	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	95%	96%	96%	94%	95%	92%	89%	91%	96%	97%	95%	94%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	-	-	-	82.6%	71.6%	93.5%	89.6%	94.7%	85.0%	87%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	90.9%	91.3%	90.8%	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	90.59%	90.6%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.17%	6.21%	6.22%	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.90%	6.9%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	6.53%	6.62%	6.67%	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	5.98%	6.53%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	14.1%	13.9%	13.9%	
	Care hours per patient day (CHPPD) - number of wards below 6.1	Safe, high quality care	CN	No of wards ≤3	WUTH	-	-	-	-	-	-	-	3	1	4	5	4	7	4	

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	98.3%	95.9%	96.3%	96.4%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.3%	99.0%	98.9%	98.4%	98.5%	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 79 (Revised April 2022)	WUTH	126	132	126	141	157	206	195	187	220	194	211	214	226	226	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	84.7%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	1	2	2	3	8	3	2	3	1	1	1	5	1	9	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	78.2%	75.6%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.2%	94.4%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.1%	94.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	100.0%	97.6%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	61.5%	63.1%	63.4%	64.5%	62.3%	63.6%	63.4%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	7	11	8	6	6	13	7	17	39	24	17	69	155	304	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	54.0%	52.5%	53.5%	58.6%	53.6%	57.9%	55.2%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	5.0%	9.2%	8.2%	9.4%	8.8%	11.0%	8.1%	11.6%	13.7%	10.7%	10.5%	14.6%	14.1%	12.7%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	90.2%	88.6%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	25.2%	23.9%	21.9%	18.5%	16.0%	12.5%	18.5%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.38%	64.08%	66.72%	65.46%	64.80%	64.77%	64.77%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	27306	27424	26935	27046	27406	28665	29445	30430	31504	32373	33306	34933	35742	35742	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	560	606	575	510	557	475	525	582	730	811	1028	1119	1122	1122	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	177	163	116	70	72	59	65	60	70	73	82	91	62	62	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	3	7	10	5	5	4	5	1	0	0	0	8	0	0	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	85.2%	82.8%	86.0%	87.2%	87.5%	85.3%	85.7%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	92.6%	92.8%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	94.95%	-	-	91.63%	-	-	76.7%	-	-	92.5%	-	-	92.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	96.5%	96.4%	96.0%	95.7%	95.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	96.41%	-	-	94.85%	-	-	94.1%	-	-	94.9%	-	-	94.9%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.6%	75.7%	83.3%	67.1%	77.0%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	85.05%	-	-	79.38	-	-	78.1%	-	-	78.2%	-	-	78.2%	
	Cancer Waits - reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - max 68	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	81	97	118	152	167	158	158	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	78.2%	77.9%	79.8%	79.2%	80.5%	70.5%	78.9%	79.5%	76.7%	75.4%	78.3%	79.7%	81.8%	78.4%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	213	218	216	177	149	180	187	211	170	185	174	207	191	185	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.05	4.50	3.96	2.88	4.13	5.02	4.10	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	94%	94%	100%	61%	100%	100%	100%	100%	100%	86%	100%	91%	96%	95%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	5	2	3	4	3	2	0	0	2	2	1	3	0	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	-	-	-	85%	85.2%	88.3%	89.7%	89.1%	89.6%	88%	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

September 2022
Upated 22-09-22

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents	Outstanding Patient Experience	CN	0	WUTH	-	-	-	-	-	-	-	-	0	1	0	0	0	1	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 22/23 (cumulative 59 per month until year total achieved)	National	457	613	774	958	1121	1445	1575	1666	21	57	83	108	143	143	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	77.9%	77.2%	83.2%	85.2%	86.2%	86.7%	86.7%	

	Indicator	Objective	Director	Threshold	Set by	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-1.0	-0.4	-0.2	-0.4	-0.5	-0.5	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-0.9	0.3	-1.2	-0.6	-0.7	-0.7	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	7.26%	45.26%	47.60%	57.50%	51.00%	51.00%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-43.9%	-316.0%	-88.0%	-218.8%	-216.0%	-216.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-20.0	-21.4	-12.0	-16.6	-16.4	-21.4	-21.4	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	100.0%	0.7%	1.4%	4.0%	8.7%	13.0%	13.0%	

Metrics Added

Metrics Amended

Safe Domain

Clostridioides difficile (Healthcare Associated)

Executive Lead: Chief Nurse

Performance Issue:

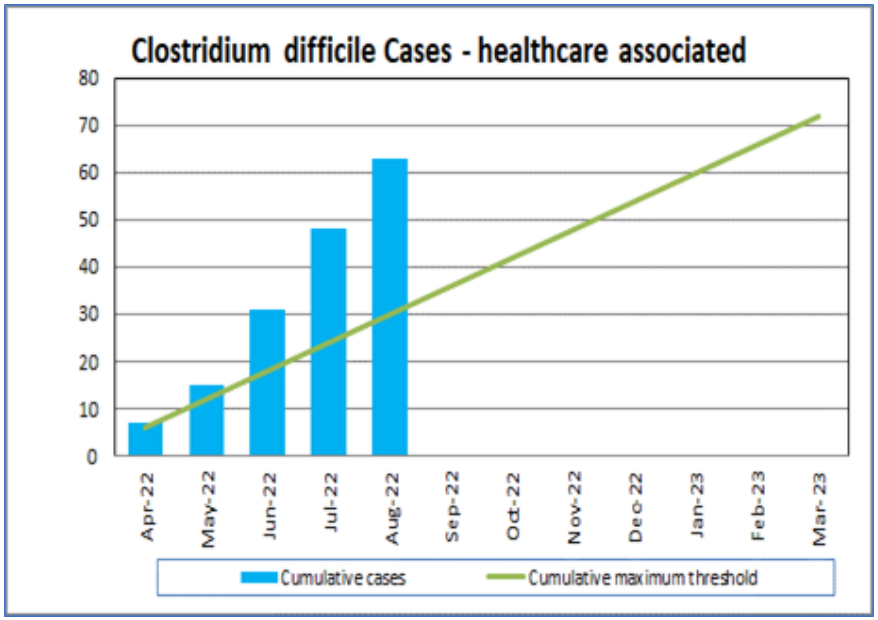
The threshold target set for healthcare associated *Clostridioides difficile* infections (CDI) for 2022-23 is 72 (equaling a monthly threshold of 6 cases).

The monthly threshold of 6 has been exceeded: 15 cases have been reported in August. A total of 63 cases since April 2022. This is 110% (33 cases) above the cumulative year to date threshold of 30.

Action:
Themes and key challenges have informed a Trust improvement plan that is governed through the IPC group and directly overseen by the Chief Nurse. The Trust's improvement plan has been shared with partners to inform the development of system wide improvements that will be overseen by the Health Protection Board for Wirral.

Engagement with Facilities to provide enhanced cleaning has resulted in strengthening shared processes and improved oversight to enable prompt action to be taken as necessary. Scrutiny of cases continue with a focus on identifying causative factors and learning opportunities for specific areas and to inform continued development of the Trust improvement plan. Divisional responsibility for progressing local improvements plans enables wards and department changes to occur without delay.

Key initiatives commenced in July continue; focus on prompt sampling, isolation of patients, use of environmental audits results to inform cleaning



practices and frequency, and the use of the new daily digital sit rep to improve overview of single rooms to provide a risk-based approach to patients who require isolation. Additional initiatives to commence are 'gloves off' campaign and a focus on patient hand hygiene.
Expected Impact: Reduction in patients diagnosed with healthcare associated *Clostridioides difficile* by Q4.

Gram-Negative bloodstream infections - *E-coli* bacteraemia

Executive Lead: Chief Nurse

Performance Issue:

For 2022-23 the Gram-negative blood stream infection objective has been separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, (the most recent available data at the time of calculating the figures).

The threshold for Gram-negative *E-coli* is set at a maximum 56 cases, with a monthly threshold of 4 per month. In August 10 patients were diagnosed with an *E-coli* bacteraemia.

Action:

Scrutiny of cases are taking place to determine causative factors and learning opportunities for improvements in practice to be made. A Senior IPC nurse attends the Patient Safety Learning Group to apply specialist knowledge to the scrutiny of cases and development of local remedial actions. Urinary management has been identified as a learning theme. Divisions are responsible for progressing the improvement plans, that are monitored at Divisional Quality Board meetings.

The IPC Trust improvement plan for *Clostridioides difficile* is commensurate to preventing the spread of *E-Coli*. In addition, a multi-disciplinary programme of work focusing on catheter care and aseptic non-touch technique (ANTT) to strengthen the prevention of device-associated infections is being developed.

Expected Impact:

The number of patients diagnosed with an *E-coli* blood stream infection is reduced to below the monthly threshold and the annual objective for 2021 – 2022 is achieved.

Gram-Negative bloodstream infections - klebsiella

Executive Lead: Chief Nurse

Performance Issue:

For 2022-23 the Gram-negative blood stream infection objective has been separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). The threshold for Gram-negative *Klebsiella* is set at 19 cases, with an alternating threshold of 1 and 2 per month for monitoring purposes.

There were 6 cases reported in August 2022, against a threshold of 1. Since April 2022 14 cases have been reported; this is 5 over a trajectory of 9.

Action:

Scrutiny of cases are taking place to determine causative factors and learning opportunities for improvements in practice to be made. Senior IPC nurse attends the Patient Safety Learning Group to apply specialist knowledge to the scrutiny of cases and development of local remedial actions. Divisions are responsible for progressing the improvement plans, that are monitored at Divisional Quality Board meetings.
The IPC Trust improvement plan for *Clostridioides difficile* is commensurate to preventing the spread of Gram- negative Klebsiella. In addition, a multi-disciplinary programme of work focusing on catheter care and aseptic non-touch technique (ANTT) to strengthen the prevention of device-associated infections is being developed.

Expected Impact:

The number of patients diagnosed with a *Klebsiella* blood stream infection is reduced to below the monthly threshold and the annual objective for 2022 – 2023 is to be achieved.

Safeguarding Audit

Executive Lead: Chief Nurse

Performance Issue:

A regular rolling audit program to provide assurance that Safeguarding practice is in line with national and local standards is in place. The audit is undertaken by the Safeguarding team and can be viewed as a stand-alone audit or part of WISE Ward Accreditation programme. The threshold of minimum 90% compliance was not achieved for August, with compliance recorded as 85%.

Action:

In August, 2 areas were audited (ward 38 and 11) by the Safeguarding team. Ward 38 achieved 100% and ward 11 achieved 70%.

Each area is reviewed against a set criterion which consider the care delivered to individual patients, staff knowledge and application of knowledge in the care setting. Detailed improvement plans are completed by the area and overseen by the Divisional Leadership Team with support as necessary from the Corporate Nursing team. Bespoke training and education specific to the audit findings has been provided by the Safeguarding team and the Ward Manager has been supported to strengthen processes and areas of oversight to enable required improvement.

The safeguarding inspection is now available on Tendable for Ward Managers to use as part of the self-assessment improvement plans, although their self-assessment scores are not used for reporting.

Expected Impact:

The expectation is for each area to achieve greater than 90% within their safeguarding audits.

Sickness absence % (in-month rate)

Executive Lead: Chief People Officer

Performance Issue:

The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. Sickness absence in August 2022 was 5.98%. Of this 0.69% is related to COVID-19. Whilst there have been peaks of sickness absence, mainly due to increases COVID-19 related absence, there has been an overall improvement since January 2022.

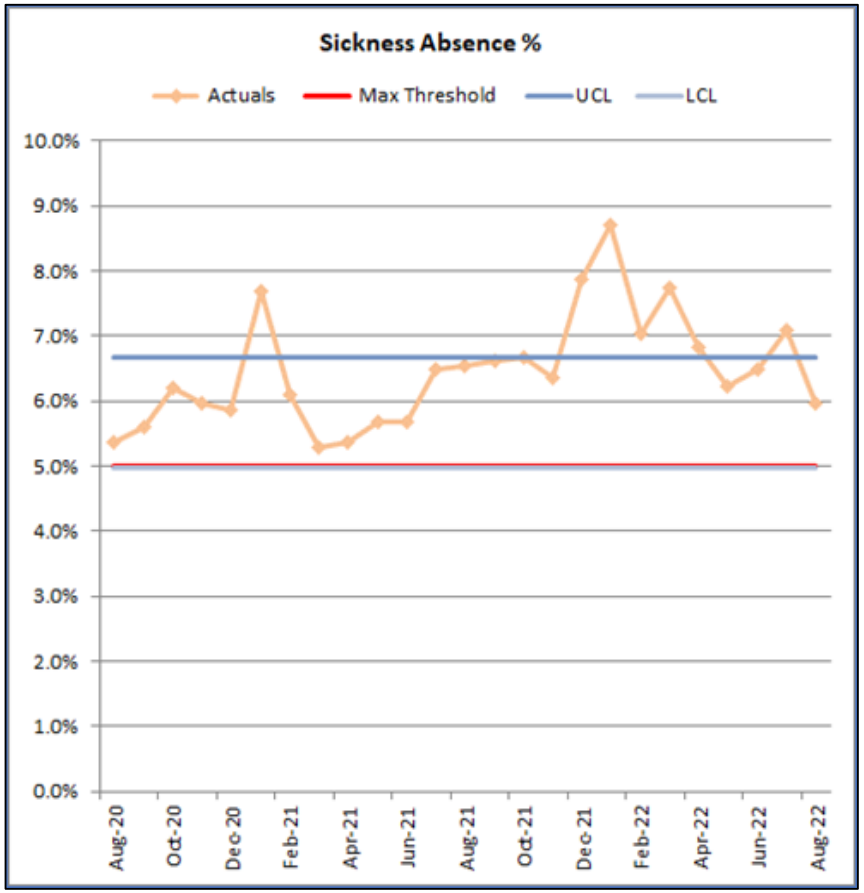
All Divisions, except for Corporate, in August 2022 have exceeded the 5% KPI, however they have all seen a reduction in sickness absence.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The category 'Gastro Problems' was the highest reported reason for short-term sickness, followed by 'Infectious Diseases'.

Action:

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews (DPRs). All Divisions have reintroduced Sickness Auditing to ensure the Attendance Management Policy is being consistently applied at departmental level.

Managers continue to be supported by HR and are heavily focusing on short term sickness and targeting hot spot areas with high episodes of sickness absence and rolling sickness absence. A new approach is being trialed in Women and Children and Acute Division to instill better governance and a data led approach to short term sickness, ensuring that the Attendance Management policy is being applied consistently and in a timely manner. It will continue to be developed over time and if proven to be beneficial it will be rolled out to other areas.



People Strategy
Significant progress has been made in relation to the 'year 1' deliverables against the four key principles (Looking After Ourselves and Each Other, Belonging at WUTH, Transforming Ways of Working and Shaping Our Future). The collectively delivery against the strategic priorities are expected to have a positive impact the Trust's ability to achieve the 5% sickness absence target.

Workforce Wellbeing
We continue to focus on the implementation of support provisions and improvements in the areas of Physical Health, Mental Health, Morale boosters and Enabling Resilience. Wellbeing Surgeries take place every three months with each focusing on a particular theme chosen by staff.
The Health and Wellbeing Conversations continue to be promoted across the Trust and uptake monitored via recording on ESR.

Flu Vaccination Programme
We are currently awaiting delivery of vaccine stock to commence this year's programme. Training is underway for existing staff to support the programme this year.

Expected Impact:

The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety.

Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over time. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover % (12-month rolling average)

Executive Lead: Chief People Officer

Performance Issue:

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover was 13.92% for the rolling 12 months to August 2022. Rolling 12-month turnover to August 2022, calculated on permanent assignments only, is 12.01%. The Trust in-month performance is 1.77% - 0.94% over target.

All Divisions are over the 10% KPI for the rolling 12 months. Acute Division have the highest turnover at 16.7%.

The most commonly occurring voluntary reasons for leaving were attributed to:

- Work Life Balance
- Relocation

Actions:

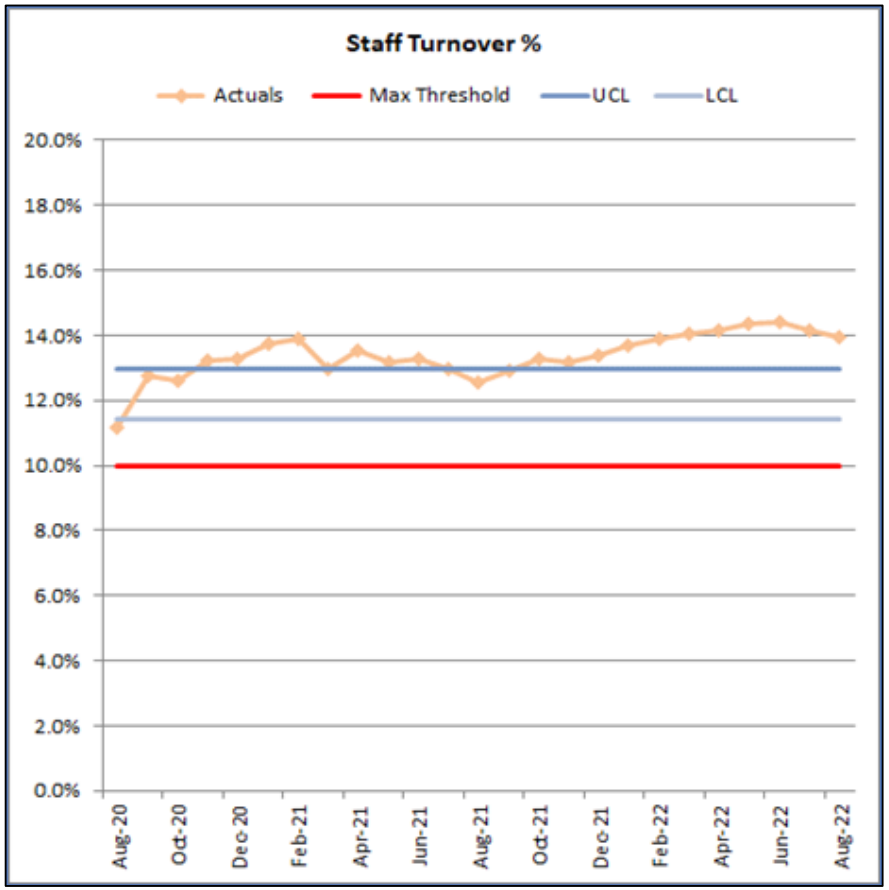
Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs), with specific actions in place according to the local feedback.

<u>Current Interventions to support retention.</u>

Significant progress has been made by the Retention Workstream in relation to Q1 and Q2 deliverables.

Q2 ongoing activities include:

- Development of a Retention Delivery Plan to capture activities across functions, task and finish groups and the Trust Strategic Retention Group



- Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan.
- Ongoing links with NHS England and NHS Improvement's National Retention Programme Team. Specifically linking in with the Retention Manager for the Northwest and ICB to obtain good practice.
- Terms of reference and membership of the Strategic Trust Retention Group and the 4 Task and Finish Groups.
- Nursing Task and Finish Group collaborating with Recruitment for the introduction of an internal transfer option for nursing Band 5 roles.

<u>CSW Apprenticeships</u>

There are five cohorts planned for this financial year. The aim is to recruit between 15-20 on each cohort. Two cohorts have started, one in August and one in September. The next cohorts are due in November 2022, January 2023 and March 2023. Additional resourcing has been implemented to provide pastoral support to CSW apprentices to support them in their development pathways and improve attrition.

The Trust is currently on target with its recruitment campaigns, recently recruiting individuals for the November start date.

To supplement the planned cohort, start programme, the apprenticeship pathway is supporting the wider Trust when recruiting CSWs. If successful applicants who do not hold the essential qualifications and/or suitable/relevant experience, then applicants are offered an apprenticeship position. Since its integration in May, 18 applicants have been signposted via this process.

At present we have had 5 cohort start with a 6-month retention rate of 88%.

Expected Impact:

The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety.

Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should reduce as Turnover improves over time with the interventions outlined above.

Care Hours Per Patient Day – number of wards below 6.1

Executive Lead: Chief Nurse

Performance Issue:
The Trust monitors the number of wards that are below a care hours per patient day (CHPPD) threshold of 6.1. The metric for the Trust overall is set at a maximum of 3 wards to be below this threshold.

The number of wards for August 2022 was 7: Ward 20 = CHPPD 6; Ward 26 = CHPPD 6; Ward 37 = CHPPD 6; Ward 36 = CHPPD 5.9; Ward 38 = CHPPD 5.7; M1 Rehab = CHPPD 5.7, Ward 22 = CHPPD 5.7.

Action:
The Trust has a series of robust safer staffing review measures in place. A CHPPD tracker is one such measures, introduced in May 2022 to monitor if any areas are consistently recording CHPPD <6.1. This CHPPD data is triangulated with further staffing metric data to monitor the impact on care.

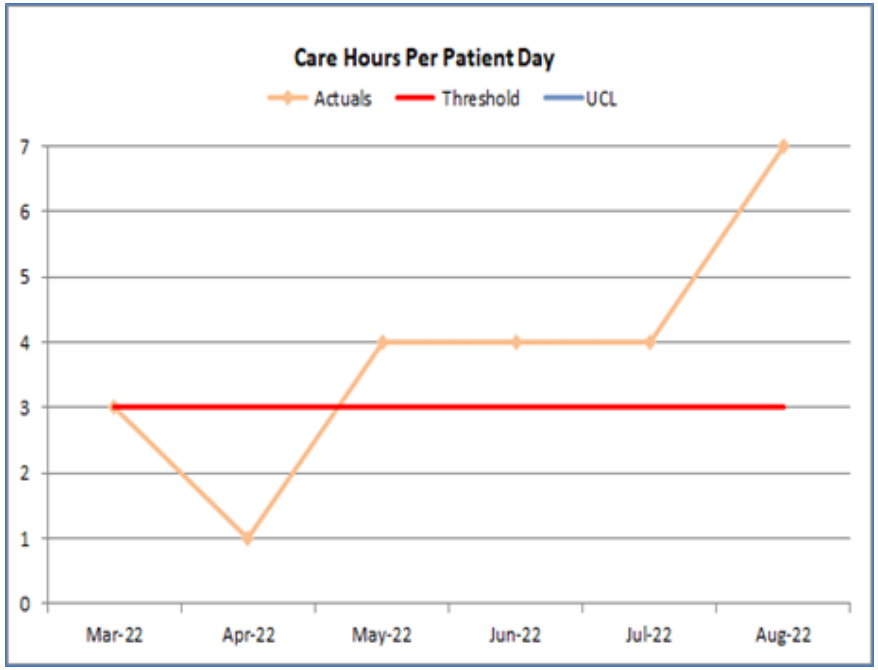
3 of the wards who had a CHPPD of <6.1 had a variance of 0.1 this is equivalent to 6 minutes of care.

Ward 38 staffing levels has had a CHPPD consistently below 6.1 since November 2021. This is a result of clinical support worker (CSW) shortfalls due to staff moves to support higher risk staffing challenges across the Trust.

Ward 36 have had a CHPPD of <6.1 since May 22 variance has been minimal with 2 months at 5.9 and 2 months at 6.

Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD. The Trust has a targeted CSW recruitment campaign, as well as working with partners to support the recruitment of CSW's. In addition, CSW apprenticeship programs continue to be promoted to enable the Trust to maintain low CSW vacancies.

Expected Impact:
A reduction in the number of wards with a consistent CHPPD of <6.1 by Q4.



Effective Domain

Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall August performance was 84.7%, just below the threshold and up from July's 82.0%.

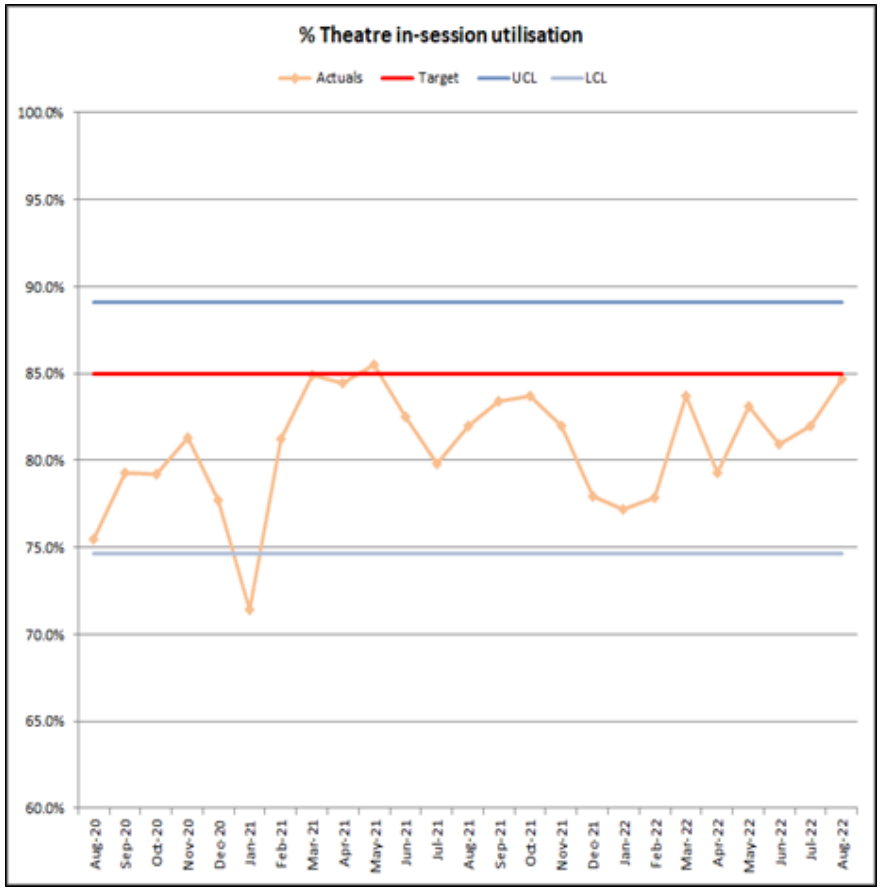
Focus remains on improving utilisation of core sessions as part of reset and recovery. August saw an overall reduction in on the day cancellations, with most being non-clinical, due to a lack of operating time. Perioperative Programme has been refreshed and key focus is E-Booking to ensure list planning is accurate using surgeon defined operating time.

Theatre scheduling meeting remains locked down to 3 weeks (barriers to 4 weeks includes anaesthetic cover and theatre staffing (vacancies in ODPs, Ortho Staffing, and increased sickness. Service teams have been challenged to book out to 4 weeks, which is almost achieved with one specialty booked to 5 weeks. This aids theatre planning and reduces, both DNAs and cancelations on the day.

The formation of a protected EL bed base on Ward 14 as reduced the likelihood of cancelation for no bed.

Action:

- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation
- Identifying a "golden patient" for each theatre to prevent late starts and list over runs.
- Continue to attempt to deliver above core capacity through backfills and additional requests for sessions



• Continue with revamped TRG meetings to support increase in planned session utilisation
Expected Impact: Increase in in session utilisation and increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should deliver same sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

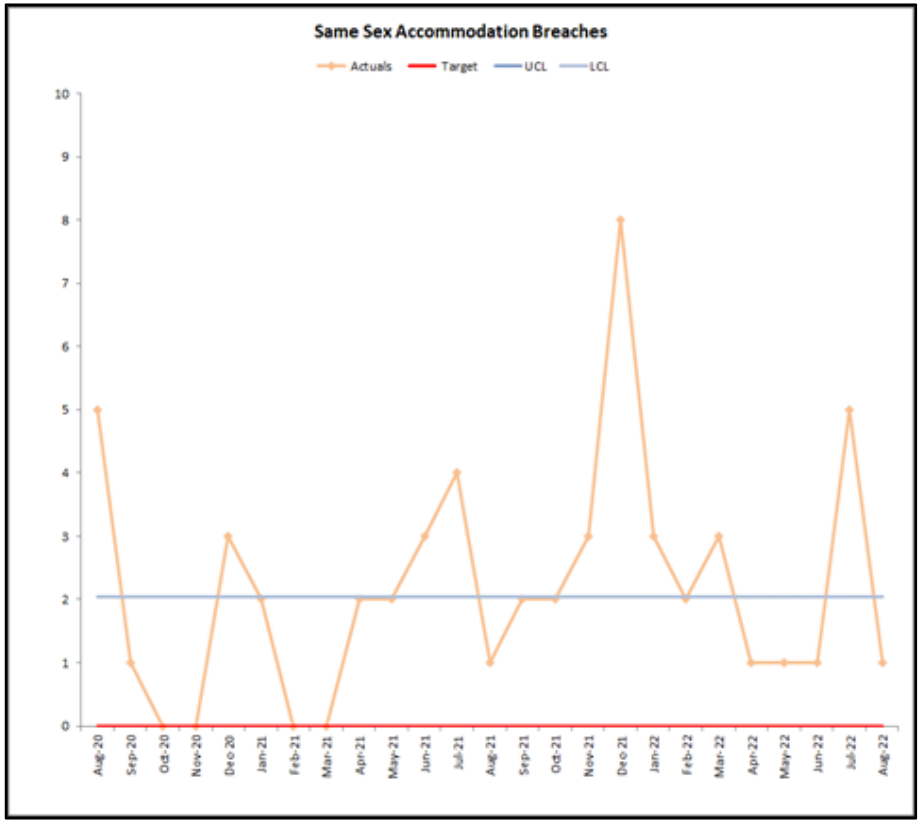
Same sex accommodation breaches are most often due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there was 1 such breaches in August 2022. This did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed capacity was available at this time. Patient's privacy and dignity needs are met whilst in critical care and the team ensures their specialty care is not compromised due to a lengthened critical care stay.

Action:

Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in August 2022.
Joint working processes are in place between Critical Care Unit, Patient Flow Team and Divisional Directors to expedite critical care stepdown. This includes daily oversight of individual patients requiring a stepdown indicating and the length of time waiting.
Robust processes remain in place to ensure that delivering same sex accommodation continues to be a high priority and that breaches are managed promptly via bed capacity and operational meetings.

Expected Impact:

All patients are transferred to their specialty bed within 24 hours of discharge.



Friends & Family Test – Overall Experience

Executive Lead: Chief Nurse

Performance Issue:

A Trust standard of 95% is set for achieving an overall experience rating of very good or good for each of the main care settings.

Performance against the 95% threshold for August 2022 was:

- Emergency Department (ED) – 78.2% (below threshold)
- Outpatients – 94.1% (below threshold)
- Inpatients – 94.6% (below threshold)

Maternity 100% (better than threshold)

Action:

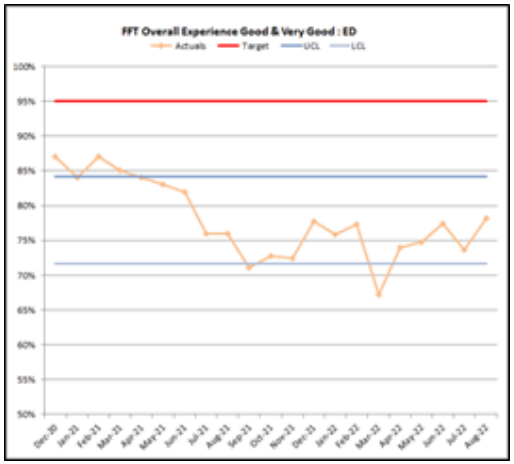
Consistent with the national position, operational pressures within ED continue. FFT scores have made a slight improvement this month from 73.6% in July to 78.2% in August but remains below threshold. The negative feedback focuses on waiting times as previously reported.

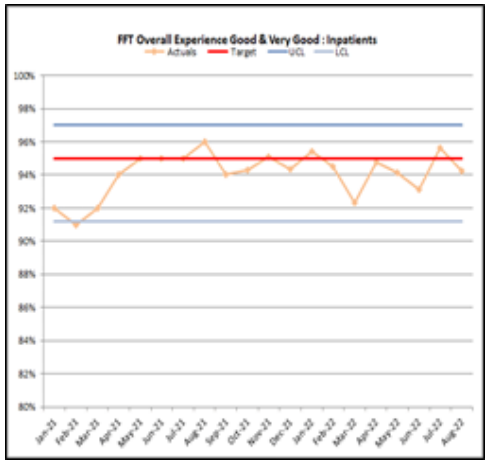
Effective communication to patients is a priority focus for the Divisional Triumvirate. Digital methods of informing patients of the current length of wait and key messages will be available this month.

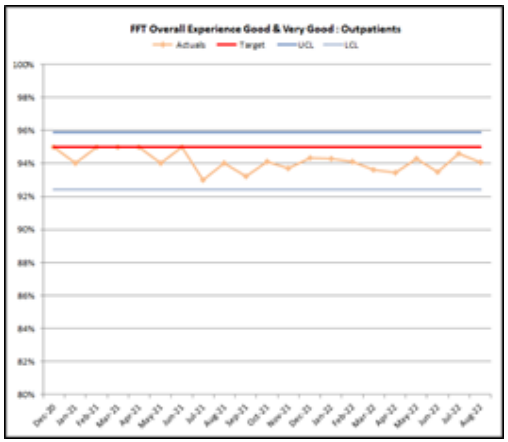
The Trust's Patient Experience Strategy, launched on 4 April 2022, has 5 strategic promises; Welcome, Safe, Inclusive, Care, and Supported. Promise action groups have commenced with a focus on identifying patients' experience improvement opportunities.

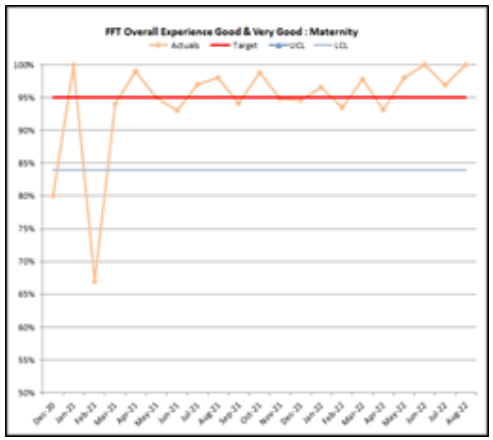
Expected Impact:

Improved FFT scores within the Emergency Department and an expectation to reach the Trust target for Outpatients in Q4.









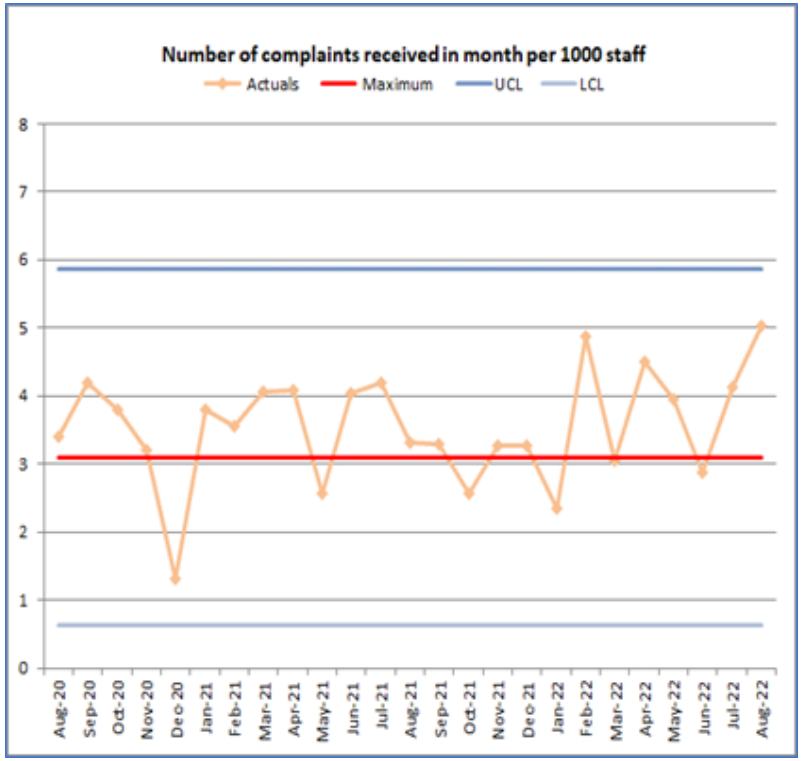
Responsive

Number of complaints received in month per 1000 staff

Executive Lead: Medical Director

Performance Issue:

WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for August 2022 was 5.02



Action:

The Trust's complaints numbers (5.02 per 1000 staff) remain below the national average for acute trusts in England, which in the fourth quarter of 2021/22 was 19.9 per 1000 staff (source NHS Digital, K041 data). For our 7 neighboring acute trusts, the average was 11.7. Nationally, in 2021/22 there was a 26% rise in complaints over 2020/21 (although 7% lower than pre-pandemic numbers).

In line with this national trend, the number complaints logged in August 2022 has once more risen from previous months, with the average number of monthly complaints logged year-to-date up 29% from 2021/22.

During August 2022, 29 new formal complaints were registered and 25 closed complaints.

Divisions have localised plans to address the main continuing causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these might be addressed, as well as any seasonal surges in numbers.

The Deputy Director for Quality Governance has introduced a weekly complaints management meeting attended by all divisions. The purpose of

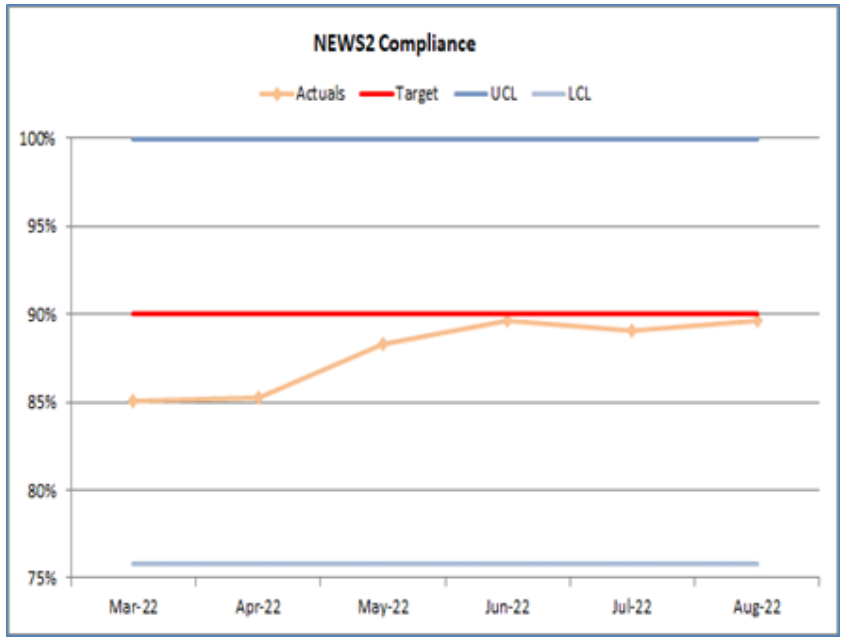
the meeting is to support management of complaint responses and to identify and address barriers to completion as early as possible.
Expected Impact: Not applicable.

NEWS2 Compliance

Executive Lead: Chief Nurse

Performance Issue:

A threshold of greater than 90% compliance with NEWS2 patient observations conducted within national guidelines and Trust NEWS2 policy has been set. Compliance is measured by a rolling programme of monthly ward audits: sustained improvement has been achieved since April 2022; August 2022 compliance was just below target by 0.4% at 89.6%.



Action:

Two workstreams to support an increase in compliance with the recording of NEWS2 observations continues:

The fast-track improvement programme has provided enhanced communications in the form of a 'Deteriorating Patient Take 5' poster and a created a live report from the Trust's electronic patient record that identifies each ward / department NEWS2 compliance status. The introduction of integrated systems to enable observations to be recorded on modified observations machines to instantly migrate into patient medical records, increasing compliance is in progress. The process has been introduced whereby the Corporate Nursing Team Clinical Practice Facilitator reviews patients that are scoring NEWS2 observation of either 5 – 6* or 7* and above and feeds back directly to ward staff enabling improvements to be made. A monthly report will be sent to the Divisional Nurse Directors for divisional level oversight.

The Deteriorating Patient Faculty, led by the Chief Nurse, has overseen quality improvement projects. One initiative has proved to be successful from the outset, resulting in the roll out of a trust wide change. The observational live report (available on BiPortal) identifies patients whose NEWS2 observation have ran over the recording time. Using this

information as a supplement to the nursing worklist enables patient needs to be responded to and has saved nursing time.
Expected Impact: The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

Well-led Domain

Appraisal compliance %

Executive Lead: Chief People Officer

Performance Issue:

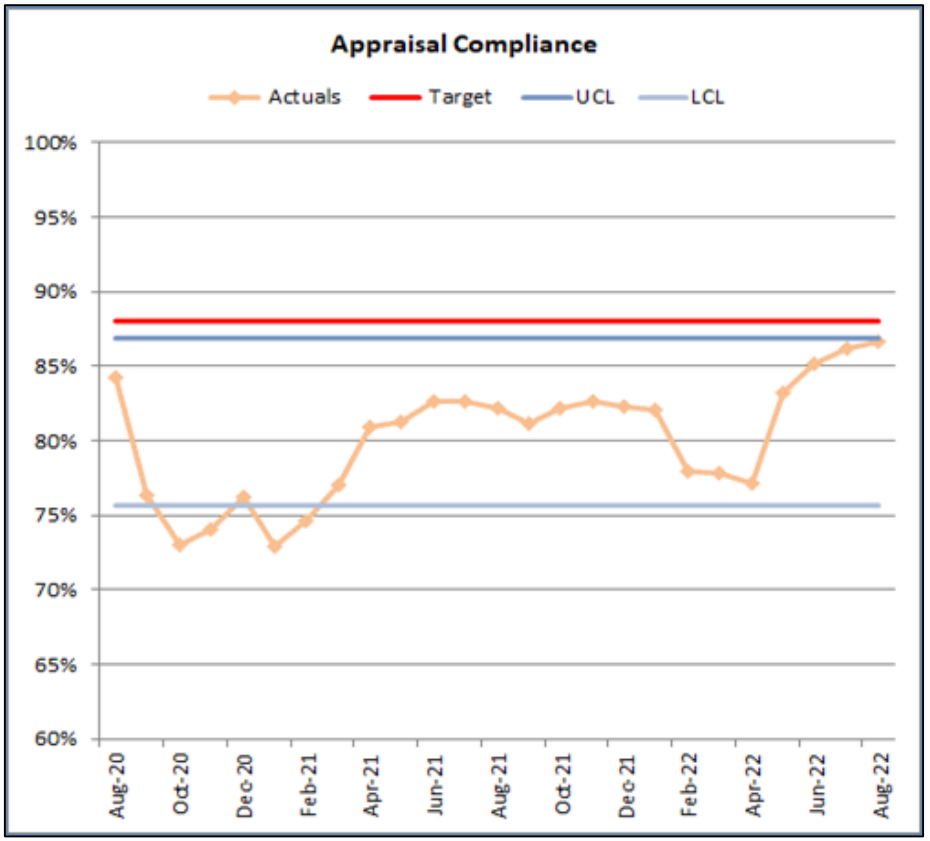
The target for annual appraisal compliance is 88%. Compliance continues to improve. At the end of August 2022 86.7% of the workforce had received an appraisal in the last 12 months.

From a Divisional perspective, both Diagnostics and Clinical Support Division and Women and Children's Division have achieved the Trust target. Acute division are the lowest with 74.04% compliance however the division are achieving above their agreed improvement trajectory.

Please note that medical appraisal is currently excluded from the above figures

Action:

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas. In addition, managers are provided with alerts of appraisals due generated via the ESR system. HR Business Partners continue to support Divisional Management teams to identify opportunities for improvement and to deliver actions to address low levels of compliance in specific areas. Increased focus upon appraisal compliance is being placed at Divisional Performance Review (DPR) meetings. All Divisions have produced improvement trajectories and have confirmed expected date of compliance to Trust Management Board. This is closely managed via Divisional Performance Reviews. Acute division will be provided with additional support to address a backlog in recording appraisals onto ESR.



The review of appraisal has concluded and a proposal with recommendations to transform the current process was approved at Workforce Steering Board on 25th August 2022. This work stream, which forms part of the People Strategy deliver for 2022/23 will shift emphasis from performance review and performance rating to one that is more congruent with Trust values. The new person-centered process will focus upon an individual's contribution (including performance), their development and their wellbeing. It will also seek to measure the quality of appraisal and supervision discussions alongside compliance figures to enhance the assurance provided to Board that staff are having a quality experience. Plans are in place to pilot the new process in quarter 3 and 4 of 2022/23 and launch in April 2023. The newly developed Manager Essentials programme has launched. This includes training for managers on appraisal and management supervision.
Expected Impact: Whilst actions will continue to increase compliance within the existing appraisal framework, the longer-term solution for maintaining compliance is to place a longer-term focus on quality improvement. It is acknowledged that any increase in clinical pressures may create continuing challenges in maintaining appraisal completion rates over forthcoming months.

Board of Directors in Public
5 October 2022

Item No 9.2

Title	M5 Finance Report
Area Lead	Mark Chidgey, CFO
Author	Robbie Chapman, Deputy CFO
Report for	Information

Report Purpose and Recommendations

At Month 5 (M5) the Trust is reporting a deficit of £2.435m which is an adverse variance against budget of £3.129m. Whilst the Trust continues to forecast a break-even position, achievement of this should be considered as at risk by the Board and a revised annual forecast will be provided to the Finance Committee and Board in November.

The year to date variance remains primarily attributed to overspends on employee costs, driven by:-

- under-delivery of recurrent CIP
- the continued use of escalation wards, staffed at premium rates.
- the additional costs of employing Consultants and Junior Doctors at Agency rates of pay.

The Trust has been able to partially, but not fully, mitigate these overspends by non-recurrent mitigations such as the release of deferred income and underspends in non-pay resulting from reduced elective activity.

As agreed across the ICS, the financial position assumes that the Trust will retain 100% of the Elective Recovery Fund (ERF) income. This is a risk to the forecast because national policy on this may change and performance against the agreed elective plan is significantly below the target level of 104% of 19/20 levels.

It is recommended that the Board of Directors:

- Notes the report.

Key Risks

This report relates to the following key risk:

- PR3: failure to achieve and/or maintain financial sustainability.

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

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

Governance journey
This is a regular update provided to each Board meeting.

Month 5 Finance Report 2022/23

Contents

1. Executive Summary

1.1 Table 1: Financial position – M5

Month 5 Financial Position	In Month (£'000)			Year to Date (£'000)		
TRUST	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Income from Patient Care Activities	£33,200	£33,114	-£87	£166,000	£165,967	-£34
Other Income	£3,472	£3,826	£354	£17,191	£19,225	£2,033
Total Income	**£36,672**	**£36,939**	**£267**	**£183,192**	**£185,191**	**£2,000**
Employee Expenses	-£25,274	-£26,219	-£945	-£126,489	-£130,305	-£3,816
Operating Expenses	-£11,247	-£11,137	£110	-£56,649	-£53,511	£3,138
Total Operating Expenditure	**-£36,521**	**-£37,356**	**-£835**	**-£183,138**	**-£183,816**	**-£678**
CIP	£1,571	£1,524	-£47	£7,858	£3,851	-£4,007
Total CIP	**£1,571**	**£1,524**	**-£47**	**£7,858**	**£3,851**	**-£4,007**
Non Operating Expenses	-£1,443	-£1,562	-£119	-£7,217	-£7,661	-£444
Surplus/(Deficit)	**£278**	**-£455**	**-£733**	**£694**	**-£2,435**	**-£3,129**

1.2 The Trust is reporting a deficit of £2.435m at M5, an adverse variance against plan of £3.129m.

1.3 Total income was £185.191m at M5, a positive variance of £2.000m. This relates to the release of deferred income in respect of international nurse recruitment and teledermatology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are offset by increases in expenditure. Income is discussed in more detail in 3.1.

1.4 The Trust is at risk of financial penalties for any underperformance in respect of the elective programme at 75% of the value. We estimate the potential risk at M5 to be penalties of £4.002m. This is not reflected within the position. This is discussed in more detail from 3.1.3.

1.5 Total employee expenses were £130.305m at M5, this represents an overspend against our budget of £3.816m. The overspend against plan is discussed in more detail at 3.2.1 but is primarily driven by the continued reliance on premium cost medical agency staff and use of escalation wards, together with the under-delivery of pay CIP.

Table 2: Pay cost analysis

Pay Analysis	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,142	-£4,350	-£208	-£20,723	-£21,070	-£347
Other medical	-£2,707	-£3,148	-£441	-£13,518	-£14,672	-£1,154
Nursing and midwifery	-£7,154	-£7,708	-£555	-£36,012	-£38,851	-£2,838
Allied health professionals	-£1,396	-£1,481	-£85	-£6,970	-£7,203	-£233
Other scientific, therapeutic and technic	-£588	-£548	£40	-£2,937	-£2,797	£140
Health care scientists	-£1,145	-£1,116	£29	-£5,732	-£5,508	£223
Support to clinical staff	-£4,659	-£4,787	-£128	-£23,276	-£24,000	-£724
Non medical, non clinical staff	-£3,390	-£2,988	£402	-£16,852	-£15,731	£1,121
Apprenticeship Levy	-£94	-£92	£2	-£469	-£472	-£3
Total	**-£25,274**	**-£26,219**	**-£945**	**-£126,489**	**-£130,305**	**-£3,816**

1.6 Operating expenses were £53.511m at M5, an underspend of £3.138m. This is reflective of reduced elective activity, most notably within the Surgery division, and lower than expected spend with the independent sector. This is discussed in more detail from 3.3.1.

1.7 The Trust has delivered £1.129m of recurrent CIP at M5, an adverse variance of £4.552m. This is discussed in more detail from 3.5.

1.8 Cash balances at the end of M5 increased to £32.628m. We are forecasting to hold £4.815m at year end.

1.9 The Trust has recorded a capital spend of £5.937m at M5 compared to an expected spend of £13.779m, a variance in plan of £7.842m. The biggest contributing factors to this under-spend are delays in approval in respect of UECUP and Phase 2 of the Modular Theatres. We are forecasting to spend our entire capital budget by year end.

2. Risk

2.1 The revised Oversight Framework does not require us to report our Use of Resources rating. We do, however, believe that there are two previously reported indicators (cash liquidity and agency spend) that warrant inclusion in this report.

2.2 Cash liquidity at 31 August 2022 was -21.47 days which is a deterioration from M4 (-16.4 days). The Trust's deficit is putting greater pressure on cash and further deterioration of this metric.

2.3 The agency spend cap is expected to be monitored at ICS level from M6 onwards, with all Trusts expected to reduce expenditure on Agency by 10% from the prior period. Agency spend at M5 is £4.275m which is £2.922m above budget and a 5.2% increase against 21/22. By way of comparison the cap would be £3.657m, so we are £0.618m above the target. This is explained in more detail at 2.5.4.

2.4 **Risk summary (as per risks identified in risk register)**

2.4.1 Risk 1 – Failure to deliver financial position

- Our ability to deliver the planned deficit is dependent on effective cost management, CIP delivery and the delivery of activity trajectories. Our financial performance in M5, the limited progress against the CIP plan (see below) and potential clawback against ERF all indicate that this risk has increased.

2.4.2 Risk 2 – Failure to deliver CIP

- The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently. We are forecasting £5.488m in respect of recurrent CIP, a shortfall against plan of £8.148m. At M5 only £1.129m CIP has been transacted recurrently and £2.330m has been transacted non-recurrently.

2.4.3 Risk 3 – Failure to complete capital programme

- Our capital expenditure envelope for 22/23 totals £44.851m which will be the largest capital programme the Trust has delivered in one financial year. The internally generated capital plan for 22/23 totals £9.765m and is described in more detail at 4.2.

2.5 **Risk summary (as per risks identified in budget report)**

2.5.1 CIP

- Failure to deliver CIP remains our most significant risk and achievement so far this year indicates this risk has increased. Please see 3.4 for more detail.

2.5.2 Shortfall in funding

- With all funding confirmed, the most significant risk in respect of funding is any potential clawback in respect of ERF. This is discussed in more detail from 3.1.3.

2.5.3 Activity below plan

- As at M5, the Trust has delivered £5.335m less elective activity than plan, resulting in potential clawback of £4.001m. Despite the fact that all but one of the theatres are now back in use, it will not be possible to recover all of the lost activity in the remaining

months of the year. The risks and opportunities associated with potential clawback are discussed from 3.1.3.

2.5.4 Reliance on agency staff

- Workforce information indicates that the reliance upon high cost agency staff has reduced from the peak in M1 and M2 but remains higher than plan, principally due to the numer and high cost of specialist doctors in Medicine and Surgery and the continued use of escalation wards.

2.5.5 Inflation

- Inflation continues to run significantly higher than forecast and despite receiving funding equivalent of 0.7% increase in tariff (£2.682m) this is likely to be offset by further increases in energy costs alone. A detailed piece of work is being completed in respect of energy costs and will be incorporate into the M6 forecast.

2.5.6 COVID-19

- The Trust has spent less on COVID-19 at M5 than plan. Please see from 3.3.4 for more detail.

3.1 **Income**

3.1.1 The Trust has received £185.191m at M5, a positive variance of £2.000m.

Table 4: Income analysis for M5

	IN MONTH			YEAR TO DATE		
Point of Delivery	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Elective & Daycase	£4,408	£4,522	£114	£24,956	£20,642	-£4,315
Elective excess bed days	£94	£41	-£53	£506	£370	-£137
Non-elective	£8,579	£9,671	£1,092	£44,601	£45,955	£1,353
Non-elective Non Emergency	£1,115	£1,199	£85	£5,787	£5,543	-£244
Non-elective excess bed days	£531	£446	-£85	£2,747	£2,323	-£424
A&E	£1,427	£1,386	-£41	£7,312	£7,160	-£152
Outpatients	£3,474	£3,624	£150	£18,361	£18,590	£229
Diagnostic imaging	£282	£255	-£26	£1,486	£1,163	-£324
Elective Recovery Fund	£899	£899	£0	£4,493	£4,493	£0
Maternity	£439	£423	-£16	£2,068	£2,140	£72
Non PbR	£6,802	£8,549	£1,747	£34,511	£31,273	-£3,238
HCD	£1,485	£1,452	-£33	£7,579	£7,554	-£26
National Top up	£2,328	£2,328	£0	£11,641	£11,641	£0
Other	£1,338	-£1,683	-£3,021	-£48	£7,123	£7,170
Sub-Total Clinical Income	**£33,200**	**£33,114**	**-£87**	**£166,000**	**£165,967**	**-£34**
Other patient care income	£239	£1,009	£769	£1,215	£2,229	£1,014
Non-NHS: private patient & overseas	£24	£15	-£9	£122	£77	-£45
Injury cost recovery scheme	£43	£33	-£10	£216	£294	£79
Total Patient Care Income	**£307**	**£1,057**	**£750**	**£1,553**	**£2,600**	**£1,047**
Other operating income	£3,165	£2,769	-£396	£15,638	£16,625	£987
Other non operating income	£0	£0	£0	£0	£0	£0
Total Other income	**£3,165**	**£2,769**	**-£396**	**£15,638**	**£16,625**	**£987**
Total income	**£36,672**	**£36,939**	**£267**	**£183,192**	**£185,191**	**£2,000**

3.1.2 Clinical income at M5 was £165.967m, a negative variance against budget of £0.034m. However, as shown in the table, income is lower than budget across a larger number of activity categories and this is offset by back to block, system top up monies (under "National Top Up") and other, which includes release of non-recurrent deferred income. Whilst this does not represent the same risk that would be the case under full Payment by Results, the introduction of AIP does mean that underperformance against activity should have had an impact on the Trust's financial position.

3.1.3 Income includes 5/12ths of the Trust's allocation of Elective Recovery Funding (ERF) which is to support delivery of 104% of 2019/20 elective activity thereby reducing the length of time patients are waiting for treatment. The baseline is calculated using 104% of 19-20 trust activity valued at 22-23 tariffs as per the national guidance. As per the guidance, the Trust's funding should be adjusted up or down by 75% of tariff if actual activity delivered is above or below the 104% baseline value.

3.1.4 At M5 the elective baseline is £45.774m and the actual M5 activity valued at national and local tariffs is £40.438m, this includes capping the outpatient follow ups at 85% of the baseline as per the published guidance. Therefore, at M5 the Trust is £5.335m below the baseline with 75% of this is at risk of being recouped by the ICB (as a commissioner), which equates to £4.001m. Table 5 below demonstrates the position at M5.

Table 5 Comparison of actual performance against 19/20 baseline

	Cumulative Position at M5			
	Plan	Actual (inc FUPs @ 85% of 19/20 levels)	Variance	75% up or down
Day cases	£13,318,787	£12,089,778	(£1,229,009)	(£921,756)
Elective	£10,734,254	£8,898,051	(£1,836,203)	(£1,377,153)
OP Procedures	£2,357,010	£1,592,801	(£764,209)	(£573,157)
OP First Attendances	£9,612,390	£9,887,617	£275,227	£206,420
OP Follow Up Attendances	£9,752,211	£7,970,557	(£1,781,654)	(£1,336,240)
	£45,774,653	**£40,438,804**	**(£5,335,848)**	**(£4,001,886)**

3.1.5 However, as of M5 we have been directed by NHSE not to include provision for any adjustment for under-performance against this target.

3.1.6 In line with national guidance, the financial plan assumes Car Parking income will revert back to pre COVID-19 level (i.e. patient and staff charges will be reintroduced). The Trust reintroduced charges for parking on the 1st September but the suspension of charging until M5 created an adverse variance of £0.220m.

3.2 Expenditure: Pay

3.2.1 The Trust has spent £130.305m on pay costs at M5, an overspend of £3.816m. Table 6 details pay costs by staff group, Table 7 details WTE by staff group and Table 8 details pay costs by pay category type.

Table 6: Pay costs by staff type

Pay Analysis	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,142	-£4,350	-£208	-£20,723	-£21,070	-£347
Other medical	-£2,707	-£3,148	-£441	-£13,518	-£14,672	-£1,154
Nursing and midwifery	-£7,154	-£7,708	-£555	-£36,012	-£38,851	-£2,838
Allied health professionals	-£1,396	-£1,481	-£85	-£6,970	-£7,203	-£233
Other scientific, therapeutic and technic	-£588	-£548	£40	-£2,937	-£2,797	£140
Health care scientists	-£1,145	-£1,116	£29	-£5,732	-£5,508	£223
Support to clinical staff	-£4,659	-£4,787	-£128	-£23,276	-£24,000	-£724
Non medical, non clinical staff	-£3,390	-£2,988	£402	-£16,852	-£15,731	£1,121
Apprenticeship Levy	-£94	-£92	£2	-£469	-£472	-£3
Total	**-£25,274**	**-£26,219**	**-£945**	**-£126,489**	**-£130,305**	**-£3,816**

Table 7: WTE by staff type

Pay Analysis	WTE		
	Budget	Contracted	Actual
Consultants	288.90	272.74	284.59
Other medical	371.37	423.73	443.68
Nursing and midwifery	1,690.52	1,610.74	1,724.12
Allied health professionals	334.14	325.83	343.81
Other scientific, therapeutic and technic	113.82	111.23	108.45
Health care scientists	283.34	276.29	274.51
Support to clinical staff	1,815.72	1,760.31	1,947.85
Non medical, non clinical staff	1,135.51	1,053.64	1,111.80
Apprenticeship Levy	-	-	-
Total	**6,033.32**	**5,834.51**	**6,238.81**

Table 8: Pay costs by pay category (excluding COVID)

Trust	IN MONTH			YEAR TO DATE		
Month 5 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Substantive	-£24,276	-£22,772	£1,504	-£121,498	-£114,495	£7,003
Waiting List	-£103	-£143	-£40	-£515	-£647	-£132
Bank	-£211	-£1,381	-£1,170	-£1,053	-£6,894	-£5,841
Medical Bank	-£320	-£971	-£651	-£1,601	-£3,521	-£1,920
Agency	-£270	-£859	-£589	-£1,353	-£4,275	-£2,922
Other Employee	-£94	-£92	£2	-£469	-£472	-£3
Total Employee Expenses	**-£25,274**	**-£26,219**	**-£945**	**-£126,489**	**-£130,305**	**-£3,816**

3.2.2 The biggest overspends in month related to Medicine (£0.352m in month, £1.822m YTD), Acute (£0.554m in month, £0.1.497m YTD) and Surgery (£0.328m in month, £1.659m YTD).

3.2.3 The pay pressure in Acute is partly attributable to ED Nursing and the continuing need to provide care for patients on corridors due to flow pressures throughout the hospital.

This is being provided by premium cost bank and agency staffing, at an approximate cost of (£0.110m) per month. There is also sickness in excess of the trust target (8% in July against a target of 5%) and maternity leave (4 WTE) contributing to increased levels of bank and agency usage.

3.2.4 The other principal variance relates medical staffing across Acute (£0.410m in month and £0.683m YTD). This is being driven by vacancies, rota gaps and the ongoing need to pay escalated rates to fill these gaps. There was an increase in medical bank spend in M5 of (£0.193m) versus M4 across the Division and patchwork filled shifts increased by 30%. This was the highest number of filled shifts seen since the introduction of patchwork and 96% of these shifts were paid at an escalated rate. The significant increase in month was due to the F2 rotation and additional cover provided from 3rd August to 22nd August. Plans for future rotations are currently being considered.

3.2.5 The pressure in Medicine is largely attributable to unfunded escalation costs (£0.284m in month & £1.510m YTD) for additional beds on W26, M3 and HDU contingency and associated medical cover for these areas. Plans for de-escalation of the unfunded ward areas or the ability to staff them in a more cost effective way are currently being worked up, however, this is being impacted by the non-achievement of criteria to reside reductions across the system. There are also increased costs at junior medical staffing level (£0.043m in month) from filling vacancies, sickness, and rota gaps at escalated and agency rates. Work is ongoing with medical staffing to review rotas and plan for gaps in a more proactive and cost effective way moving forward.

3.2.6 There are currently 3 additional, high cost agency consultants in post in Haematology and Gastroenterology to deliver additional activity. The cost of these posts was (£0.066m) in month. This is reflected in the over achievement of activity in these areas. Haematology OP FUP's has overachieved by 25% cumulatively above plan and DC 6%. The FUP backlog in Haematology has now been cleared and clinic templates have been switched to FST's from August. Gastroenterology OP FUP's have delivered activity 35% cumulatively above plan and DC activity was above plan in month by 16% but does remain below plan by 5% cumulatively. There is also a high cost agency Consultant in Dermatology (£0.028m) covering a substantive vacancy. There is currently an advert out to recruit a Specialty Doctor into this post, which closes mid-September with an anticipated start date of December.

3.2.7 The main driver of the adverse variance in Surgery is Medical bank spend which is 29% higher than run rate due to additional extras in Anaesthetics to cover core sessions due to high levels of annual leave in August. In addition, there is agency spend of £0.095m in month, this is associated with Agency consultants within Pain and ENT, agency junior doctors covering rotational gaps and £0.010m of agency nursing covering an interim Associate Director of Nursing post (now left the Trust). A substantive post for a Pain consultant recruitment is to be advertised and it is anticipated recruitment will be in Q3 2022. The additional agency spend on Pain consultants is required pending implementation of service changes in Q2 2022. An ENT agency consultant will be required to cover maternity leave until November. Junior doctor maternity cover in Urology will be required until at least the end of September and an additional Junior Fellow to cover a vacancy.

3.3 Expenditure: Non-Pay

3.3.1 The Trust has spent £53.511m on non-pay operating expenditure excluding COVID at M5, a positive variance of £3.138m.

Table 9: Non-pay analysis (excluding COVID-19 costs)

Trust	IN MONTH			YEAR TO DATE		
Month 5 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Supplies and services - clinical	-£3,429	-£2,668	£761	-£17,359	-£15,460	£1,899
Supplies and services - general	-£437	-£488	-£50	-£2,148	-£2,277	-£129
Drugs	-£2,342	-£2,325	£17	-£11,852	-£11,704	£148
Purchase of HealthCare - Non NHS Bodies	-£985	-£534	£451	-£4,940	-£3,886	£1,055
CNST	-£1,072	-£1,070	£2	-£5,358	-£5,350	£8
Consultancy	-£28	-£208	-£180	-£140	-£215	-£75
Other Operating	-£2,954	-£3,845	-£891	-£14,852	-£14,619	£233
Total Operating Exenses	**-£11,247**	**-£11,137**	**£110**	**-£56,649**	**-£53,511**	**£3,138**

3.3.2 Elective activity at M5 represented 88.3% of the value plan submitted to NHSEI. This has resulted in significant underspends in respect of clinical supplies and services and drugs, most notably in surgery.

3.3.3 The underspend in respect of purchase of healthcare from non-NHS bodies relates to the Community Diagnostic Centre and reduced reliance on insourcing and outsourcing compared to plan, with more activity being delivered by our own staff. This is offset by reductions in income.

3.3.4 The Trust has spent £1.622m on COVID-19 costs at M5, with £0.897m on pay and £0.726m on non-pay.

3.3.5 The vaccination costs were £0.422m at M5 which was in line with plan and is funded centrally so offset in income. We have been informed by NHSE that from September we will no longer be reimbursed retrospectively for our vaccination costs and will instead receive a fixed budget based on average costs and number of planned vaccinations but the budget has yet to be confirmed. The Trust is in the process of completing an exercise to review our operating model for vaccination with the intention of reducing costs in anticipation of the reduction in funding.

3.3.6 The testing costs were £0.935m at M5 and are funded centrally so offset in income.

3.4 **CIP Performance**

3.4.1 The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently.

3.4.2 As at the 20th September, 260 opportunities had been submitted by divisional teams with a recurrent value of £5.586m against a target of £13.849m. This represents an improvement of £0.571m compared with the figure reported at M4.

3.4.3 QIA panels are established on a fortnightly basis to prioritise CIP schemes and are chaired by the Deputy Medical Director and Deputy Director of Nursing. 52% of schemes identified have been approved at QIA to date.

Table 10 Identified savings by Division

Division	Annual Target	Forecast	FYE Variance	% Variance
DCS	£2,400,897	£776,113	-£1,624,783	-68%
Corporate	£1,260,526	£730,928	-£529,598	-42%
Medicine	£2,698,861	£1,233,917	-£1,464,944	-54%
Acute	£879,014	£97,228	-£781,786	-89%
Surgery	£2,617,788	£1,034,311	-£1,583,477	-60%
Estates	£1,131,379	£97,732	-£1,033,647	-91%
W&C	£1,136,000	£104,900	-£1,031,099	-91%
Trust Central	£1,510,992	£1,510,992	£0.00	0%
Total	**£13,635,457**	**£5,586,121**	**-£8,049,335**	**-59%**

3.4.4 £1.130m has been delivered in M5 against targets assigned of £5.681m and validated plans of £2.159m.

Table 11 YTD performance by Division

Division	YTD Target	YTD Plan	YTD Actual	YTD Variance to plan	YTD Variance to target
DCS	£1,000,375	£234,428	£216,292	-£18,136	-£784,083
Corporate	£525,220	£182,010	£192,611	£10,601	-£332,609
Medicine	£1,124,525	£773,202	£416,724	-£356,478	-£707,801
Acute	£366,255	£23,952	£36,804	£12,852	-£329,451
Surgery	£1,090,745	£203,007	£196,648	-£6,359	-£894,097
Estates	£471,410	£204,446	£38,477	-£165,969	-£432,933
W&C	£473,330	£33,947	£32,576	-£1,371	-£440,754
Trust Central	£629,580	£503,664	£0	-£503,664	-£629,580
Total	**£5,681,440**	**£2,158,656**	**£1,130,132**	**-£1,028,524**	**-£4,551,308**

3.4.5 26 projects have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

3.4.6 92 projects with a value of £1.313m have progressed to design & plan (gateway 2), meaning documentation is now being completed on Smartsheets with the support of the PMO. All schemes in gateway 2 are awaiting QIA completion by project leads.

3.4.7 9 projects with a value of £0.073m are in the governance and assurance (gateway 3), awaiting QIA panel 26th October.

3.4.8 43 projects with a value of £1.571m have been approved at QIA panel and are now in the implementation gateway.

4. Financial Position

4.1 **Statement of Financial Position (SOFP)**

4.1.1 The movement in total assets employed from M4 was £0.480m.

Statement of Financial Position (SoFP)					
Actual as at 31.03.22 £'000		Actual as at 31.07.2022 £'000	Actual as at 31.08.2022 £'000	Variance (monthly) £'000	Month- on-month movement
	Non-current assets				
187,353	Property, plant and equipment	187,268	187,862	594	↑
14,871	Intangibles	14,185	13,785	(400)	↓
968	Trade and other non-current receivables	397	397	0	→
203,192	**Total non-current assets**	**201,850**	**202,044**	**194**	↑
	Current assets				
4,924	Inventories	4,894	4,677	(217)	↓
21,288	Trade and other receivables	24,757	19,205	(5,552)	↓
36,435	Cash and cash equivalents	25,835	32,628	6,793	↑
62,647	**Total current assets**	**55,486**	**56,510**	**1,024**	↑
£265,839	**Total assets**	**£257,336**	**£258,553**	**£1,218**	↑
	Current liabilities				
(60,592)	Trade and other payables	(54,947)	(57,622)	(2,674)	↓
(10,702)	Other liabilities	(11,245)	(10,872)	372	↑
(1,023)	Borrowings	(1,083)	(1,098)	(15)	↓
(9,213)	Provisions	(8,151)	(7,642)	509	↑
(81,530)	**Total current liabilities**	**(75,426)**	**(77,234)**	**(1,808)**	↓
-£18,883	**Net current assets/(liabilities)**	**-£19,940**	**-£20,724**	**-£785**	↓
£184,309	**Total assets less current liabilities**	**£181,910**	**£181,320**	**-£591**	↓
	Non-current liabilities				
(2,371)	Other liabilities	(2,371)	(2,371)	0	→
(4,177)	Borrowings	(4,177)	(4,177)	0	→
(6,348)	Provisions	(5,905)	(5,794)	111	↑
(12,896)	**Total non-current liabilities**	**(12,453)**	**(12,342)**	**111**	↑
£171,412	**Total assets employed**	**£169,458**	**£168,977**	**-£480**	↓
	Financed by				
	Taxpayers' equity				
186,445	Public dividend capital	186,445	186,445	0	→
(64,185)	Income and expenditure reserve	(65,452)	(65,932)	(480)	↓
49,152	Revaluation reserve	48,464	48,464	0	→
£171,412	**Total taxpayers' equity**	**£169,458**	**£168,977**	**-£480**	↓

4. Financial Position

4.2 **Capital Expenditure – M5**

4.2.1 The Trust's programme for 22/23 is now £44.851m and is made up as follows:

Capital plan 2022/23	
IT - various schemes	1,976
Medical equipment	737
Facilities equipment	93
Bathroom refurbishment	137
Simulation suite refurbishment	98
Doctors mess refurbishment	72
Ventilation works	400
Flooring	80
Fire compartmentation	400
Ward 1 - Renal Unit refurbishment	2,800
Modular theatre build completion	2,972
Initial CDEL allocation	**9,765**
Heating and chilled water pipework replacement	2,132
Total CDEL	**11,897**
Modular theatre - phase 2	14,954
UECUP	18,000
Total PDC	**32,954**
TOTAL CAPITAL PLAN 22/23	**44,851**

4.2.2 At M5 spend was £5.937m against a plan of £13.779m, a variance of £7.482m. The key areas of underspend were UECUP (£3.667m), phase 2 of the modular theatres (£1.926m), IT (£1.020m) and backlog maintenance (£1.726m). UECUP is delayed as formal approval has yet to be received for the business case. However, enabling works have commenced. Delays in IT spend is due to ongoing issues with suppliers but should be fully recovered before year end. Backlog maintenance continues to be impacted as a result of the pipework project as well as phase one of the modular theatres which are reaching the end of the build programme. Final design sign off of phase two of the theatres is expected at the start of October and it is anticipated that the groundworks will be completed and the modules delivered by the start of the new calendar year.

4.2.3 We are currently considering all uncommitted spend in light of significant issues in respect of estates and winter adjustments.

4.2.4 At this stage we do not anticipate there being any impact on the planned outturn position with the exception of UECUP. As the spend on this scheme is PDC funded this year, we should be able to reduce our drawdown in consultation with the C&M and the NHSE/I Capital and Cash Team. Discussions between finance and the UECUP team take place on a weekly basis but at this stage it is too early to determine what the reduction in drawdown might be.

4. Financial Position

4.3 **Statement of Cash Flows – M5**

Statement of Cash Flow (SoCF)	
	Actual as at 31.08.2022 £'000s
Opening cash	**36,435**
Operating activities	
Surplus / (deficit)	(2,435)
Net interest accrued	(48)
PDC dividend expense	1,960
Unwinding of discount	(13)
(Gain) / loss on disposal	0
Operating surplus / (deficit)	**(536)**
Depreciation and amortisation	5,760
Impairments / (impairment reversals)	0
Donated asset income (cash and non-cash)	0
Changes in working capital	3,226
Other movements in operating cash flows	
Investing activities	
Interest received	144
Purchase of non-current (capital) assets	(12,401)
Sales of non-current (capital) assets	0
Receipt of cash donations to purchase capital assets	0
Financing activities	
Public dividend capital received	0
ITFF loan principal drawdown	
Support funding 2 principal drawdown	
ITFF loan principal repaid	0
Support funding 2 principal repaid	
Interest payable	(0)
PDC dividend paid	
Total net cash inflow / (outflow)	**(3,807)**
Closing cash	**£32,628**

4.3.1 Cash balances have reduced by £3.807m, adjusting for our variance from budget documented within plan this is in line with our expectations.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.3**

05 October 2022

Title	Quarterly Maternity Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Jo Lavery, Director of Midwifery & Nursing
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services Update Report to the Trust Board of Directors was presented in July 2022, with the following paper providing a further update and oversight regarding the quality and safety of Maternity Services at Wirral University Teaching Hospitals (WUTH).

This paper provides a specific update regarding the regional NHSE/I maternity insight visit with the LMNS held on 16th August 2022 following the final Ockenden report, together with a workforce update with specific reference to the Continuity of Carer model of maternity care and Year 4 of the Maternity Incentive Scheme.

An update is also provided on the Continuity of Carer Implementation Plan and the workforce requirements to purse this model in line with Birth Rate Plus recommendations.

It is recommended that the Board note the report, and specifically:

- The NHSE/I maternity insight visit with the LMNS held on 16th August 2022
- Report of One to One published in September 2022
- The Trust's position of Year 4 of the Maternity Incentive Scheme
- Following the second Ockenden together with a workforce update with specific reference to the Continuity of Carer model of maternity care and the Trust's position to implement as a default model.

Key Risks

This report relates to these key Risks:

- BAF 1, 2 and 4

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

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

1	NSHE/I Insight Visit
1.1	An insight visit to the Wirral University Teaching Hospital (WUTH) took place on 16th August 2022. The purpose of the visit was to provide assurance against the 7 immediate actions from the interim Ockenden report. The regional team used an appreciative enquiry and learning approach to foster partnership working to ensure the actions taken to meet the interim Ockenden recommendations are embedded in practice. A gap analysis against the Ockenden recommendations was included in the last Quarterly Maternity Services Update to the Board of Directors meeting in July 2022 outlining the Trusts current position and feedback has been provided at Appendix 1 outlining the findings of the visit. Key Headlines: • The Trust was open, honest, and transparent in relation to the challenges they faced • The Insights team observed MDT working across the whole service by a well engaged and dedicated team at all levels • There was evidence of co-production, with the Trust able to articulate achievements as part of the MVP and with support of the MVP Chair • The Trust should as a matter of urgency review its capacity and demand for caesarean sections to ensure it is able to meet elective activity • The Trust operated "care improvement forms" as opposed to "incident reporting" to support a culture of continuous improvement • The estate for the neonatal unit as challenging, FiCare was accredited at amber with improvement plans in place to achieve gold. The unit had as a pilot, linked with Wirral employment solutions to offer maternity rights and employment law advice • The workforce model for midwifery supported succession planning, with lead Obstetric roles shared across the Obstetric team supported by job planning • The Trust operated a bleep holder system for midwifery, out of hours senior midwives remained available on a good will basis without remuneration, the Insights team felt this should be addressed • The Insights team heard the Trust (estates team) had been nominated for a staff health and wellbeing initiative of the year award for creating 1 wellbeing space for staff and partners Recommendations: • The Trust should as a matter of urgency review its capacity and demand for caesarean sections to ensure it is able to meet elective activity • The neonatal estates must be reviewed as a priority as it was cramped and not inviting. The Trust should in partnership with the MVP undertake a 15-step challenge within the NICU • The Trust must review the maternity senior cover out of hours to ensure the midwifery teams are adequately supported by a senior member of staff who is appropriately remunerated

	• The Trust should work with commissioners to ensure the MVP Chair is adequately resourced by way of equipment e.g., phone and laptop • The Trust should consider implementing electronic patient records that can be accessed and input into by the service user • Progress against the recommendations are included in an action plan with appropriate timescales to deliver.

2	**Ockenden Review of Maternity Services: Final Report – Update on Trust Compliance with the Immediate and Essential Actions/Recommendations**
2.1	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in April 2022 along with a revised gap analysis following a review with the Chief Nurse in July 2022. The Gap Analysis is included at Appendix 2 and remains in the same RAG rated position. Progress against the recommendations/IEAs across Cheshire & Merseyside is has been submitted to the Local Maternity and Neonatal System (LMNS) prior to the submission to NHSE/I in August 2022.

3	**Independent Midwifery Service Review of One to One**
3.1	NHSE/I commissioned an independent review of the One-to-one Midwifery service published 8th September 2022. The independent review report and appendices is available to read on the NHS England website. One to One Midwives was an independent sector provider established in 2010 to provide maternity services to NHS-funded clients through a midwifery-led, community-based, 'case loading' model. One to One Midwives was one of a small number of similar businesses over the last ten years which aimed to bridge the gap between greater choice and the NHS maternity offer; none of these businesses are still in operation. In 2019 One to One Midwives announced it was withdrawing the services it provided for the NHS and subsequently entered insolvency proceedings. It should be noted within the report that there was learning for NHS maternity providers for women who received shared care and WUTH will identify any lessons learnt and consider all the recommendations within the current service to inform current services and future commissioning arrangements.

4	**Maternity Incentive Scheme (MIS) – Year 4 Update**
4.1	A detailed MIS update is included to Board of Directors Quarterly Maternity Services Update, which will further inform the Trust declaration with the MIS due for submission before a deadline of 5 January 2023. Now in its fourth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. NHS Resolution in conjunction with NHSE/I confirmed the relaunch of the Year 4 MIS in May 2022 following its pause in 2021-22. The W&C Division has continued with its work to progress the 10 safety actions (Appendix 3). At the July 2022 Board of Directors, it was updated WUTH was on track to meet the requirements of each safety

	action with one action requiring support from IT relating to the reporting of CO monitoring in pregnancy (at 36 weeks gestation) and the urgent need for a mandated question being added to the maternity records. The works will be completed in September 2022 to ensure the submission of data three months prior to the Trust's compliance declaration in January 2023. Provider compliance with the ten Safety Action Standards across C&M continues to be closely monitored by the LMNS and NHSE/I.

5	**Perinatal Clinical Surveillance Quality (PCSQ) Assurance Report**
5.1	The Clinical Surveillance Quality Tool dashboard is included within the papers (Appendix 4) providing an overview of the latest (July 2022) key quality and safety metrics. The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard which are linked to the quality and safety of Maternity Services. The dashboard is provided for information and there is no indication to escalate any of the metrics to the Board to Directors.

6	**Northwest Coast Outlier Report**
6.1	A summary from the Northwest Coast Outlier Report for the period August 2021 – July 2022 is included in Appendix 5 and refers to data from the regional (Northwest Coast).

7	**Serious Incidents (SI's) & Health Care Safety Investigation Branch (HSIB)**
7.1	SIs continue to be reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria (Northwest Coast). SIs are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity SI's across the region. There are no confirmed maternity SIs reported in June, July and August 2022 and no new cases referred to HSIB. Quarterly engagement meetings continue to be held with HSIB, with good engagement with all cases.

8	**Workforce Update – Implementing a Continuity of Carer Model of Maternity Care**
8.1	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. A consultation with staff has taken place to support staff transitioning to work within a continuity of carer model. This consultation was positively received with plans finalised for the implementation of 100% Maternity Continuity of Carer (MCoC). The target date as guided by NHSE/I date is for each provider to have this as the default model of care should be by March 2024. As a provider WUTH has four MCoC teams with a fifth team who have upskilled to be launched in January 2023. The assurance plans submitted to the LMNS and NHSE/I

	indicated the building blocks to upskill would continue with full roll our anticipated by Autumn 2023. NHSE/I has been changed that has within the Trust was initially planned for June 2022, however there were recommendations included in the Ockenden report that have delayed its implementation, this included the need for a further review of the midwifery workforce. As previously presented to Board a workforce review using the Birthrate+ tool was undertaken in 2021 and a paper presented to the Workforce Assurance Committee outlining midwifery staffing requirements to deliver 100% CoC. Funding from NHSE/I supported the recruitment of an additional Obstetrician and additional midwifery staff to support the roll out of this model of care. The workforce review has looked at skill mix and the uplift in the establishment needed given the additional training each midwife needs to complete. This uplift considered sick leave, maternity leave, training and annual leave and was calculated over a 3 Year period as outlined in the Ockenden recommendations. WUTH received funding to recruit 10.1 wte Band 5 Midwives in 2021/22 and a further funding was anticipated to fund the remainder of the workforce to deliver MCoC. However, it is not confirmed and discussion continues with NHSE/I the exact details of the funding and confirmation if it is recurrent. The outcome of this will impact on the implementation plan to meet 100% Continuity of Carer requirement and therefore a paper will be prepared for consideration at Workforce Steering Board with a potential financial burden to the Trust to deliver the default model of care.

9	**Maternity Escalation and Divert – Update**
9.1	The weekly C&M Gold Command meetings continue to identify any particular hotspots in a timely manner and have improved collaborative working within C&M. This has undoubtedly reduced the need for maternity providers to formally divert services to another provider. There have been no diverts from WUTH during 2022 / to date and mutual aid from WUTH has supported other providers within the region and on two occasions out of region. The C&M Escalation and Divert policy was revised, operationalised and adopted by Trusts on 1 September 2021 which further supports the management of escalation and divert. This policy has been further updated and ratified in August 2022 and had been circulated to C&M Trusts.

10	**Conclusion**
	The next board paper will continue to update on the delivery of safe maternity services to include a detailed update on the Maternity Incentive Scheme (MIS) and will also focus on the publication of the East Kent Maternity Service review (delayed from Autumn 2022). An update will continue to be provided on the Continuity of Carer Implementation Plan.

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Wirral University Teaching Hospitals NHS FT

Maternity Services – Overview findings of Regional and System Insight Visit

1/09/22

NHS England and NHS Improvement

Visit Purpose

An Insight visit to the Wirral University Teaching Hospital NHS FT services took place on the 16 August 2022.

The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the interim Ockenden recommendations were embedded in practice.

Conversations were held with various members of the senior leadership team and various frontline staff ranging in job roles.

Emerging themes from conversations were organised under the immediate and essential actions headings

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Insight Visit Team members: Susan Stansfield, Mandy Platt, Janine Dyson, Catherine McClennan, Debby Gould and Victoria Walsh.

Key Headlines

- The Trust was open, honest and transparent in relation to the challenges they faced.
- The Insights team observed MDT working across the whole service by a well engaged and dedicated team at all levels.
- There was evidence of co-production, with the Trust able to articulate achievements as part of the MVP and with support of the MVP Chair.
- The Trust should as a matter of urgency review its capacity and demand for caesarean sections to ensure it is able to meet elective activity.
- The Trust operated "care improvement forms" as opposed to "incident reporting" to support a culture of continuous improvement.
- The estate for the neonatal unit was challenging, FiCare was accredited at amber with improvement plans in place to achieve gold. The unit had as a pilot, linked with Wirral employment solutions to offer maternity rights and employment law advice.
- The workforce model for midwifery supported succession planning, with lead Obstretric roles shared across the Obstetric team supported by job planning.
- The Trust operated a bleep holder system for midwifery, out of hours senior midwives remained available on a good will basis without renumeration, the Insights team felt this should be addressed.
- The Insights team heard the Trust (estates team) had been nominated for a staff health and wellbeing initiative of the year award for creating a wellbeing space for staff and partners.

Summary of Insight Visit Review of Ockenden IEAs Status

IEA								
1) Enhanced safety	Q1 Dashboards	Q2 – External review of SIs	Q3 – SIs to Board/LMNS	Q4 - PMRT	Q5 - MSDS	Q6 - HSIB	Q7 - PCQSM	Q8 – SIs to Board/LMNS
2) Listening to women and families	N/A	N/A	Q11 – NED	Q12 - PMRT	Q13 – Service user feedback	Q14 – Bimonthly safety champ meetings	Q15 – Service user feedback	Q16 – NED
3) Staff training and working together	Q17 – MDT Training	Q18 – Cons. Ward Rounds	Q19 – Ring-Fenced Funding	Q20 – workforce planning	Q21 – 90% MDT Training	Q22 – Cons Ward Rounds	Q23 – MDT Training Schedule	
4) Managing complex pregnancy	Q24 – MMC Criteria	Q25 – Named Consultant	Q26 – Complex Pregnancies	Q27 – SBLCBv2	Q28 – Named Cons/Audit	Q29 – MMC		
5) Risk assessment throughout pregnancy	Q30 – Risk assessment	Q31 – Place of Birth RA	Q32 – SBLCBv2	Q33 – RA recorded with PCSP				
6) Monitoring fetal well-being	Q34 – Leads in post	Q35 – Leads expertise	Q36 – SBLCBv2	Q37 – 90% MDT Training	Q38 – Leads in post			
7) Informed consent	Q39 – Accessible Information, Place of Birth	Q40 – Accessible Information, All Care	Q41 – Decision making and Informed Consent	Q42 – Women's Choices Respected	Q43 – Service User Feedback	Q44 - Website		
Workforce Planning	Q45 – Clinical Workforce Planning	Q46 – Midwifery Workforce Planning	Q47 – D/HoM Accountable to Exec Dir	Q48 – Strengthening Midwifery Leadership				
Guidelines	Q49 - Guidelines							

IEA1 Enhanced Safety

- The triumvirate met monthly; the Insights team felt the minutes should be made clearer by recording titles and purpose of meeting in addition to actions.
- The evidence submitted supported external reviewers attended PMRT reviews to provide external scrutiny and were conducted to the required standard..
- Serious incidents were shared with the Board and the LMNS for scrutiny and learning.
- The Insights team heard the decision that a serious incident met the criteria StEIS was made by the MDT, they felt this was good practice.
- Safety huddles were embedded and well documented.
- The Trust had implemented "care improvement forms" to report incidents to encourage staff to report episodes where they felt care could be improved and build a culture of safety and learning.
- The Insights team attended a Care Improvement Form meeting, this was an MDT meeting in the clinical area and open to all team members, the Insights team felt this was good practice and informed immediate actions for learning.

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA2 Listening to Women & Families

- The Insights team heard families were asked for their input into PMRT reviews and offered debriefs as part of the process and on completion of the report.
- The Trust was part of the MVP, the Insights team observed a partnership approach with the MVP and MVP Chair who was able to articulate co-produced service design.
- The evidence submitted demonstrated the Safety Champions met regularly inclusive of the NED and neonatal Safety Champion.
- The Insights team heard the Trust held weekly listening events hosted by the MVP Chair and Consultant Midwife via Facebook live (with subtitles) and Instagram. The events are recorded and shared via HealthWatch, the Merseyside deaf society and Birkenhead youth group, the Insights team felt this was good practice.
- The neonatal unit had achieved amber FiCare accreditation, the Insights team felt the neonatal team should work with the MVP and MVP Chair and undertake a 15 steps challenge to assist them in their ambition for gold accreditation.
- The Insights team felt the estate for the neonatal unit should be reviewed as a priority by the Trust as it was cramped and not inviting.

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA3 Staff Training and Working Together

- The evidence submitted demonstrated external monies for training were ringfenced.
- The Insights team observed a culture of MDT working at all levels.
- MDT twice daily ward rounds were embedded on delivery suite.
- The Insights team observed the specialist midwives were co-located enabling a culture a culture of quality improvement and shared learning.
- On review the evidence submitted for training was dated 2020/21 with the TNA due for review in June 22, the Insights team met with the training team and were assured MDT training was compliant.
- PROMPT training was inclusive of human factor training.
- The Trust had professional midwifery advocates at all levels, the Insights heard they offered group reflections in addition to individual facilitated reflective discussions.
- The Insights team heard reflection was embedded into handover as part of the RCOG Each Baby Counts programme.

IEA3	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 – workforce planning	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA4 Managing Complex Pregnancy

- The Trust forms part of the North West Maternal Medicine Network. The Trust was engaged within the Network and with the LMNS.
- The Insights team heard there were good informal links with specialities, the Insights team felt these would need to be formalised as the Network matures.
- The audit submitted as evidence demonstrated 87.5% of service users who required Consultant led care had evidence of a named Consultant with an action plan in place, on review of the evidence the Insights team noted the audit was due to be repeated.
- The screening midwife had a deputy in post to ensure cover during periods of leave and to support succession planning, the Insights team felt this was good practice.
- The Trust employed a Failsafe Clerk, the Insights team felt this was good practice.
- Job planning had been undertaken to ensure adequate PA time for Obstetric leads, the rotas were discussed monthly at the Consultant meeting to ensure there are no gaps in service provision.
- There was a Obstretric Consultant lead for Maternal Medicine in post.

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA 5 Risk Assessment Throughout Pregnancy

- The antenatal risk assessment guidance submitted as evidence supports risk assessment at every contact and recoded within PCSP.
- The audit submitted as evidence demonstrated risk assessments had been conducted in 97% of cases at booking, with plans in place to include risk assessment at every contact a mandated field in the electronic patient record.
- The Trust offered 50% provision of continuity of carer with plans in place for this to be 100% by the Autumn of 2023.
- The delivery suite had a Band 7 co-ordinator supported by an additional Band 7 co-ordinator based on triage.
- The Insights team the Truste operated electronic patient records, though these were not accessible by the service user. The Insights team felt the Trust should be moving to electronic records that allowed service users to read and input into.

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

IEA6 Monitoring Fetal Well-Being

- Although the Trust had not appointed a SBL champion midwife they were able to demonstrate that overall responsibility for the sustainability of the SBL care bundle sat with a team of identified leads for each element.
- The Trust had reintroduced CO monitoring at booking and 36/40 the rates were 92% at booking and 60+% at 36/40.
- They team were aiming for CO monitoring at every antenatal contact.
- The Trust had introduced impatient NRT to women during inpatient stay.
- The Trust were auditing all growth restricted babies under the 10th centile and had mechanisms in place to facilitate training where required.
- UtAD scanning is offered to all eligible women at approximately 23/40. This was performed by the fetal medicine obstetric consultant.
- The Trust had an established a pre-term birth clinic with an identified pre–term birth obstetric lead. The high-risk midwife also supported this service within her role.
- The Trust was implementing central CTG monitoring.

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	

IEA7 Informed Consent

- The evidence submitted demonstrated service users who wished to birth out of guidance would be supported by the Consultant midwife in shared decision making.
- The Trust provided a birth options clinic.
- The Insights team observed a number of co-produced Ockenden posters displayed.
- The website was easy to navigate and had accessibility options for translation and those with cognitive impairments.
- The Trust offered home birth, community birth centre, obstetric led unit and an alongside midwifery led unit to support choice. Service users are able to self-refer to services either via the telephone or during drop-in clinics at the birth centre.
- The Trust and MVP Chair articulated clearly how service user feedback informed service delivery and quality improvement programmes, an example of this was the co-designed induction of labour suite.

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce Planning & Guidelines

- The Trust demonstrated adequate job planning, roles and responsibilities of Consultants and compensatory rest in line with RCOG guidance.
- The evidence submitted demonstrated the Director of Midwifery directly reported to the Chief Nurse, on review the job description had not been allocated an AfC Band.
- The BirthRate+ assessment was undertaken in 2021, with a six-monthly midwifery staffing paper provided to Board, the Insights team heard the establishment was in line with BirthRate+ with a vacancy rate of less than 1%.
- The Insights team heard recruitment will continue to enable full midwifery continuity of carer by Autumn 2023 from the 50% position currently.
- The Trust had invested in midwifery leadership with a significant number of specialist roles and a Consultant midwife, the Insights team felt the workforce plans were inclusive of succession planning and this was good practice.
- The was an Obstetric lead for guidelines with adequate PA time.

WFP & G	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Recommendations / Points for Consideration

- The Trust should as a matter of urgency review its capacity and demand for caesarean sections to ensure it is able to meet elective activity.
- The neonatal estates must be reviewed as a priority as it was cramped and not inviting. The Trust should in partnership with the MVP undertake a 15-step challenge within the NICU.
- The Trust must review the maternity senior cover out of hours to ensure the midwifery teams are adequately supported by a senior member of staff who is appropriately remunerated.
- The Trust should work with commissioners to ensure the MVP Chair is adequately resourced by way of equipment e.g. phone and laptop.
- The Trust should consider implementing electronic patient records that can be accessed and inputted into by the service user.

Offers of Support to Trust

- The Trust will receive an offer of support from the National Workforce team as part of the Direct support programme.
- The Trust will participate in the cultural survey nationally roll out later this year.
- The Quadrumvirate will participate in the national offer of leadership training roll out later this year.

The visiting team would like to express thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.

Ockenden Essential Actions - April 2022

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating e	Lead	When	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.				
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		DE	31/7/22	Neonatal service Staffing Review undertaken and bid for national monies successful.: Adam Brown with Angela MacDonald. Anaesthetic staffing review to be undertaken :Medical & Anaesthetic staffing review to be undertaken; Alice Arch. Libby Shaw and Mustafa Sadiq. Midwifery Staffing review undertaken but same to be reviewed and updated pending CoC model: Debbie Edwards and Jo Lavery. Deadline - July 2022. On target to achieve by 31/7/22
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		DE	31/7/22	On target and within timeframes to achieve target date
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		DE	31/7/22	Local uplift to be calculated and compared to BR+ staffing requirements. To be included in staffing review. Completion date - June 2022.
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.				Recommendation reviewed - WUTH ready however awaiting Regional / National review
			Essential Action : Training				
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.				
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.				National programme being developed however robust preceptorship in place currently. For review once national work completed. Completion date TBC
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.				Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion date TBC; awaiting national
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		DE	30/9/22	Orientation pack currently in use but same to be reviewed and to include study time for profrssional development. Completion date of review - September.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.				EMC Team based on DS and all midwives have undergone recognised specific HDU training.
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		DE	31/12/22	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING				
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the				
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		DE	31/10/22	Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight. Review of need for SOP to compliment policy by LMNS. Completion date TBC; SoP to be devised
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		DE,MS & LS	31/8/22	Escalation in-house at present therefore formal process - SOP to be developed and agreed at Board to formalise process.Leads: Mustafa Sadiq and Libby Shaw. Completion date - August 2022.
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.				Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		DE, JL	31/8/22	Debbie Edwards and Jo Lavery to review staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending staffing review. Completion date - June 2022.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A			Final position statement on this to be formalised nationally - completion date awaited. No code as MCofC not withheld
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		DE	31/8/22	Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw to finalise. Completion date - June 2022.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.				Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		DE	31/12/22	Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.				CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		DE	31/1/23	Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gapa analysis required with assurance mechanisms
			3: ESCALATION AND ACCOUNTABILITY				
			Processes in place - same to be auditted with clear SOPs.				
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		DE	31/12/22	Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		DE	31/12/22	Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable				Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit				Guidance in place / in policy
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		DE	31/4/23	Partial guidance in place and currently no dedicated maternity on call rota in place - same being reviewed - Debbie Edwards and Jo Lavery to look at midwifery manager on-call. Completion date June 2022
			4. Clinical governance and leadership				

			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.				
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		DE	31/12/22	Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assesment including governance structures and any remedial plans must be shared with their trust board				Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in July.
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services				In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		DE	31/12/22	In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		DE	31/12/22	Staff currently trained however review of staff group required and additional training to be identified.Completion date - July 2022.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.				Multi-discipinary leads - include Angela Kerrigan
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		DE	31/12/22	Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
			5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS				
			Robust governance processes in place - same to be reviewed with MVP Chair				
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.				In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.				In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		DE	31/12/22	Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		DE	31/12/22	Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		DE	31/12/22	Clear MDT process in place - SI Panel
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent				Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.				Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
			6: LEARNING FROM MATERNAL DEATHS				
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			7: MULTIDISCIPLANRY TRAINING				
			MDT in place - same to be extended and recorded (ad hoc drills)				
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		DE	31/12/222	Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.				SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.				For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		DE	31/12/22	PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT Completion date - July 2022.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.				Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.				Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory				PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
			8: COMPLEX ANTENATAL CARE				
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.				
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		DE	31/3/23	Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		DE	31/3/23	Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.				Guidance in place - to link wth Rachel Tildesley and Lauren Everitts
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.				In place but could be subject to audit to demonstrate compliance
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		DE	31/1/23	Guidance in place to support this practice - specific clinic to be reviewed. Completion date - July 2022.
			9: PRETERM BIRTH				Link with Kellie Weaver
			Both 9 + 10 are in place - audit of processes needed				
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.				Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.				Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.				Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.				Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
			10: LABOUR AND BIRTH				
		1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.				Practice in place - Demonstrated in care metrics

10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	2	Midwifery-led units must complete yearly operational risk assessments.				In place however Discuss with Emma Rohmann, Katherine Willkinson and Kate McCabe re review content of risk assessment
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		DE	31/12/22	All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		DE	31/12/22	Transfer policy in place regionally and adopted locally - same under review currently. Completion date - July 2022; Community transfer document and leaflet to be provided
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.				Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		DE	31/12/22	Purchase of system currently being undertaken. Procurement In progress. Completion date - July 2022.
11: OBSTETRIC ANAESTHESIA							
			Close links with Anaesthetic leads with compliance to standards - same to be auditted				
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		DE	31/3/23	Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		DE	31/3/23	Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		DE	31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		TBC		Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	5	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		DE	31/3/23	Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		DE	31/3/23	Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		DE	31/3/23	As point 5: assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		DE	31/3/23	All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE							
			Audit and review of processes / policies re postnatal care				
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		DE	31/1/23	Check if this is in written policy; document to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		DE	31/1/23	Document to be produced to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		DE	31/1/23	Document to be produced to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.				Acuity tool
13: BEREAVEMENT CARE							
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.				Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.				EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome				In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway				Pathway in place and in use.
14: NEONATAL CARE							
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support				
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.				Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.				This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		DE	31/12/22	Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		DE	31/12/22	NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		DE	31/12/22	Staffing review to be undertaken as above -Adam Brown and Anand to lead staffing review.
15: SUPPORTING FAMILIES							
			Ensure support covers maternity and neonatal care/services				
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		AK	31/12/22	Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		AK	31/12/22	Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		AK	31/12/22	Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Comoliant/risk identified on risk reaister
NOTE: Completion dates are provisional pending detailed improvement plan.

Maternity Incentive Scheme (MIS) – Year 4:

Year 4 of the MIS continues to support the delivery of safer maternity care through the ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care.

From its introduction in 2018, the Trust has been compliant with all 10 maternity safety standards and benefitted from a significant rebate to its CNST premium.

Quality Improvement work has continued within the W&C Division to ensure compliance with all ten safety actions prior to the declaration sign off on 5 January 2023.

The following table provides an update to current compliance with the 10 Standards of the scheme are outlined below:

Safety Action	Comment / update	RAG
Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	All cases to date that meet the PMRT criteria have been reviewed using the PMRT tool. All such cases have been reported to MBRRACE and have external clinical input to provide an independent professional opinion. WUTH continue to provide external representation at PMRT cases outside of the Trust which is reciprocated. The PMRT process is embedded into practice.	
Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?	Confirmation with the latest MSDS submission is awaited from NHSD but to date the Trust has met the required standard of reporting on 9 out of 11 metrics. Work is ongoing to develop a maternity specific Digital Strategy which will be submitted to the LMNS before the end of October 2022.	
Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Transitional Care (TC) provision is delivered on the Maternity ward supported by the bespoke Neonatal Support Worker (NSW) team. The clinical pathway (including admission criteria of HRG XAA04) that supports the delivery of the service clinically is in place and audited. The number of avoidable term admissions into the neonatal unit at WUTH is one of the lowest across C&M and is monitored monthly through the dashboard outlier report. The TC service is embedded and effective with defined clinical criteria.	
Safety Action 4: Can you demonstrate an effective	Workforce planning in both the Obstetric and Neonatal services is ongoing. The Neonatal ODN support the	

system of clinical workforce planning to the required standard?	review of the neonatal workforce including nursing and medical staffing. Funding has been identified to increase the Advanced Neonatal Nurse Practitioner (ANNP) team. The anaesthetic medical workforce currently meet the Anaesthesia Clinical Services Accreditation (ACSA) standards.	
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A detailed midwifery workforce review has been undertaken by Birthrate+ (which specifically looks at acuity and demand within the Maternity service to determine safe staffing levels) with a report presented at Workforce Steering Board in August 2021. Midwifery workforce updates have been provided to Board every 6 months as per the initial Safety Action requirement. Given the evolving changes to the midwifery model of care to one of continuity of carer a further paper is to go to Workforce Steering Board prior to the next quarterly monthly update and declaration/sign off date.	
Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle v2?	All 5 elements of the Saving Babies Lives care bundle (SBL) v2 are met within the Antenatal Outpatient department and quality improvement continues depending on the audit findings. Scanning capacity is a challenge at times but measures are in place to address any gaps as and when required. CO2 monitoring which is an element of the bundle was paused during the pandemic and once reintroduced compliance with this had dropped off. Work has been ongoing with the IT team to update a specific question regarding CO monitoring which will improve compliance to 100% for the 36 week visit.	
Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to co-produce local maternity services?	The Wirral MVP Chair meets weekly with the maternity leads to discuss service user feedback. The consultant midwife and the MVP Chair continue to do a joint live 'open session' for service users to update on service provision and to answer any queries service users may have. Quality improvement work continues as the feedback and engagement from MVP continues.	

Safety Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	The multidisciplinary staff training - PROMPT training continues to be delivered through focused on online learning and 1:1 drills. The Trust has met the 90% compliance rate with midwives in August 2022 and there is a plan to ensure all other staff groups are complaint before the end of December 2022. Rotational medical staff has a particularly low compliance therefore the option of transferring training records from one provider to another is being looked at within the LMNS.	
Safety Action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Regular meetings of the Trust Safety Champion were paused during Covid19 but walkabouts did take place separately. Unfortunately the last Safety Champion meeting was cancelled but the Safety Champions at all levels continue to be active and enthused by the role. At a recent Oversight meeting by NHSE the Safety Champions were interviewed and fed back on the work undertaken.	
Safety Action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme(ENS)	The Director of N&M and Q&S Lead for the W&C Division continue to meet with HSIB on a quarterly basis. A monthly update report is also sent by HSIB to support timely progress of each case review. These cases are included in the Maternity Services quarterly Board report. At present there are no ongoing new cases. This process is embedded into practice.	

Provider compliance with the ten Safety Action Standards continues to be closely monitored by the Local Maternity & Neonatal System (LMNS).

The Trust will report its compliance with the MIS Safety Standard Actions to NHSR before the 5 January 2023, with a final compliance update going to the Board of Directors meeting in December 2022.

Ockenden update:

An Independent Maternity Working Group jointly chaired by the RCM and RCOG was set up nationally following the publication of the final Ockenden report to specifically review the implementation of the 15 IEAs and the recommendations from other reports.

The first meeting was held on the 31 August 2022 with representatives from the other royal colleges and professional bodies who support maternity services, a Director of Midwifery, midwife, two women's voices representatives, NHSE/I and the

Department of Health and Social Care (DHSC).

The purpose of the independent group is that they will act as a ‘critical friend’ with regard to the implementation of the15 IEAs, ensuring that any plans are workable and sustainable in services considering best practice. The East Kent report is expected on the 21st September 2022 and the recommendations from that report and any future reports will also come under the remit of the group to advise on and guide implementation.

A further update on Ockenden will be provided in the next quarterly Maternity update to Board of Directors.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region.
	Number of SI's	no	There is currently one SI in progress
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP.
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and staff	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints. Improvement continues with the number of complaint responses outstanding and with the division significant reduced.
	Trainee survey	no	Consistently high scoring year on year. No update this month
	Staff survey	no	Nil to report this month.
	CQC National survey	no	Nil to report this month.
	Feedback via Deanery, GMC, NMC	no	There are 5 midwives who have been referred to the NMC by a patient and that we have responded to the NMC to state there are no practice concerns - NMC investigation continues.
	Poor staffing levels	no	Current vacancy rate of 4.2% for midwives.
	Delivery Suite Coordinator not supernummary	no	Supernummary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	New Director of Midwifery in post. Head of Midwifery has been appointed with an anticipated start date in October 2022.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates.
	False declaration of CNST MIS	no	Externally audited by MIAA. Year 4 preparation ongoing. Next update to Board of Directors in October 2022.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged
	Lack of transparancy	no	Being open conversations are regularly had and 100% compliance with duty of candour evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. Gap analysis against the final Ockenden report completed with update to the Board of Directors in October 2022
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No maternity or neonatal never events in July 2022. All Locssipps currently in review as part of a Trust-wide review
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes		Clear governance processes in place that follow the SI framework - Maternity specific Risk Management Strategy in draft for comments prior to ratification. Within division there is maternity and neonatal review of governance processes: 3 separate meetngs. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	The service was able to continue to provide an acute service from the start of the pandemic due to the robust contingency plans in place. Business as usual was operated following changes necessary to safegaurd staff and service user well being. Continued involvement of MVP throughout the pandemic.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Last CQC core service review was undertaken in May 2021 which did not highlight any concerns. Insight meeting planned for 16/08/2022.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

North West Coast Clinical Network Maternity Dashboard Statistical & Graphical Report, Full Version

Wirral University Teaching Hospital NHS FT

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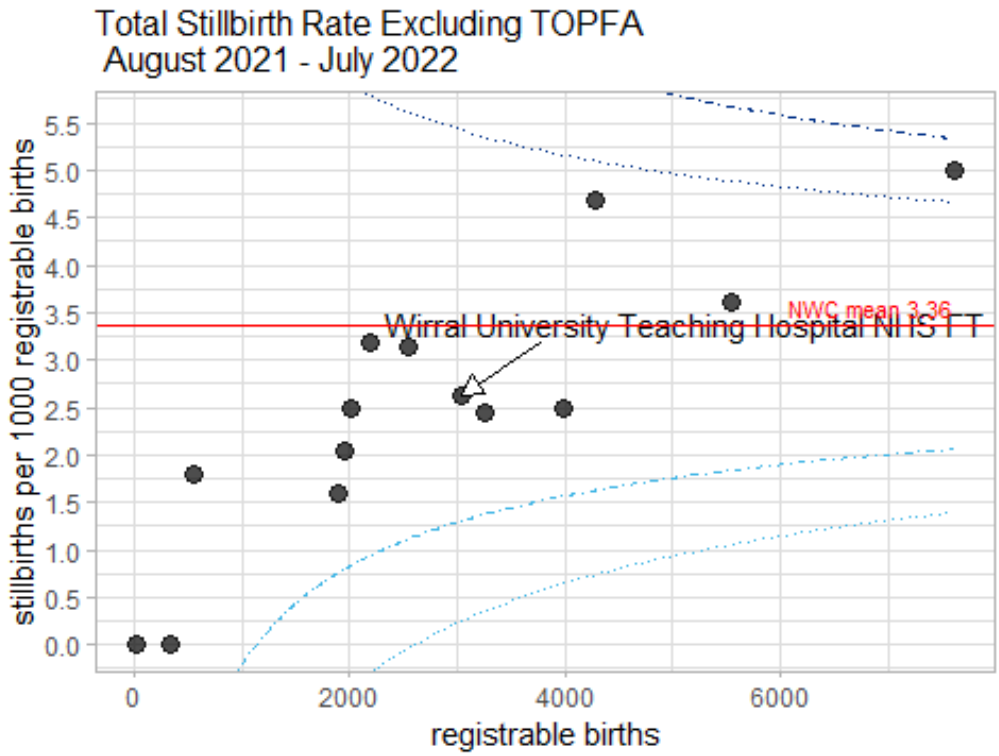
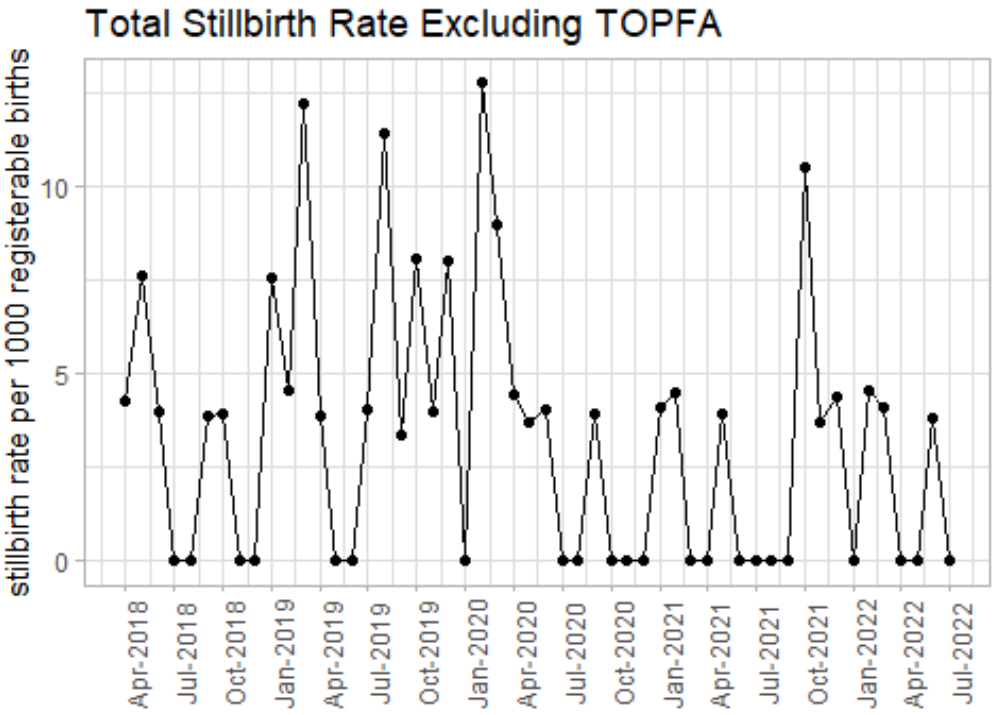
Stillbirths

Total Stillbirth Rate Excluding TOPFA



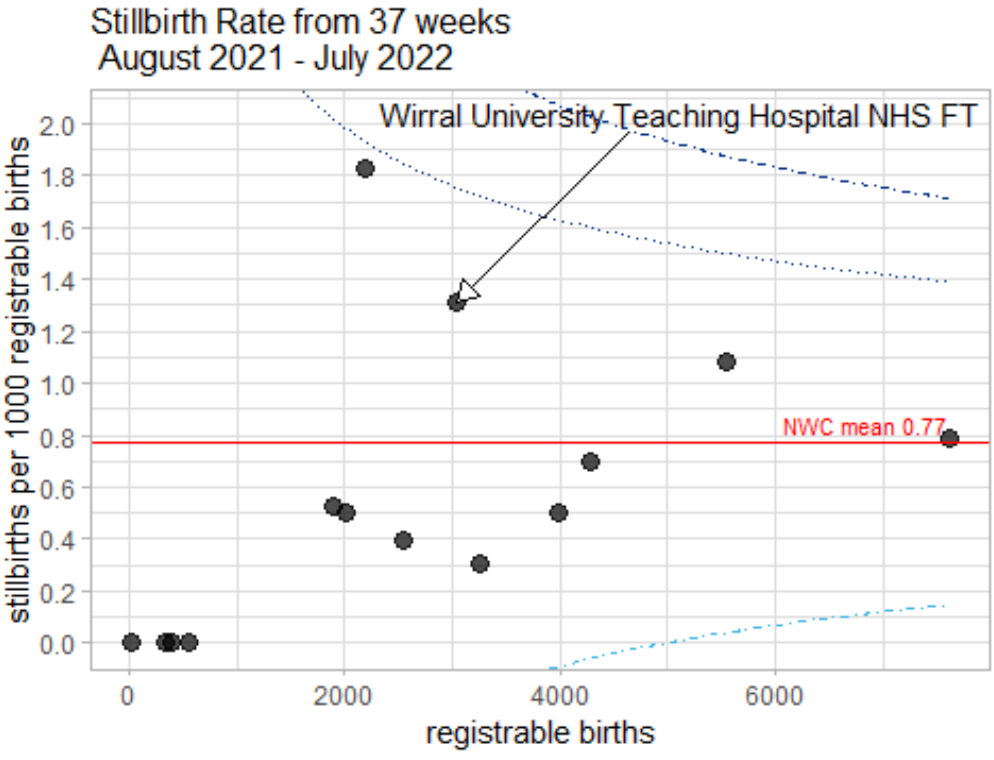
Data Source: NWC CN Maternity Dashboard

Run Chart for Total Stillbirth Rates Excluding TOPFA



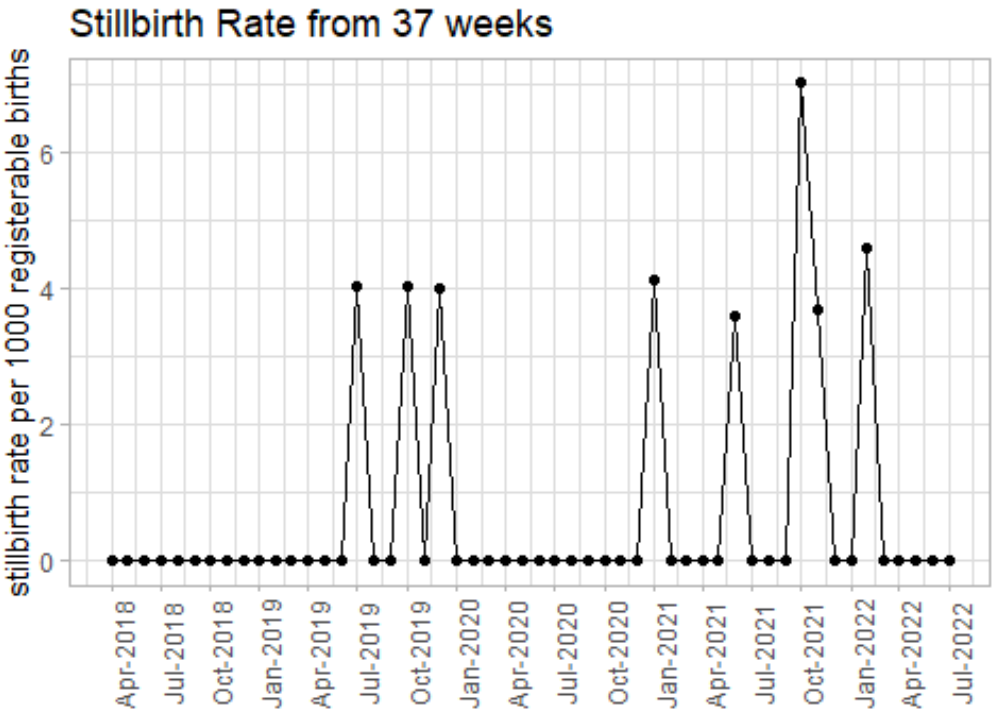
Data Source: NWC CN Maternity Dashboard

Stillbirth Rate from 37 weeks



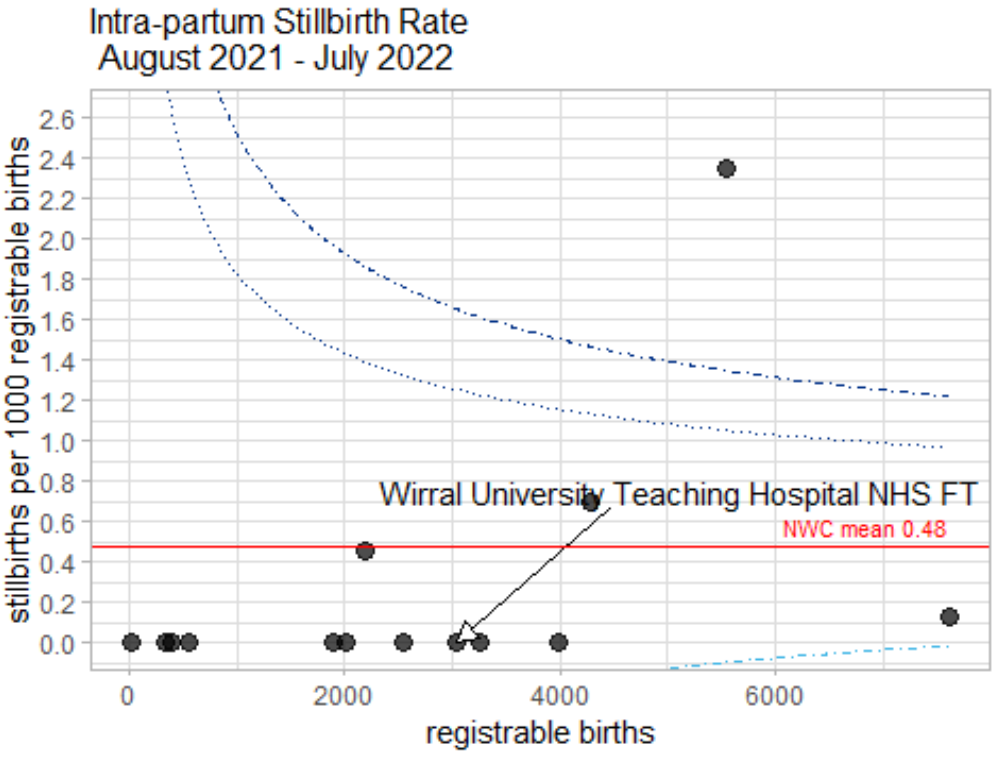
Data Source: NWC CN Maternity Dashboard

Run Chart for Stillbirth Rates from 37 weeks



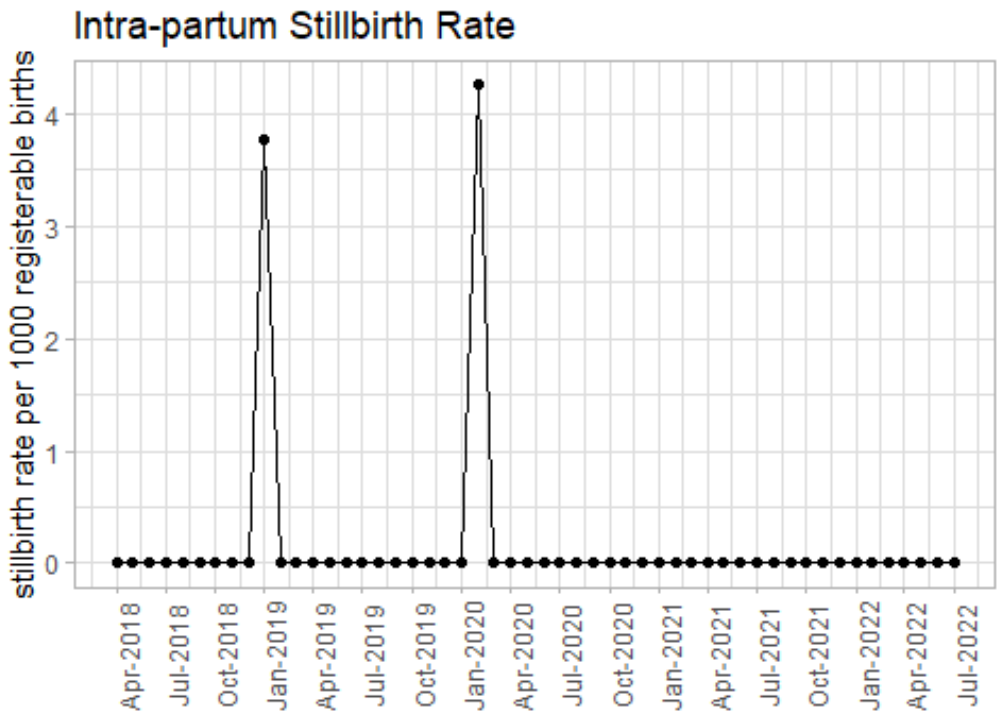
Data Source: NWC CN Maternity Dashboard

Intra-partum Stillbirth Rate



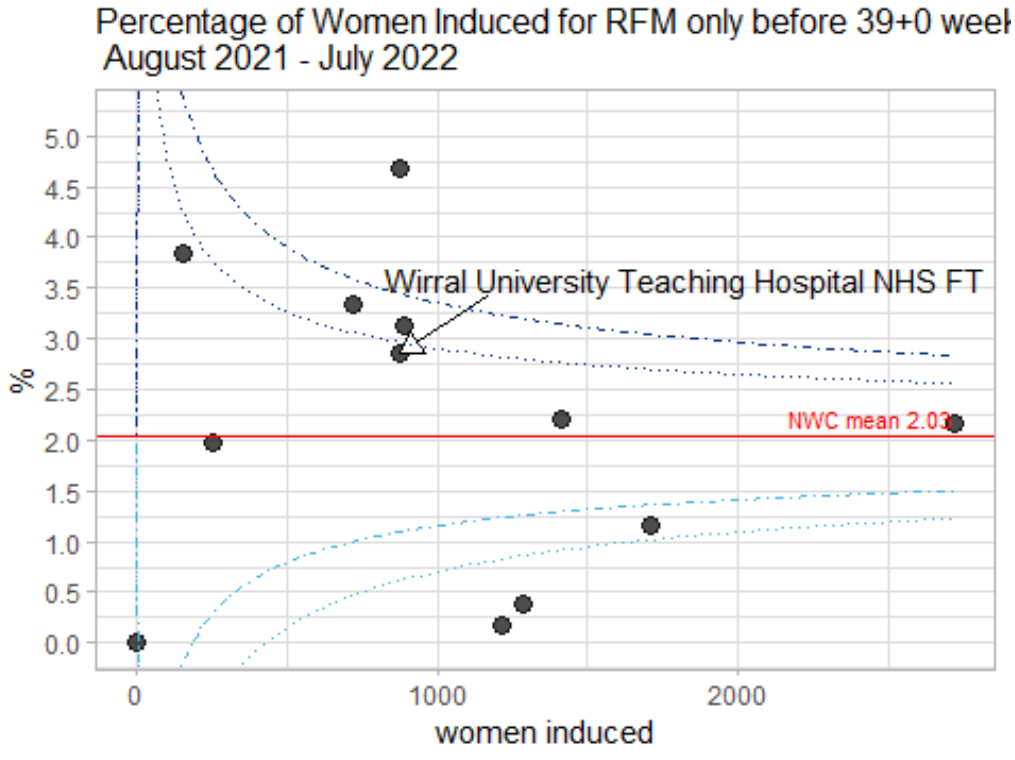
Data Source: NWC CN Maternity Dashboard

Run Chart for Intra-partum Stillbirth Rate



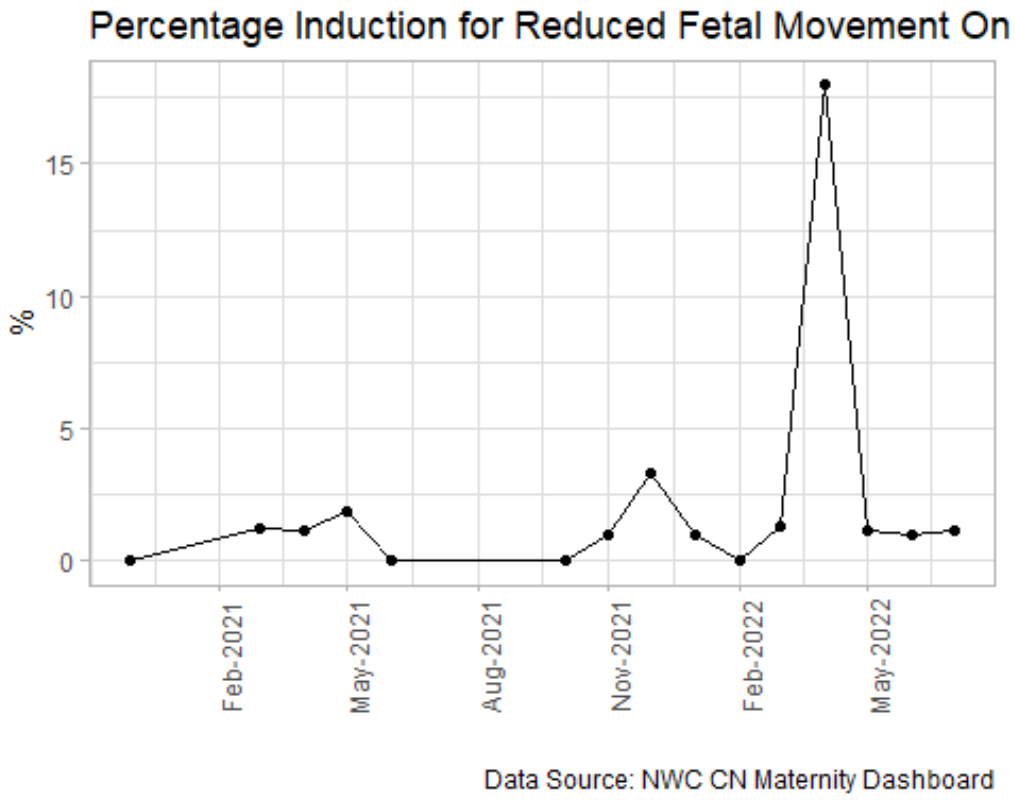
Data Source: NWC CN Maternity Dashboard

Induction for Reduced Fetal Movement Only



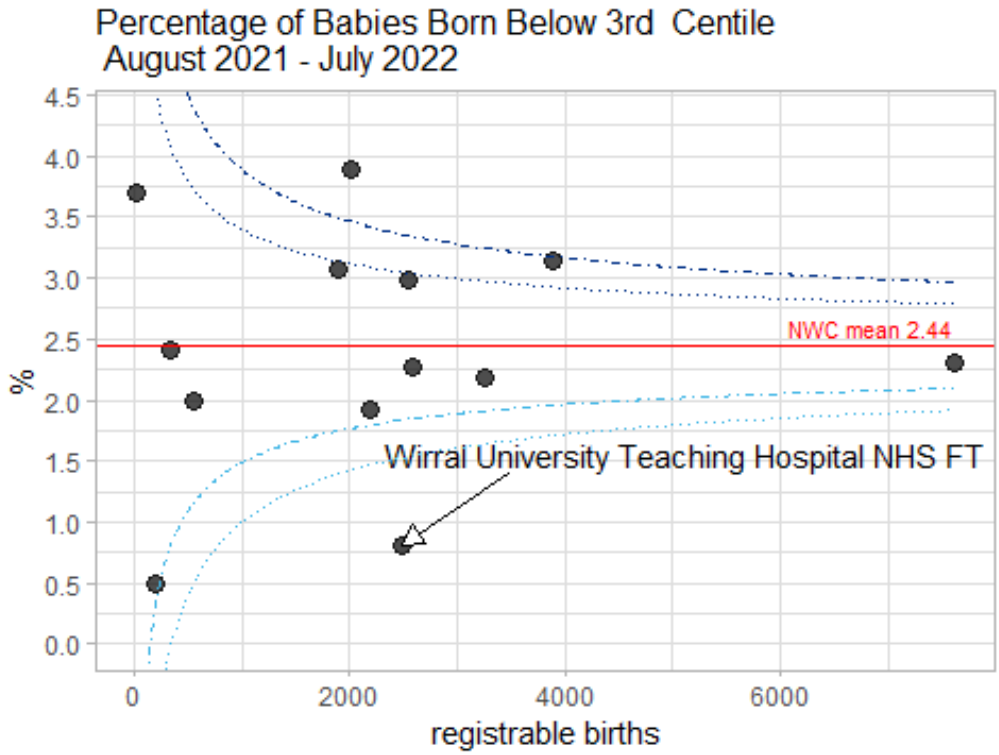
Data Source: NWC CN Maternity Dashboard

Run Chart for Induction for Reduced Fetal Movement Only



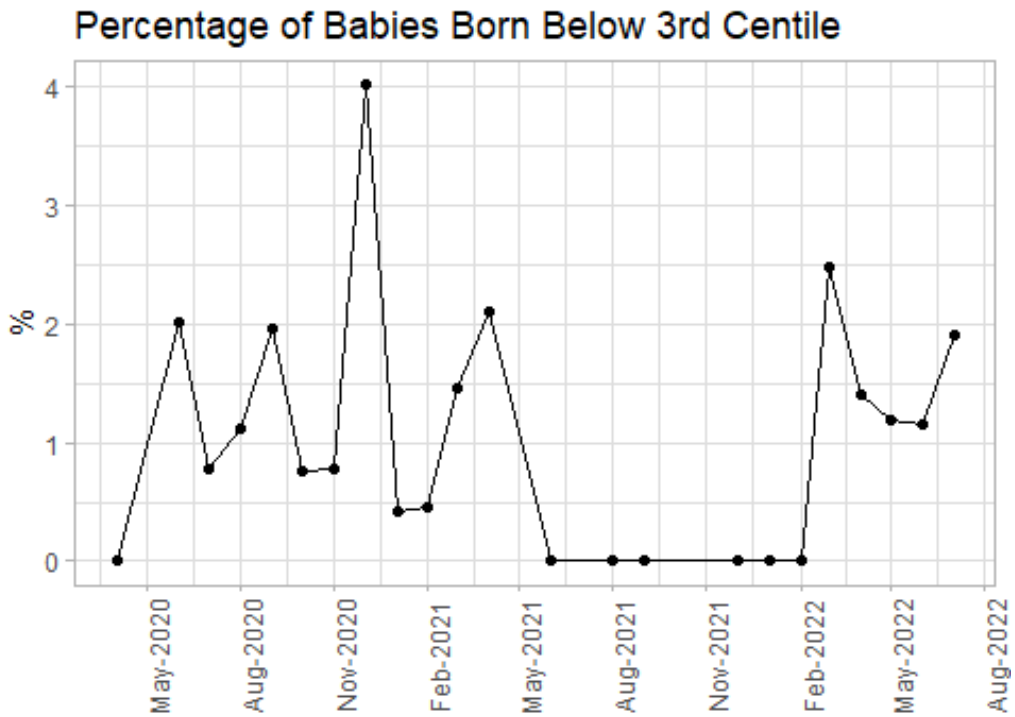
Low Birth Weight

Babies Born Below 3rd Centile



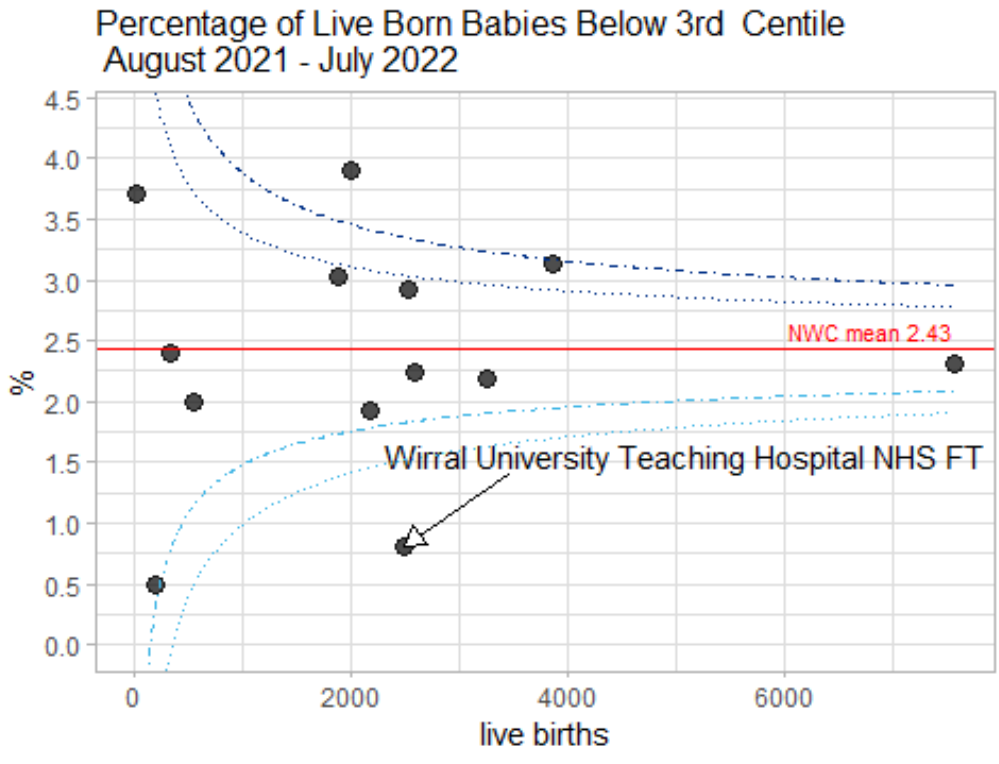
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born Below 3rd Centile



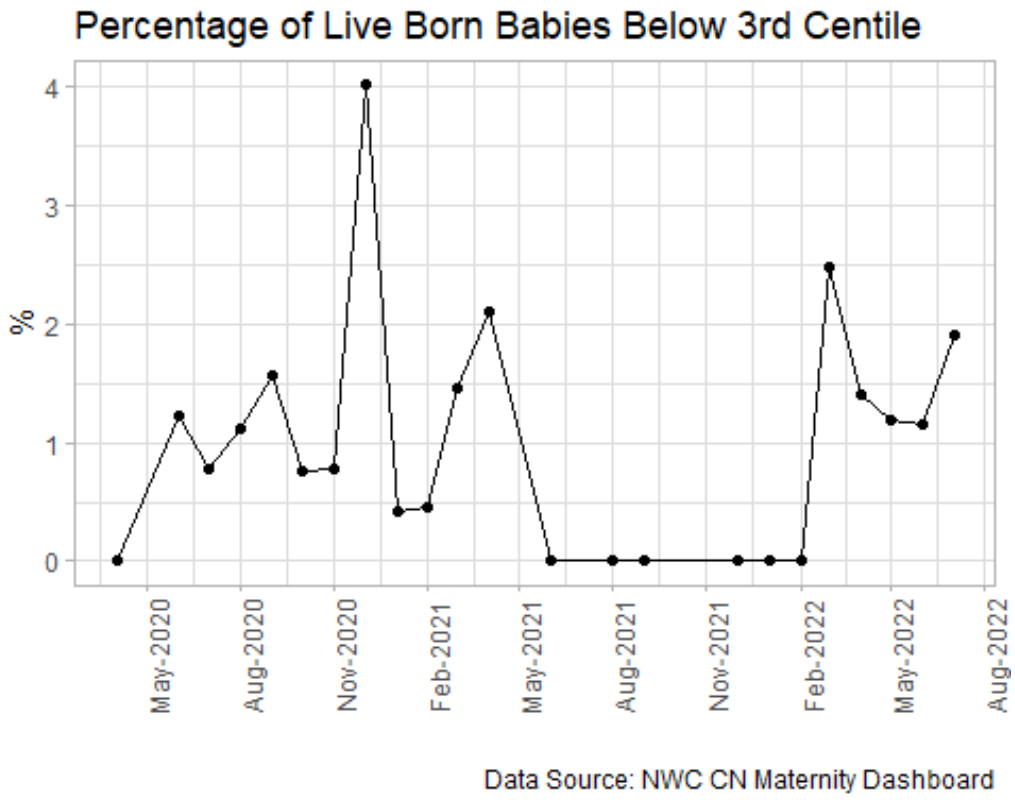
Data Source: NWC CN Maternity Dashboard

Live Born Babies Below 3rd Centile



Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Live Born Babies Below 3rd Centile

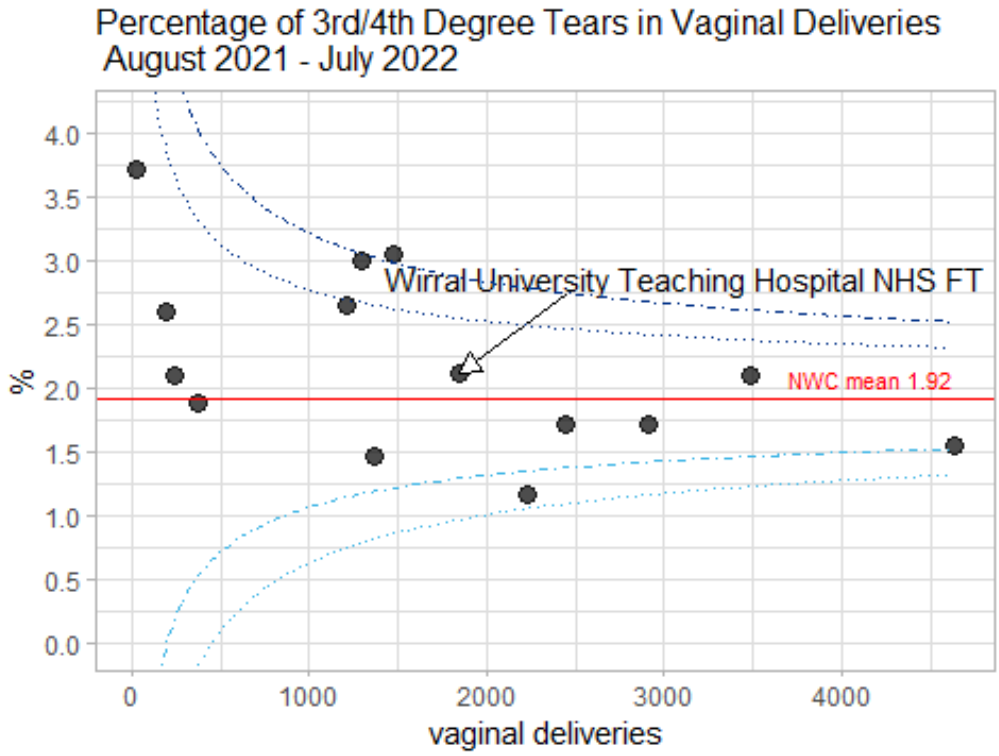


Data Source: NWC CN Maternity Dashboard

Safety

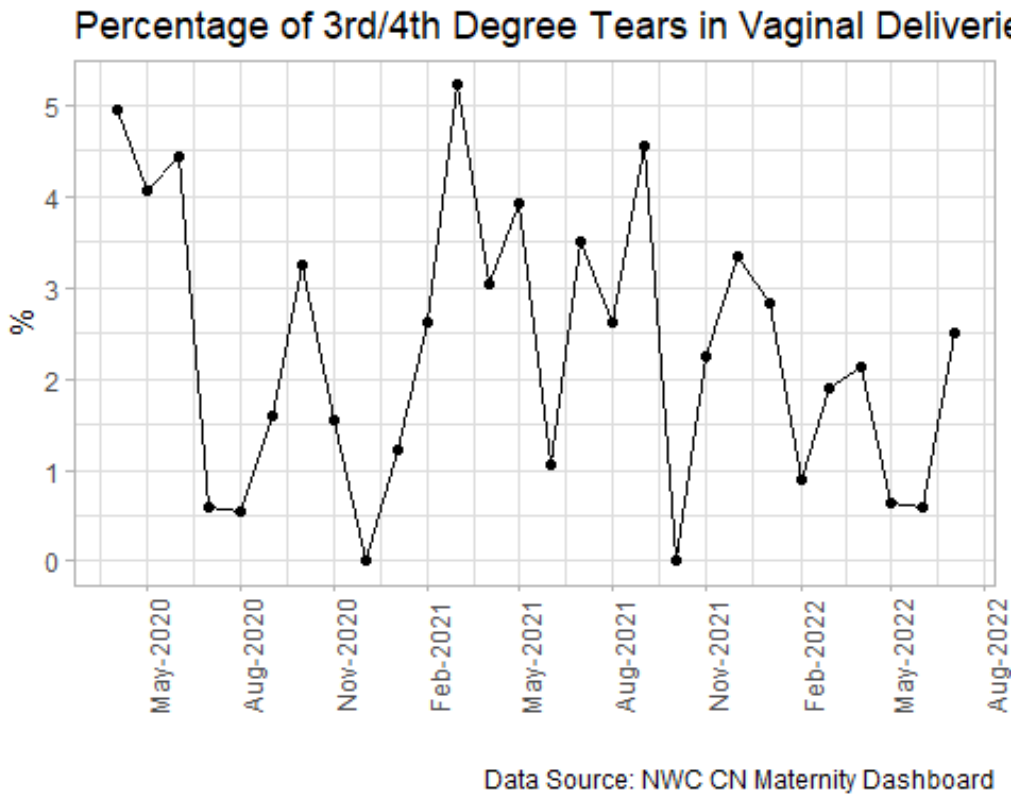
3rd/4th Degree Tears

3rd/4th Degree Tears in Vaginal Deliveries



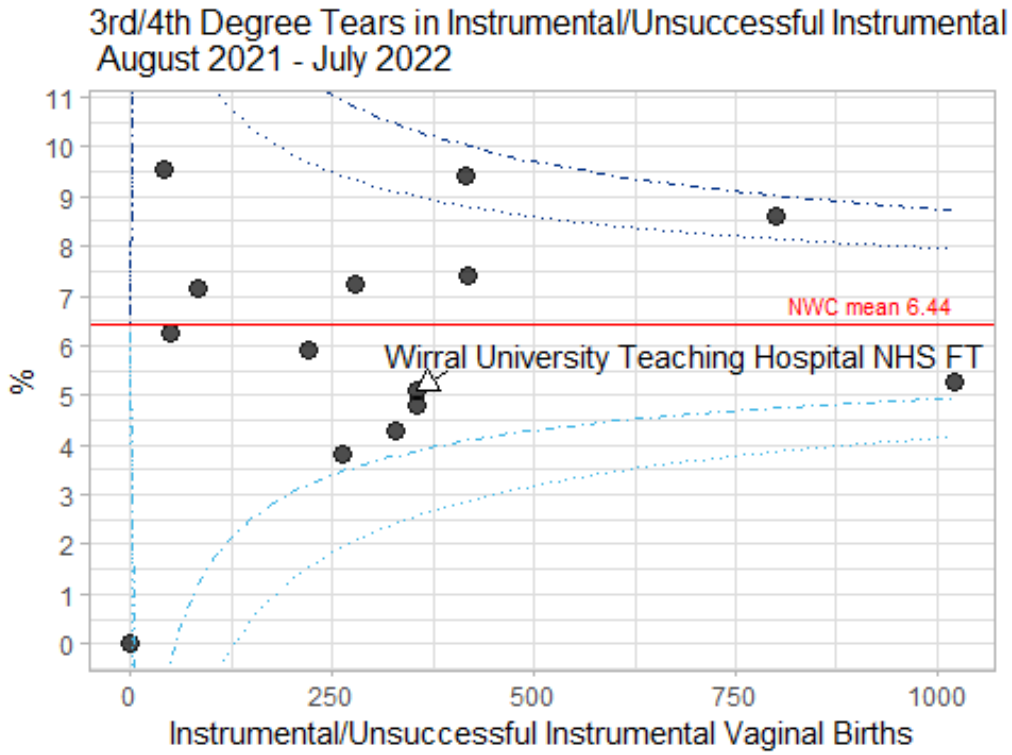
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of 3rd/4th Degree Tears in Vaginal Deliveries



Data Source: NWC CN Maternity Dashboard

3rd/4th Degree Tears in Instrumental/Unsuccessful Instrumental Vaginal Births



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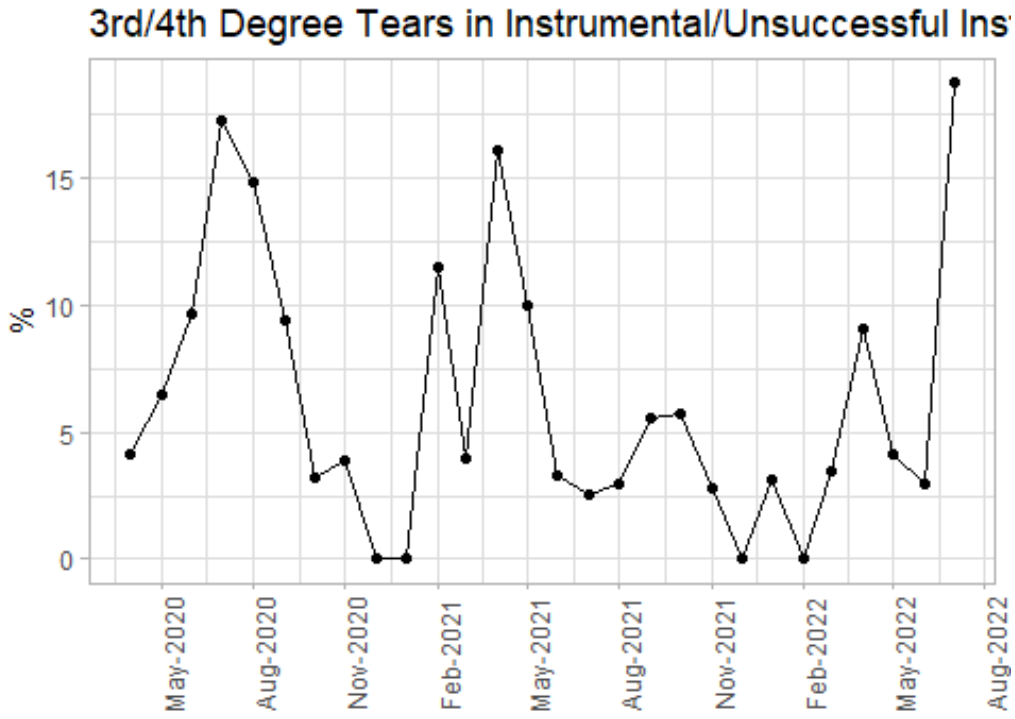
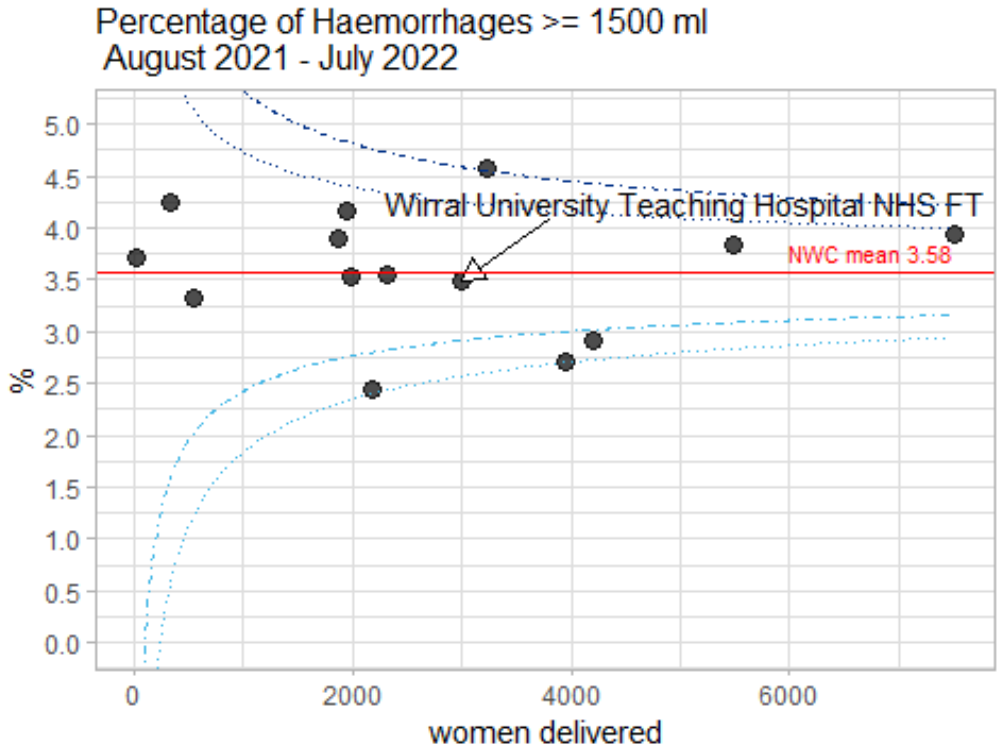


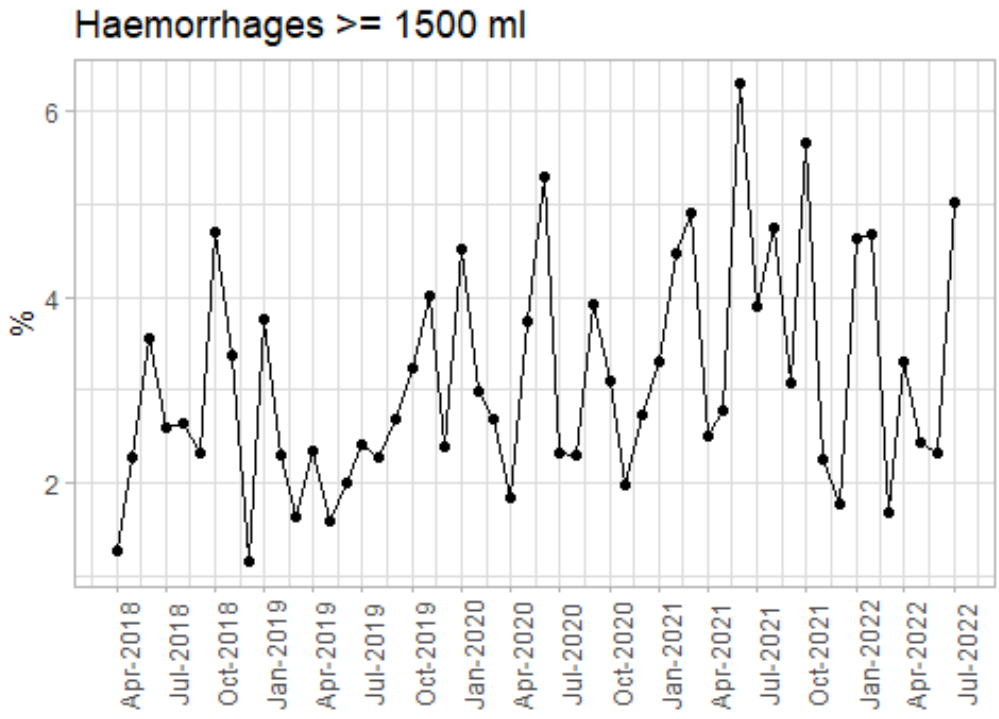
Data Source: NWC CN Maternity Dashboard

Percentage of Haemorrhages ≥1500 ml



Data Source: NWC CN Maternity Dashboard

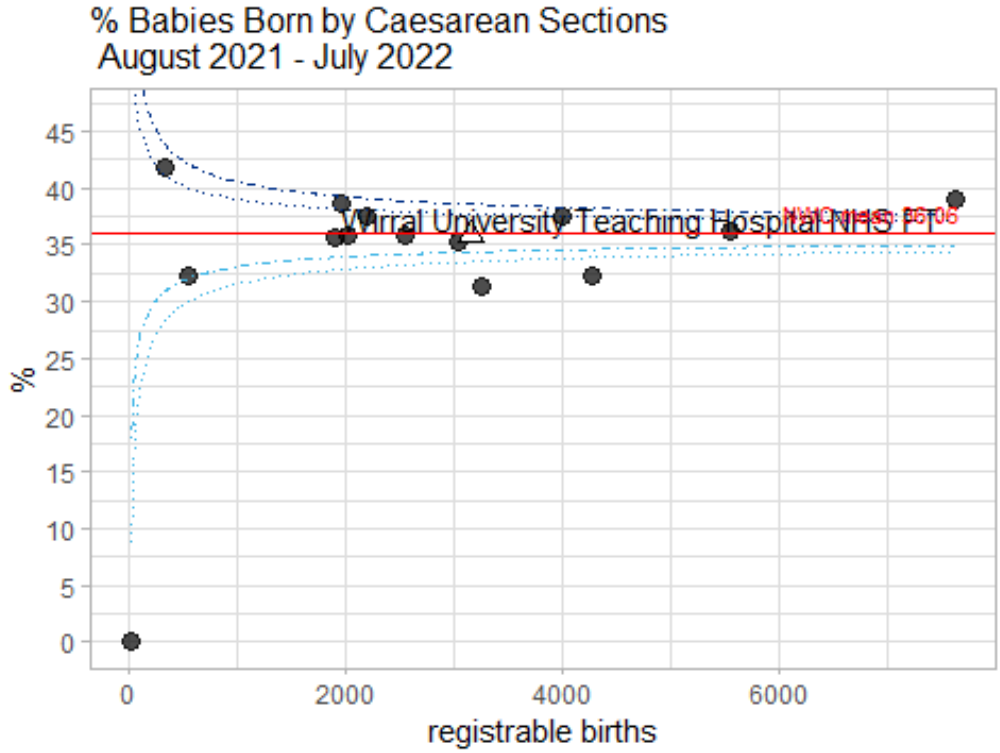
Run Chart for Percentage of Haemorrhages ≥1500 ml



Data Source: NWC CN Maternity Dashboard

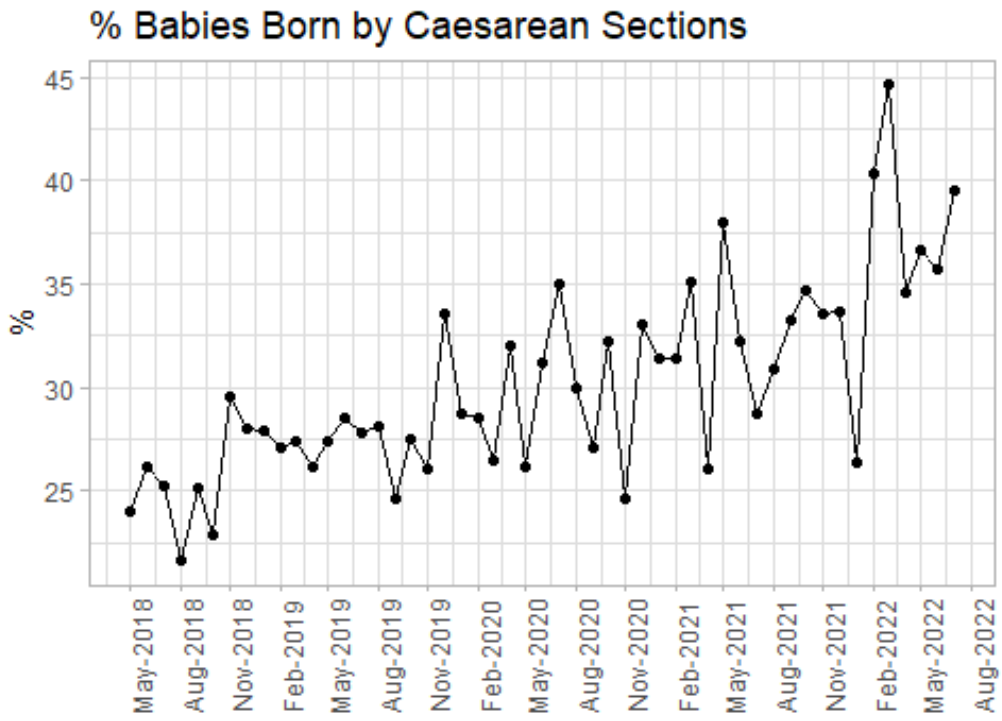
Caesarean Sections

Total Caesarean Sections



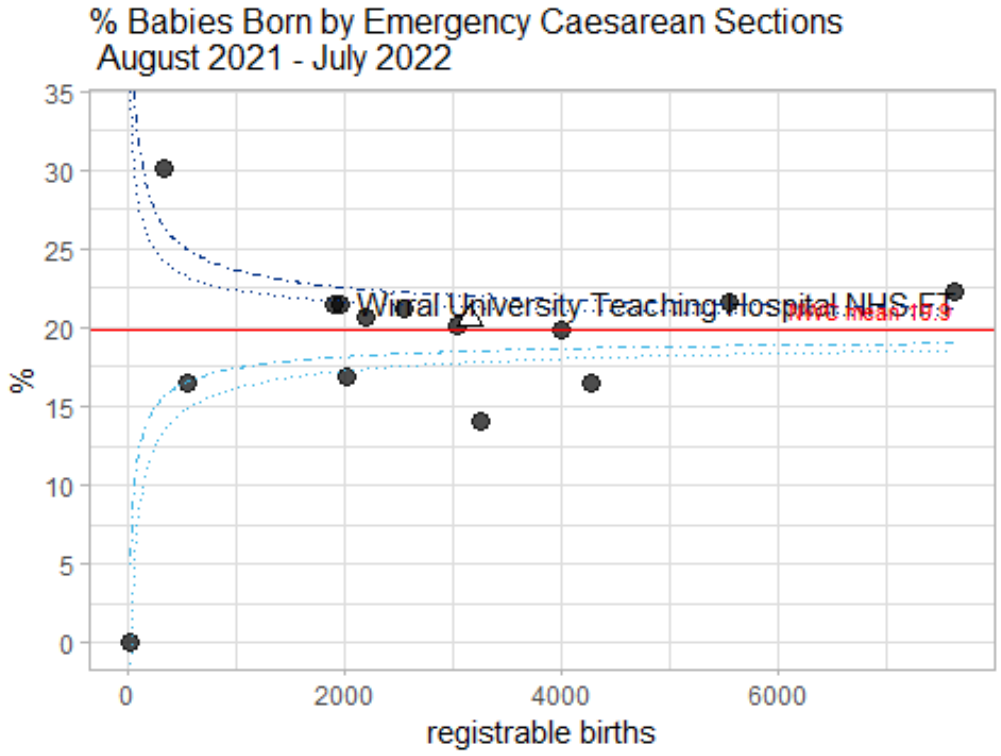
Data Source: NWC CN Maternity Dashboard

Run Chart for Caesarean Section



Data Source: NWC CN Maternity Dashboard

Emergency CS Rate



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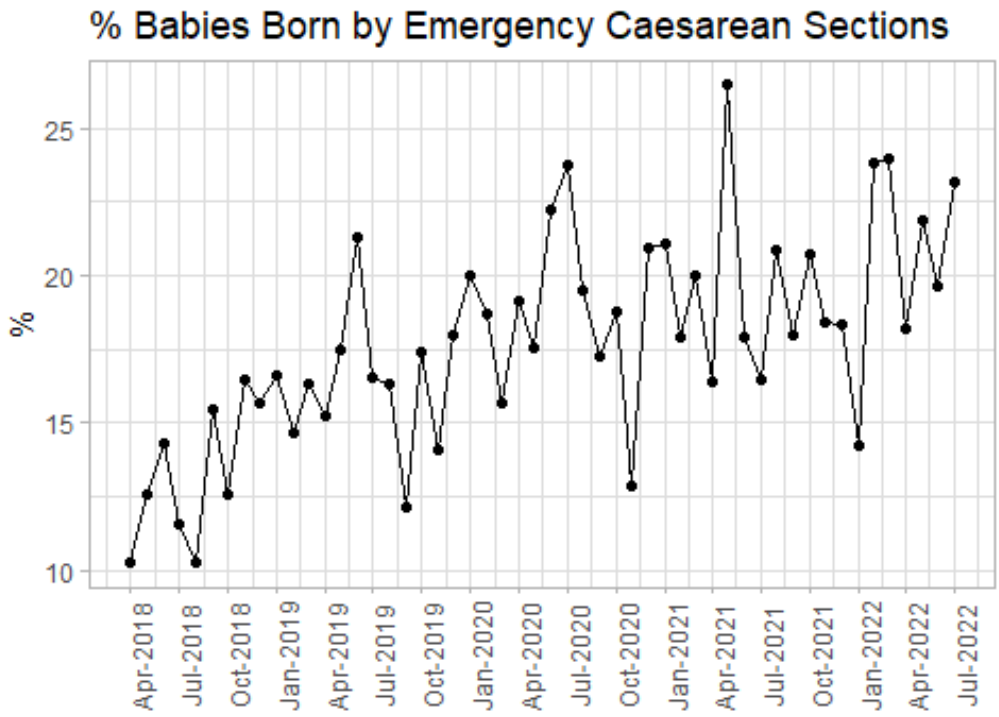
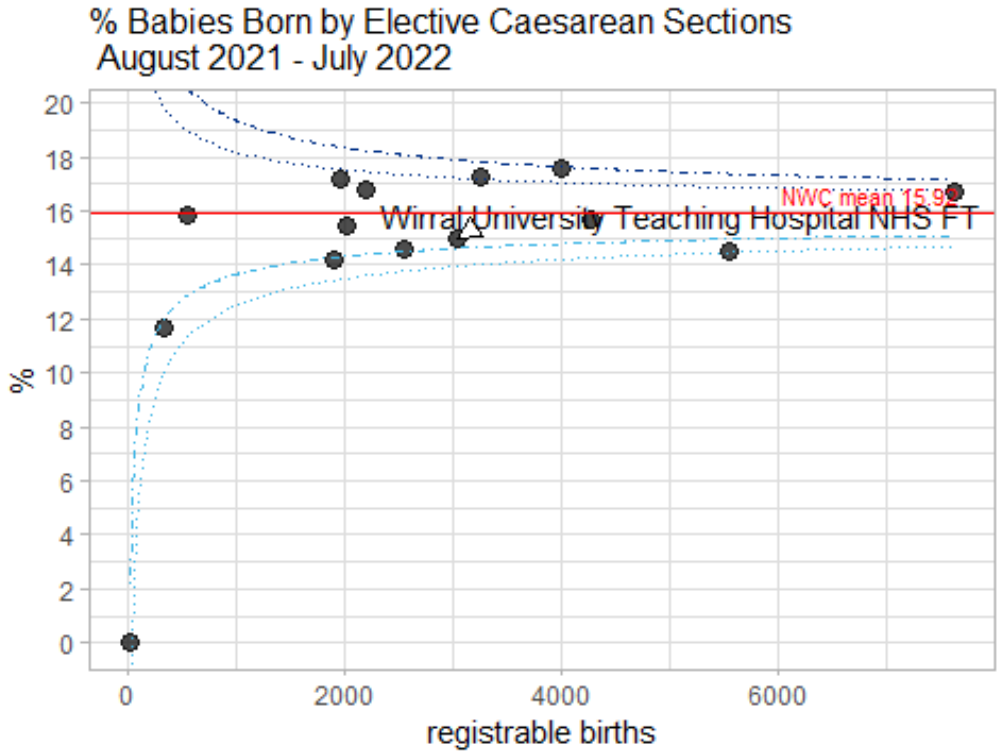
Run Chart for Emergency Caesarean Section



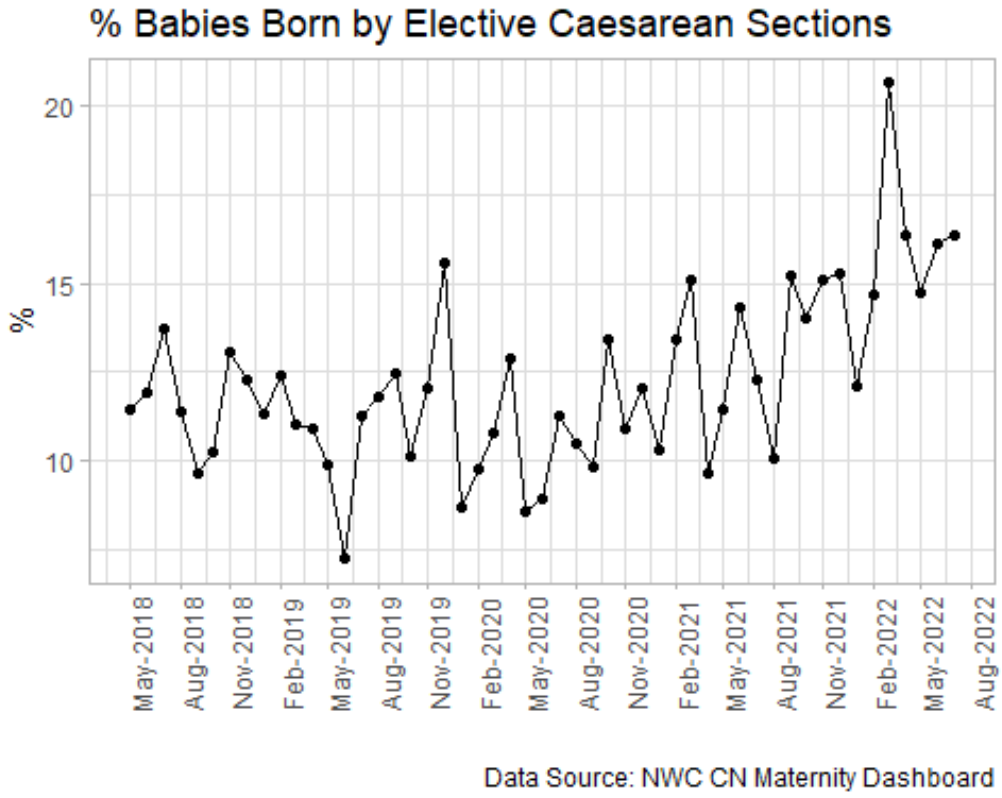
Data Source: NWC CN Maternity Dashboard

Elective (Cat 4) Caesarean Section



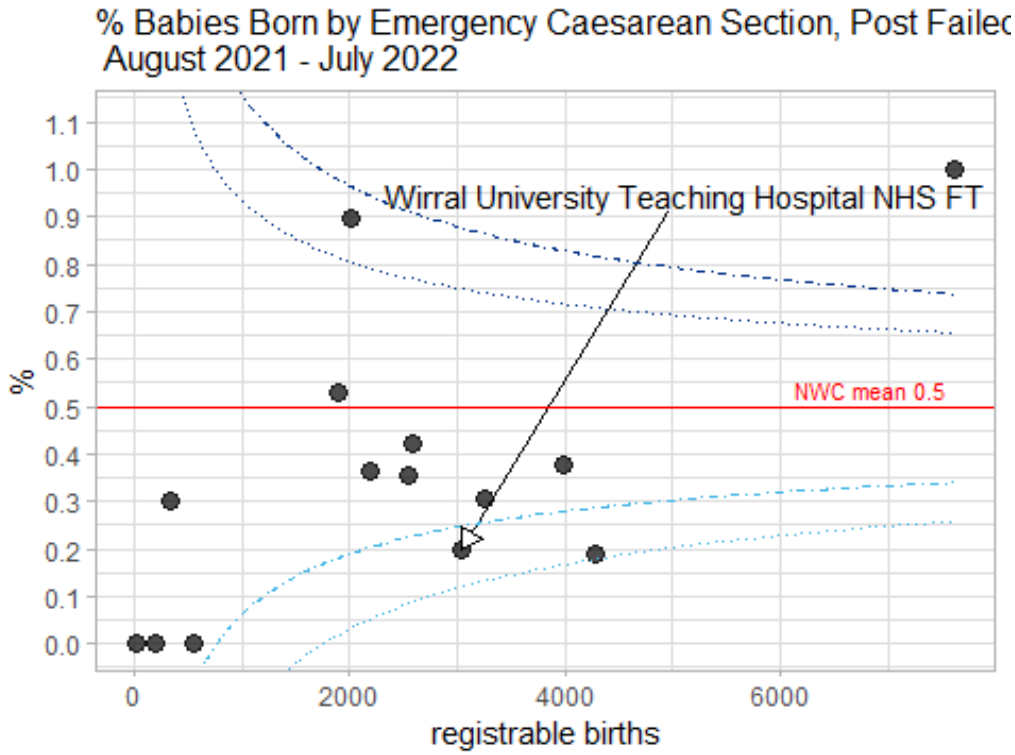
Data Source: NWC CN Maternity Dashboard

Run Chart for Elective Caesarean Section



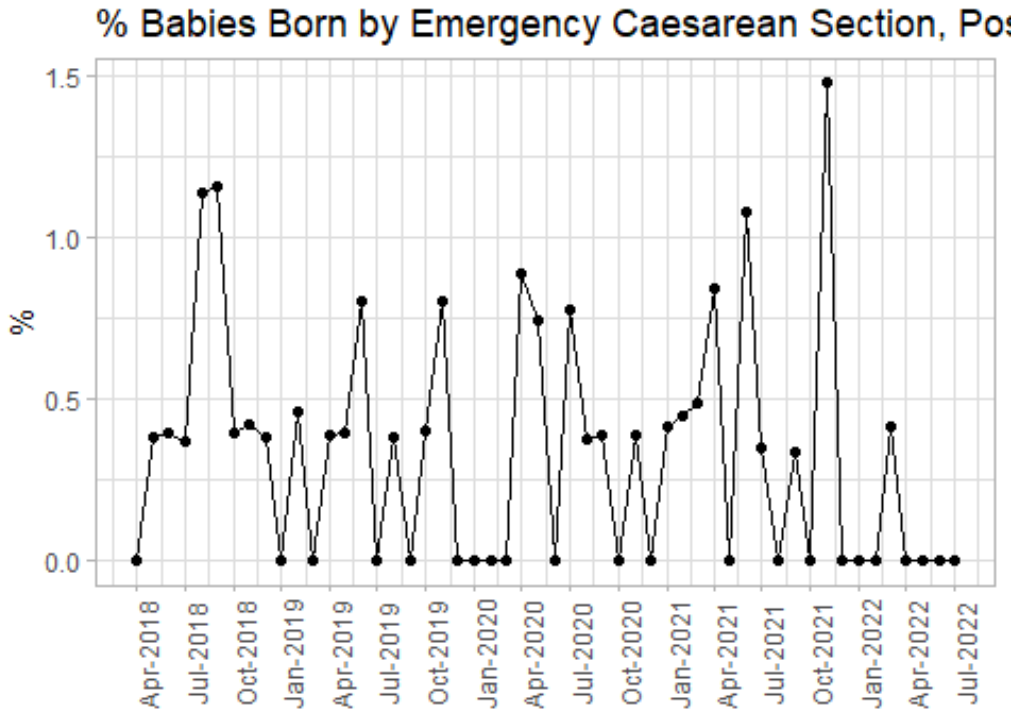
Data Source: NWC CN Maternity Dashboard

Babies Born by Emergency Caesarean Section, Post Failed Instrumental Delivery



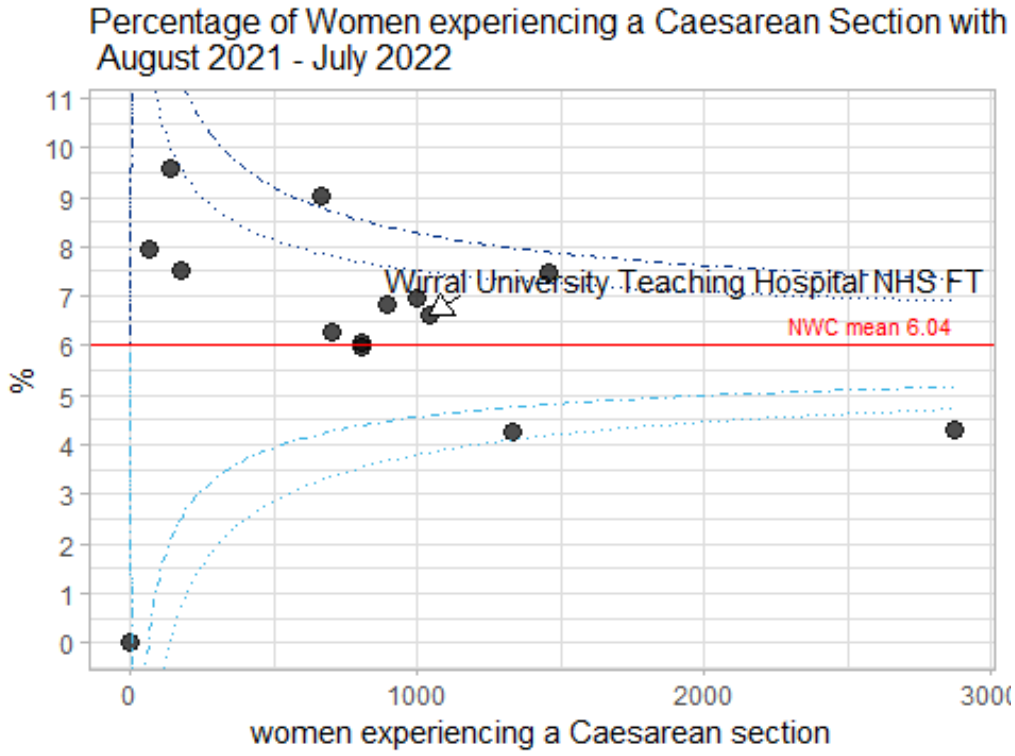
Data Source: NWC CN Maternity Dashboard

Run Chart for Emergency Caesarean Section, Post Failed Instrumental Delivery



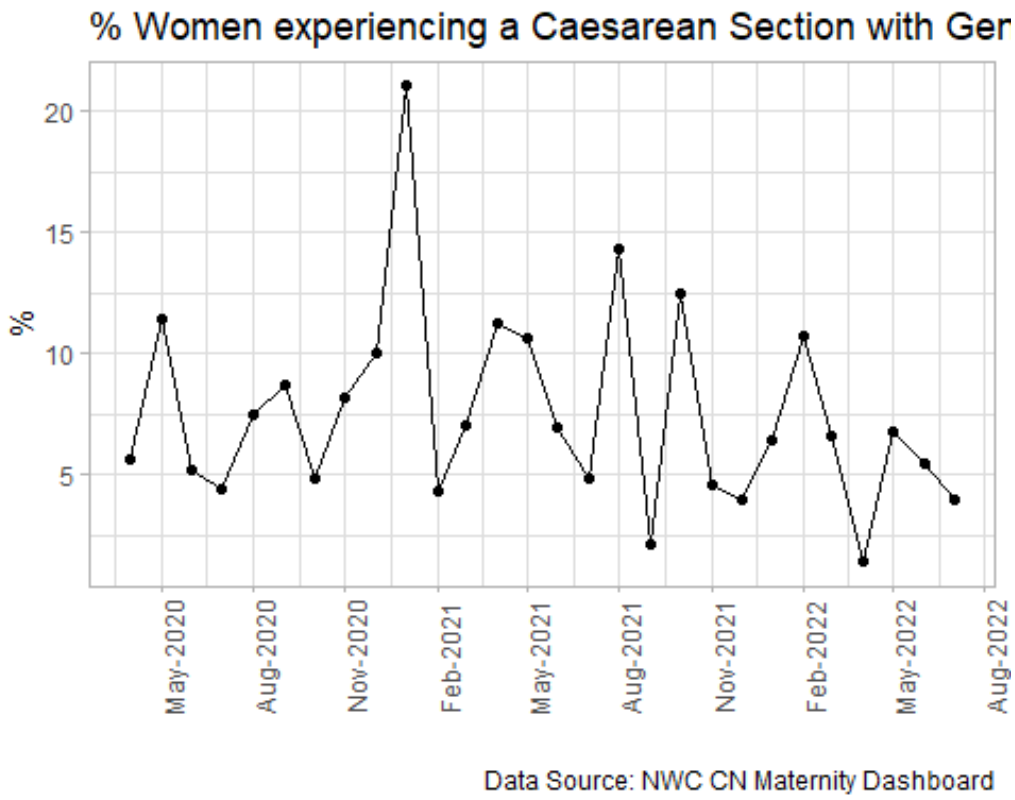
Data Source: NWC CN Maternity Dashboard

Women experiencing a Caesarean Section with General Anaesthesia



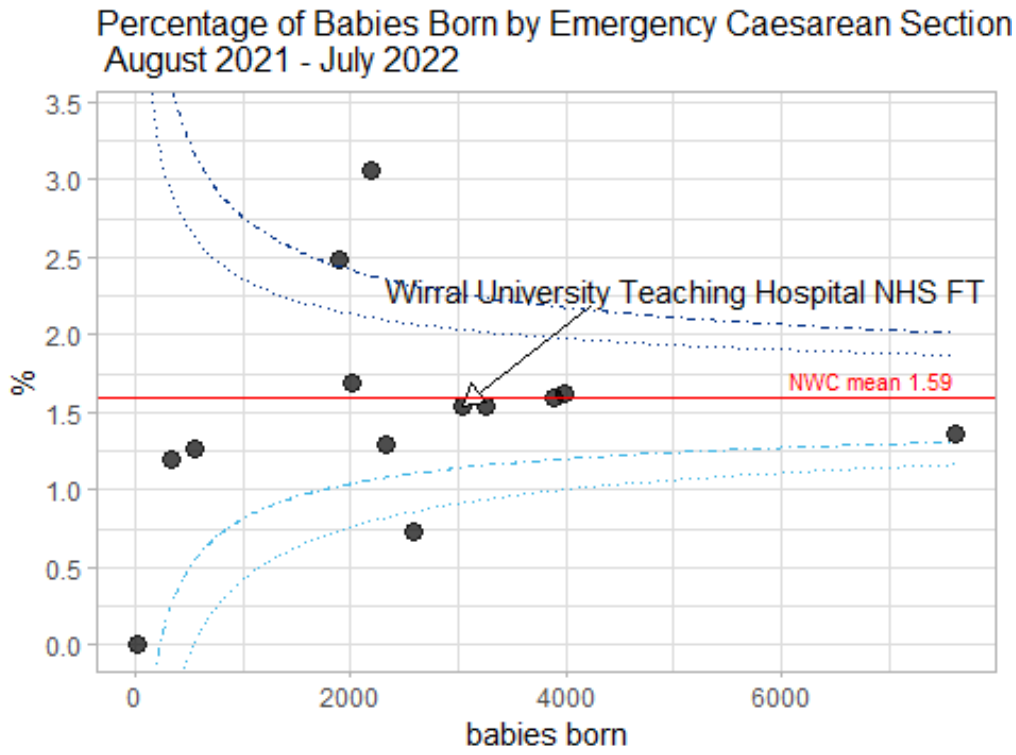
Data Source: NWC CN Maternity Dashboard

Run Chart for Women experiencing a Caesarean Section with General Anaesthesia



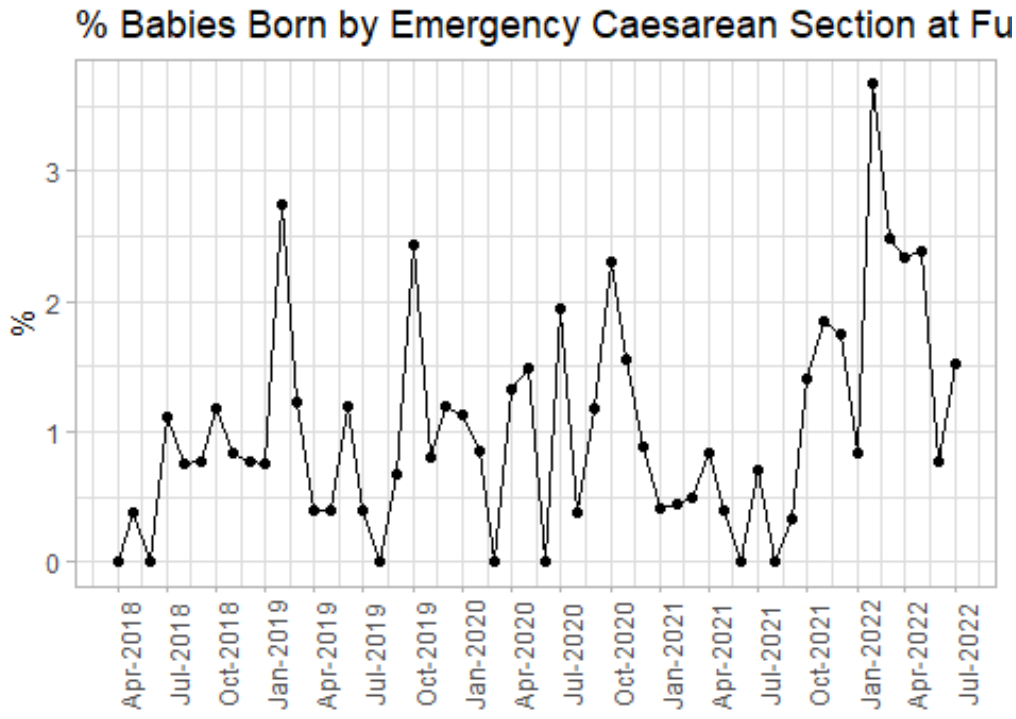
Data Source: NWC CN Maternity Dashboard

Babies Born by Emergency Caesarean Section at Full Dilation



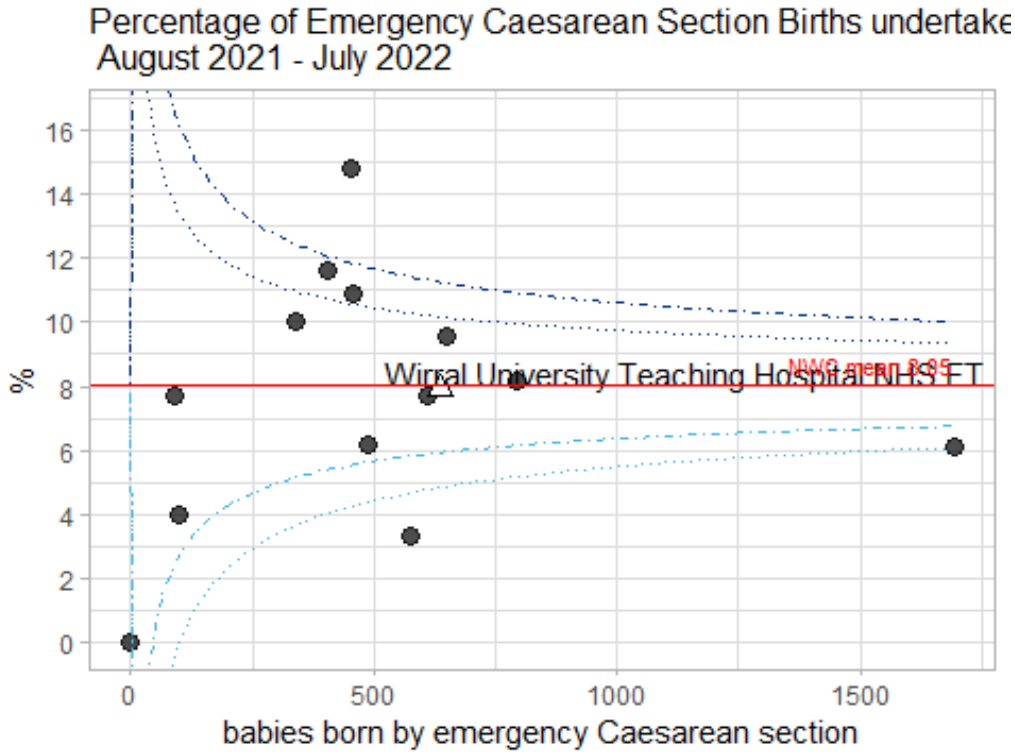
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Born by Emergency Caesarean Section at Full Dilation



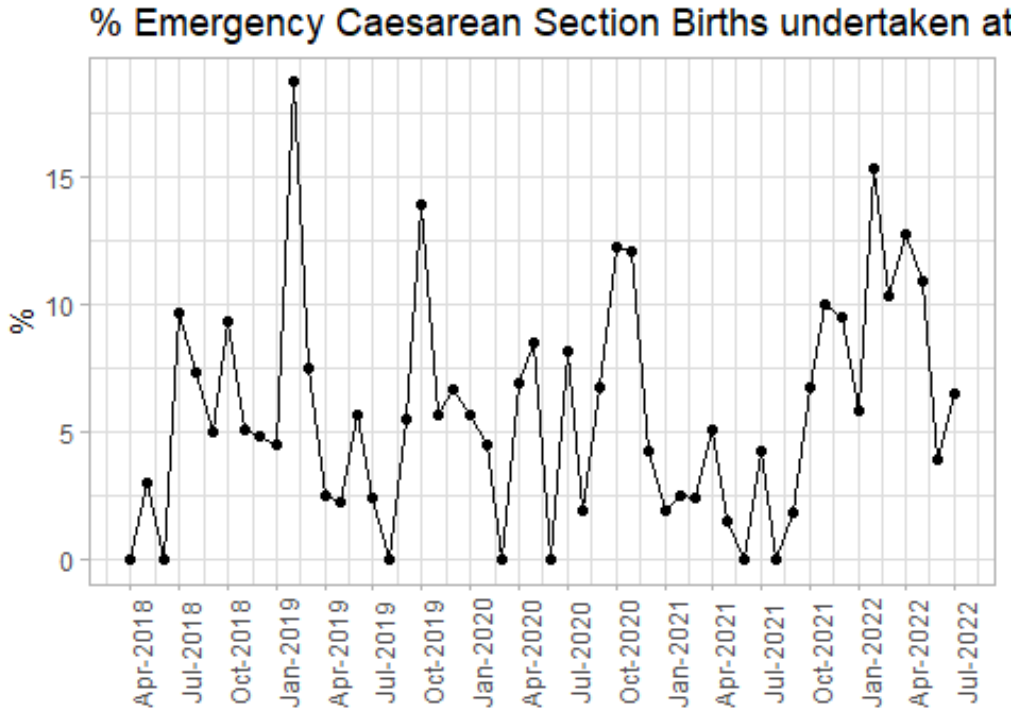
Data Source: NWC CN Maternity Dashboard

Emergency Caesarean Section Births undertaken at Full Dilation



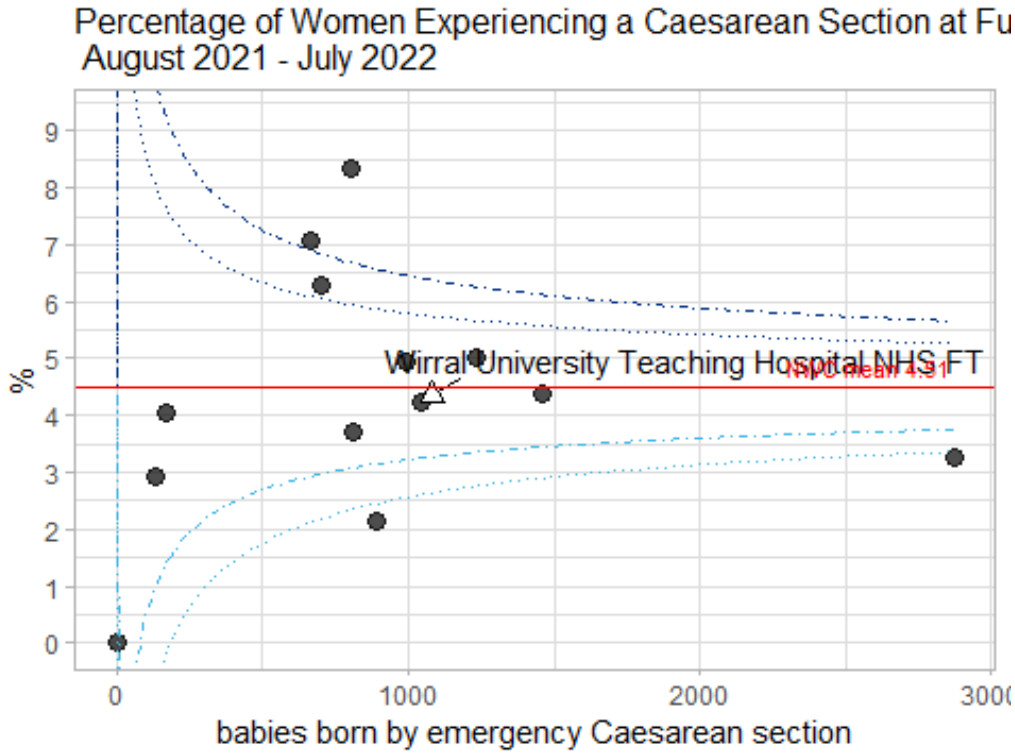
Data Source: NWC CN Maternity Dashboard

Run Chart for Emergency Caesarean Section Births undertaken at Full Dilation



Data Source: NWC CN Maternity Dashboard

Women Experiencing a Caesarean Section at Full Dilation



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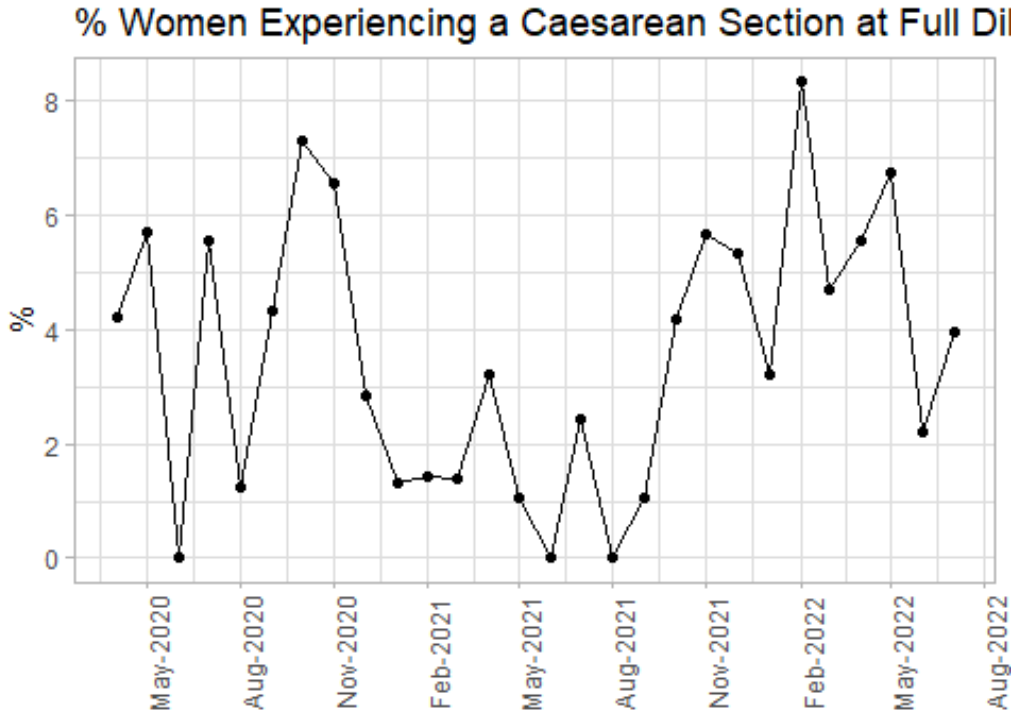
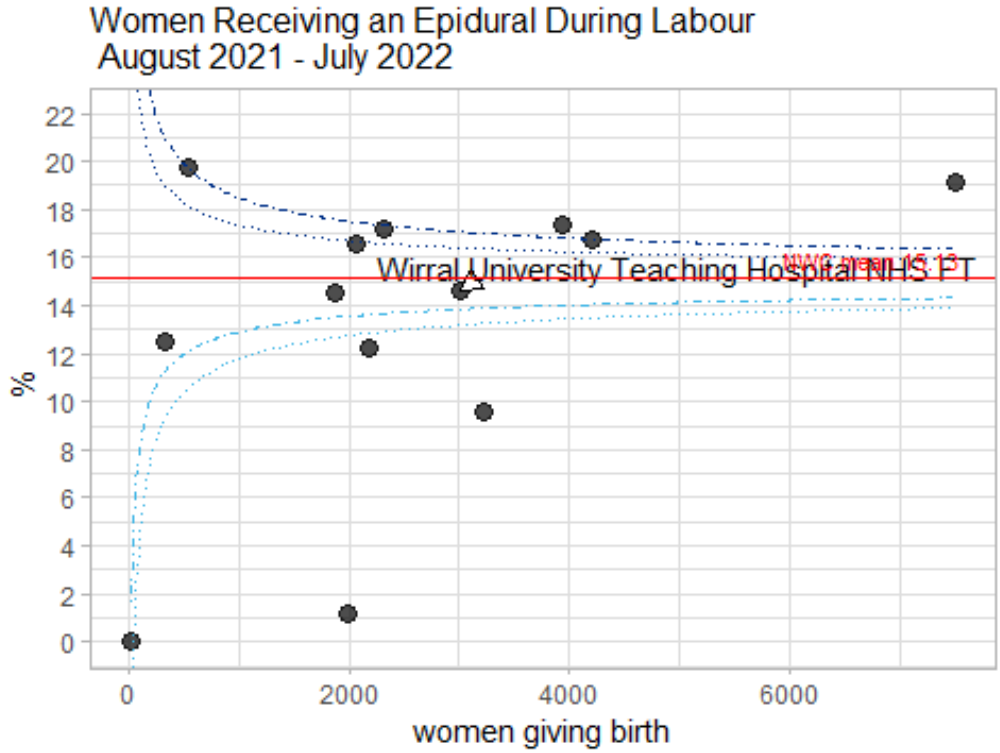
Run Chart for Women Experiencing a Caesarean Section at Full Dilation



Data Source: NWC CN Maternity Dashboard

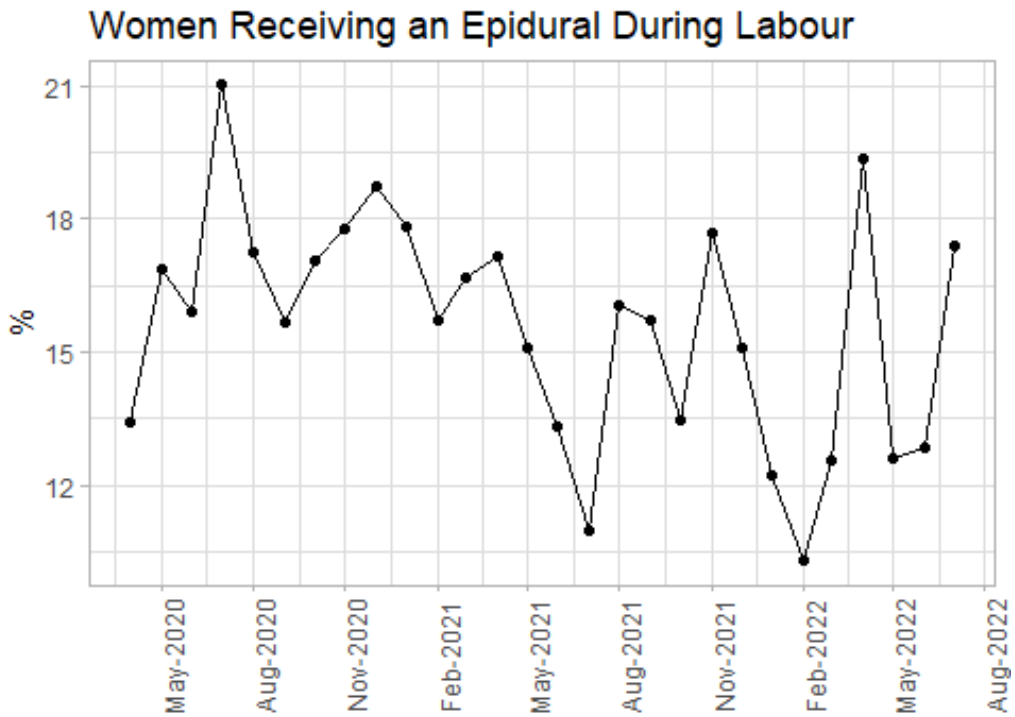
Epidural

Women Recieving an Epidural During Labour



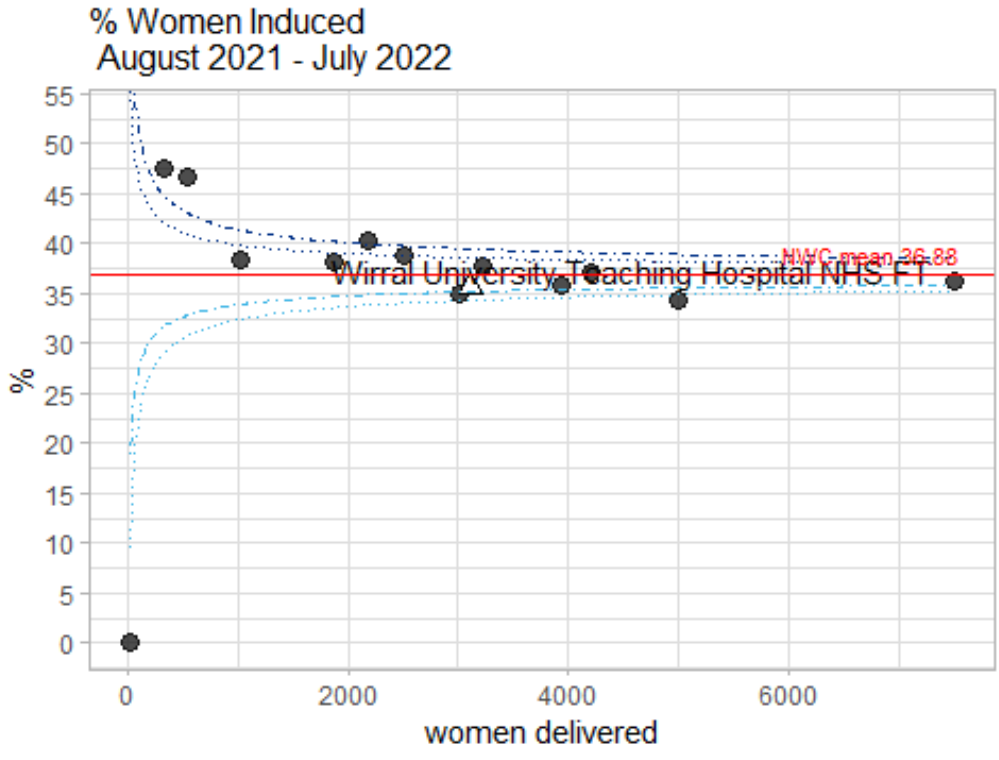
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Receiving an Epidural During Labour



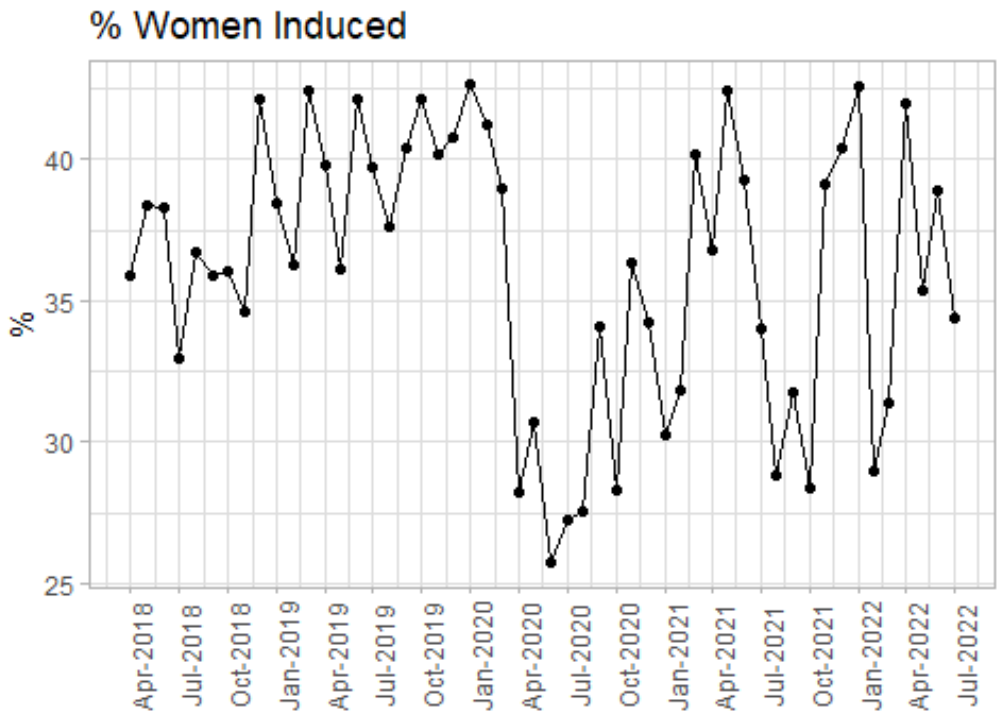
Data Source: NWC CN Maternity Dashboard

Induction of Labour



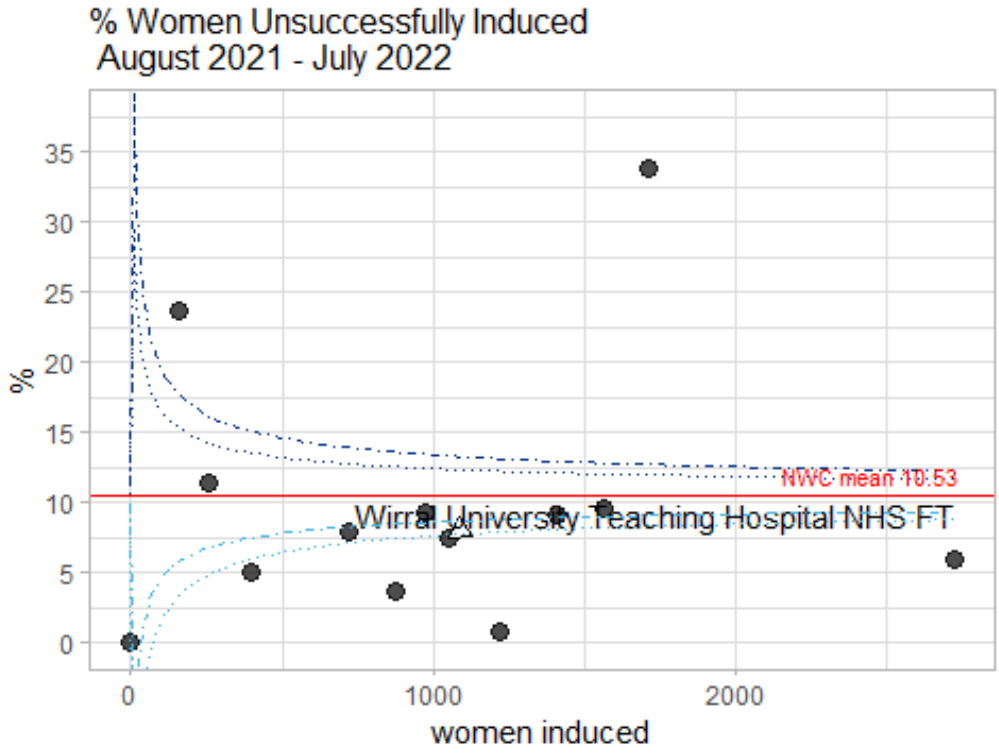
Data Source: NWC CN Maternity Dashboard

Run Chart for Induction of Labour



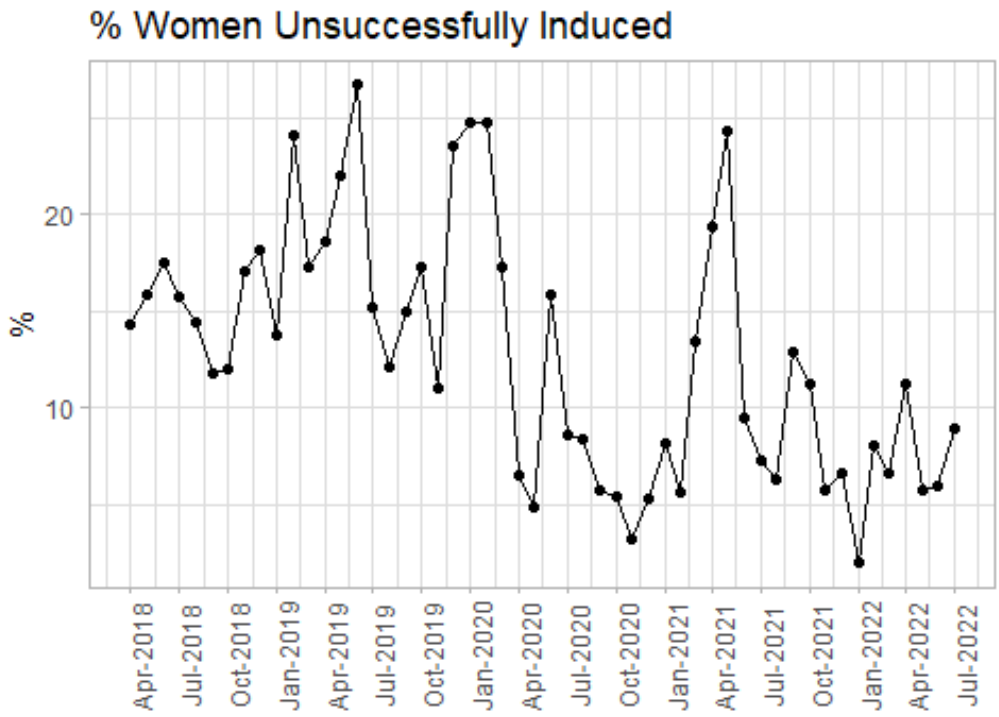
Data Source: NWC CN Maternity Dashboard

Unsuccessful Induction of Labour



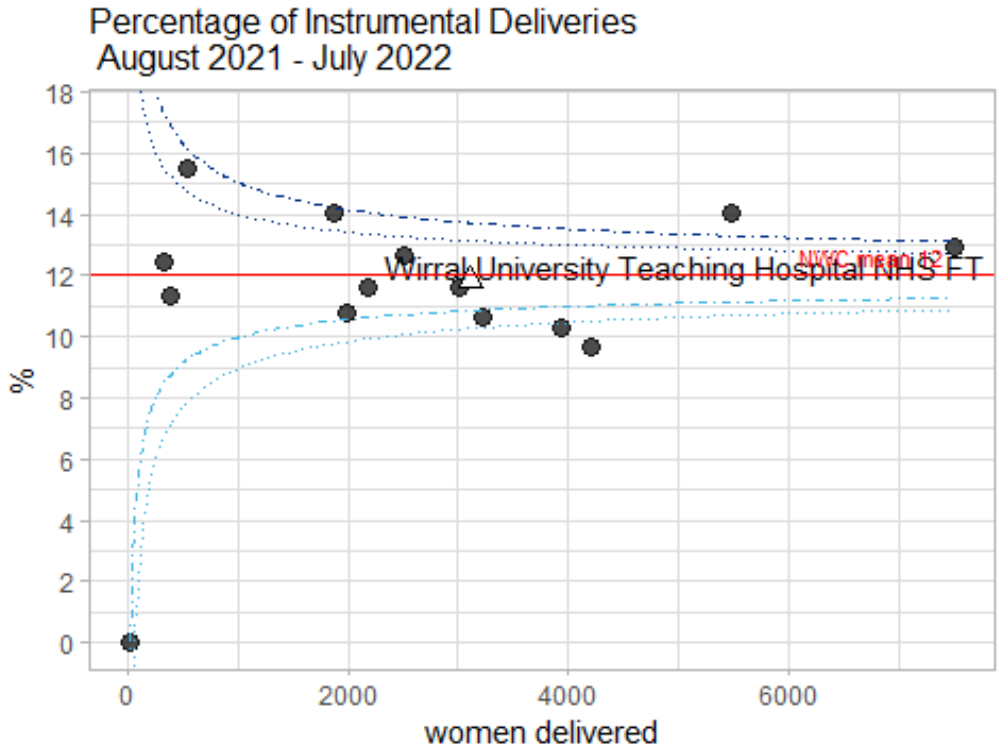
Data Source: NWC CN Maternity Dashboard

Run Chart for Unsuccessful Induction of Labour



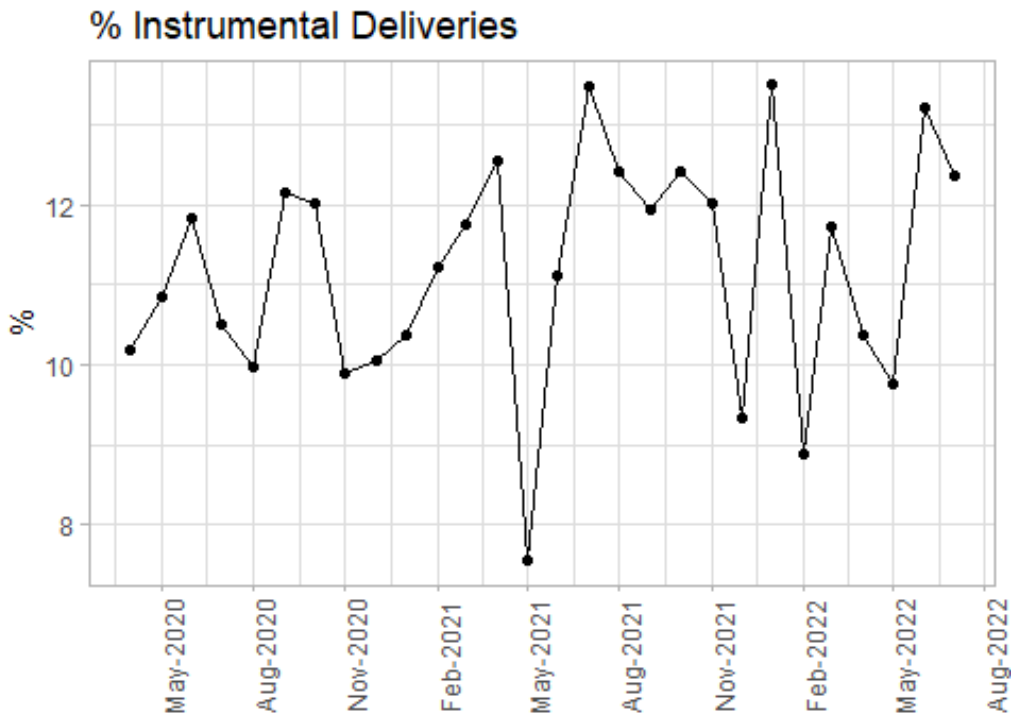
Data Source: NWC CN Maternity Dashboard

Instrumental Deliveries



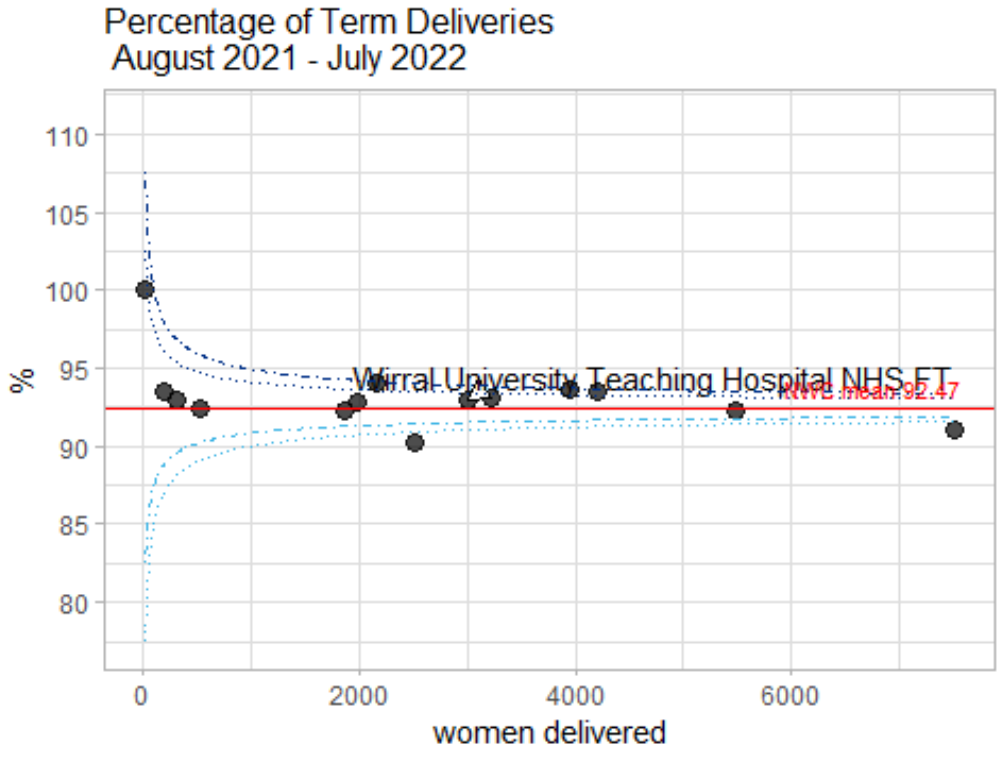
Data Source: NWC CN Maternity Dashboard

Run Chart for Instrumental Deliveries



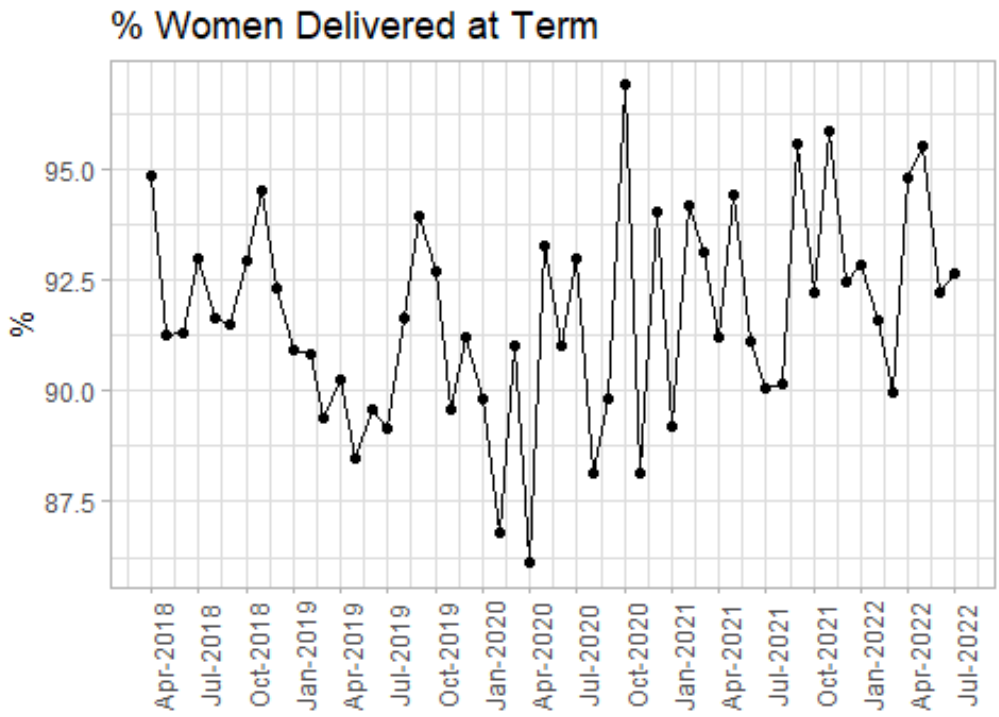
Data Source: NWC CN Maternity Dashboard

Term Deliveries



Data Source: NWC CN Maternity Dashboard

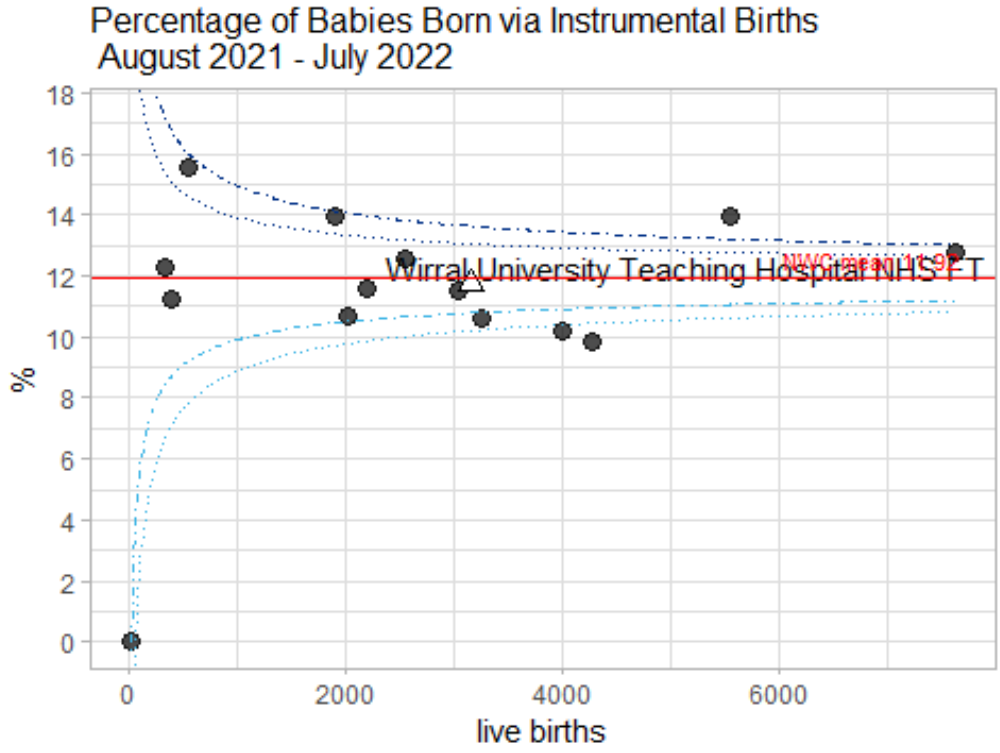
Run Chart for Term Deliveries



Data Source: NWC CN Maternity Dashboard

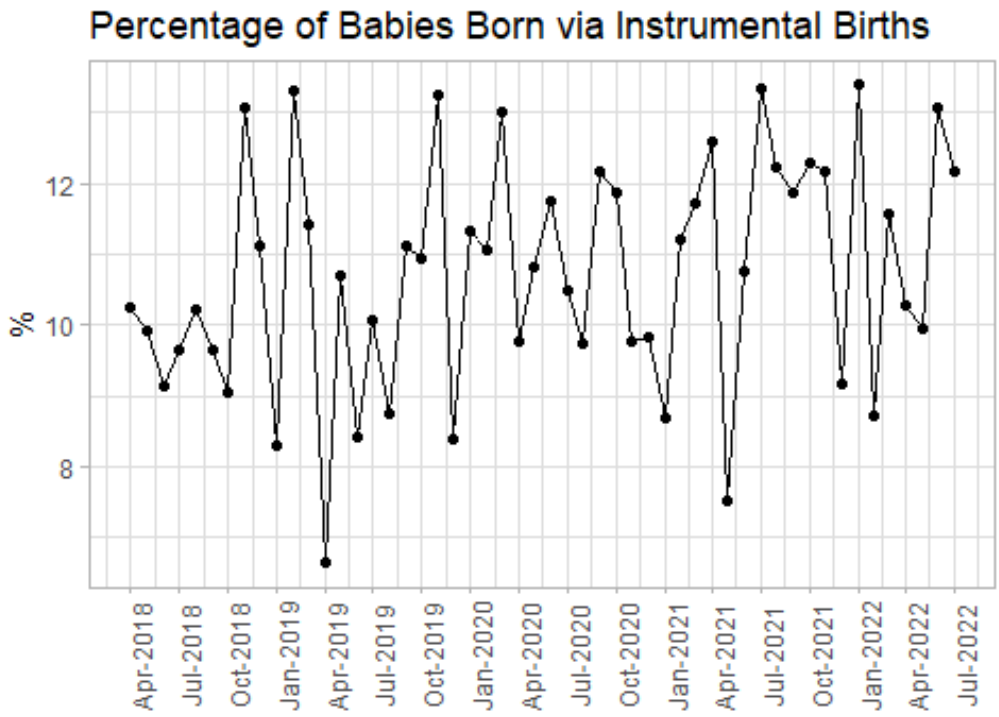
Assisted Vaginal Births

Babies Born via Instrumental Births



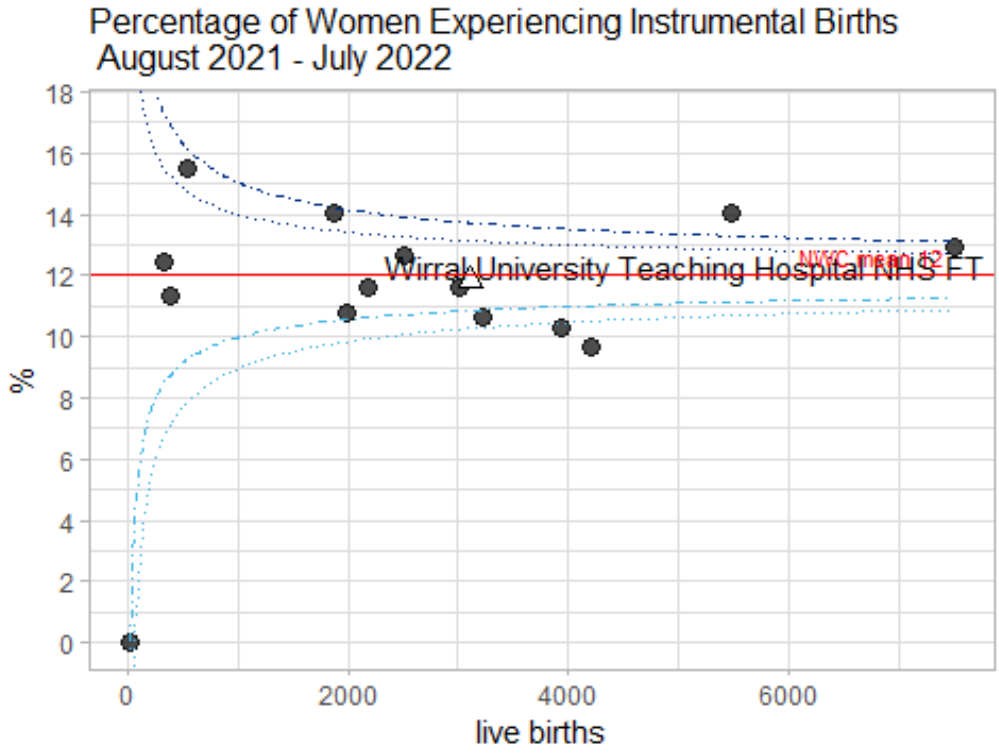
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born via Instrumental Births



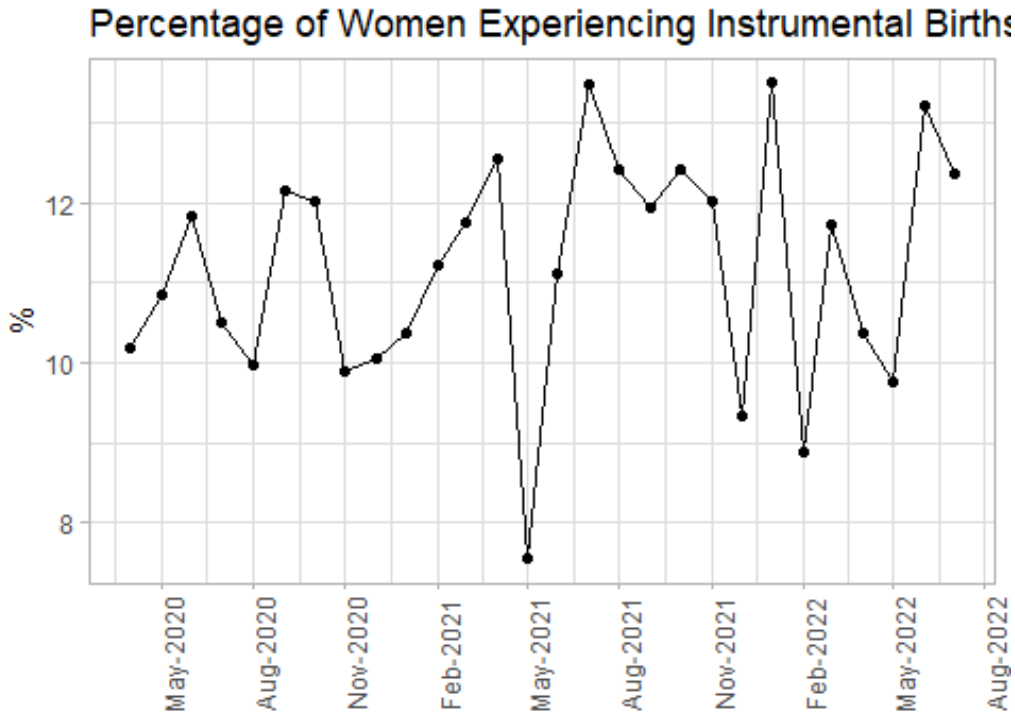
Data Source: NWC CN Maternity Dashboard

Women Experiencing Instrumental Births



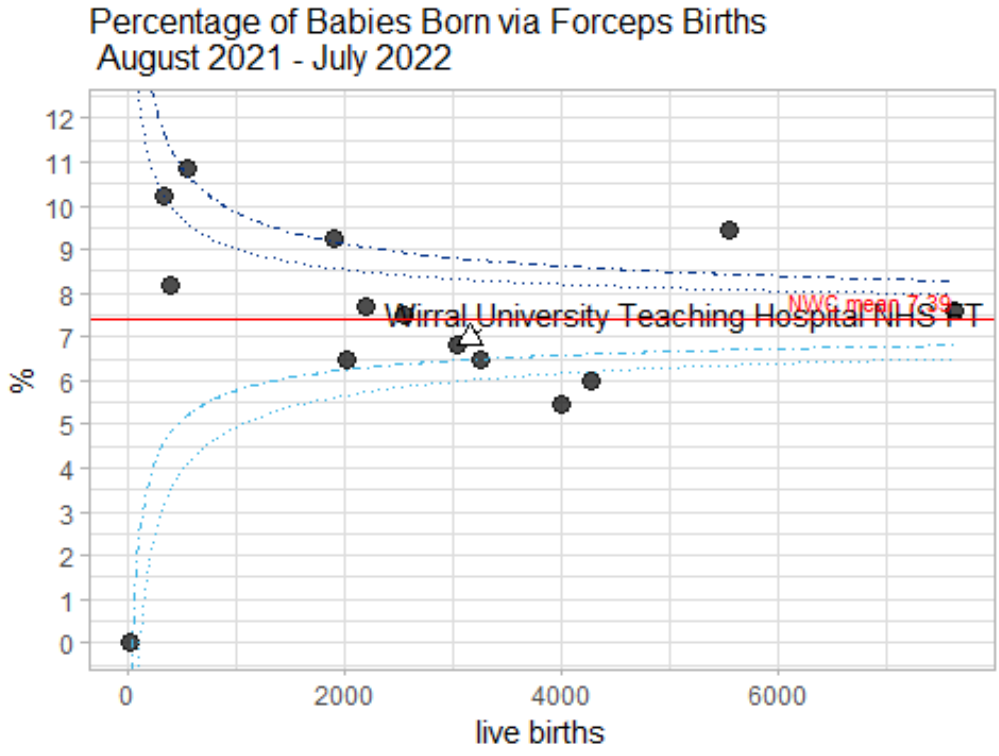
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Women Experiencing Instrumental Births



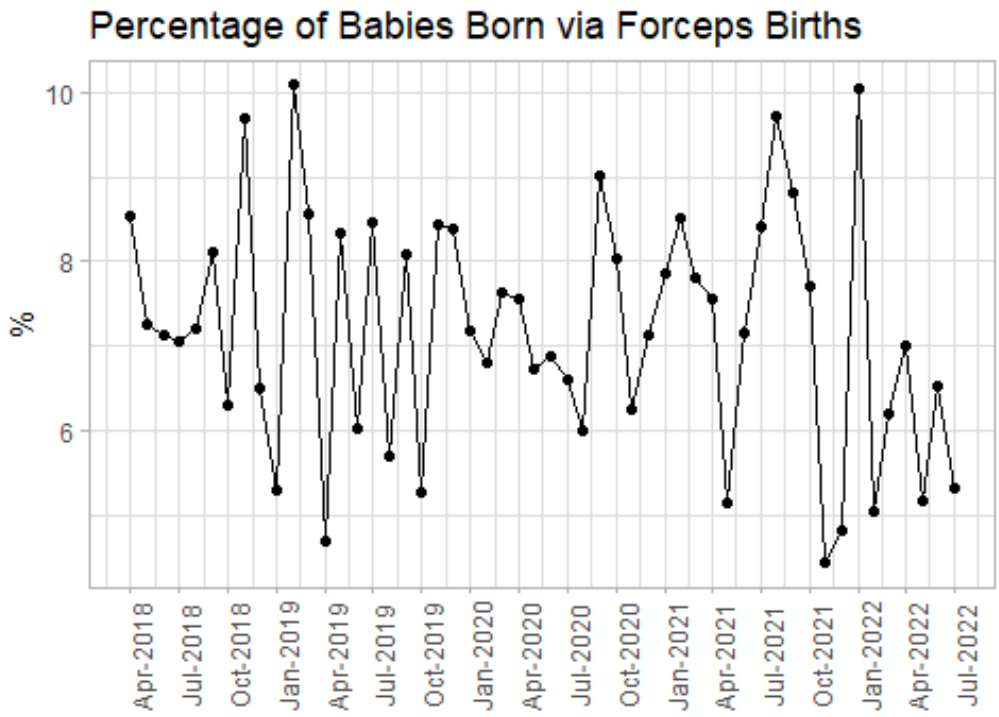
Data Source: NWC CN Maternity Dashboard

Babies Born via Forceps Births



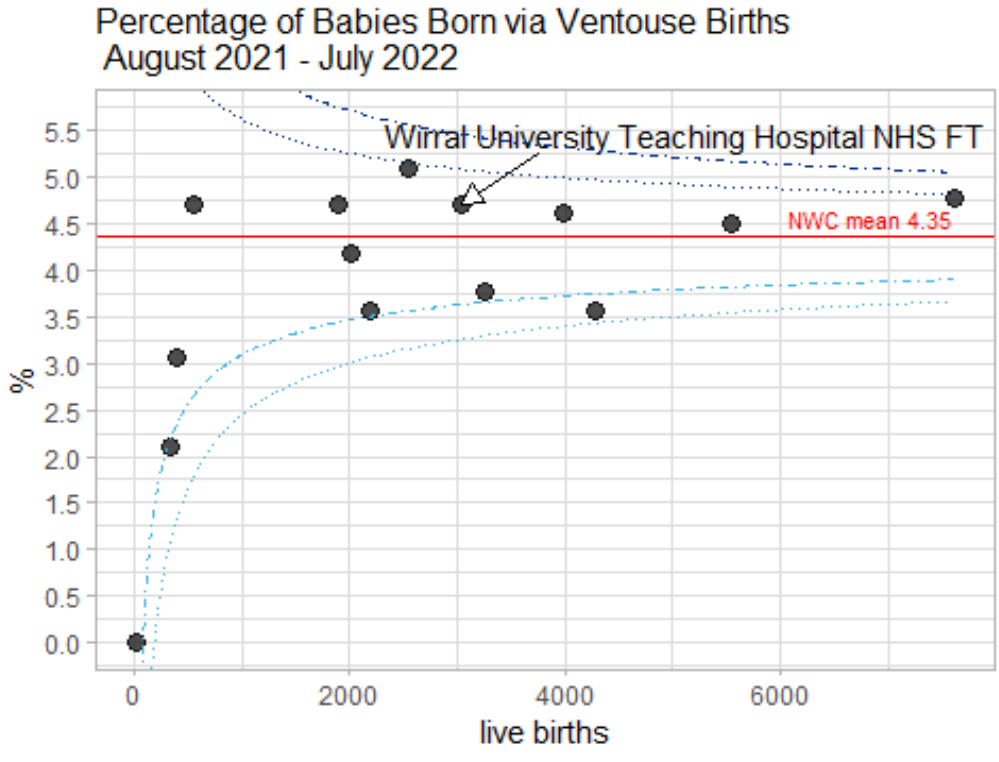
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born via Forceps Births



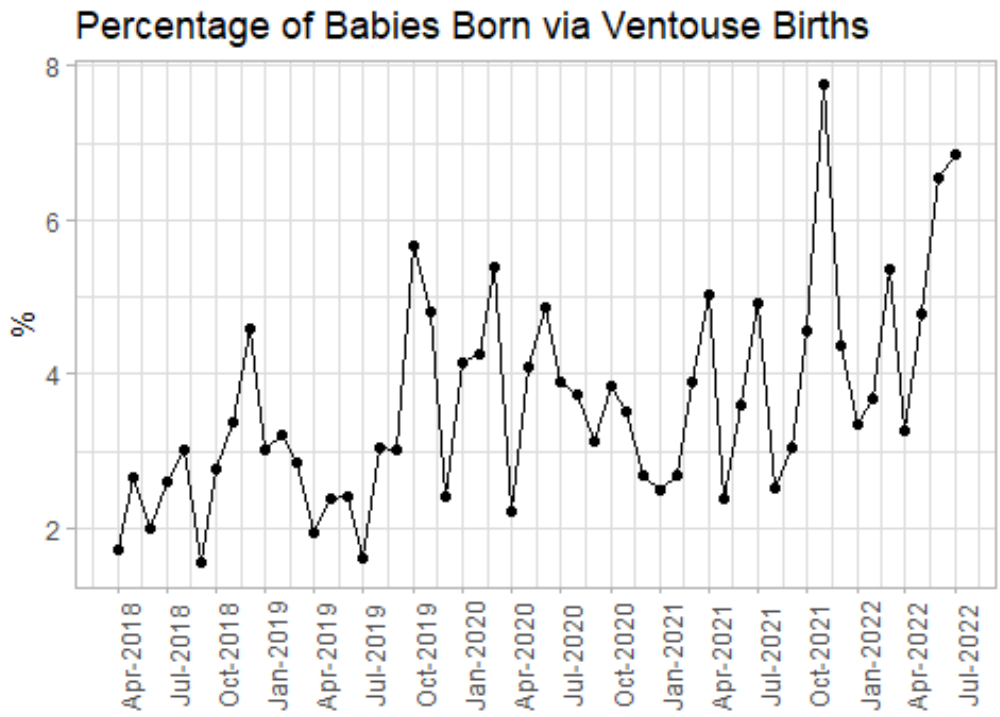
Data Source: NWC CN Maternity Dashboard

Babies Born via Ventouse Births



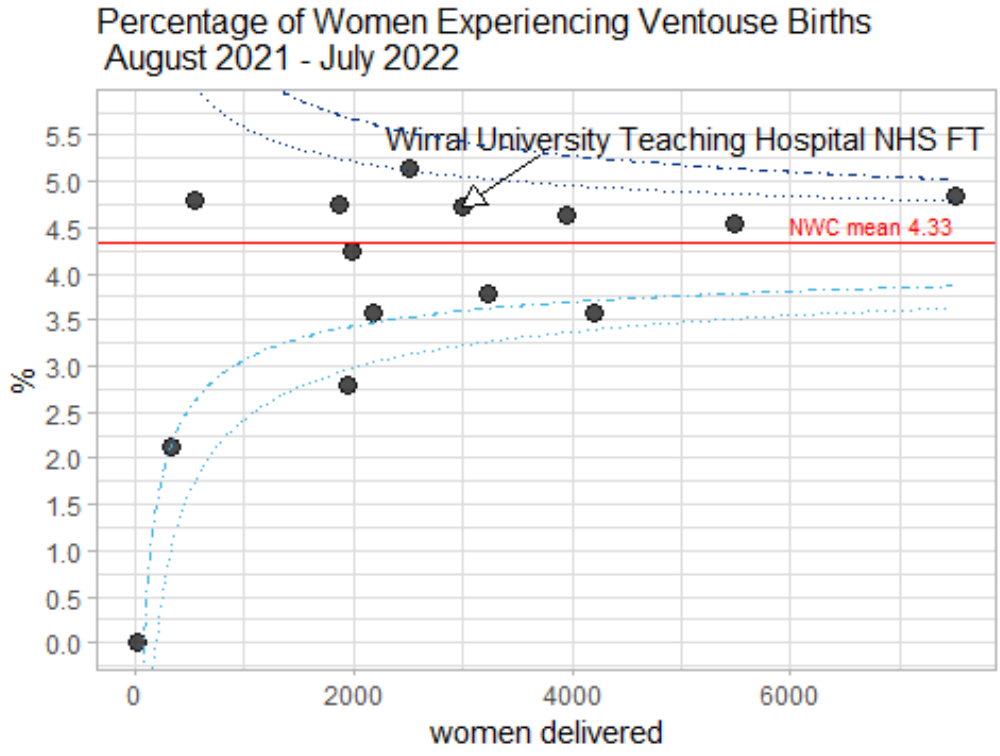
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born via Ventouse Births



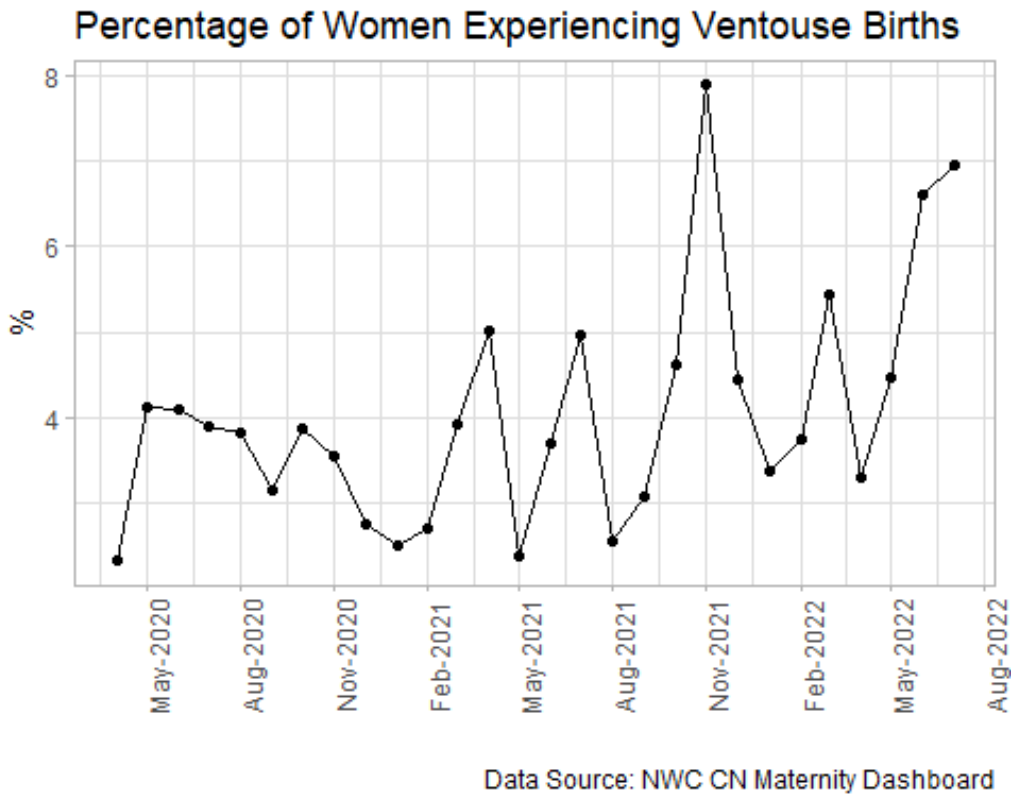
Data Source: NWC CN Maternity Dashboard

Women Experiencing Ventouse Births



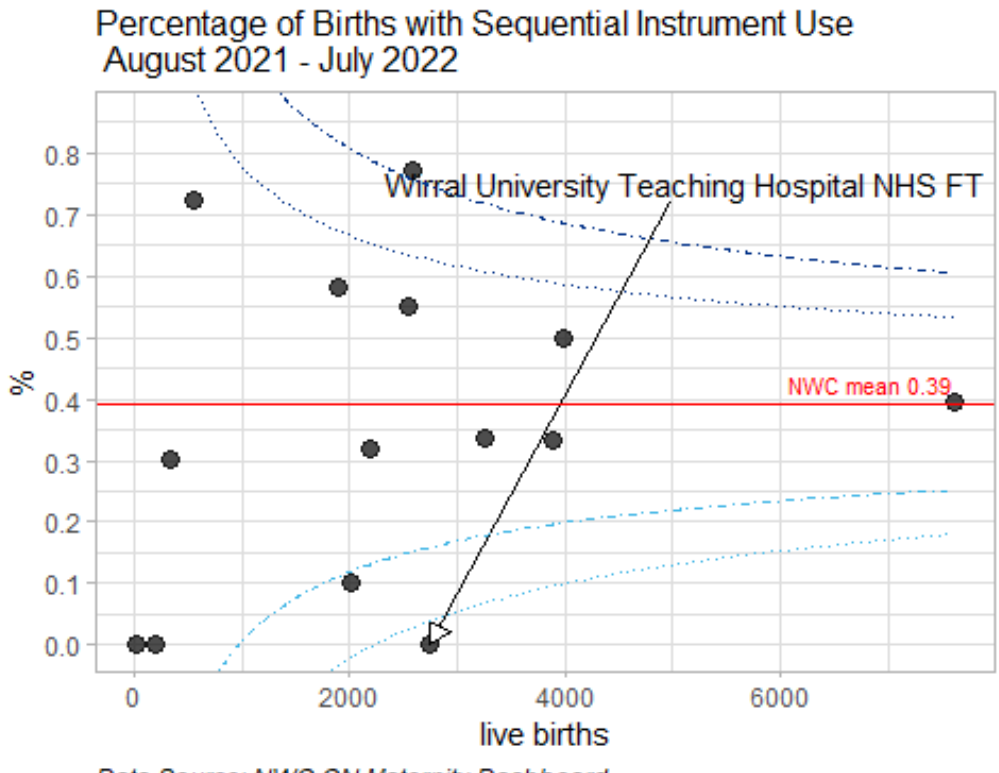
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Women Experiencing Ventouse Births



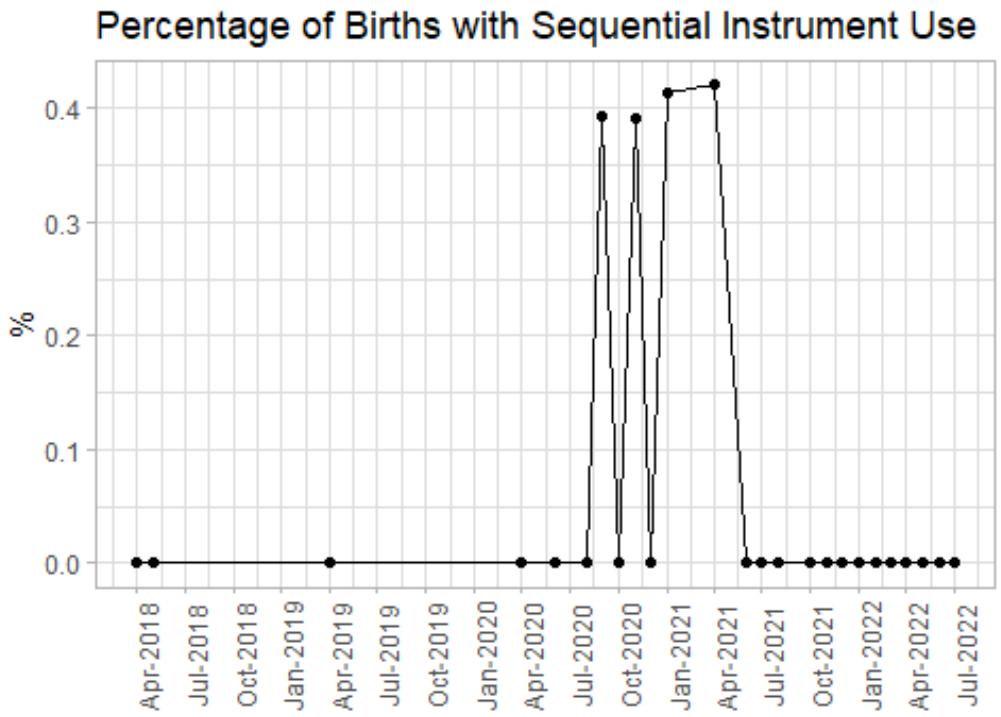
Data Source: NWC CN Maternity Dashboard

Births with Sequential Instrument Use



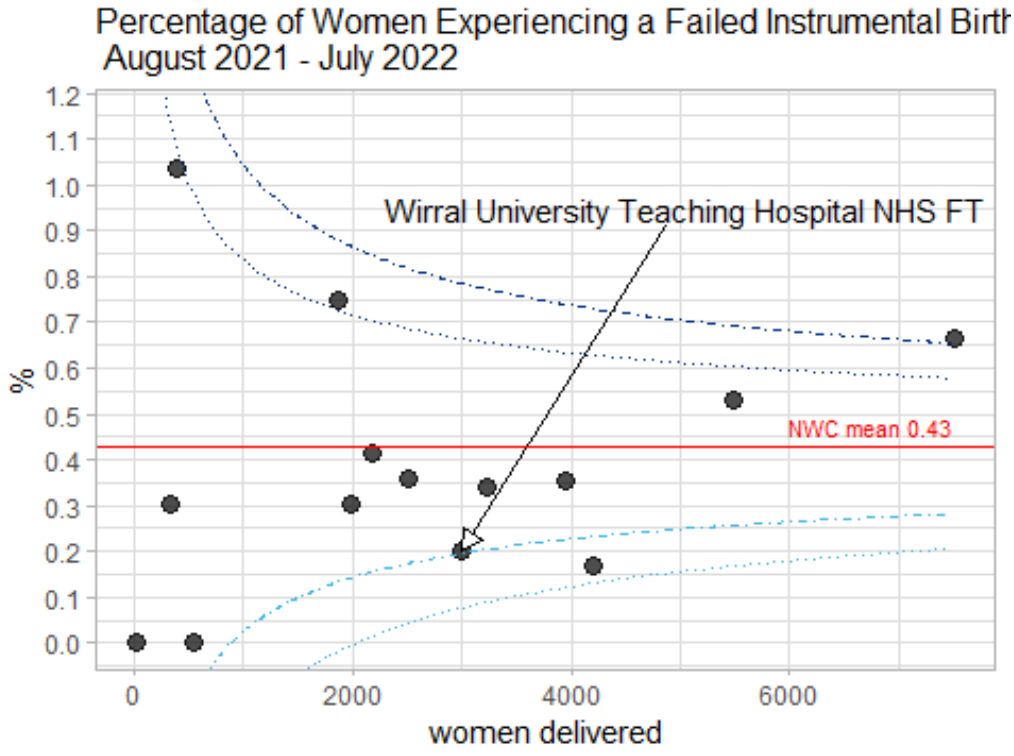
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Births with Sequential Instrument Use



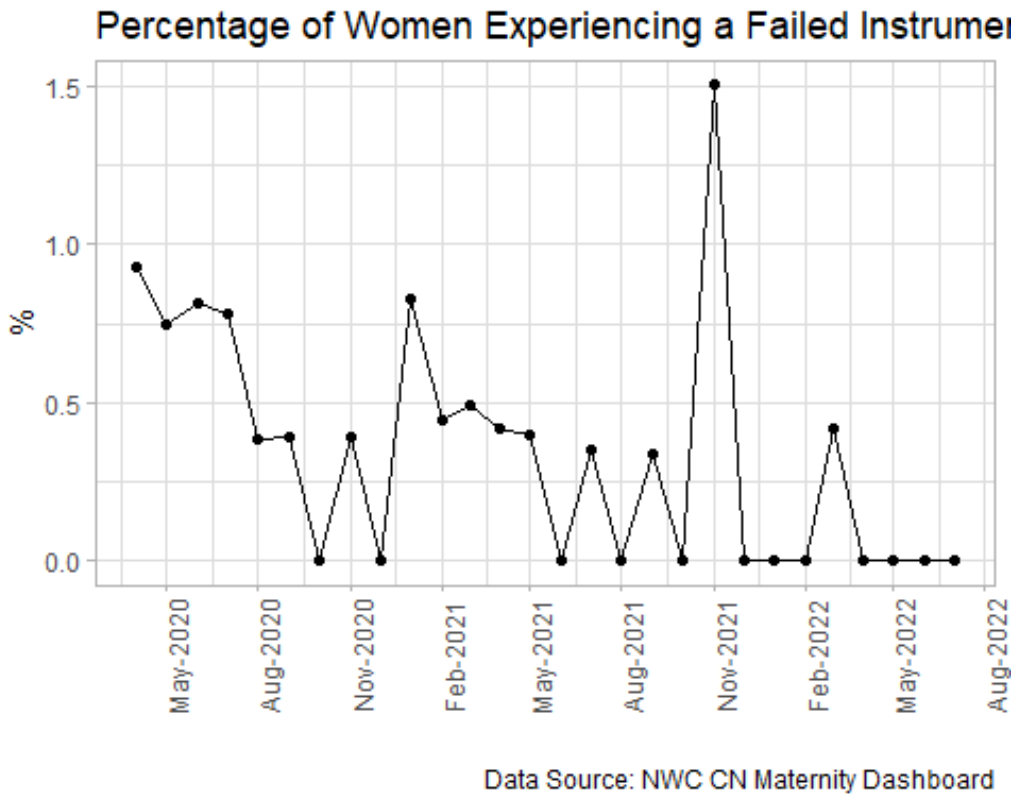
Data Source: NWC CN Maternity Dashboard

Women Experiencing a Failed Instrumental Births

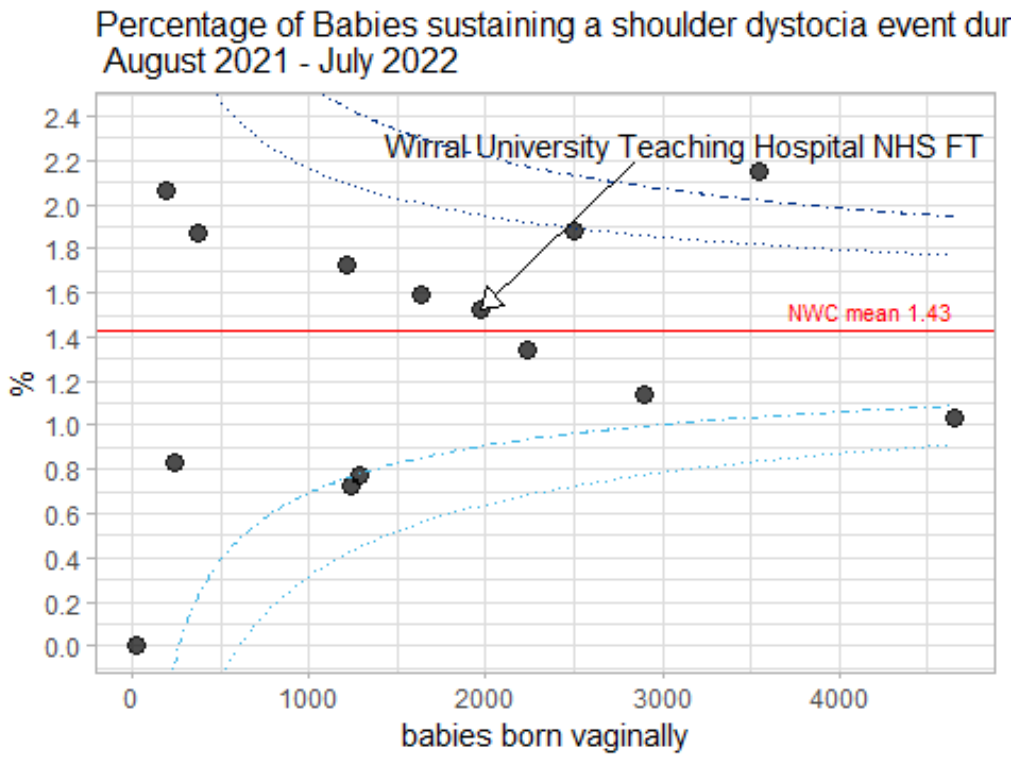


Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Women Experiencing a Failed Instrumental Births

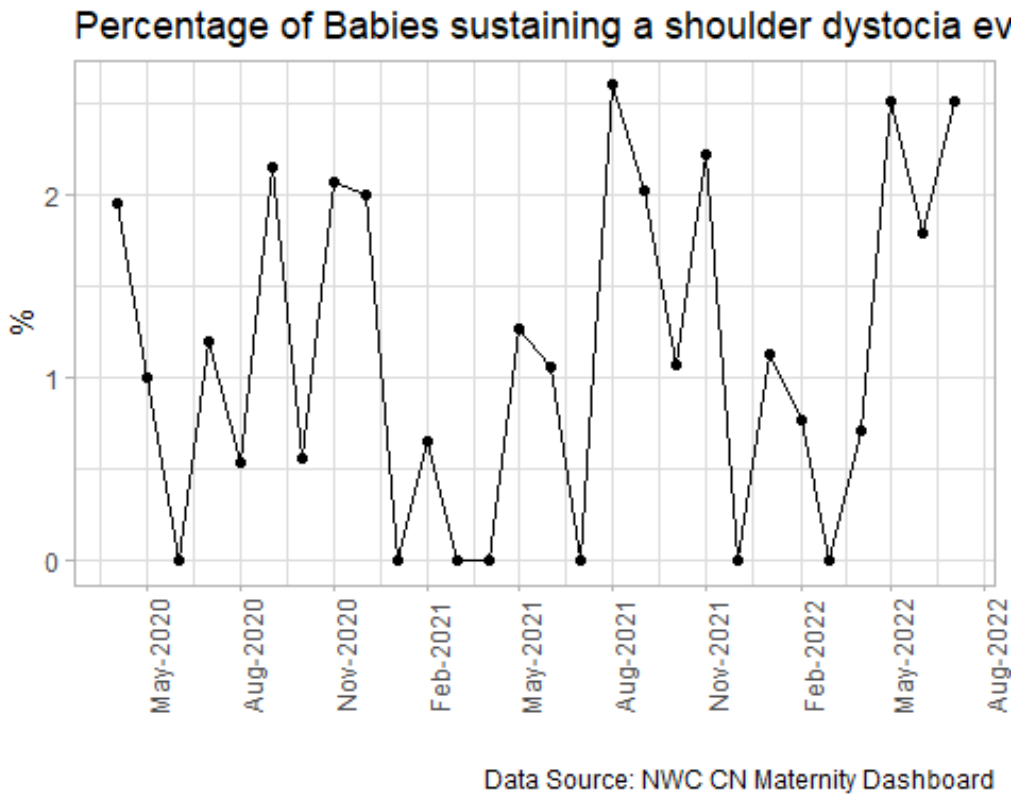


Babies sustaining a shoulder dystocia event during labour / birth



Data Source: NWC CN Maternity Dashboard

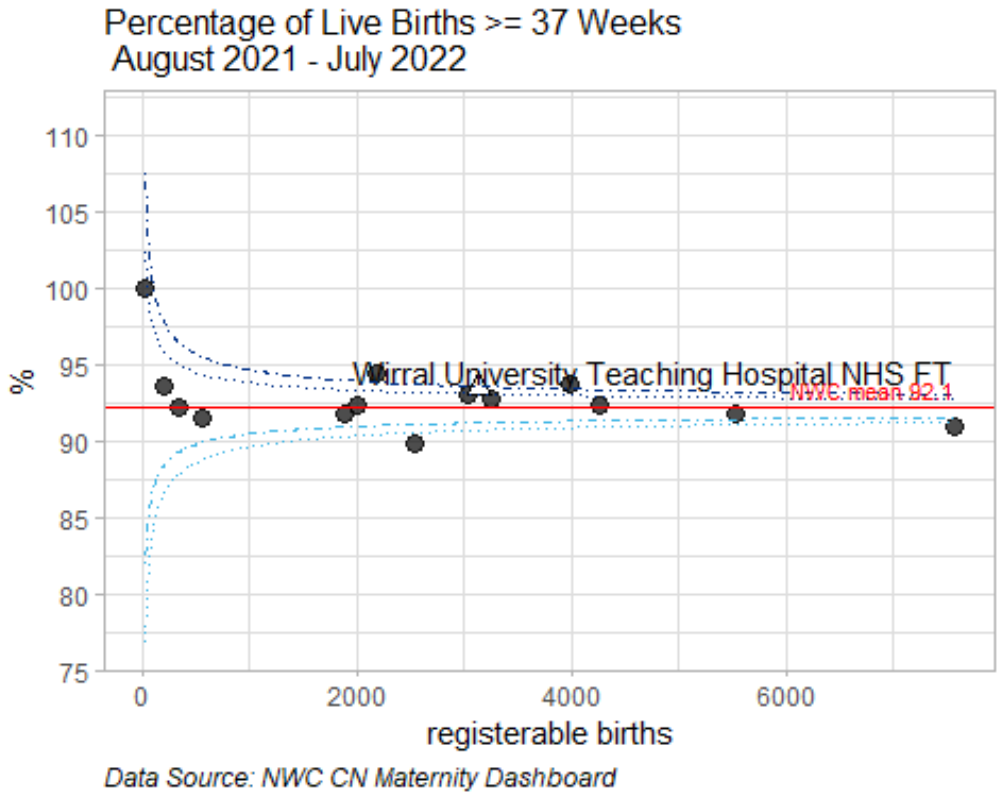
Run Chart for Shoulder Dystocia



Data Source: NWC CN Maternity Dashboard

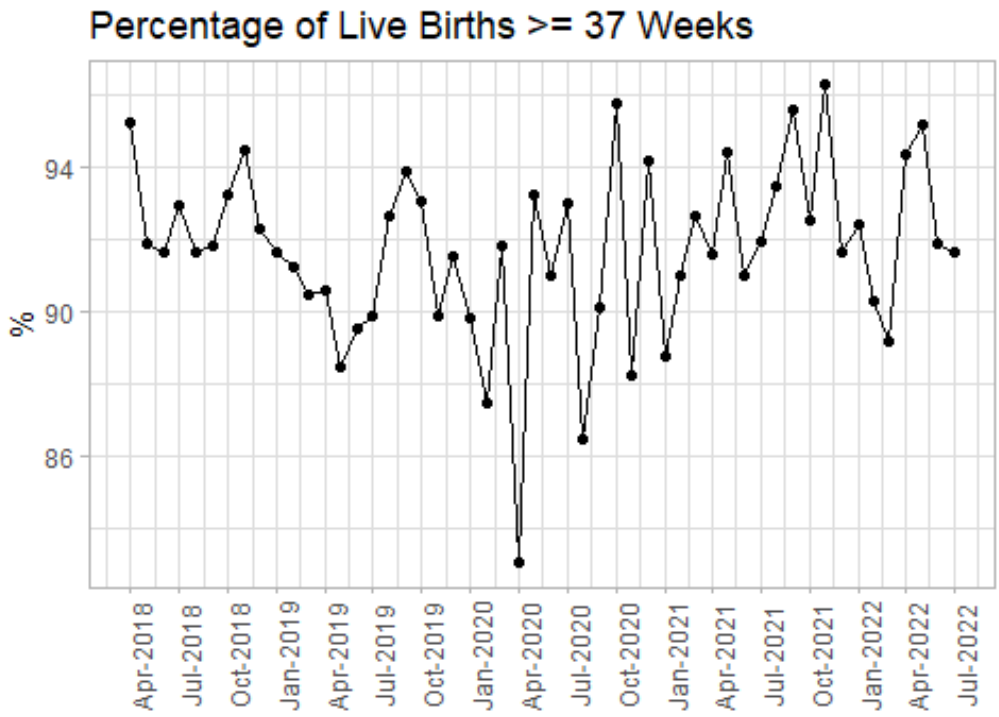
Pre Term

Live Births >= 37 Weeks



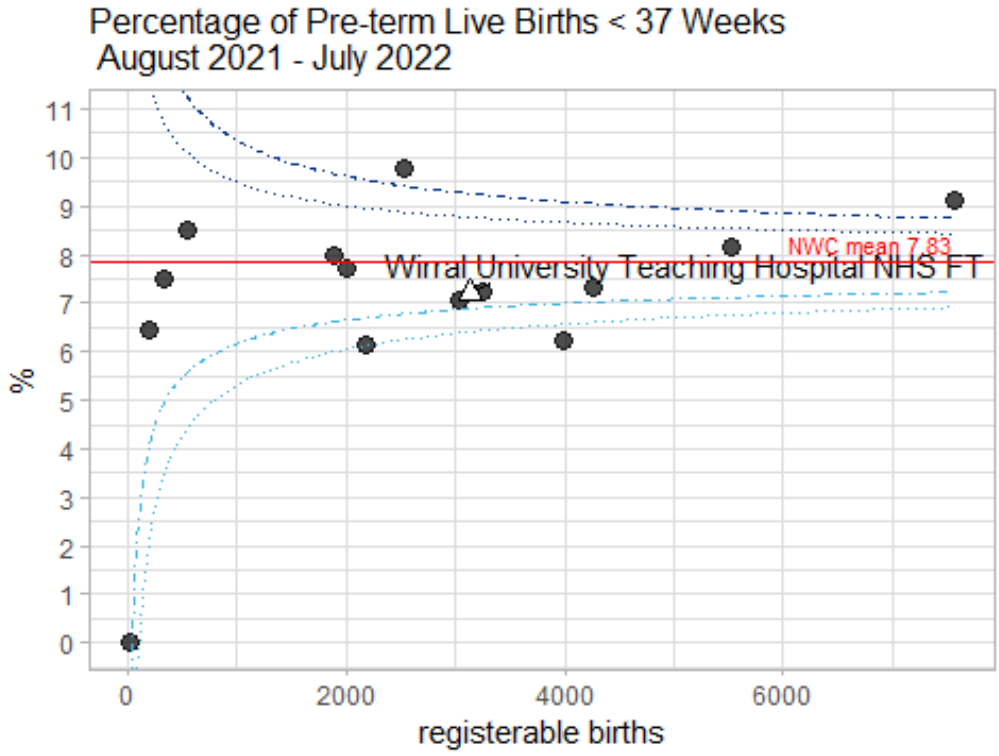
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Live Births >= 37 Weeks



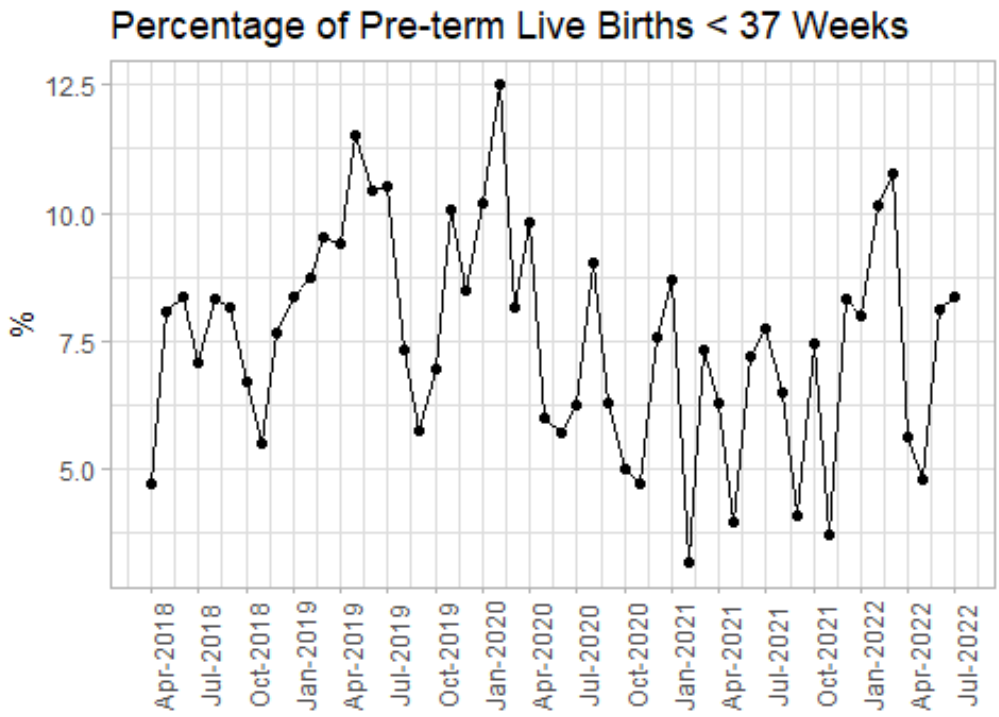
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 37 Weeks



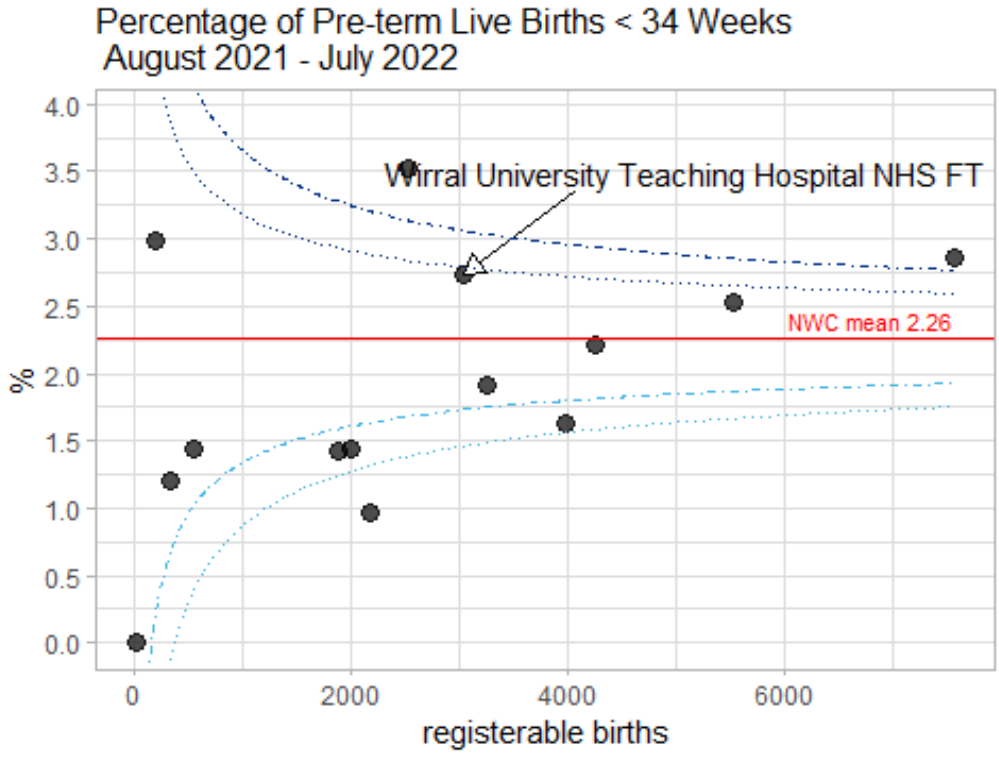
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Pre-term Live Births < 37 Weeks



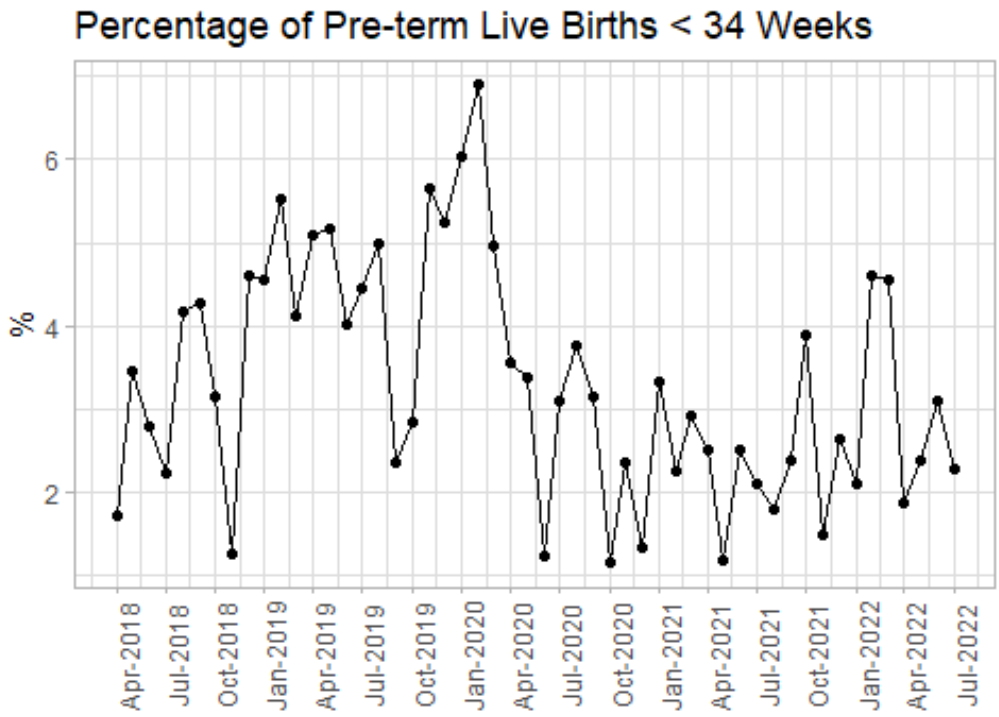
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 34 Weeks



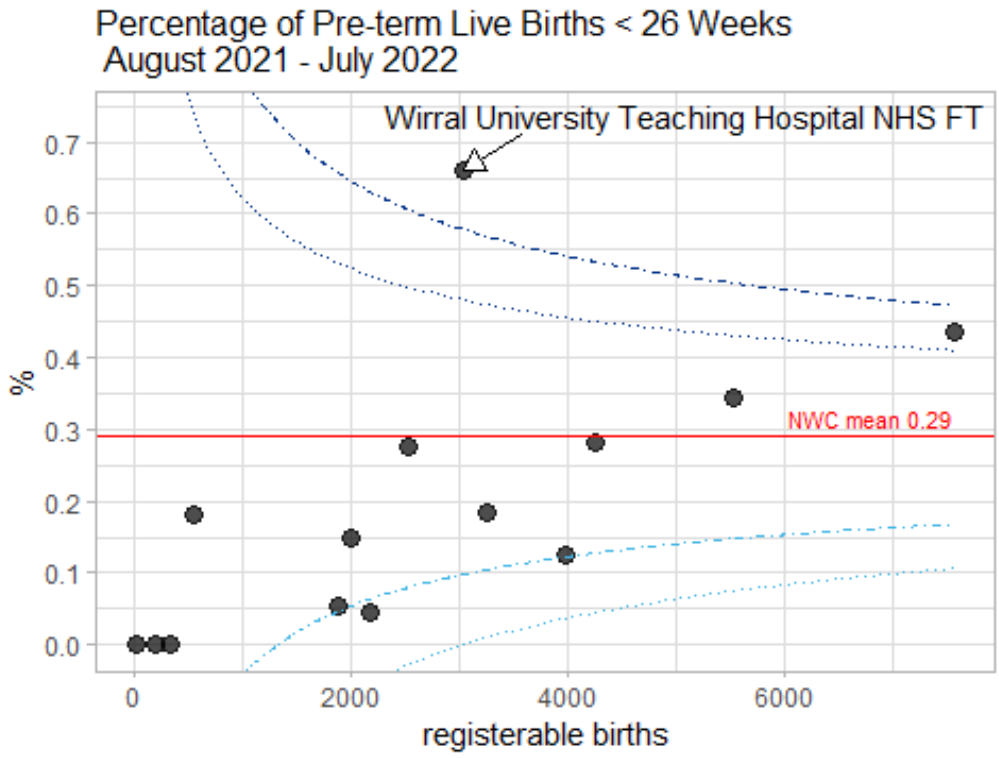
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Pre-term Live Births < 34 Weeks



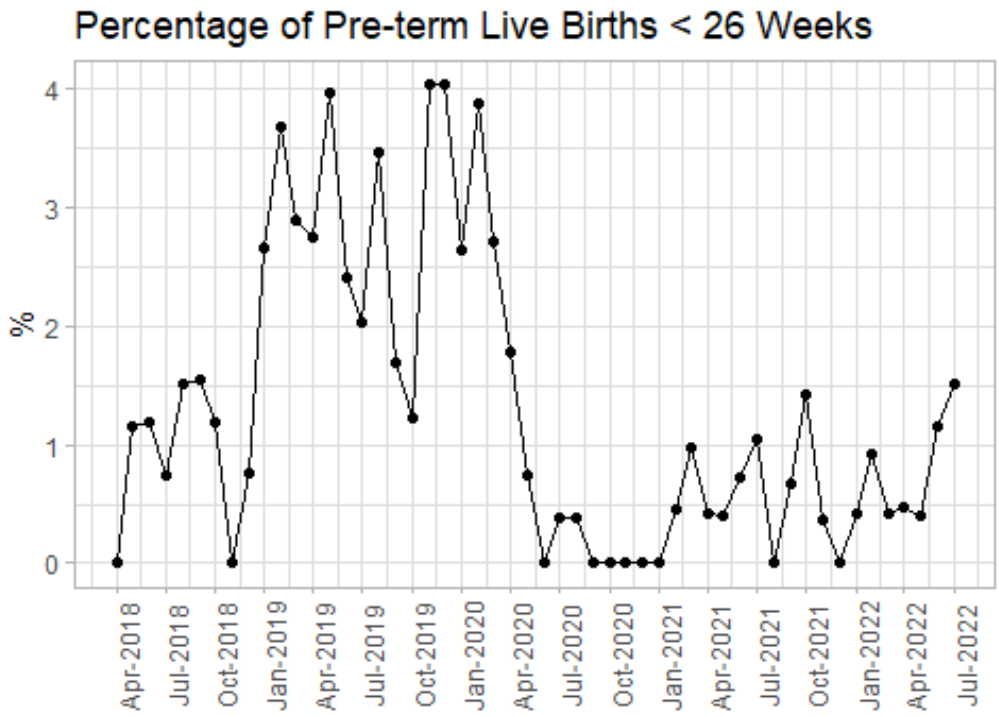
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 26 Weeks



Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Live Births < 26 Weeks

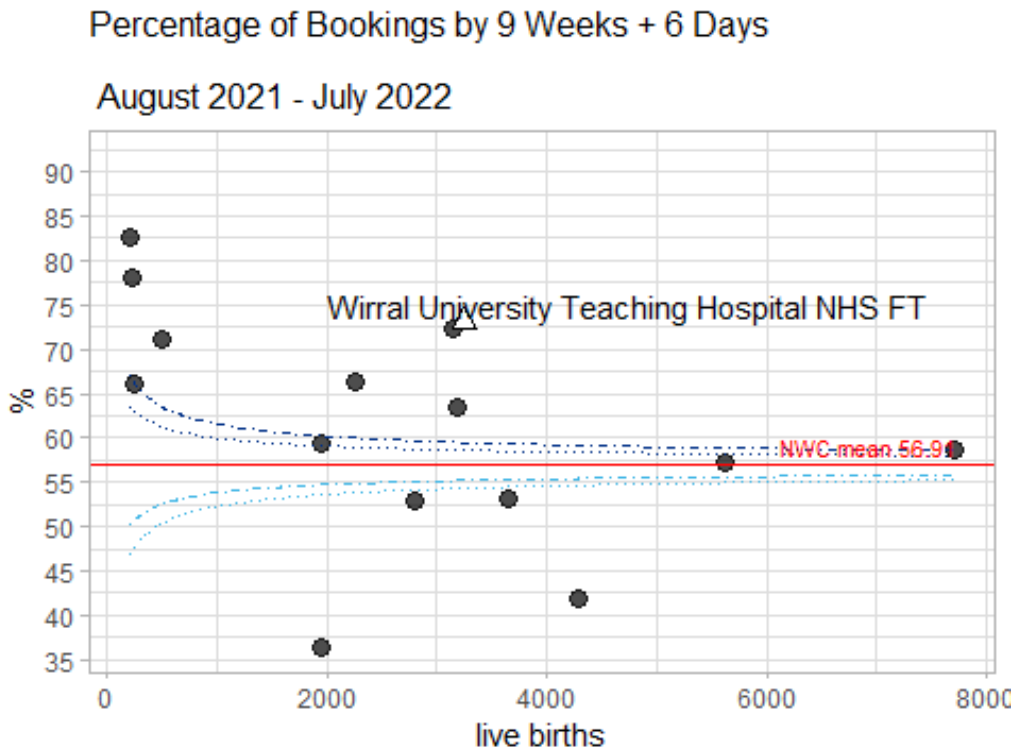


Data Source: NWC CN Maternity Dashboard

Additional Metrics

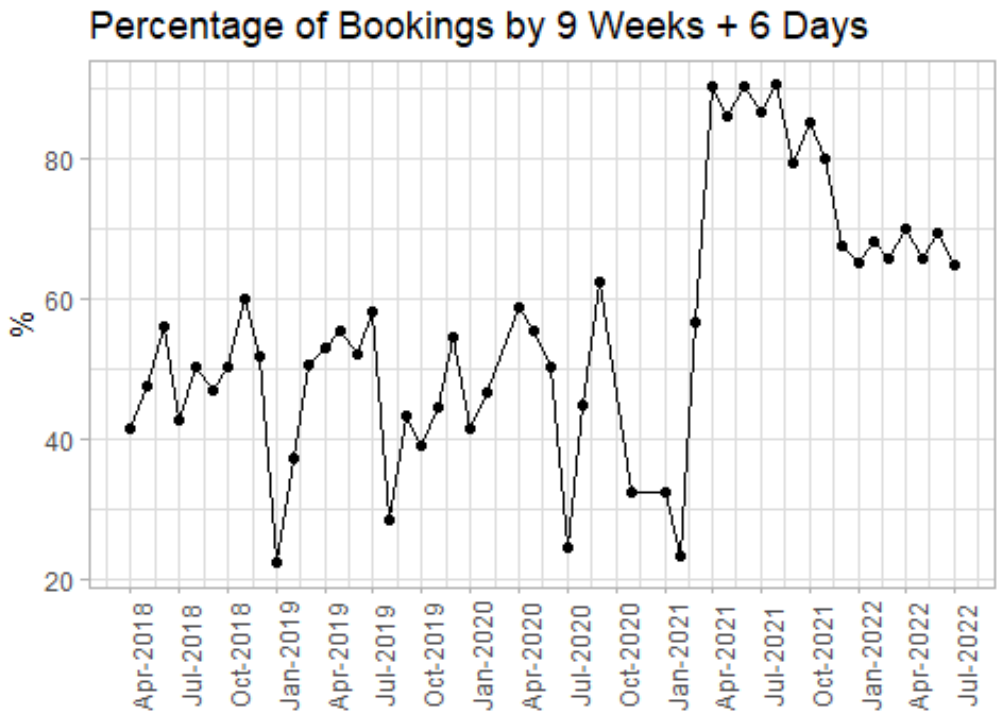
Bookings

Bookings by 9 Weeks + 6 Days



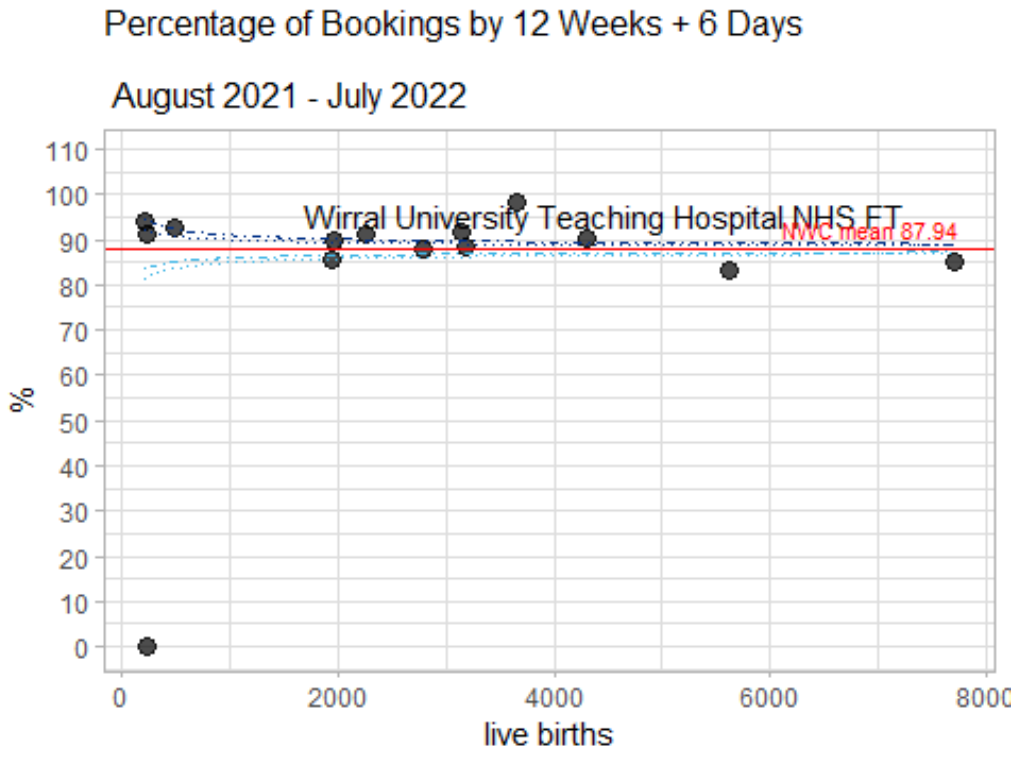
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Bookings by 9 Weeks + 6 Days



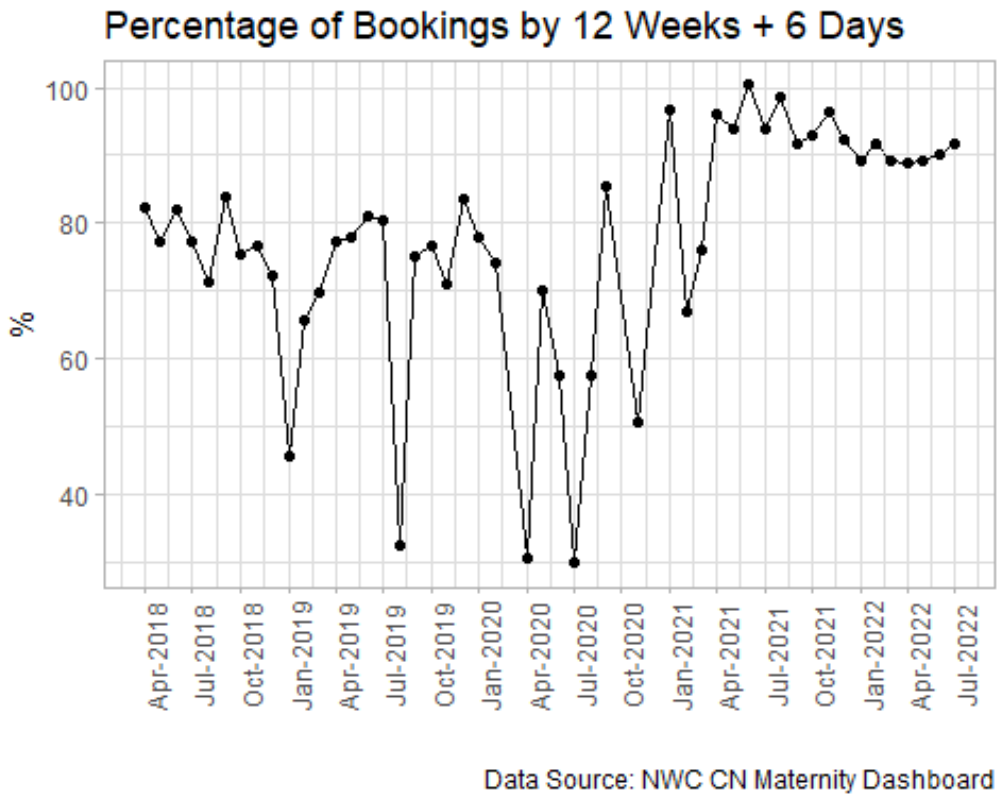
Data Source: NWC CN Maternity Dashboard

Bookings by 12 Weeks + 6 Days



Data Source: NWC CN Maternity Dashboard

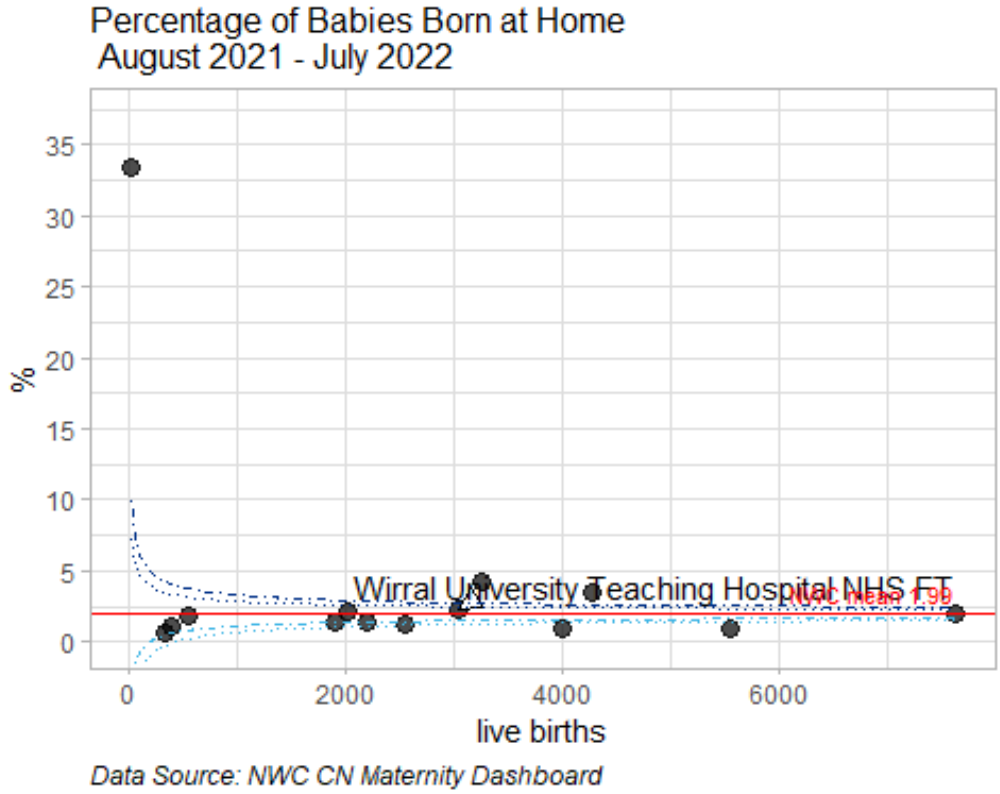
Run Chart for Percentage of Bookings by 12 Weeks + 6 Days



Data Source: NWC CN Maternity Dashboard

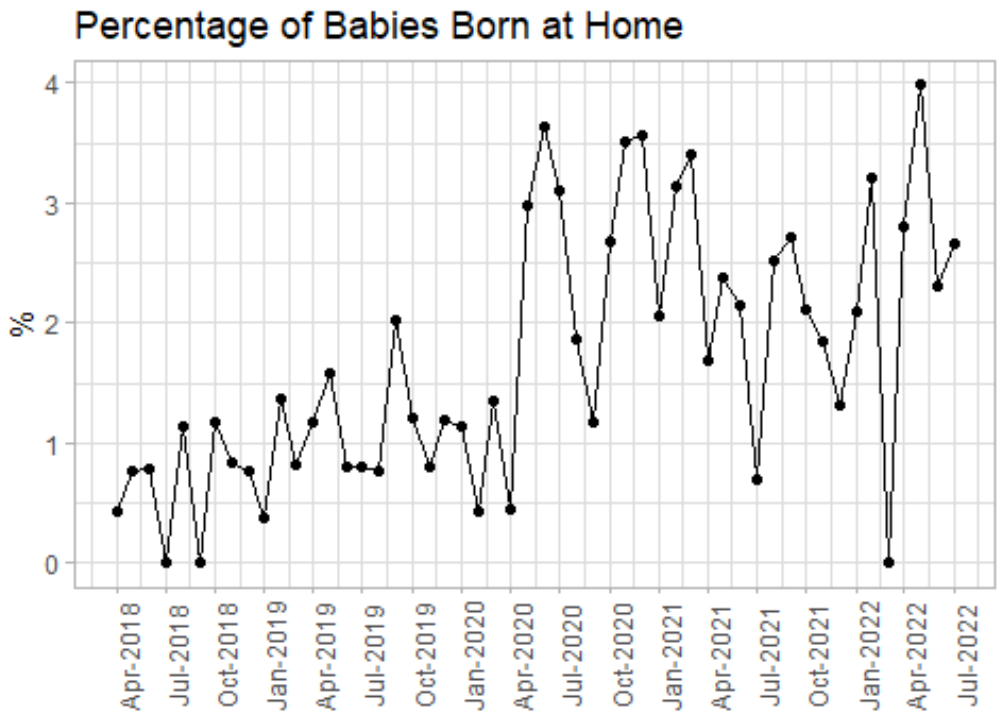
Birth Location

Babies Born at Home



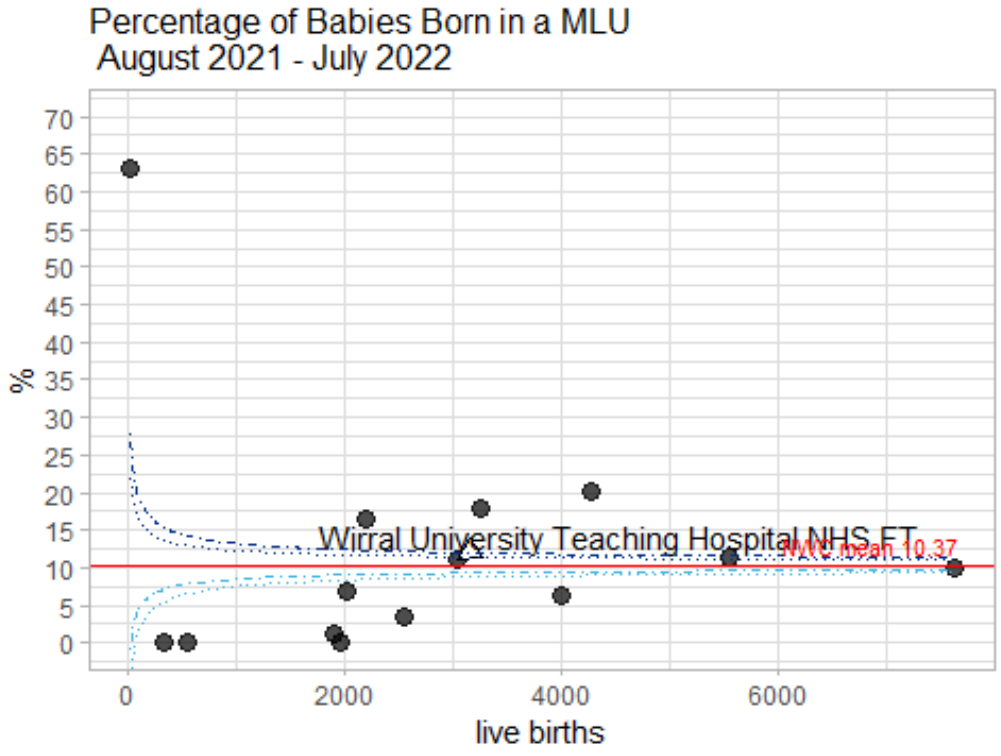
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born at Home



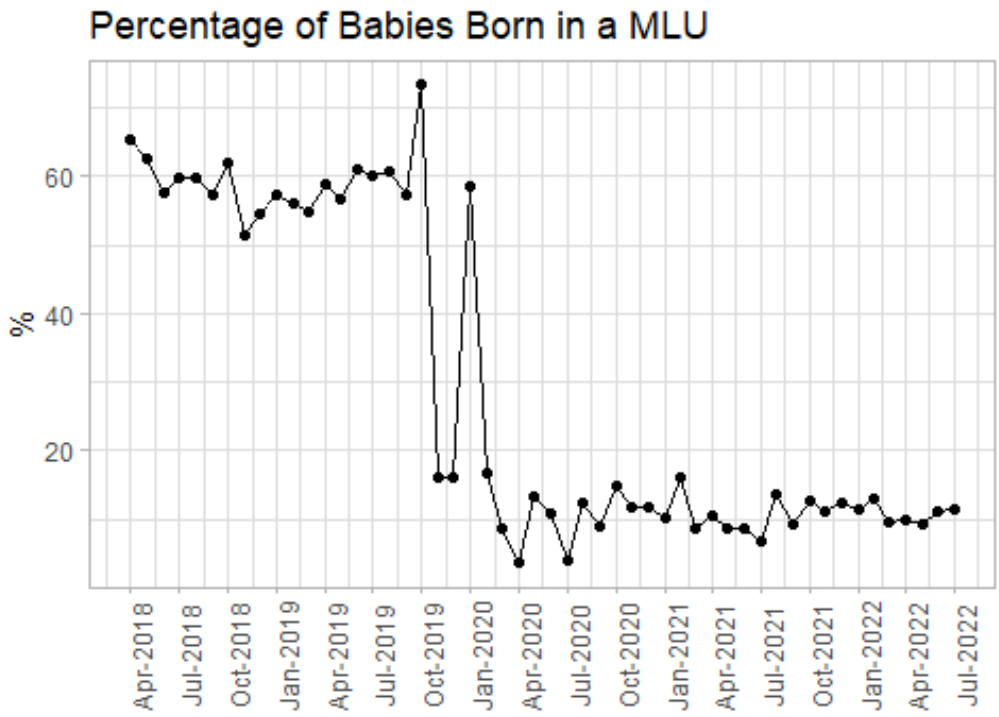
Data Source: NWC CN Maternity Dashboard

Babies Born in a MLU



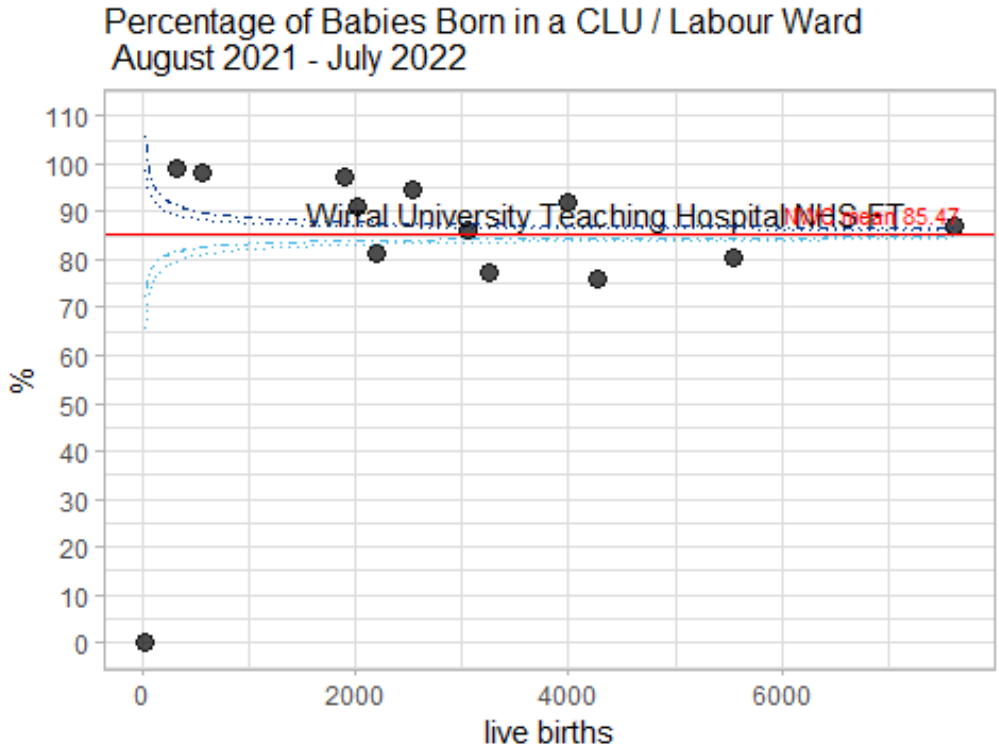
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born in a MLU



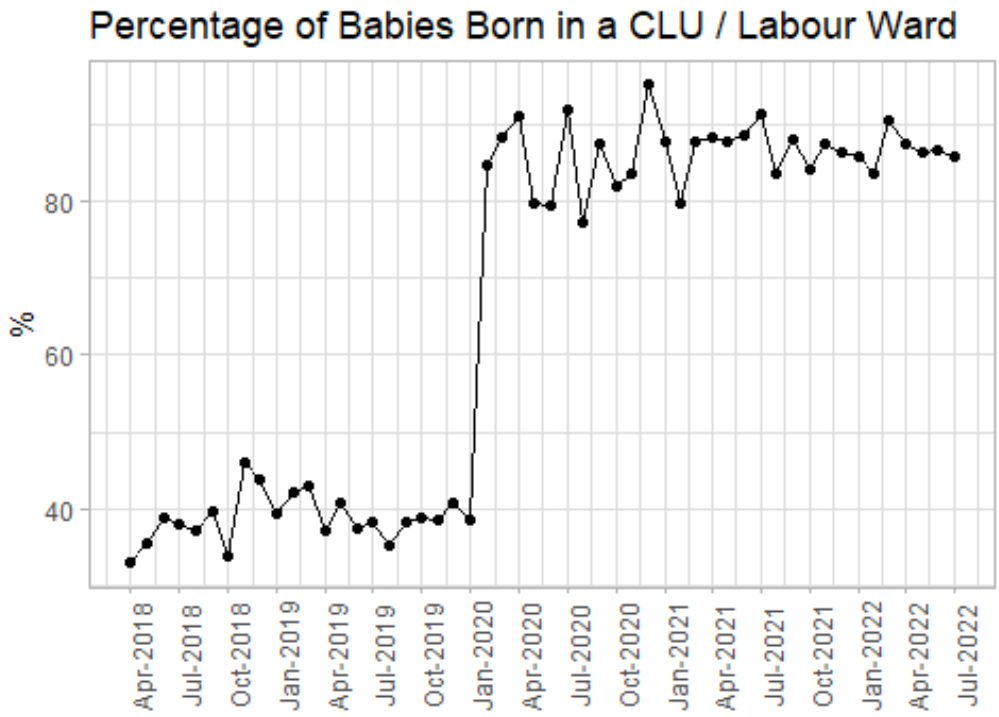
Data Source: NWC CN Maternity Dashboard

Babies Born in a CLU / Labour Ward



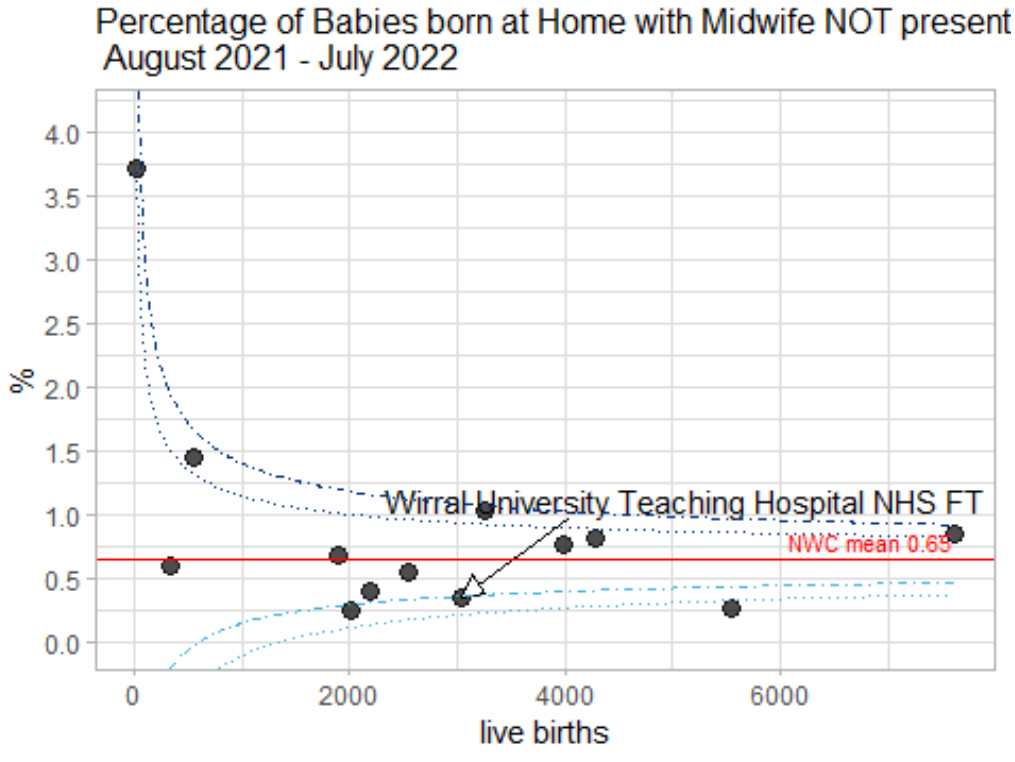
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies Born in a CLU / Labour Ward



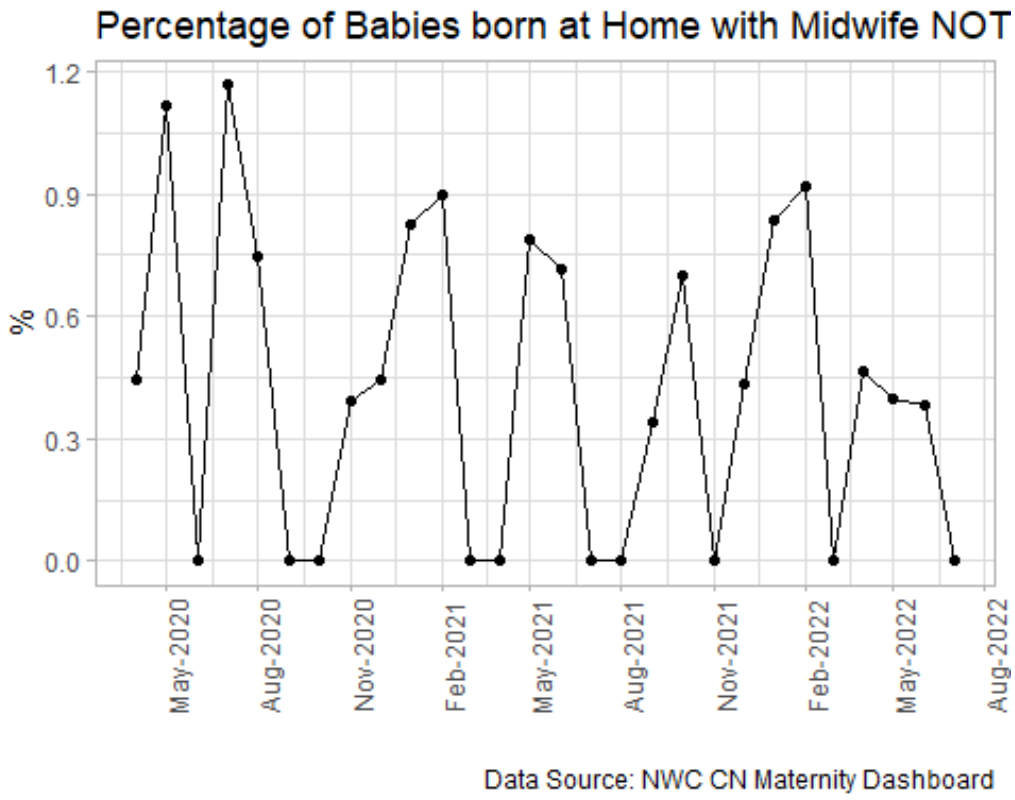
Data Source: NWC CN Maternity Dashboard

Babies born at Home with Midwife NOT present



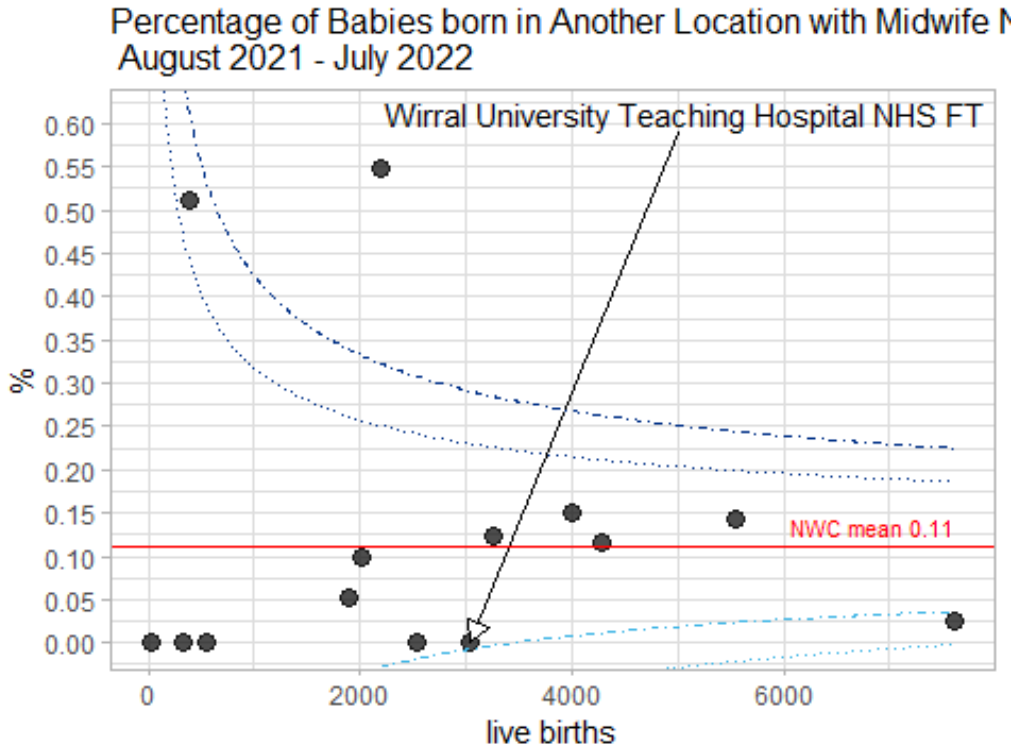
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Babies born at Home with Midwife NOT present



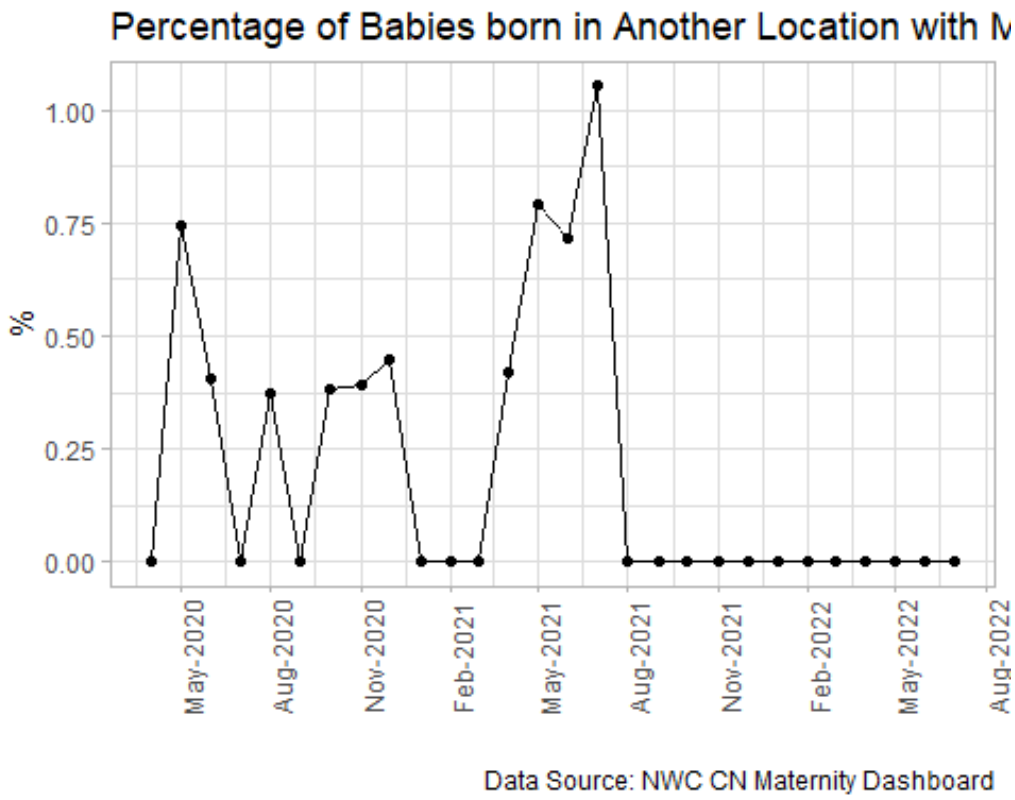
Data Source: NWC CN Maternity Dashboard

Babies born in Another Location with Midwife NOT present



Data Source: NWC CN Maternity Dashboard

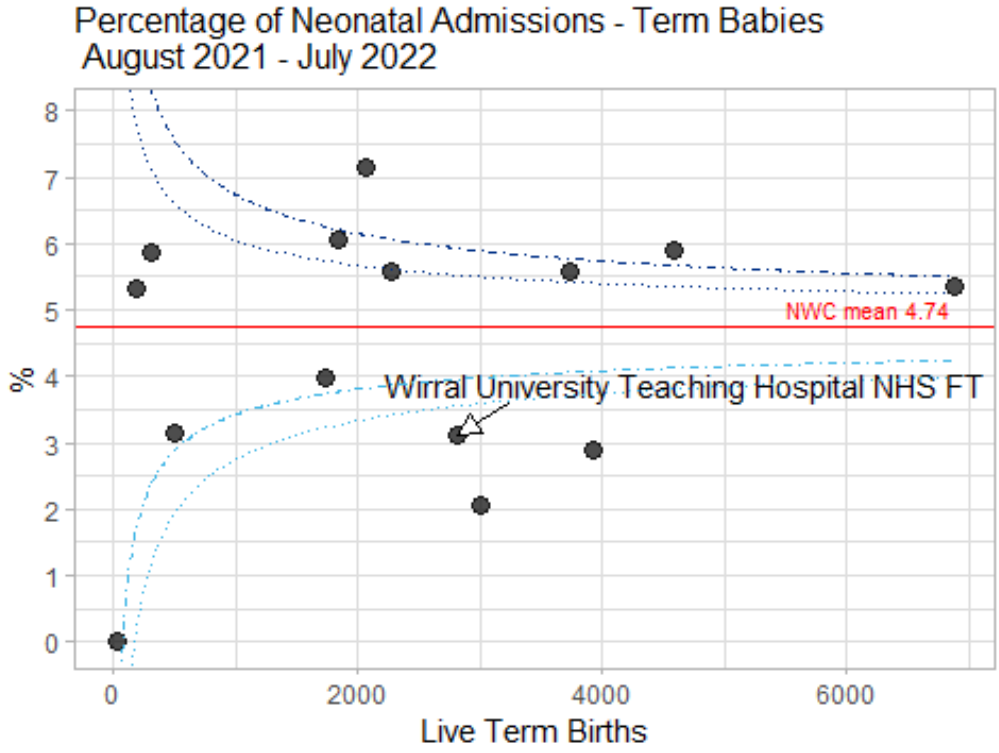
Run Chart for Percentage of Babies born in Another Location with Midwife NOT present



Data Source: NWC CN Maternity Dashboard

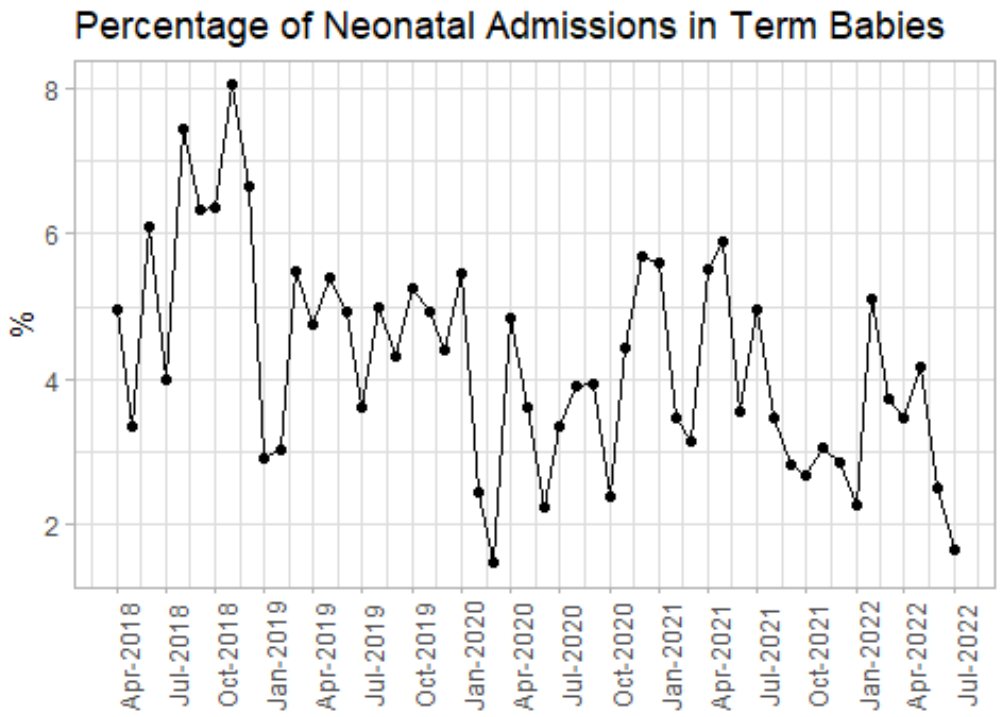
Neonatal Care

Neonatal Admissions in Term Babies



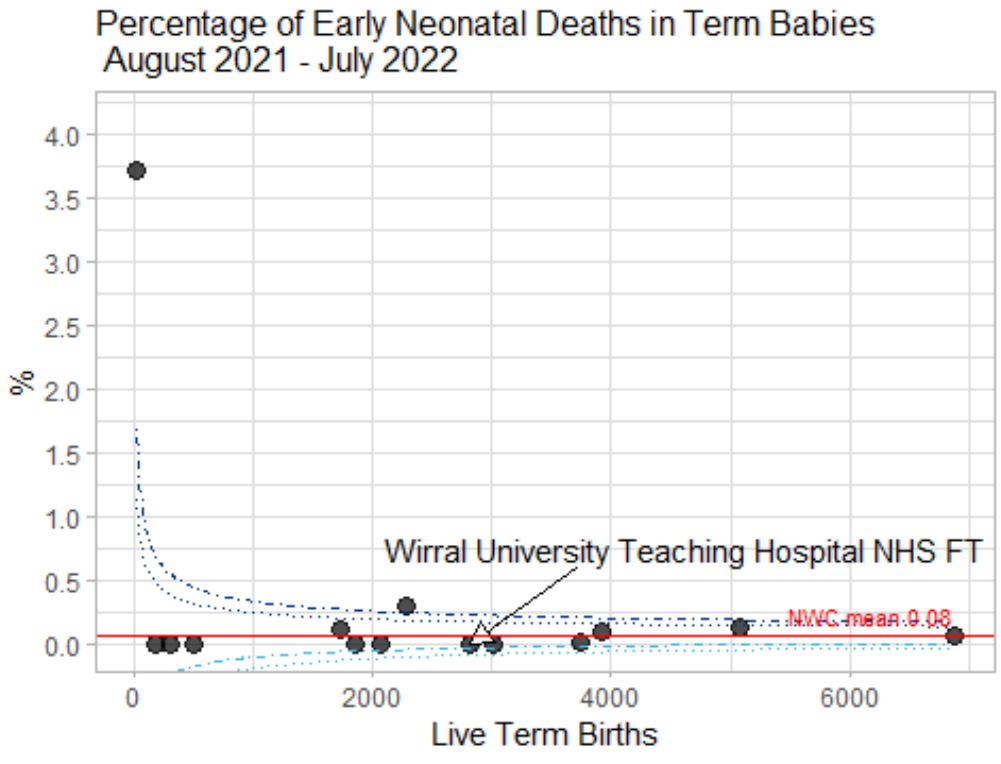
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Neonatal Admissions in Term Babies



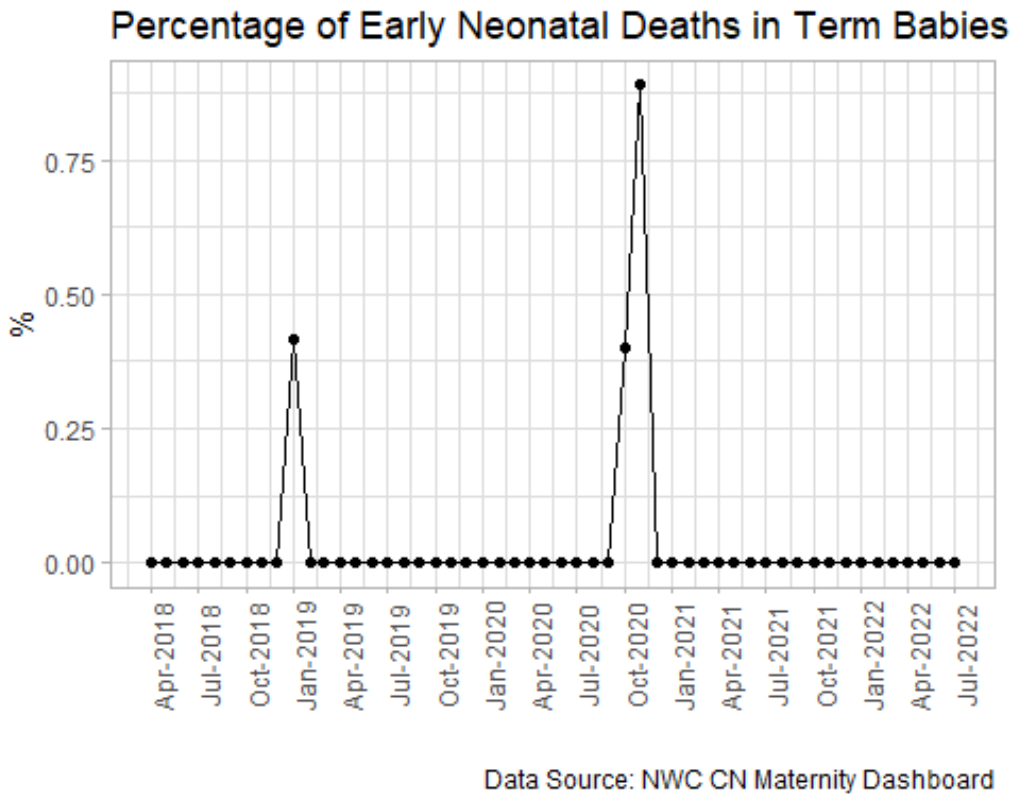
Data Source: NWC CN Maternity Dashboard

Early Neonatal Deaths in Term Babies



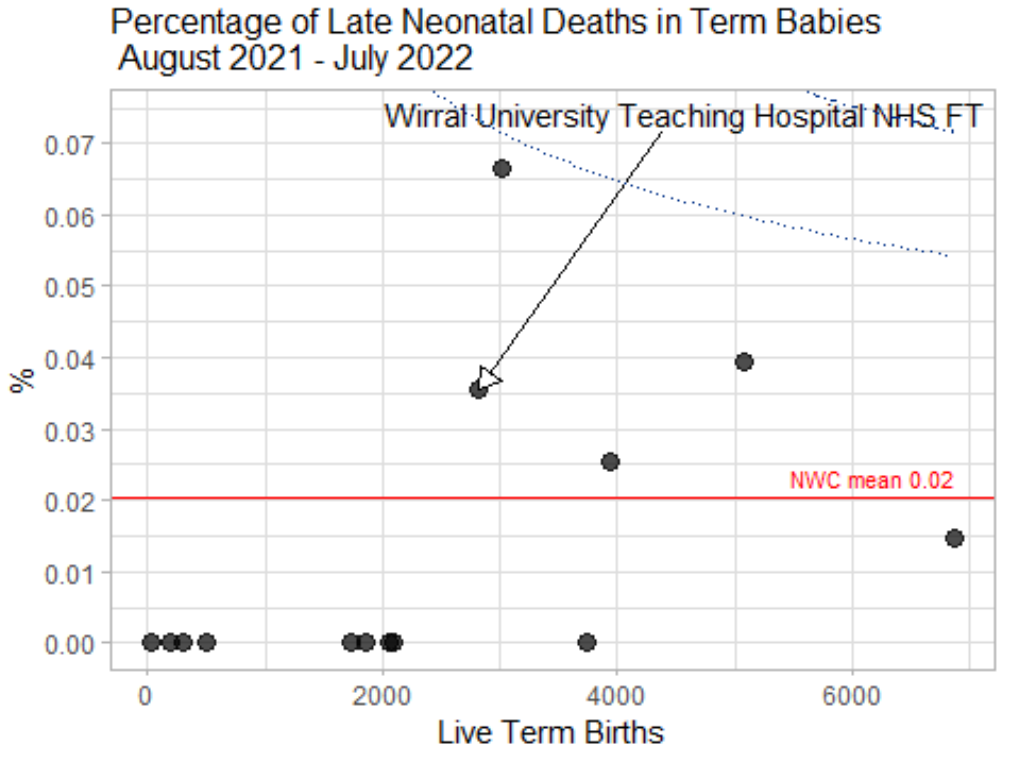
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Early Neonatal Deaths in Term Babies



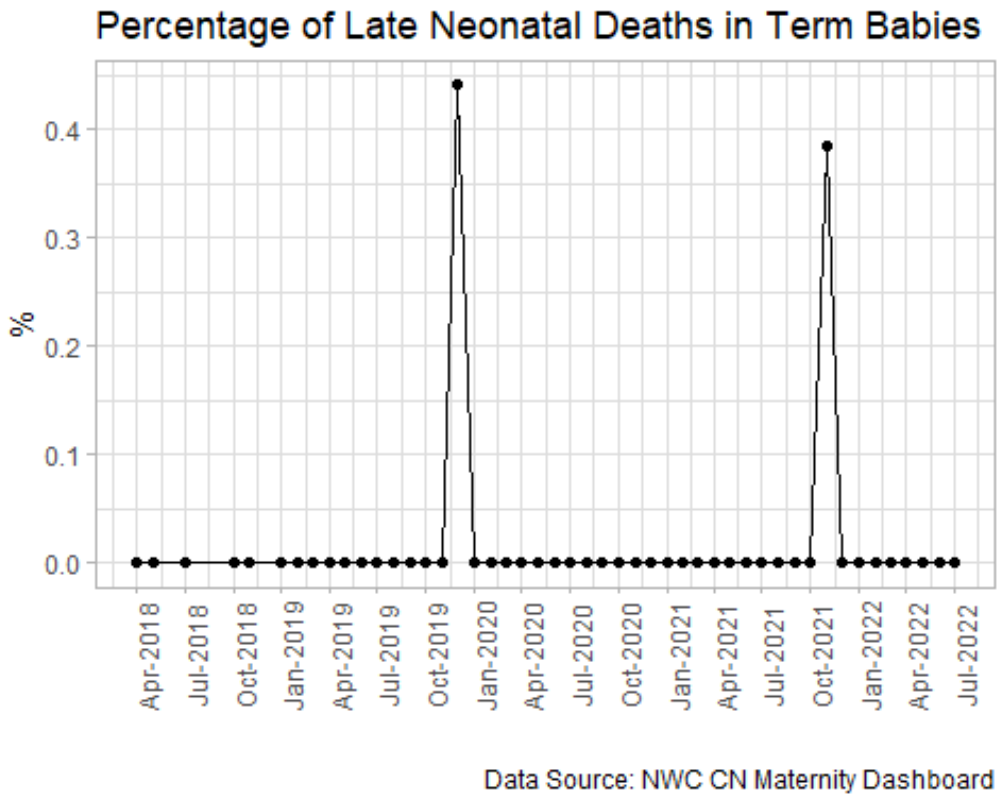
Data Source: NWC CN Maternity Dashboard

Late Neonatal Deaths in Term Babies



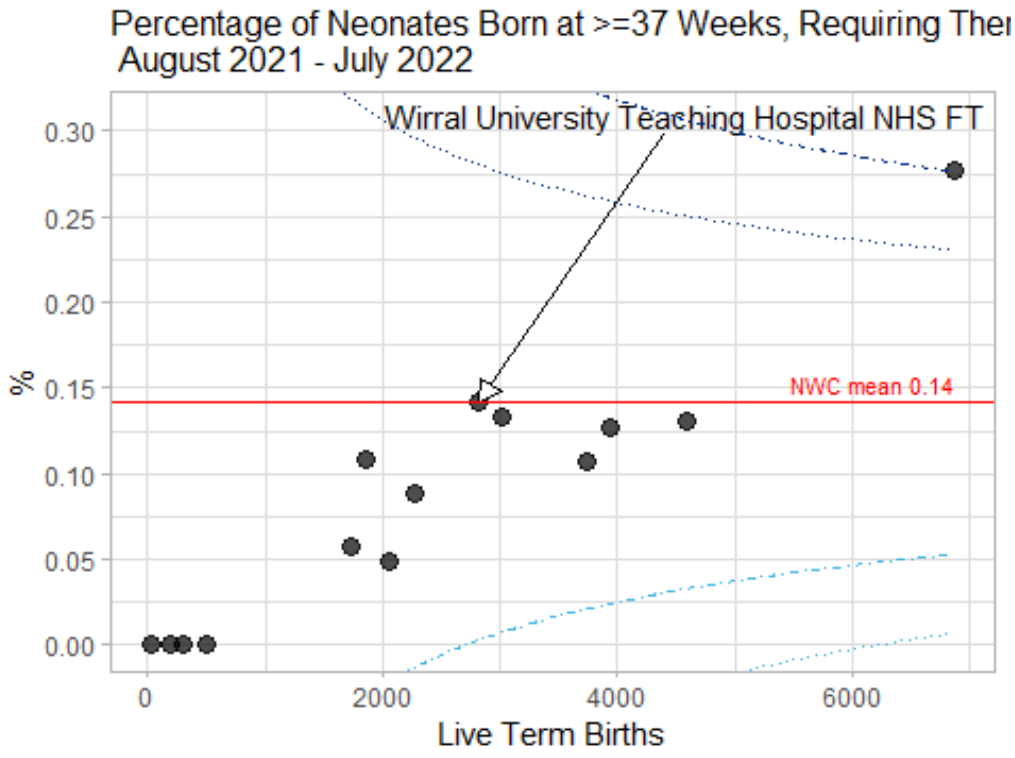
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Late Neonatal Deaths in Term Babies



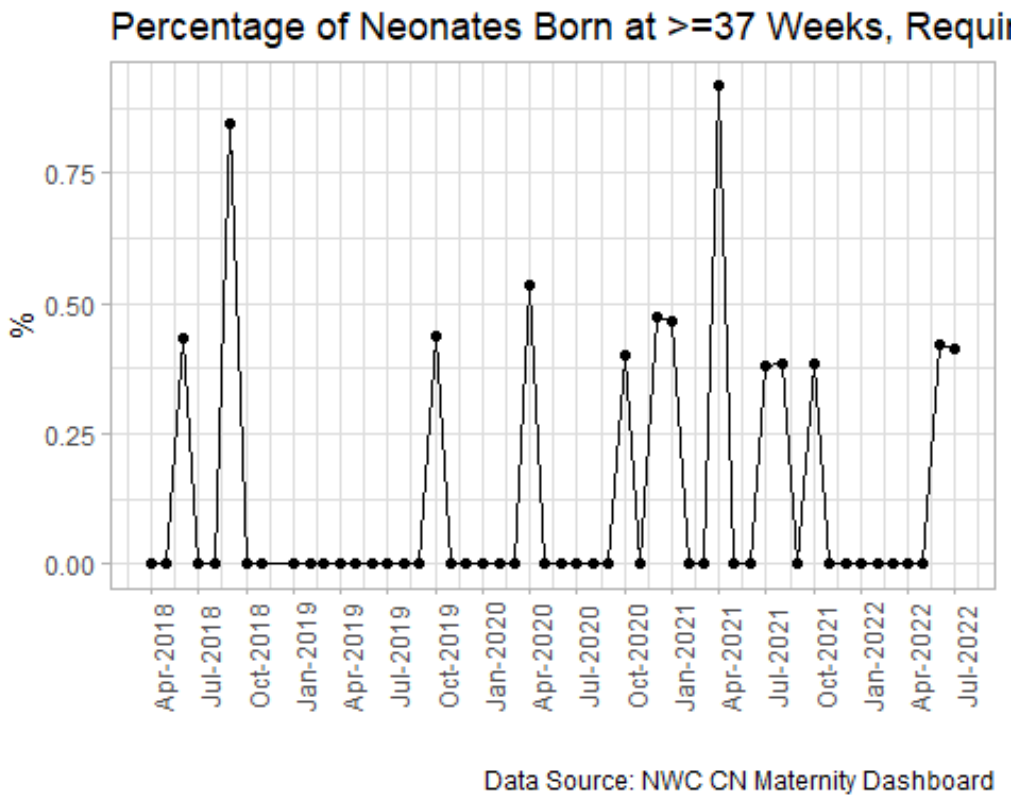
Data Source: NWC CN Maternity Dashboard

Neonates Born at >=37 Weeks, Requiring Therapeutic Cooling



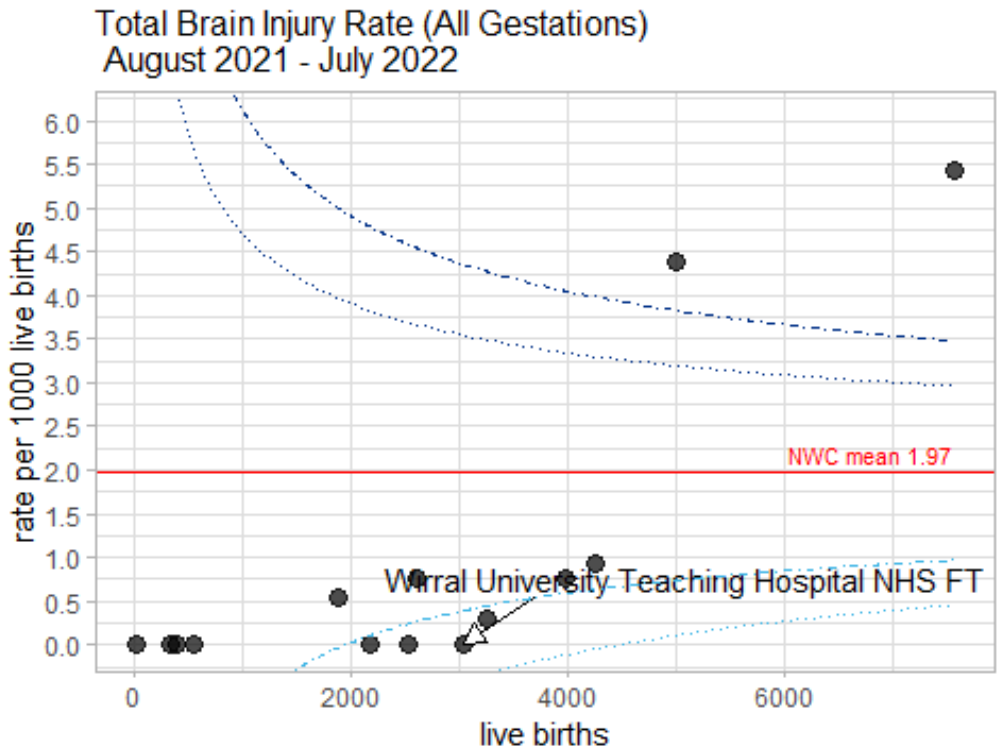
Data Source: NWC CN Maternity Dashboard

Run Chart for Percentage of Neonates Born at >=37 Weeks, Requiring Therapeutic Cooling



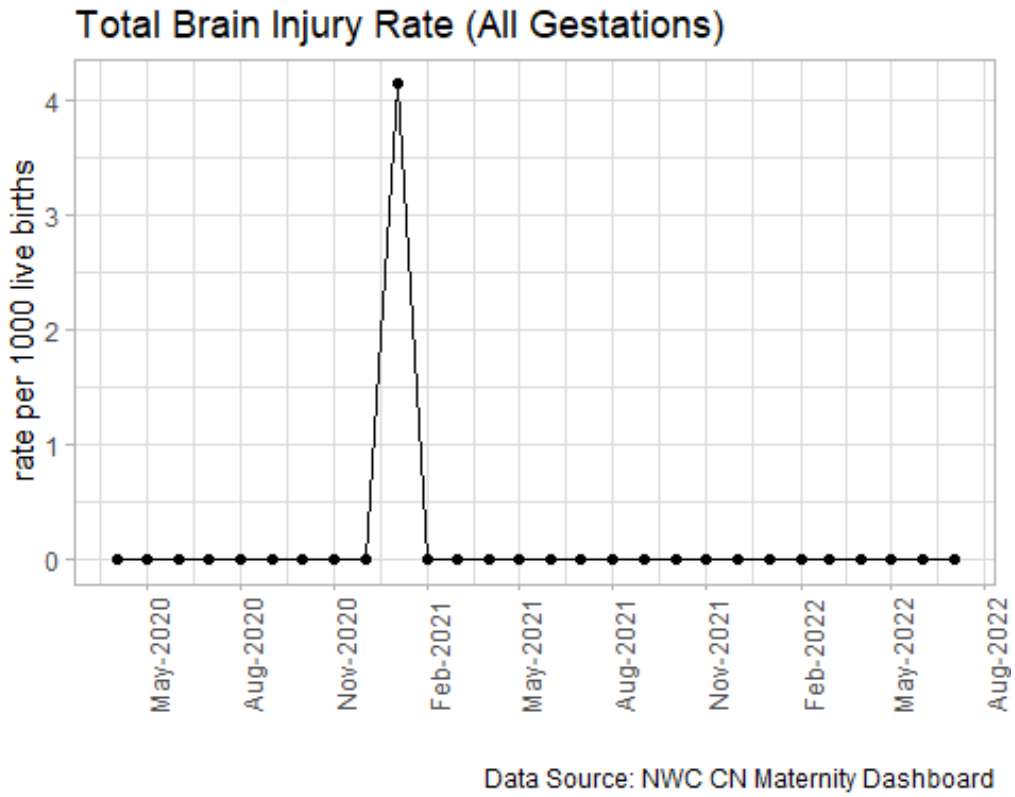
Data Source: NWC CN Maternity Dashboard

Total Brain Injury Rate (All Gestations)



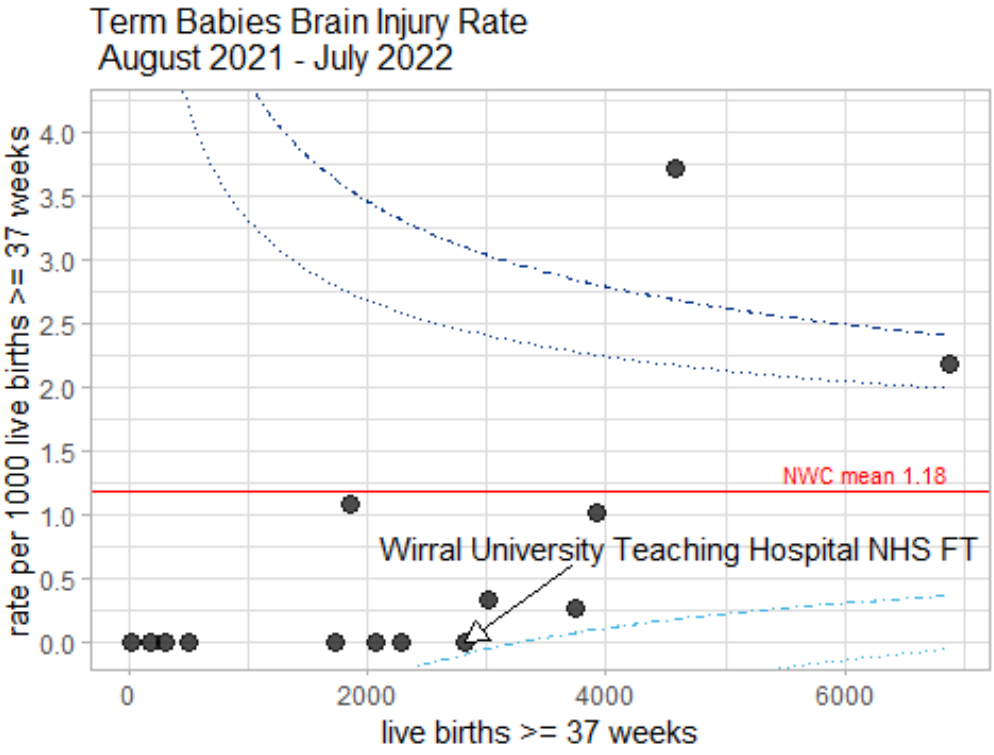
Data Source: NWC CN Maternity Dashboard

Run Chart for Total Brain Injury Rate (All Gestations)



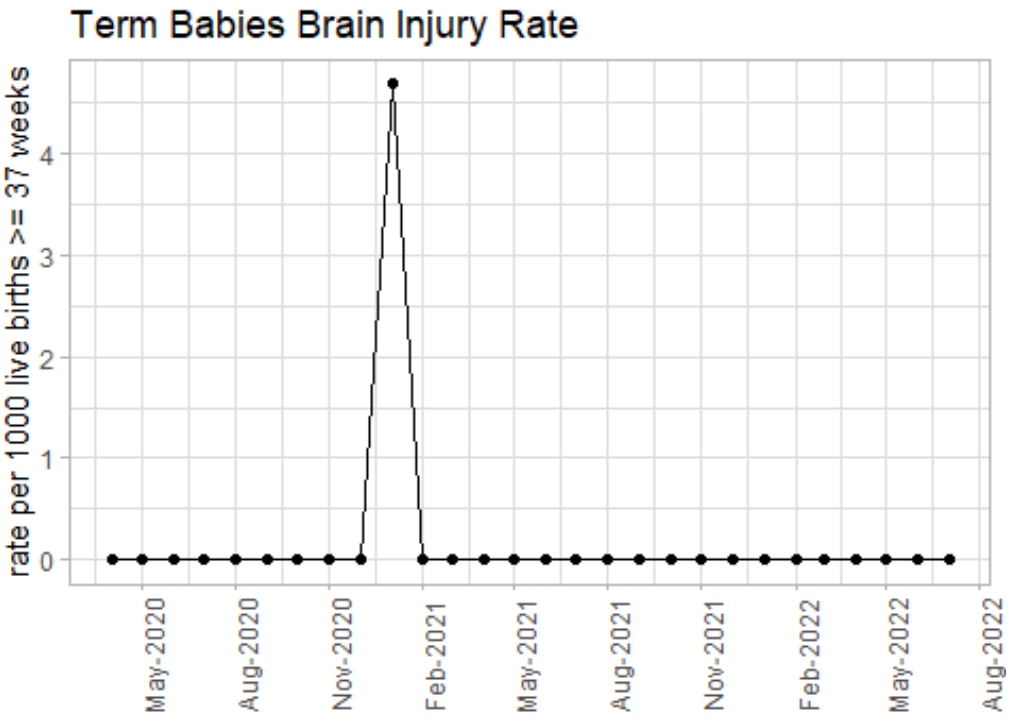
Data Source: NWC CN Maternity Dashboard

Term Babies Brain Injury Rate



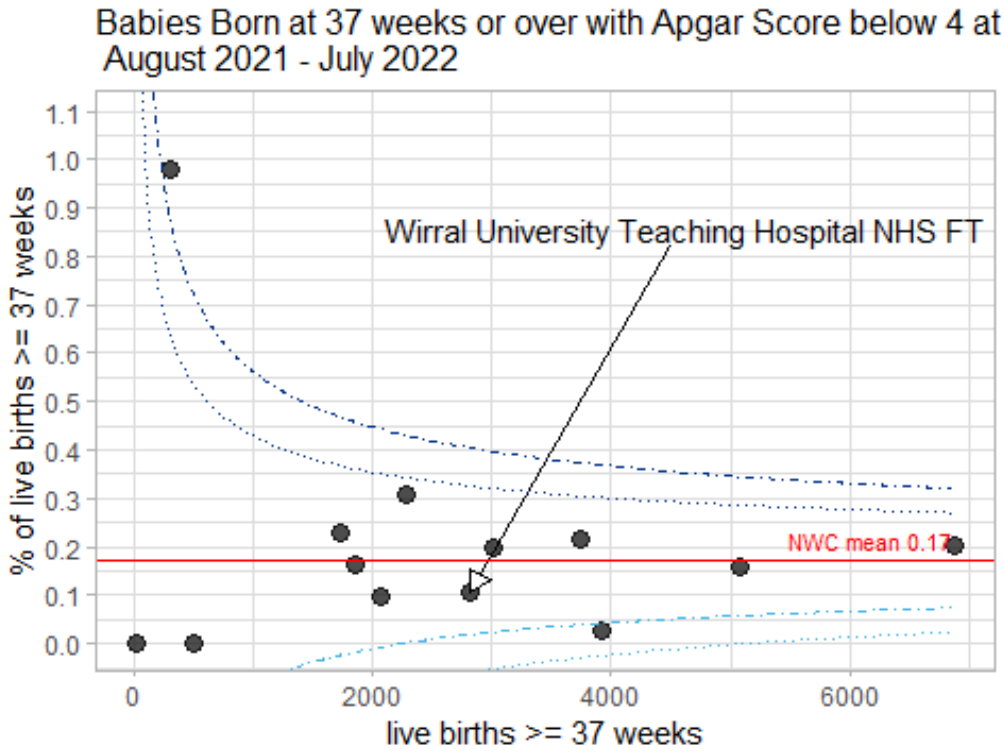
Data Source: NWC CN Maternity Dashboard

Run Chart for Term Babies Brain Injury Rate



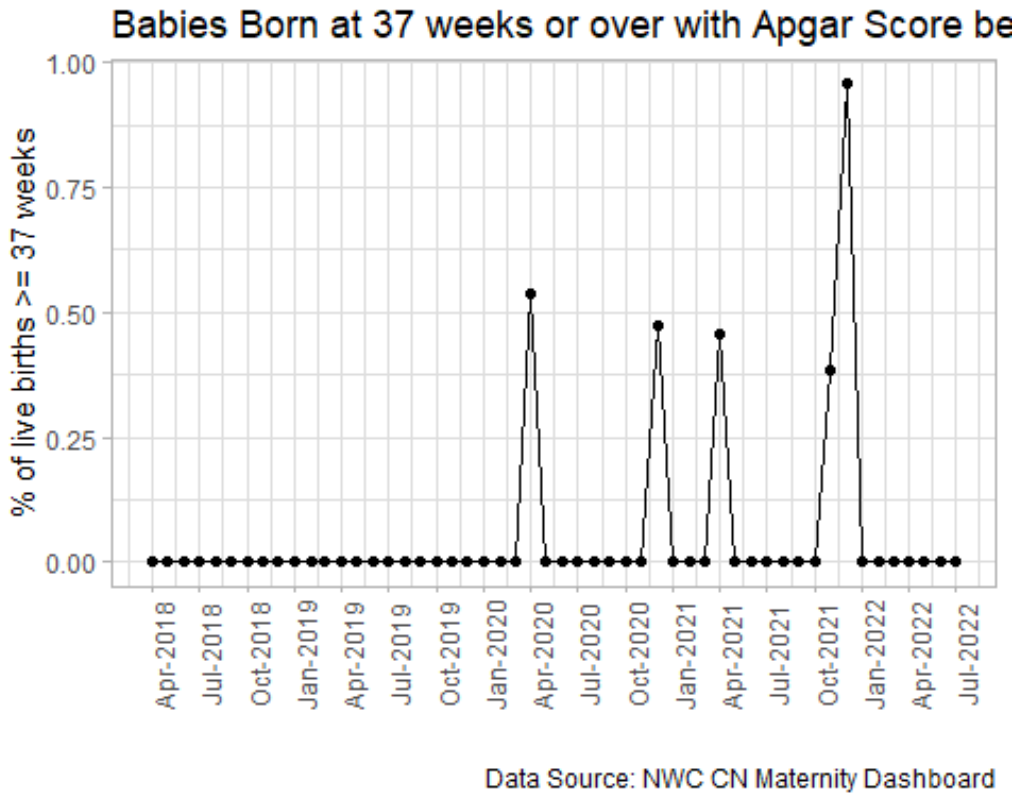
Data Source: NWC CN Maternity Dashboard

Babies Born at 37 weeks or over with Apgar Score below 4 at 5 minutes

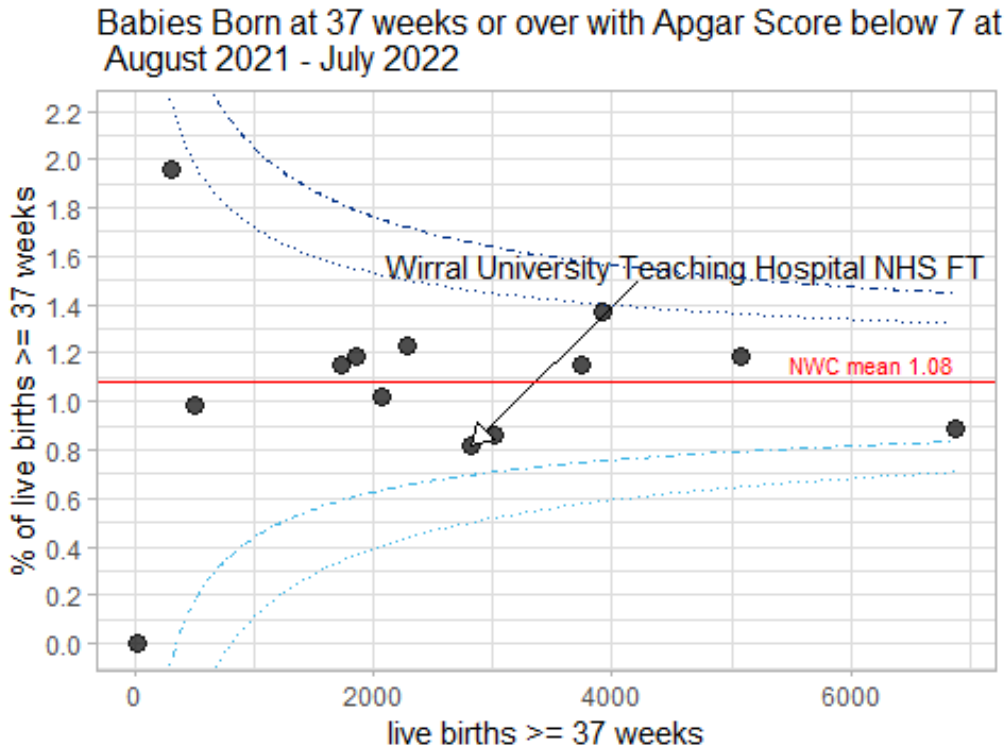


Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Born at 37 weeks or over with Apgar Score below 4 at 5 minutes

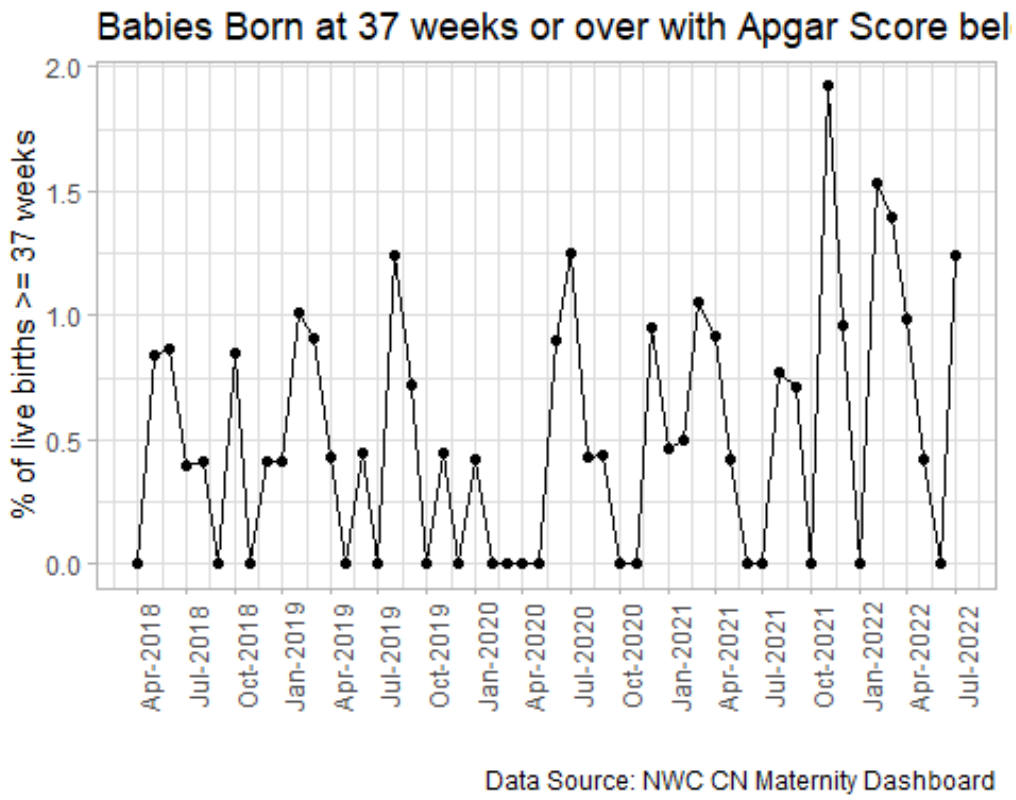


Babies Born at 37 weeks or over with Apgar Score below 7 at 5 minutes



Data Source: NWC CN Maternity Dashboard

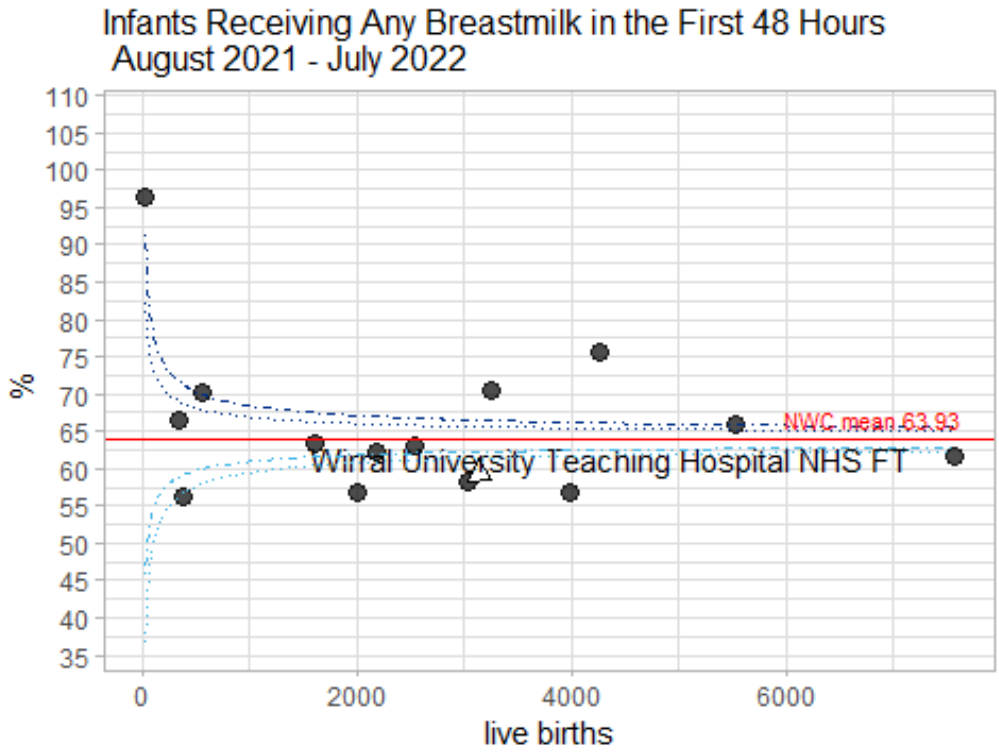
Run Chart for Babies Born at 37 weeks or over with Apgar Score below 7 at 5 minutes



Health Promotion

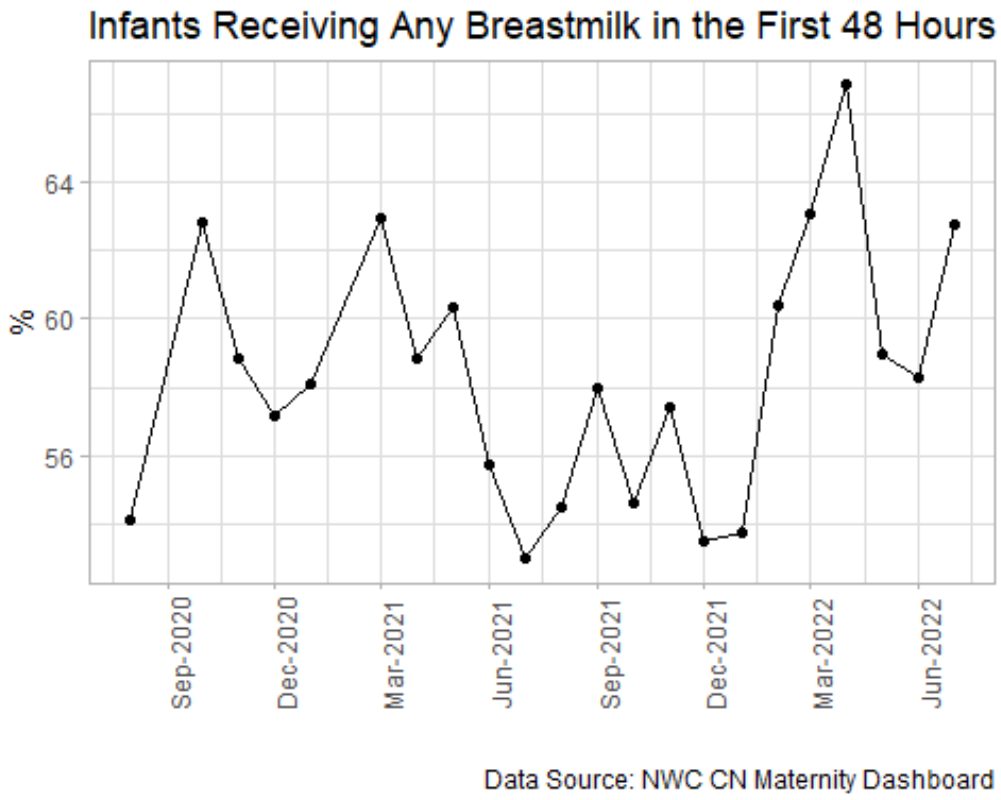
Breast Feeding

Infants Receiving Any Breastmilk in the First 48 Hours



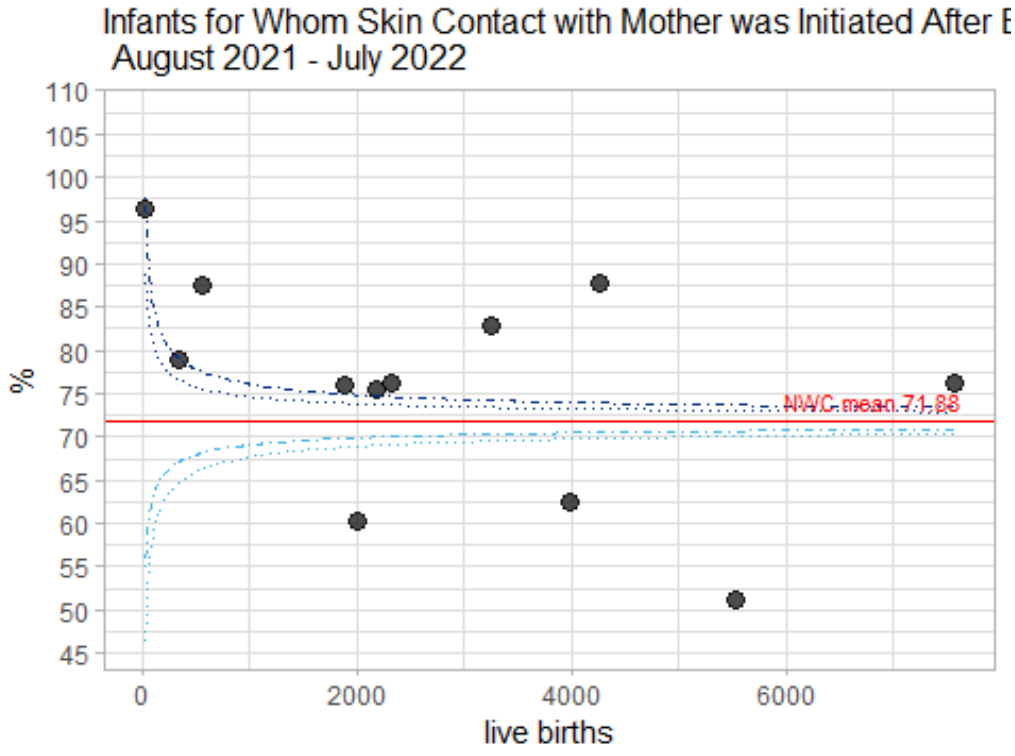
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants Receiving Any Breastmilk in the First 48 Hours



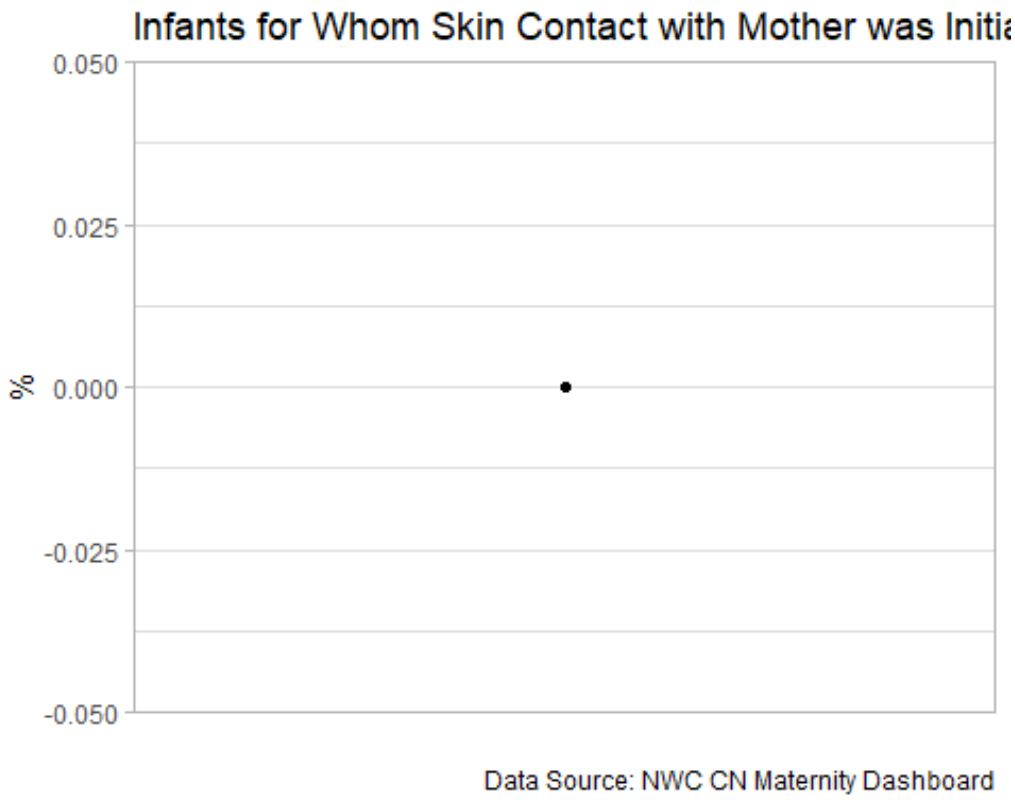
Data Source: NWC CN Maternity Dashboard

Infants for Whom Skin Contact with Mother was Initiated After Birth

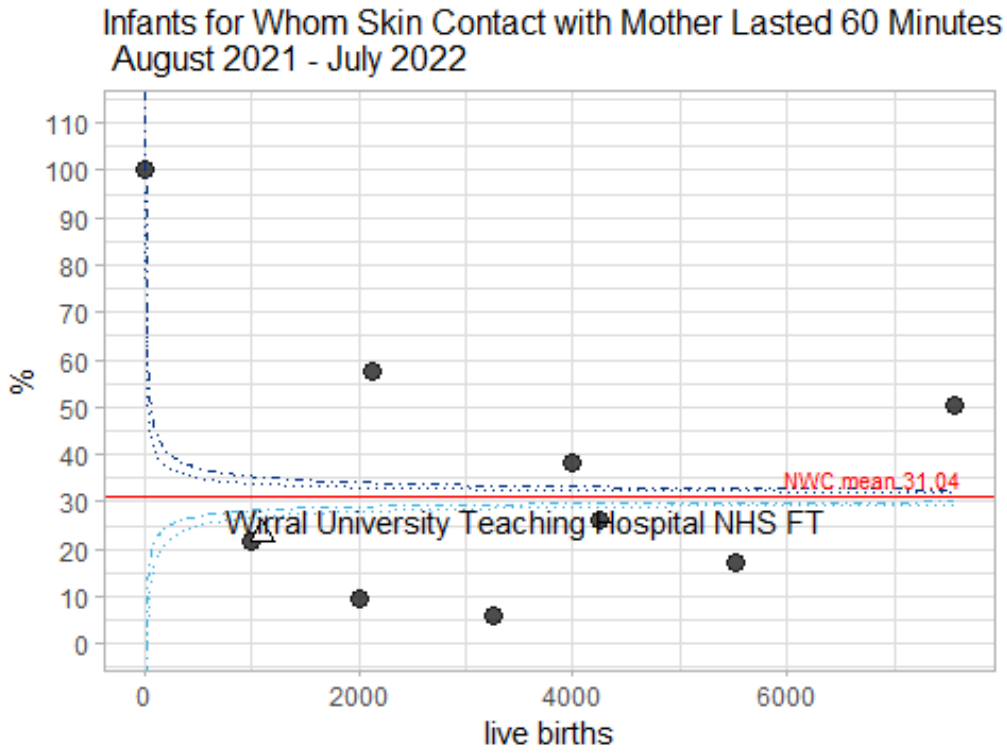


Data Source: NWC CN Maternity Dashboard

Run Chart for Infants for Whom Skin Contact with Mother was Initiated After Birth

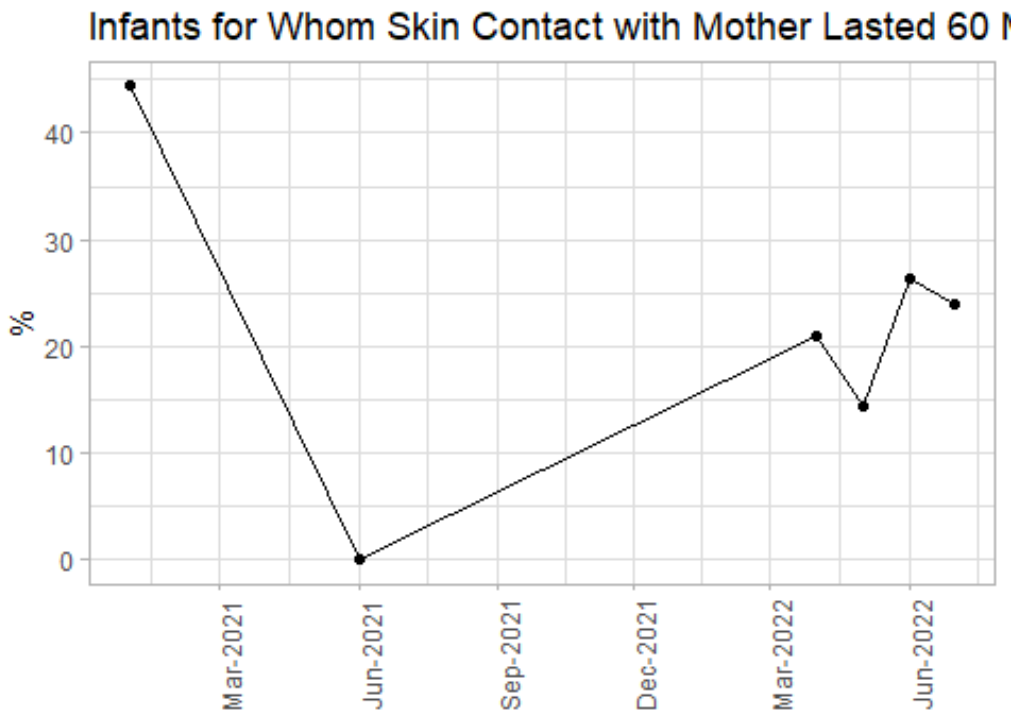


Infants for Whom Skin Contact with Mother Lasted 60 Minutes or More



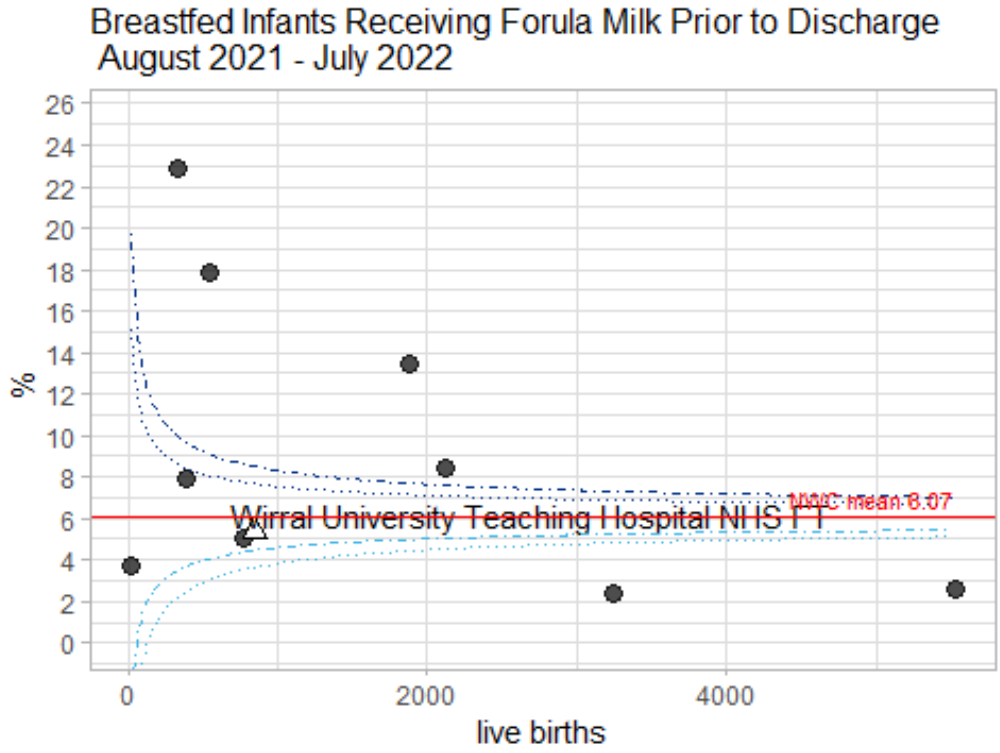
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants for Whom Skin Contact with Mother Lasted 60 Minutes or More



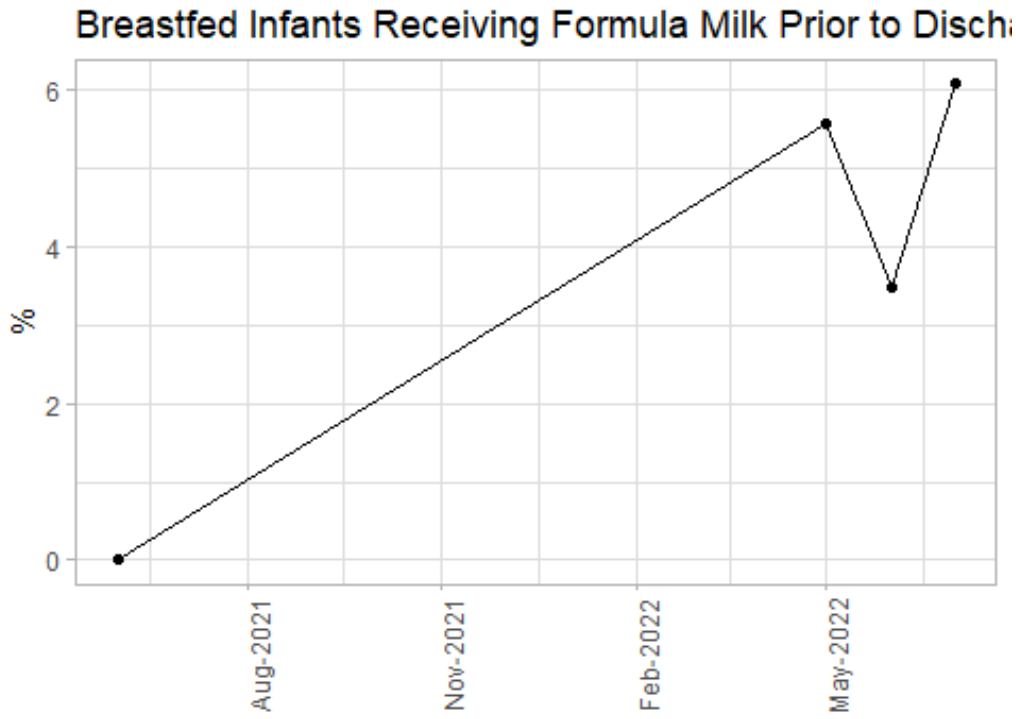
Data Source: NWC CN Maternity Dashboard

Breastfed Infants Receiving Formula Milk Prior to Discharge



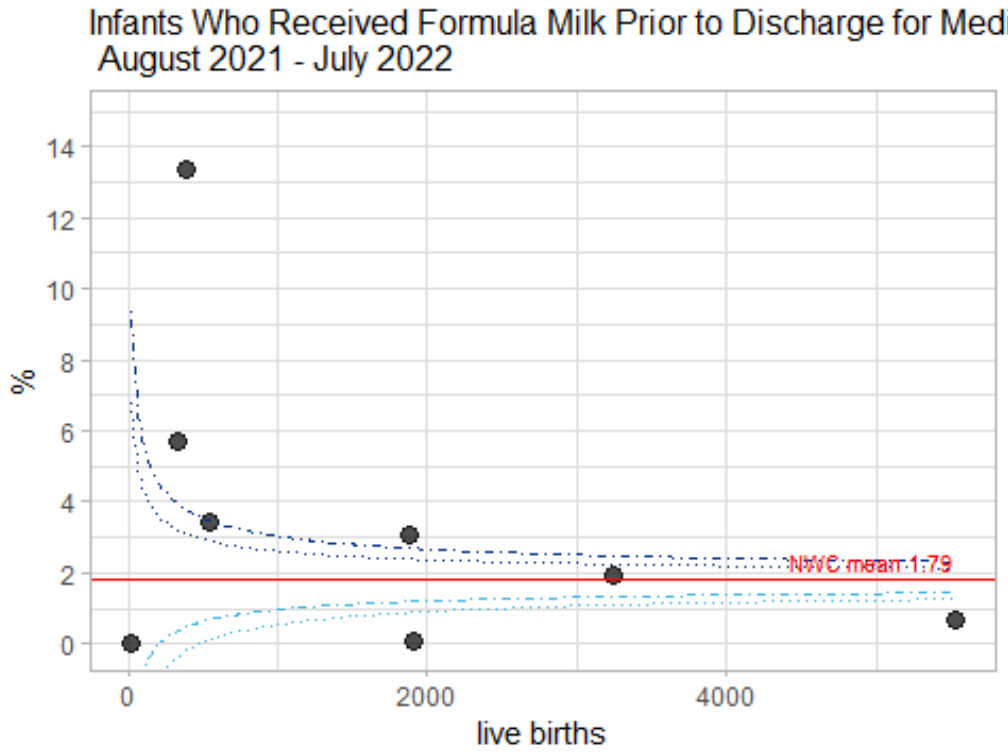
Data Source: NWC CN Maternity Dashboard

Run Chart for Breastfed Infants Receiving Formula Milk Prior to Discharge



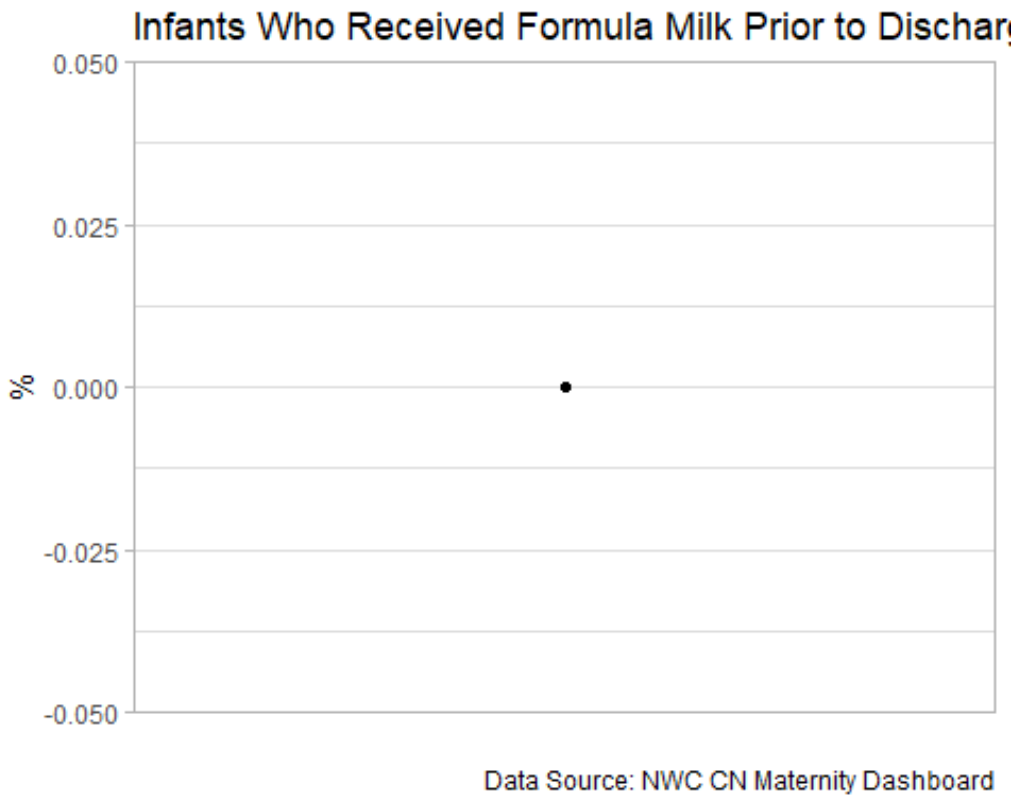
Data Source: NWC CN Maternity Dashboard

Infants Who Received Formula Milk Prior to Discharge for Medical Reasons and are Discharged Breastfeeding

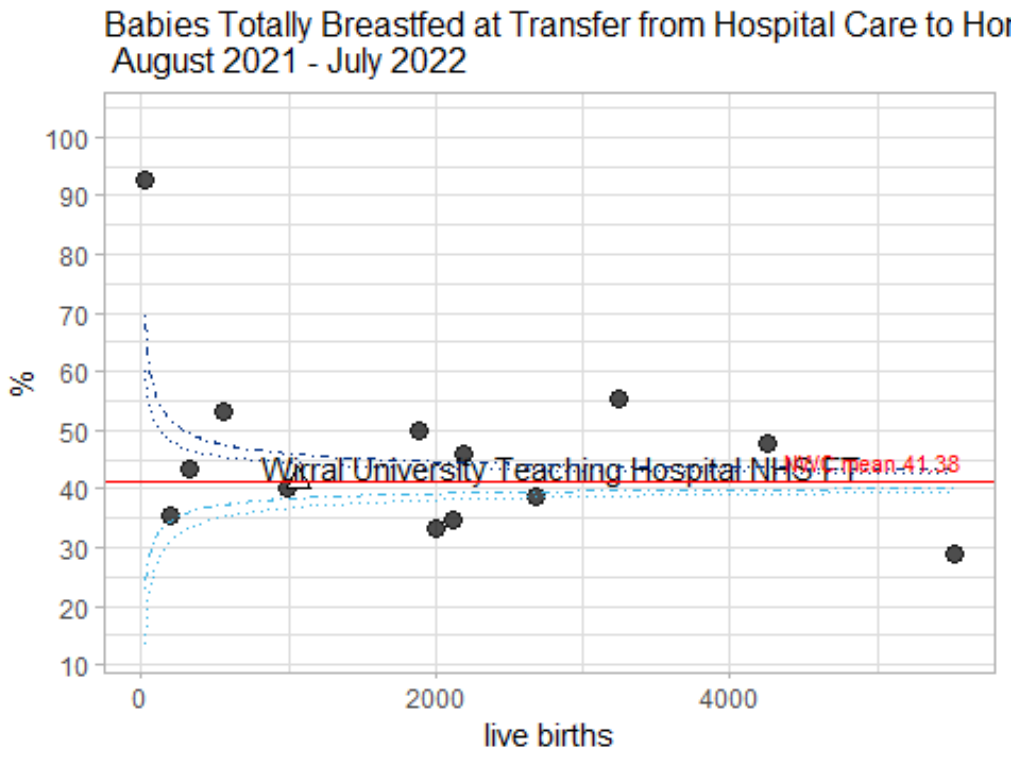


Data Source: NWC CN Maternity Dashboard

Run Chart for Infants Who Received Formula Milk Prior to Discharge for Medical Reasons and are Discharged Breastfeeding

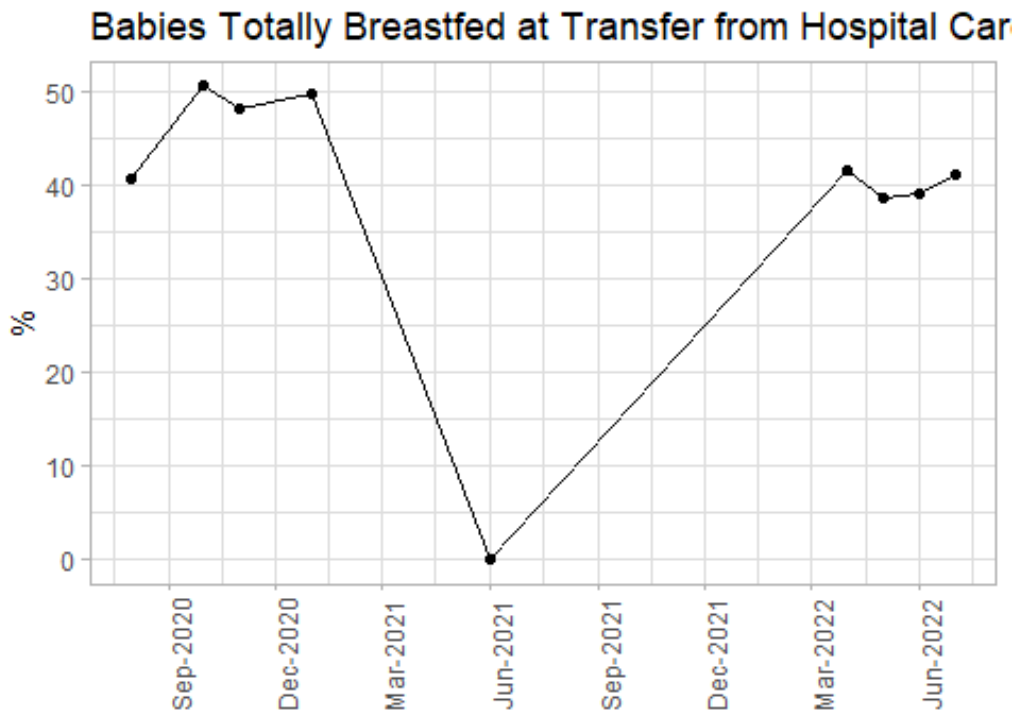


Babies Totally Breastfed at Transfer from Hospital Care to Home Care



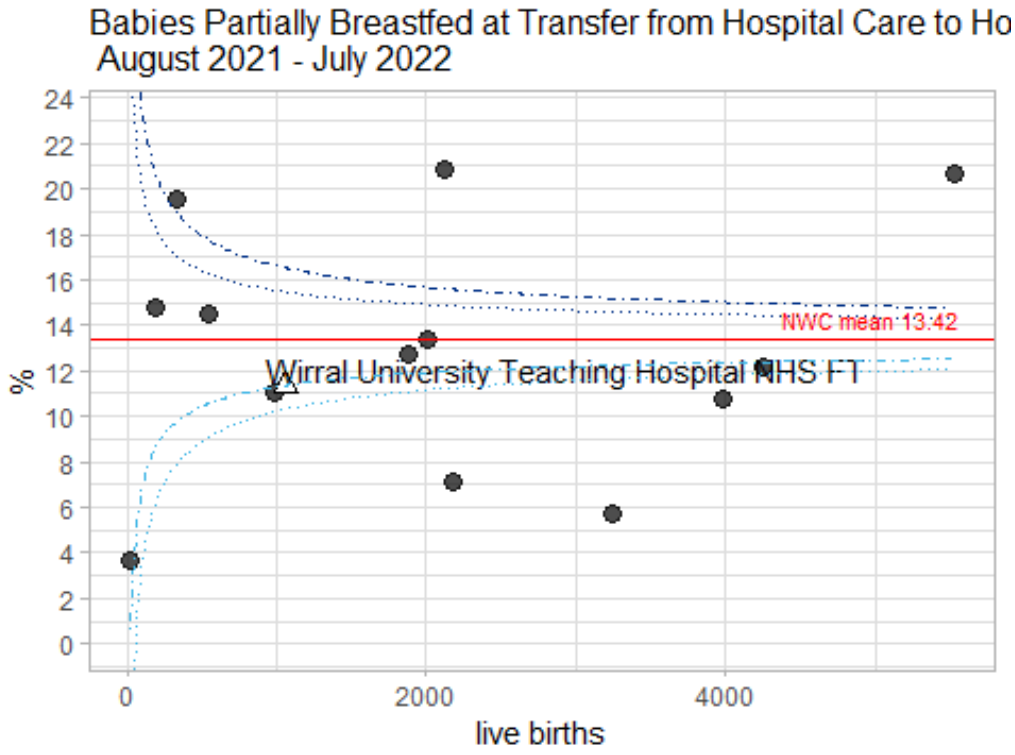
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Breastfed at Transfer from Hospital Care to Home Care



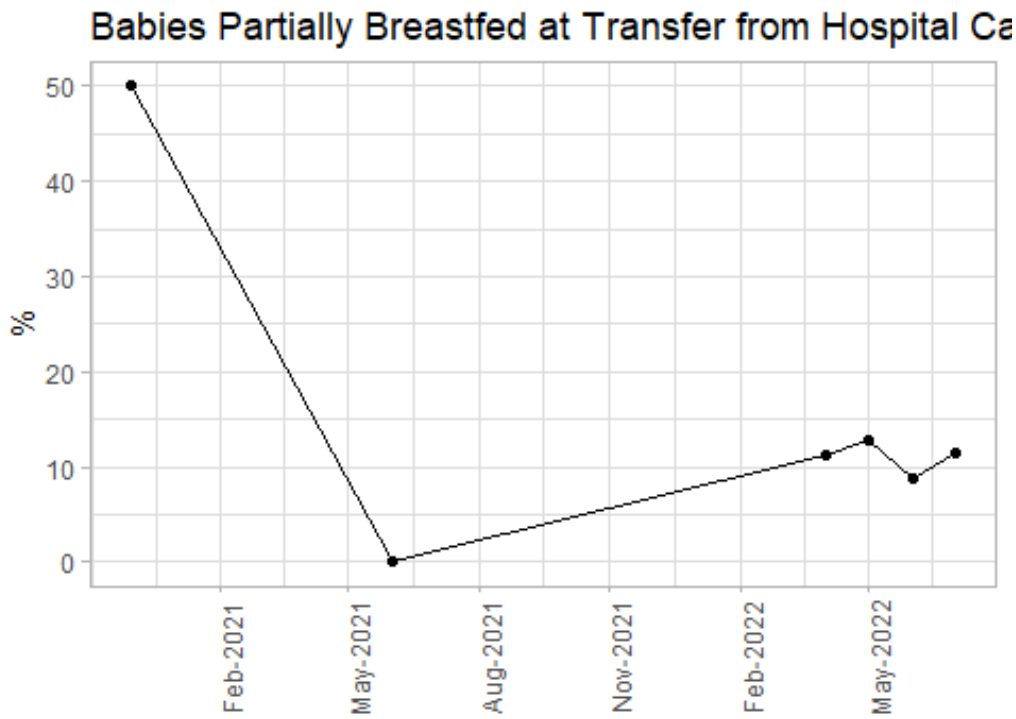
Data Source: NWC CN Maternity Dashboard

Babies Partially Breastfed at Transfer from Hospital Care to Home Care



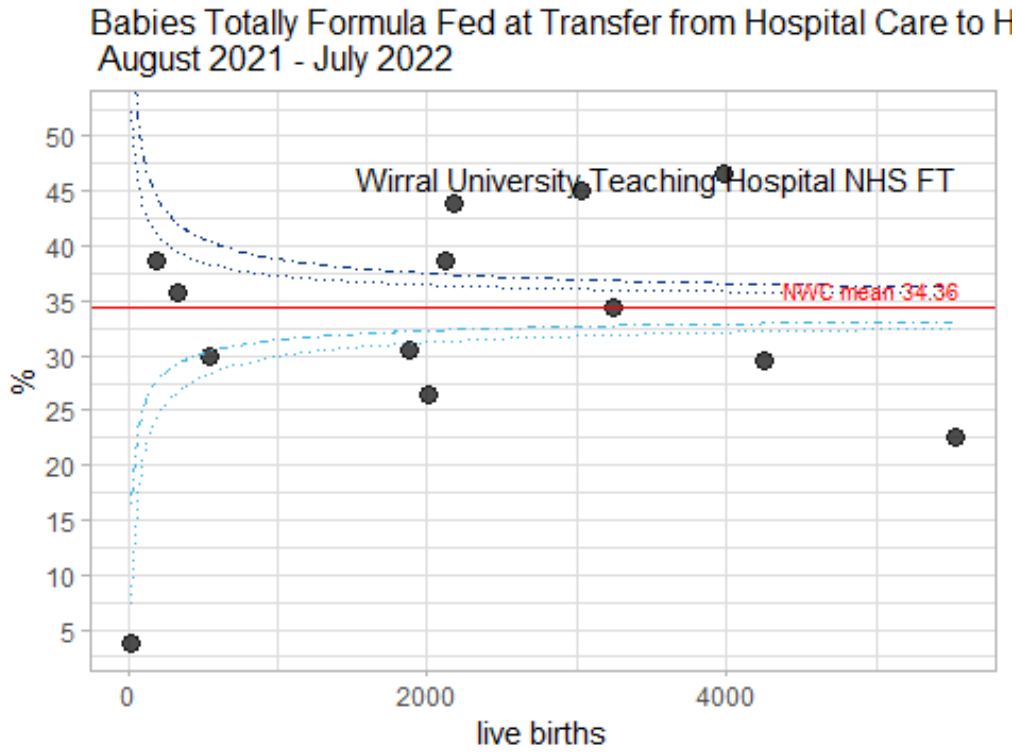
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Partially Breastfed at Transfer from Hospital Care to Home Care



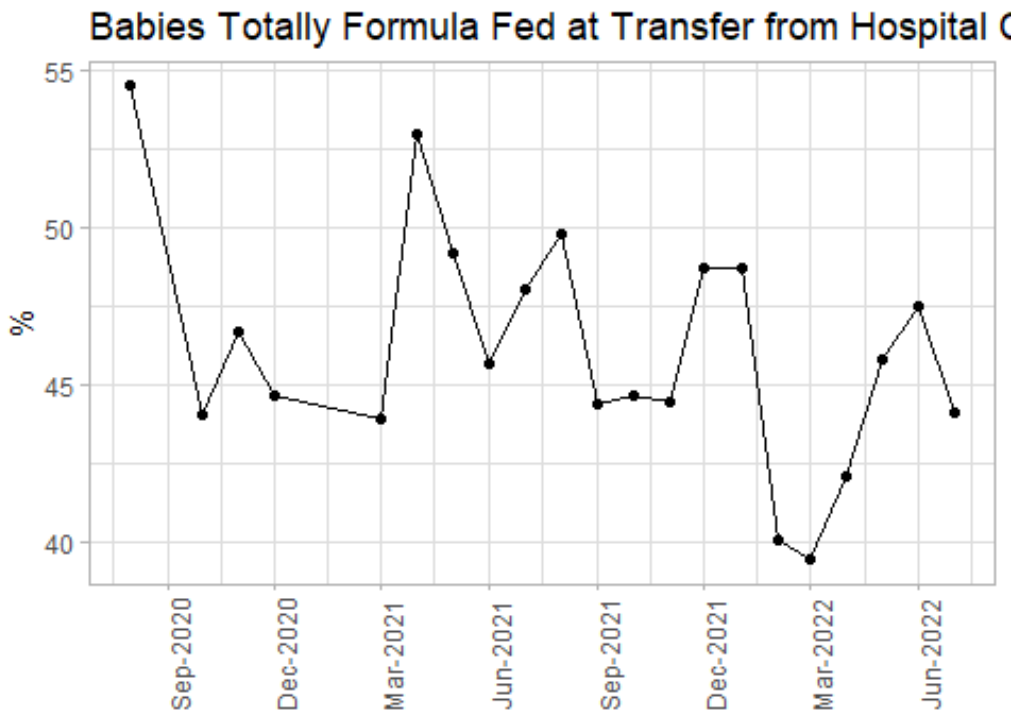
Data Source: NWC CN Maternity Dashboard

Babies Totally Formula Fed at Transfer from Hospital Care to Home Care



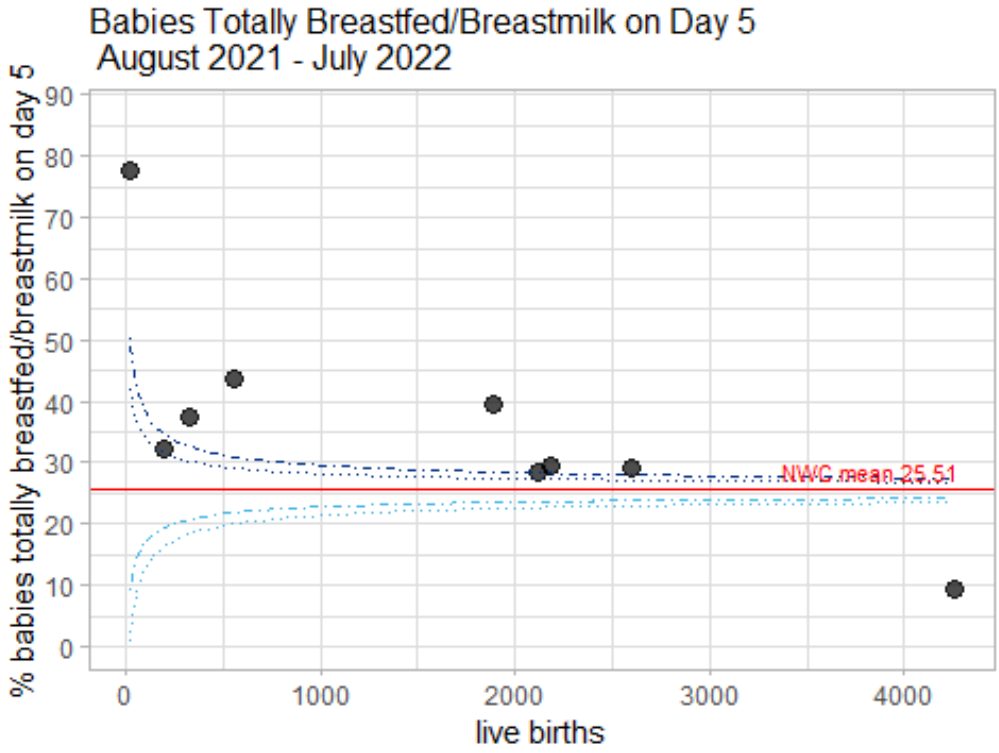
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Formula Fed at Transfer from Hospital Care to Home Care



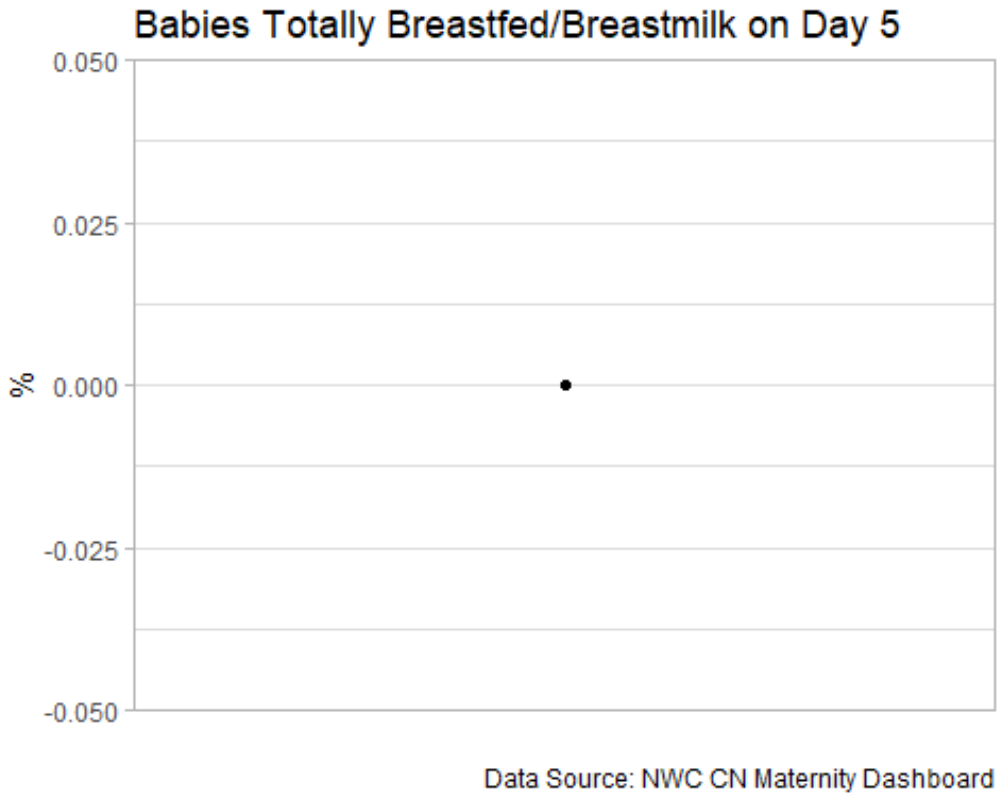
Data Source: NWC CN Maternity Dashboard

Babies Totally Breastfed/Breastmilk on Day 5



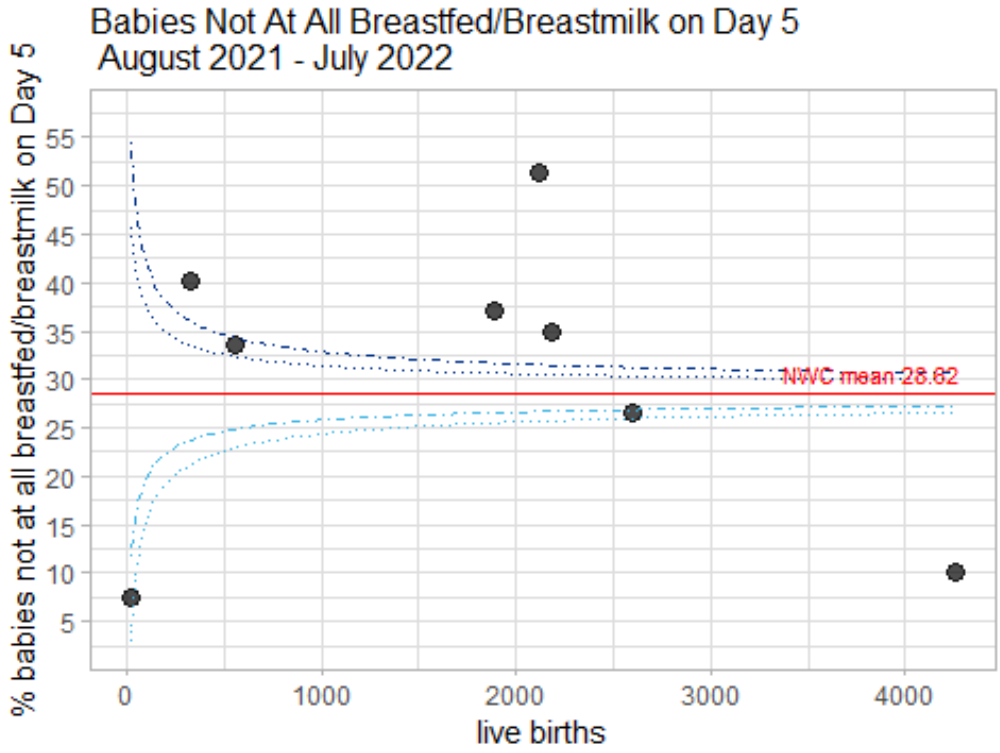
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Breastfed/Breastmilk on Day 5



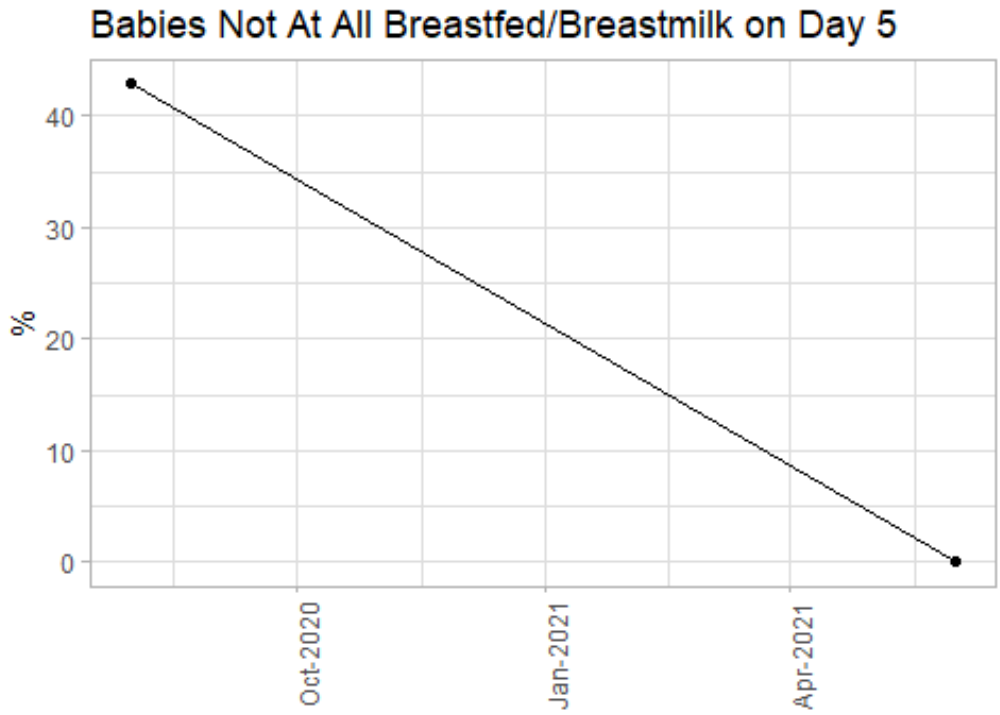
Data Source: NWC CN Maternity Dashboard

Babies Not At All Breastfed/Breastmilk on Day 5



Data Source: NWC CN Maternity Dashboard

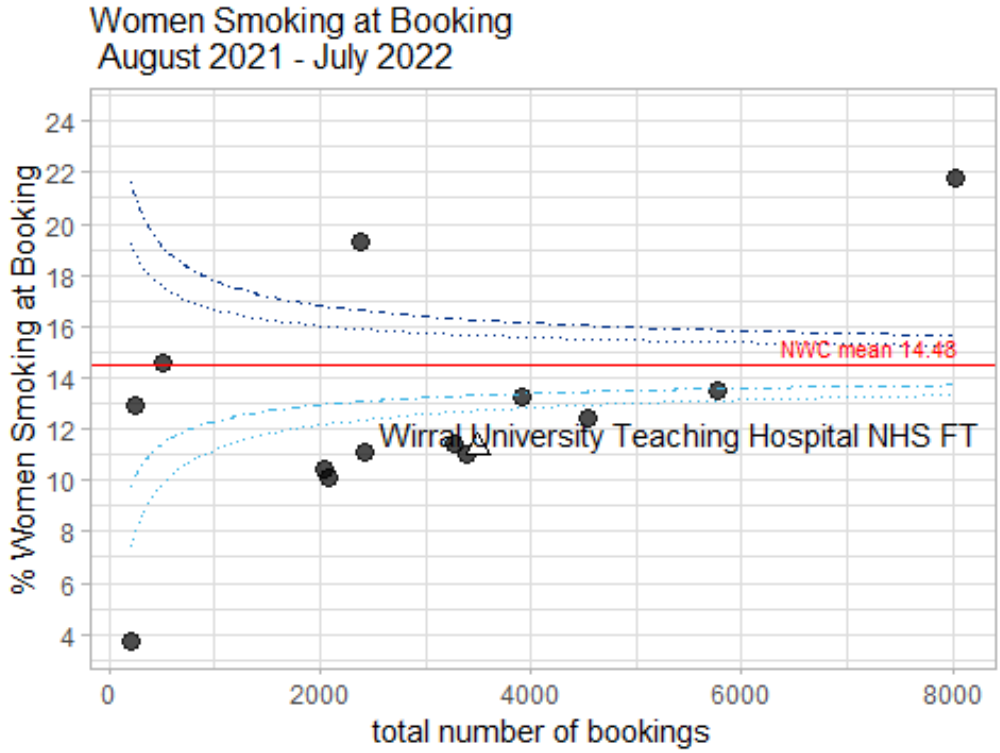
Run Chart for Babies Not At All Breastfed/Breastmilk on Day 5



Data Source: NWC CN Maternity Dashboard

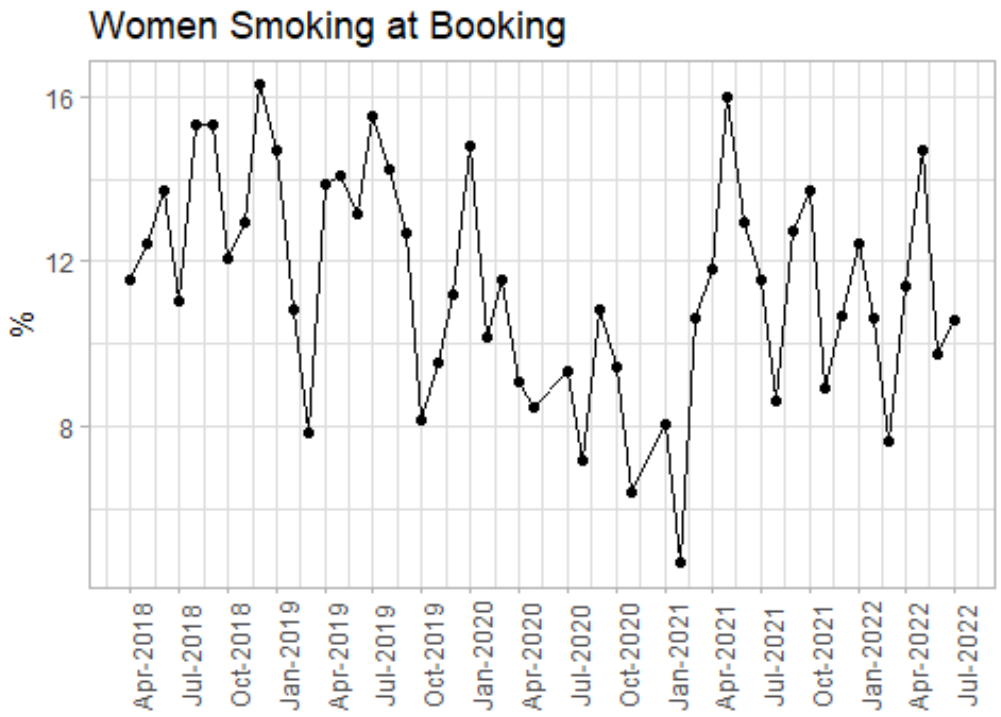
Smoking in Pregnancy

Women Smoking at Booking



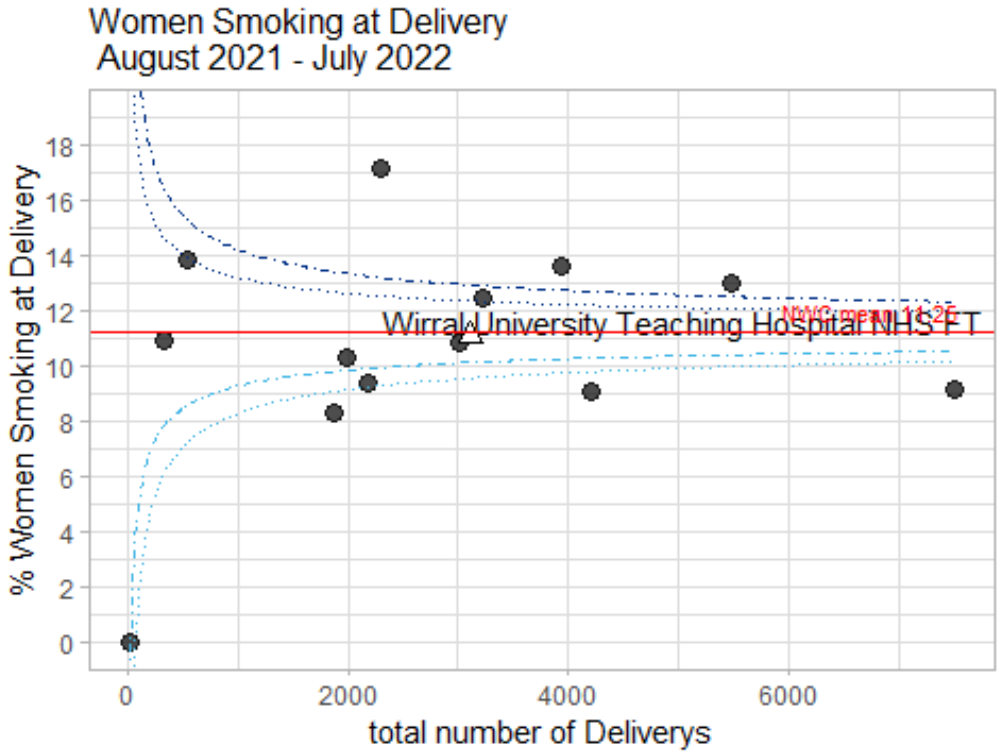
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Smoking at Booking



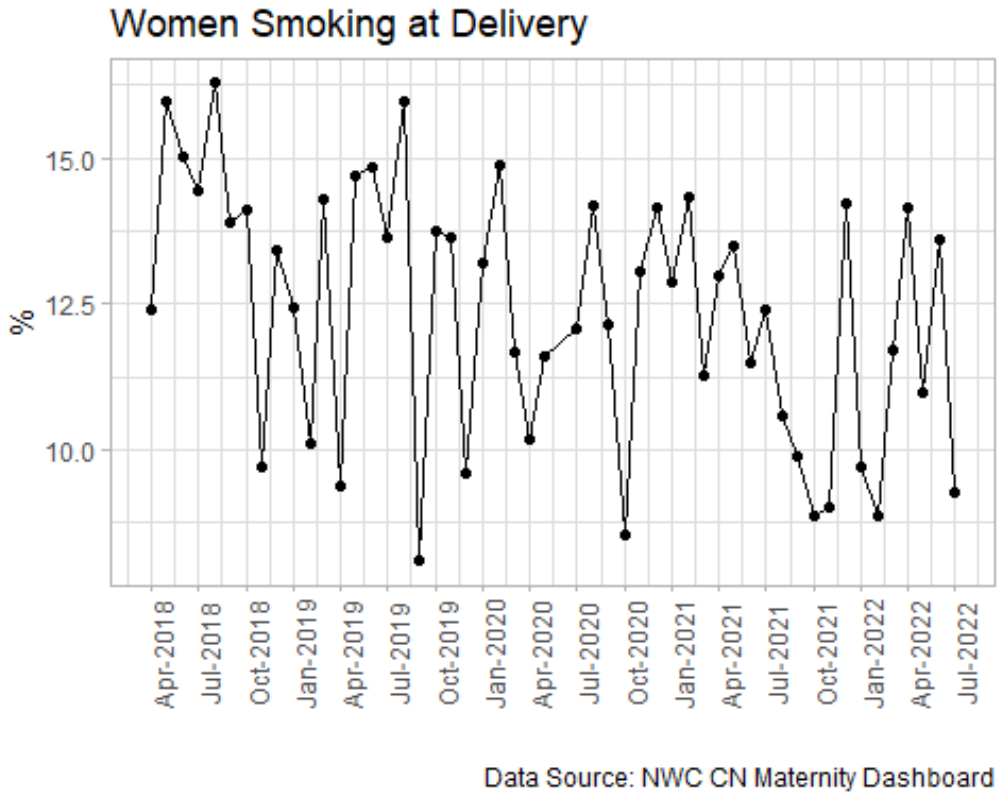
Data Source: NWC CN Maternity Dashboard

Women Smoking at Delivery



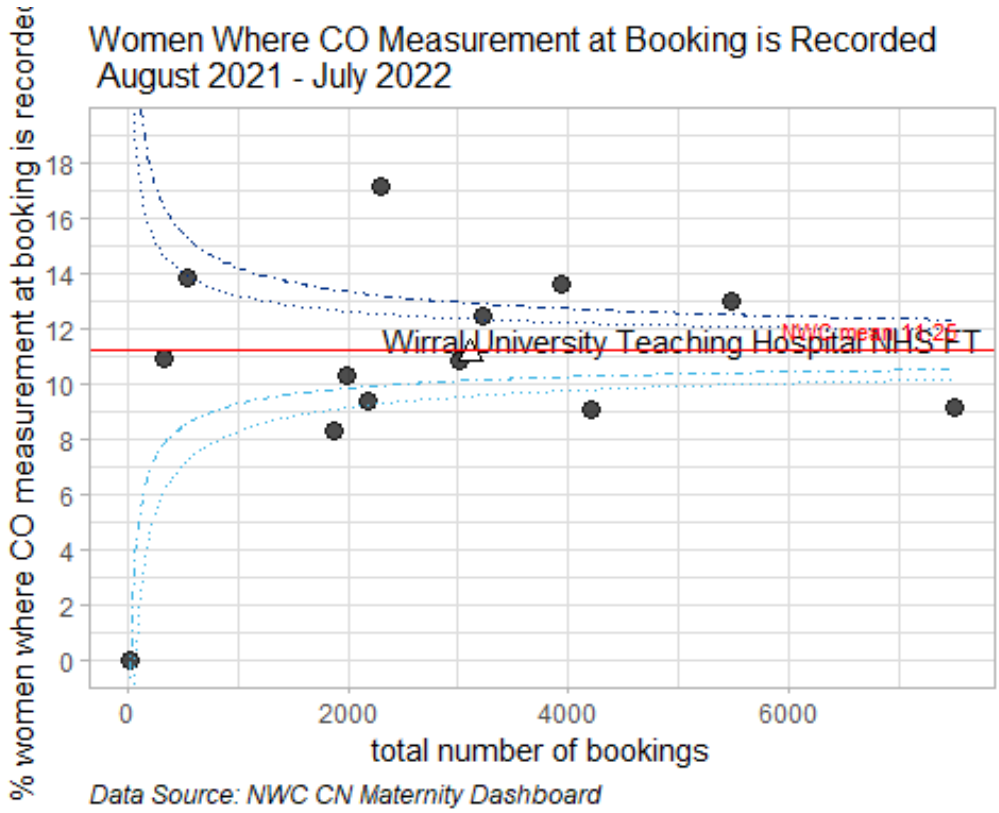
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Smoking at Delivery



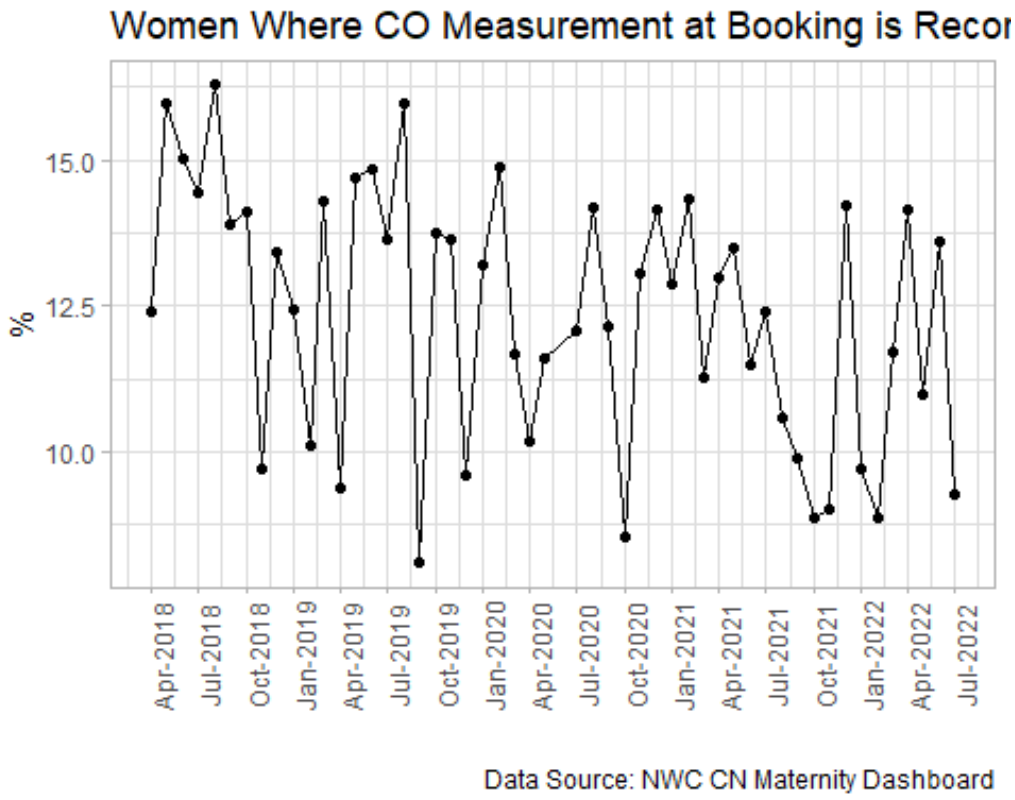
Data Source: NWC CN Maternity Dashboard

Women Where CO Measurement at Booking is Recorded

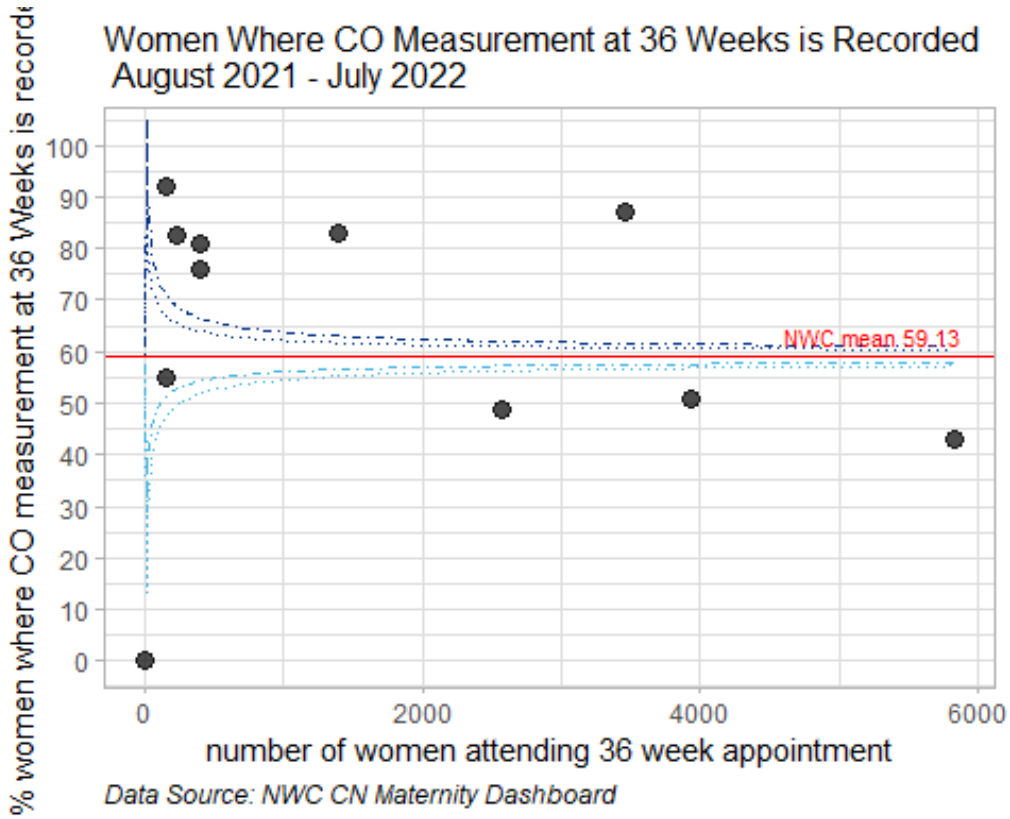


Data Source: NWC CN Maternity Dashboard

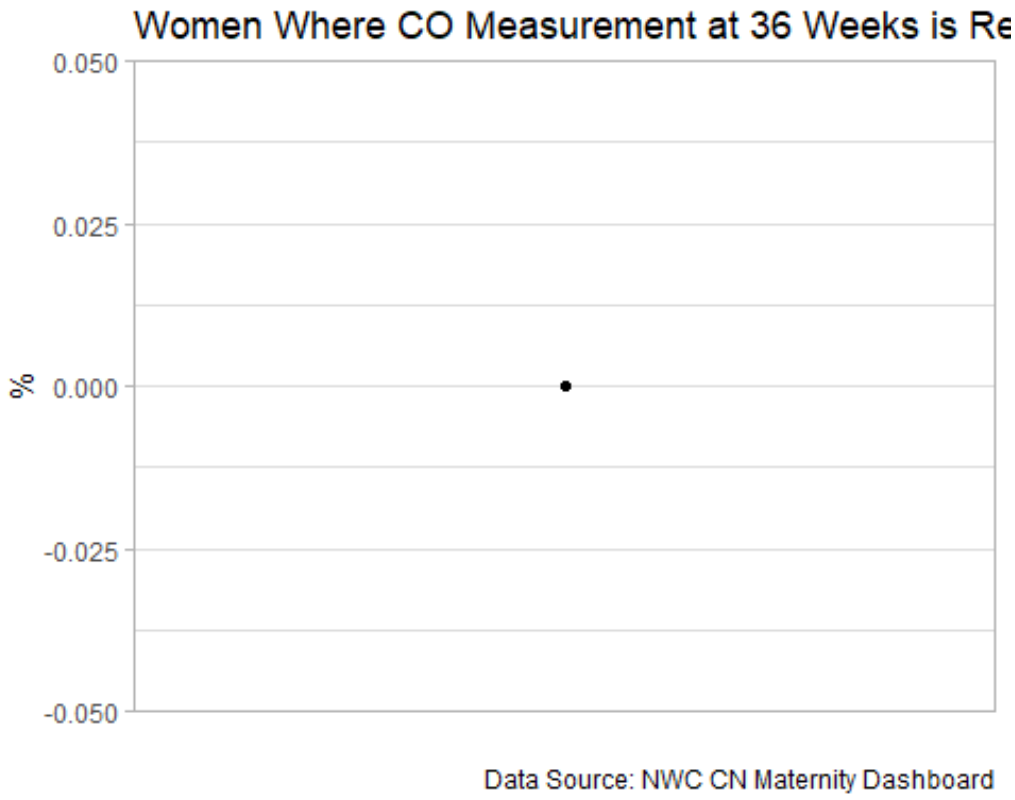
Run Chart for Women Where CO Measurement at Booking is Recorded



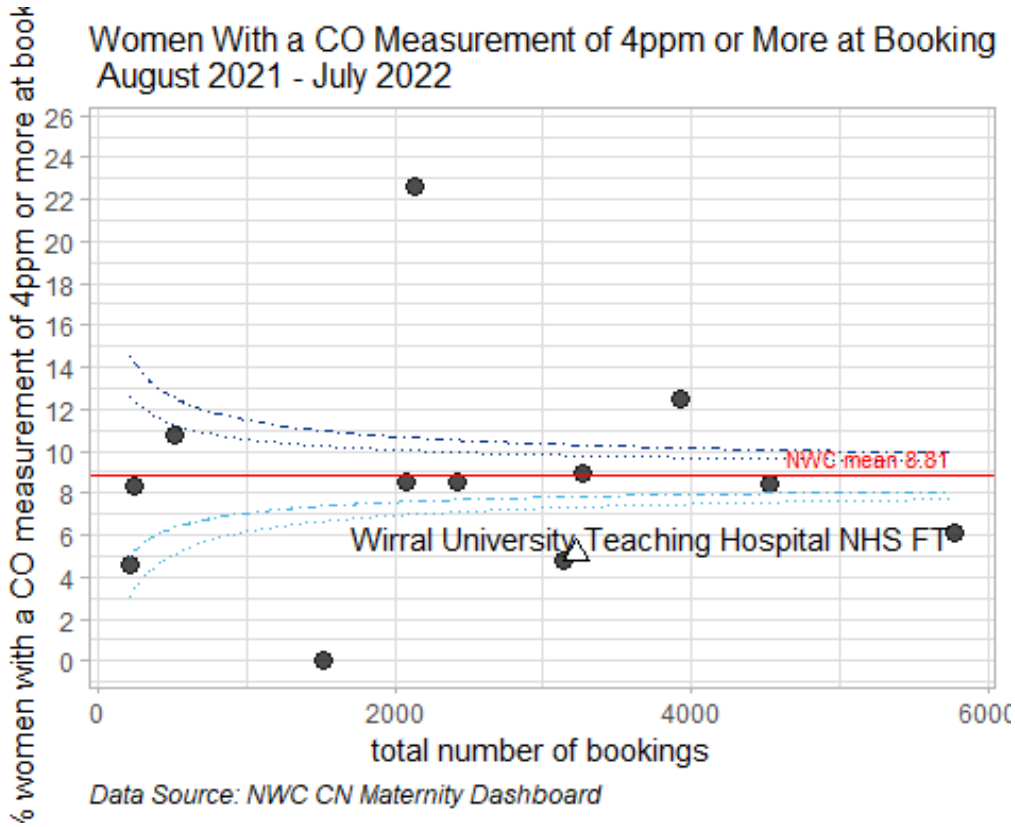
Women Where CO Measurement at 36 Weeks is Recorded



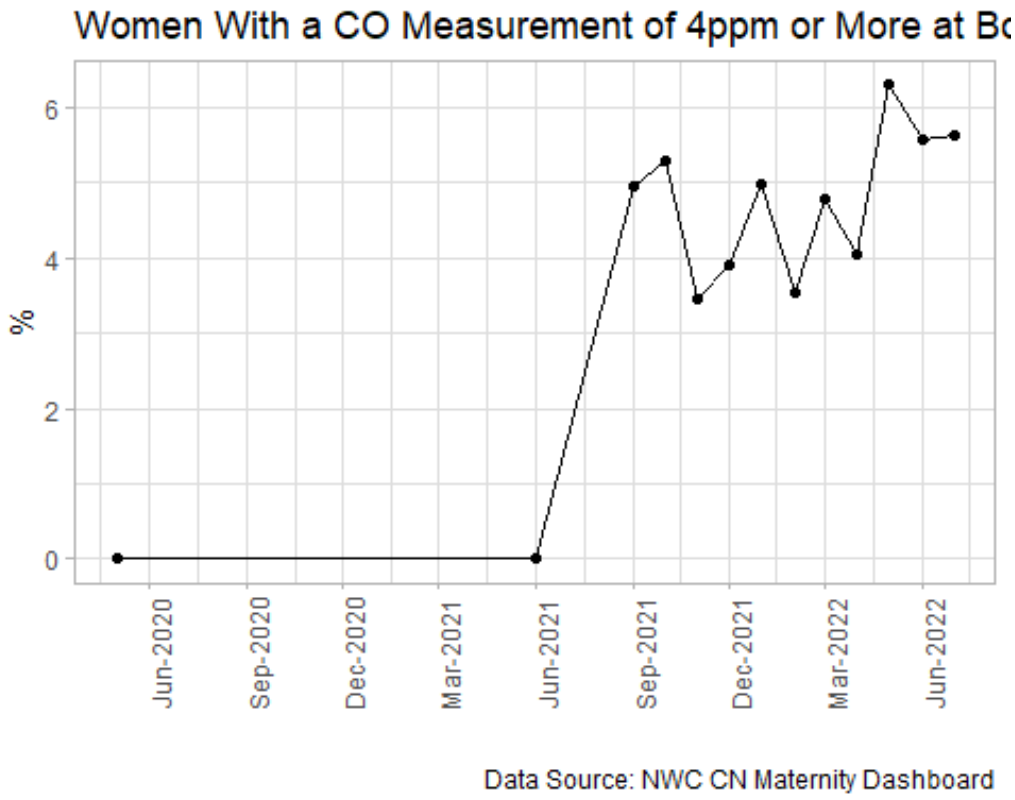
Run Chart for Women Where CO Measurement at 36 Weeks is Recorded



Women With a CO Measurement of 4ppm or More at Booking

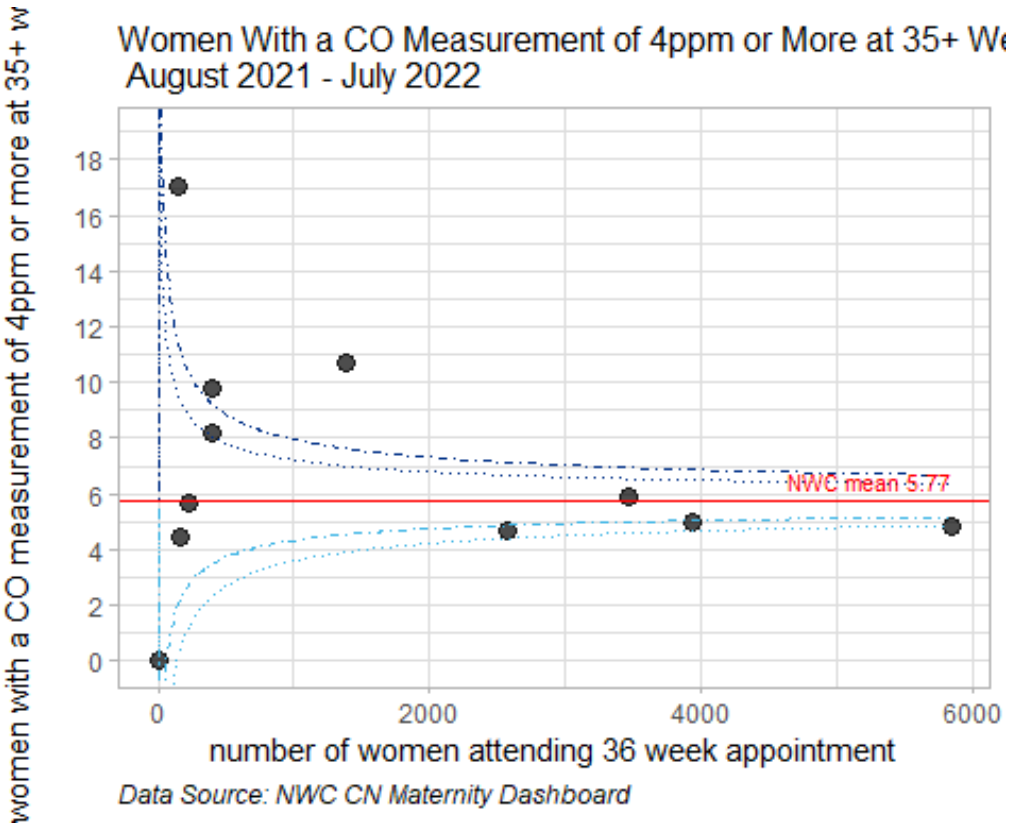


Run Chart for Women With a CO Measurement of 4ppm or More at Booking



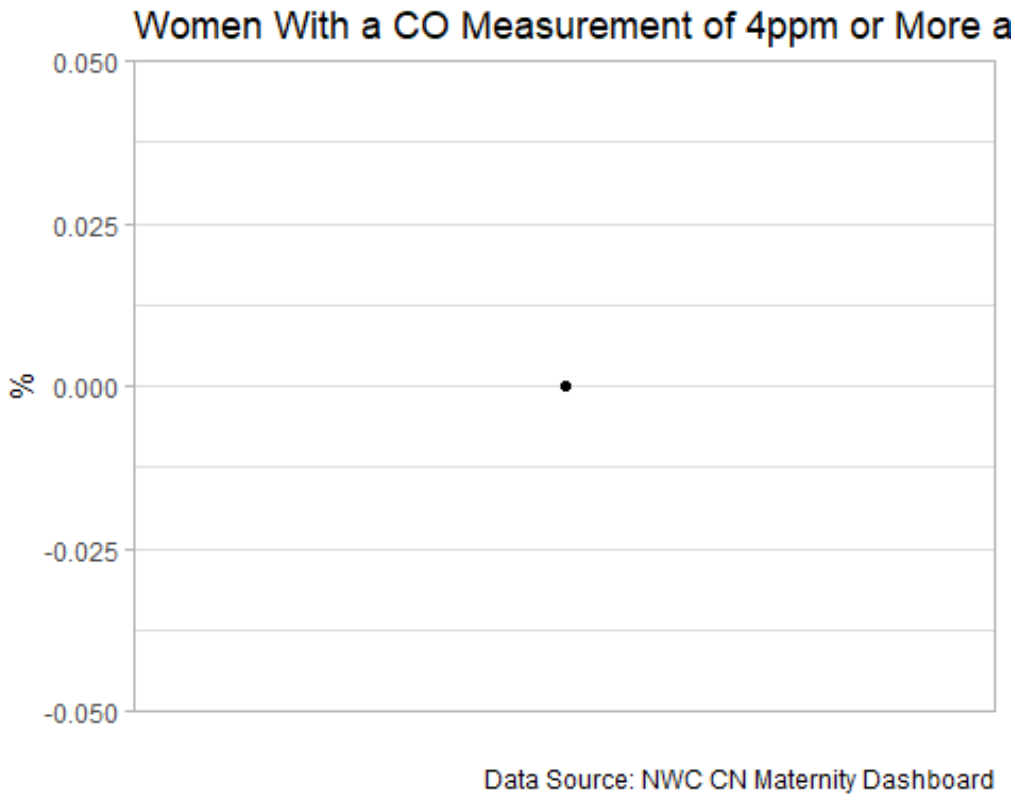
Data Source: NWC CN Maternity Dashboard

Women With a CO Measurement of 4ppm or More at 35+ Weeks



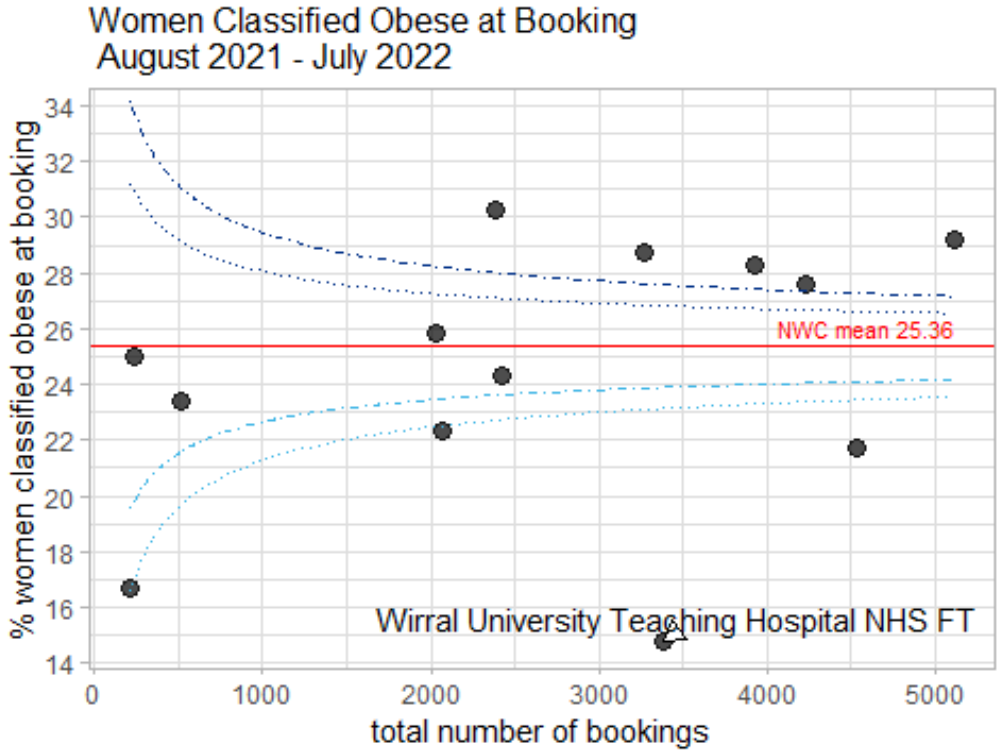
Data Source: NWC CN Maternity Dashboard

Run Chart for Women With a CO Measurement of 4ppm or More at 35+ Weeks



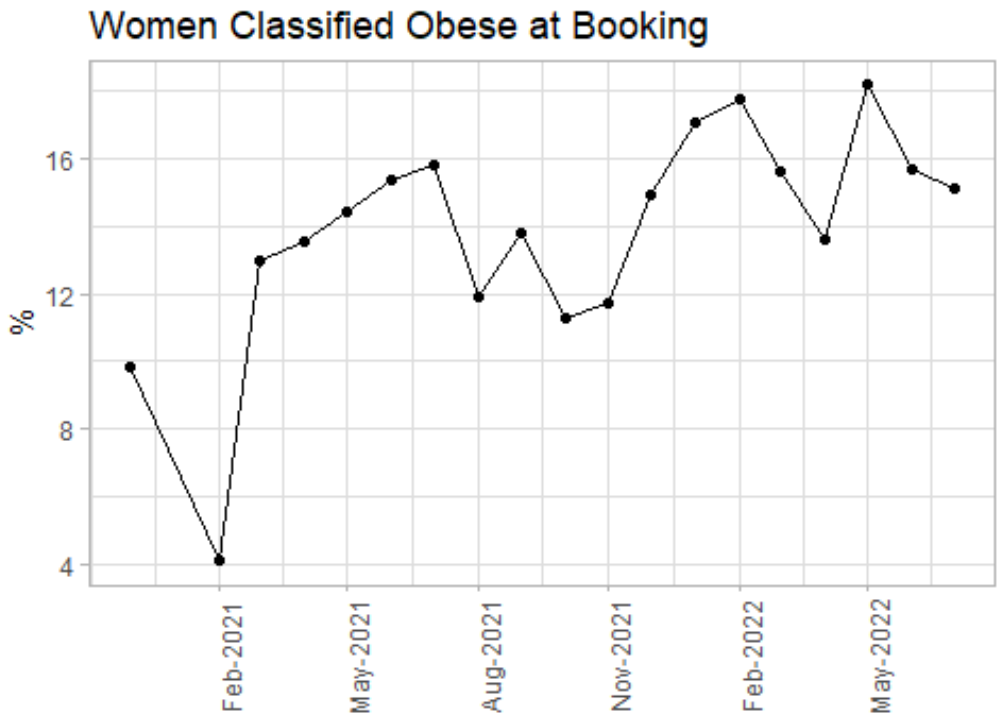
Obesity

Women Classified Obese at Booking



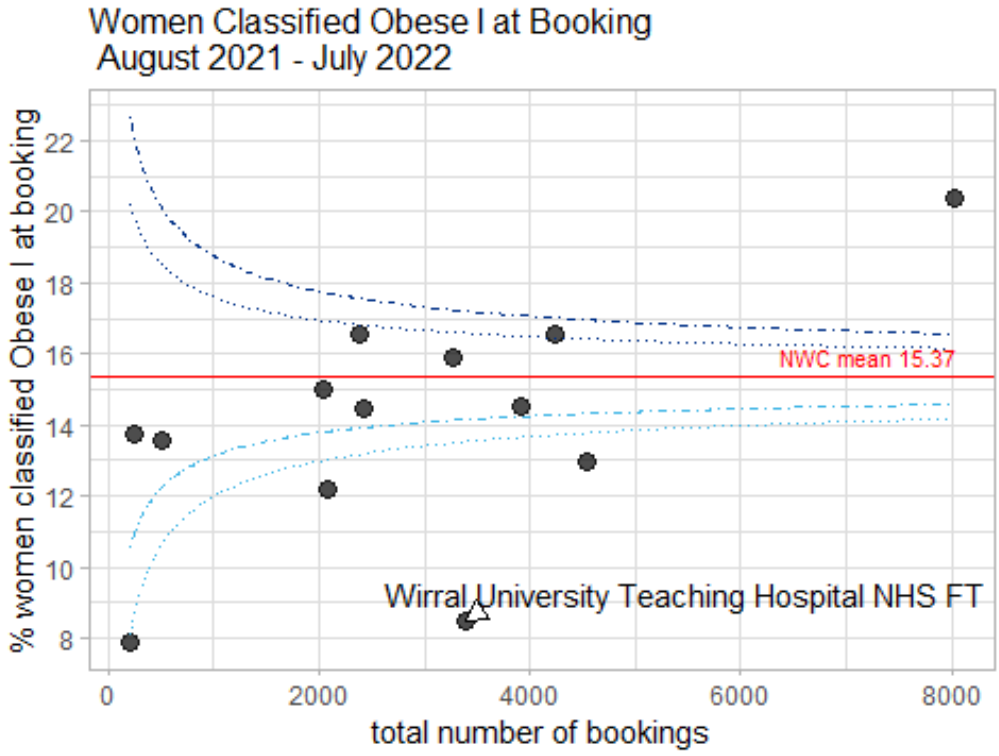
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese at Booking



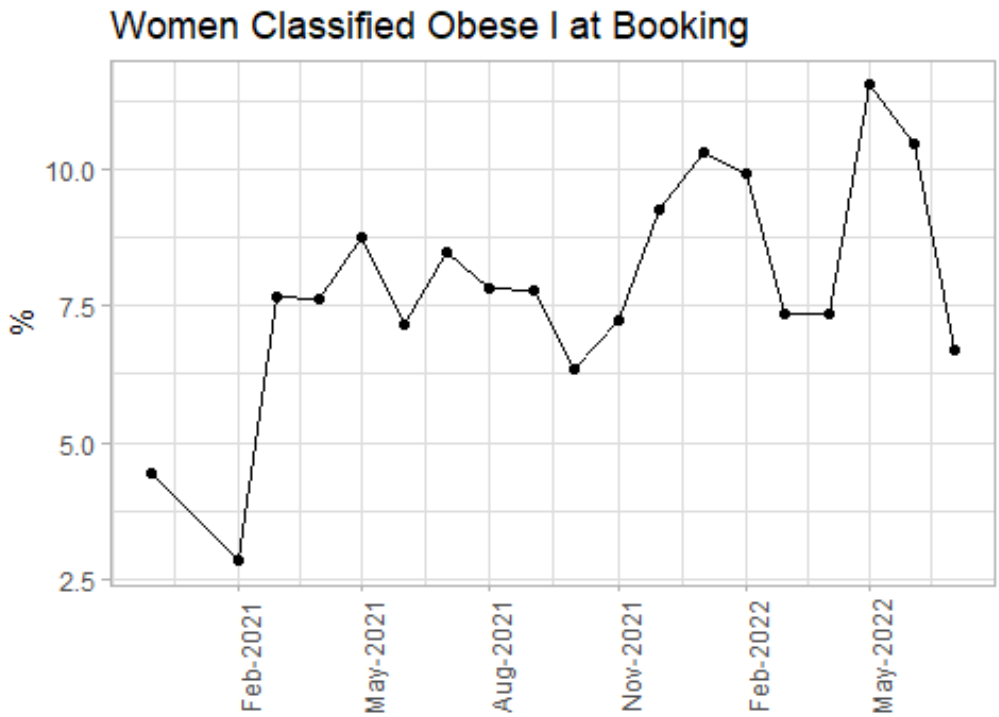
Data Source: NWC CN Maternity Dashboard

Women Classified Obese I at Booking



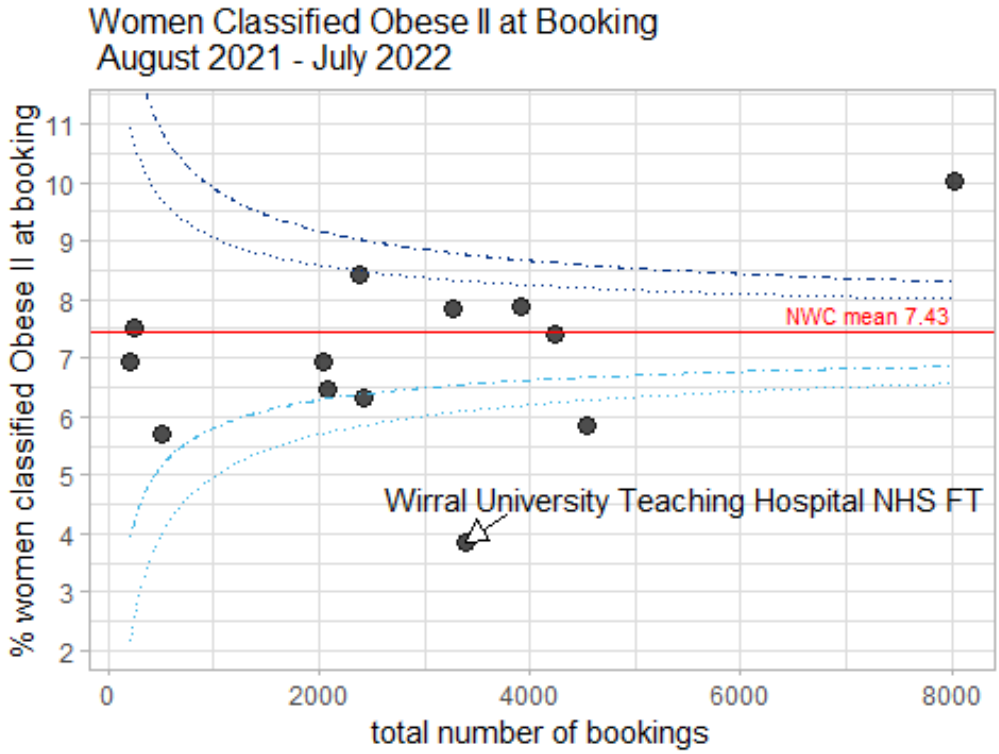
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese I at Booking



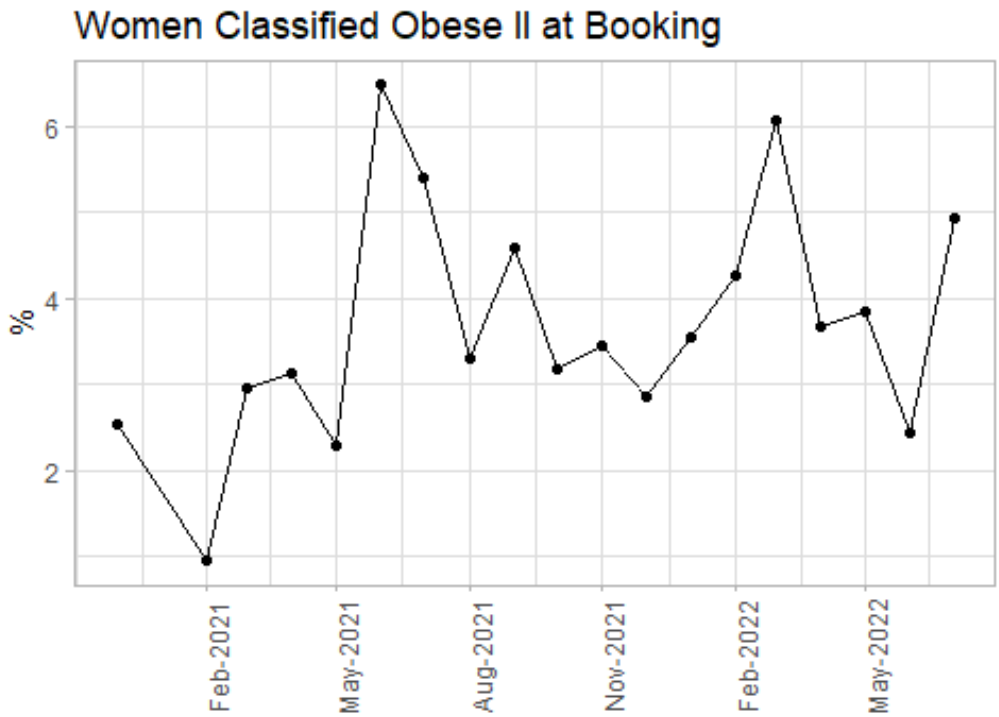
Data Source: NWC CN Maternity Dashboard

Women Classified Obese II at Booking



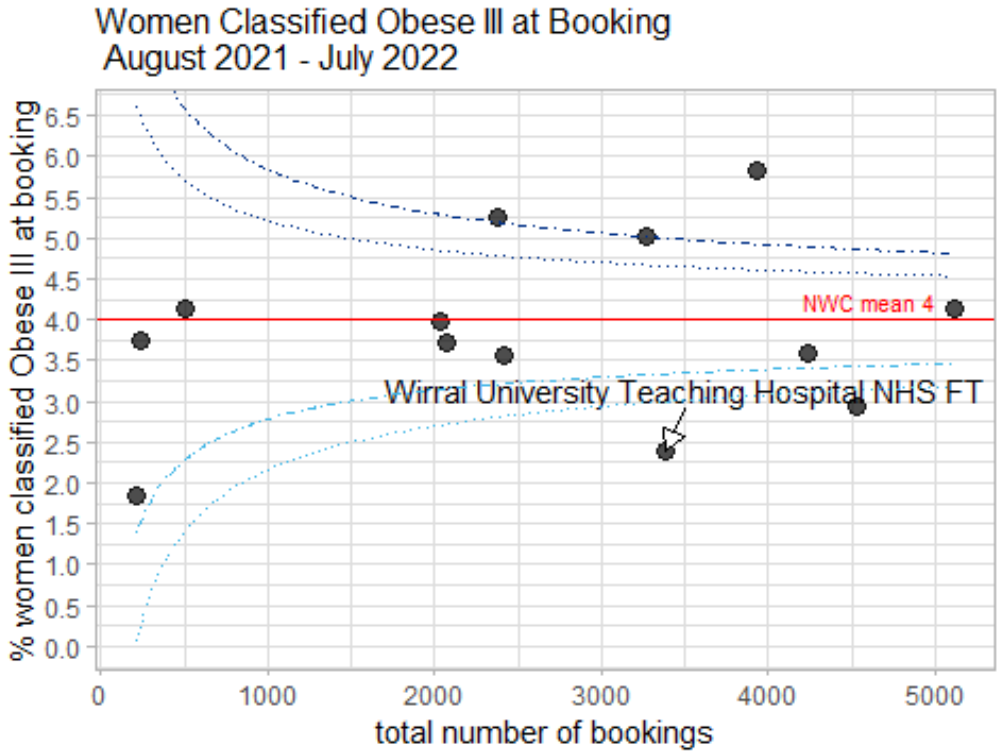
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese II at Booking



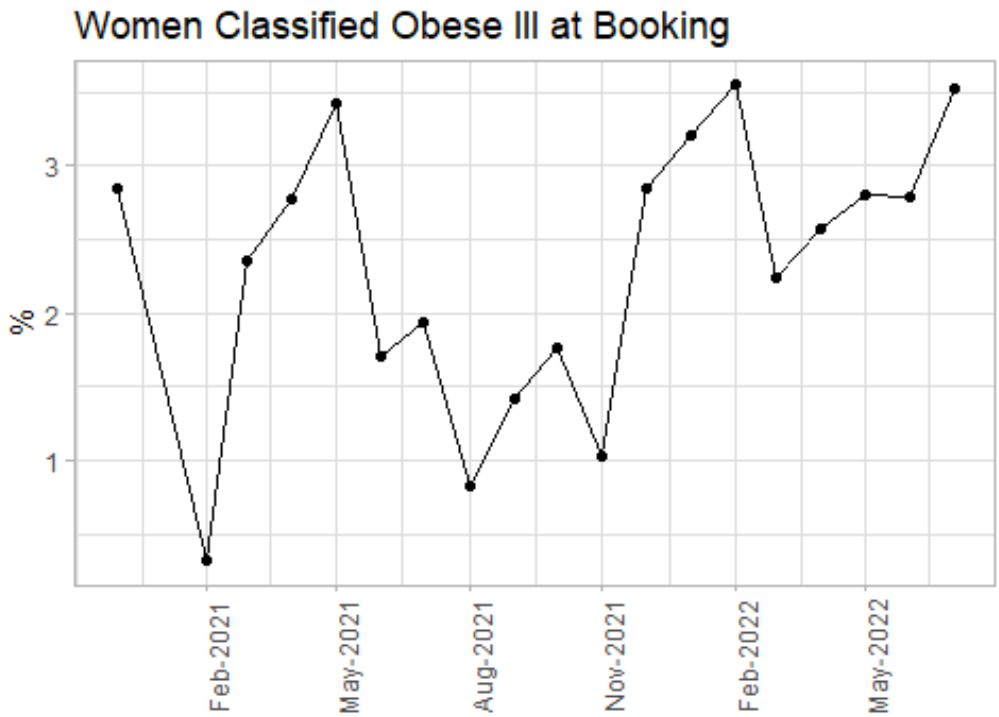
Data Source: NWC CN Maternity Dashboard

Women Classified Obese III at Booking



Data Source: NWC CN Maternity Dashboard

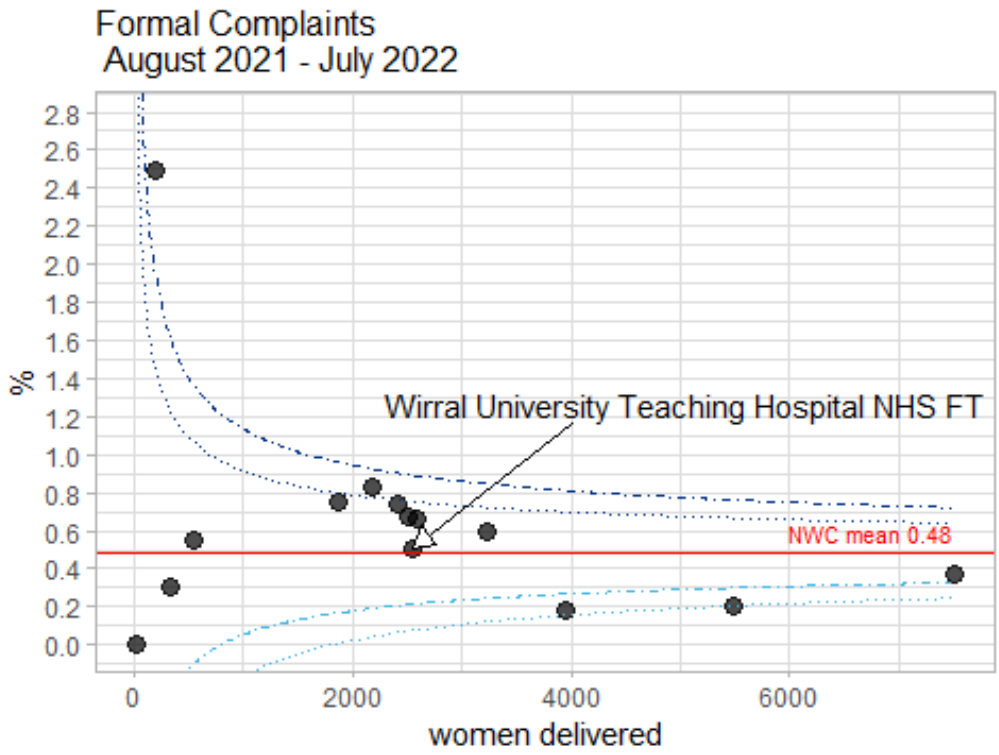
Run Chart for Women Classified Obese III at Booking



Data Source: NWC CN Maternity Dashboard

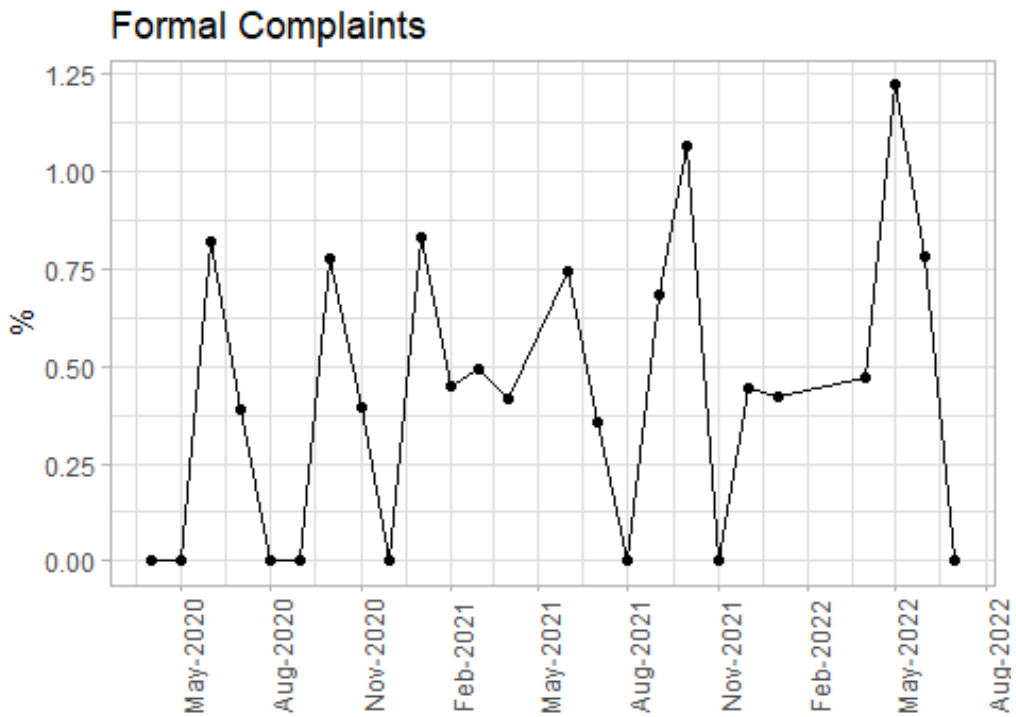
Complaints & Incidents

Formal Complaints



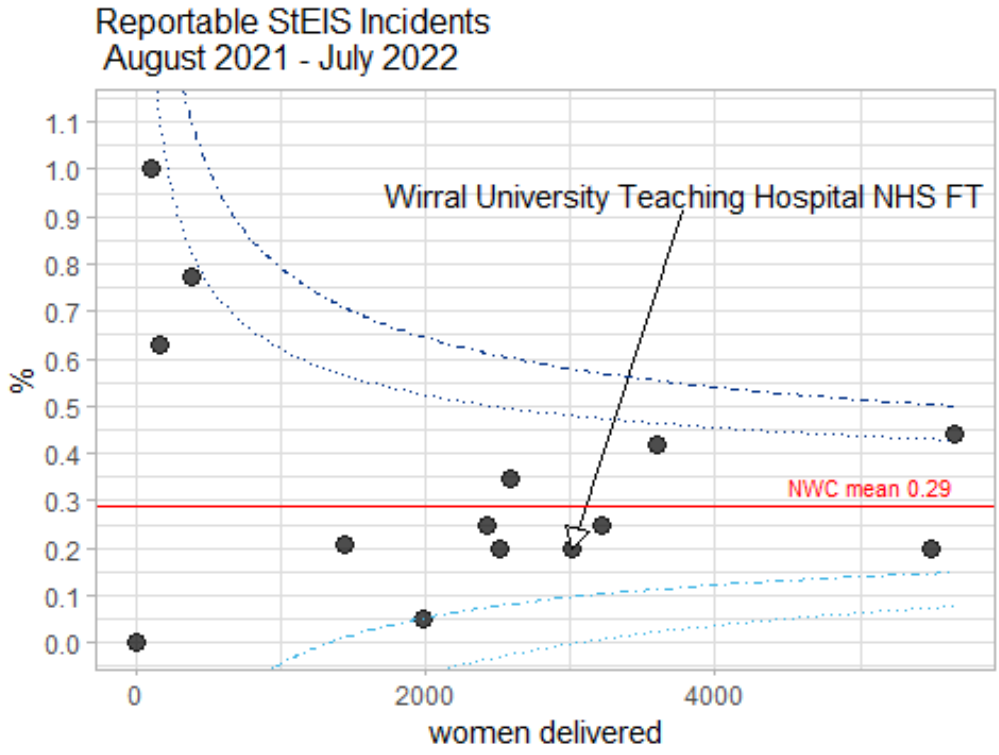
Data Source: NWC CN Maternity Dashboard

Run Chart for Formal Complaints



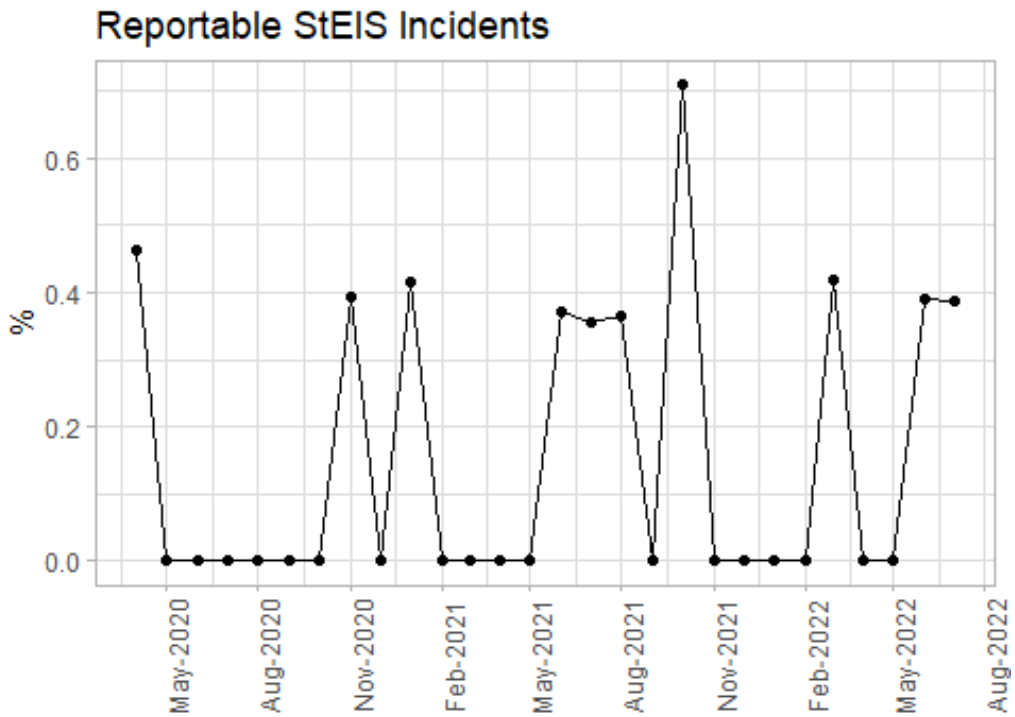
Data Source: NWC CN Maternity Dashboard

Reportable StEIS Incidents



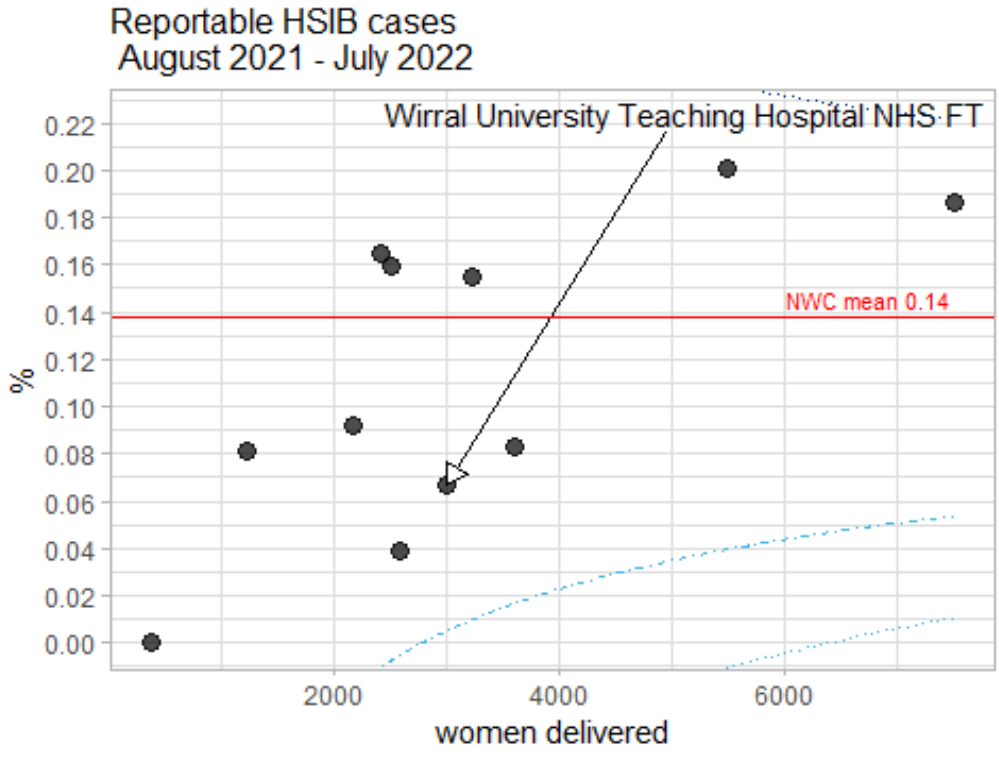
Data Source: NWC CN Maternity Dashboard

Run Chart for Reportable StEIS Incidents



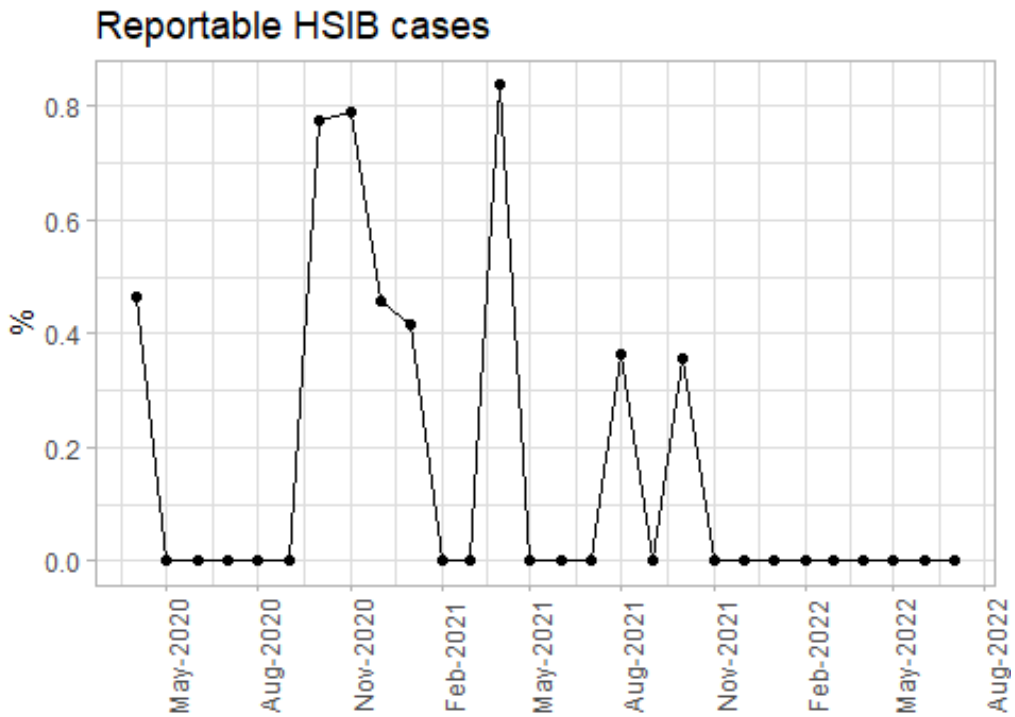
Data Source: NWC CN Maternity Dashboard

Reportable HSIB Cases



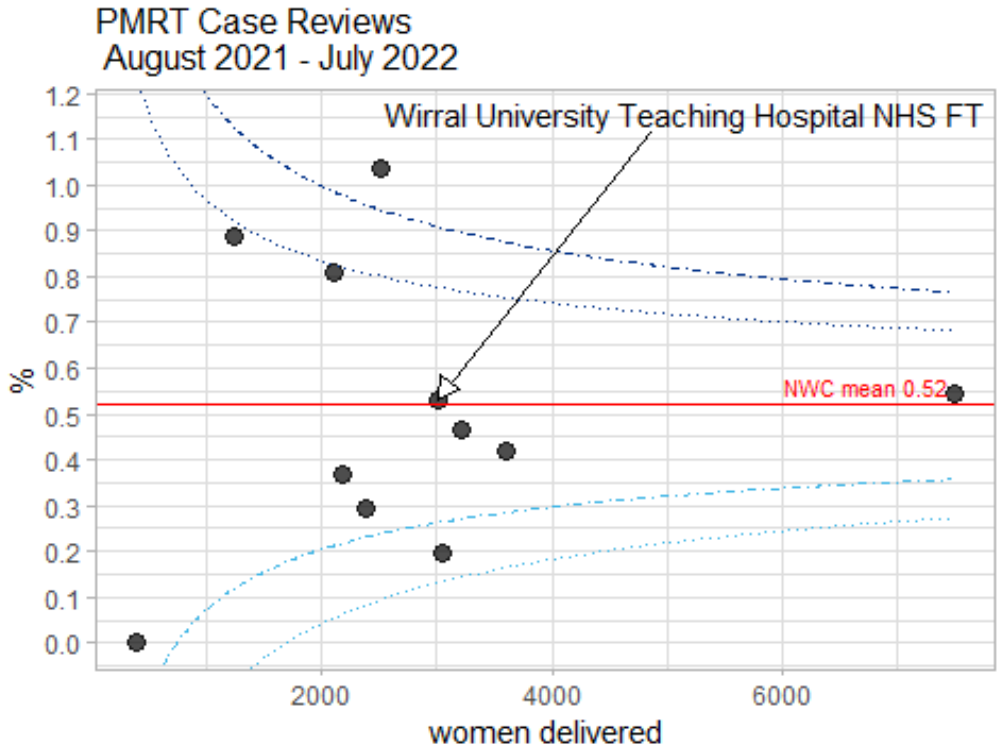
Data Source: NWC CN Maternity Dashboard

Run Chart for Reportable HSIB Cases



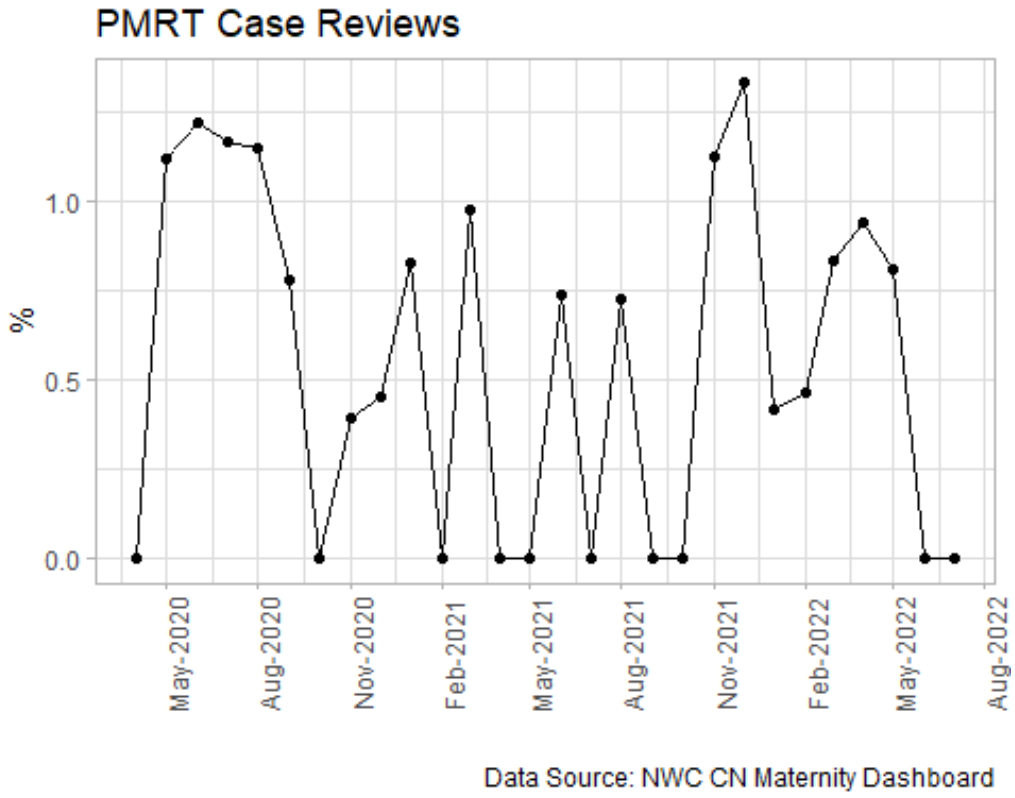
Data Source: NWC CN Maternity Dashboard

PMRT Case Reviews



Data Source: NWC CN Maternity Dashboard

Run Chart for PMRT Case Reviews



Data Source: NWC CN Maternity Dashboard

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 9.4**
5 October 2022

Title	Digital Healthcare Update
Area Lead	Chris Mason, Chief Information Officer
Author	Chris Mason, Chief Information Officer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to give a brief general update of progress on development and agreement of operational plans to deliver strategic priorities of the Trust over the next 12 months.

The associated assurance dashboard in the appendices covers the delivery of strategic priorities and performance of "business as usual" activities that ensure the day-to-day provision of the robust digital infrastructure within the organization.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 5.2 Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of care.
- BAF Risk 5.3 Failure to successfully implement the digital strategy, resulting in an adverse impact on patient care.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**

23.09.2022	Digital Healthcare Team Senior Management Forum	Departmental Performance Management Review	To ratify figures reported in the dashboard and raise any points for specific focus.

1	Narrative
1.1	**Delivering our strategy** Following the publication of the Digital Strategy in August of 2021 the Digital Healthcare Team (DHT) have worked closely with Divisions to understand the clinical and operational priorities where enabling technologies are critical to achieving our strategic goals. **The operational plan:** The schedule satisfies the required strategic deliverables of the Trust in financial year 22/23. Key projects due for implementation in the next financial year include: • Extensive digital provision for the South Mersey Elective Hub • Replacement of the wired network infrastructure across the estate • Robotic Process Automation for streamlining of back office processes • Substantial roll out of Patient Portal offering including patient self-booking • Development of an in-house data warehouse to initially deliver clinical reporting • Completion of migration to the regional PACS solution • Introduction of a Learning Management System to baseline staff educational needs. • Digital consent – continuing our journey to one patient record. **Monitoring delivery:** Appendix A shows the RAG status for each of our Digital Programmes. Of the 41 projects within those programmes – 29 are currently green, 10 Amber and 2 are red. The 2 projects currently showing as red sit under the Innovation portfolio, they are: *PACS migration* – timescales impacted due to resource lost during the Millennium system upgrade – that were required to check migrated images. *South Mersey Elective Hub* – due to high scoring risk around limited time available for IT tasks to be completed between building handover and the scheduling of the first patient. **Changes to plan:** There have been no requested changes to plan in the last period although it is expected that there maybe upcoming requests for additional work to help cope with Winter pressures. Requests will be progressed through the agreed change control process with any proposed changes to the operational plan being approved at DPSOC.

Financials:

The majority of projects within the 22/23 schedule can be delivered within the allocated cost envelope. This has been funded from both Trust capital and central funding. From a central funding perspective, monies have been obtained from successful bids to the Unified Tech Fund and from Health Education England for our learning management system.

There are a small number of exceptions to this:

1. Digital Dictation/Voice Recognition: Business case being developed
2. Oral Scanners: Business Case being developed
3. Foetal Monitoring: Alternative funding being sought from W&C
4. South Mersey Elective Hub: To be funded from elective recovery monies.

Approval has been received from execs in regards to the new Zesty patient portal which makes up a significant portion of this years capital allocation.

High Level Risks

- Current lack of clarity around requirements for imminent large scale projects not in the schedule – This includes implications from projects such as the Regional Digital Diagnostic Care Programme and digital elements of the UECUP programme.
- Resource - There are significant risks around any projects within the Innovation portfolio that involve integration work. The department are in the process of recruiting to integration posts but have reported for a number of months the difficulty in doing so. This has been exacerbated recently with the unexpected and sad loss of a senior staff member within the integration team. The operational plan is currently being reviewed with a revised schedule due to be presented at Digital Programme & Services Oversight Committee in October (DPSOC).

Business Continuity & Service Delivery

In addition to delivery of strategic elements of the service, we also have a responsibility to ensure that our digital infrastructure, including networks, servers, desktop and all of our applications continue to function on a daily basis to ensure effective, efficient and safe clinical care, whilst minimizing the threat from Cyber attack. From a customer facing perspective our Service desk aims to deliver a highly responsive fault fixing service, supplemented by self-serve functionality. Appendix B shows our BAU dashboard.

Monitoring Delivery

Outstanding Care

Availability of both the network and our EPR continued at 100% throughout September. Access to this critical Patient Healthcare Information is integral to the running of the hospital in all settings. Although this currently sits at 100% there have been increasing reports of network issues on the APH site, specifically within Central Outpatients. A risk has been logged on the Trust risk register and the team continue to investigate in conjunction with our third party network supplier. One mitigation is to prioritise the replacement of hardware in the affected areas (as part of the new network replacement project). As of yet the root cause has not been discovered.

	Continuous Improvement The number of helpdesk calls opened in September was the highest reached in the calendar year so far – with a total of 3674 new calls being logged. Despite the high numbers the team still managed to close 3527 calls in month, leaving the total number of open calls at month end at 2,088. From a risk perspective, DHT has one significant risk which relates to Information Governance. This is being actively progressed with both our EPR supplier and another Cerner organization. Mitigations have been put in place but we await the implementation of a technical fix. **Our Partners.** Interfaces to systems outside of WUTH were at 100% for July ensuring that healthcare professionals both inside and outside of the organization have all the information available to deliver quality care. As highlighted previously, there is a high scoring risk associated with integration skills within the team. Priority for the team over the coming months is to ensure business continuity, before we start to look at new developments. **Digital Future** In terms of national data submissions the team continually delivers a high level of compliance and this month is no exception. Over 97% of submissions (301 reports) were made on time with 7 reports being delayed due to technical issues with data being loaded into the data warehouse. **Future Developments** We are currently developing some simple KPI's in relation to cyber security to give assurances on the measures we have in place to combat cyber threat.

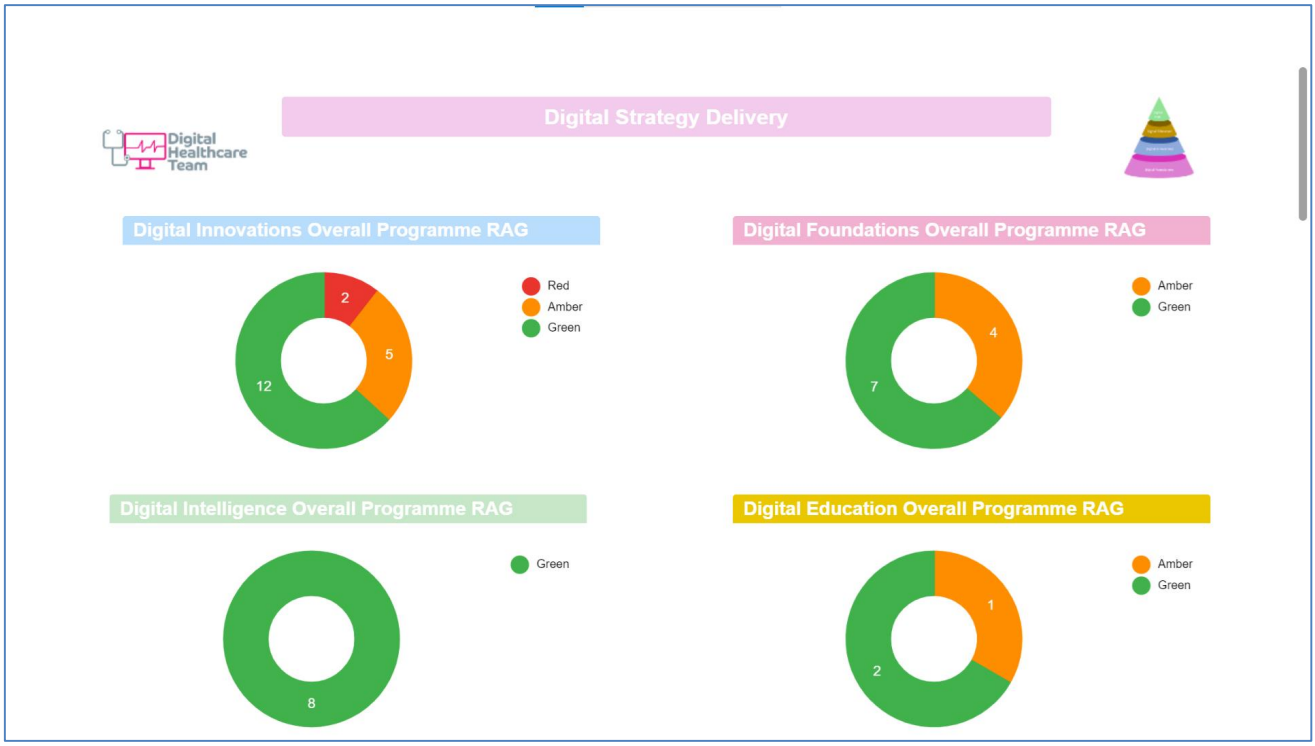
2	Implications
2.1	Delivery of the proposed 22/23 Digital Healthcare operational plan will ensure achievement of the strategic priorities outlined in the Digital Strategy. Namely: - Using technology to reduce waste, automate processes and eliminate bottlenecks. - Empowering patients with the data and tools to manage their own health and wellbeing. - Allow business Intelligence to drive clinical decision making - Use health information to enable population health management for Wirral. Continued availability of our infrastructure and key applications ensures that all information is available for the delivery of safe patient care.

3	Conclusion
3.1	It is imperative that the situation around current lack of integration skills within the team is rectified as soon as possible, predominantly for business continuity purposes but also in the longer term to continue delivery of strategic plans. This is the number one priority for the senior management team over the coming month.

	Changes to help with winter pressures may require significant resource. A strong governance model supports the prioritization of key pieces of work and ensures alignment to strategic goals. Change control processes will be invoked as and when necessary to ensure continued focus on organizational priorities.

Report Author	Chris Mason, Chief Information Officer
Contact Number	Ext 5475
Email	chrismason@nhs.net

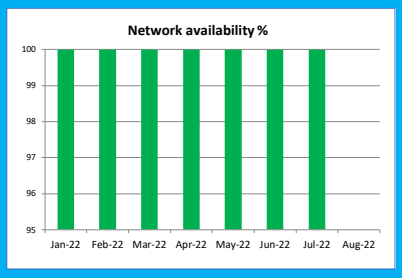
Appendix A: Digital Healthcare Team – Delivering Our Strategy



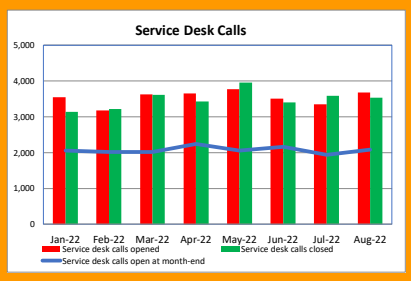
Appendix B: Service Delivery Dashboard

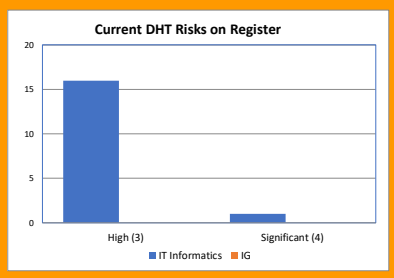
DHT - Business Continuity and Service Delivery | September 2022

Outstanding Care

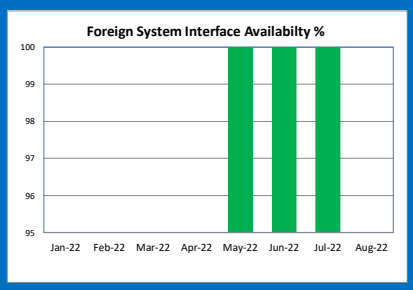


Continuous Improvement

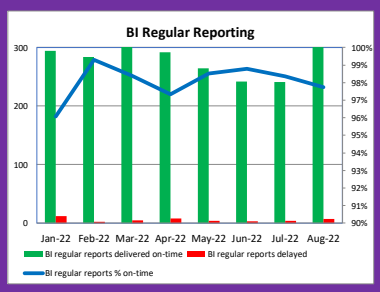




Our Partners



Digital Future



Board of Directors in Public **Item 9.5**

05 October 2022

Title	Cost Improvement Programme 2022/23
Area Lead	Matthew Swanborough, Chief Strategy Officer Mark Chidgey, Chief Finance Officer
Author	Hope Lightfoot, Associate Director of Productivity, Efficiency & PMO
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with an update on current 22/23 CIP position and identified plans to date, along with the revised approach to cost improvement across the Trust.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- Delivery of the financial position
- Delivery of CIP

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

1	CIP Performance YTD
	The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently. As at the 20th September, 260 opportunities had been submitted by divisional teams with a recurrent value of £5.586m against a target of £13.849m. This represents an improvement of £0.571m compared with the figure reported at M4.

QIA panels are established on a fortnightly basis to prioritise CIP schemes and are chaired by the Deputy Medical Director and Deputy Director of Nursing. 52% of schemes identified have been approved at QIA to date.

The YTD position is detailed in table 1 below:

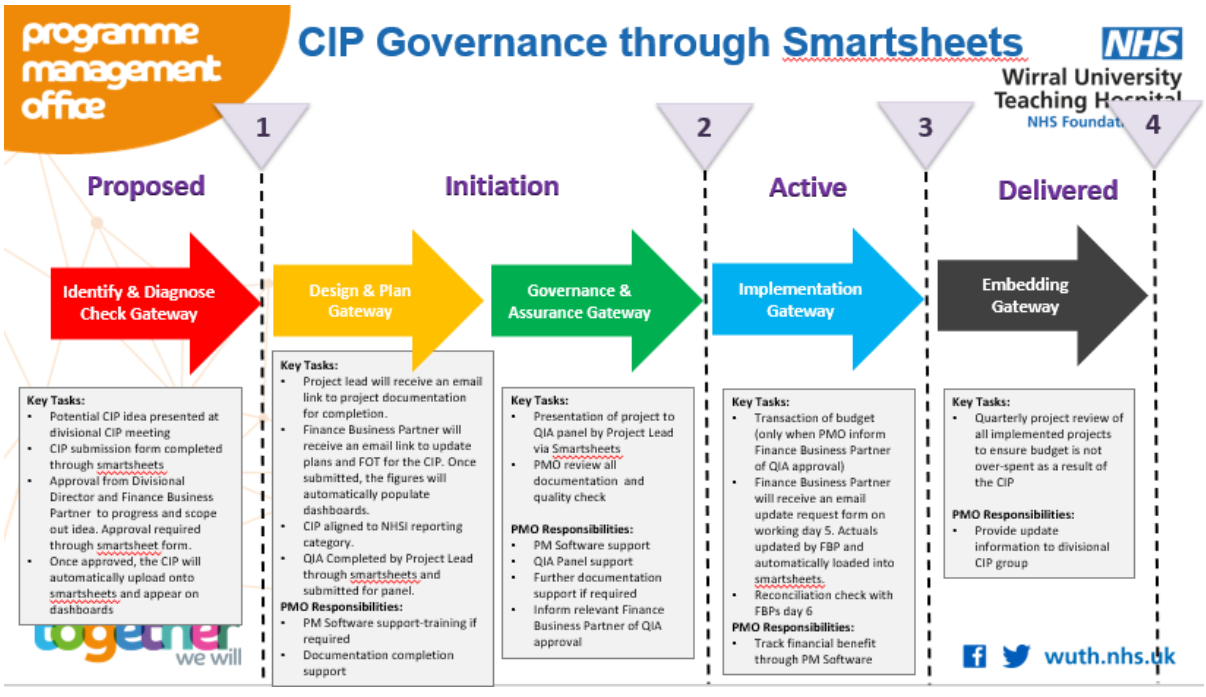
Table 1

Division	YTD Target	YTD Plan	YTD Actual	YTD Variance to plan	YTD Variance to target
DCS	£1,000,375	£234,428	£216,292	-£18,136	-£784,083
Corporate	£525,220	£182,010	£192,611	£10,601	-£332,609
Medicine	£1,124,525	£773,202	£416,724	-£356,478	-£707,801
Acute	£366,255	£23,952	£36,804	£12,852	-£329,451
Surgery	£1,090,745	£203,007	£196,648	-£6,359	-£894,097
Estates	£471,410	£204,446	£38,477	-£165,969	-£432,933
W&C	£473,330	£33,947	£32,576	-£1,371	-£440,754
Trust Central	£629,580	£503,664	£0	-£503,664	-£629,580
Total	**£5,681,440**	**£2,158,656**	**£1,130,132**	**-£1,028,524**	**-£4,551,308**

2 CIP Governance

To effectively manage the CIP, the Trust use a governance framework to track CIP projects from idea to implementation.

The CIP governance framework is detailed below.



	26 projects have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2. 92 projects with a value of £1.313m have progressed to design & plan (gateway 2), meaning documentation is now being completed on Smartsheets with the support of the PMO. All schemes in gateway 2 are awaiting QIA completion by project leads. 9 projects with a value of £0.073m are in the governance and assurance (gateway 3), awaiting QIA panel 26th October. 43 projects with a value of £1.571m have been approved at QIA panel and are now in the implementation gateway. 90 projects with a value of £2.629m have been transacted.

3	**Quality Impact Assessment**
	Quality Impact Assessment (QIA) are required to be undertaken on new plans, programmes, projects, and savings schemes. This including but not limited to: • commissioning decisions • organisational Cost Improvement Plans (CIP) • transformation programmes • business cases • any other plans for change in any department They support quality governance by assessing the impact on quality to inform and enable appropriate decision-making. The QIA will cover the following areas: • Patient Safety • Clinical effectiveness • Patient experience • Equality and Diversity • Non-Clinical organisational impact • Staff experience The impact on equality and diversity listed above will be assessed on whether people could be treated differently in terms of race, religion, disability, gender, sexual orientation, pregnancy, gender reassignment, civil partnerships, or age. This supports the Trust in meeting its obligations under the Equality Act 2010 to undertake equality analysis. The QIA panel consists of the following decision makers: • Deputy Chief Nurse • Deputy Medical Director • Deputy Chief People Officer All CIPs are required to be reviewed by the QIA panel prior to transaction.

4	Revision of the Cost Improvement Programme

For the 21/22 and YTD 22/23, the cost improvement approach has been focussed on recurrent Divisional level schemes.

Given the CIP and budget performance at Month 5, there has been a requirement to alter the approach to the identification, planning and delivery of cost improvement for the remainder of 22/23.

This approach includes the introduction of cross cutting Workstreams, led by an Executive Director, supporting cost improvement delivery across multiple Divisions. Further management controls will be undertaken to manage and reduce the run rate.

The Chief Strategy Officer and Associate Director of Productivity, Efficiency & PMO have undertaken a Trust wide diagnostics review. The findings of the review have formed 10 transformation workstreams to support delivery of the financial position.

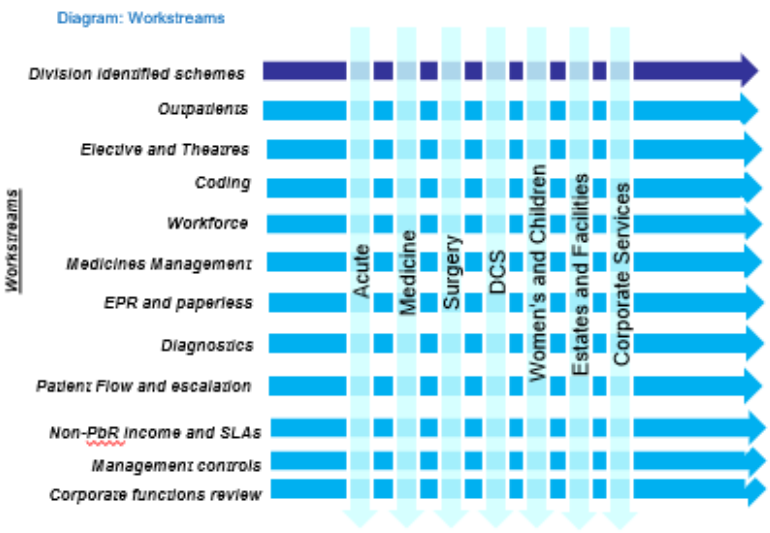
The governance and reporting of cost improvement will also be enhanced, with Workstream reporting and overall CIP programme reporting on a fortnightly basis to Executive Team and monthly to Programme Board.

As indicated, several workstreams will be established as part of the 22/23 CIP, with the aim of leading and supporting the delivery of major change and cost saving projects across a number of areas, within the Trust.

Each Workstream will include an Executive Lead and lead Director, to director and manage the development of a plan or plans and implementation of schemes. Workstreams are accountable for the delivery of identified schemes, with targets and the delivery of savings or additional revenue held within individual Divisions.

Table 2 below sets out the new Workstreams for 22/23.

Table 2



The Productivity and Efficiency teams are currently holding workshop sessions to develop the programmes further, supporting completion of robust project plans and risk and issues logs.

	Progression on the programmes will be reported using Statistical Process Control charts (SPC's) to track and monitor improvement of key performance indicators. To support the process further, the Trust has established the Robotic Process Automation (RPA) programme board, chaired by the Chief Information Officer. The team have identified initial areas of RPA implementation in the planned care control team, reviewing clinical outcoming and data quality process. The workforce directorate are in the process of developing their proposals for RPA within their areas. The Deputy Chief Finance Officer, Chief Information Officer and Associate Director of Productivity, Efficiency and PMO are working closely with the Cheshire & Merseyside RPA project team and the Royal Free to learn areas of best practice and success. The team are also planning a visit to Alder Hey to understand best practice and keys to successful implementation. The Productivity and Efficiency team will continue to support the project movement through the gateways. Finance, along with the Productivity and Efficiency team will provide continued support to the departments throughout the financial year in identifying, developing, and implementing CIP projects.

Author	Hope Lightfoot, Associate Director of Productivity, Efficiency & PMO
Contact Number	07920297757
Email	Hope.lightfoot@nhs.net

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9.6**

05 October 2022

Title	Guardian of Safe Working Report
Area Lead	Nikki Stevenson, Medical Director, and Deputy Chief Executive
Author	Helen Kerss, Guardian of Safe Working
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update on compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

The Guardian of Safe Working is a senior person, independent of the management structure, within the organisation by whom the doctor in training is employed. The Guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training.

This report provides:

- Details of the actual number of doctors in training
- Details of the exception reports submitted for the reporting period by specialty and grade
- Details of breaches of safe working hours and fines incurred.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7 September 2022	People Committee	As above	Information

1	Narrative
1.1	The number of gaps present in the trainee medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive and to reduce overall locum and agency spend. There are currently a total of 288 doctors/dentists in training in the Trust. To monitor compliance with the working hours directive, Doctors/Dentists in Training (DiT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. This report details a summary, exception reports and locum bookings submitted for the Q1 2022/2022 (April to June). Staff vacancies are managed by medical staffing in a proactive manner. It is important for them to be noted as it will have an impact on both doctor and patient safety. Reasons behind the vacant shifts include less than full time doctors, long term sickness and acute illnesses. Following on from the peoples committee on the 7th of September. The data collected going forward will be the number of uncovered shifts. This will be collected weekly. **Exception reports** The tables below provide a summary of the exception reports submitted during the Q1 period. Exception reports for this reporting period were all submitted by all levels of junior doctors. All exceptions approved for payment have been actioned. Table 1.2. Exception reports by specialty

Exception reports by Specialty				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	4	4	0
General Medicine	0	47	47	0
General Surgery	0	14	14	0
O&G	0	5	5	0
T&O	0	9	9	0
Total	0	79	79	0

Table 1.3. Exception reports by grade

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	57	57	0
F2	0	2	2	0
F3/CMT	0	17	17	0
SPR	0	3	3	0
Total	0	79	79	0

Table 1.4. Response time for exception reports

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	11	14	18	14	0	0
F2	1	0	0	1	0	0
F3/CMT	3	2	8	3	1	0
ST3-8	1	0	1	0	1	0
Total	16	16	27	18	2	0

Breach of Safe Working Hours

Fines by department		
Department	Number of fines levied	Value of fines levied
Surgery	3	£196.19
Total	3	£196.19

(£106.43 to Guardian fund and £89.76 to the juniors)

There have been 3 fines issued against the surgical division due to breach in contract with juniors shifts exceeding their 13-hour rule.

2 Conclusion

2.1 Most of the exception reports submitted this quarter were in connection with working hours, however some were submitted due to missed educational opportunity. These will be reviewed by Professor Barrett. There has been an increase in exception reports due to poor staffing levels. This could be due to the vacancy numbers, or the staffing levels are the same, but juniors are now feeling more confident in completing exception reports, further analysis may be beneficial.

The Trust continues to support junior doctors to complete exception reports as if gives the Trust greater understanding of what is happening on the ground with the workforce.

The junior doctor's forum continues to be an open platform for juniors to raise issues. The IMT doctors had concerns that they were not able to attend clinics due to ward pressures and changes to how clinics are run due to the pandemic. This is an issue across the region and not isolated to APH. Professor Barrett is trailing a solution for IMT

	doctors having specified clinic days and this will be monitored through the educational department to make sure the IMT are receiving the correct clinical training. One suggestion the junior doctors have raised is related to locum shifts that are currently advertised on Patchwork having a notice period that is often short e.g., a couple of weeks, they wondered if they could be visible earlier. This could make the ability to cover these shifts higher as they could plan for them more effectively in advance. This quarter there have been 3 fines issued against the surgical division. There has been a breach of contract with juniors shifts exceeding their 13-hour rule. This is in relation to the Trauma and Orthopaedic SHO carrying the Urology bleep as well. The Trust is awaiting the surgical division to propose a solution to this.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
5 October 2022

Item 9.7

Title	Learning from Deaths Report (Q1 2022-23)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

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 Q1 2022-2023.

Key points:

- The medical examiners continue to provide independent scrutiny of all adult deaths
- The Trust SHIMI for the 12 months to March 2022 is 106.6 (within expected range)
- HSMR on the latest available data is 94.6 (significantly lower than expected)
- MRG continues to review Dr Foster data to benchmark nationally and highlight areas of concern. No concerns have been identified for Q1
- The Mortality review group meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- In Q1 one case was escalated from MRG to the Trust Serious Incident Review panel
- Learning form mortality reviews is fed back to clinical areas by the Divisional Morality leads.

It is recommended that the Board:

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

Key Risks

- BAF Risk 1.3 – Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

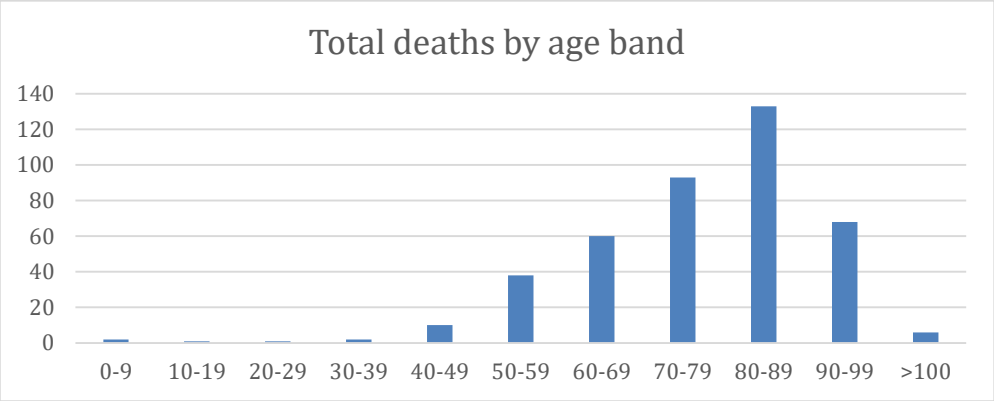
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working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

Governance journey
This is a standing report.

1	Narrative
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. WUTH is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. WUTH uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There was a total of 414 deaths in Q1 2022-23. 69 of these deaths were in patients who died within 28 days of a positive COVID-19 swab. 11 of these patients were determined to have developed nosomial COVID-19. All nosocomial deaths have been reviewed or are currently being reviewed via a mortality review and then are discussed at the Serious Incident Review panel.

Category	Female	Male	Total
COVID	24	45	69
Non- COVID	161	184	345
Total			**414**

As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	377
White - Irish	1
White - Any other White background	1
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups - Chinese	1
Not stated/ Not known	33
Total	414

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The SHIMI has remained relatively stable when compared to the previous quarter. The latest available data (up to March 2022) shows the SHIMI to be 106.6, within the acceptable range.

SHIMI can be broken down into specific disease groups to highlight any areas of concern. There were no disease groups highlighted as statistically significant for Q1.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR on the latest available data id 94.6, which Is significantly below expected range.

As discussed in the previous Learning from deaths papepr the difference in HSMR and SHMI can be explained by the fact that SHMI does not exclude deaths with a

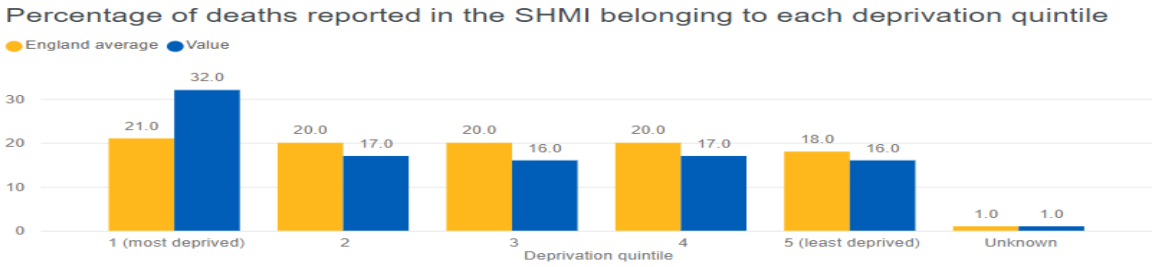
palliative care code, whereas HSMR does. Palliative care coding for WUTH is higher than peers, reflecting the proactive nature of our palliative care team.

SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.3	0.1
Percentage of provider spells with palliative care diagnosis coding	3.1	2.0
Percentage of provider spells with palliative care coding	3.1	2.0
Percentage of deaths with palliative care treatment specialty coding	5.0	2.0
Percentage of deaths with palliative care diagnosis coding	61.0	40.0
Percentage of deaths with palliative care coding	61.0	40.0

MRG has been given assurance that processes around palliatve care coding are robust, and that this doees not represent a potential patient safety risk, but is a reflecton of good clinical practice.

Our SHIMI is also impacted by high deprivation, with higher-than-average deaths in the most deprived quintile. The SHIMI model does not correct for level of deprivation.



COVID-19

National Mortality comparators are not calibrated to predict mortality due to COVID-19, so it is difficult to compare different organisations in terms of COVID-19 mortality if using SHIMI or HSMR.

In terms of raw mortality (total number of deaths as a percentage of admissions) WUTH has a crude mortality rate slightly lower (better) than the average for England at 16.5% compared to the national average of 17.78% (latest available data from Jan 2022)

During Q1 11 Covid-19 deaths were in patients who had hospital acquired infection. Each one of these deaths is scrutinised via a mortality review and Infection control review to identify learning and prevent future infections.

Mortality Dashboard

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

21 cases escalated by the ME to the mortality review group have undergone a review during Q1. These cases have been reviewed using a revised PMR template (15 cases) or via the Royal College of Physicians Structured Judgement review tool (6 cases). One case was escalated to the Serious Incident Review panel for discussion as to whether a Serious Incident should be declared.

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 25 deaths were reviewed in Q1 (6%) using the PMR template. 1 of these deaths were further reviewed for potential learning identified.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Total Reviewed by Med Examiner or MEO	Total No of cases escalated from Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's undertaken	Total number of case reviews by MRG
Q2 (21-22)	415	415	26	9	3	20	46
Q3 (21-22)	485	485	27	9	1	24	51
Q4 (21-22)	477	477	33	7	1	21	54
Q1 (22-23)	414	414	21	6	0	25	46

Grading of Adult Care and avoidability following SJR review (Includes SJRs opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	2	5	2	1

During Q1, 4 deaths were reported in patients identified as having a Learning disability. All 4 of these deaths have been reviewed using the SJR template and have also been referred for external review through the national LeDeR programme. Completed SJR reviews for this group of patients identified 3 cases where there were care issues, but none of these was felt to have been contributory factors in the patient's death.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q2 (21-22)	4	4	0	4
Q3 (21-22)	6	6	3	6
Q4 (21-22)	4	4	0	4
Q1 (22-23)	4	4	0	4

Perinatal and Neonatal deaths

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

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q4 (21-22)	2	1	0	3
Q1 (22-23)	1	0	0	1

Outcome of PMRT reviews completed in Q1				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	2	2	0	0

Learning identified through review of mortality reviews during Q4

Learning for mortality is derived from 3 main sources

1. Mortality reviews (collated into a learning log)
2. Themes and trends escalated from the Medical Examiner
3. Learning identified through the SI process

Specific learning and themes identified during Q4 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Medication delays and errors	Mortality reviews	All cases are feedback via the Medications safety Pharmacist (who is a member of MRG) to relevant areas and MSOP committee that has oversight of medication safety across the Trust.
Delays in fast-track discharge home due to lack of availability in community	Mortality reviews	Fed back to End-of-Life lead for on ging discussion at system level.
Poor documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. Review of EPR and noting underway lead by DMD
Communication issues	Medical Examiner feedback	Communication issues still feature as a theme from the ME department, but are far less prevalent than previous quarters
Poor documentation and process around DNACPR decisions	Mortality reviews	All these cases are feedback to individual teams and the Trust CPR committee. Most issues relate to application of the Mental Capacity Act during decision making.

		MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.

Additionally, several reviews have identified areas of good practice, and these have been feedback to the teams looking after patients.

Dr Foster Data

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

During Q1 there were no specific disease groups highlighted as significant outliers in terms of SHIMI. Deaths due to pancreatic cancer were trending upwards during Q1, but these were felt to be palliative care patients as the patients with pancreatic cancer are managed at the local tertiary centre and not at WUTH.

The table below summarises ongoing as well as recently closed work resulting from Dr Foster data.

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Non-Specific Gastroenteritis	Q2 21-22	CUSM alert	Case note review	Closed. High alert triggered by inaccurate coding from clinical teams
Malignancy of unspecified site	Q2 21-22	CUSM alert	Case note review	Closed. Case not review (8 cases) did not show any concerns with care at WUTH. However, the majority of cases were late cancer presentation, and this raised questions around screening and GP access during the pandemic. This review has been shared with the Trust Cancer Lead and the MD of the CCG to discuss any further actions required from a system point of view.
COPD	Q3 21-22	High SHIMI	Review by Clinical Lead	Data reviewed with GIRFT and national COPD audit data. No concerns identified via GIRFT or National COPD audit. High SHIMI due to deaths post discharge form hospital. New virtual ward service to begin in Sept 2022 that will improve post discharge care and support for COPD patients.
Cerebral vascular Disease	Q3 21-22, Q4 21-2	High SHIMI	Review By Clinical Lead	Ongoing, case note review added to original review in Q4

2	Conclusion
2.1	Mortality indicators do not show cause for concern and remain relatively stable. The difference between SHIMI and HSMR can be explained by the relatively high palliative care coding at WUTH and the higher-than-average deprivation on Wirral when compared to the average for England. Deaths attributable to COVID-19 are comparable to previous quarters. Nosocomial deaths are investigated through the SI process. It is difficult to compare Covid-19 deaths as the mortality comparators exclude these deaths. However, WUTH has a crude mortality rate that is slight better than the average for England The medical examiner continues to provide scrutiny for all adult deaths and escalates concerns to the Mortality Review Group for further review. Learning from these reviews is disseminated through the Trust Divisional structures as well as relevant service leads. Perinatal and Neonatal mortality does not show any cause for concern, with all deaths subject to investigation through the Perinatal Mortality Review Tool (PMRT). Dr Foster data has not highlighted any specific concerns during Q1.

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Board of Directors in Public **Item 10**

05 October 2022

Title	Safeguarding Annual Report 2021-2022
Area Lead	Tracy Fennell Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control Executive Lead for Safeguarding
Author	Karolyn Shaw, Associate Director of Nursing for Safeguarding
Report for	Information

Report Purpose and Recommendations

The Safeguarding Annual Report will provide the Board of Directors an overview of the national and local context of safeguarding and the current Trust position by providing assurance that the Trust is meeting its statutory obligations and national safeguarding standards. Analysis of the annual safeguarding activity including progress made against the objectives set out in the Safeguarding Annual Report 2020-21 and an overview of the Trust safeguarding priorities and challenges it may face as we forward in 2022-23. This includes preparation to transition from Deprivation of Liberty Safeguards (DoLs) to Liberty Protection Safeguards (LPS) and the Domestic Abuse Bill.

The report provides an end of year position of compliance against the following areas:

1. Protecting Vulnerable People (PVP) training against the target of 90%
2. Care Quality Commission updates:
    - Child Protection Information Sharing (CP-IS)
    - Children Looked After (CLA) and Initial Health Assessment's (IHA)
    - Deprivation of Liberty Safeguards (DoLS) expiry dates
3. Trust safeguarding activity

Improvements have been noted in the following areas:

- Improvements in the completion of IHA's to meet statutory timeframes as a result the associated risk has been closed down on the Trust risk register. Compliance challenges remain due to late referrals from the Local Authority (LA); this remains a system priority.
- Protecting Vulnerable People (PVP) compliance has been a challenge to achieve during times of extremis within the Trust this year. However, trust wide improvements have been reached within the year. Q4, below, figures provide overview of each PVP level from end of year position 2020 / 21 to 2021 / 22:
- Level 1 improvement from 79.88% to 87.33% (7.45% increase)
- Level 2 improvement from 82.33% to 84.97%. (2.64% increase)
- Level 3 improvement from 67.04% to 72.2% (5.16% increase)
- Level 4 improvement from 59.17% to 77.74% (18.57% increase)

- Improvements noted to the compliance for CP-IS checks by staff in the Emergency Department (ED) from 77.5% (Q1) to 79.8% (Q4) an improvement from Q4 last year (66%).
- Annual compliance for CP-IS for Women's and Children's division remains over 90%.
- Improved information sharing processes with the LA through the provision of read only access to the LA information system 'Liquid Logic' for adults and children.
- Noted increase (28%) in safeguarding referrals for children and adults with caring responsibilities received in 2020/21 compared to 2021/22 highlighting staff are sharing information with services to ensure children and families are safeguarded.
- Following the release of the Somerset ruling March (2014) 42 cases were escalated to the Trust by the LA, 32 urgent cases were reviewed by the Adoption Medical Advisor (AMA). Assurance has been provided by the Designated Doctor at Safeguarding Assurance Group (SAG) and that the remaining less urgent cases by agreement will be completed by the appointment of a second AMA in Q1 2022/23.
- Governance process launched in Q1 for managing and investigating external safeguarding concerns against the Trust through a safeguarding Rapid Review template which requires completion within statutory timeframes. The process allows for the dissemination of identified learning via the divisional governance leads.
- Inclusion of the Department of Health and Social Care Safeguarding Adult's Protocol - Pressure Ulcers and the interface with a safeguarding enquiry within the Tissue Viability Policy and Procedure. Implementation to reflect the tool in clinical incidents is expected in Q1 2022/23.

Targeted areas requiring improvements in 2022/23:

- PVP to meet the required 90% and above compliance trust wide.
- CP-IS compliance to acheive 100%; this is a key priority for ED and Women's and Children's division.
- Improved education and knowledge in Mental Capacity Act including the implementation and transition from DoLs to LPS.
- Continued collaborative working with the LA and Designated Nurse for Safeguarding Children to enable system wide IHA improvements.
- Progress of pre-adoption medicals in accordance with the Somerset Ruling through the appointment of an additional AMA, alignment with the Named Dr for CLA.
- Progress the ability to screen and report disclosures of female genital mutilation (FGM) within urology as the outstanding key area.
- Develop processes to enable guardians to be recorded on CLA health care records.
- Progress of outstanding CQC action following the 2019 Health Services for CLA and safeguarding across Wirral inspection.
  'Ensure children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance for emergency paediatric care. (CQC Safeguarding Wirral Wide Action Plan 2019).'
- Improved quality of applications for DoLS inclusive of Relevant Persons Representee details, discussions, and plan of medical care.

It is recommended that the Board note the assurance provided within the Safeguarding Annual Report and the actions being taken to rectify the areas for improvement. Recognition is given to the hard work and commitment of the Safeguarding Team and all Trust staff who work tirelessly in ensuring, 'Safeguarding is Everyone Business'.

Key Risks
This report relates to these key risks: • Trust Risk 612 - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate • Trust Risk - 0221 - FGM screening Cerner – FGM routine enquiry is currently only asked in Maternity and Gynecology services • Trust Risk - 347 – Risk that next of kin is incorrectly recorded on Cerner, and parental records inadvertently changed, due to process for recording guardian not being followed correctly for CLA • Trust Risk - 599 - LPS introduction following parliamentary passing of the Bill

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
29 July 2022	Quality Committee	Safeguarding Annual Report	Information

Contents

Glossary

ACE	Adverse Childhood Effects
ADNS	Associate Director of Nursing for Safeguarding
AMA	Adoption Medical Advisor
BI	Best Interests
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panels
CLA	Children Looked After
CP-IS	Child Protection information sharing
CQC	Care Quality Commission
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
FGM	Female Genital Mutilation
IFD	Integrated front door
IHA	Initial Health Assessments
IDVA	Independent Domestic Violence Advisor
HV	Health visitors
KPI	Key performance indicators
LA	Local Authority
LPS	Liberty Protection Safeguards
MAR	Multi Agency Referral
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NOK	Next of Kin
NRLS	National Reporting and Learning System
OPD	Out Patients Department
PBL	Pre-Birth Liaison
PiPoT	People in Positions of Trust

PVP	Protecting Vulnerable People Training
PSQB	Patient Safety Quality Board
RPR	Relevant Persons Representative
RRM	Rapid Response Meeting
SAG	Safeguarding Assurance Group
SARs	Serious Case Reviews
SIRG	Serious Incident Review Group
SJR	Structured Judgement Review
SOP	standard operating procedure
SUDIC	Sudden Unexpected Deaths of Child
WSAPB	Wirral Safeguarding Adults Partnership Board
WHCC	Wirral Health and Care Commissioning
WISE	Wirral Individual Safe Care Every Time Accreditation Programme
WLSSG	Wirral Local Safeguarding Strategy Group
WRAP	Workshops to Raise Awareness of Prevent
WSCP	The Wirral Safeguarding Children Partnership

1	Background and Statutory Legislation
1.1	**Introduction** Wirral University Teaching Hospital NHS Foundation Trust, thereafter referred to as the Trust, is committed to ensuring that the safeguarding of our patients, their families, our staff and our communities is at the foundation of our 'Together we will' Trust values. We strive to improve and build upon the safeguarding practices we offer by promoting the Trust ethos that safeguarding is everyone's business in the drive to continuously make improvements to the service we provide. The term "safeguarding" covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect, which enables them to retain independence, wellbeing, dignity and choice. Safeguarding encompasses prevention of harm, exploitation, and abuse through provision of high-quality care, effective responses to allegations of harm and abuse that are in line with multi-agency procedures. Importantly safeguarding embraces the use of learning to improve services for our patients, their families, and carers. The Trust Safeguarding Team continues to provide a range of activities to support key areas of safeguarding work, embrace change and respond to emerging themes both local and nationally and strive to ensure all safeguarding processes are robust and effective. The team safeguarding structure and further definitions have been elaborated on in appendix 1 and 2. Effective safeguarding of adults, young people and children is heavily reliant on the development of robust professional relationships and multi-agency working arrangements. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to safeguarding and patient safety. There is a culture of 'Think Family' that is embedded throughout the Trust as it is recognised that children, young people and adults do not exist or operate in isolation of one another. This report provides assurance that the Trust is fulfilling the duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services. This report reflects the high level of activity across all work streams to improve internal and multi-agency processes and build on existing systems and procedures. We continue to strive to further improve and achieve strong compliance against all our safeguarding standards internally and externally to safeguard the most vulnerable in our society.
1.2	**Statutory Framework and National Policy Drivers.** There are significant differences in the laws and policies that shape how we safeguard children and adults. The legal framework to protect children is contained in Working Together to Safeguard Children (2018) and for adults, the Care Act (2014). The overarching objective for both is to enable children and adults to live a life free from harm, abuse, or neglect. This report provides a summary of how the Trust discharges its statutory duties in relation to:

	• Children Act (1989, 2004) • Children and Social Work Act (2017) • Working Together to Safeguard Children (2018) • Promoting the Health and Well-being of Looked after Children (2015) • Safeguarding Adults at risk in line with the Care Act (2014) • The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007 • The Domestic Abuse Act (2021) • The Counter Terrorism and Security Act (2015) • CQC Regulation 13: Safeguarding service users from abuse and improper treatment
1.3	**Working Together to Safeguard Children (2018)** The Children Act (1989) and Section 11 of the Children Act (2004) in conjunction with Working Together to Safeguard Children (2018) places a statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of children. The Wirral Safeguarding Children Partnership (WSCP) established in September 2019 replaced Wirral Safeguarding Children's Board (WSCB) arrangements. The WSCP is led by three statutory partners Local Authority (LA), Police, and Wirral Health and Care Commissioning. Structure can be found in appendix 3. Section 11 audit is monitored through the WSCP and provides evidence of effective safeguarding arrangements by demonstrating compliance with relevant legislation, provides evidence of reflective practice, identifies areas of good practice, and highlights organisational development and improvement. Collectively the review of organisation section 11 and cross triangulation of other areas of intelligence can enable local partnership developments to be identified. The WSCP published a local review of the 'Anderson' Children who had been subject to neglect. The case is contributing to the partnership arrangements neglect priority for 2022-23. **Trust Position** • The Trust is represented at the Wirral WSCP by the Associate Director of Nursing for Safeguarding, Named Nurse for Safeguarding Children and Children Looked After, and the Named Midwife for Safeguarding the unborn. • In 2021/22 there has been 10 recorded deaths within the sudden unexpected deaths infant and child (SUDIC) process; 7 of these deaths were unexpected, 3 were expected deaths and required co-ordination as per process to partner agencies. • In 2021, WSCP published the 'Scarlet' Child Safeguarding Practice Review. There was key learning related to understanding the impact of trauma and how allegations and complaints are managed for all partner agencies. The Trust demonstrated robust processes in accordance with policy in place for staff allegations. Further work will be completed in 2022-23 alongside our partners to raise awareness and knowledge regarding adverse childhood effects (ACE's). • Compliance with Section 11 audit requirements was achieved in 2021 / 2022: with improvement actions within year being achieved. • Information sharing processes improved with the LA. The Safeguarding Team were granted read only access to LA electronic systems called Liquid Logic.

	This enhanced multiagency working and timely information sharing assisting health practitioners to make decisions on a child's plan of care. This has been replicated for Adult's. • Improved understanding of the "Think Family approach" by staff has been evidenced by increased numbers of referrals for parental concerns; 152 referrals in 2021/22 compared to 131 in 2020/21. This indicates that staff are using professional curiosity to determine if the presenting adult has parental responsibility or caring needs for children within their care and referring appropriately. Quality assurance processes confirm that the voice of the child is recorded throughout. Evidencing the effectiveness of mandatory training Protecting Vulnerable People (PVP). • Improved compliance when identifying and acknowledging a child's status in law, a previous CQC action that has had continued monitoring throughout 2021/22. 95% of all children who attended ED in 2021/22 had their status as a child recognised and appropriate paediatric assessments and treatment offered, compared to 81% in 2020/21. • There has been a noted 28% increase in the number of internal safeguarding referrals for children and adults with caring responsibilities received in 2021/22 compared to 2020/21. Evidencing staff are discharging their safeguarding duties appropriately and sharing information with services to ensure children and families are safeguarded. • Audits reviewing the compliance of CP-IS within the ED continue to be completed by the Children's Liaison Team,are below the 100% compliance. 24,693 children attended ED in 2021/22 and 19,410 children (78.6%) had Child Protection Information System (CP-IS) accessed and checked. 5,283 children had CP-IS retrospectively checked by Children's ED Liaison Team. • Monthly escalations of non-compliance of CP-IS continue to the Divisional Director of Nursing (DDN) for Acute Care. Improvement plans include: ➢ Provision of weekly educational sessions to ED (Q4) ➢ Additional SMART card readers provided to ED ➢ Arrangements for ESR Team to attend the ED department in April 2022 • Annual compliance for CP-IS for the Women's and Children's division is as follows: ➢ Children's Outpatient 98.5% ➢ Children's ward 94% ➢ Paediatric Assessment Unit 90.5%
1.4	**Children Looked After (CLA) and Initial Health Assessments (IHAs)** Children coming into care must have a high-quality initial health assessment (IHA) within 20 working days of becoming a Child Looked After (CLA). The Trust has a statutory and contractual responsibility to provide this service. Assurance of compliance is monitored via the quarterly Safeguarding Accountability and Assurance Framework (SAAF) data submissions against a set of key performance indicators (KPIs) which cover Adults, Children and CLA. **Trust Position.** • Completion of IHA for CLA within the designated timeframes is an action following CQC inspection in 2019/20. Close monitoring of IHA completion against the agreed internal standard operating procedure (SOP) has provided assurance of compliance of the statutory 20 working days. • Delays continue in receiving referrals from the LA outside of the agreed 48hrs time scale which subsequently impacts on the Trust's ability to complete within the statutory timeframes. Monthly escalation reports are completed to the LA

	and the Designated Nurse for Children and CLA. As a result of these delays the Trust continues to remain below the statutory compliance rate of 100%. • Further delays have been identified through the process of quality assurance due to partial or no information regarding the child's birth history or family history being provided by the LA. • In Q4 the Named Doctor for CLA completed a review of IHA compliance data which provided assurance to the Safeguarding Assurance Group (SAG). • Findings confirmed that despite delays in receiving referrals from the LA internal processes are in place to enable to IHA to be completed within required timescale from point of referral being received. This resulted in Trust risk 86 being closed on 6 July 2021/22. • The Named Doctor for CLA has worked in conjunction with the LA through the provision of training sessions, in the completion of IHA forms. Training supports staff to ensure they capture all required information which will improve compliance and reduce delays in IHAs. Quality assurance monitoring highlights an improvement which is reported as part of the SAAF. • Risk 347 - Process for recording CLA Next of Kin (NOK) on Cerner 2019/20. This risk is not specific to safeguarding however was discovered through a safeguarding case whereby NOK details were changed for a child taken into care. Due to the related records functionality in Cerner NOK changes replaced the records of identified NOK. Workstreams have progressed and a draft SOP has been written by the Digital Healthcare Team and requires review and sign off by Safeguarding and Information Governance in Q1 2022/23.
1.5	**Somerset Ruling March 2022** The Somerset Ruling identified a procedural flaw in the creation of adoption medical reports, particularly that an Adoption Medical Advisor (AMA) must take responsibility for the advice given in the pre-adoption medical reports completed, which in effect means that they must provide advice and a signature. **Trust Position.** • The Trust have one AMA, in view of this ruling, with plans to have another identified AMA. This will be the Named Doctor for CLA. • The LA have escalated 42 cases that require review by the AMA and are being overseen by the Designated Doctor for CLA. • Assurance has been provided by the Designated Doctor at SAG that 32 of the urgent requests have been completed during February and March 2021/22. The remaining 10 cases are not urgent and will be completed as agreed by the new appointment of an additional AMA in Q1 2022/23.
1.6	**The Care Act (2014)** The Care Act (2014) states that adult safeguarding is established as a core function of every LA's care and support system. The Care Act sets out the statutory framework for safeguarding adults which replaced the No Secrets guidance (2000). The Care Act (2014) requires each LA to have a Safeguarding Adults Board (SAB) with core membership from the LA, police, NHS, alongside members from other emergency services, probation services and the voluntary sector. One of SAB's key functions is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

	Wirral Safeguarding Adults Partnership Board (WSAPB) was re-established in July 2021, following the disbandment of the Merseyside Safeguarding Adults Board. The primary responsibility of the WSAPB is to ensure that adults in Wirral, who may be at risk, are able to live fulfilling lives, free from abuse and neglect. The WSAPB held its inaugural meeting in September 2021/22 and has a statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively to safeguard and promote the welfare of adults who live in Wirral (appendix 4). The WSAPB meets quarterly with 2 development days a year with members representatives of agencies across Wirral, including representation from the Trust by the Associate Director of Nursing for Safeguarding. The Named Nurse for Safeguarding Adults represents the Trust at the 4 WSAPB subgroups. The WSAPB strategic priorities for the forthcoming 18 months are: • Be Assured • Be Heard • Be Skilled and Knowledgeable With agreed additional subgroups and workstreams looking at quality of care, citizen engagement, and multiagency training in 2022/23. The WSAPB works collaboratively with 3 other adult boards across Merseyside to undertake work in relation to Safeguarding Adult Reviews (SARs). During the annual reporting in year 2021/22 the group received 23 SAR referrals, 4 of those were for Wirral. Only 2 cases met the criteria for SAR and reports are currently in draft awaiting approval of the WSAPB. Findings and learning will be shared across agencies in order to provide assurance of actions taken to improve practice. **Trust Position.** • No requests have been made to contribute to a chapter 14 audit for the annual reporting period for 2021/2022. The Trust was last requested to contribute to a Safeguarding Board 'Adults at Risk' Chapter 14 Audit in January 2019/20. • During 2021/22 there have been no legislative changes in policy or guidance in respect of safeguarding adults. • Trust 'Safeguarding Adults Procedure and Guidance – policy has been updated in December 2021/22 and reflects the new WSAPB threshold flow chart. • Governance processes were launched in Q1 2021/22 for managing external safeguarding concerns made against the Trust directly from the LA. This new process allows for safeguarding concerns to be managed through the governance divisional leads within required safeguarding statutory timeframes, using the safeguarding rapid review template and oversight provided by the Named Nurse for Safeguarding Adults. Identified themes throughout 2021/22 were discharge related issues such as package of care provision, missed or wrong medications, and poor communication. Learning identified and subsequent actions are monitored by the divisions involved. Themes and trends are reported through the Quality & Patient Safety Intelligence Report feeding into the PSQB for wider learning and assurance. This new process is reflected within Trust policy. • Since starting this process the number of external concerns raised that have been progressed to a section 42 (S42) investigation has decreased from 45% in 2020/21, to 31% in 2021/22. The decrease is felt to be due to the new process allowing for the Named Nurse for Adults to work in collaboration with the LA to identify which concerns are progressed as S42, any concerns not identified as a

	meeting the thresholds for a S42 are managed as clinical incidents. Where no concerns are identified following initial enquiry then no further action is required. • The Named Nurse for Safeguarding Adults has worked together with the Tissue Viability Matron to ensure that policy reflects the Department of Health and Social Care Safeguarding Adult's Protocol - Pressure Ulcers and the interface with a safeguarding enquiry. The decision tool will be used to support staff to determine if pressure ulcers require safeguarding processes to be followed. The policy is currently out for consultation and due to be ratified in June 2022/23. Work has begun with the Governance Support Unit to build and embed the decision support tool into the clinical incident form as a questionnaire and will continue into the coming year.
1.7	**The Mental Capacity Act (2004) and Deprivation of Liberty (2007)** The Mental Capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care, and treatment to people aged 16 and over who live in England and Wales. The five principles of the MCA are: 1. Assume a person has the capacity to make a decision themselves, unless it's proved otherwise 2. Wherever possible, help people to make their own decisions. 3. Don't treat a person as lacking the capacity to make a decision just because they make an unwise decision 4. If you make a decision for someone who doesn't have capacity, it must be in their best interests 5. Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms The MCA allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future. Any individual is deemed to lack capacity to make a decision if they are unable to: • Understand the information relevant to the decision • Retain that information • Use or weigh up that information as part of the process of making the decision The MCA (2005) allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if restraint and restrictions are used to deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). DoLS is due to be replaced by Liberty Protection Safeguards (LPS) and initial plans to implement statutory changes were due 1st October 2020, however deferred in response to COVID 19 pandemic with no confirmed launch date. The combined draft code of practice was released for a 16-week consultation process in March 2021/22. The Trust will complete a review of the consultation and feedback as part of a multiagency system and highlight required actions ahead of the LPS transition. NHS England regional LPS meetings continue, information is shared by the Designated Professional for Safeguarding Adults (WHCC) to providers and through local multi-agency networks to look at joint practices.

Trust Position.

- Trust policy is in place 'Role of the Mental Capacity Act 2005 in Acute Healthcare – policy reference 237' and was reviewed in February 2022.
- Trust policy for Deprivation of Liberty Safeguards – policy refence 217 is in place, and will be reviewed in June 2022
- Statutory 7 day urgent and standard DoLS applications are made by staff via the Ulysses incident reporting system. Quality assurance of all DoLS applications inclusive of MCA and Best Interests (BI) is completed by the Lead Nurse for MCA and DoLS.
- A total of 2306 referrals were received for 2021/22 noting an increase in each quarter, 1987 referrals were processed as DoLS 7-day urgent authorisation's and standard applications which was an increase of 255 (12%) compared 2020/21. 319 applications not progressed to standard applications were either duplicate applications, discharged, fluctuating/regained capacity or application of a mental health section used. Duplicate and discharged patients was the most common theme. This is an increase from last year by 15 (5%).
- All applications are quality assured, key areas of focus being care and treatment details, and discussion of DoLS application with the Relevant Persons Representative (RPR) inclusive of the mandatory RPR booklet and RPR details (name, address, and contact numbers)
    - In 2021/22 57% of RPRs who required the RPR booklet had received them compared to 56.4% in 2020/21. This is likely due to the visiting restrictions, associated face to face opportunities, throughout the COVID-19 pandemic, options to post or email booklets were available to staff.
    - 99% of RPR discussions were attempted or completed which shows excellent communication in relation to DoLS in 2021/22 compared to 98.8% in 2020/21.
    - Inclusion of RPR demographics remains unchanged from 2020-21 (61%), awareness continues to be raised which includes the importance of details for DoLS and emergency contact purposes.
    - Q3 data collection began for the QA of care and treatment details included within applications. 72% (Q3) and 62% (Q4) required further information prior to submission to the Supervisory Body (LA). This section requires a short synopsis of the current medical plan, the theme of content provided is either not medically fit or medically fit.
- BI completion for DoLS MCAs is 100%, an improvement from 2020/21 (95%).
- Staff knowledge of expiry dates of DoLS continues to be monitored via Wirral Individual Safe Care Every Time accreditation programme (WISE). Bespoke training provision to areas requiring further education have been actioned, no escalations have been required to PSQB.
- 2 requests for DoLS for children under 18 years have been received in 2021/22, support was provided via the Trusts Legal Team
- Monitoring of delays in DoLS applications began in Q3, data highlights that 71% (Q3 and Q4) of patients requiring DoLS applications at admission point were completed within 72hrs of admission. The Trust does not have an internal benchmark; however, legislation requires it to be applied at the time a person is deprived of their liberty. The Trust has approached other NHS organsiations to compare; no other Trusts reported they monitor this data. Deep dive case reviews are completed for any significant delays (over 8 days) to identify learning and raised via a clinical incident form for the division to investigate. 41 clinical incidents were completed in 2021/22 and a further breakdown of data will be completed in 2022/23.

	• Further proactive work developing Cerner ahead of LPS to incorporate MCA, BI and DoLS as follows: ➢ Q1 request for DoLS restrictions to be monitored via Cerner by ward staff to provide the intelligence to monitor changes of restriction /capacity status providing staff accountability with restrictive practice. Request prioirtised as medium at the System Change Request Review Meeting (SCRRM). ➢ Inclusion of MCA/BI within the Cerner training package and crib sheets for clinicians and advanced nurse practitioners. This includes the decision to consent to hospital admission and the requirement for it to be completed within medical clerking ahead of LPS. ➢ Addition to the nursing adult admission assessment prompting nursing staff to consider patient's capacity at point of admission. ➢ Discussions commenced with N-Compass Advocacy regarding making the IMCA referral form digital on Cerner to become more accessible to staff, raise awareness of the statutory requirement of Independent Mental Capacity Advocates (IMCAs), audit purposes and allow inclusion within the patient's electronic record. ➢ Joint working with the Deputy Medical Director/Lead for Consent converting paper consent form 4 to electronic with a view to improve compliance in documentation of MCA/BI decisions. • Outside of mandatory training bespoke training is delivered to all staff groups raising awareness of the requirements of MCA (2005) decision specific assessments and use of appropriate template documentation. MCA is included in the falls training and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) programmes. • Safeguarding bulletins have been disseminated throughout the year raising awareness in the following areas: MCA, DoLS, Lasting Power of Attorney, Court Appointed Deputy and Advanced Decisions to Refuse Treatment. • Safeguarding is represented on the Trust's Mental Health Transformation Group and subgroups. • In April 2021/22 a survey monkey was completed to understand barriers faced by staff in relation to MCA completion, a total of 13 surveys were sent out to all divisional triumvirates during April – June 2021/22. Findings supported the development of scenario-based MCA training in conjunction with MCA Lead, ED Mental Health Lead and Cheshire and Wirral Partnership NHS Foundation Trust (CWP). • Following allocation of monies via continuing professional development (CPD) funding Eye Film company were commissioned to support the filming of a scenario-based training package to support in the use of MCA with Mental Health and complex patients, this was completed in March 2021/22. The training package will be piloted to staff within ED in Q1 2022/23.
1.8	**The Counter Terrorism and Security Act (2015)** The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components: • Pursue - to disrupt terrorist activity and stop attacks • Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities • Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack

- Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack

The NHS and its partners have a role in the 'PREVENT' section of this strategy. Whilst the Trust continues to be a non-priority site, the reporting mechanism is required via NHS Digital and via the SAAF to WHCC.

The Counter Terrorism and Security Act (2015), places a specific duty on statutory bodies including the police, LA's and health organisations to have 'due regard' to help prevent people being drawn into terrorism. The Channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) is a legal requirement for public bodies across the country.

Trust position.

- Trust policy 'PREVENT Policy and Guidance protecting those who are vulnerable to exploitation and radicalisation through a multi-agency approach' (policy reference 305) is in place; due review in December 2022/23.
- There have been no recent changes to legislation or guidance regarding Prevent during 2021/22.
- The collection of data began in Q3 to monitor the number of Channel panel requests for information received. The Trust received 9 requests for information to be shared, 7 for children and 2 for adults.
- The Trust has not had any cases that required Prevent referral during 2021/22.
- Quarterly data submissions for Prevent continue to NHS Digital and via the SAAF to WCCH; this includes referral numbers and training data.
- Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP) training continues as part of all levels of PVP training. The Department of Health and Social Care has set compliance for Prevent at 85%. Compliance is monitored via PVP through the SAG and PSQB

Level	**Compliance 85%**
Level 1 - Basic Awareness (PVP)	87.33%
Level 2 - Basic Awareness (PVP)	84.97%
Level 3 - Workshops to Raise Awareness of Prevent (WRAP)	72.2%

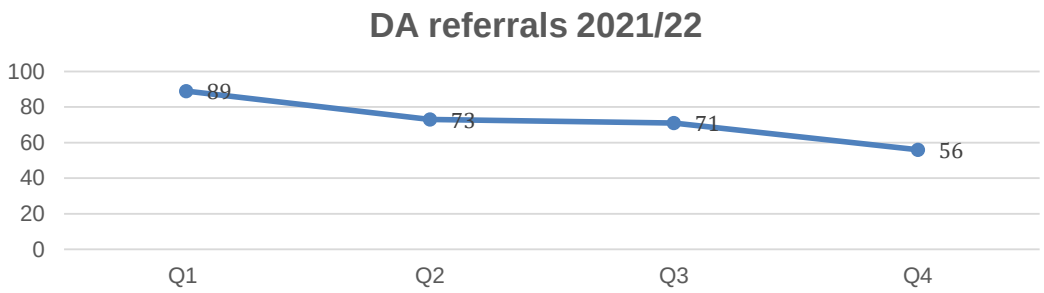
1.9 **The Domestic Abuse Act (2021)**

Following a period of consultation, the Domestic Abuse Bill (2021) became statute in Q1 2021/22. The Act aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. Most of the provisions in the Act will be brought into force by commencement regulations, once the necessary preparatory work has been completed, for example, the making of court rules or the issue of guidance.

Trust Position.

- Domestic abuse and harmful practices is included across all levels of PVP training which supports staff in the completion of risk assessing victims of domestic abuse.

- The Trust has 2 policies in place; 1 to support staff with patients and 1 for support for staff that may experience domestic abuse:
  - Domestic Violence and Abuse policy reference 035 due for review in July 2022/23
  - Domestic Abuse Workplace Policy: Support for Staff policy reference 344 and due for review in June 2022/23
- The Trust has an identified lead for Domestic Abuse and Harmful Practices (Named Midwife for Unborn) supports both patients and staff following any disclosures or concerns. The Trust was supported by a hospital based domestic abuse advocate (IDVA) however following the position becoming vacant in November 2021/22 the Trust made the decision not to replace this role. The function of the role is embedded within practitioner's responsibilities and support from the Safeguarding Team.
- In 2021/22 the Safeguarding Team received 289 referrals relating to domestic abuse in comparison to 337 in 2020/21. A decline in referrals from Q1 to Q4 throughout this year has been noted. Further analysis of the data for 2022/23 will evidence whether this is an ongoing trend and the reasons for this.



- In 2021/22 the Safeguarding Team supported 5 staff members following disclosure of domestic abuse which was a decrease in comparison to supporting 8 staff members in 2020/21.
- The domestic abuse routine enquiry questions were embedded within Cerner in 2019/20, prompting all patients 16yrs and above to be given the opportunity to disclose concerns to staff. Compliance of this question is monitored through daily IT reports and using the WISE audit programme. Compliance within ED is noted to require improvement and will continued to be monitored. Additional training has been provided in conjunction with the ED Practice Development Nurse in block training throughout Q4 2021/22.
- The domestic abuse CAADA-DASH risk assessment is embedded within Cerner supporting practitioners to identify high risk cases of domestic abuse, stalking and 'honour' based violence. This assessment assists decision making of cases that require referral to MARAC and enables support mechanisms to be identified.
- The Lead for Domestic Abuse is a member of the Wirral Domestic Abuse Alliance which has senior membership from across services and community groups.
- The Trust has contributed towards 2 new Domestic Homicide Reviews (DHRs) in Wirral and 1 ongoing review from 2020/21. Reviews await approval and publication, identified learning specific to the Trust will be shared and implemented through safeguarding action plans and training.

Harmful Practices Trust Position

- There were no referrals received relating to Harmful Practice for 2021/22.

	• The Safeguarding Team received 12 referrals relating to identified cases of Female Genital Mutilation (FGM). These were all identified through midwifery services at the point of women booking into midwifery care. This is an increase from 7 cases in 2020/21. • FGM screening remains an open risk on the Trust risk register (Risk 0221) - FGM routine enquiry questions are required to be asked within key areas of the Trust, Maternity, Gynaecology, and Urology services as directed by the Department of Health. FGM routine enquiry is currently only asked in Maternity and Gynaecology services. Implementation for Urology outpatient's department has been delayed as functionality could not be localised to only Urology. This risk is being led by the Women's and Children's division and ongoing discussions continue with the Cerner Team.
1.10	**People in Positions of Trust (PiPOT) (Staff allegations)** All incidents or allegations of abuse are taken seriously by the Trust and are treated in accordance with Wirral Safeguarding Children's Partnership (WSCP) and Wirral Safeguarding Adults Partnership Board (WSAPB) procedures. **Trust position.** • Allegations against staff continue to be raised to the Safeguarding Team following the People in Positions of Trust (PiPOT) policy and process. Allegations that do not require safeguarding involvement are managed via the divisions and/or Human Resources. Regular bi-weekly meetings continue to monitor progress of any cases to ensure all required actions have been completed. • Any allegations requiring safeguarding reporting processes to be initiated are also reported to the Designated Nurse/Professional Lead for Adults/Children and to the Local Authority Designated Officer (LADO) for children's concerns. • Staff allegations data and information is reported via the Quality and Patient Safety Intelligence Report into PSQB for wider learning and assurance.

2	Inspections/Reviews	
2.1	**Care Quality Commission (CQC) of Health Services for Children Looked After (CLA) and safeguarding across Wirral – May 2019 (update).** Ensure children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance for emergency paediatric care (CQC Safeguarding Wirral Wide Action Plan 2019). This action remains the only outstanding red action. A business case completed by the Women's and Children's Division is due to be presented to the Executive Team in May 2022/23.	
2.2	**Trust CQC inspection (October 2021)** The Trust underwent an unannounced inspection of Urgent and Emergency Services and Medical Care in October 2021 and a full report was published 14 January 2022. From a safeguarding perspective the overall summary of the inspection identified that: • Staff understood how to protect patients from abuse, and managed safety well. However, the inspection identified that most nursing but not all medical staff had training on how to recognise and report abuse and they knew how to apply it.	

- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they had made a safeguarding referral and the circumstances around the Referral.
- The safeguarding Team supported staff to compete applications for DoLS. They informed staff members when they needed to be updated. There were daily prompts at the safety huddles to review any DoLS if they needed to be extended and staff received prompts from the safeguarding Team.
- Staff checked the national CP-IS system for every patient under 18 years old who attended the department to check if there was a safeguarding alert in place.

As a result, the Trust was issued with a Regulation 18 (1)(2) (a) must do action of:

- The Trust must ensure medical staff complete mandatory training (Regulation 18 (1)(2) (a)).

The Associate Director of Nursing for Safeguarding continues to support the improvements in safeguarding mandatory training. Overall, the Trust ended 2021/22 with some improvement has noted across levels 2, 3 and 4 since the report was published in January 2022 for medical and dental staff:

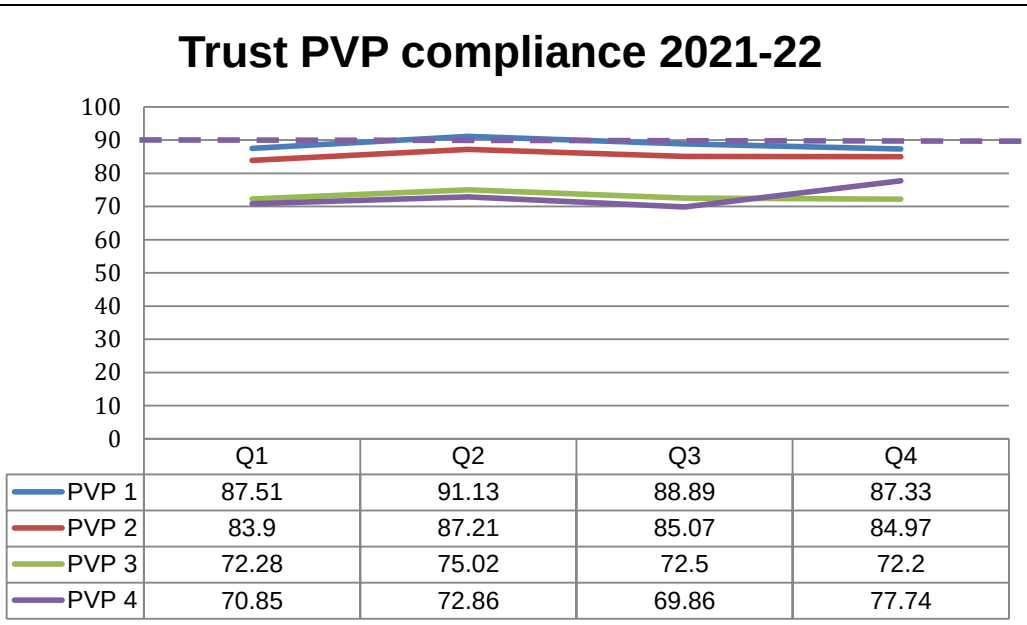
	October 2021 (CQC visit)	**March 2022**	**Variance**
PVP 1	75%	66.67%	- 8.33%
PVP 2	73.02%	74.60%	+ 0.83%
PVP 3	33.33%	39.33%	+ 6%
PVP 4 (additional level 3 hours face to face)	39.06%	42.50%	+ 3.44%

3	**Protecting Vulnerable People Mandatory Training (PVP).**

The Trusts PVP Strategy outlines the pathway for staff to access appropriate safeguarding education relevant to their role and competencies required written within the legislative framework and which reflects the findings and recommendations from the Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document (2014) and the Safeguarding Adults: roles and competencies for health care staff Intercollegiate Document (2018).

Trust Position.

- PVP training level 1-3 is delivered through an eLearning package and the additional hours aspects of level 3 requirements set out in the safeguarding Intercollegiate documents is delivered as a face-to-face package (including MCA and DoLS) which has continued virtually via Microsoft Teams as a result of COVID 19.



	Q1	Q2	Q3	Q4
PVP 1	87.51	91.13	88.89	87.33
PVP 2	83.9	87.21	85.07	84.97
PVP 3	72.28	75.02	72.5	72.2
PVP 4	70.85	72.86	69.86	77.74

- Unfortunately, the Trust did not reach its mandatory training compliance target of 90% for PVP by the end of the year 2021/22. In comparison to Q4 2020/21 the Trust has seen an overall improvement across all levels:

PVP	Q4 2020-21	Q4 2021-22	% Improvement
Level 1	79.88	87.33	7.45%
Level 2	82.33	84.97	2.64%
Level 3	67.04	72.2	5.16%
Level 3 (additional face to face hours)	59.17	77.74	18.57%

- The Trust has maintained compliance across all levels through the continued restrictions and impacts of COVID 19.
- A training needs analysis was completed during Q3 to ensure that all staff were mapped against the appropriate levels of training as stipulated in the Intercollegiate documents for adults and children. The review identified 212 staff that required to be moved into the appropriate levels of PVP training as per individual role requirements. Bespoke sessions were offered to staff for them to achieve the required compliance and avoid decrease in overall compliance.
- Women's and Children's division have achieved compliance in level 1, 2 and 4 PVP for (Q4). Medicine, Estates and Facilities have achieved compliance for level 1 PVP and Surgery for level 2 PVP at the end of Q4. A heat map in appendix 5 highlights divisional compliance.
- Throughout the year visibility and bespoke training has continued to multiple departments and wards. Bespoke sessions are implemented for various reasons such as identified learning from incidents, lessons learnt following multi agency reviews, following WISE audit or requests made from managers.
- Assurance of safeguarding knowledge is monitored through WISE. WISE was restarted as business as usual from April 2021/22. 24 clinical areas have been audited during 2021/22 and the provision of bespoke training is completed in areas identified as requiring improvement. The average score for all audits

	completed during this period is 90.1% highlighting that staff have a good understanding and knowledge base for safeguarding and MCA (2005).

4	Governance Arrangements for Safeguarding
4.1	**Safeguarding Assurance Group (SAG) and Patient Safety and Quality Board (PSQB).** The Safeguarding Assurance Group (SAG) provides opportunity for challenge and assurance regarding safeguarding arrangements within the Trust, monitor compliance and benchmarking with external standards, clinical effectiveness indicators including CQC outcomes and addresses any areas requiring improvement. The SAG meets quarterly which allows for a defined and joint approach to safeguarding across all divisions within the Trust. The group has divisional representation alongside the named/lead professionals and is attended externally by the designated professionals for adults, children and CLA from the WHCC to allow scrutiny and oversight. SAG agenda includes the compliance with safeguarding standards, including the safeguarding assurance framework and mandatory safeguarding training compliance. The Associate Director of Nursing for Safeguarding provides a quarterly report into the PSQB and yearly annual report. Trust Governance structure arrangements are detailed in appendix 6. **Trust Position.** • Following the effects of COVD 19 in 2020/21 the Trust were able to reinstate the SAG via Microsoft Teams which recommenced in April 2021/22. 4 SAG meetings were planned for 2021/22: February 2022 SAG was unfortunately cancelled due to operational pressures of COVID 19, a safeguarding oversight report was shared with PSQB by way of assurance and escalation.
4.2	**Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults.** The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to WHCC.
4.3	**Safeguarding Incident Reporting** Safeguarding incident notifications are integrated into the Trust's Safeguard database to record all safeguarding incidents both internally and externally. Following receipt of the incident documentation received by the Safeguarding Team, it is recorded in Cerner to ensure all staff has access to all safeguarding information. The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS). Any alerts required are escalated to WHCC and the CQC as required. The Associate Director Nursing for Safeguarding or a deputy attends the weekly Trust's Serious Incident Review Group (SIRG) to provide safeguarding expertise and MCA (2005) expertise and advice and overview of any incidents with MCA involvement.

	Clinical incident forms are be raised by the Safeguarding Team when concerns have been raised that do not meet the thresholds for safeguarding investigations highlighting potential gaps in processes directly to the divisions.
4.4	**Safeguarding Supervision and Support.** Safeguarding supervision is a term used to describe a formal practice of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. There are 2 mechanisms for safeguarding supervision: • Advice on individual case management • Ensuring that those working with cases with safeguarding issues have sufficient knowledge, skills, and appropriate attitude. The requirement for Trust employees to have access to safeguarding supervision is explicitly stated in Working Together to Safeguard Children (2018): "Effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family." The Care Act (2014) dictates the requirement for safeguarding supervision: "Skilled and knowledgeable supervision focused on outcomes for adults is critical in safeguarding work. Managers have a central role in ensuring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available." **Trust Position.** • Safeguarding supervision is provided to all health practitioners who case hold safeguarding cases. • Safeguarding Supervision Policy – policy reference 247 is in place and due for review in March 2024. • In line with recommendations from The Care Act (2014) safeguarding supervision sessions continue to be delivered via monthly drop-in sessions within the ED. This allows staff opportunity to access supervision for both adults and children. Records of supervision are recorded and kept securely by the safeguarding supervisors on a case-by-case basis. 142 members of staff have been recorded as being offered supervision, 104 staff did not have any concerns/cases they wanted to discuss. The Safeguarding Team used these opportunities to educate staff, discuss safeguarding processes and promote training, CP-IS and domestic abuse questions. • ED Paediatric Peer Review continues to be delivered on a quarterly basis to share learning and identify how to improve practice. • The Trust Named professionals all access safeguarding supervision from Designated professionals and are 100% compliant with the agreed KPIs of the agreed SAAF. • Moving into 2021/22 the Designated Professional for Adults will include group supervision to be held with other organisation's with an aim of sharing learning and sharing good practice. • Within 2021/22 it was noted that the compliance of safeguarding supervision had fluctuated throughout the year for case holding staff. This was escalated as an area of concern to the Divisional Director of Women and Children. To remedy this

	the division has sourced funding and secured training for an additional 6 safeguarding supervisors who will commence the course in Q2 in 2022/23.

5	Looking forwards into 2022/2023
	Safeguarding remains a priority area of work for the Trust and this section defines the strategic priorities and work plan within safeguarding as we move forward into 2022-2023. The strategic safeguarding aims related to the Trusts workforce are: • Appointment of a second Adoption Medical Advisor in line with the recommendations set out in the Somerset Ruling 2022. • Contribution to the LPS consultation and subsequent transition and implementation from DoLS to LPS. • To focus on domestic abuse and further embedment and strengthening of the Domestic Abuse Act (2022) once further guidance and regulations are confirmed. • Benchmark across other NHS organisation's regarding delivery of safeguarding training to the workforce. • Further audit to monitor for improvements in MCA knowledge. • Audit plan to look at MCA assessments outside of DoLS, such as medical intervention and consent. • The Health and Care Act (2022) will make major changes to the NHS in England including dissolution of the CCG's to be replaced by an Integrated Care System (ICS). The ICS will bring together NHS, LA and third sector bodies to take responsibility for the resources and health of Wirral and Merseyside. The aim is to deliver better, more integrated care to patients. This change is planned for 1st July 2022/23. Safeguarding will continue to work in line with statutory legislation and national guidelines and support the work of the new ICS. • To sustain positive partnership engagement with key stakeholders, to ensure the continuation of robust and transparent conversations in addressing and identifying solutions to rapidly evolving safeguarding issues. • Moving forward in 2022/23 collaborative working is planned with the Named Nurse for Children and Children Looked After and LA to ensure further integration of IHA systems to reduce system delays in achieving statutory timeframes. • Support the Tissue Viability service with the implementation of the Department of Health and Social Care Safeguarding Adult's Protocol - Pressure Ulcers and the interface with a safeguarding Eequiry into the tissue viability clinical incident forms. • Increase the pool of trained safeguarding supervisors to ensure that all professionals are supported to enable individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. • Achieve the 90% and above compliance for PVP mandatory training and sustain this compliance providing further assurance that staff can make every contact count to prevent all forms abuse. • As a key priority work with divisional leads to make improvements in compliance of CP-IS checks completed by practitioners within Acute and Women's and Children's divisions.

6	Conclusion and Recommendations
6.1	This Annual Report demonstrates the commitment of the Trust to safeguarding children and adults and robustness of the arrangements in place. The Safeguarding Team continue to strive to ensure all safeguarding processes are robust and effective. We look forward to the strategic direction for safeguarding as we look towards the future with the implementation of the ICB and how that will shape the functions of the ICS functions in terms of safeguarding across the Cheshire and Merseyside footprint. We recognise that there is still much to do with demand for services continuing to grow against shifting sets of priorities and the continuing impact of the pandemic, despite the full lifting of all restrictions. This year has continued to be a challenge to all key stakeholders and remains so as we learn to live with the virus which remains active within society. There have been many positive aspects to comment on during the last year, in particular the improvements of IHAs, which allowed us to remove the associate risk from the Trusts risk register and completion of all but one outstanding safeguarding CQC actions. We have supported staff in all matters of safeguarding providing safeguarding supervision, support and improvement in education compliance demonstrating assurance that staff have appropriate safeguarding and MCA knowledge to fulfil their duties and responsibilities.

Appendix 1
Definitions

Safeguarding: The Care Quality Commission (CQC) states; ‘Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care’ (CQC, 2022).

Safeguarding Children: A child is defined within the Children Act 1989 as “an individual who has not reached their 18th birthday”, and the fact that a child may;

- Live independently
- Is a parent themselves
- Is in custody
- Is a member of the armed forces

does not change their entitlement to protection under The Children Act (1989). This is important because young people aged 16 and 17 years with safeguarding needs access, ‘adult’ services in the Trust and are seen and treated by adult trained and registered staff who may not acknowledge this entitlement.

Safeguarding Adults: An adult is an individual aged 18 years or over.

The Care Act (2014) defines an ‘adult at risk’ as:

- An adult who has care and support needs (whether the needs are being met or not).
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All Wirral University Teaching Hospital NHS Foundation Trust (WUTH) all staff have a statutory responsibility to safeguard and protect those who access their care regardless of their position in the organisation. However, some defined named safeguarding roles exist, they include:

Named Professionals.

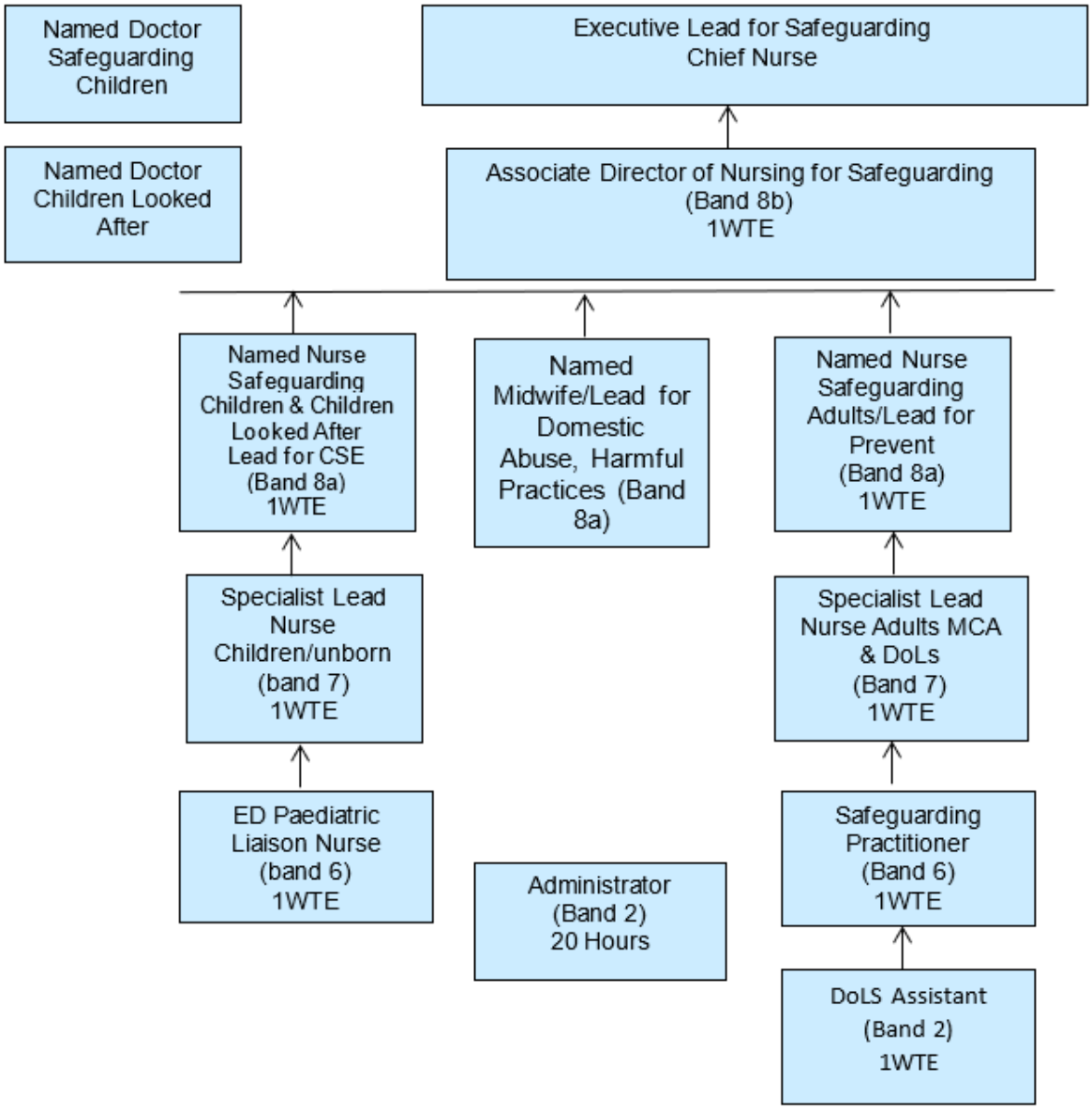
Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

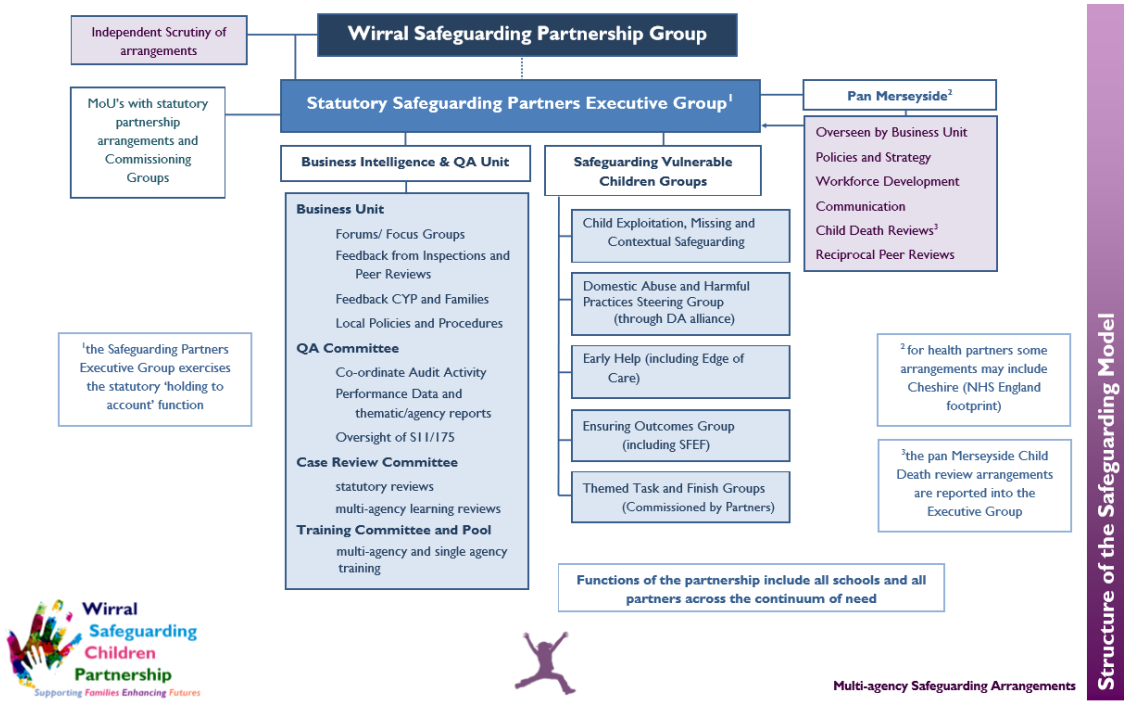
From April 2021 - March 2022 the WUTH named professionals were:

- Named Doctor for Children and Young People – Dr Elizabeth Thompson
- Named Doctor for Children Looked After – Dr Vidya Raghavan
- Named Nurse for Children and Children Looked After – Nicola Denton
- Named Professional (Nurse) for Adults – Helen Brookes
- Named Midwife – Michelle Beales-Shaw

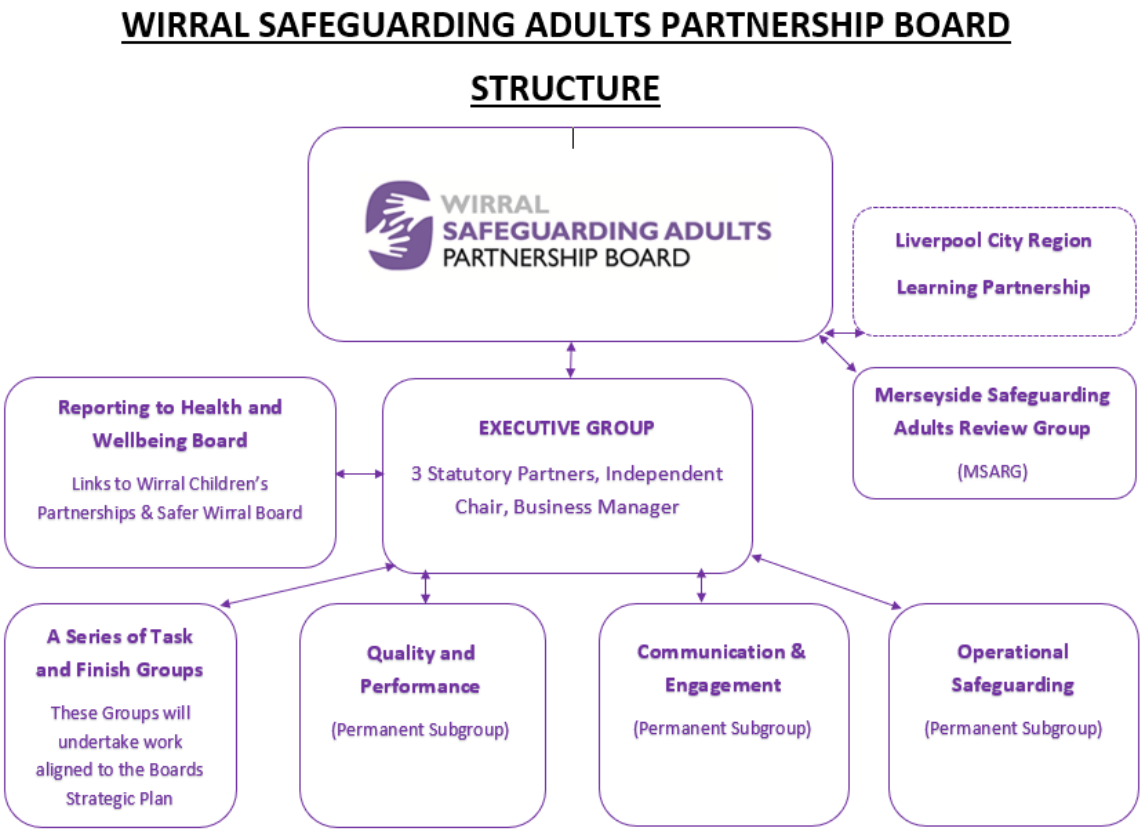
Appendix 2
Safeguarding Structure



Appendix 3
Wirral Safeguarding Children's Partnership Structure



Appendix 4
Wirral Safeguarding Adults Partnership Board Structure



Appendix 5
Protecting Vulnerable People training – Divisional Heatmap

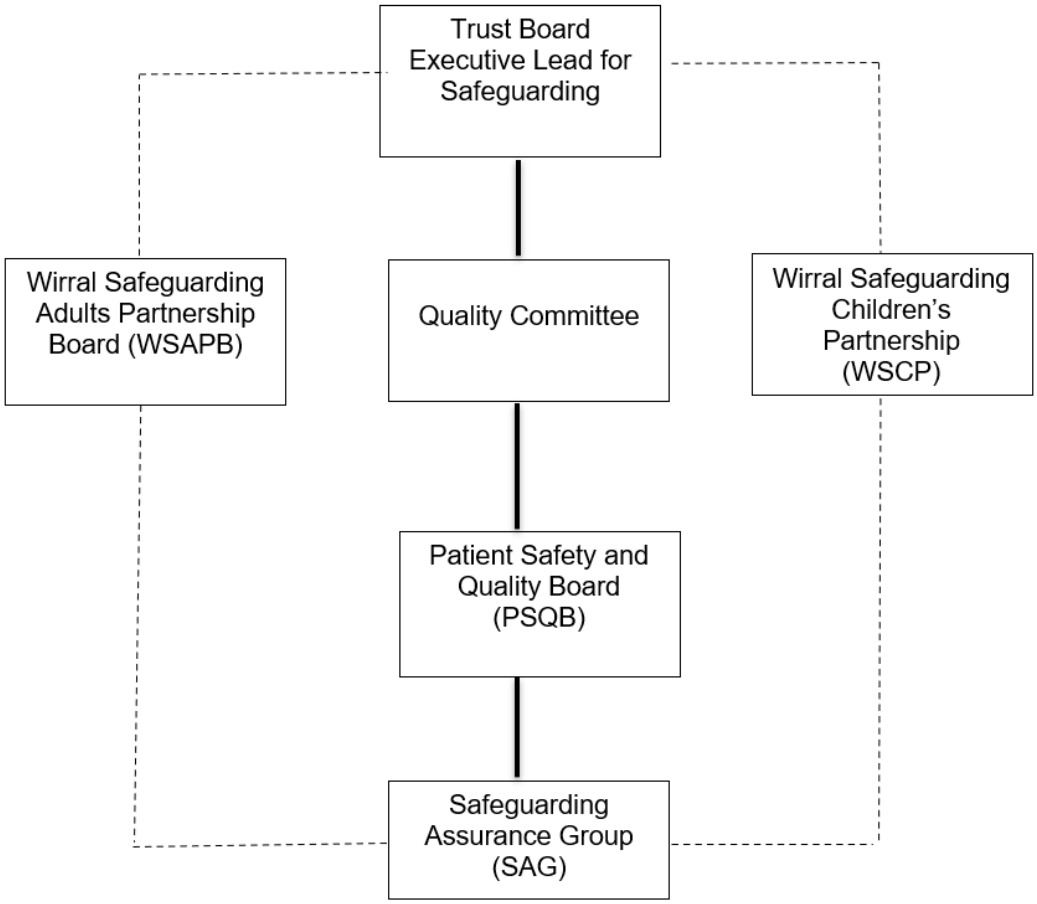
	PVP 1	PVP 2	PVP 3	PVP 4
Surgery	85.86	91.08	74.09	86.21
Medicine	90.98	84.12	70.42	0
Acute	80.7	76.67	82.5	62.14
Women's & Children's	91.35	90	88.89	90.3
Clinical Support	88.33	82.64	87.35	50
Corporate Services	77.1	87.93	51.28	87.59
Estates & Facilities	91.5	69.17	N/a	N/a

There has been noted increase in compliance in (Q4) across PVP 4 with only minimal changes across the remaining 3 levels from a Trust perspective. Divisional Safeguarding Reports provided the SAG with trajectories and plans for improvements.

Some divisions have achieved compliance across levels of PVP as highlighted in green below. Yellow highlights areas of over 85% close to compliance. Surgery have achieved a significant increase of 53% in Level 4 compliance from 33.87% (Q3) to 86.21% (Q4) through 'focus of the month' and Women's and Children have complacence across levels 1,2 and 4. Both divisions were highlighted in SAG for their positive improvements.

The DDN for Surgery was invited by the Named Nurse Children and Children Looked After to consider sharing an effective case study at the Wirral Partnership Quality and Assurance Safeguarding Group to showcase the innovative focus approach for Mandatory training, highlighting the difference that this makes for vulnerable people in terms of quality and organisational gains.

Appendix 6
WUTH Governance Structure



Board of Directors in Public **Item 11**

05 October 2022

Title	2022-2023 Annual Core Standards for Emergency Preparedness, Resilience & Response
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Steve Povey, Head of EPRR
Report for	Ratification

Report Purpose and Recommendations

The Department of Health and Social Care and NHS England require all Trusts to undertake an annual assessment of their Core Standards for Emergency Preparedness, Resilience & Response.

The Trust undertakes a self assessment against each applicable core standard and requires an action plan for any standard that is not Fully Compliant

Regionally Trusts meet to discuss the core standards and Peer Review dates have been set for the 14th and 20th October 2022 prior to the Regional ICB submission deadline of the 28th October 2022.

For 2022/23 the Trust has declared Partial Compliance. Areas which require improvement are largely as a result of national changes to the approach to EPRR as part of the response to Covid-19. The Trust is putting in place robust plans to update these standards in the shortest timeframe possible to ensure full compliance with these standards.

It is recommended that the Board:

- Note the scoring of the self-assessment
- Approve the submission to the Cheshire and Merseyside ICB.

Key Risks

This report relates to these key Risks:

- None to note

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

1	Background
1.1	On an annual basis the Department of Health and Social Care and NHS England require all Trusts to undertake an annual assessment of their Core Standards for Emergency Preparedness, Resilience and Response. This takes the form of a self-assessment against each applicable standard and requires a response to be documented and evidenced and an action plan for any standard that is not Fully Compliant put in place to achieve that compliance. In addition, annually, a specific work area is selected for a 'Deep Dive' focus on its arrangements. For 2022/23 this area is 'Evacuation and Shelter'. Theses Deep Dive standards are answered in the same way but do not count towards the overall compliance rating. Peer Review dates have been set for the 14th and 20th October prior to the Regional ICB submission deadline of the 28th October. The timeline for the standards is as follows: • 28th October – deadline for providers to complete self-assessment, peer review and submit to ICB • 11th November – ICB to have completed local assurance processes with provider organisations. • 18th November – Deadline for ICB's to submit LHRP level and ICB core standards to regional team. • 25th November – deadline for RHRP to have met and reviewed submissions across NW ICB's.

2	Areas to note
2.1	The Board of Directors should note the self-assessment completed at Appendix 1. Overall, the Trust has assessed itself as partially compliant with a score of 81% against the standards broken down in the following areas:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	11	0	0	0
Command and control	2	1	1	0	0
Training and exercising	4	2	2	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	5	5	0	1
CBRN	14	10	4	0	0
Total	**64**	**52**	**12**	**0**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	13	0	0	0
Total	**13**	**13**	**0**	**0**	**0**

	There are no areas where the Trust is assessed as not compliant and 12 areas where partial compliance has been declared, mainly due to the addition of new standards following Covid. The Trust has plans in place to achieve compliance over the next six months and a further update will follow to the Board of Directors for completion.

3	Recommendation
3.1	The Board of Directors is asked to note the scoring of the self-assessment and approve the submission to the Cheshire and Merseyside ICB.

Author	Steve Povey, Head of EPRR
Contact Number	7215
Email	stevepovey@nhs.net

Please choose your | Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	11	0	0	0
Command and control	2	1	1	0	0
Training and exercising	4	2	2	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	5	5	0	1
CBRN	14	10	4	0	0
Total	**64**	**52**	**12**	**0**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	13	0	0	0
Total	**13**	**13**	**0**	**0**	**0**

Percentage Compliance	81%
Overall Assessment	**Partially Compliant**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY compliant standards

Notes
Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Hayley Kendall, Chief Operating Officer.	Fully Compliant			
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy, last reviewed May 2022	Fully Compliant			
3	Governance	EPRR board reports	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	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	EPRR Annual Report & Core Standard Assurance Statement approved at Risk Management Committee and noted in Chair's RMC Report to Board of Directors in March 2022.	Fully Compliant			
4	Governance	EPRR work programme	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 The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Not used in 2021 The trust has an Annual Work Plan that is published each year and updated throughout the year. Reporting structure being reviewed post-Covid	Fully Compliant			
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Major Incident Plan (reviewed March 2022) and action cards describe resourcer and roles and responsiblities.	Fully Compliant			

6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Major Incident Plan, Annual Report Risk Register entries Debriefs from exercises and incidents which detail learning	Fully Compliant			
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Signifcant/major incidents are recorded on the trust BAF. Trust attendance at LHRP Strategic and Practitioner meetings where EPRR risks are considered and recorded. Trust EPO is part of the working group for the LHRP Risk Register.	Fully Compliant			
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR policy references the Trust risk management policy	Fully Compliant			
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Plans such as winter, holiday and escalation all developed in conjunction with system partners	Fully Compliant			
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plans reviewed 3 yearly in line with EPRR framework. WUTH has been involved in several major incidents in previous years. No significant command issues highlighed by the subsequent debriefs and command framework has been used for pandemic response.	Fully Compliant			
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Severe weather plan in place, reviewed in March 2022	Fully Compliant			
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	Policies and procedures as detailed in the health & Social care act. COVID Board assurance framework IPC Team Outbreak policy Fit testing service PPE policy Isolation policy Ongoing surveillance Infection Prevention & Control Group that is chaired by the DIPC and signs of all relevant policies and procedures Annual work plan 3 yr IPC strategy Trust intranet has current guidelines	Fully Compliant			
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fit testing service for FFP3 masks Local COVID policy reflecting national guidelines. Local monkey pox plan Weekly Clinical Advisory group that oversees all new and emerging pandemics Trust intranet has current guidelines IPC COVID BAF Collaborative flu preparedness meetings	Fully Compliant			

14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	MOU in place between our community/partner organisations to work in collaboration as and when needed. Monthly collaborative meetings between partner organisations	Fully Compliant			
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	NHS England Concept of Operations for managing Mass Casualties incorporated into the Trust Major Incident Plan. Patient identification included in the ED major incident plan/action cards. Mass casualty action card (Plato Action Card) included in the Hospital on-call booklet and Major Incident Plan. NWAS regional casualty allocations agreed with ED	Fully Compliant			
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation Plan in place Shelter is the responsibility of the Local Authority Evacuation Policy review undertaken with NWAS & MFRS Evacuation Workshop held with On-call managers, Hospital Clinical Coordinators & Executive Directors on-call	Fully Compliant			
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy in place	Fully Compliant			
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referred to in the Major Incident Plan Referred to the Communications Plan	Fully Compliant			
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust engages and contributes to the LHRP	Fully Compliant			

20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	24/7 Manager & Executive Director level on-call in place Major Incident Plan Switchboard Cascade In & out of hours Plan in place, tested every 6 months On-call booklet WUTH has been involved in 3 major incidents with no significant issues highlighted • Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff."	Fully Compliant			
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	1st and 2nd On Call staff are undertaking Principals of Health Command Training on an ongoing basis due to be completed November 2022. Trust EPO/Head of EPRR undergoing Train the Trainer course which will become part of on call training for all staff.	Partially Compliant	Tactical 1st On Call training running to 29/10/22, Strategic 2nd On Call training running to 30/09/22, all staff will be trained by these dates. Post October the trust Head of EPRR will deliver the training to staff who are new to on call.	Steve Povey	Oct-22
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.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning Record of 1:1 induction checklist sent to delegate Certificate of Attendance for training sent to delegates for their portfolios Attendance Sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintaing centrally by Emergency Planning • Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for all on call staff, new requirement and will be delivered through the year	Partially Compliant	Ongoing training of staff to achieve updated requirements - personal portfolios will be completed by the end of the financial year	Steve Povey	Apr-23
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)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidenced in EPRR Annual Report Debrief Reports produced and shared at LHRP for shared learning • Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully Compliant			

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	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning Record of 1:1 induction checklist sent to delegate Certificate of Attendance for training sent to delegates for their personal portfolios. Attendance Sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintained centrally by Emergency Planning - Training records - Evidence of personal training and exercising portfolios for key staff. - Personal portfolios to be included in PADR process for On Call staff.	Partially Compliant	Ongoing training of staff to achieve updated requirements - personal portfolios will be completed by the end of the financial year	Steve Povey	Apr-23
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.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	On Call and key responder staff receive training for their specific rsponse roles. All staff receive introductory induction training on the role of EPRR.	Fully Compliant			
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Radiology Conference Room is the Major Incident Room The Boardroom is the back up room All on-call forums and 1:1 inductions are held in the Major Incident Room to ensure on-call are clear on where the room is and what is available in the room Site Maps, action cards and plans etc are in a locked cupboard in the room. The key located and door codes for Radiology are described on the on-call major incident action card which is inlcuded in the on-call booklet. Major Incident Room used a number of times for major and critical incidents etc and no significant issues highlighted.	Fully Compliant			
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	All polices are verision controlled under the trust document control processes. Digital copies are available vis MS Teams and Resilience Direct with hard copies present in the Major Incident Room. External partners are issued with digital versions.	Fully Compliant			
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity Response plans in place and available on the Emergency Planning Intranet page	Fully Compliant			
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	List of volunteers for trainined Loggists kept in the Major Incident Room (out of hours)and the Quality & Safety Department (in hours) Request of Loggist included in the Commander's action card (out of hours) and Quality & Safety Action Card (in hours) Record of training maintained centrally by Emergency Planning • Documented processes for accessing and utilising loggists • Training records	Fully Compliant			
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Inlcuded in the on-call booklet Information Team, Infection Control Team and Emergency Preparedness able to upload SitReps via Strategic Data Collection Service (SDCS).	Fully Compliant			
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance	Fully Compliant			

32	Response	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	Trust CBRN policy ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance	Fully Compliant			
33	Warning and informing	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Trust communications and media policy Major Incident Plan Social Media Policy Inclusion of communicaitons Lead in the Command Team Information tracking sheets held in the Major Incident Room WUTH has been involved in 4 major incidents in the past 4 years that have been noted as being well managed	Fully Compliant			
34	Warning and informing	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Trust communications and media policy Major Incident Plan Social Media Policy Inclusio of communicaiton sLead in the Command Team Information tracking sheets held in the Major Incident Room WUTH has been involved in 4 major incidents in the past 4 years that have been noted as being well managed	Fully Compliant			
35	Warning and informing	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Trust communications and media policy Major Incident Plan Social Media Policy Inclusio of communicaitons lead in the Command Team Information tracking sheets held in the Major Incident Room	Fully Compliant			
36	Warning and informing	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust Communications Policy details the forms of response during a business continuity/major incident.	Fully Compliant			
37	Cooperation	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The Trust AEO attends LHRP Strategic Meetings, in their absence, another Director or the trust EPO will attend with delegated authority.	Fully Compliant			
38	Cooperation	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The trust is represented at both the Cheshire and Mersey Resilience Forums by the ICB with support from NHS England. LRF business is fed through the LHRP meetings.	Fully Compliant			
39	Cooperation	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Included in the Major Incident Plan	Fully Compliant			
40	Cooperation	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	This Standard is Not Applicable to the trust				

41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	This Standard is Not Applicable to the trust				
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas	This Standard is Not Applicable to the trust				
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Major Incident Plan Code of Conduct - handling personal identifiable information Information Governence Policy Information Security Policy EPRR data sharing protocols with Trust IG Lead	Fully Compliant			
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	EPRR Policy	Fully Compliant			
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Included in EPRR Policy & Risk Management Strategy Requires updating based on updated guidance	Partially Compliant	Policy to be reviewed and updated to include all specific details	Steve Povey	Dec-22
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	EPRR policy BIAs available on the Trust intranet, the response to Covid-19 resulted in plans being used in earnest and a review is now required as part of the opeartyional debrief.	Partially Compliant	Policy to be reviewed and updated to include all specific details	Steve Povey	Dec-22

47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCPs available on the Trust intranet Policies are available for departments but reviews range from 2019 to 2022. Review needed to ensure that column D subjects are covered by all plans. Currently Partial Compliance	Partially Compliant	Policy to be reviewed and updated to include all specific details	Steve Povey	Dec-22
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	The trust remains part of the regional and national response to the worldwide pandemic and the UK Level 3/4 response which is taken as a Live Response to meet this criteria.	Partially Compliant	Following Covid need to re-establish the annual process to review all plans as these were stood down during the national response period	Steve Povey	Mar-23
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Revised DPST for 2022 has one action for WUTH.	Fully Compliant	List of medical devices connected to the trust network being completed	Lynsey Booth	Dec-22
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The trust has in place policies and regular Board Reports and an Annual Report.	Fully Compliant			
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	EPRR policy Annual Report Major Incident debriefs The Trust has been invloved in 4 major incidents in the last 4 years with no significant issues highlighted	Fully Compliant			
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	EPRR Policy Ref debrief Millennium - during Covid regular reporting and testing BCPs postponed in line with national policy. Trust re-establish the annual planned reviewed of the effectiveness of the BCMS	Partially Compliant	Review annual plan and testing of BCMS	Steve Povey	Apr-23
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Responsibility of the Contracting Department	Fully Compliant			
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning	This Standard is Not Applicable to the trust				

55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	CBRN Plan Toxbase UKHSA	Fully Compliant			
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	CBRN Plan Major Incident Plan	Fully Compliant			
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	CBRN Plan ED Training Trust Waste Policy	Fully Compliant			
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Rotas are available in ED. Each shift has at least one trained member of staff: Shift Leader/ Band 6. More trained staff are needed to strengthen capability. The Trust Ed has indicated that more training is eeded including train the Trainer for staff cascade	Partially Compliant	Train the trainer session required for 4+ ED staff to roll out new and refresher training. Notified to NHSE, NWAS run courses, demand to be identified by Core Standards process	Steve Povey	Mar-23
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Equipment checklist is wall mounted within external container at the front of ED. Equipment held is reviewed against the checklist annually- last reviews July 2020 & September 2021	Fully Compliant			
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Completed and available in the ED external container at the front of ED. PRPS suits serviced as per manufacturers requirements.	Fully Compliant			
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Annual checks are carried out by Decontamination lead. Checked July 2020 & September 2021. 22nd September 22 full check	Fully Compliant			
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	PPM in place. Last PPM completed July 2020. Works department PAT tested equipment. Suit Servicing 22nd September, need to check/visit store	Fully Compliant			
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	NHSE guidance followed. Kit destroyed in line with NHSE guidance.	Fully Compliant			

64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Records maintained by CBRN leads in ED. Decontamination training lead in place. Last formal training in 2018. Need for more trraining identified which has been highlighted to NHSE & NWAS.	Fully Compliant			
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Training recorded in ED. As aresult of staff changes firther training is required fo staff to roll out refresher training. Train the Trainer session is required for staff in the ED.	Partially Compliant	Further training required based on NWAS providing training	Steve Povey	Apr-23
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Records maintained by CBRN leads in ED. 4 staff are trained decontamination trainers which is not a sufficent number.	Partially Compliant	Further training required based on NWAS providing training	Steve Povey	Apr-23
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	CBRN Plan and ED action cards. Training for new staff and refresher training identified as being required.	Partially Compliant	Further training required based on NWAS providing training	Steve Povey	Apr-23
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		ICP Department run FFP3 training Records maintained by clinical skills lab FFP3 kit maintained	Fully Compliant			

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 12**
5th October 2022

Title	CQC Inspection Preparedness Programme
Area Lead	Janelle Holmes, Chief Executive
Author	David McGovern, Director of Corporate Affairs
Report for	Information

Report Purpose and Recommendations

This report is intended to inform the Board of work that has commenced in preparation for a CQC Inspection, and the means by which this work will be monitored.

It is recommended that the Board:

- Note the report.

Key Risks

This report relates to the risks to achieving an improved rating from any upcoming CQC inspection.

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

Governance journey

This is the first report on this topic to the Board.

1	Narrative
1.1	**Background** The Trust is anticipating a CQC inspection given our current overall provider rating of 'Requires Improvement'. The attached paper provides an update on progress with the programme of work that is

	underway in order to prepare ourselves for inspection and includes detail around specific areas of work being undertaken as part of our previous CQC action plan and the Well Led Review action Plan. The Board has previously been briefed on this.
1.2	**Introduction** Our last inspections by the CQC were in 2018/19, with the report being received in 2019. Ordinarily 'Requires Improvement' rated sites would then be reinspected within 2 years. However, since then we have had the ongoing COVID-19 Pandemic, and there have been changes to the CQC approach. The Trust also underwent a focused inspection relating to Infection, Prevention and Control in February 2021, with the report published in April 2021. This inspection did not result in any requirements for an improvement plan and praised the Trust for the improvements made. In addition to the above, during 2021, CQC undertook monitoring activities within the following services: Maternity, Radiology and Surgery, although this activity did not constitute an inspection and therefore did not result in the publication of a report, no regulatory actions were taken as a result. There was also an unannounced on-site inspection in Medicine and Urgent & Emergency Care Services in 2021 for which we received the following ratings:

	Medical Services		Urgent and Emergency Care Services	
	2019 Inspection	2021 Inspection	2019 Inspection	2021 Inspection
Overall Rating	Requires Improvement	Good	Requires Improvement	Requires Improvement
Domains				
Safe	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good	Good	Good
Responsive	Requires Improvement	Good	Requires Improvement	Requires Improvement
Caring	Good	Good	Good	Good
Well Led	Requires Improvement	Good	Requires Improvement	Good

	It should be noted that this inspection did not change the overall rating of Requires Improvement due to the fact that it was not a whole site inspection. Whilst we are not sure when we will next be inspected, the CQC have conducted unannounced visits at a number of NHS Trusts recently. They have stated that, although their visits have a different approach and will be shorter in duration, they will continue to inspect any Trust rated as Requires Improvement or where they have specific safety concerns. Given that we are currently rated as Requires Improvement, there is a high likelihood that they will inspect us in the near future. We should continue to prepare on the basis of imminent inspection.
1.3	**The Programme** The internal approach being taken is one of continuous quality improvement where upon we are currently carrying out a full self-assessment against the CQC regulations and key lines of enquiry (KLOEs). This work is being led by the Governance Support Unit in conjunction with colleagues from across the Trust and will provide for a

refreshed CQC Assurance Framework that will be continuously monitored and updated along with actions from the last inspection and other reviews e.g. Well Led.

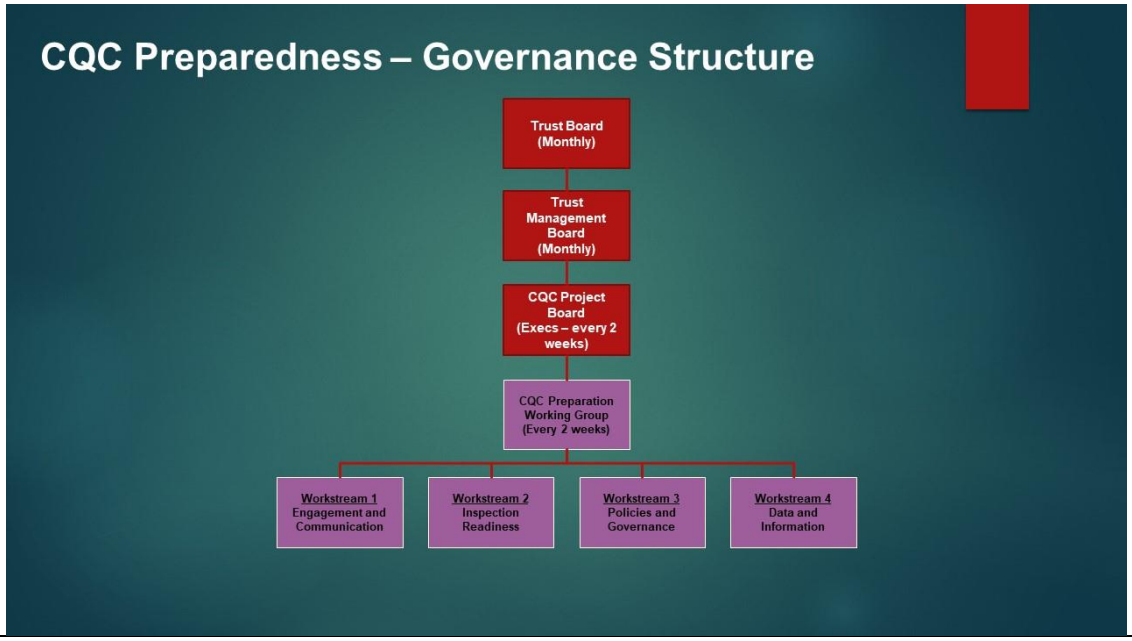
The Trust has also instigated an assessment against our preparedness which will be carried out by an independent advisor, who has carried out previous activity for the Trust and has an awareness of the Trust and its systems and processes.

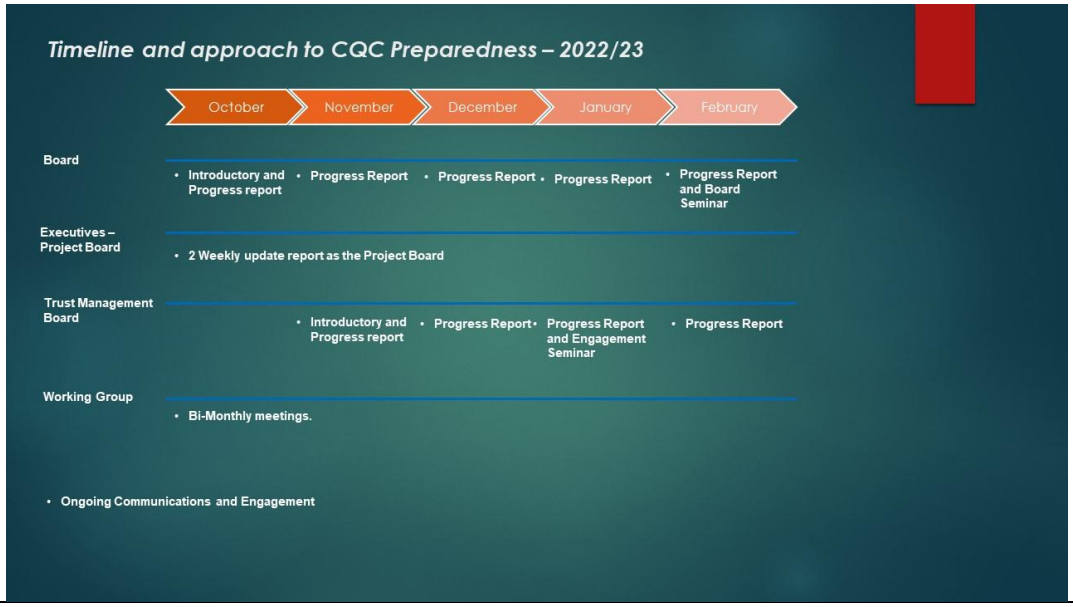
The advisor has been asked to prioritise activity in assessing the Trusts readiness for inspection including:

Action	Timeline
Immediate diagnostic of governance framework with particular focus on Well-Led	October 1st to October 31st
Review and where required implement/strengthen critical quality standards supporting operational functions and committee reporting structure providing the Board with comprehensive assurance on patient safety and service quality	October 1st to October 31st
Review and where required strengthen integrated governance processes; fully harnessing the benefits of the existing Integrated Governance Model	October 31st to December 15th
Provide expertise on implementation and effectiveness of the Trust control frameworks	Ongoing
Review interdependencies across the transformation portfolio including the development of a compelling narrative on WUTH's leadership in the development of the Integrated Care System for the Wirral	November 15th to November 30th
Ensure Trust compliance levels for staff mandatory & role specific training (particularly relating to patient level risk assessment)	November 15th to December 15th

1.4 **Governance, Work Streams and Considerations**

In order to support the programme governance and reporting, structures have been created and an initial proposal for key activity/workstreams has been suggested. The proposed programme Governance and proposed work streams is illustrated below:



	Initial workstreams have been identified as illustrated, however it should be noted that there will be additions to these works streams as the programme progresses and areas of work are identified. A number of actions will be developed in each work stream to support the Trusts preparedness, but some initial considerations include: • Assessing the level of awareness in the actions required to prepare for any inspection and ensuring that policies in support of the process are up to date and communicated. • Ensuring there is good project management in place and that there is appropriate engagement of, and reporting to, senior leadership across the Trust (Including Board). • To ensure the development of a Trust narrative that fully reflects the progress that has been made and ensure that this matches the experience of staff, service users and stakeholders. • Provide a transparent assessment of progress against KLOEs and ensure that progress and achievements/successes are properly collated. • Develop an engagement plan with relevant literature for all staff across the Trust. • Raise awareness of CQC insight reports with organisational leaders. • Give consideration to mock inspections of key services aligned to the work of the external advisor.
1.5	**Board Reporting and Governance** Board will note that this work builds on previous activity and work that has already commenced and will be completed early in the New Year (2023). There will be regular reporting to all relevant fora along with ongoing communications and engagement across the trust. The Board will receive progress reports at each of its meetings along with a presentation on completion of the programme. An initial reporting timeline is outlined below: 

3	Conclusion
3.1	The Board are asked to note and receive this report.

Report Author	David McGovern, Director of Corporate Affairs
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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No. 13**
5th October 2022

Title	ICB and Place Update - (CMAST) Joint Working Agreement and Committee in Common
Area Lead	Janelle Holmes, Chief Executive Officer
Author	David McGovern, Director of Corporate Affairs
Report for	Decision

Report Purpose and Recommendations

Prior to and as part of the introduction of the ICS/ICB the Cheshire and Merseyside Acute and Specialist Trust provider alliance has brought Trusts together to establish joint priorities. C&M Trust leaders have been working together to explore collaborative potential, develop ways of working and define priorities over the last year. Through the Leadership Board it had been determined that the arrangements for CMAST will be formalised through a joint working agreement and the establishment of a Committee in Common by each Trust. The Board has continued to be informed of the work of the ICS including CMAST and the emerging governance arrangements.

The Trust has a duty to collaborate and to be part of one or more provider collaboratives. Trust approval of the Joint Working Agreement and Committee in Common TOR is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

The paper is seeking Board approval of the CMAST Joint Working Agreement and Committee in Common Terms of Reference.

It is recommended that the Board:

- Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board.
- Approve the establishment of a Committee in Common with Terms of Reference as proposed.
- Adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals.

Key Risks

BAF Risk 12: Risk that ongoing uncertainty regarding the infrastructure of the Cheshire and Merseyside ICS causes material variability in strategic resourcing and planning, resulting in a change in strategic direction and uncertainty regarding Trust role in PLACE governance arrangements.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
August 2022	Board	ICS and Place Update	Noting

1	Narrative
1.1	**Background** Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance. In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures and now, also require all providers to be part of a collaborative. Furthermore, such a policy imperative is seen as a way to ensure all providers support the delivery of the *triple aim* through: • Aligning priorities, • Supporting establishment of the ICS with the capacity to support population-based decision-making, and • Directing resources to improve service provision. Cheshire & Merseyside Trust leaders have been working together to explore collaborative potential, develop ways of working and defining priorities over the last year. This work has included working with Hill Dickinson (as advisors) and has involved, both, Chief Executives and Chairs. In addition to the triple aim priorities CMAST has identified a number of complimentary, key functions, that the collaborative can and should perform: • Prioritising key programmes for delivery on behalf of the system, and • Creating an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.
1.2	**CMAST Governance Arrangements** Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB it has been proposed, by CMAST members, and is now advocated that CMAST's ways of working should be embedded through a Joint Working Agreement. Such an approach provides a means to document the progress

made, together within Cheshire & Merseyside, and provides an opportunity for Boards to demonstrate a shared commitment to the vision, priorities and programmes of work that they have identified and initiated, both internally and externally.

It is also proposed that CMAST more formally establish its governance to provide a route for shared and formalised decision making as and when required. This decision-making framework aims to underpin existing ways of working and provide a framework to build from, as necessary, to fulfil either the need, potential or ambition of CMAST Boards. The proposed approach is for Trusts to establish a Committee in Common, now enabled through the NHS Health and Care Act 2022.

The full documents are provided as separate attachments, with a summary provided below.

- **Joint Working Agreement**

  The Joint working Agreement:

  - Covers: vision; function; priorities and work programme.
  - Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making.
  - Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach.

- **Committee in Common - Terms of Reference**

  The Terms of reference:

  - Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach.
  - Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance.
  - Sets aims and objectives of Committee in Common.
  - Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement.
  - Confirms the quorum.
  - Annex A establishes potential activities delegated to the Committee in Common when in scope of the work as set in the Joint Working Agreement.

  To note: NWAS is proposed as a participant of the meeting rather than as a Member.

The documentation provides outputs that represent the culmination of a period of engagement and development with Cheshire & Merseyside Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of Cheshire & Merseyside's preferred way of operating.

The document delivers both a foundation and framework for CMAST development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expand, vary or diminish. Examples of decision making have been developed to help Boards understand how the documents will work in practice.

	These examples will be shared through further presentations and reporting to all CMAST boards in future along with regular reporting to Boards on the work of the collaborative.
1.3	**Place Based Governance Arrangements** As well as the work to create structures to support CMAST similar work is ongoing to create governance structures for Wirral place. Key documents are currently being prepared to outline the Place based governance arrangements including Committee structures with TORs and a proposed joint working agreement. These proposals will be presented to Wirral partner boards in December for approval.

3	**Conclusion**
3.1	The Trust has a duty to collaborate and to be part of one or more provider collaboratives. WUTH continues to work collaboratively through CMAST and also a range of well-established networks, in addition to a number of joint posts, services and mutual aid. Trust approval of the Joint Working Agreement and Committee in Common Terms of Reference is an important step in formalising the governance arrangements to enable CMAST to operate effectively.
3.2	The Board is asked to: • Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board. • Approve the establishment of a Committee in Common with Terms of Reference as proposed. • To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals. **Attachments** (a) CMAST Joint Working Agreement. (b) CMAST Leadership Board WUTH Committee in Common Terms of Reference.

Report Author	David McGovern, Director of Corporate Affairs
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Draft No: 1 - 6
Date of Draft: 5 September 2022

Dated 2022

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(3) **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

(4) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(5) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(6) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(7) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(8) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(9) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(10) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(11) **EAST CHESHIRE NHS TRUST**

(12) **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

(13) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

and

(14) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.

2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.

Key functions

2.3 The key functions of CMAST are to:

2.3.1 Deliver the CMAST vision;

2.3.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.3.3 Align priorities across the member Trusts,

2.3.4 Support establishment of ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.3.5 Direct operational resources across Trust members to improve service provision;

2.3.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.3.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.4 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

2.4.1 Reduce health inequalities;

2.4.2 Improve access to services and health outcomes;

2.4.3 Stabilise fragile services;

2.4.4 Improve pathways;

2.4.5 Support the wellbeing of staff and develop more robust workforce plans; and

2.4.6 Achieve financial sustainability.

2.5 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.6 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

2.6.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.6.2 Cancer Alliance delivery and enablement – subject to the request of the Alliance;

2.6.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.6.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.6.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.6.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.6.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, 104 weeks wait delivery; and

2.6.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.7 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will ensure that each CMAST programme should have a Chair sponsor

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement, then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998)

and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential;'

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of CMAST across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and their relevant information officers), this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests

on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;

- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;

- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and

- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the St Helens and Knowsley Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 15 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources, but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust, and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 16 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

CMAST LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the Wirral University Teaching Hospital NHS Foundation Trust CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.5 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport

	And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Wirral University Teaching Hospital NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust of Arrowe Park Road, Upton, Wirral CH49 5PE;
Wirral University Teaching Hospital NHS Foundation Trust CiC	the committee established by Wirral University Teaching Hospital NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The Wirral University Teaching Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the Wirral University Teaching Hospital NHS Foundation Trust CiC

2.1 The aims and objectives of the Wirral University Teaching Hospital NHS Foundation Trust CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The **Wirral** University Teaching Hospital NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to

be known as the Wirral University Teaching Hospital NHS Foundation Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

3.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The Wirral University Teaching Hospital NHS Foundation Trust CiC is a committee of **the** Wirral University Teaching Hospital NHS Foundation Trust's board of directors and therefore can only make decisions binding Wirral University Teaching Hospital NHS Foundation Trust. None of the Trusts other than the Wirral University Teaching Hospital NHS Foundation Trust can be bound by a decision taken by the Wirral University Teaching Hospital NHS Foundation Trust CiC.

3.4 The Wirral University Teaching Hospital NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Wirral University Teaching Hospital NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in the Wirral University Teaching Hospital NHS Foundation Trust's Constitution.

4.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by the Wirral University Teaching Hospital NHS Foundation Trust's Board or Council of Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of the Wirral University Teaching Hospital NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Wirral University Teaching Hospital NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to the Wirral University Teaching

Hospital NHS Foundation Trust's Board for inclusion on the private agenda of the Wirral University Teaching Hospital NHS Foundation Trust's next Board meeting in order that the Wirral University Teaching Hospital NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall send the minutes of the Wirral University Teaching Hospital NHS Foundation Trust CiC meetings to the Wirral University Teaching Hospital NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of the Wirral University Teaching Hospital NHS Foundation Trust's Board meeting.

6.3 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by the Wirral University Teaching Hospital NHS Foundation Trust's Board for inclusion on the agenda of the Wirral University Teaching Hospital NHS Foundation Trust's Board meeting.

7 Membership

7.1 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall be constituted of directors of the Wirral University Teaching Hospital NHS Foundation Trust. Namely the Wirral University Teaching Hospital NHS Foundation Trust's Chief Executive who shall be referred to as a "Member."

7.2 Each Wirral University Teaching Hospital NHS Foundation Trust CiC Member shall nominate a deputy to attend Wirral University Teaching Hospital NHS Foundation Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for the Wirral University Teaching Hospital NHS Foundation Trust's Chief Executive shall be an Executive Director of Wirral University Teaching Hospital NHS Foundation Trust.

7.4 In the absence of the Wirral University Teaching Hospital NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 Attend the Wirral University Teaching Hospital NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of the Wirral University Teaching Hospital NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a Wirral University Teaching Hospital NHS Foundation Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members."

7.5 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC. The Wirral University Teaching Hospital NHS Foundation Trust's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – as set out in the CMAST Agreement under clause 4) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.3 below, the Wirral University Teaching Hospital NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Wirral University Teaching Hospital NHS Foundation Trust CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall be confidential to the Wirral University Teaching Hospital NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Wirral University Teaching Hospital NHS Foundation Trust's Board.

10 Quorum and Voting

10.1 Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC have a responsibility for the operation of the Wirral University Teaching Hospital NHS Foundation Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall have one vote. The Wirral University Teaching Hospital NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in the Wirral University Teaching Hospital NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in the Wirral University Teaching Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Wirral University Teaching Hospital NHS Foundation Trust CiC.

11.2 All Members of the Wirral University Teaching Hospital NHS Foundation Trust CiC shall declare any new interest at the beginning of any Wirral University Teaching Hospital NHS Foundation Trust CiC meeting and at any point during a Wirral University Teaching Hospital NHS Foundation Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 The Wirral University Teaching Hospital NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, the Wirral University Teaching Hospital NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend the Wirral University Teaching Hospital NHS Foundation Trust CiC meetings (in person) and fully participate in all Wirral University Teaching Hospital NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Wirral University Teaching Hospital NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Wirral University Teaching Hospital NHS Foundation Trust CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each Wirral University Teaching Hospital NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Wirral University Teaching Hospital NHS Foundation Trust CiC meeting.

13.2 The agenda for the Wirral University Teaching Hospital NHS Foundation Trust CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to the Wirral University Teaching Hospital NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Wirral University Hospital NHS Foundation Trust CiC meeting with a view to the Wirral University Teaching Hospital NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by the Wirral University Teaching Hospital NHS Foundation Trust's Board). Any proposals discussed at the Wirral University Teaching Hospital NHS Foundation Trust CiC meeting outside of these parameters would come back before the Wirral University Teaching Hospital NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Wirral University Teaching Hospital NHS Foundation Trust CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;

	Decisions delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements;

	Decisions delegated to the Wirral University Teaching Hospital NHS Foundation Trust CiC
	d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: [DATE] 2022

Board of Directors in Public **Item No 14**

05 October 2022

Title	Managing Conflicts of Interest
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

The purpose of this report is to provide a refreshed version of the Managing Conflicts of Interest Policy.

It is recommended that the Board:

- Approves the policy.

Key Risks

This report relates to these key Risks:

- Ensuring robust processes and compliance with probity and transparency requirements.

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
21st September 2022	Audit and Risk Committee	Managing Conflicts of Interest	Approval and information

1	Narrative
1.1	**Conflicts of Interests** The Trust has an obligation to manage conflicts of interest and gifts/hospitality in a transparent way, with safeguards in place around the use of taxpayer funds. This is set out both in guidance from NHS England, and in the Trust's policies. **Managing Conflicts of Interest Policy** A review of this policy now been completed in line with policy review timescales, and the current version is attached. The detail of the policy is largely dictated by the NHS model policy, though some Trust-specific variations are included, such as the enhanced requirement for staff band 7+ to register interests (this contrasts with the guidance which is set at band 8d+.) The Audit and Risk Committee retains the detailed monitoring of this policy and the processes in place to achieve it, and an update on this was taken to the last Committee meeting in September. A standing annual update on this is scheduled for every April, and the Committee will continue to receive updates on compliance with declarations of interests, as well as gifts and hospitality. Board are asked to approve this policy.

2	Implications
2.1	A clear policy and strong processes on managing conflicts of interest are key for the Trust, underpinning the principles of good governance and probity which will form part of the requirements of the well-led review.

3	Conclusion
3.1	The Committee is asked to approve the policy and note the role of the Audit and Risk Committee in monitoring this.

Author	Cate Herbert, Board Secretary
Email	Catherine.herbert5@nhs.net

Wirral University Teaching Hospital NHS Foundation Trust

Policy Reference: 101

MANAGING CONFLICTS OF INTEREST POLICY

Version: 7

Name and Designation of Policy Author(s)	Catherine Herbert, Board Secretary
Ratified By (Committee / Group)	Audit and Risk Committee
Date Ratified	TBC
Date Published	TBC
Review Date	August 2024
Target Audience	All staff
Other Associated Strategies, Policies, Procedures, etc	Trust Policy 115 – Anti-Fraud, Bribery and Corruption Policy & Response Plan Standing Orders Standing Financial Instructions Scheme of Reservation and Delegation

CONTENTS

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1 Introduction

Wirral University Teaching Hospital NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take. The Policy brings together the Trust policies currently in place relating to Conflict and Declaration of Interests; Gifts and Hospitality; and Sponsorship.

As a member of staff, you should:

- Familiarise yourself with this policy and follow it.
- Use your common sense and judgement to consider the interests you have could affect the way taxpayers money is spent
- Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
- NOT misuse your position to further your own interests or those close to you
- NOT be influenced, or give the impression that you have been influenced by outside interests.
- NOT allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money

As an organisation, we will

- Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
- Identify a team or individual with responsibility for:
    - Keeping this policy under review to ensure they are in line with the guidance.
    - Providing advice, training and support for staff on how interests should be managed.
    - Maintaining register(s) of interests
    - Auditing this policy and its associated processes and procedures at least once every three years.
- NOT avoid managing conflicts of interest.
- NOT interpret this policy in a way which stifles collaboration and innovation with our partners

2 Scope

This policy applies to all employees of the Trust. This includes bank and agency staff, honorary staff, non-executive directors, governors, volunteers and contractors.

This policy will help our staff manage conflicts of interest risks effectively.

The policy:

- brings together under one policy the Trust policies relating to Conflict and Declaration of Interests; Gifts and Hospitality; and Sponsorship;
- Introduces consistent principles and rules;
- Provides simple advice about what to do in common situations;
- Supports good judgement about how to approach and manage interests.

This policy should be considered alongside Trust policies:

- Anti-Fraud, Bribery and Corruption Policy & Response Plan
- Freedom of Information Act 2000
- Freedom to Speak Up: Raising Concerns at work policy
- Medicines Management (General) Policy
- WUTH Charity Fundraising and Income Guidance

The policy should also be read in conjunction with the Trust's Corporate Governance Documents and national guidance.

3 Duties & Responsibilities

Board of Directors	The Board of Directors is responsible for ensuring the proper running of the Trust, including proper financial running, and for policies, audit and monitoring arrangements, regulation and control arrangements.
Audit and Risk Committee	The Audit and Risk Committee is one of the most significant means by which the Board of Directors ensures effective internal control arrangements are in place. It also provides a form of independent check upon the executive arm of the Board. The Audit and Risk Committee is responsible for critically auditing/ reviewing the registers contained in this policy to ensure compliance and propriety.
Chief Executive	The Chief Executive is liable to be called to account for specific failures in the Trust`s system of internal controls. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all the Trust`s employees. The Chief Executive must act impartially and honestly in the conduct of their business and should ensure they remain beyond suspicion.
Board Secretary	The Board Secretary will maintain registers contained in this policy which will be made available for inspection by the Audit and Risk Committee and in accordance with the conditions of the policy, to the general public. The Board Secretary must act impartially and honestly in the conduct of their business and should ensure they remain beyond suspicion.

All Employees	All staff acting under the authority of the Trust must act impartially and honestly in the conduct of their business and should ensure they remain beyond suspicion.
All Governors	All governors of the Trust must act impartially and honestly in the conduct of their business and should ensure they remain beyond suspicion. Further specifics on interests which Governors should declare can be found in the Constitution at Annex 7, Section 7.

4 Managing Conflicts of Interest

4.1 Key terms

4.1.1 A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

4.1.1.1 Interests fall into the following categories:

- Financial interests:
  Where an individual may get direct financial benefit (which could be a gain or avoidance of loss) from the consequences of a decision they are involved in making.
- Non-financial professional interests:
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-financial personal interests:
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect interests:
  Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Note: A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

4.1.2 Staff

We use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency/bank staff
- All Governors
- Volunteers acting on behalf of the Trust; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust)

4.1.3 Decision Making Staff

The group(s) of staff that is considered to be 'decision making staff' is listed below for the purpose of this policy and are required to make a declaration of interest:

- Executive and Non-Executive Directors (or equivalent roles)
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Agenda for Change band 7 and above, which includes but is not limited to Matrons, Nurses, Midwives and Management
- All Medical Staff
- Administrative and clinical staff who have the power to enter into contracts on behalf of the Trust
- Administrative and clinical staff involved in decision making concerning the operation of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

4.2 Fraud, Bribery and Corruption

4.2.1 When considering whether a situation constitutes a conflict of interest, or whether to accept gifts/hospitality (regardless of whether the parameters of this policy permit it), staff should give careful consideration to and act in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy & Response Plan.

4.3 Managing and Declaring Interests

4.3.1 Identifying and Declaration interests

4.3.1.1 All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

Declarations should be made:

- On appointment with the Trust.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance ina meeting when interests staff hold are relevant to the matters in discussion).

4.3.1.2 All declarations of interest should be registered through the online WUTH 'Declare' system which is accessible through the staff intranet: Declarations of Interest | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk).

The portal requires all information laid out within guidance to ensure that each declaration complies with requirements.

The policy owner is the Chief Executive with the administrator Director of Corporate Affairs, who manages all aspects of the policy, including any changes to national guidance. All staff are made aware of their duties to record interests at corporate induction, annual appraisal, and internal communication aligned to the year-end declaration processes within the organisation. Advice on any issues to be declared should be sought from line managers and where escalation is required referred to the Director of Corporate Affairs.

An annual report of compliance against this policy will be reported internally to the Executive Team and externally through the Chief Executive Annual Report. Internal Audit will, at least every three years, audit compliance against the policy.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

4.3.2 Proactive review of interests

The Trust will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

4.4 Records and publication

4.4.1 Maintenance

The Trust will maintain a register of interest that will hold all declared interests that are material in nature.

4.4.2 Publication

The Trust will:

- Publish the interests declared by decision making staff.
- Refresh this information annually.
- Make this information available on the Trust's website (via Civica Declare).

Please note that in some cases it might not be appropriate to publish information about the interests of some decision making staff, or their personal information might need to be redacted.

4.4.3 If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Director of

Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

4.5 Wider transparency initiatives

4.5.1 The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

4.5.2 Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative.

These "transfers of value" include payments relating to:

- Speaking at and chairing meetings.
- Training services.
- Advisory board meetings.
- Fees and expenses paid to healthcare professional
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK.
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

4.5.3 Staff are reminded that these must be disclosed as part of Trust declarations.

4.6 Management of interests – general

4.6.1 If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making
- Removing staff from the whole decision making process
- Removing staff responsibility for an entire area of work
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

4.6.2 Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

4.6.3 If staff or managers have any concerns or disputes about the appropriate management action they should contact the Director of Corporate Affairs.

4.7 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

4.7.1 Gifts

4.7.1.1 Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

4.7.1.2 Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6*[1] in total, and need not be declared.

4.7.1.3 Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined. Should the person providing the gift refuse its return, the gift should be accepted on behalf of the Trust Charity as a donation and passed to the Charity Office and recorded as a donation.
- Staff should not ask for any gifts.
- Modest gifts accepted **under a value of £50** do not need to be declared.
- Gifts valued at **over £50** should be treated with caution and only be accepted on behalf of the Trust and not in a personal capacity. These should be declared by staff. If appropriate the gift should be passed to the Charity Office and recorded as a donation for raffle or other such fundraising.
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

4.7.2 Hospitality

4.7.2.1 Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

4.7.2.2 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

4.7.2.3 Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable and management approval has been obtained.

4.7.2.4 Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[2] - may be accepted and must be declared.

[1] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Over a value of £75 - should be refused unless (in exceptional circumstances) manager's approval is given. A clear reason should be recorded on the Trust's register of gifts and hospitality as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

4.7.2.5 Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval of an Executive Director, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's registers as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel)
  - offers of foreign travel and accommodation.

4.7.3 **Outside Employment**

4.7.3.1 Staff should declare any existing outside employment on appointment and any new outside employment when it arises.

This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section)

4.7.3.2 Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.7.3.3 Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the Trust to engage in outside employment.

4.7.3.4 The Trust may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict. *Please refer to your terms and conditions of employment.*

4.7.4 **Shareholdings and other ownership issues**

4.7.4.1 Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business,

[2] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.

4.7.4.2 Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.7.4.3 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

4.7.5 **Patents**

4.7.5.1 Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.

4.7.5.2 Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.

4.7.5.3 Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.7.6 **Loyalty interests**

4.7.6.1 Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that
  can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

4.7.7 **Donations**

4.7.7.1 Donations to the Trust or Charity made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

4.7.7.2 Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.

4.7.7.3 Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own.

4.7.7.4 Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

4.7.7.5 Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

4.7.7.6 Note on declaring donations: The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

4.7.8 **Sponsored events**

4.7.8.1 Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the Trust and the NHS.

4.7.8.2 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation

4.7.8.3 No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

4.7.8.4 At the Trust's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

4.7.8.5 The involvement of a sponsor in an event should always be clearly identified.

4.7.8.6 Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

4.7.8.7 Staff arranging sponsored events must declare this to the Trust. The Trust will maintain records regarding sponsored events in line with the above principles and rules.

4.7.9 **Sponsored research**

4.7.9.1 Funding sources for research purposes must be transparent.

4.7.9.2 Any proposed research must go through the relevant health research authority or other approvals process.

4.7.9.3 There must be a written protocol and written contract between staff, the Trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

4.7.9.4 The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

4.7.9.5 Staff should declare involvement with sponsored research to the Trust. The Trust will retain written records of sponsorship of research, in line with the above principles and rules.

4.7.10 Sponsored posts

4.7.10.1 External sponsorship of a post requires prior approval from the Trust.

4.7.10.2 Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

4.7.10.3 Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which the Trust has the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

4.7.10.4 Sponsored post holders must not promote or favour the sponsor's products, andinformation about alternative products and suppliers should be provided.

4.7.10.5 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

4.7.11 Clinical private practice

4.7.11.1 Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[3] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

4.7.11.2 Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of the Trust before taking up private practice.

[3] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[4]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/

4.7.11.3 Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

4.8 Management of interests – advice in specific contexts

4.8.1 Strategic decision making groups

4.8.1.1 In common with other NHS bodies the Trust uses a variety of different committees and groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

All staff are governed by the principles set out in WUTH Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.8.1.2 The interests of those who are involved in these groups should be well known so that they can be managed effectively. These committee and groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s).
- A non-conflicted member should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

4.8.1.3 If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

[4] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

4.8.1.4 The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

4.8.1.5 Staff declaring interests within decision making groups should have registered such interests in the electronic register of interests via the WUTH Declare system.

4.8.2 **Procurement**

4.8.2.1 Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

4.8.2.2 Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process, and the Procurement Team should be involved at all stages of the process.

4.8.2.3 Guidance of the Trust's Procurement control policy can be found within the Trust Corporate Governance documents and Standard Operating Procedure.

4.9 Dealing with breaches

4.9.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

4.9.2 Identifying and reporting breaches

4.9.2.1 Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should in the first instance report these concerns to the Director of Corporate Affairs or the Trust Counter Fraud Specialist as set out in the Anti-Fraud, Bribery and Corruption Policy & Response Plan.

4.9.2.2 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Freedom to Speak Up: Raising Concerns at work policy that sets out the process for an employee to raise serious concerns where they feel it is in the public interest to do so. The Freedom to Speak Up: Raising Concerns at work policy takes into account responsibilities under the Public Interest Disclosure Act (1998).

4.9.2.3 The Trust will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

4.9.2.4 Following investigation the Trust will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the Trust should be made aware
- Take appropriate action as set out in the next section.

4.10 Taking action in response to breaches

4.10.1 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the Trust and could involve the Trust's leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and auditors.

4.10.2 Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

4.10.3 Inappropriate or ineffective management of interests can have serious implications for the Trust and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

4.10.4 Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the Trust can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

4.11 Learning and transparency concerning breaches

4.11.1 Reports on breaches, the impact of these, and action taken will be considered by Audit and Risk Committee annually.

4.11.2 To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and made available for inspection by the public upon request.

5 References

ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)

6 Equality Analysis

Equality Analysis (EA) Form

Title	Managing Conflicts of Interest Policy			
Agenda Item/Policy Reference	101			
Lead Assessor	Catherine Herbert			
Date Completed	08/09/2022			
What groups have you consulted with? Include details of involvement in the EA process	Staff in area concerned	☐	Staff side colleagues	☐
	Service users	☐	HR	☐
	Other	☐	Other	☐
	Audit and Risk Committee Mersey Internal Audit Agency			
What is being assessed? Please provide a brief description and overview of the aims and objectives				
Managing Conflicts of Interest Policy				
Who will be affected (Staff, patients, wider community?)				
Staff				

The Equality Analysis (EA) form should be completed in the following circumstances:

- **All new policies**
- **All policies subject to renewal**
- **Business cases submitted for approval to hospital management impacting on service users or staff**
- **Papers submitted to hospital management detailing service redesign/reviews impacting on service users or staff**
- **Papers submitted to Board of Directors for approval that have any impact on service users or staff**

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your proposal/document has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed overleaf.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis. For further support with this, please refer to the Library and Knowledge Service accessible via the Trust's intranet site or switchboard.

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Positive: • Advance equality of opportunity • Foster good relations between different groups • Address explicit needs of equality target groups	**Negative:** • Unlawful discrimination, harassment and victimisation • Failure to address explicit needs of equality target groups	**Neutral:** • It is quite acceptable for the assessment to come out as Neutral impact • Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Group	**Any potential impact? Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (inc physical and mental impairments)	**No**	The policy is based guidance on Managing Conflicts of Interest in the NHS (the guidance) came into force from June 2017. It applies to all staff regardless of any protected characteristics.
Age	**No**	
Race (all ethnic groups)	**No**	
Religion or belief	**No**	
Sexual Orientation	**No**	
Pregnancy & Maternity	**No**	
Gender	**No**	
Gender Re-assignment	**No**	
Human Rights	**No**	
Other e.g. Carers	**No**	

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

In all cases - you should submit this document with your paper and / or policy in accordance with the governance structure with copies to wih-tr.EqualityWUTH@nhs.net for monitoring purposes.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

Who and how have you engaged to gather evidence to complete your full analysis? (List)	
Name & Job Title	**Name & Job Title**
What are the main outcomes of your engagement activity?	
What is your overall analysis based on your engagement activity?	

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the risk register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Following completion of the full analysis you should submit this document with your paper and or policy in accordance with the governance structure.

You should also send a copy of this document to wih.tr.equalityWUTH@nhs.net for monitoring purposes.

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Catherine Herbert		This document is embedded within the Policy template
Policy Author Checklist	Catherine Herbert		Checked for workforce / development, medicines, finance or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Current Version Development	Audit and Risk Committee Mersey Internal Audit Agency		
Trust Staff Consultation via Intranet			

Date notice posted in the News Bulletin.	N/A	**Date notice posted on the intranet**	

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
Information will be provided at Trust Corporate Induction The policy will be made available on the staff intranet and a trust-wide email will be sent informing staff that the policy has been approved and is available to view online.	Board Secretary Director of Corporate Affairs L&D – Induction team

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Feb 2008	1	Rod Jones, Director of Finance	New Standards of Business Conduct Policy
Jun 2009	2	Rod Jones, Director of Finance	
July 2012	3	John Vanderwerff, Deputy Director of Finance	Policy review
November 2016	4	Carole Self, Director of Corporate Affairs	To take into account changes in legislation
March 2019	5	Andrea Leather, Trust Secretary	Policy revised in line with national guidance - Conflicts and Declaration of Interest and Gifts Policy & Hospitality Policy combined into one overarching policy. Change of policy name
February 2021	6	Andrea Leather, Trust Secretary	Policy updated to reflect introduction of electronic system for making declarations 'Civica Declare'
August 2022	7	Catherine Herbert, Board Secretary	Policy updated to reflect changes to model policy guidance, to remove detail replicated from the Anti Bribery and Corruption Policy, and to remove appendices no longer required due to Civica Declare portal being implemented.

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All incidents will be investigated in line with this policy.	100%	On occurrence of an event a review of compliance will take place.	Audit and Risk Committee	On an ad hoc basis	Director of Corporate Affairs
The Trust has recorded declarations of interest for all staff required by this policy	100%	Audit of the system.	Audit and Risk Committee	Year end annual report to the Audit and Risk Committee	Board Secretary

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Director of Corporate Affairs and Board Secretary	Audit and Risk Committee	Annually

Safety of Patients and Public

Confirm the content of this policy does **not** risk the safety of patients or the public if it is uploaded to the public facing website	X
*If the content **does** affect the safety of patients or the public* if it is uploaded to the public facing website *please contact the Policy Coordinator or Risk Management Team for advice*	

Board of Directors in Public **Item 15**

05 October 2022

Title	Committee Terms of Reference
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

The purpose of this report is to provide the final Terms of Reference for approval for the Committees that have met during September. These are the People, Estates and Capital, Quality, Audit and Risk, Research and Innovation, and Finance Business Performance Committees.

It is recommended that the Board:

- Approve the Terms of Reference as appended.

Key Risks

This report relates to these key Risks:

- The Trust should ensure that there is robust governance processes and documentation in place to support effective decision making and delivery of objectives.

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
1st December 2021	Board of Directors	Committee Membership and NED Portfolios	Approval of interim arrangements for Champion roles, and approval of Champion role profile.
31st August	Board of Directors	Governance and Committee Membership Update	Terms of Reference were provided for feedback.

7th September 2022	People Committee	Draft Committee Terms of Reference	Terms of Reference approved by the Committee.
21st September 2022	Audit and Risk Committee	Draft Committee Terms of Reference	Terms of Reference approved by the Committee.
30th September 2022	Estates and Capital Committee	Draft Committee Terms of Reference	Terms of Reference taken for approval by the Committee.
30th September 2022	Quality Committee	Draft Committee Terms of Reference	Terms of Reference taken for approval by the Committee.
4th October	Research and Innovation Committee	Draft Committee Terms of Reference	Terms of Reference taken for approval by the Committee.

1	Narrative
1.1	**Terms of Reference** As Board will recall from the 31st August meeting, a full refresh has been undertaken on all terms of reference for Board Assurance Committees. These were provided to the August Board meeting for feedback, and have been subsequently submitted to each of the Committees that have met since. Members should note the following amend which was requested by People Committee and which has been included at 3.4.2: To oversee the development of workforce safeguards. The Board are asked to approve the attached documents for implementation and to note that the final two Terms of Reference for the Remuneration Committee and Charitable Funds Committee will be reviewed during those meetings in October and submitted to the November Board for approval.

2	Implications
2.1	Clear terms of reference will support effective decision making and good governance.

3	Conclusion
3.1	It is recommended that the Board approve the terms of reference for the Committees outlined in the paper.

Author	Cate Herbert, Board Secretary
Email	Catherine.herbert5@nhs.net

Wirral University Teaching Hospital NHS Foundation Trust

People Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: Sepember 2023
Issue Date:
Version: 1.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure effective governance in respect of the delivery of the People Strategy and other workforce-related initiatives, and the strategic monitoring of people-related issues. The Committee will also seek assurance that the Trust has robust systems and processes to deliver a positive working environment to in turn deliver safe and high quality patient care.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To monitor internal workforce performance indicators on behalf of the Board of Directors and report to the Board via the integrated performance report and on an exception basis;

3.1.2 To monitor and review the risks associated with the people agenda, workforce issues, and strategy as set out in the BAF, and recommend any new risks to the Board for inclusion;

3.1.3 To monitor progress on the Internal Audit Report actions that are relevant to workforce – related risks and provide progress updates to Audit Committee.

3.2 Strategy and Policy

3.2.1 To inform the direction and priorities for the development of workforce strategies, including approval of the Trust's People Strategy and monitoring its effectiveness on an ongoing basis.

3.2.2 To review the annual staff survey report against the Trust's People Strategy, monitor progress and outcomes, and advise the Board.

3.2.3 To influence and drive improvements across the integrated workforce agenda, working with our partners across health and social care.

3.3 Regulation

3.3.1 To receive and monitor the implementation of Equality and Delivery statutory delegations under the single Equality Duty (2011). These include annual review of the Equality Delivery system, Equality Duty Assurance Report, Workforce Race Equality Standard (WRES) and other relevant reports. The Committee is to act as the Trust's champion for all workforce-related Equality and Diversity issues.

3.3.2 To receive the annual report from the Freedom to Speak-Up Guardian.

3.3.3 To receive the quarterly reports from the Guardian of Safe Working.

3.4 Workforce

3.4.1 To oversee and monitor the evolution of a positive, forward thinking, people-focused culture in the Trust, including the embedding of just and learning culture principles. This will include consideration of the experiences of our staff and how we engage with them, and will be underpinned by a focus on Trust values.

3.4.2 To oversee the development of workforce safeguards

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non- Executive Directors
- Chief People Officer
- Chief Nurse
- Medical Director
- Chief Operating Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may be attended by:

- Deputy Chief People Officer
- Equality and Diversity Lead
- Assistant Director of OD
- Director of Communications
- Head of HR
- Head of Occupational Health and Wellbeing
- Head of Employment Services
- Governor Representative

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, Executive Directors may not take part in any discussions or decisions which pertain to their own employment or performance.

It will be for the Chair of the Committee to determine whether or not it is appropriate for Directors to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors, and two Executive Directors (or their nominated deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Estates,Capital and Safety Committee Terms of Reference

Document Owner: David McGovern, Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: October 2020
Version: 2.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance with regards to the design, development and delivery of the Trust's capital programmes, and health and safety monitoring and compliance.

This includes the financial and operational delivery of capital programmes and development of future capital and estates plans, within the context of the requisite licence regulatory requirements and statutory obligations. This is a Non-Executive chaired committee.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any reasonable request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources within the delegated limits of the Committees members.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To receive, monitor and seek assurance on risks relating to capital, estates, and estates related safety management, referred in accordance with the Risk Management Strategy
3.1.2 To review the policies and risks associated with estates and capital related to maintenance, health and safety, fire, security, and other related areas.
3.1.3 To receive audit reports and action plans as relate to capital and estates management areas
3.1.4 To agree a set of key performance indicators for the assessment of capital programmes, estates delivery, and health and safety compliance.
3.1.5 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meetings.

3.2 Estates Management

3.2.1 Ratify and review policies required for effective management the estates function andcompliance across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups
3.2.2 Approval of the Campus Master Plans and strategies for estates and capital
3.2.3 To keep under review the land holdings of the Trust, advise the Board on acquisitions and disposals and monitor progress against schemes
3.2.4 To monitor capital delivery against plan

3.3 Health and Safety

3.3.1 Ratify and review policies required for effective management the health and safety across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups
3.3.2 To approve the Trust's Health and Safety plan, recommending it to the Board for final approval
3.3.3 To monitor health and safety reviews to the annual health and safety plan
3.3.4 To consider any findings of major investigations of internal control over safety critical matters, as delegated by the Board or on the Committee's initiative and management's response
3.3.5 To review the effectiveness of the Trust's frameworks for and to provide scrutiny of occupational health and safety compliance, safety outcomes and achievement of KPI's, safety culture and staff experience/ satisfaction in relation to workplace safety, and any compliance disclosure made or to be made by the Board.

3.4 Capital Programme

3.4.1 Review proposed new developments and investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.
3.4.2 Ratify and review policies and procedures required for effective management of capital programme
3.4.3 Receive assurance on all aspects of the delivery of capital programme and significant variances to planned levels of achievement.
3.4.4 To monitor the development of capital commercial opportunities across the Trust
3.4.5 To monitor and review business cases associated with major and minor capital developments, and to approve as necessary those business cases that fall within the capital budget;
3.4.6 To approve and recommend to the Board the strategy for capital works, and to monitor the implementation of the capital strategy and annual capital plan

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Three additional nominated Non-Executive Directors
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Chief Strategy Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may, at the request of the Chair, be attended by:

- Director of Capital Planning, Estates and Facilitites
- Associate Director of Estates (Chief Engineer)
- Director of Corporate Affairs
- Head of Health and Safety

Other officers of the Trust will be invited to attend as requested by the Committee.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors.

The Committee shall meet as needed and at least 4 times per year.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Quality Committee
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: TBC
Version: 1.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to provide assurance in relation to clinical quality and effectiveness, patient safety and patient experience (including complaints); the effectiveness of the quality governance framework; and learning and quality improvement. The Committee shall also provide assurance concerning clinical Health and Safety arrangements which ensure a safe environment for patients.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

- To review the policies and practices that relate to patient safety and experience, clinical health and safety, and quality governance.
- To review and approve the Trust's Quality Strategy, recommending them to the Board for final approval
- To provide scrutiny of the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with fundamental standards of care, and learning effectiveness
- To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis
- To provide to the Board such assurances as it may reasonably require regarding compliance by the Trust with all CQC and other quality regulations or legal obligations to which they are subject. This will include assurance on the outcomes of CQC and other quality related inspections;
- To review the effectiveness of the Trust's frameworks for patient safety, quality governance, and clinical Health and Safety management, including providing scrutiny of risks, operational challenges, resourcing, etc.
- To consider reports following relevant investigations or failures in clinical Health and Safety arrangements and to discuss and agree subsequent ation required to keep residual risk under prudent control
- To monitor and review the BAF, in particular the risks associated with patient safety, quality governance
- To consider any findings of major investigations of internal control over safety critical matters, clinical effectiveness, patient concerns, or clinical health and safety matters
- To consider and review the Trust's compliance with the statutory duty of candour, and to be satisfied that the Trust is being open, honest and effectively engaging and supporting with patient's and relatives who have been victims of moderate or serious harm.
- To be informed of the outcomes of clinical audits and to progress and monitor improvements highlighted by those audits, while acknowledging the role of the Audit Committee in tracking and monitoring the recommendations and risks associated with those recommendations. The Committee may also be informed and/or consulted on the clinical audit work plan for the internal auditors.
- To review the general approach, nature and scope of the clinical audit programme and reporting obligations before the programme commences including, in particular:
    - the nature of any significant unresolved findings or reservations arising from interim reviews,
    - major judgemental areas (including all safety critical policies and procedures used by the Trust, the Trust's Quality Governance Framework, and changes thereto)
    - all alternative treatments to compliance that have been discussed with management together with the potential ramifications of using those alternatives,
    - the nature of any significant adjustments to the Quality Account, compliance with CQC fundamental standards and legal requirements,
    - reclassifications or additional disclosures proposed which are significant or which may in the future become a material concern.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Three Non Executive Directors, one of whom shall be appointed the Chair
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Chief People Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee will generally be attended by:

- Director of Quality & Governance
- Director of Corporate Affairs

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

No officer shall be present for discussions about his/her own remuneration.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least 2 Non Executive Directors and either the Medical Director or Chief Nurse (or their deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to approve the Quality Account.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will report annually on its work in support of the Annual Governance Statement and Quality Account/Report, as laid out in the reporting guidance for the creation of those documents.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Research and Innovation Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Research and Innovation Strategy 2021-2026** **Research Policies and SoPs** **UK Policy Framework for Health and Social Care**

Review Date: 1st April 2022
Issue Date: TBD
Version: 1.0
Authorisation Date: TBD

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of Research and Innovation activity across the Trust.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives and Duties

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 The primary purpose of the Committee is to drive, promote and support both the research and innovation cultures across the Trust and to ensure strong governance in line with relevant frameworks, policies, procedures and guidelines

3.2 The Committee is responsible for developing and fostering a close and meaningful relationship between research activity and clinical practice. To this end, the core purpose of the committee is to create an environment across all parts to the Trust to support excellent clinical delivery, and promote a culture of service innovation and evidence-based practice.

3.3 The Committee will lead decision-making regarding overall responsibility for research including sponsorship, study prioritisation and resolution of barriers to delivery.

The Committee will undertake the following duties:

3.4 **To develop, review and update the strategic direction and business planning for research and innovation by:**

3.4.1 Leading, contributing and supporting the delivery of the Trusts strategic objectives, priorities and ambitions;

3.4.2 Developing and delivering the research and innovation strategy, promoting and establishing collaborative relationships with universities, NHS partners, research and innovation networks and other key stakeholders such as social care and service user and carer groups;

3.4.3 identifying and reviewing changes in legislation and policy or guidance that impacts on the local delivery and management of Research and/or Innovation;

3.4.4 ensuring that service users/carers are involved with research and innovation activities;

3.4.5 monitoring outcomes arising from research and innovation carried out within the Trust and support the integration of findings, outcomes, R&I intelligence into business planning for clinical and corporate divisions;

3.4.6 overseeing, reviewing, and steering research and innovation finance and funding including management of any Research and Innovation fund;

3.4.7 embedding research and innovation at every level of the organisation.

3.5 **To develop and promote NIHR portfolio research by:**

3.5.1 monitoring the Trust's performance against DHSC high level objectives and regional metrics the NIHR high level objectives, including recruitment to portfolio studies;

3.5.2 providing infrastructure to support grant applications primarily for (but not exclusively) NIHR grant applications;

3.5.3 ensuring the communication of key messages regarding the importance of research and innovation as a routine part of clinical practice;

3.5.4 ensuring that a research advice and support service is provided to all Trust staff as required, and contributes to new and innovative ways to support research and research related activity.

3.6 **To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer. Activities include:**

3.6.1 ensuring information is widely available regarding all research undertaken within the Trust;

3.6.2 ensuring that headlines from research, evaluation, and research related activity are regularly publicised, to include early findings, progress and final outcomes;

3.6.3 profiling good practice regarding service improvements based on research findings;
3.6.4 ensuring that the library service resource is fully utilised to enable research application in clinical practice.

3.7 **To oversee and coordinate the activities relating to the development and promotion of innovation within WUTH. These activities will include:**

3.7.1 distributing and maintaining a Trust innovations framework and associated guidance;
3.7.2 developing regular communications to WUTH staff members to ensure they are aware of how to submit ideas and how to apply for innovation funding;
3.7.3 linking with individual staff, teams and/or service areas to generate and prioritise innovative ideas which align to the Trust objectives or which are designed to solve problems which have been identified in our clinical settings;
3.7.4 establishing WUTH as a leading organisation for innovation through a variety of methods e.g. networking, relevant event attendance, hosting of conferences;
3.7.5 identification of potential collaborative partners through external networks.

3.8 **To assure high robust management and governance of research and innovation:**

3.8.1 develop, monitor and regularly review the Trust's Research and Innovation policies and procedures;
3.8.2 ensure that other research-related policies, guidelines and standard operating procedures are developed and ratified as and when necessary;

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- A Non Executive Director (Chair)
- 3 other Non Executive Directors
- Medical Director
- Chief Strategy Officer

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Deputy Medical Director
- Research Leads (TBC)

Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members or attendees are unable to attend, they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least two Non-Executive Directors (including the Chair or Deputy Chair) and one Executive Director.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Finance Business Performance Committee Terms of Reference

Document Owner: David McGovern, Director of Corporate Affairs
Related Documents: **Corporate Governance Manual (including Scheme of Reservation and Delegation and Standing Financial Instructions)**

Review Date: September 2023
Issue Date: October 2017
Version: 4.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance about the Trust's financial and operational performance, delivery of the in-year plans and the development of future plans within the context of the requisite licence regulatory requirements, statutory obligations and Trust strategy..

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individual authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To review any areas of specific risk or assurance highlighted within the Board Assurance Framework, and make recommendations for amendment if required.
3.1.2 Receive assurance on all aspects of the effective outturn delivery of financial, specified operational performance targets and significant variances to planned levels of achievement.
3.1.3 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meeting.

3.2 Financial Management and Assurance

3.2.1 To review the adequacy of the budget setting process and assumptions at Divisional and Corporate Services Level ahead of recommending the financial plan to the Board for approval.
3.2.2 To review the Trust's Financial Plan in accordance with agreed timescales and in line with the Trust's strategic objectives, making appropriate recommendations to the Board of Directors
3.2.3 Consider the robustness of the M12 and year-end out turn ahead of review of the Annual Accounts by the Audit Committee to provide assurance on the reliance of these
3.2.4 To review and recommend business, operational and financial plans to the Board of Directors
3.2.5 To seek assurance of effective due diligence in respect of business cases, approving those within the financial limits delegated and referring those in excess of delegated limits to the Board with recommendations
3.2.6 To consider future options for all non NHS income with specific reference to private patient income and ensure that income derived from activities related to the Trust's principal purpose of the NHS meets the limits as set by national governing bodies
3.2.7 To review, monitor and seek assurance on the achievement of value for money through use of benchmarking data, including reference costs and the work of the model hospital
3.2.8 To monitor and seek assurance on provider to provider and third party contractor SLA's that present a material risk to the organisation.
3.2.9 To review and seek assurance on the development, implementation and clinical engagement in the Service Line Management (SLM) process through Divisional representation.
3.2.10 To seek assurance on the Trust overall cash management position
3.2.11 Review proposed new investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.

3.3 Performance and Improvement

3.3.1 To monitor the operational financial performance and agree, as necessary, corrective action
3.3.2 To instigate investigation into any aspect of performance that gives cause for concern, providing exception reports to the Board of Directors
3.3.3 To monitor and seek assurance on digitalisation agenda and associated action plans as pertains to its financial implications
3.3.4 To monitor and seek assurance on compliance against the procurement strategy
3.3.5 To monitor and seek assurance on compliance with the Agency Cap focussing particularly on recurrent risks and resource utilisation.

3.3.6 To review, monitor and seek assurance on the financial performance of the Trust including, income, expenditure, activity, oversight framework metrics and contract performance ensuring that actions are taken as necessary to remedy adverse variation
3.3.7 To monitor delivery and seek assurance of the CIP
3.3.8 To review and seek assurance on the capital programme and expenditure as required

3.4 Governance

3.4.1 To review and seek assurance on compliance against relevant legislation
3.4.2 To consider and seek assurance on the implementation and compliance of relevant national guidance, including directives from NHSI, CQC, DHSC, and national and local commissioning guidance where these have a new or significant financial impact on the Trust
3.5.3 To approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee
3.5.4 Ratify and review policies required for effective management of financial, performance and business development practice across the Trust

The Committee will promote a holistic approach to managing risk that will encourage all staff to integrate the management of finance into achieving their objectives in order to provide safe, effective, timely and efficient care to patients.

The Committee Chair and Chief Finance Officer will work with the Executive Management Team and Board to integrate clinical, financial and organisational governance and risk management processes and systems.

The Committee will work with other Committees including the Audit Committee to provide assurances required to support the Annual Governance statement.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Two additional nominated Non-Executive Directors
- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Chief Operating Officer
- Chief Strategy Officer

6. Attendance

The following officers will attend the Committee:

- Board Secretary
- Director of Quality & Governance
- Deputy Chief Finance Officer
- Either the Medical Director or Chief Nurse, or their deputy.

Other officers of the trust will be invited to attend as requested by the Committee.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should consider sending a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance they will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be four members, to include two Non Executive Directors, and the Chief Finance Officer (or Nominated Deputy).

The Committee shall meet as needed and at least 4 times annually.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

The committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: October 2022
Version: 1.0
Authorisation Date: TBD

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of annual reporting, strategic risk oversight, and the amendment of governance documents. The Committee will also seek assurance that the Trust has robust systems and controls in place via an internal and external audit programme.

The Committee is a Non-executive Committee of the Board and has no powers other than those specifically delegated in these Terms of Reference.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The role of the Committee will be to take a wide responsibility for the overarching scrutiny for the Trust's risk and assurance structures and processes which affect all aspects of the Trust's business.

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Governance, Risk Management and Internal Control:

3.1.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. This includes reviewing the effectiveness of the organisation's committee structure.

3.1.2 To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.1.3 To review the adequacy of underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.1.4 To review the adequacy of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

3.1.5 To review the adequacy of policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

3.1.6 To review the integrity of the statutory financial statements of the Trust and any formal announcements relating to the Trust's financial performance, reviewing statutory financial reports and judgements contained therein.

3.1.7 To review the adequacy of annual plans / reports from the Local Counter Fraud Specialist and the Local Security Management Specialist.

3.1.8 To satisfy itself that the organisation has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work.

3.1.9 To review on behalf of the Board of Directors the operation of, and proposed changes to the Governance manual including standing financial instructions, scheme of delegation, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

3.1.10 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.2 Internal Audit:

3.2.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit charter, strategy, audit operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work, management's response and progress on the implementation of recommendations;
- ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring adequate independent assurances are provided; and
- annual review of the effectiveness of internal audit.

3.2.3 The Committee will involve the Chief Finance Officer in the selection process of the Internal Auditor.

3.2.4 The internal auditors will have a right of access to the Chair of the Audit and Risk Committee.

3.3 External Audit:

3.3.1 To make a recommendation on behalf of the Committee to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor . To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

3.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

3.3.3 To assess the external auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

3.3.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

3.3.5 To review external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.6 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

3.3.7 To receive a statutory report and opinion on the annual report and accounts.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other assurance functions, both internal and external to the organisation, and consider any governance implications.

3.4.2 These will include, but will not be limited to, any reviews by Department of Health arms length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

3.4.3 In addition, the Committee will work closely with the other Committees and be informed particularly on the work of risk through regular updates from the Risk Management Committee.

3.4.4 The Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function. This includes a review of the clinical audit plan and its effectiveness.

3.4.5 The Committee will review on an annual basis the the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3.5 Annual Accounts Review

3.5.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. At this time the Committee will also receive the Annual Report which summarises the outcome of the external audit. This review will cover but is not limited to:

- The rigour with which the Auditor has undertaken the audit;
- the meaning and significance of the figures, notes and significant changes;
- areas where judgment has been exercised;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements;
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved; and
- letter of representation.

3.5.2 To annually review the accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.5.3 To review the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

3.5.4 The Committee will also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.6 Other

3.6.1 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

3.6.2 To ensure the effective use of the Board Assurance Framework to guide the Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions and reports and assurances sought from Directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

3.6.3 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors

Members will be appointed by the Board from amongst the Non-Executive Directors of the Trust (excluding the Chairman) and at least one member shall have recent and relevant financial experience.

The composition of the Committee should be given in the Trust's Annual Report.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Chief Finance Officer
- Director of Corporate Affairs

Other senior managers will attend when they have papers to present or when the Committee is discussing areas of risk or operation that are the responsibility of that Director/officer.

The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Attendance is also anticipated from Internal and External Auditors and the Local Counter Fraud Specialist.

The Director of Corporate Affairs will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chairman and committee members.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where non-voting members are unable to attend, they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be two members.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

The Internal or External Auditors may request additional meetings if they consider such a meeting necessary.

Both the Internal and External auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Board of Directors in Public **Item 16**

05 October 2022

Title	Review of Standing Financial Instructions
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Jillian Burrows, Assistant Director of Finance – Financial Services
Report for	Ratification

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with an update on the revisions to the Standing Financial Instructions (SFIs) and to seek approval, following ratification at the Audit and Risk Committee on 21 September 2022.

It is recommended that the Board:

- Approve the revised SFIs

Key Risks

This report relates to these key Risks:

- PR3: failure to achieve and/or maintain financial sustainability.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
21 September 2022	Audit and Risk Committee	As above	Ratification

1	Narrative
1.1	**SFI update** Over the last 12 months various minor changes have been made to reference changes such as the EU thresholds transition to the PCR 2015 thresholds. We have recently

	amended the tender waiver process, and this is the most significant change in this version of the SFIs. In addition, there are changes to: • Clarifying the Charity expenditure approval process in the scheme of delegation and financial limit appendices (section 16). • Updating the declaration of interest process (section 18). • Minor text changes. Alongside the review of SFIs the Director of Corporate Affairs and Board Secretary have undertaken a review of the terms of reference of Committees. At this stage the review has not extended to the scheme of delegation, however this will be given further consideration as terms of reference are finalised.

2	**Implications**
2.1	The Trust is required to review and amend its SFIs on a regular basis. The SFIs ensure that expenditure has been committed appropriately, with the correct level of scrutiny and authorisation.

3	**Conclusion**
3.1	The Board of Directors is asked to approve the updated SFIs.

Author	Jillian Burrows, Assistant Director of Finance – Financial Services
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Wirral University Teaching Hospital
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Incorporating Budgetary Control, the Scheme of Delegation and Financial Limits

FOREWORD

1. Within their Terms of Authorisation, NHS foundation trusts are required to demonstrate the existence of comprehensive governance arrangements.

2. The Trust's Board of Directors is required to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to all staff and those representing the Trust. Additionally, the Board has drawn up locally generated rules and instructions, including delegation arrangements and financial procedural notes, for use within the Trust. Collectively these comprehensively cover all aspects of (financial) management and control. They set the business rules which Directors, employees and the Council of Governors (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

3. Standing Financial Instructions (SFIs) are mandatory for all Directors, employees and members of the Council of Governors.

4. **Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other Directors or employees who have been duly authorised to represent them.**

   The job titles are generic, such that Director of Nursing is taken to be the same as the Trust's Chief Nurse, and Director of Finance is taken to be the same as the Trust's Chief Finance Officer.

   This operational delegation is detailed in the Scheme of Delegation (an extract is included in Appendix 1 to these SFIs).

CONTENTS

POLICY REFERENCES

The following policies, available via the Trust's intranet, are specifically referenced.

- Managing Conflicts of Interest Policy (formerly, *Standards of Business Conduct*) Policy reference 101
- Anti-Fraud, Bribery and Corruption Policy and Response Plan Policy reference 115
- Security Policy and Procedure Policy reference 065
- Management of Suppliers and Supplier Representatives Policy Policy reference 105
- Security of Patients' Cash & Valuables Policy reference 026
- Adult Death Administration Policy and Procedure Policy reference 032
- Condemning and Disposal of Scrap and Surplus Equipment Policy reference 024
- Innovation & Intellectual Property Rights Policy reference 129
- Freedom to Speak Up: Raising Concerns at Work Policy reference 174
- Information Governance Policy Policy reference 095
- Travel and Associated Expenses Policy Policy reference 214
- Budget Virement Policy *Finance policy*
- The Charity's Expenditure Guidance and Fundraising and Income Guidance policy documents.

In cases where a policy and the Standing Financial Instructions (SFIs) do not agree, the SFIs are presumed to take precedence.

The Trust's Constitution and Standing Orders, and the Schedule of Matters Reserved to the Board are also referenced**.**

FURTHER SUPPORT

Associated documents and support materials can be found on the staff website.

https://www.wuth.nhs.uk/your-wuth/finance-and-procurement/procurement/standing-financial-instructions/

https://www.wuth.nhs.uk/about-us/governance/

In particular, ***Key messages – informal guide to the SFIs for budget holders*** covers high-level messages and outlines how to seek further help.

SFIs sessions are offered to budget holders on an annual cycle.

Please send feedback and update suggestions to the Assistant Director of Finance – Financial Services.

INTRODUCTION

1.1 Purpose and scope

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and the Scheme of Delegation (a finance-based extract is included in Appendix 1) which comprise the Scheme of Reservation and Delegation (SoRD) adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with detailed departmental and financial procedure notes which must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance **[del]** must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

1.1.5 **Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance **[del]** as soon as possible.

1.1.7 These Instructions are equally applicable to the Trust's Charity with regards to procurement / non-pay transactions.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the National Health Service Act 2006 ('the NHS Act 2006') and other acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions.

1.2.2 **'Trust'** means **Wirral University Teaching Hospital NHS Foundation Trust.**

1.2.3 '**Accounting Officer'** means the officer responsible to Parliament for the resources under their control. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS Foundation Trust (NHS FT) as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the *NHS foundation trust accounting officer memorandum*.

1.2.4 **'Board of Directors'** or 'Board' means the (non-executive) Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

1.2.5 **'Council of Governors'** is the constitutional body which holds the Non-Executive Directors individually and collectively to account for the performance of the Board, and which represents the public interest.

1.2.6 **'Budget'** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.7 **'Budget holder'** means the Director or employee with delegated authority from the Accounting Officer to manage finances (income and expenditure) for a specific area of the organisation.

1.2.8 **'Chair of the Board (or Trust)', or 'Chair'** is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'the Chair of the Trust' shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.9 **'Chief Executive'** means the Chief Officer (and the Chief Accounting Officer) of the Trust in accordance with the NHS Act 2006 – an Executive Director.

1.2.10 **'Director of Finance'** means the Chief Financial Officer of the Trust – an Executive Director.

1.2.11 **'Executive Director'** means a (voting) member of the Board who is also an officer.

1.2.12 **'Non-Executive Director'** means a (voting) member of the Board of Directors who does not hold an executive office of the Trust.

1.2.13 **'Officer'** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.14 **'Board Secretary'** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and guidance from government / regulatory bodies.

1.2.15 **'Committee'** means a committee or sub-committee created and appointed by the Trust.

1.2.16 **'Committee members'** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.17 **'Charitable funds'** shall mean those funds which the Trust holds for purposes relating to the National Health Service in accordance with the NHS Act 2006. These funds are held on trust by the Corporate Trustee. We refer to the reporting entity comprising these funds as 'the Trust's Charity', 'the Charity' or 'WUTH Charity'.

1.2.18 **'SFIs'** means Standing Financial Instructions (this document).

1.2.19 **'SoRD'** means Scheme of Reservation and Delegation, which outlines the decisions that are reserved to the Board and the Council of Governors, and the authority delegated to Committees and to Trust employees.

1.2.20 **'SOs'** means Standing Orders, which are contained within the Trust's Constitution.

1.2.21 **'Significant transactions'** are defined via NHSI's *Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions,* and are separately and differently defined in the Trust's Constitution. In line NHSI's guidance and the Trust's Constitution, and with regards to both definitions, they are subject to approval by the Council of Governors and/or NHSI.

1.2.22 Wherever the term '**employee'** is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Convention

1.3.1 **Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include differently titled officers of equivalent role, or such other Directors or employees who have been duly authorised to represent them**. **This further operational delegation is detailed in the SoRD (an extract is included in Appendix 1 to these SFIs).**

Where there is further, specific operational delegation, and where necessary or helpful for the reader's understanding of 'who does what', the SFIs will indicate this in the body of the text by

a) explaining the arrangement directly; or

b) indicating further delegation by '[del]', for referencing against Appendix 1.

1.4 Responsibilities and delegation

1.4.1 **The Trust Board** exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within approved allocations / overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) defining specific responsibilities placed on members of the Board and employees as indicated within the SFIs and SoRD.

1.4.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established. These provisions are set out in the Trust's full SoRD, which is issued separately from the SFIs.

1.4.3 **It is a duty of the Chief Executive [del] to ensure that members of the Board, employees, and all new appointees are notified of, and put in a position to understand their responsibilities within, these Instructions.**

1.4.4 **The Chief Executive and Director of Finance** will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within these SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources.

The Chief Executive

- has overall executive responsibility for the Trust's activities;
- is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met;
- must ensure that the Trust delivers efficient and economical conduct of its business in line with the principles set out in HM Treasury's *Managing Public Money*, safeguarding financial propriety and regularity throughout the organisation;

- must ensure that financial considerations are fully taken into account in decisions taken by the Trust; and
- has overall responsibility for the Trust's system of internal control.

1.4.5 In line with the requirements of the NHS Act 2006, the Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standard Contract and Service Conditions on fraud, bribery and corruption including the Bribery Act 2010 requirements.

1.4.6 **The Director of Finance [del]** is responsible for:

a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

1.4.7 Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

a) the provision of financial advice to the Trust, Directors and employees **[del]**;

b) the design, implementation and supervision of systems of internal financial control including suitable policies; and

c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties and to explain the financial position.

1.4.8 **All Directors and employees**, **severally and collectively, are operationally responsible for:**

a) the security of the property of the Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming with the requirements of Standing Orders, the SoRD, SFIs and financial procedures.

1.4.9 The duties outlined under SFI 1.4.8 apply whether

a) any assets in question are gifted, donated, leased or purchased; or

b) any transaction in question is funded by sponsorship, research and development funds, charity funding or other grant or donation, or the Trust.

1.4.10 Section 4 of the Fraud Act 2006 provides that it is an offence for an employee who occupies a position in which they are expected to safeguard or not act against the financial interests of the Trust, to abuse that position to cause a loss or expose the Trust to the risk of loss.

1.4.11 **Any contractor or employee of a contractor** who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive **[del]** to ensure that such persons are made aware of this.

1.4.12 **For any and all Directors and employees who carry out a financial function,** the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

1.5 Nolan principles – principles of conduct in public life

1.5.1

1.5.1 All staff are expected to adopt the **seven overarching Nolan principles** (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) when participating in financial activities and conducting official Trust business, so that appropriate ethical standards can be demonstrated at all times. Ethical standards are explored in more detail in the Trust's *Managing Conflicts of Interest Policy*.

2. AUDIT, ANTI-FRAUD, CORRUPTION, BRIBERY AND SECURITY

2.1 Audit Committee

2.1.1 In accordance with the Constitution, the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, following *The NHS Foundation Trust Code of Governance* and guidance from the *NHS Audit Committee Handbook* and *Governance over audit, assurance and accountability: guidance for foundation trusts*.

2.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 The Audit Committee will review the adequacy of

a) all risk and control-related disclosure statements;

b) the underlying assurance process;

c) the policies for ensuring compliance with relevant regulatory and legal requirements;

d) policies and procedures for all work relating to fraud and corruption; and

e) the Trust's internal controls.

2.1.4 The Audit Committee may also review arrangements by which staff of the Trust may raise concerns about possible improprieties in matters of financial reporting and control, clinical quality or patient safety ('raising concerns'). All such concerns are to be treated in confidence and the Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

2.1.5 Where the Audit Committee considers there is evidence of ultra vires transactions or improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. The matter should be referred to the Director of Finance in the first instance and exceptionally may then need to be referred to NHS England.

2.1.6 It is the responsibility of the Audit Committee to make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor, and to approve the remuneration and terms of engagement of the external auditor.

2.1.7 It is the responsibility of the Audit Committee to ensure an adequate counter-fraud service and internal audit service is provided, and the Audit Committee shall consider the recommendations of the Director of Finance in approving a service provider.

2.1.8 The Audit Committee considers, on behalf of the Board, the operation of, and proposed changes to, the ***Corporate Governance Manual* suite of documents**, which includes the Constitution, these SFIs, the full SoRD and *Managing Conflicts of Interest Policy*.

2.2 Director of Finance

2.2.1 The Director of Finance is operationally responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the applicable audit standards, and all aspects of counter-fraud work;

c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, corruption or bribery; and

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control including, for example, compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of internal audit recommendations;

(iv) progress against plan over the previous year;

(v) a strategic audit plan covering the coming three years; and

(vi) a detailed plan for the next year.

2.2.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require or receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board and Council of Governors or employees of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of the Board or employee's control; and

d) explanations concerning any matter under investigation.

2.3 Role of internal audit

2.3.1 Internal audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the design and operation of financial and other related management controls;

c) the suitability of financial and other related management data; and

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences; or

(ii) poor value for money or other causes, including waste, extravagance, or inefficient administration.

2.3.2 Whenever any internal audit matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property, or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately by the internal auditor.

2.3.3 The Director of Internal Audit (Head of Internal Audit) will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Director of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Director of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.3.5 The Director of Internal Audit will present annually to the Audit Committee the Head of Internal Audit Opinion. This contributes to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the Trust's system of internal control. This Opinion therefore assists in the completion of the Annual Governance Statement within the Trust's Annual Report.

2.3.6 Managers have a duty to take appropriate remedial action, within the agreed and specified timescales, for recommendations specified within audit reports. The Director of Governance and Quality Improvement and the Director of Finance shall identify a formal review process to monitor the extent of compliance with internal audit recommendations. Where appropriate, when remedial action has failed to take place by the manager within a reasonable period, the matter shall be reported to the Audit Committee.

2.4 External audit

2.4.1 *Audit and assurance: a guide to governance for providers and commissioners* - The Trust is expected to comply with this guidance, which addresses external audit engagement, including

a) appointment, re-appointment or removal of the external auditor; and

b) procuring non-audit services by the external auditor.

2.4.2 The external auditor is appointed, re-appointed or removed by the Council of Governors in accordance with paragraph 23(2) of Schedule 7 to the NHS Act 2006.

2.4.3 The Council of Governors' decision to appoint, re-appoint or remove the external auditor is based on recommendations from the Audit Committee which are based on the following.

a) The Audit Committee should annually review and monitor the external auditor's fees, independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

b) The Audit Committee shall oversee the conduct of a market-testing exercise for the appointment of an auditor at least once every five years.

2.4.4 In considering the Audit Committee's recommendations, the Council of Governors should ensure that the audit firm and audit engagement leader have an established and demonstrable standing within the healthcare sector and are able to show a high level of experience and expertise.

2.4.5 The Audit Committee should develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external auditor.

2.4.6 The Council of Governors should receive a report at least annually of non-audit services that have been approved for the auditors to provide under the above-mentioned policy (on the basis of services approved, regardless of whether they have started or finished) and the expected fee for each service.

2.4.7 In accordance with paragraph 2 of Schedule 10 to the NHS Act 2006, the external auditor has a right of access at all reasonable times to every document deemed necessary for the purposes of audit, and the Trust must additionally provide any facilities and information reasonably required by the auditor in the course of their work.

2.4.8 In the event of the external auditor issuing a 'report in the public interest', the report and a proposed Trust response will be made immediately available to the Board and the Council of Governors. The report, with a Board-approved Trust response, will be forwarded to NHS England within 30 days of the report being issued.

2.5 Fraud, corruption and bribery

2.5.1 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust's Chief Executive and Director of Finance **[del]** are responsible for providing an *Anti-Fraud, Bribery and Corruption Policy and Response Plan*, and monitoring and ensuring compliance with the *Government Functional Standard GovS 013: Counter Fraud* as set out in the NHS Standard Contract and Service Conditions.

2.5.2 The Director of Finance shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist (LAFS).

2.5.3 The LAFS shall report to the Director of Finance and shall work with, and notify incidents to, the NHS Counter Fraud Authority in accordance with the *Government Functional Standard GovS 013: Counter Fraud*.

2.5.5 The LAFS will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report will be produced at the end of each financial year.

2.5.5 Any employee or contractor discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud, corruption or bribery, should usually **directly inform the Trust's Local Anti-Fraud Specialist (LAFS)**, or the Director of Finance, and neither of these officers' delegates their role in receiving fraud reports. Other routes for employees reporting fraud are outlined in the Trust's *Fraud, Bribery and Corruption Policy and Response Plan* policy document (SFI 13).

2.5.6 If reports of fraud, corruption or bribery are received under the *Raising Concerns* process, they will be redirected in line with the Instruction above.

2.5.7 Further information on the reporting of losses is offered in SFI 13.

2.6 Security management

2.6.1 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. The Chief Executive **[del]** is responsible for providing the Trust's *Security Policy* and will monitor and ensure compliance with relevant legislation and guidance.

2.6.2 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key operational tasks are delegated to the appointed Local Security Management Specialist (LSMS), to whom staff should refer any suspected security incidents.

2.6.4 Further information on the reporting of losses is offered in SFI 13.

2.7 Money laundering

2.7.1 All employees and contractors are expected to comply with money laundering guidelines, as provided by the National Crime Agency https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/money-laundering-and-terrorist-financing

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and approval of plans and budgets

3.1.1 The Chief Executive will compile and submit to the Board an Operational Plan, which takes into account capacity and demand, and HR, estates and financial targets, within forecast limits of available resources. The Operational Plan will contain:

a) a statement of the significant assumptions on which the Plan is based; and

b) details of major changes in workload, delivery of services, or resources required to achieve the Plan.

The Operational Plan will be submitted to NHS England in line with issued deadlines, guidance and requirements.

3.1.2 Prior to the start of the financial year, the Director of Finance **[del]** will, on behalf of the Chief Executive, prepare and submit financial plans (budgets) for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the Operational Plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds; and

e) identify potential risks.

3.1.3 In accordance with the Health and Social Care Act 2012, the Council of Governors must

a) approve any proposed 'significant transactions' (SFI 1.2.21);

b) decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England; and

c) approve any proposed increase in non–NHS income of 5% or more in any financial year.

3.1.4 The Trust shall submit information in respect of its financial plans to NHS England, once approved by the Board of Directors.

3.1.5 The Director of Finance **[del]** will monitor actual financial performance against plan / budget and report variances and risks to the Board.

3.1.6 All budget holders must provide information as required by the Director of Finance to enable plans / budgets to be compiled.

3.1.7 All budget holders will sign up to their allocated plans / budgets at or before the commencement of each financial year.

3.1.8 The Director of Finance **[del]** has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders, to help them manage their delegated financial performance successfully.

3.2 Budgetary delegation

3.2.1 The Chief Executive **[del]** may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by information about:

a) the value of the delegated budget;

b) the purpose(s) of each budget heading;

c) whole time equivalents (WTEs) in respect of pay budgets;

d) individual and group responsibilities;

e) authority to exercise virement; and

f) planned levels of service.

Budgetary delegation is supported by the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board **[del]**, as captured in the Finance Department's budget virement policy.

3.2.3 Virement between different budget-holders requires the agreement of both parties. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets shall not be used to finance recurring expenditure without approval through the business case process (SFI 7).

3.2.5 Capital budgets cannot be used to finance revenue expenditure and vice-versa.

3.3 Budgetary control and reporting

3.3.1 The Director of Finance **[del]** will devise and maintain systems of budgetary control and reporting. These will include the following.

a) Monthly financial reports to the Board, including:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan; and

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation.

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

c) Investigation and reporting of variances from financial, workload and manpower budgets.

d) Monitoring of management action to address variances.

e) Arrangements for the authorisation of budget transfers.

f) Advice to the Chief Executive and the Board on the consequences and economic and financial impact on future plans and projects of a change in policy, pay awards and other events and trends affecting budgets.

3.3.2 Each budget holder is responsible for ensuring that:

a) they remain within their budget allocation;

b) the amount provided in an approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) they identify and implement cost improvements and income generation initiatives in accordance with the requirements of the approved budget; and

d) recruitment of a fixed term or permanent employee to a post, not covered by funded establishment, must be approved beforehand by following the Trust's current establishment control / recruitment policies, and this process requires approval through the business case process (SFI 7). Approval must be gained prior to engaging services of any and all agency workers.

e)

3.3.3 Any proposal to reduce income or increase revenue spending (that cannot be met from virement) must be approved through the business case process (SFI 7).

3.3.4 The Chief Executive has overall responsibility for identifying and implementing cost improvements and income generation initiatives in accordance with the regulatory requirements for an approved budget.

3.4 Capital expenditure

3.4.1 Capital planning is addressed through SFI 12. The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.5 External monitoring of performance

3.5.1 The Chief Executive **[del]** is responsible for ensuring that the appropriate monitoring returns are submitted to NHS England (or other regulatory body) in line with prevailing guidance and timescales.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 In respect of each financial year, the Chief Executive (as the Trust's Chief Accounting Officer) is responsible for ensuring that the following requirements are met, in line with the *NHS foundation trust accounting officer memorandum.*

a) The Trust must keep accounts and financial records, and prepare annual accounts, in such form as NHS England may, with the approval of HM Treasury, direct.

b) In preparing annual accounts, the Trust must comply with any directions given by the Department of Health and Social Care and NHS England with the approval of HM Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

4.2 The Trust's audited annual accounts must be presented by the Director of Finance to the Board for approval. A copy of the annual accounts, with associated disclosures and supporting schedules, and any report of the external auditor on them, must be sent to NHS England in accordance with issued timetables.

4.3 The external auditor of the Trust's annual accounts must be appointed by the Council of Governors. The Trust's audited annual accounts must be received by the Council of Governors at a public meeting and made available to the public.

4.4 The Trust will publish an Annual Report, including the audited annual accounts and a quality report, and will present it at the public meeting. The document is compiled in line with NHS England's Annual Reporting Manual and is submitted to NHS England and laid before Parliament, in accordance with issued instructions and timetables.

5. BANK AND GBS ACCOUNTS, AND THE SECURITY OF CASH AND CASH EQUIVALENTS

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's and Charitable Funds banking arrangements and for advising the Trust on the provision of banking services and the operation of accounts.

5.1.2 The Board shall approve the Trust's banking arrangements.

5.1.3 The Director of Finance is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

5.1.4 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals / departments. Any employee aware of the existence of such an account shall report the matter immediately to the Director of Finance.

5.1.5 General operational delegation to Financial Services for cash and banking activity is as listed in Appendix 1.

5.2 Bank and GBS accounts

5.2.1 The Director of Finance is responsible for:

a) bank accounts, including Government Banking Service (GBS) accounts;

b) establishing separate bank accounts for the Trust's charitable funds;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

d) reporting to the Board any arrangements for accounts to be overdrawn.

5.3 Banking procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

a) the conditions under which each bank and GBS account is to be operated;

b) the limit to be applied to any overdraft; and

c) those authorised to issue cheques or other orders drawn on the Trust's accounts.

5.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Banking tendering and review

5.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

5.5 Security of cash, cheques and other negotiable instruments

5.5.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) prescribing systems and procedures for handling cash and negotiable securities, including card and contactless payment protocols, on behalf of the Trust; and

e) the prompt banking of all monies received.

5.5.2

5.5.2 **Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, ad hoc temporary banking of employee funds, 'intermediary' bank transfers or temporary loans. Trust accounts must not be credited with any monies unrelated to Trust business and income, except patient monies held in trust.**

5.5.3 Credit cards or payment cards must not be used by employees outside the Finance and Procurement Department for business-as-usual Trust purchasing, as this would bypass Procurement processes and the 'no PO no pay' procedure (SFI 9.2). Trust credit cards / payment cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

5.5.4 The Finance and Procurement Department may use a credit card or payment card in cases where this is the only method of payment available, or where it is proven to be the most efficient payment method.

5.5.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss (see SFI 15).

5.5.6 The opening of incoming post shall be undertaken by one officer. All cash, cheques, postal orders and other forms of payment received shall be entered into an approved form of remittance register.

5.5.7 All cheques issued shall be crossed *'Not Negotiable Account Payee'* or equivalent.

5.5.8 All unused pre-signed cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

5.5.9 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately in accordance with the procedures for losses and special payments. Any significant trends should be reported to the Director of Finance. Where there is prima facie evidence of fraud and corruption it will be necessary to follow the Trust's *Fraud, Bribery and Corruption Policy and Response Plan* (see SFI 13).

6. INCOME - FEES AND CHARGES, AND CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

6.1 Income systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and charges

6.2.1 Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England (principal) must be greater than its income from the provision of goods and services for any other purposes (non-principal).

6.2.2 The Trust shall follow NHS England / NHS England guidance in setting prices for NHS service contracts, where services are not covered by a mandatory National Tariff, in conjunction with the principles set out in the latest version of the Department of Health and Social Care's *NHS Costing Manual.*

6.2.3 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.4 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the Trust's *Managing Conflicts of Interest Policy* must be followed. Only the Chief Executive or Director of Finance can approve commercial sponsorship proposals.

6.2.5 In accordance with the Health and Social Care Act 2012, the Council of Governors must:

a) decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England; and

b) approve any proposed increase in non–NHS income of 5% or more in any financial year.

6.2.6 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate / undertake, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Income contracts – whole-life value equal to or exceeding £2m

6.3.1 The Director of Finance is responsible for negotiating contracts with the Trust's commissioners for the provision of services to patients in accordance with the Operational Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the following will be taken into consideration:

a) costing and pricing of services;

b) payment terms and conditions; and

c) amendments to contracts and extra-contractual arrangements.

6.3.2 For any service for which the National Tariff mandates or specifies a price, the 'national price' modified as permitted under the NHS Standard Contract shall be payable.

6.3.3 Only the Chief Executive and the Director of Finance may sign these contracts.

6.4 Income contracts and service level agreements (SLAs) – whole-life value below £2m

6.4.1 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply of services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, Divisional Directors and corporate managers are responsible for negotiating the contracts on behalf of the Trust, and the responsible contracting officer should ensure that an appropriate SLA/contract is in place and has been signed by both parties.

6.4.2 This contract should incorporate:

a) NHS terms and conditions based on the most relevant and current NHS Contract;

b) a description of the service and indicative activity levels;

c) the term of the agreement including termination arrangements;

d) the value of the agreement, including arrangements for annual review / inflationary uplifts;

e) the operational lead;

f) performance and dispute resolution procedures;

g) risk management and clinical governance arrangements;

h) quality requirements;

i) indication as to who will pay or provide cover for long-term absences such as sickness, maternity and vacancies; and

j) key performance indicators.

6.4.3 Annual uplifts will be applied to each contract and SLA in line with inflation, and any relevant pay or price increases.

6.4.4 These contracts are signed off in accordance with Appendix 2 - *Matrix of Financial Limits.*

6.5 Income contracts - general

6.5.1 Any proposed service changes/developments that have not been incorporated in the revenue plans previously agreed by the Trust Board will require an approved business case before proceeding (SFI 7).

6.5.2 Contracts should minimise risk whilst maximising the Trust's opportunity to generate income.

6.5.3 SLAs/contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

6.5.4 The Director of Finance **[del]** shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

6.5.5 These Instructions apply equally to contract variations.

6.5.6 Copies of signed SLAs/contracts should be retained on file in accordance with the Trust's document retention procedures by the contracting officer and, where the SLA/contract specifies financial information, a copy should be issued to the divisional finance team within Finance.

6.6 Grants

6.6.1 Negotiations and applications for (Trust or Charity (SFI 16.5.3)) grant income which does not fund research and development ('non-clinical grants') must have the approval and sign off of the Director of Finance **[del]**. This ensures that:

a) such applications are subject to professional review and assistance, with the aim of maximising potential revenues;

b) all capital, revenue and accounting consequences are acceptable and recorded correctly;

c) VAT is administered correctly;

d) all grant conditions are reviewed and are agreed to be acceptable, with escalation to managers, Directors, Groups or Committees where appropriate; and

e) the grant (including its conditions) is logged in the Trust's non-clinical grant register, and prime records are archived centrally.

6.6.2 The Trust's Research Department approves, supports and administers research and development ('clinical') grants.

6.7 Income collection and the issuing of credit notes to customers / commissioners

6.7.1 The Director of Finance **[del]** is responsible for the appropriate recovery procedures and action on all outstanding debts.

6.7.2 Employees (other than those in the Trust's Financial Services - Accounts Receivable department) must never create or issue invoices for Trust income to customers.

6.7.3 Employees creating invoices for their own private income must never use Trust branding or otherwise give the impression that their activity is directly related to the Trust.

6.7.4 Employees must never amend or retain inbound cheques. Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash Office is closed.

6.7.5 Income, which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 13.1.9) where appropriate. Overpayments (such as salary overpayments) should be detected (or preferably prevented) and recovery initiated in line with specific Finance policies.

6.7.6 In cases where the Trust has raised an invoice to a customer or commissioner and has found the invoice to be incorrect / overstated, a credit note may be raised for issue, against the original invoice. Credit notes represent a potential loss of Trust income and can only be requested and authorised by the original invoice requestor or their manager. All such transactions are reviewed by the Director of Finance **[del]** prior to transaction.

7. BUSINESS CASE PROCESS

7.1 Rationale

7.1.1 These Instructions outline the business case process that must be followed for all service changes/developments which have either revenue or capital financial implications. The Trust's business case process has been established to ensure that there is full involvement from any party within the Trust that could be affected by new developments. A sound and well-understood process is critical to ensure there are no unforeseen financial or non-financial consequences from the Trust's investment decisions.

7.1.2 Any proposed service changes/developments that have not been incorporated in the revenue plans previously agreed by the Trust Board will require a business case.

7.2 Business case process summary

7.2.1 **The Trust's Business Case Process Pack is available via the Trust's intranet. It contains policy, guidance and templates for the completion of business cases.**

7.2.2 SFI 3.2.3 states that any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive. Therefore, any proposal to do something differently, beyond authorised virement, must also be supported by an approved business case before implementation.

7.2.3 Any item of capital expenditure which is not already **specifically** itemised in the approved capital plan will require a capital bid form (CBF), and capital projects of high value and complexity will need a full business case. Every item or scheme should have been approved through the CBF or business case process at some point prior to procurement.

7.2.4 The business case process does not replace, but rather precedes, the Trust's tendering process, which must be followed when purchasing goods, works or services.

7.2.5 The Chief Executive and the Director of Finance are responsible for approving all lower value business cases as detailed in Appendix 2 - *Matrix of Financial Limits* and are responsible for ensuring that all business cases link to Trust strategy, are technically feasible, contain valid assumptions, detailed and accurate financial information and that the sponsor has liaised with all relevant parties, i.e. internal and external organisations prior to the business case being submitted.

7.2.6 Financial limits applicable to the approval of business cases are detailed in Appendix 2 - *Matrix of Financial Limits.*

7.2.7 All significant leases (annual rents exceeding £100,000) are notified to Board, if not already Board-approved.

7.2.8 Business cases should not assume VAT recovery unless this has been pre-approved by the Director of Finance through a referral to the Financial Accounts team.

7.2.9 Any proposals including leases, rentals, 'managed service contracts' or other service models where the asset is provided 'for free', or which involve the use of a contractor's assets without using the word 'lease', should be pre-approved by the Director of Finance through a referral to the Financial Accounts team. It is possible that such proposals will come under the Trust's capital business case process and be funded by capital budgets.

7.2.10 Any proposals including collaborative working, beyond 'normal' SLA contracts, with other bodies - including joint ventures, joint operations, and other partnerships should be pre-approved by the Director of Finance through a referral to the Financial Accounts team.

7.2.11 All business cases containing elements of capital expenditure, including capital bid forms, are subject to compliance checks and verification of the capital nature of spend is signed off by the Financial Accounts team prior to the formal approval of the business case.

7.2.12 Any business case including expenditure on management consultants is subject to a higher level of approval control, as detailed in Appendix 2 - Matrix of Financial Limits.

7.2.13 Any business case involving 'significant transactions' *(PFI, mergers etc)* or large capital investments / leases must be referred to NHS England or other regulatory body as per prevailing guidelines, including NHSI's *Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions* and *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts* guidance documents. In particular, SFI 8.21 applies to PFI for capital procurement.

7.2.14 In approving business cases, it should be noted that in accordance with the Health and Social Care Act 2012, the Council of Governors must

a) approve any proposed 'significant transactions' (SFI 1.2.21);

b) decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England; and

c) approve any proposed increase in non–NHS income of 5% or more in any financial year.

8. PROCUREMENT - TENDERING AND CONTRACTING PROCEDURE

8.1 General

8.1.1 The procedure for procurement and making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions (except where the suspension of Standing Orders is applied).

8.1.2 The Chief Executive is responsible for ensuring that best value for money is demonstrated for all goods, works and services provided under contract or in-house and shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

8.1.3 Contracts of employment, and agency/temporary staffing arrangements are addressed in SFI 19.

8.1.4 The approval of business cases prior to the procurement process is addressed in SFI 7.

8.1.5 The Director of Finance will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated into these SFIs and the accompanying appendices, and regularly reviewed; and

b) prepare procedural instructions or guidance within these SFIs and appendices on the procurement of goods, works and services incorporating the thresholds.

8.1.6 As a general rule, the procurement sequence for spend over £5,001 (ex VAT), not already covered by existing NHS national or local contracts, is as follows:

a) a need for goods/services is identified.

b) a business case is approved for expenditure outside approved budgets;

c) either competitive quotations or tendering are usually required, depending on value;

d) a quotation / tender is accepted and contracts are approved and signed off;

e) a requisition is entered to the electronic ordering system and approved; and

f) an order is created in Procurement which is issued to the supplier.

b), d) and e) involve staff approvals subject to financial limits, and these are detailed in Appendix 2 - *Matrix of Financial Limits*.

8.1.7 In the absence of an approved business case, the Procurement Department will ensure that the controls and provisions of SFI 7.2 are satisfied during the quotation / tender process.

8.1.8 Purchases must not be disaggregated to avoid financial limits / thresholds.

8.1.9 The limits below refer to the expenditure on a particular category of goods, works or service over a period of time. They should not be interpreted to mean expenditure committed in an individual transaction particularly where there is an ongoing requirement for those goods, works or service

8.1.10 The provisions of these SFIs are applicable in all instances where cumulative spend across a year exceeds or is expected to exceed the limit for quotations or tenders, be that within a category of spend or with a particular supplier.

8.1.11 Where the spend is recurrent (i.e. will occur in more than one year) the limit refers to the total value of spend over a period of three years. The values stated are exclusive of VAT.

Revenue and capital – goods, works and services

Below £5,000	Direct requisition
£5,001 - £30,000	Official quotations
£30,001 – PCR 2015 threshold	Official tender exercise
In excess of PCR2015 threshold	Tender exercise conducted in accordance with regulations set out in PCR2015

8.2 Directives governing public procurement

8.2.1 The Public Contract Regulations 2015 and The Public Procurement (Amendment etc.) (EU Exit) Regulations, Procurement Policy Notes (PPN) and other regulations promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

8.3 Delivering Social Value

8.3.1 The Chief Executive is responsible for ensuring that the Trust takes into account the additional social benefits that can be achieved through the Trust's contracts, and that these benefits are explicitly evaluated where the requirements are related and proportionate to the subject matter of the contract.

Contracts should include measures that support:

a) Fighting climate change and the delivery of the Net Zero Target

b) Tackling Economic Inequality

c) COVID-19 Recovery

d) Equality of Opportunity and

e) Improved Health & Wellbeing

Fighting climate change and the delivery of the Net Zero Target

8.3.2 Where the Trust lets a contract for goods, works or services , that is subject to the Public Contracts Regulations 2015 this should take account of the supplier's Net Zero Carbon Reduction Plan where the annual value of the contract is expected to exceed £5 million p.a (ex Vat) save where the requirement would not be related and proportionate to the contract.

8.4 The Procurement Process - Competitive Quotations

Competitive quotations are required where the intended expenditure or income exceeds, or is reasonably expected to exceed, £5,001 but not exceed £30,000 (**ex VAT).**

a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

b) Quotations should be submitted in writing, via the Trust's electronic sourcing software, to the Procurement Department. In exceptional cases where written quotations are impractical due to urgency, telephone quotations may be obtained by the Procurement Department and only with the approval of the Chief Executive or their nominated officer. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

c) Potential bidders must be provided with sufficient time to prepare and submit their proposal- which should in all cases be a minimum of five working days unless the requirement is of an urgent nature.

d) All quotations should be treated as confidential and must be retained for inspection.

e) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which provides the best value for money. If this is not the lowest compliant quotation (if payment is to be made by the Trust), or not the highest (if payment is to be received by the Trust), then the choice made, and the reasons why should be recorded in a permanent record.

8.3.2

8.4.1 **Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal acceptance and authorisation of a quotation and the awarding of a contract may be decided in line with financial limits set out in Appendix 2 - *Matrix of Financial Limits*.**

8.4.2 The Head of Procurement is authorised to transact a contract approved in accordance with Appendix 2- Matrix of Financial Limits and may sign the Call Off Agreement (or equivalent document) on behalf of the Trust.

8.4.3 Contract and tendering procedures within these SFIs, particularly SFI 8.9 and SFI 8.10, should be applied to quotations as best practice.

8.5 The Procurement Process - Competitive Tenders

8.5.1 Competitive tenders are required where the intended expenditure or income exceeds, or is reasonably expected to exceed £30,001 ex VAT but not exceed the relevant PCR2015 threshold inc VAT.

8.5.2 The Trust shall ensure that competitive tenders are invited for:

a) the supply of goods, materials and manufactured articles;

b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);

c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

d) disposals of Trust property or goods (unless specified in SFI 8.22).

8.5.3 Formal tendering procedures need not be applied where:

a) the estimated expenditure or income does not or is not reasonably expected to exceed £30,001 excluding VAT, however the provisions of SFI 8.3 should be followed.

b) the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

c) the Trust is disposing of Trust assets, as set out in SFI 8.22;

d) the requirement is covered by an existing framework agreement or contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain) (8.8.2 refers to the conditions under which this option can be exercised)

e) where a consortium arrangement is in place and a lead organisation has been appointed to carry out the tendering activity on behalf of the consortium members

8.6 The Procurement Process – Public Contracts Regulations (PCR2015)

8.6.1 A competitive procurement exercise that is fully compliant with the provisions of PCR 2015 is required where the intended expenditure exceeds or is reasonably expected to exceed the PCR 2015 thresholds. The thresholds are reviewed periodically and include Vat.

8.6.2 The Trust shall ensure that PCR2015 compliant procurement exercises are undertaken for:

a) the supply of goods, materials and manufactured articles.

b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);

c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

8.7 Use of Framework Agreements

8.7.1 The Trust may use an established framework in lieu of a quotation o, tender exercise or PCR 2015 compliant procurement exercise where the framework offers the best value for money.

8.7.1 The use of a further competition process between approved suppliers to the framework will be the default procurement route.

8.7.2 The use of the direct award option may only be used in exceptional circumstances and in all cases the reasons should be documented and recorded in an appropriate Trust record.

8.8 Invitations to tender or provide quotation– specifications, fair and adequate competition, and exclusions

8.8.1 Specifications should not be designed with the intention of artificially narrowing competition or creating favour or disadvantage to contractors or sectors and should only be drawn up by Trust staff or an authorised third-party representative.

8.8.2 Contract award criteria will be determined in advance of invitations to quote or tender, will be notified to all bidders, and may not be altered or amended during the procurement process.

8.8.3 Contracts with an estimated value of the PCR 2015 threshold and above will include contract award criteria relating to Social Value. Such criteria will account for not less than 10% of the total qualitative assessment score.

8.8.4 Contracts with an estimated value that exceeds the thresholds set out in PCR2015 will be advertised on the UK Find a Tender Service and then in Contracts Finder

8.8.5 Contracts with an estimated value of £30,000 (ex VAT) and above will be advertised on Contracts Finder in accordance with the provisions of PPN07/21.

8.8.6 Where the value of a contract does not necessitate the publication of an advert in accordance with 8.9.3 or 8.9.4 the Trust shall ensure that invitations to quote are issued to a sufficient number of suppliers to provide fair and adequate competition, and unless not practicable, in no case less than three suppliers, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.8.7 A supplier submitting a tender must satisfy the Trust as to their technical and financial competence.

8.8.8 All invitations to tender for Trust business must include a notice of warning with regard to the consequences of engaging in any corrupt activity involving employees of the Trust. Under the terms of the Public Contracts Regulations 2015 (PCR 2015), potential contractors must be excluded from a procurement procedure if they have been convicted of a common law offence or bribery within the meaning of Sections 1, 2 or 6 of the Bribery Act 2010.

8.8.9 A record shall be kept of tender invitations issued, and all invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

8.9 Receipt, acceptance and safe custody of tenders

8.9.1 No tender will be considered for acceptance unless submitted through the e-tendering system, as instructed within the tender documentation.

8.9.2 Electronic tenders must be issued and managed via the Trust's, or other approved, electronic tendering systems.

8.9.3 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

8.9.4 The Chief Executive or their nominated representative **[del]** will be responsible for the receipt, endorsement and safe custody of tenders received by the Trust until the time appointed for their opening.

8.10 Opening of tenders

8.10.1 All tenders will be managed via an electronic tendering solution. The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. The Trust's verifiers (Appendix 1 – *Scheme of Delegation (extract)*) are authorised to access the electronic tenders and release them once the sealed date and time has passed. A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

8.10.2 Through the electronic tendering system, a record shall be maintained by the Chief Executive, or a person authorised by him/her, to show for each set of competitive tender invitations issued:

(i) the name of all suppliers that have downloaded the tender document or have been invited to tender;

(ii) the names of suppliers from which tenders have been received;

(iii) the date and time at which the tenders were opened;

(iv) the name of the Trust's verifier; and

(v) the price shown on each tender.

8.11 Admissibility of tenders, and late tenders

8.11.1 In considering which tender to accept, if any, the designated officer(s) in the tender evaluation panel, as well as those formally awarding the contract, shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

8.11.2 Incomplete or qualified tenders cannot be considered.

8.11.3 Tenders received after the due time and date but prior to the opening of the other tenders, may be considered only if the Chief Executive or Director of Finance decide that there are exceptional circumstances, in consultation with the Head of Procurement.

8.11.4 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

8.11.5 Any communications with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender. All communication with tenderers must take place within the e-tendering system.

8.11.6 All tenders should be treated as confidential and should be retained for inspection.

8.12 Formal authorisation of tenders

8.12.1 The Most Economically Advantageous Tender (MEAT) shall be accepted by the tender evaluation panel unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that the lowest price does not always represent the best value for money. Other quality factors affecting the success of a project, which are considered under MEAT, include but are not limited to:

(i) technical expertise and experience of the bidding organisation;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach; and

(iv) ability to deliver the goods or service or complete the project on time.

(iii) The extent to which the proposal can satisfy the social values requirements for the contract.

8.12.2 The contract award criteria taken into account in selecting a tender, must be clearly recorded and documented in the contract award recommendation report, and where applicable the reason(s) for not accepting the most economically advantageous tender clearly stated.

8.12.3 Post-tender negotiations on price are strictly prohibited, unless permitted in the choice of procurement process and expressly outlined in the invitation to tender.

8.12.4 Where only one tender/quotation is received, the Chief Executive shall, as far as is practicable, ensure that the price to be paid represents value for money.

8.12.5 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate / price current at the time the contract was awarded, and that best value for money was achieved.

8.12.6 All contracts must be the result of a procurement exercise conducted in line with these SFIs, the Trust's procurement rules, and PCR 2015 (where applicable). All contracts must be the result of fair, open and transparent competition.

8.12.7 A recommendation report for the contract award is compiled by the Procurement Department, on behalf of the tender evaluation panel. The report is forwarded to an officer with adequate financial limits for the award of a contract, or the Board, per Appendix 2 - *Matrix of Financial Limits.*

8.13.8 **Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation of the tender and the awarding of a contract may be decided in line with financial limits set out in Appendix 2 - *Matrix of Financial Limits*.**

8.12.9 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board, this shall be recorded in their minutes.

8.13 Contracts - signatories

8.13.1 Employees of the Trust should under no circumstances sign a contract, unless authorised through the Scheme of Delegation, with financial limits outlined in Appendix 2 - *Matrix of Financial Limits.*

8.13.2 **The Head of Procurement is authorised to sign the contract document, call off or other agreement on behalf of the Trust in order to transact a contract approved in accordance with the Scheme of Delegation**.

8.13.3 Only the Chief Finance Officer can sign credit agreement documents, with the exception of HR salary sacrifice arrangements.

8.14 Expenditure to be within financial limits

8.14.1 No tender or quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust (for example, through budgets and/or the business case approval process (SFI 7)), or which is otherwise not in accordance with these Standing Financial Instructions, except with the authorisation of either the Chief Executive or Director of Finance.

8.15 Items which subsequently breach thresholds after original approval

8.15.1 Purchases estimated to be below the formal tendering threshold set in these Standing Financial Instructions, which subsequently prove to have a value above such limits, shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

8.16 Non–competitive tenders and quotations - waivers

8.16.1 In exceptional instances where competitive tenders and quotations are not deemed possible, Trust officers should seek the approval of the Chief Executive to waive these requirements, delegated to the Director of Finance. The Director of Finance does not further delegate this responsibility.

8.16.2 In all circumstances the request to waive the requirements should be made formally using the Waiver Request Form.

8.16.3 Requests must be made prospectively

8.16.4 No further action may be taken in respect of securing the goods, works or services which are the subject of the request until the appropriate authorisation has been obtained (see 8.17)

8.16.5 The waiving of a competitive tendering or quotation procedure must not be used :

a) to avoid competition

b) for administrative convenience

c) to award further work to a supplier originally appointed through a competitive procedure (except where the provisions of 8.6.2 (v) or (vi) apply).

d) to award further work to a supplier appointed through a previously approved waiver.

8.16.6 Expenditure exceeding the PCR2015 Regulations threshold may only be waived in exceptional circumstances.

8.16.7 Tendering and Quotation procedures may only be waived in the following circumstances:

a) very exceptionally, where the Chief Executive **[del]** decides that a formal tendering or quotation procedure would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are documented and approved. The Trust's Waiver Request form, to be used in all cases;

b) where the timescale genuinely precludes a competitive tendering or quotation procedure - failure to anticipate the requirement or plan for the work properly would not be regarded as a justification for a single tender;

c) where specialist expertise is required and is available from only one source;

d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor(s) for the new task would be inappropriate; or

e) when there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

8.17 Exemptions from the requirement to seek a waiver

8.17.1 A waiver need not be sought in the following instances:

a) Training courses specific to an individual(s) member of staff

b) subscriptions and memberships,

c) conference fees

d) Equipment maintenance or repair where the maintenance or repair is to be carried out by the original Equipment manufacturer (OEM)

e) Equipment maintenance or repair where the supplier is mandated by the OEM

f) Licences -where the license can only be purchased by the manufacturer or developer (in the case of software).

8.18 Authorisation of waivers – general principle

8.18.1 Operationally, only the Chief Executive can authorise the waiver of a competitive tender procedure where the value of the contract will exceed £100k ,

8.18.2 The Chief Finance Officer may authorise the waiver of a competitive tender process where the value of the contract will exceed £30k but is below £100k.

In the absence of the Chief Finance Officer the Deputy Chief Finance Officer is able to approve a waiver up to that value.

8.18.3 The Deputy Chief Finance Officer may authorise the waiver of a competitive quotation process where the value of the contract is below £30k

8.18.4 If the purchase is in the Chief Finance Officer's own area of spend, the Chief Executive must authorise the waiver regardless of value.

8.19 Reporting of Breaches

8.19.1 Where it is decided that a competitive quotation / tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee according to its workplan.

8.20 Tender reports to the Trust Board

8.20.1 Reports to the Board will be made on an exceptional circumstance basis only (for example, high value contracts).

8.21 Compliance requirements for all contracts

8.21.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) the Trust's Standing Orders and Standing Financial Instructions;

b) PCR2015, other statutory provisions and any relevant directions including the Department of Health and Social Care's *Health Building Note 00-08: Estate code*;

c) appropriate NHS guidance regarding the form of contracts with foundation trusts, as set out from time to time by the Trust's commissioners; and

d) such of the NHS Standard Contract Conditions as are applicable.

8.21.2 Where the NHS Standard Contract Conditions cannot be fulfilled, the Trust must only enter into such a contract if it is felt to be materially beneficial and having undertaken a full assessment of the risks associated with proceeding. All such circumstances must be approved by the Board.

8.21.3 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

8.21.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place. A nominated officer shall oversee and manage each contract on behalf of the Trust.

8.21.5 **Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department.**

8.22 Reverse e-auctions

8.22.1 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf. The use of an e-auction will be identified in the procurement strategy for the project.

8.22.2 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

8.23 Healthcare services agreements

8.23.1 The Chief Executive shall nominate officers to commission agreements with healthcare bodies for the supply of healthcare services, which shall be drawn up in accordance with relevant legislation and administered by the Trust.

8.24 Private Finance Initiative (PFI) for capital procurement

8.24.1 The Trust will market-test for PFI funding when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

b) a business case must be referred to the Department of Health and Social Care / NHS England / HM Treasury or other regulatory body as per prevailing guidelines;

c) the proposal must be specifically agreed by the Board of the Trust in the light of such professional advice as should be sought, with particular regard to *vires*; and

d) the selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

e)

8.25 Disposals

8.25.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

a) any assets in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policies of the Trust;

c) items to be disposed of with an estimated sale value of less than £5,000 ex VAT, with this figure to be reviewed on a periodic basis;

d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

e) land or buildings which have been identified as subject to specific Department of Health and Social Care disposal guidance.

8.26 In-house services and benchmarking

8.26.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market-tested by competitive tendering. This will be undertaken adopting a two-stage process. The first stage involves benchmarking.

8.26.2 On the basis of the outcome of the benchmarking exercise, the Board may determine that in-house services should be market tested by competitive tendering. In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Director of Finance. For services having a likely annual expenditure exceeding £1,000,000, a non-officer member should be a member of the evaluation team.

8.26.3 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

8.26.4 The evaluation team shall make recommendations to the Board.

8.26.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.27 Applicability of SFIs on tendering and contracting for the Trust's Charity

8.27.1 These Instructions shall equally apply to expenditure from charitable funds.

8.28 Additional / general instructions

8.28.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance, and the relevant staff must ensure that:

a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in an ongoing liability are notified to the Director of Finance (via the Procurement Department) in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with the Public Contracts Regulations (PCR 2015) and the Trust's own SFIs and procurement procedures;

c) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care / NHS England *(see Matrix of Financial Limits)*;

e) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied (per the Trust's *Innovation & Intellectual Property Rights* policy); and

f) **discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department.**

9 PROCUREMENT – REQUISITIONS, ORDERING AND PAYMENTS (NON-PAY EXPENDITURE)

9.1 Delegation of authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive **[del]** will determine the level of delegation to budget holders.

9.1.2 The Chief Executive **[del]** will set out:

a) the list of officers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

9.2 Requisitioning – 'no PO no pay'

9.2.1 To ensure best value for money, all purchases of non-Pharmacy goods and services must be made utilising the advice and services of the Trust's Procurement Department. Non-Pharmacy requisitions must be raised through the Trust's order processing system (NEP Oracle Cloud).

9.2.2 **The Trust operates a 'no PO no pay' procedure for all purchasing**. The Director of Finance requires that requisitions are raised prior to all purchases or commitments, with the exception of controlled petty cash withdrawals, credit card transactions made by employee cardholders, and other exceptional payments listed in Appendix 3 – *Exceptional Payments.* An exceptional items list is maintained by the Treasury Services Manager. Breaches, including retrospective ordering, will be addressed under the Trust's escalation procedure, and may result in disciplinary action.

9.2.3 The financial limits for budget-holder approval of requisitions for all goods / services are included in Appendix 2 - *Matrix of Financial Limits.*

9.3 Receipting

9.3.1 The Director of Finance requires that staff involved in the requisitioning and receiving of goods ensure that there is a 'receipt' entered to the Trust's order processing system (Oracle). This is because prompt payment cannot be made to a supplier without a 'receipt' being entered.

9.3.2 **'Receipts' should be entered to the Trust's order processing system (Oracle) promptly at the point when the requisitioned goods or services are delivered, but not sooner.**

9.3.3 The only exception to SFI 9.3.2 is for arrangements where there is a contractual commitment to prepay. If this is the case, exceptionally, receipts should be entered in line with *scheduled payments*, and the divisional Finance Business Partner must be notified that this is taking place.

9.4 System of payment and payment verification

9.4.1 Officers must ensure that, in their dealings with suppliers, it is made clear that all payable invoices should be sent directly to the Trust's Financial Services - Accounts Payable team, in line with purchase order instructions. Officers must **immediately** forward any invoices which have been misdirected to their departments / teams to the Accounts Payable team.

9.4.2 Officers must never attempt to amend a supplier invoice or create an invoice in the absence of an official invoice from a supplier.

9.4.3 The Director of Finance shall be responsible for the prompt payment of accounts and claims, subject to employees' accurate requisitioning, prompt receipting (SFI 9.3) and the timely presentation of a supplier invoice to the Accounts Payable team. The payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.4.4 The Director of Finance will:

a) be responsible for the prompt payment of all properly authorised and reconciled accounts and claims;

b) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 9.5 below; and

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following.

(i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iii) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

9.4.5 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Director of Finance shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract. The default position is that 'no PO no pay', and the main provisions of SFI 9, still apply to works payments.

9.5 Prepayments

9.5.1 Prepayments are conventionally acceptable in the following cases:

a) commercial insurance;

b) subscriptions and memberships, and, where mandated, courses/conferences and expenses;

c) media licences;

d) NHSLA payments;

e) certain taxations; and

f) salary sacrifice assets and regular lease cars.

9.5.2 Otherwise, prepayments are only permitted where exceptional circumstances apply, and where the financial advantages are demonstrated (for example, through discounted cash flow calculations) to outweigh the disadvantages, or where this is the only payment method available.

9.5.3 All prepayment proposals must be approved by the Director of Finance in advance of any arrangements / contracts being entered into.

9.5.4 The appropriate authorised staff member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase, including details of the creditworthiness of the proposed supplier. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments.

9.5.5 The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the public procurement rules where the contract is above a stipulated financial threshold).

9.5.6 The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.6 Official purchase orders (POs)

9.6.1 Official purchase orders must:

a) be consecutively numbered;

b) be in a form approved by the Director of Finance;

c) refer to the Trust's terms and conditions of trade; and

d) only be issued by those duly authorised by the Chief Executive.

9.7 Petty cash

9.7.1 Purchases from petty cash are strictly restricted in value per Appendix 2 - *Matrix of Financial Limits,* and by type of purchase in accordance with instructions issued by the Director of Finance **[del].**

9.7.2 Petty cash records are maintained in a form as determined by the Director of Finance **[del].**

9.8 Duties of all staff

9.8.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance, and the relevant staff must ensure that:

a) no requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

b) **all goods, services, or works are ordered through an official purchase order under the 'no PO no pay' process, except for very exceptional payments listed in Appendix 2 - *Matrix of Financial Limits*, and purchases from petty cash;**

c) verbal orders must only be issued in very exceptional circumstances and be accompanied by a purchase order number - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

d) **purchases / requisitions / orders / petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;** and

e) vouchers must not be requisitioned to bypass the direct ordering of goods / services through the Procurement Department.

10 PROCUREMENT – PRINCIPLES AND PROPRIETY

10.1 Conflicts of interest, in the context of procurement

10.1.1 Staff must ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts. Contracts awarded to such businesses must be won in fair competition and the selection process must be conducted impartially.

10.1.2 Staff who are aware of, or who become aware of, a potential conflict of interest during the procurement process that might affect, or be seen by others to affect, impartiality in decision making, must withdraw from the process as soon as the conflict is known and must take no further part in the evaluation of tenders or award of the contract. The Procurement Officer with responsibility for the project should be notified of the potential conflict immediately.

10.1.3 More general guidance and details regarding the requirements of all staff, including the completion of declarations of interest, are covered in the Trust's *Managing Conflicts of Interest Policy* and SFI 18.

10.2 Gifts and hospitality, in the context of procurement

10.2.1 As a general rule, no order or instruction shall be issued, or Trust business transacted, for any goods, works or services to any supplier which has made an offer of material gifts / hospitality to directors or employees. Suppliers must not attempt to influence business decision making by offering hospitality to Trust staff. The frequency and scale of any gifts / hospitality accepted will be managed openly by the Trust.

10.1.1 Gifts / hospitality for the purposes of these SFIs includes travel arrangements, accommodation, research funding and sponsorship, training, expenses, business lunches and gifts (excepting isolated gifts of a trivial character such as pens / diaries / calendars). The definition also includes benefits to relatives and associates. Cash gifts must never be accepted, regardless of value.

10.1.2 If material gifts / hospitality are accepted, and business is subsequently awarded to the supplier in question, then the individuals who are in receipt of said gifts / hospitality should be aware that they may be in breach of the Trust's *Managing Conflicts of Interest Policy* and are also open to allegations of corruption under the Trust's *Fraud, Bribery and Corruption Policy and Response Plan* and the Bribery Act 2010. Staff should contact the Trust's Local Anti-Fraud Specialist for advice if unsure.

10.1.3 **In particular, gifts / hospitality including expenses payments must not be received whilst a tender exercise is being undertaken**, or any other contractual negotiation, unless specifically authorised by the Director of Finance.

10.1.4 **Furthermore, staff are required to formally declare gifts / hospitality,** as the Trust is required through the NHS Standard Contract to keep trust-wide records of gifts / hospitality received. NHS staff found not complying with the requirement to declare gifts / hospitality could be subject to disciplinary action; more serious allegations involving fraud, bribery or corruption will involve criminal investigations and prosecutions where appropriate.

10.1.5 Further information on the ethical requirements of staff in relation to gifts / hospitality in a direct procurement context is available in the Trust's *Management of Suppliers and Supplier Representatives Policy*. More general guidance and details regarding the requirements of all staff, including the completion of declarations, are covered in the Trust's *Managing Conflicts of Interest Policy*.

10.3 Bribery and inducements, including Bribery Act 2010

10.3.1 Under the Bribery Act 2010, it is a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe. The maximum penalty for bribery is 10 years imprisonment, with an unlimited fine.

10.3.2 The Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them.

10.3.3 Irrespective of the legal position, the Trust has the power to terminate the employment of staff if it has reasonable belief that improper behaviour has occurred.

10.3.4 All contractors should be made aware of the Trust's *Raising Concerns* and *Fraud, Bribery and Corruption Policy and Response Plan* policy documents. SFI 8.9 describes Trust warnings to potential contractors.

10.3.5 It is an offence under Section 3 of the Fraud Act 2006 for an employee to fail to disclose information to an employer to make a gain for themselves or another, or to cause a loss or expose the Trust to the risk of loss. Additionally, Section 4 of the Fraud Act 2006 provides that it is also an offence for an employee who occupies a position in which they are expected to safeguard or not act against the financial interests of the Trust, to abuse that position to cause a loss or expose the Trust to the risk of loss.

10.3.6 Reporting of suspected bribery or corruption is addressed in SFI 2.5.

11 STORES, DISTRIBUTION AND RECEIPT OF GOODS

11.1 General position

11.1.1 Stores, defined in terms of controlled stores, distribution centres and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stock take; and

c) valued in line with the Department of Health and Social Care's *Group Accounting Manual* (GAM).

11.2 Control of stores, stocktaking, condemnations and disposal

11.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel, for heating and power, shall be the responsibility of a designated estates manager.

11.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

11.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses.

a) All goods received shall be checked as regards quantity and / or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery / service and signed by the staff member receiving the goods / service.

b) For goods supplied via NHS Supply Chain regional stores, the receiving ward / department shall check receipt against the delivery note ('priced advice note'), with discrepancies notified to the Goods Distribution Centre (GDC), which has the responsibility for notifying discrepancies and returning goods to NHS Supply Chain.

c) Particulars of all goods / services received shall be registered on the day of receipt, with unsatisfactory goods returned by the GDC to the supplier within the set timescales of that supplier.

d) Pharmacy stock shall only be issued / released upon receipt of an authorised internal requisition.

11.2.4 All stock records shall be in such form and shall comply with such systems of control as the Director of Finance may require.

11.2.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

11.2.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

11.2.7 The designated manager / pharmaceutical officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods. SFI 12.4 contains further information about disposals and condemnations.

12 CAPITAL INVESTMENT, FIXED ASSET REGISTERS, SECURITY OF ASSETS AND DISPOSALS AND CONDEMNATIONS

12.1 Capital investment

12.1.1 Consistent with SFI 3.1.2, prior to the start of the financial year, the Director of Finance **[del]** will, on behalf of the Chief Executive, prepare and submit financial plans (budgets) for approval by the Board, and these plans contain capital scheme budgets.

12.1.2 The Chief Executive **[del]**:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans and service strategies;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that capital investment is not undertaken without the confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

12.1.3 For all capital expenditure, the Chief Executive **[del]** shall ensure:

a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs (both financial and non-financial), including consideration of PFI (SFI 8.21);

(ii) the involvement of appropriate Trust personnel and external agencies (SFI 7.2.13);

(iii) appropriate project management and control arrangements;

b) that the business case has been considered by the appropriate Trust officers to ensure accuracy, completeness, project feasibility, and value for money; and

c) that the Director of Finance **[del]** has certified professionally the costs and revenue consequences detailed in the business case.

12.1.4 Capital business cases are approved in line with Appendix 2 - *Matrix of Financial Limits.*

12.1.5 The approval of a capital plan shall not constitute final approval for expenditure on any scheme.

12.1.6 The Chief Executive shall delegate via the setting of financial limits (see Appendix 2 - *Matrix of Financial Limits)* to the manager responsible for any scheme (or their manager, should limits require):

a) specific authority to commit expenditure;

b) authority to proceed to tender; and

c) approval to accept a successful tender.

12.1.7 The Director of Finance **[del]** is responsible for financial monitoring and reporting on all capital scheme expenditure.

12.1.8 The Director of Finance **[del]** shall issue procedures governing the financial management of capital investment projects, including their recognition/valuation for accounting purposes, and any limits, targets or measures issued by the Department of Health and Social Care / NHS England.

12.1.9 Financial limits for all capital approvals (business cases, tender approval and contract sign-off, requisitioning) are included in Appendix 2 - *Matrix of Financial Limits.*

12.1.10 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Department of Health and Social Care's *Health Building Note 00-08: Estatecode*. The default position is that 'no PO no pay', and the main provisions of SFI 9, will still apply.

12.2 Asset registers

12.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

12.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as required by the Department of Health and Social Care's *Group Accounting Manual* and IFRS accounting standards.

12.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records / timesheets for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

12.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, officers must discuss and notify their proposals to the Procurement Department. This activity must be in line with the Trust's *Condemning and Disposal of Scrap and Surplus Equipment* policy. In particular, proformas must be returned to, and approved by, the Director of Finance so that the asset value can be removed from the accounting records, with each disposal validated by reference to authorisation documents and invoices (where appropriate).

12.2.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in the financial ledger against balances on fixed asset registers.

12.2.6 The value of each asset within the asset register shall be impaired / depreciated using methods and rates as specified in the Department of Health and Social Care's *Group Accounting Manual.*

12.2.7 The value of assets comprising the Trust's built estate shall be periodically professionally revalued in line with guidance specified in the Department of Health and Social Care's *Group Accounting Manual,* and the asset register shall be updated accordingly.

12.2.8 As required by Condition 9 (4) of the Trust's Terms of Authorisation, the Trust must make the asset register available for inspection by the public. The Trust may charge a reasonable fee for access to this information.

12.3 Security of assets

12.3.1 The overall control of assets is the responsibility of the Chief Executive.

12.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance **[del]**. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.3.3 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within their service area. All discrepancies revealed by the verification of physical assets to the fixed asset register or other register shall be notified to the Director of Finance.

12.3.4 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

12.3.6 Where practical, assets should be marked as Trust property.

12.4 Disposals and condemnations

12.4.1 The Director of Finance **[del]** must prepare detailed procedures for the disposal of assets (capital or stock) including condemnations and ensure that these are notified to managers.

12.4.2 The Director of Finance **[del]** is responsible for preparing procedures for the discretionary sale of assets.

12.4.3 When it is decided to dispose of a Trust asset, the head of department or deputy will advise the Director of Finance (via Procurement and Financial Services) and must gain prior written consent from the Director of Finance before proceeding.

12.4.4 This consent is granted via the Director of Finance's approval of a Disposal / Condemnation Form (SD12). This form must be pre-approved by a 'condemning officer' - an employee authorised for that purpose by the Director of Finance through the *Condemning and Disposal of Scrap and Surplus Equipment* policy. No arrangement for disposal by any route may be entered into without this prior written authority.

12.4.5 Advice will be given by the Head of Procurement as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

12.4.6 The sale of medical equipment is strictly forbidden unless approved by the Head of Procurement in conjunction with the EBME Manager.

12.4.7 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

12.4.8 Items which have been involved in an incident / accident should not be disposed of until investigations have been concluded.

12.4.9 A signed copy of the SD12 should be kept by the asset manager for departmental reference and used in any subsequent business case to replace the asset. A signed copy must also be sent immediately to both the Head of Procurement and Financial Accounts.

13 LOSSES AND SPECIAL PAYMENTS

13.1.1 The Director of Finance **[del]** must prepare procedural instructions on the recording of, and accounting for, condemnations (impairments), losses, and special payments, with regard to HM Treasury's *Managing Public Money*, and NHS-specific guidance and directions.

13.1.2 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud, corruption or bribery, should usually **directly inform the Trust's LAFS** (SFI 2.5), or the Director of Finance, and neither of these officers' delegates their role in receiving fraud information. Other routes for employees reporting fraud are outlined in the Trust's *Fraud, Bribery and Corruption Policy and Response Plan* policy document.

13.1.3 The Director of Finance / LAFS will report notified frauds to the NHS Counter Fraud Authority and consider notifying the police in accordance with the provisions of the Trust's policy document *Fraud, Bribery and Corruption Policy and Response Plan*.

13.1.4 Any employee discovering or suspecting a loss of any kind, other than invoiced debts, fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance, or inform the Trust's LSMS (SFI 2.6) via the Security Team, who will then inform the Director of Finance and/or Chief Executive.

13.1.5 Where property loss / damage is suspected, including theft or criminal damage (including burglary, arson, and vandalism) to staff / patient / NHS property or equipment, the Chief Executive or Director of Finance must immediately be informed.

13.1.6 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, and other offences may be notified to the police after consideration. Any member of staff seeing or suspecting that a crime is taking place may call the LSMS / Security Team, or the police, in line with the Trust's *Security Policy and Procedure.*

13.1.7 The Director of Finance will

a) immediately report all losses apparently caused by theft, arson, neglect of duty or gross carelessness, unless trivial, to the Board and the external auditor;

b) ensure all verified frauds are notified to the external auditor;

c) refer any novel, contentious or repercussive cases to NHS England / Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury directions; and

d) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS England, who will deal directly with HM Treasury to get the necessary approval.

13.1.8 NHS England and the general public are informed of specific individual losses and special payments which exceed £300,000 via the Annual Report and Accounts process.

13.1.9 Within limits delegated to it by the Department of Health and Social Care, the Board shall approve the writing-off of losses. The Board's delegated limits for the approval of registered losses are set out in Appendix 2 - *Matrix of Financial Limits.*

13.1.10 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations.

13.1.11 The Director of Finance **[del]** will consider financial redress for the recovery of losses and will consider whether any insurance claim can be made.

13.1.12 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care. The Board's delegated limits for the approval of special payments are set out in Appendix 2 - *Matrix of Financial Limits.*

13.1.13 The Director of Finance **[del]** shall maintain a Losses and Special Payments Register, which is completed on an accruals basis.

13.1.14 All registered losses and special payments must be reported to the Audit Committee in accordance with its annual workplan.

14 TREASURY MANAGEMENT – PDC, LOANS AND INVESTMENTS

14.1 Public Dividend Capital (PDC)

14.1.1 In broad terms, PDC represents the level of investment of the Department of Health and Social Care in the Trust to date. In exchange for this, a 'dividend' (PDC dividend) is paid back to the Department. Additional PDC may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

14.1.2 Draw down of additional PDC should be authorised in accordance with the mandate held by the Department of Health and Social Care PDC Team and is subject to approval by the Secretary of State. The Director of Finance and delegated finance officers are the Trust's signatories for the purposes of approving PDC draw downs in accordance with these mandates.

14.1.3 The Trust is required to pay PDC dividend to the Department of Health and Social Care twice a year, at a rate to be determined from time to time (currently 3.5% per annum) by the Secretary of State for Health.

14.1.4 The Director of Finance **[del]** shall calculate and pay PDC dividend charges in line with Department of Health and Social Care guidance.

14.2 Loans

14.2.1 The Director of Finance will advise the Board concerning the Trust's ability to

a) pay financing costs, including dividend on PDC, and interest on loans; and

b) repay principal on loans held;

and will advise the Board on any proposed new loans. The Director of Finance is responsible for reporting periodically to the Board on PDC and all loans and overdrafts, for minimising the use of loans and finance costs, and for monitoring **[del]** the liquidity risk presented by the maturity date of existing facilities.

14.2.2 All PDC and loans for over one month must be approved by the Board in advance of the draw down of principal. This may occur through the approval of the Trust's Plan.

14.2.3 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement for less than one month can be authorised by the Director of Finance, then duly reported to the Board. Any short-term borrowing requirement in excess of one month must be authorised by the Board.

14.2.4 The Director of Finance and delegated finance officers are the Trust's signatories for the purposes of approving the draw-down of all approved loans in accordance with lender mandates.

14.2.5 The Director of Finance must prepare detailed procedural instructions concerning applications for commercial loans and overdrafts.

14.2.6 The Director of Finance **[del]** shall calculate and pay finance costs on borrowings.

14.2.7 For the purposes of these SFIs, the Trust's working capital facility is taken to be a long-term loan, and loans may be from any commercial or non-commercial source

14.3 Investments

14.3.1 The Trust may invest money for the purposes of, or in connection with, its functions. Such investment may include forming, or participating in forming, or otherwise acquiring, membership of bodies corporate or joint arrangements.

14.3.2 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board. Should the Trust find itself in a position to invest, this activity would be controlled through a Board-approved *Treasury Management Policy.* The Director of Finance would prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

14.3.3 The Director of Finance is responsible for advising the Board on investments and would report periodically to the Board concerning the performance of investments held. The Director of Finance is responsible for maximising returns and minimising credit risk.

15 PATIENTS' PROPERTY

15.1 Overview

15.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. The Trust may be held liable for loss or damage to a patient's belongings.

15.1.2 The Chief Executive **[del]** is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and an official receipt book record is obtained.

Such notification is through:

a) notices, displays and information booklets;

b) hospital admission documentation and property records; and

c) the oral advice of administrative and nursing staff responsible for admissions.

15.1.3 The Director of Finance **[del]** must provide detailed written instructions [via the Trust's *Security of Ward-level Cash and Patients' Cash & Property* policy] on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

15.1.4 Due care should be exercised in the management of patients' property / money.

15.1.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, with reference to the Trust's *Security of Ward-level Cash and Patients' Cash & Property* policy.

15.1.6 Within these Instructions, patients' property is taken to mean 'valuables'. In exceptional circumstances, clothing and other non-valuable property may be handed in to the ward for safekeeping, and the ward-level instructions for this are outlined in the *Security of Ward-level Cash and Patients' Cash & Property* policy.

15.2 Receiving and safekeeping of cash and valuables

15.2.1 A *Receipt Book*, in a form determined by the Director of Finance, shall be completed in respect of the following:

a) property handed in for safekeeping by any patient (or guardian as appropriate); and

b) property taken into safe custody having been found in the possession of:

- mentally ill patients;
- confused and/or disoriented patients;
- unconscious patients;
- patients dying in hospital;
- patients found dead on arrival at hospital; or
- patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in this category, including a nil return if no property is taken into safe custody.

15.2.2 The *Receipt Book* shall be completed by a member of ward staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

15.2.3 Property / money handed over for safe keeping shall be placed immediately into the care of a cashier (or deposited in a night safe) except where there are no administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty. Property or money can be held securely (in a safe or equivalent) in a ward or department for up to 8 hours before depositing with cashiers / in the safe. The Emergency Department may hold property / money for up to 48 hours, and these specific processes are detailed in the *Security of Ward-level Cash and Patients' Cash & Property* policy.

15.2.4 Where patients' property / money is received for specific purposes and held for safekeeping, they shall be used only for that purpose, unless any variation is approved by the patient in writing.

15.3 Release of cash and valuables

15.3.1 Release of property / money handed in for safe custody to the patient will be dealt with in accordance with the *Security of Ward-level Cash and Patients' Cash & Property* policy. The return shall be receipted by the patient (or guardian as appropriate). The receipts are then retained by the hospital cashier for audit inspection.

15.4 Deceased patients

15.4.1 In all cases where property / money of a deceased patient has a total value in excess of £5,000 (as required by the Administration of Estates (Small Payments) Act 1965), one of the following documents will be required before the property / money is released.

a) A Grant of Representation / Probate, which shows the claimant to be the executor named in the patient's will.

b) Letters of Administration, which verify that the claimant is the next of kin, when there is no will.

15.4.2 Where the total value of property is £5,000 or less, a Trust 'form of indemnity' shall be completed by the next of kin.

15.4.3 The Trust will only dispose of the property of a deceased patient - as approved by their representative - once the conditions in SFI 15.4.1 or SFI 15.4.2 have been met in relation to verifying the rights of that representative over the assets.

15.4.4 If there is no will and no lawful kin, and the net value of assets *(e.g. total held less Trust-paid funeral expenses)* is above £500, the case is referred to, and the estate is administered by, the Bona Vacantia division (BVD) of the Government Legal Department.

15.4.5 Property unclaimed and below the BVD threshold is retained for six years and then sold / disposed of, with the proceeds credited to the Trust.

15.4.6 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

15.4.7 Further guidance can be found in the Trust's *Adult Death Administration Policy and Procedure*.

16 CHARITABLE FUNDS AND FUNDRAISING

16.1 Creation of charities and fundraising opportunities related to the Trust

16.1.1 **Employees must not be involved in the establishment of any independent charity with objectives in support of the Trust, including its assets, staff, patients and its operations.** All official fundraising opportunities and activities related to the Trust are subject to SFI 16.5.2.

16.1.2 In these Instructions, 'fundraising' is the active seeking of financial support, which could be in the form of cash or other assets.

16.1.3 When performed by Trust staff, even via approved activities, fundraising involving potential suppliers to the Trust may generate a conflict of interest, and SFI 10 and SFI 17 must be followed. There is often little distinction between corporate fundraising, seeking sponsorship and (non-clinical) grant application; in most cases, the Head of Fundraising should be involved to advise and, if within their scope, approve and/or escalate (SFI 16.5).

16.2 The charity framework and the applicability of these SFIs to the Trust's Charity

16.2.1 'Charitable funds', 'the Charity' and 'WUTH Charity' are defined in SFI 1.2.

16.2.2 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and non-pay transactions, as expressed through the Charity's *Expenditure Guidance* policy document.

16.2.3 The Standing Financial Instructions state the **Trust's responsibilities as a Corporate Trustee** for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although management processes may overlap with those of the Trust, all Corporate Trustee responsibilities must be discharged separately, and full recognition must be given to the Corporate Trustee's accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2011.

16.2.4 The discharge of the Trust's Corporate Trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Charitable Funds Committee is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure on behalf of the Corporate Trustee.

16.2.5 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund, which is a registered charity in support of purposes relating to the National Health Service. The funds chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

16.3 Systems and policies

16.3.1 The Director of Finance **[del]** is responsible for the design and implementation of financial systems for the Charity.

16.3.2 The Director of Finance **[del]** must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

16.4 Fund management and expenditure

16.4.1 It is expected that charitable expenditure should be timely, avoiding the unnecessary accumulation of funds. The only exception to this is when fund-holders gain approval from the Charitable Funds Committee to build funds up for a major purchase (not necessarily, but possibly, as the result of an 'appeal' campaign).

16.4.2 The Board of the Corporate Trustee has delegated limits for the approval of expenditure. These are included in Appendix 2 - *Matrix of Financial Limits*.

16.4.3 In the first instance, it is the responsibility of a delegated fund-holder or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

a) the fund's objectives;

b) Charity policies; and

c) patient benefit criteria set out in charity law.

16.4.4 **All charitable expenditure is subject to 'technical approval' by the Director of Finance [del] to ensure it is appropriate and in line with the *Expenditure Guidance* policy.**

16.4.5 Capital charitable expenditure is additionally subject to the same capital approvals as are in place for Trust-funded capital expenditure.

16.4.6 Central 'general fund' projects, strategic and governance expenditure is approved directly by the Charitable Funds Committee.

16.4.7 Under no circumstances shall a fund be allowed to go into deficit.

16.5 Fundraising (for either the Charity or the Trust) and income

16.5.1 No new fund or appeal shall be established without first obtaining the support of the relevant divisional managers and fund-holders, and the written (such as Committee minutes) approval of the Charitable Funds Committee.

16.5.2 No new fundraising activity for the Charity or the Trust (except those 'for the general purposes of the Charity' or any of its official funds, and not undertaken during work-time) shall be undertaken without first obtaining the support of the relevant divisional managers and fund-holders, and then the written approval of the Head of Fundraising, who may refer to the Charitable Funds Committee if the proposal is contentious or significant (SFI 16.1).

16.5.3 No new (non-clinical) grant applications may be made for the Charity or the Trust without first obtaining the support of the relevant divisional managers and fund-holders, and then the written approval of the Head of Fundraising, who may refer to the Charitable Funds Committee if the proposal is contentious or significant (SFI 6.6).

16.5.4 For significant or complex income generation proposals, business cases may be required by the Director of Finance.

16.5.5 **All charitable gifts, donations and fundraising activities are governed by the Charity's *Fundraising and Income Guidance* policy document.**

16.5.6 All charitable proceeds (including cheques) must be handed **as soon as possible** to the Director of Finance **[del** - via an authorised Cash Office], to be banked directly to the Charity's charitable fund bank account. All monies received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new legal trusts.

16.5.7 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a cashier at the next earliest opportunity.

16.5.8 Anyone expressing an interest in making a Charity donation should be advised to make the cheque payable to '*WUTH Charity'*. Under no circumstances should cheques be made payable to individuals, wards or departments, or individual funds.

16.5.9 Neither Trust income (including research income), nor pre-tax personal income, should be deposited into the Charity, as these are not charitable donations.

16.5.10 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest non-cash gifts, and are covered by the Trust's policy on gifts and hospitality, contained within the Trust's *Managing Conflicts of Interest Policy* (SFI 17).

16.5.11 Due to data protection regulations, donor records and correspondence (including copies) must not be kept locally by departments or wards but must be forwarded directly to a Cash Office or the Charity's Head of Fundraising, who is responsible for coordinating all donor correspondence including official *thank-you* letters.

16.5.12 All donated gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Director of Finance **[del]** before accepting gifts of any kind. That is, officers must not make promises / representations to donors about the specific future use of funds, unless referring to the objectives of an existing fund or official appeal.

16.5.13 The Director of Finance **[del]** is responsible for maximising compliant revenues under HMRC's Gift Aid scheme.

16.5.14 The Director of Finance shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Director of Finance **[del]** shall:

a) negotiate the terms and conditions of legacies; and

b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

16.6 Banking and investments

16.6.1 The Director of Finance shall be responsible for ensuring that appropriate banking, investment and reserves arrangements are in place in respect of the charitable funds.

16.6.2 Operational delegation is as per the Charity's Committee-approved *Treasury Management Policy,* in tandem with its *Reserves Policy*.

16.7 Asset management

16.7.1 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure that:

a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

16.8 Charity Commission registration

16.8.1 The Director of Finance **[del]** is responsible for maintaining the Charity's Charity Commission registration.

16.9 Reporting

16.9.1 The Director of Finance **[del]** shall:

a) ensure that regular reports are made to the Charitable Funds Committee with regard to, inter alia, plans / targets, fund balances, investments and reserves, fundraising, income and expenditure, and performance against plans / targets;

b) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Charity;

c) prepare an Annual Report and Accounts in the required manner, which shall be submitted to the Charitable Funds Committee within agreed timescales; and

d) prepare a Trustee's Annual Report and other required returns for the Charity Commission.

17 ACCEPTANCE OF GIFTS BY STAFF

17.1 Gifts / hospitality for the purposes of these SFIs includes cash, travel arrangements, accommodation, research funding and sponsorship, training, expenses, business lunches and gifts (excepting isolated gifts of a trivial character such as pens / diaries / calendars).

17.2 The Chief Executive shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff, which should be adhered to in all dealings with organisations and people outside of the Trust. This policy is contained within the Trust's *Managing Conflicts of Interest Policy*, which includes instructions on the requirement to register any gifts / hospitality received.

17.3 Further instructions pertaining to gifts / hospitality in the context of procurement are included at SFI 10.

17.4 Gifts to staff, including *'thank-yous'*, intended to benefit individual staff members or teams, are not charitable donations to the Trust's Charity. They are personal gifts as per the *Managing Conflicts of Interest Policy*. As such, they should not comprise cash or equivalents (e.g. vouchers) and should be modest.

18 DECLARATION OF INTEREST

18.1 General declarations of interest

18.1.1 It is a requirement that the Chair and all Board Directors and Governors should declare any conflict of interest that may arise in the course of conducting NHS business. All Board members, including members of the Senior Management Team in regular attendance at the Board, are therefore expected to declare any personal or business interests which may influence or may be perceived to influence their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner, or being employed by, a person with such an interest.

18.1.2 It is a requirement that all staff identified within the Trust's *Managing Conflicts of Interest* Policy must declare any conflict of interest that may arise in the course of conducting business.

18.1.3 All employees, regardless of grade, need to declare cases where either they or a close relative or associate has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS body and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply goods, works or services to the Trust. Those interests of spouses, civil partners and cohabiting partners should be regarded as relevant.

18.1.4 All employees should declare such interests either on commencement of employment or on acquisition of the interest, if later.

18.1.5 Further guidance and declaration proformas are available through the Trust's *Managing Conflicts of Interest Policy*.

18.2 Annual declaration of interest exercise for senior managers

18.2.1 An annual declarations of interest exercise will be undertaken, and this is mandatory for all staff who receive a request for information.

18.2.2 The Trust has in place an electronic process which issues notifications to all Trust Board members and senior managers when declarations are due.

18.3 Failure to disclose

18.3.1 If there is any doubt with regard to declaration of interests, these should be discussed with the Board Secretary or the Director of Finance, or in the case of Board members, with the Chair.

18.3.2 All staff should be aware that disciplinary action can be taken in cases where an employee fails to declare a relevant interest, or is found to have abused their official position, or knowledge, for the purposes of self-benefit, or that of family and/or friends. Disciplinary action may lead to dismissal.

18.3.3 This is also an offence under Section 3 of the Fraud Act 2006 - *Fraud by failing to disclose information.*

19 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EMPLOYEES

19.1 Remuneration and terms of service

19.1.1 In accordance with Standing Orders, the Board shall establish a Remuneration and Appointments Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

19.1.2 The Committee's delegated authority from the Board is outlined in the full Scheme of Reservation and Delegation, which is separately available.

19.1.3 The Council of Governors shall decide the remuneration and allowances, and other terms and conditions of office, of the Chair and the other Non-Executive Directors.

19.2 Funded establishment

19.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

19.2.2 Unless already in accordance with an establishment control procedure approved by the Board,

a) the funded establishment of any department may not be varied without the approval of the Chief Executive **[del]**; and

b) all budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

19.3 Staff appointments

19.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Executive **[del];** or

b) unless the changes are within the limit of their approved budget and funded establishment.

19.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

19.4 Processing payroll

19.4.1 The Trust's payroll function is the responsibility of the Chief People Officer, who manages the Trust's Human Resources service. A number of the Trust's financial controls over payroll are the responsibility of the Director of Finance.

19.4.2 The Chief People Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications; and

b) the final determination of pay and allowances.

19.4.3 The Chief People Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment; and

f) authority to release payroll data under the provisions of the Data Protection Act and General Data Protection Regulation.

19.4.4 The Director of Finance will issue instructions regarding:

a) making payment on agreed dates and the methods of payment available various categories of employees;

b) payment by cheque or bank credit to employees and officers;

c) the recall of cheques, and bank credits;

d) pay 'advances' (SFI 19.5);

e) maintenance and reconciliation of pay control accounts;

f) segregation of duties in preparing records and handling cash; and

g) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust, by agreement with the Chief People Officer.

19.4.5 Appropriately nominated managers (Appendix 1 – *Scheme of Delegation (extract)*) have delegated responsibility for:

a) submitting new starter / hire notifications, time records and other notifications in accordance with agreed timetables, and in the form prescribed by the Chief People Officer, in accordance with the Chief People Officer's instructions; and

b) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief People Officer and Director of Finance must be informed immediately.

19.4.6 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

19.5 Advances and loans

19.5.1 'Advances' of pay may only be given to staff to ensure timely remuneration of pay earned, or reimbursement of legitimate expenses incurred, *in advance of normal pay processing*, in cases where payroll deadlines have been missed. They are not intended to provide payment to staff in advance of work completed.

19.5.2 'Advances' are considered to be exceptional transactions and may only be paid to staff on the approval of an appropriate operational ('hiring') manager and after review by the Payroll Department and by Financial Services.

19.5.3 It is the responsibility of all hiring managers to complete the payroll 'new starter' process in a timely manner (SFI 19.4.5). The Director of Finance may consider disciplinary action against hiring managers or departments generating repeated 'advances' requests.

19.5.4 Loans may not be made to staff even if secured against potential future earnings.

19.6 Transaction and reimbursement of travel expenses and related costs

19.6.1 Expenses must be transacted / reimbursed as follows.

a) Air and rail travel must be requisitioned **in advance**, via the Trust's business travel contractor.

b) Accommodation must be requisitioned **in advance**, via the Trust's business travel contractor.

c) Course or conference-related costs should be requisitioned **in advance**, through the Trust's order processing system (Oracle).

d) Mileage and ad hoc fees (e.g. parking charges) must in all cases be claimed through payroll expenses, once incurred.

19.6.2 Any cancellations or alterations to travel plans through the Trust's business travel contractor must be notified immediately to the Procurement Department.

19.6.3 The Trust's credit card will not generally be available for travel expenses and related costs, without evidence that there is no other payment method available, and that this is not due to avoidable booking delays.

19.6.4 If there is a failure to procure in advance, such that SFIs 19.6.1 a), b) or c) are breached, then the default position for discretionary reimbursement is that the expenses should be reimbursed via payroll. Under no circumstances will reimbursement occur by personal cheque. The Director of Finance should be notified of such breaches and may consider disciplinary action.

19.6.5 There must be no reimbursement for Trust purchases (operational goods and services) via payroll.

19.6.6 Any reimbursement of expenses incurred, or similar personal subsidy, must be referred to the Payroll Department for payment and/or assessment as to whether additional taxes are due.

19.6.7 An employee may not be the sole approver of their own travel, course or conference arrangements or the reimbursement of any associated costs or expenses.

19.6.8 The Trust will not reimburse visitors (such as guest speakers) or contractors / agency workers for travel or incidental expenses, other than in the following cases.

a) If the individual is assessed as within the scope of IR35 (SFI 19.10), then SFI 19.6.1 applies.

b) If the individual is assessed as outside the scope of IR35, then payment can be made as follows.

- If the costs are implicitly included within contract charges, they can be paid (subject to VAT) through a company's payable invoice.
- If there is no invoicing company (such as in the case of visiting speakers), then Treasury Services can *exceptionally* make direct payments to an individual on receipt of evidence of their HMRC UTR number and associated documents.

19.6.9 The Trust's *Travel and Associated Expenses Policy* applies.

19.6.10 SFI 19.6 applies to all expense's transactions, whether funded by sponsorship, research and development funds, charity funding or other grant, or the Trust, in line with SFI 1.4.9.

19.7 Training costs

19.7.1 Contracts, agreements and local policies which refer to training must outline each employee's obligation to pay back training costs incurred by the Trust, in the event that the employee leaves the Trust's employment within a specified period.

19.8 Contracts of employment

19.8.1 The Board shall delegate responsibility to the Chief People Officer for:

a) ensuring that all employees are issued with a contract of employment in a form approved by the Board, and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

19.9 Salary sacrifice

19.9.1 The Chief Executive **[del]** is responsible for all legal arrangements relating to salary sacrifice agreements, including checks on applicants' eligibility, scheme governance, and HMRC compliance.

19.10 Agency and bank staff and off-payroll engagements / IR35 engagements

19.10.1 All employees are responsible for ensuring that the engagement of temporary workers is in line with Trust policy, that workers are engaged through the Trust's contracts and that all engagements are fully compliant with NHS England's Agency Rules.

19.10.2 All employees are responsible for ensuring that accurate information about the engagement is supplied to:

a) the Trust's Human Resources team for the purposes of assessing IR35 status; and

b) the Finance and Procurement Department for the purposes of ensuring correct financial reporting, compliance and VAT recovery.

19.10.3 The Chief Executive **[del]** will be responsible for maintaining up-to-date procedures, to ensure that

c) the correct tax and NI contributions are being paid to HMRC for engagements which fall under IR35 'intermediaries' legislation'; and

d) assurance is obtained regarding taxation arrangements from off-payroll engagements which fall outside the scope of IR35.

19.10.4 Any 'non-IR35' assessed engagements, wishing to be paid as a supplier but invoicing as an individual, must provide the Trust with information regarding their tax arrangements, such as HMRC UTR number, sufficient for the Trust to satisfy itself that their arrangements are in order, prior to payment by the Accounts Payable team.

19.10.5 **No employee may engage bank or agency staff unless authorised to do so. The approval arrangements for such staff are subject to frequent change, and therefore they are not captured in the Scheme of Delegation. Staff must consult the latest guidance and policies to ensure compliance.**

20 INFORMATION TECHNOLOGY AND GOVERNANCE

20.1 Responsibilities and duties of the Director of Finance

20.1.1 The Director of Finance **[del]**, who is responsible for the accuracy and security of the computerised **financial** data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Director of Finance is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 (DPA 2018), the EU General Data Protection Regulation (GDPR);

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary are being carried out.

20.1.2 The Director of Finance **[del]** shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

20.2 Contracts for computer services with other bodies

20.2.1 In the case of computerised financial systems which are proposed to be 'general applications' (i.e. applications which the majority of trusts in the region wish to sponsor jointly), all responsible directors and employees will send to the Director of Finance:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

c) support arrangements for the system including business continuity and disaster recovery plans.

20.2.2 The Director of Finance **[del]** shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

20.2.3 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance **[del]** shall periodically seek assurances that adequate controls are in operation.

20.3 Risk assessment

20.3.1 The Director of Finance **[del]** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

20.4 Requirements for computer systems, which have an impact on corporate financial systems

20.4.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

a) systems acquisition, development and maintenance are in line with corporate policies;

b) data produced for use by/from financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) only appropriate staff have access to such data; and

d) computer audit reviews are carried out, as considered necessary.

20.5 Information governance in the context of financial systems

20.5.1 Employees must be familiar with the Trust's *Information Governance Policy*, with particular regard to the data held in financial systems, and its use and release.

20.5.2 The requirements of DPA 2018, GDPR, the Freedom of Information Act 2000 and NHS Digital's *Code of Practice on Confidential Information* must be achieved.

20.5.3 The Chief Executive is responsible for maintaining archives for all records required to be retained in accordance with *Records Management Code of Practice for Health and Social Care (2016)*, which has been published by the Information Governance Alliance (IGA) for the Department of Health and Social Care. It covers all media, including electronic and scanned documentation as well as hard-copy documents.

20.5.4 The records held in archives shall be capable of retrieval by authorised persons.

20.5.5 Records shall only be destroyed in accordance with the *Records Management Code of Practice for Health and Social Care (2016)*, and a record shall be maintained of those records so destroyed, together with the date of their destruction.

21 RISK MANAGEMENT - INSURANCE

21.1 Programme of risk management

21.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which must be approved and monitored by the Board.

21.1.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) promotion among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including internal audit, clinical audit, and health and safety review;

f) a clear indication of which risks shall be insured; and

g) arrangements to review the risk management programme.

21.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to compile an Annual Governance Statement within the Annual Report and Accounts as required by NHS England's Annual Reporting Manual.

21.1.4 The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some, or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme, then this decision shall be reviewed annually.

21.1.5 The Director of Finance shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care / NHS England guidance. This will comprise NHS Resolution cover, and in some instances, commercial insurance. There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

c) pressure vessels such as boilers and other associated risks;

d) directors and officer's liability insurance;

e) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution; and

f) in any other case where the Trust has decided to insure through the risk pooling schemes administered by NHS Resolution, where the Trust does not consider the insurance cover provided under those risk pooling schemes to be appropriate and/or sufficient to cover the Trust's potential risks and liabilities arising from its activities.

21.1.6 All commercial insurance policies are to be approved by the Director of Finance, as advised by the Department of Health and Social Care / NHS England.

21.2 Arrangements to be followed by the Board in agreeing insurance cover

21.2.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

21.2.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

21.2.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'excess' / 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the excess / deductible in each case.

Wirral University Teaching Hospital
NHS Foundation Trust

Appendix 1 – Scheme of Delegation

This document summarises authority delegated by the Board to Trust employees, in the context of Finance

This is an extract from the Trust's full Scheme of Delegation, specifically covering matters addressed within the Standing Financial Instructions

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
1. Corporate Governance Manual – Standing Orders / Standing Financial Instructions			
a) Final authority in interpretation of Standing Orders	Chair, advised by Chief Executive and Director of Finance	Chair, advised by Chief Executive and Director of Finance	Constitution - Standing Orders
b) Notifying directors, employees and contractors of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand their responsibilities	Chief Executive	All directors and employees (particularly, relevant line managers)	SFI 1.4.3 / 1.4.11
c) Ensuring security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, SFIs and financial procedures	Chief Executive	All directors and employees	SFI 1.4.8
d) Suspension of Standing Orders	Board of Directors	Board of Directors	Constitution - Standing Orders
e) Reviewing suspension of Standing Orders	Audit Committee	Audit Committee	Constitution - Standing Orders
f) Variation or amendment to Standing Orders	Board of Directors	Board of Directors	Constitution - Standing Orders
g) Emergency powers relating to the authorities retained by the Board of Directors. *(The exercise of emergency powers must be reported to next Board meeting for ratification)*	Chair and Chief Executive, with two Non-Executives	Chair and Chief Executive, with two Non-Executives	Constitution - Standing Orders
h) Disclosure of non-compliance with Standing Orders	Chief Executive / Director of Finance (report to the Board of Directors)	All staff (disclose to Chief Executive)	Constitution - Standing Orders
i) Disclosure of non-compliance with SFIs	Chief Executive / Director of Finance (report to Audit Committee)	All staff (disclose to Director of Finance, delegated to Deputy Director of Finance / Assistant Director of Finance - Financial Services)	SFI 1.1.6
j) Giving advice on interpretation or application of SFIs including this Scheme of Delegation	Director of Finance	Assistant Director of Finance - Financial Services	SFI 1.1.4
k) Reviewing and updating SFIs including the Financial Scheme of Delegation, for approval by Audit Committee / Board	Director of Finance	Assistant Director of Finance - Financial Services	SFI 2.1.8 / 8.1.5
l) Reviewing and updating Corporate Governance Manual material other than SFIs and the Financial Scheme of Delegation, for approval by Audit Committee / Board	Chief Executive / Director of Finance / Director of Governance and Quality Improvement	Board Secretary	SFI 2.1.8

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
2. Annual reporting			
a) Keeping proper accounts - ensuring the proper form and content of the accounts	Chief Executive	Director of Finance / Senior Finance Team	SFI 4.1
b) Preparing and submitting an Annual Report	Chief Executive	Board Secretary	SFI 4.4
c) Preparing and submitting annual accounts, other 'for audit' Annual Report material and consolidation schedules	Director of Finance	Assistant Director of Finance - Financial Services	
d) Preparing a quality report for inclusion in the Annual Report	Director of Governance and Quality Improvement	Head of Quality Governance	SFI 4.4
3. Financial procedures and systems			
a) Designing and maintaining effective systems of internal financial control, including policies and financial procedures	Director of Finance	Deputy Director of Finance / Assistant Directors of Finance	SFI 1.4.6 / 7
b) Ensuring that adequate (statutory and other) records are maintained to explain the Trust's transactions and financial position	Director of Finance	Deputy Director of Finance / Assistant Directors of Finance	SFI 1.4.6 / 7
c) Providing financial advice to Directors and staff	Director of Finance	Director of Finance / Deputy Director of Finance / Assistant Directors of Finance / Finance teams	SFI 1.4.7
4. Financial planning / budgetary responsibility and business cases			
a) **Operational Plan (approved by Board)** Compiling and submitting to the Board an Operational Plan which takes into account financial targets and forecast limits of available resources, to be forwarded to NHS England	Chief Executive	Executive Directors	SFI 3.1.1 / 3.1.4
b) **Budget setting (budgets approved by Board)**			
Submitting financial plans (budgets), in accordance with the Operational Plan, to Board	Director of Finance, on behalf of the Chief Executive	Deputy Director of Finance	SFI 3.1.2

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
c) **Budget monitoring and control**			
• Devising and maintaining systems of budgetary control	Director of Finance	Director of Finance / Senior Finance Team	SFI 3.3.1
• Delegating budgets to budget holders	Chief Executive	Director of Finance	SFI 3.1.7 / 3.2.1 / 9.1.1
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget	Director of Finance	Deputy Director of Finance / Senior Finance Team	SFI 3.1.8
• Identifying and implementing cost improvements and income generation initiatives in line with the Operational Plan	Chief Executive	Executive Directors / Directorate Management Teams All budget holders	SFI 3.3.2
• Authorising Board-delegated virement between different budget holders, subject to delegated limits, requiring the agreement of both parties	Director of Finance	Per Finance Department's Budget Virement Policy	SFI 3.2.2
• Ensuring approved budget is not used for any purpose other than that specifically authorised, subject to rules of virement	Chief Executive	All budget holders	SFI 3.3.2
• Monitoring performance against budget, reporting variances and risks to Board	Director of Finance	Director of Finance / Deputy Director of Finance Senior Finance Team	SFI 3.1.5 / 3.3.1
• Completing and submitting financial monitoring returns to NHS Improvement in accordance with regulatory requirements	Chief Executive	Deputy Director of Finance / Senior Finance Team	SFI 3.5.1
d) **Business cases**			
• Pre-approval of the following technical elements within business cases • VAT recovery; • leases / rentals, 'managed service' models, 'free asset' models; • collaborative working - joint ventures, joint operations, partnerships; • capital expenditure and revenue consequences	Director of Finance	Director of Finance, advised by Assistant Director of Finance - Financial Services *Proposals should be forwarded to Financial Accounts in the first instance.*	SFI 7.2.8 / 7.2.9 / 7.2.10 / 7.2.11
• Approving business cases *All new significant leases (annual rents > £100,000) are notified to Board* *Proposals for the use of management consultants are subject to special controls*	Chief Executive / Director of Finance	**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 7.2.5 / 7.2.7 / 7.2.12

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
5. Income - fees, charges and debt			
a) Notifying Director of Finance (with delegation to divisional Finance teams) of all moneys due	All staff	All staff	SFI 6.2.6
b) Reviewing and approving all fees and charges other than those determined by government or statute	Director of Finance	Director of Finance	SFI 6.2.3
c) Approving commercial sponsorship proposals	Chief Executive	Director of Finance	SFI 6.2.4
d) Negotiating contracts with commissioners, and establishing arrangements for extra-contractual services	Chief Executive / Director of Finance	Director of Finance (> £2m) Divisional Directors and corporate managers (< £2m)	SFI 6.3.1 / 6.4.1
e) Signing income-related contracts	Chief Executive / Director of Finance	**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 6.3.3 / 6.4.4
f) Monitoring and reporting on income from commissioners	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Contracting & Commissioning	SFI 3.1.5 / 3.3.1 / 6.5.4
g) Approval of 'non clinical / non research' grants	Director of Finance	**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 6.6.1 / 16.5.3
h) Recovery of debt	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager	SFI 6.7
i) Final approval of credit note issue	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager	SFI 6.7
6. Capital investment			
a) **Capital investment programme**			
• Preparing capital plans	Director of Finance, on behalf of the Chief Executive	Deputy Director of Finance / Financial Services	SFI 12.1.1

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
• Ensuring that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that each proposal has on business plans and service strategies	Chief Executive	Director of Finance / Chief Operating Officer	SFI 12.1.2 / 12.1.3
• Verifying a capital business case in terms of accuracy, completeness, project feasibility, value for money, and inclusion of revenue consequences	Chief Executive	Director of Finance / Deputy Director of Finance / Senior Finance Team	SFI 12.1.3
• Demonstrating for capital expenditure cases whether the use of private finance represents best value for money and transfers risk to the private sector. *Proposal to use PFI models must be specifically agreed by the Board of Directors*	Chief Executive	Director of Finance / Deputy Director of Finance	SFI 12.1.3
• Approving a capital business case		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 12.1.4
• Approving a capital requisition		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 9.2.3 / 12.1.6
• Financial monitoring and reporting on all capital scheme expenditure	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services	SFI 12.1.7 / 3.3.1
• Management of capital schemes and ensuring that they are delivered on time and within cost	Chief Executive	Director of Finance / Chief Operating Officer	SFI 12.1.2
• Issuing procedures governing the financial management of capital investment projects, including their recognition/valuation for accounting purposes, and any limits, targets or measures issued by DHSC / NHSI	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services /	SFI 12.1.8
• Issuing procedures to support staged payments	Chief Executive	Director of Finance	SFI 12.1.10
7. Procurement - tendering and contracting procedure - non-pay expenditure			
a) Ensuring that best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Particular functions delegated to Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Procurement	SFI 8.1.2
b) Approving authorisation limits for competitive quotations, as advised by Director of Finance	Board via Audit Committee	Board via Audit Committee	SFI 8.1.5
c) Waiving the requirement for competitive quotations	Chief Executive	Director of Finance or Deputy Director of Finance (up to £30,000) *(unless the purchase is within the Director of Finance's budgets, in which case, the Chief Executive must authorise)*	SFI 8.4.1 / 8.7

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
d) Accepting and authorising a quotation and the awarding of a contract		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 8.3.2
e) Approving authorisation limits for tenders, as advised by Director of Finance	Board via Audit Committee	Board via Audit Committee	SFI 8.1.5
f) Waiving the requirement for tendering	Chief Executive	Director of Finance or Deputy Director of Finance (up to £30,000) *(unless the purchase is within the Director of Finance's budgets, in which case, the Chief Executive must authorise)*	SFI 8.6 / 8.7
g) Ensuring fair and adequate competition, and that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Assistant Director of Finance - Procurement	SFI 8.9
h) Receiving, and ensuring safe custody of tenders prior to opening	Chief Executive	Assistant Director of Finance - Procurement	SFI 8.10.4
i) Accessing and releasing electronic tenders as 'authorised verifiers'	Chief Executive	Board Secretary / Assistant Director of Finance - Procurement (either/or)	SFI 8.11.1
j) Deciding whether late tenders should be considered	Chief Executive or Director of Finance	Chief Executive or Director of Finance, advised by Assistant Director of Finance - Procurement	SFI 8.12.3
k) Approving a tender and the awarding of a contract		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 8.13.7 / 8.13.8
l) Signing expenditure-based contracts on behalf of the Trust		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 8.14
m) Nominating officers to oversee and manage the contract on behalf of the Trust	Chief Executive	Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Procurement / Divisional Manager / Head of Department	SFI 8.18.4
8. Procurement - requisitions, ordering and payments - non-pay expenditure			
a) Designing and maintaining a requisitioning/ordering/payment system, including ● procedural instructions; ● certification that goods / services have been received and that accounts are in order for payment, prior to payment; and ● instructions regarding the manner of payments to suppliers within the Finance Department	Chief Executive / Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Assistant Director of Finance - Procurement / Finance Systems Manager	SFI 9.1.2 / 9.2 - 9.7
b) Maintaining a list of managers authorised to approve requisitions and payments, and their financial limits	Chief Executive	Assistant Director of Finance - Financial Services / Finance Systems Manager	SFI 9.1.2
c) Maintaining petty cash instructions and records, including financial limits by seniority and types of purchase	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager	SFI 9.7

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
d) Approving requisitions and petty cash purchases (exceptional circumstances)		**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 9.2.3 / 9.7
e) Approving prepayments (payment in advance of receipt of goods / services) - **exceptional cases only**	Director of Finance	Director of Finance	SFI 9.5
9. Audit arrangements			
a) Making recommendations to the Council of Governors in respect of the appointment, re-appointment, remuneration and removal of the external auditor	Audit Committee *(for recommendation to the Council of Governors for approval)*	Director of Finance	SFI 2.1.6 / 2.4.3
b) Appointing the internal auditor	Audit Committee	Audit Committee, advised by Director of Finance	SFI 2.1.7
c) Monitoring / reviewing the operational effectiveness and cost-effectiveness of the internal audit and counter-fraud functions	Audit Committee	Director of Finance	SFI 2.1.7 / 2.2.1
d) Monitoring / reviewing the external auditor's fees, independence and objectivity and the effectiveness of the audit process, market-testing at least once every five years	Audit Committee	Director of Finance	SFI 2.4.3
e) Providing a view on internal control and probity	Audit Committee	Internal auditor / external auditor	SFI 2.1.3 / 2.3.5
f) Monitoring actions taken by management in response to audit recommendations	Audit Committee	Board Secretary / Director of Finance	SFI 2.3.6
g) Undertaking remedial action regarding accepted audit recommendations in an timely manner	Chief Executive	Relevant managers	SFI 2.3.6
10. Fraud and security management			
a) Appointing the Local Anti-Fraud Specialist (LAFS)	Audit Committee (contract of service)	Director of Finance	SFI 2.5.2
b) Providing the *Anti-Fraud and Corruption Policy and Response Plan*. Monitoring and ensuring compliance with the NHS Standard Contract and Service Conditions on fraud, bribery and corruption including the Bribery Act 2010 requirements	Chief Executive and Director of Finance	LAFS	SFI 1.4.5 / 2.5.1
c) Reporting of suspected fraud (usually directly to LAFS or Director of Finance)	All staff	All staff	SFI 2.5.5 / 13.1.2

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
d) Notifying NHS Counter Fraud Authority of suspected fraud, and external auditor of verified fraud	Director of Finance	LAFS *(NHS CFA only)*	SFI 2.5.3 / 13.1.3 / 13.1.7
e) Appointing the Local Security Management Specialist (LSMS)	Chief Executive	Associate Director of Estates	SFI 2.6.3
f) Providing the Trust's *Security Policy.* Monitoring and ensuring compliance with relevant legislation and guidance	Chief Executive	LSMS	SFI 2.6.1
g) Reporting of suspected security incident or breach to LSMS *Where property loss / damage is suspected, including theft or criminal damage (including burglary, arson, and vandalism) to staff / patient / NHS property or equipment, the Chief Executive or Director of Finance must be informed*	All staff	All staff	SFI 2.6.3 / 13.1.5
11. Reporting incidents to the police			
a) Immediately reporting to the police where arson or theft are suspected	Director of Finance	Director of Finance	SFI 13.1.6
b) Reporting after advice, if fraud is suspected (reporting to NHS Counter Fraud Authority in the first instance)	Director of Finance	LAFS	SFI 13.1.3
c) Deciding at what stage to involve the police in cases of other irregularities not covered by a) or b)	Chief Executive / Director of Finance	Director of Finance, or another relevant Executive Director	SFI 2.2.1 / 13.1.6
d) Calling the police during a security incident - seeing or suspecting that a crime is taking place (*Security Policy and Procedure)*	All staff	All staff	SFI 13.1.6
12. Asset management (including capital assets and stock), including disposals and condemnations, and security management			
a) Responsibility for security of Trust assets	Chief Executive	All staff	SFI 1.4.8 / 12.3
b) Approving asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets)	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager	SFI 12.3.2
c) Non-stock assets			
• Maintaining an asset register for capital assets, including the periodic verification of entries and reconciliation to financial ledger	Chief Executive / Director of Finance	Assistant Director of Finance - Financial Services	SFI 12.2

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
● Maintaining an asset register for medical equipment assets, including the periodic verification of entries	Chief Executive / Director of Finance	Chief Operating Officer	SFI 12.2
● Notifying the Director of Finance (Procurement and Financial Accounts) when capital assets are lost or damaged	Department heads (all staff)	Department heads (all staff)	SFI 12.2 / 13.1.4
● Approving procedures for reconciling balances on fixed assets accounts in the financial ledger against balances on fixed asset registers	Director of Finance	Assistant Director of Finance - Financial Services	SFI 12.2.5
● Assessing and applying depreciation / impairment to capital assets, and processing revaluations of the Trust's built estate.	Director of Finance	Assistant Director of Finance - Financial	SFI 12.2.6 / 12.2.7
● Developing detailed procedures for the disposal / sale / condemnation of assets and advising staff on disposal procedures	Director of Finance	Assistant Director of Finance - Procurement	SFI 12.4.1 / 12.4.2 / 12.4.5
● Approving condemnation or disposal of Items which are obsolete, redundant, irreparable or which cannot be repaired cost-effectively	Director of Finance	Director of Finance *Proformas are pre-approved by an authorised condemning officer.* *The sale of medical equipment requires additional pre-approval by the Head of Procurement in conjunction with the EBME Manager*	SFI 12.4.4 / 12.4.6
d) Control of stores, including minimising stockholdings, annual physical checks and the condemnation, disposal and replacement of unserviceable articles			
● Controlling pharmaceutical stocks	Chief Executive	Director of Pharmacy & MM / Chief Pharmacist	SFI 11.2
● Designing and implementing (non-Pharmacy) stock control arrangements, including stocktaking procedures, and procedures for the receipt of goods, issues from stores, and returns to suppliers	Director of Finance	Director of Pharmacy & MM / Chief Pharmacist / Department heads	SFI 11.2
● Controlling fuel stocks	Chief Executive / Director of Finance	Associate Director of Estates	SFI 11.2
● Controlling other stocks / stores	Chief Executive / Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Procurement	SFI 11.2
e) Notifying asset and stock discrepancies to the Director of Finance (via Procurement and Financial Accounts), and/or LSMS/LAFS if a security management / fraud event is suspected	All staff	All staff	SFI 2.5.5 / 2.6.3 / 12.3.5 / 13.1.4
f) Formally reporting asset and stock losses to the Audit Committee	Director of Finance	Assistant Director of Finance - Financial Services	SFI 13.1.14

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
13. Losses and special payments - including debt write-offs and ex gratia payments			
a) Designing and implementing procedures for recording and reporting losses and special payments, including maintenance of Losses Register and general reporting to Audit Committee	Director of Finance	Assistant Director of Finance - Financial Services	SFI 13.1.1 / 13.1.13 / 13.1.14
b) Reporting of suspected fraud losses (usually directly to LAFS or Director of Finance)	All staff	All staff	SFI 2.5.5 / 13.1.2
c) Reporting of all non-fraud losses (not including invoiced debts) to the Chief Executive / Director of Finance (via Financial Services)	All staff *(via Department heads or Security Team / LSMS)*	All staff *(via Department heads or Security Team / LSMS)*	SFI 13.1.4
d) Referring novel, contentious or repercussive cases to DHSC for approval	Director of Finance	Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Financial Services	SFI 13.1.7
e) Referring non-Treasury-approved severance payments to NHSI	Director of Finance	Deputy Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Financial Services	SFI 13.1.7
f) Approval of losses and special payments	Board, via Audit Committee	**Refer to Appendix 2 - Matrix of Financial Limits**	SFI 13.1.9
g) Reviewing options for financial redress and insurance claims	Director of Finance	Deputy Director of Finance	SFI 13.1.11
14. Treasury management - bank accounts, cash, investments and borrowings			
a) Approving banking arrangements, and loans > 1 month and additional PDC (in advance of drawdown) which exceed £100k	Trust Board	Not delegated further	SFI 5.1.2 / 14.2.2
b) Managing the Trust's and Charitable Funds cash-handling and banking arrangements, including ● establishing/administering bank mandates and signatories; ● providing advice on the provision of banking services and the operation of accounts; ● preparing instructions on the operation of accounts, including limits and authorities for staff, and procedures for cash-handling; and ● undertaking cash management processes, including moving funds between accounts and short-term instruments	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager *(on behalf of, and approved by, Director of Finance)*	SFI 5.1.1 / 5.1.3 / 5.2.1 / 5.3 / 5.5

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
c) Reviewing commercial banking arrangements at regular intervals, as appropriate	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager *(on behalf of Director of Finance)*	SFI 5.4
d) Minimising finance costs and liquidity risk, in the use of loan instruments	Director of Finance	Assistant Director of Finance - Financial Services / Treasury Services Manager	SFI 14.2.1
e) Authorising drawdown of loans or PDC via lender / DHSC mandates *Loans > 1 month, including any working capital facility, and PDC must be approved by the Board in advance of drawdowns*	Director of Finance	Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Financial Services (PDC) Director of Finance / Deputy Director of Finance (loans)	SFI 14.1.2 / 14.2.4 / 14.2.7
f) Calculating and paying PDC dividend and interest on borrowings	Director of Finance	Assistant Director of Finance - Financial Services	SFI 14.1.4 / 14.2.6
g) Monitoring the liquidity risk presented by the maturity date of existing facilities.	Director of Finance	Assistant Director of Finance - Financial Services	SFI 14.2.1
h) Maximising returns and minimising credit risk associated with investments	Director of Finance	Assistant Director of Finance - Financial Services	SFI 14.3.3
15. Patients' property - cash and valuables			
a) Design and implementation of procedures for the administration / handling of patients' monies and property	Director of Finance	Treasury Services Manager	SFI 15.1.3
b) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Ward Managers	SFI 15.1.2
c) Informing staff of their duties in respect of patients' monies and property	Director of Finance, through a), above	Matrons / Ward Managers	SFI 15.1.4
d) Retaining, releasing or disposing of the property of deceased patients in accordance with the legal framework	Director of Finance	Treasury Services Manager / Assistant Director of Finance - Procurement Cashiers (Cash Offices)	SFI 15.4

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
16. Charitable funds			
a) Approving fundraising and related activity, and advising on the acceptance of gifts and donations, including donor wishes and imposed trusts	Director of Finance	Head of Fundraising Assistant Director of Finance - Financial Services	SFI 16.1 / 16.5.12
b) Designing and implementing the financial systems of the Charity	Director of Finance	Assistant Director of Finance - Financial Services	SFI 16.3
c) Designing and implementing financial procedures, and creating staff-facing policies for the collection of income and the expenditure of funds	Director of Finance	Assistant Director of Finance - Financial Services Head of Fundraising	SFI 16.3
d) Timely expenditure, avoiding unnecessary accumulation of funds	Charitable Funds Committee	Fund-holders	SFI 16.4
e) Approval of any charitable expenditure	Charitable Funds Committee	Director of Finance Assistant Director of Finance - Financial Services (technical approval of ERFs) Fund-holders following technical approval of ERFs (financial limits approval per **Appendix 2 - Matrix of Financial Limits**	SFI 16.4
f) Creation of a new fund or sub-fund	Charitable Funds Committee	*Only the Charitable Funds Committee can approve the creation of funds*	SFI 16.5
g) Approval for fundraising appeals - includes any documentation or communication which states *'we are collecting donations for purpose X'*	Charitable Funds Committee	*Only the Charitable Funds Committee can approve appeals*	SFI 16.5
h) Maximising compliant revenues under HMRC Gift Aid scheme	Director of Finance	Assistant Director of Finance - Financial Services / Head of Fundraising / Treasury Services Manager	SFI 16.5
i) Liaising with executors and solicitors regarding legacies, negotiating terms where necessary / beneficial	Director of Finance	Head of Fundraising	SFI 16.5
j) Designing and implementing an appropriate *Treasury Management Policy* for the Charity, including investment policy and reserve policy elements	Charitable Funds Committee / Director of Finance	Assistant Director of Finance - Financial Services	SFI 16.6
k) Maintenance of Charity Commission registration	Director of Finance	Head of Fundraising	SFI 16.8
l) Creating plans or targets for the Charity, and monitoring performance against those targets/plans	Charitable Funds Committee / Director of Finance	Head of Fundraising	SFI 16.9
m) Preparing an Annual Report and Accounts and submission of the Trustee's Annual Return to the Charity Commission	Director of Finance	Assistant Director of Finance - Financial Services	SFI 16.9

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
17. Information technology - financial systems			
a) Ensuring the accuracy and security of the Trust's computerised financial data, through designing and implementing controls, policies and procedures	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Finance Systems Manager	SFI 20.1.1
b) Developing and implementing new financial systems (in line with the Trust's IM&T strategy), ensuring they are developed in a controlled manner and thoroughly tested	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Finance Systems Manager	SFI 20.1.2
c) Ensuring that contracts for computer services for financial applications define responsibility re: security, privacy, accuracy, completeness and timeliness of data during processing and storage	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Finance Systems Manager / Assistant Director of Finance - Procurement	SFI 20.2.2
d) Seeking third party assurances regarding financial systems operated externally	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Finance Systems Manager	SFI 20.2.3
e) Ensuring that risks arising from the use of IT are effectively identified and considered, and appropriate action is taken to mitigate or control risk	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services / Finance Systems Manager	SFI 20.3
f) Reviewing the form, and ensuring the adequacy of, the financial records of all departments	Director of Finance	Deputy Director of Finance	
18. Risk management - insurance			
a) Ensuring that appropriate insurance arrangements exist in accordance with DHSC/NHSI guidance	Director of Finance	Director of Corporate Affairs / Chief Nurse	SFI 21.1.5
b) Approval of all commercial insurance policies	Director of Finance	Director of Finance	SFI 21.1.6
c) Ensuring that the Board is informed of the nature and extent of the risks associated with self-insurance (not using the risk-pooling schemes administered by NHSR)	Director of Finance	Director of Finance	SFI 21.2.2
d) Ensuring that documented procedures cover the management of claims and payments below the excess / deductible	Director of Finance	Deputy Director of Finance / Assistant Director of Finance - Financial Services	SFI 21.2.3

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
18. HR and pay			
a) Developing HR policies and strategies for approval by the Board including training and industrial relations	Chief Executive	Chief People Officer	
b) Nominating officers to award ● contracts of employment regarding staff, or ● agency staff / consultancy service contracts	Chief Executive	Chief People Officer	
c) Advising the Board about appropriate remuneration and conditions of service of very senior managers	Remuneration Committee	Remuneration Committee	SFI 19.1.2
d) Presenting proposals to the Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee	Chief Executive	Chief People Officer	SFI 19.3.2
e) Administration / governance of salary sacrifice schemes	Chief Executive	Chief People Officer	SFI 19.9
Establishment, recruitment, contracts and variations			
f) Filling a vacancy within the funded establishment *Subject to establishment control / vacancy control processes*	Chief Executive	Budget managers in conjunction with divisional finance teams	SFI 19.2 / 19.3
g) Adding staff to the agreed establishment *Subject to establishment control / vacancy control processes*	Chief Executive	Executive team member	SFI 19.2 / 19.3
h) Ensuring that all employees are issued with a contract of employment, in a form approved by the Board, and which complies with employment legislation	Chief Executive	Chief People Officer / HRWBS Service	SFI 19.8
i) Granting additional increments to staff, outside the annual cycle, within budget	Chief Executive	Budget managers in conjunction with divisional finance & HR teams, with SMT approval	
j) Re-grading, in accordance with Trust procedures	Chief Executive	Budget managers	SFI 19.3
k) Renewing fixed-term contracts	Chief Executive	Budget managers in conjunction with divisional finance & HR teams, plus relevant Executive Director	
l) Approving local pay variations	Chief People Officer	Chief People Officer	

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
Payroll requests			
m) Approving forms effecting new starters, variations and leavers	Chief People Officer	Budget managers in conjunction with divisional finance teams	
n) Prompt 'hiring' of new staff and termination of leavers within ESR system	Hiring managers	Hiring managers	SFI 19.4.5 / 19.5.3
o) Completing and authorising payroll reporting forms (SVLs)	Chief People Officer	Matrons / Ward and departmental managers	
p) Authorising overtime	Chief People Officer	Budget managers	
q) Authorising expenses reimbursed via payroll	Chief People Officer	Budget managers	
Leave			
r) Approving annual leave	Chief Executive	Line managers *as per departmental procedure*	
s) Approving annual leave carry forward *for AfC employees, this is granted in exceptional circumstances only, and only with written consent*	Chief Executive	Line managers	
t) Approving time off in lieu	Chief Executive	General managers / departmental managers	
u) Approving ● compassionate leave; ● special leave arrangements for domestic/personal/family reasons - paternity leave, carer leave, adoption leave; ● other special leave including jury service; and ● leave without pay	Chief Executive	General managers / departmental managers / Associate Medical Directors	
v) Approving leave of absence for medical staff - paid and unpaid	Chief Executive	Medical Director / Associate Medical Directors	
w) Approving maternity leave - paid and unpaid	Chief Executive	*Automatic approval, with guidance*	
Sick leave			
x) Extending paid sick leave	Chief People Officer	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse in conjunction with divisional HR teams	
y) Approving part-time return to work, on full pay, to assist recovery	Chief People Officer	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse in conjunction with divisional HR teams	

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
Study leave			
aa) Approving study leave outside the UK	Chief Executive	Relevant Executive Director	
bb) Approving medical staff study leave (UK) - consultant / non-career-grade	Medical Director	Associate Medical Director	
cc) Approving medical staff study leave (UK) - career-grade	Medical Director	Post Graduate Tutor	
dd) Approving all other study leave (UK)	Chief Executive	Budget manager (in budget) and Training and Development Manager	
Staff benefits			
ee) Approving relocation expenses *up to a maximum of £8,000 under HMRC rules*	Chief People Officer	SMT member	
ff) Approving regular user allowance *(no longer available for non-medical staff)*	Chief People Officer	Associate Medical Director / Deputy Chief Nurse in conjunction with divisional HR teams	
gg) Approving mobile phones and other mobile devices	Director of IT and Information	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse	
Staff retirement			
hh) Authorising return to work in a part-time capacity under the *flexible retirement scheme.*	Chief People Officer	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse	
ii) Deciding to pursue retirement on the grounds of ill-health, following advice from the Occupational Health Department	Chief People Officer	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse	
jj) Approving early retirement	Chief People Officer	General managers / departmental managers / Associate Medical Director / Deputy Chief Nurse	
Exit packages		**Refer to Appendix 2 - Matrix of Financial Limits**	
Bank / agency staffing, off-payroll / IR35 engagements			
i) Ensuring that procedures are in place to ensure that the correct tax / NI arrangements and tax assurance are secured for off-payroll engagements	Chief Executive	Chief People Officer	

Appendix 1 - Scheme of Delegation (extract)

DELEGATED MATTER	DELEGATED TO [1]	OPERATIONAL RESPONSIBILITY	REFERENCES
ii) Approvals of any bank/agency staffing, potentially involving NHSP or Plus Us,	Chief Executive	Director of Finance *Particular caution to be applied for engagements at over £100 per hour, or off-framework or over-cap proposals*	SFI 19.10

[1] *If the Chief Executive is absent, powers delegated to them may be exercised by the nominated officer(s) acting in their absence, after taking appropriate financial advice; two Executive Directors will be required to ratify any decisions within the Chief Executive's thresholds.*

Appendix 2 – Matrix of Financial Limits

This document summarises the financial limits delegated by the Board and the Chief Executive to Trust employees

It should be read in conjunction with the Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation extract (Appendix 1)

This document lists a selection of delegated privileges, and therefore does not seek to outline the often extensive duties and responsibilities (such as good record-keeping and adherence to local procedures) which are associated with these privileges.

Appendix 2 - MATRIX OF FINANCIAL LIMITS

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
		In case of staff absence, authority may pass sideways (subject to cost centre restrictions) or upwards (meaning that a higher level manager must approve). In cases of Executive Director absence, authority may occasionally pass downwards to nominated deputies in line with current policies / procedures. Trust staff should only attempt to sign documents / approve activity in cases where they have the requisite authority to do so. **Except for Section 2, all limits are inclusive of VAT, wherever VAT is charged, even if presumed recoverable.**							
1.	**Ordering of goods and services**								
1.1	**Requisitioning of all goods, works and services** All requisitioning is subject to the requirements of sections 2. – 3. being met. With the exception of 1.1.e., all requisitions are input and approved through the Oracle System.	All Trust employees with Oracle system access can input a requisition for goods/services. Pharmacy employees with JAC system access can input a requisition for drugs and other medicines. All goods/works/services (except under section 4, below) are procure via the completion of a requisition, and therefore the creation of a purchase order (PO). This applies regardless of how the purchase is funded (e.g., Charity-funded items). Charity funded items should be supported by an approved ERF.							
	a. **Approval of revenue requisitions** Spend is restricted to approver's cost centres and must be within Board-approved budget and/or have an approved business case (section 3,		> PCR2015 threshold for goods / services [1]	≤ PCR2015 threshold for goods / services	≤ £30,000	≤ £10,000	≤ £5,000	≤ £1,000	Section 6 & Section 8
	b. **Approval of capital requisitions** Spend must be listed in Board-approved annual capital programme, and/or have an approved business case (section 3, below).								
	c. **Approval of annual call-off [2] requisitions** - contracted spend only.								
	d. **Approval for payment of consignment goods** [3] Requisition approval may only be given where an item of consignment stock has been used. Replacement will be on a top-up basis only, and in accordance with stock levels pre-determined by Procurement.								
	e. **Drugs inventory and other Pharmacy purchasing** Limits relate to requisitions via the Pharmacy JAC system. Unlike for non-drugs purchasing via Oracle, these limits are not wholly built into the JAC system. High-value approvals are sought via email and filed for audit		> £100,000 CEO or DoF	≤ £100,000 Director of Pharmacy and Medicines Management / Deputy Director of Pharmacy	≤ £50,000 Pharmacy Support Services Operational Manager / Team Leader, Pharmacy Clinical Support Services	≤ £25,000 6 Pharmacy officers per a local signatory list			Section 8

Appendix 2 - MATRIX OF FINANCIAL LIMITS

Wirral University Teaching Hospital

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
2.	**Quotations, tendering and contract procedures**								
2.1	**Requirement to obtain quotations / tenders** Authorised officers are specifically advised by Assistant Director of Finance - Procurement at all stages during the process. a. > EU threshold — *full OJEU procedures* b. > £30,000 & ≤ EU threshold — *competitive tenders* c. > £5,000 & ≤ £30,000 — *obtain 3 competitive written quotes* d. ≤ £5,000 — *no requirement for competitive quotations*	The financial limits here exclude VAT and refer to the anticipated value of the contract over the contract period (normally 3 years). Compliance with tendering procedures described within the SFIs is required at all times, for any type of contract for goods, services or works. Requests for tenders or quotations must be accompanied by the appropriate set of NHS Standard Terms and Conditions of Contract. Spend must not be disaggregated to avoid the requirement to obtain competitive quotations or tenders. All Trust employees can obtain goods/services or works without obtaining quotations where the total value of the contract will not exceed £5,000. However, it is strongly recommended that competitive quotations are obtained, or a national or regional framework agreement is used to demonstrate best value for money (VfM).							Section 7
2.2	**Authorisation of waivers** [4] *Authorisation of any waiver of tenders or quotations* All waivers to be reported by the Director of Finance to each meeting of the Audit Committee. Waivers are authorised by CEO where tender pertains to DoF budgets.		≤ £30,000 DoF > £30,000 CEO & DoF	≤ £30,000 Deputy DoF					
2.3	**Opening of quotations** *A record of all quotations received must be kept by the requisitioning department and must be made available for audit purposes.*						Authority at this level or higher		
2.4	**Opening / verifying of electronic tenders** *All electronic tenders are recorded by Procurement.*			Board Secretary or Assistant Director of Finance - Procurement					
2.5	**Acceptance of late tenders** *Decision as to whether late tenders are to be accepted.*		CEO or DoF						
2.6	**Selection of the tender that is not the most economically advantageous tender (MEAT)**		CEO						
2.7	**Contract award** Authorised officers are specifically advised by Assistant Director of Finance - Procurement at all stages during the process.	Contract signatories are also as below. The CEO signs on behalf of the Board. Only the Director of Finance can sign credit agreements, with the exception of HR salary sacrifice arrangements.							
	a. > £1,000,000 — *full OJEU procedures*	Board							
	b. ≤ £1,000,000 — *full OJEU*		CEO						
	c. ≤ £500,000 — *full OJEU*		CEO / DoF						
	d. > EU threshold & ≤ £250,000 — *full OJEU procedures*			Deputy DoF					
	e. > £30,000 & ≤ EU threshold — *competitive tenders*				Budget manager				
	f. > £5,000 & ≤ £30,000 — *obtain 3 competitive written quotes*				Budget manager, of a level higher than the opener (section 2.3)				

Appendix 2 - MATRIX OF FINANCIAL LIMITS

NHS Wirral University Teaching Hospital

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
3.	**Business case approval**								
3.1	**Requirement for approved business case** The business case process precedes the tendering / quotation procurement process, and is required for all capital expenditure, and for revenue spend which is not already **explicitly** within plan / budget. The Trust's ***Business case process pack*** applies to 3.2 and 3.3.	**For capital or lease schemes,** the financial limits below refer to **<u>whole-life</u>,** *total implementation costs*, including external facilitation, lease costs, enabling works, VAT even if presumed recoverable, establishment changes and depreciation. This may exceed the capital expenditure total. Capital Bid Forms (CBFs) are used for smaller capital projects with low complexity, such as medical equipment. **For revenue investment schemes**, the financial limits below refer to the maximum revenue expenditure in any given year. **For schemes with significant capital and revenue elements**, the value of each element (capital vs revenue) is assessed separately as described above.							
		Pre-approval of the following technical elements within business cases through Financial Services is required: VAT recovery / leases and rentals / 'managed service' models and 'free asset' models / collaboration - joint ventures, partnerships / capital expenditure and depreciation.							
3.2	**Approval of revenue-only business cases** Limits refer to additional spend budget required in any year, even if the scheme is self- funded, or 'invest to save'.	> £250,000 Board [5] ≤ £250,000 FBPAC	≤ £50,000 CEO or DoF						
3.3a	**Approval of capital or lease [6] business cases within Board-approved capital programme**	> £1,000,000 Board [5] ≤ £1,000,000 FBPAC	≤ £250,000 CEO or DoF						**Section 4**
3.3b	**Approval of capital or lease [6] business cases from contingency funds**	> £250,000 Board [5] ≤ £250,000 FBPAC	≤ £50,000 CEO or DoF						
		[5] **Business cases / schemes need additional NHSI / DHSC approval** if 'significant transactions' (also CoG approval) and/or if the following costs exceed £15m: capital costs, or whole-life costs (for IT, lease or *'managed service'* schemes). [6] **All significant leases** (annual rents exceeding £100,000) must be notified to Board, if not already Board-approved.							
3.4	**Approval of any proposal or case involving management consultants** 'Consultancy fees' expenditure is subject to additional controls. All cases over £50k to be referred to Director of Finance in the first instance. It is recommended that a view is sought from the Procurement Department in the first instance.	> £50,000 Board NHSI approval required	< £50,000 CEO or DoF	≤ £10,000 ED					
3.5	**Charitable funds 'bids'** Business cases are required for every item of charitable spend via Expenditure Request Form (ERF). Technical approval - all ERFs are assessed for compliance by Financial Services, prior to Procurement processes and/or forwarding for higher approval.	> £30,000 Charitable Funds Committee	≤ £30,000 Director of Finance		≤ £30,000 Fund-holders, if spend is against their delegated fund				**Section 16**

Appendix 2 - MATRIX OF FINANCIAL LIMITS

NHS Wirral University Teaching Hospital

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
4.	**Non-Treasury payments which are not linked to requisitions / orders**								
4.1	**Payment approval for exceptional non-PO transactions as specified below** Certain taxation, pay, travel, compensation, credit card, reimbursement or ex-gratia payments (6.1) also may or should not have a requisition.	The Trust operates a 'no PO no pay' procedure for all purchasing other than items specifically listed below, and ex-gratia losses. Breaches, including retrospective ordering, will be addressed under the Trust's escalation procedure, and may result in disciplinary action.							**Section 8**
	a. NHS BSA FP10s (prescriptions)			Director of Pharmacy and Medicines Management					
	b. NHS BSA quarterly injury benefits and early retirement liability			Deputy DoF					
	c. NHS Fleet Solutions - advance payment of salary sacrifice cars			Chief People Officer					
4.2	**Petty cash withdrawal approval** Petty cash is issued on presentation of a receipt, financial ledger code and completed proforma. Spend is restricted to cost centres allocated to the approving manager. Second approval may be requested if the first signatory is the beneficiary of the spend, and all travel and incidental expenses should either be requisitioned in advance of travel (e.g., tickets, accommodation) or be reimbursed via Payroll (e.g., mileage).		≤ £30 > £30 DoF	≤ £30 > £30 Deputy DoF	≤ £30	≤ £30	≤ £30	≤ £30	
4.3	**Credit / payment cards** Approval for the issue of business-use credit cards to individuals. Maximum limit on each credit card is £7,500.		Authority						
5.	**HR and pay**								
5.1	**Establishment and recruitment**	Delegated authority for establishment changes is detailed in the Scheme of Delegation (App 1).							**Section 18**
5.2	**Bank / agency staffing**	Delegated authority for approval of bank / agency staffing is detailed in the Scheme of Delegation (App 1).							
5.3	**Exit packages / severance approvals**								
	a. Individual - directors / senior managers within the scope of the Committee	Remuneration and Appointments Committee							
	b. Individual - with contractual entitlement		CEO or DoF						
	c. Trust-wide - HM Treasury approved 'mutually agreed' schemes	Board							
	d. Individual - exceeding contractual entitlement (per 6.1d)	Board HM Treasury approval required via NHSI							

Appendix 2 - MATRIX OF FINANCIAL LIMITS

NHS Wirral University Teaching Hospital

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
6.	**Losses, special payments, disposals and litigation**								
6.1	**Registered losses and special payments**	All novel and contentious or repercussive cases must be reported to DHSC / NHSI via Financial Services regardless of value.							Section 12 & Section 13 & Section 18
	a. **Debt write-offs** Limit applies at supplier level, not individual invoice level.	> £10,000 Audit Committee	≤ £10,000 DoF	≤ £1,000 Deputy DoF					
	b. **Non-clinical negligence payments** made on the advice of NHSLR - excesses pertaining to employer liability (EL) and public liability (PL) cases (*Liability to Third Parties* scheme). The limits refer to net payments.						< £10,000 excess (EL) < £3,000 excess (PL) Legal Services Manager		
	c. **Extra-statutory and extra-regulatory payments**	Board							
	d. **Severance payment exceeding contractual entitlement** (per 5.4d)	Board HM Treasury approval required via NHSI							
	e. **All other registered losses** Including losses of cash, salary overpayment write-offs, damage to or loss of Trust assets including stock write-offs, and ex-gratia payments.	Audit Committee notified	≤ £5,000 DoF ≤ £10,000 CEO > £10,000 CEO & DoF						
6.2	**Condemnation and disposal**	Under NO circumstances should any kit or equipment that has been involved in an accident / incident be disposed of until investigations have been concluded.							
	a. Approval to condemn / dispose of capital or inventory asset All disposals must be performed in line with the *Condemning and Disposal of Scrap and Surplus Equipment* policy.		DoF, via SD12 form						
	b. Condemning and disposal of non-capital, non-inventory supplies and equipment (such as office equipment).				Assistant Director of Finance - Procurement in conjunction with budget manager				
6.3	**Litigation claims**	NHSR EL and PL excess are listed under section 6.1							
	a. Authorisation of clinical negligence (CNST) premium.		DoF						
	b. Approval of payments following other legal advice that are patient-related, other than 6.1.b above.			> £10,000 Associate Medical Director			< £10,000 Legal Services Manager		
	c. Approve proposals for action on litigation against, or on behalf of, the Trust.	> £100,000 Board		< £100,000 Director of Governance and Quality Improvement and list (determined by DoGQI)					

Appendix 2 - MATRIX OF FINANCIAL LIMITS

NHS Wirral University Teaching Hospital

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	
7.	**Income**								
7.1	**Income contracts**	Values are the whole-life values of the contract.							
	Signing contracts *Board to be consulted in advance for values above £1,000,000*		> £250,000 CEO or DoF	≤ £250,000 Deputy DoF					
7.2	**Setting of fees and charges**								
	a. Reviewing and revising existing fees and charges annually	Notified to FBPAC	DoF only						**Section 5 & Section 16**
	b. Approving charges for new services	Notified to FBPAC	DoF only						
7.3	**Non-trading income**	Incomes (cash / non-cash) gifted to the Trust / Charity for no exchange (other than, say, for promotional or public benefit) should be discussed in the first instance with the Head of Fundraising, or the Trust's Research Department in the case of research and development ('clinical') grants. The Trust's *Managing Conflicts of Interest Policy* may apply.							
	Approving fundraising activity, with divisional sign-off					Head of Fundraising			
	Approving 'non-clinical' grant applications with divisional sign-off		> £50k DoF			≤ £50k Head of Fundraising			
	Agreeing commercial sponsorship proposals		CEO or DoF						
8.	**Gifts and hospitality**								
8.1	**Receiving gifts and / or hospitality, including *'thank-you'* presents**	Please refer to the Trust's *Managing Conflicts of Interest Policy* for further details including how to declare gifts / hospitality. Cash gifts cannot be accepted; personal gifts to staff must not be receipted to charitable funds.							

Appendix 2 - MATRIX OF FINANCIAL LIMITS

Ref	DELEGATED MATTER	DELEGATED AUTHORITY / FINANCIAL LIMITS							Appendix 1 SCHEME OF DELEGATION reference
		Level 8	Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	
		Board or Committee	CEO / COO / DoF or Deputy CEO	All *'very senior manager'* Directors (EDs or otherwise) or Deputy DoF	Divisional Directors Divisional Medical Leads Senior Corporate Managers	Directorate Managers Assistant Managers (Corporate)	Department Managers Matrons	Deputy Department Managers Ward Managers	

Footnotes

[1] **EU thresholds**

This is the value above which the Public Contract Regulations (PCR 2015) are applicable, and the Trust must follow the procedures therein defined.
The current thresholds for contracts governed by the Public Contracts Regulations are effective from **1 January 2020.**

The EU thresholds are as follows:
For *goods and services*, the threshold is138,760.
For *works contracts*, the threshold is £5,336,937.
For *social and other specific services* as defined in Article 74 (and listed in Annex XIV) of Dir 2014/24/EU, the threshold is £663,540.

Oracle can only apply a single limit per officer. Therefore, the EU threshold for *supply and service* contracts is used within the system and applies to capital / works as well as revenue spend.

[2] **Annual call-off order**

A single purchase order placed with a supplier at the beginning of the year to cover all goods/services ordered from the supplier during that period.
Commonly used where a large range of products are ordered very frequently, and where it would be uneconomical to place an order for each requirement e.g., provisions (foodstuffs).

[3] **Consignment goods**

These are goods provided to the Trust by a supplier and held in inventory (stock).
No payment is made to the supplier until the item is used and a requisition / order raised to replenish the used item.
Typically, this system is adopted for high-value medical devices such as orthopaedic implants where it would be prohibitively expensive for the Trust to purchase the full range of products/sizes that might be required, and there would be a high risk of obsolescence.

[4] **Waiver**

A waiver is an exemption from undertaking a competitive tendering or quotation exercise. Circumstances in which a request to waiver SFIs are clearly defined in the Trust's SFIs.

Wirral University Teaching Hospital
NHS Foundation Trust

Appendix 3 – Exceptional Payments

This document summarises authority delegated by the Board to Trust employees, in the context of Finance

Exceptional items for SFIs (not as a result of requisition approval)

There are no standing orders
Any new Direct Debits (DD) would be approved by Chief Finance Officer

Supplier / type of thing we're paying for	Method of payment (direct debit etc)	Who is it done by?	Who approves?
Credit cards - Barclaycard only	Credit card - we repay Barclays via DD	*bank pay for goods* *we pay bank via DD*	Card issue approval is controlled under SFIs. Cardholder approves spend. Statements signed as OK to pay when they arrive (c. 14th). - Chair signs off for Chief Executive (CEx) - CEx signs off for Chief Finance Officer (CFO) - Assistant Director of Finance - Financial Services signs off for Head Of Fundraising (Charity) Procurement also have 3 cards - budget holder must approve requsition before use of card.
			No creditor code - paid by direct debit straight out of the bank. Coded via Systems Team database in-month [Dr exp Cr bank].
RBS NatWest - [transaction-based costs + bankline user charge] - bank fees (subtrivial)	Bank charge	Bank	No approval required, sample checked by Treasury Services Manager.
PDC dividend	DD	DHSC	Taken by Direct Debit (DD) by DHSC on the basis of NHSI returns which are approved by CFO.
		Miscelleaneous receipt	
Loan principal repayment	DD	DHSC	Taken by DD on the basis of the loan schedule signed by CFO at inception.
		Miscelleaneous receipt	
Loan interest payment	DD	DHSC	Taken by DD on the basis of the loan schedule signed by CFO at inception.
		Miscelleaneous receipt	
Petty cash withdrawal	Cash outflow from CO/Faster payment	Cash Office	Signed (budget holder) pre-coded proforma taken to Cash Office for reimbursement against receipt. £30 limit, anything over £30 Deputy CFO
Ex gratias	Bank Transfer	Cash Office - instructed by division/Legal Team	Signed by CFO and/or CEx (limits).
HMRC (tax / NI)	BACS via AP run/HMRC Portal	AP - instructed by Payroll Team	Payroll
NHS Pensions	DD	Payroll - via Pensions Online portal	Payroll
NEST	DD	Payroll	Payroll
Voluntary pay deductions	BACS via AP run	AP - instructed by Payroll Team	Payroll
Non Voluntary pay deductions ie Court Orders	BACS / Faster payment	Cash Office - request from Payroll Team	Payroll
Net pay	BACS	Payroll	Payroll - each payroll paypoint signed off by dept mgr as correct
Pay advance/ Death in Service/BACS recall	BACS / Faster payment	Cash Office - request from Payroll Team	Payroll plus dept manager
NHSSC weekly - obvs, technically nonPO	BACS via AP run	Systems Team loads resus feeder into AP	Invoice checked to feeder and signed by Finance Systems Manager
NHS BSA FP10s (prescriptions)	BACS via AP run	AP invoice	Signed by Director of Pharmacy & Medicines Management
NHS BSA inj bens (qly)	BACS via AP run	AP invoice	Signed by Deputy CFO
NHS BSA early retirement compensation payment (qly)	BACS via AP run	AP invoice	Signed by Deputy CFO
Opticians HES reimbursements	BACS via AP run	Systems Team loads feeder into AP	Signed by Ophthalmology Manager
Neopost - franking machine	Faster payment	Cash Office	Facilities Operational Development Manager/Head of Facilities Management
AR refund requests	Faster payment	Cash Office	Accounts Receivable Supervisor
VDU glasses staff	Faster payment	Cash Office	Line managers/Operational Financial Management (OFM)
Patient Travel HC5	Faster payment	Cash Office	Appointments verified on Cerner & benefits verified by Job Centre
Governor travel	Faster payment	Cash Office	Membership Office
Volunteer travel	Faster payment	Cash Office	Kathy Orme
Patient Monies	Faster payment	Cash Office	Cash Office
Home Renal gas/elec/water	Faster payment	Cash Office	OFM
Refund AL5 course fees	Faster payment	Cash Office	Resusciatation Officer
Parking fob refund	Petty cash/Faster Payment	Cash Office	Security Manager Assistant/Security Manager
Car park refunds to the public	Petty cash/Faster Payment	Cash Office	Security Manager/Head of Facilities Management
Adhoc reimbursements	Faster payment	Cash Office	Deputy CFO

= nonPO

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item No 17**
3 October 2022

Title	Communications and Engagement Report
Area Lead	Debs Smith, Chief People Officer Sally Sykes, Director of Communications and Engagement
Author	Sally Sykes, Director of Communications and Engagement
Report for	Information

Report Purpose and Recommendations

The purpose of the report is to update the Board on the Trust's communications and engagement activities in September 2022, including media relations, campaigns, marketing, social media, website, employee communications and stakeholder engagement, WUTH Charity and staff communications to support engagement.

The Board has asked for an MP briefing to be prepared to update MPs and stakeholders on WUTH developments. A draft has been developed and will be cleared by the Execs and Chair, with regular issues and distribution thereafter.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like addressing discharges and patient flow)
- Risk 2.1 – Failure to fill vacancies (communications support on recruitment, retention, and reputation)
- Risk 3.4 – Failure of Transformation programmes (communications and engagement, including stakeholders and patients for WUTH Improvement activities for service transformation and elective recovery)
- Risk 6.1 – Estates related risks (Communications, stakeholder, and staff engagement to support delivery of Estates Strategy, Masterplans, and capital programme developments, plus communications for the Urgent and Emergency Care Upgrade Programme)

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

Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

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

1	Narrative
	This is the report of the Director of Communications and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe. **Campaigns, media, social media, internal communications, staff engagement communications and stakeholder relations.** **Campaigns** In campaigns and disease awareness, we promoted Organ Donation Week, Stoptober - Stoptober is back, World Patient Safety Day on 17th September, World Sepsis Day, World Pharmacist Day and Thyroid Cancer Awareness Month. We supported the roll out of our Patient Experience Strategy via communications on the roll out of the groups developing the 'promises' that underpin our strategy via an invitation to Welcome Promise Group workshop on 4th October. **Media** In line with national NHS, DCMS and Cabinet Office guidance, other than essential patient facing communications, proactive media and social media was not undertaken during the period of national mourning following the death of Her Majesty Queen Elizabeth II on 8th September. We issued staff and patient communications on where to sign our books of condolence, on Bank Holiday plans for services and on arrangements to watch the funeral. **Cheshire and Merseyside Surgical Centre** In late August, we announced that the new elective surgery hub at the Clatterbridge Hospital site in Wirral will be named **the Cheshire and Merseyside Surgical Centre**. WUTH was allocated £10.6 million of funding from NHS England and Improvement via Cheshire and Merseyside's Integrated Care System (ICS) to build two new 'modular theatres' at its Clatterbridge Hospital site. The Cheshire and Merseyside Surgical Centre will open in October and will treat around 3,000 patients a year. Elective procedures nationally have been impacted by the COVID-19 situation, creating a backlog of patients waiting for treatment. The funds have come from the NHS' Targeted Investment Fund to clear the backlog of people waiting for elective surgery. This project aligns with national and regional NHS strategy to have robust plans in place to ensure elective surgery is not affected by hospital pressures. Cheshire and Merseyside Surgical Centre at Clatterbridge

Awards
WUTH are entering the HSJ Partnerships award in conjunction with our application development partner Tendable for the joint development of our WISE ward accreditation system.

Our Volunteer and Vocational Development team in the Workforce Directorate won the Wirral Metropolitan College Nurturing Talent Award.

Employee Communications
We continued to highlight to patients and staff the changes necessary to facilitate the Urgent and Emergency Care Upgrade project enabling works at Arrowe Park Hospital, including changes to car parking.

Car parking charges were reintroduced in September 2022 and the package of communications supported the rationale for the changes to help with a smooth transition.

Support for staff has included signposting wellbeing services and promoting resources to assist staff with financial planning.

We are preparing for our staff awards as an in-person event on 25th November 2022 at Thornton Hall Hotel with nominations, including an award voted for by the public, closing on 27th September.

Plans are in hand for the seasonal flu vaccination campaign to staff and the COVID-19 booster programme for staff and the eligible patient cohorts is well underway with associated communications. We are planning a further open Q&A for staff on vaccinations.

October is Freedom the Speak up (FTSU) Month and so we are preparing to support wide communications of the FTSU process.

The 2022 Staff Survey also get underway this month and ends on 25th November 2022.

We produced the September issue of our staff magazine, 'In Touch'.

Stakeholders
We have started to publicise our Annual Members' Meeting (AMM) on 14th November 2022, which will be an in-person event in the Arrowe Park Education Centre. It will feature a 'marketplace' of service suppliers and further commemorations of the Arrowe Park 40th anniversary, as well as a review of the Trust's performance and finances.

We continue to share resources from our partners and stakeholders like Wired, Maternity Voices, Carers' groups and Healthwatch. The latter (Healthwatch) will join the marketplace at the AMM.

In the new integrated care system, the Wirral Communications Collaborative with partners in health and social care and Wirral Council is meeting monthly and working on plans for winter communications to signpost patients to services.

We hosted a visit from local MP Alison McGovern in late August.

The Board has asked for an MP briefing to be prepared to update MPs and stakeholders on WUTH developments. The action is in hand.

	WUTH Charity The Charity team's main focus is now our events calendar. Over 80 guests attended the special lunch and demonstration by Dave J Critchley, Executive Head Chef at Lu Ban, held at Thornton Hall Hotel to support the Tiny Stars appeal. The BBC's Great British Menu Chef hosted a lively and entertaining event, which raised £4500. The Arrowe Park Abseil took place 22-24 September with support from Santander Bank. Donations are still coming in and the total raised to date is £15000. Our Chief Strategy Officer Matthew Swanborough led from the front, going over the top as our executive representative, joined by local boxing celebrity Tony Bellew. Virtual London Marathon 2nd October - WUTH Charity has 25 places available for this year's virtual event. The Team is also preparing a range of seasonal fundraising activities for the autumn and Christmas, including a return of the 'Elf Run' for local schools, which proved to be very popular last year. Other fundraising and sales activities have resumed now, and the team are now fully focussed back on fundraising.

2	**Implications**
2.1	The Board is asked to note the progress in communications, media, campaigns, employee communications (supporting staff engagement), patient communications and the WUTH Charity.

3	**Conclusion**
3.1	The Board is asked to note the developments and progress outlined in the report. The Board is asked to note that a briefing for MPs is being developed at the Board's request.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
5 October 2022

Item No 18.1

Report Title	Committee Chairs Reports - People Committee
Author	Lesley Davies, Non-Executive Director

Overview of Assurances Received

- The committee reviewed the year one deliverables of the People Strategy and it was good to see that three deliverables have been fully implemented – Wellbeing Surgeries which offer a holistic approach and are themed and have included financial health and work/life balance advice; Health and Wellbeing conversations, which are linked to the NHS plan and supported with training and through the implementation of a best practice template consistency in approach; and the Winter Wellbeing Plan has been evaluated. Significant progress has also been made in the other seven deliverables. It was noted by the committee that considerable progress has been made in the implementation of the year one plan in the short time since the People Strategy was ratified.

- The key Workforce Performance report identified that the uptake of mandatory training was just below the 90% target at 89.73%. However, turnover continues to be higher than the target of 10% at 14.13%. Appraisal completion is encouraging and against a target of 88% is currently at 86%. The Committee was given assurance that where areas are under performing against target, oversight and monitoring was in place to improve performance. In a couple of areas where sickness is higher than other areas across WUTH and, in one instance, where the uptake of mandatory training is also slightly lower than across WUTH good assurance was given on the action being taken to monitor these areas. One area is also struggling with staff retention with staff leaving predominately to join the private sector for more pay. Good assurance was given that all these areas are being sufficiently monitored and kept under review.

- Given the age demographics of WUTH staff, assurance was also given on the work being undertaking to continue to develop the Trust's workforce planning and controls workstream. Assurance was given on the work of the retention workstream which is important in order for the Trust to be successful in retaining staff and to this end, flexible retirement options and other actions and options had already been put in place to improve retention going forward.

- The Committee received an update on all open employee relations cases which were being well managed and in line with the Trust's just and learning culture which includes a thorough review of lessons learned from each case. Confidence was taken from the detailed analysis provided and that there were no themes emerging from individual cases.

- The Committee also ratified the following policies: Redundancy, Pension Contribution Alternative Award and new Emergency Cover Arrangements for Resident/Non-Resident On-Call Duties by Consultants and SAS Doctors and for Absent Junior Doctors (Acting down arrangements).

- The Committee was given an update of the Trust's Flu Programme and supported the ambition to vaccinate all frontline healthcare workers. Work is underway to deliver the programme in time for this winter.

- International nursing recruitment is currently on hold pending a review of requirements and longer-term recruitment strategy.

- It was good to hear that the Junior Doctors' Forum was proving highly successful with Junior Doctors engaging positively in providing feedback and getting more involved in the work of the Trust, including their rotas, and offering sight into what impacts on their effectiveness as Doctors

- The Committee approved its new terms of reference and membership

New/Emerging Risks

There is a risk that clinical service will be disrupted due to industrial action. The Committee received an overview of the current position. An Industrial Action Response Cell has been established to ensure appropriate response and mitigation.

Other comments from the Chair

- The papers for the People Committee are of a very high standard – clear and detailed and provide the Committee with the level of information necessary on which to take assurance.

Board of Directors in Public
5 October 2022

Item No 18.2

Report Title	Committee Chairs Reports - Audit and Risk Committee
Author	Steve Igoe, Non-Executive Director & Deputy Chair

Overview of Assurances Received

- This report updates on the work of the Audit Committee at its meeting on 21st September 2022.The work of the Audit Committee as well as being documented in its terms of reference is prescribed by Accounting /Auditing Standards and Regulatory requirements.
- The Chair commenced the meeting by welcoming Chris Clarkson and Rajan Madhok as two new non-executive director members of the committee. Lesley Davies another non-executive director as observer and Mark Chidgey as CFO to his first meeting

Internal Control and Risk Management

- Regular reports were received relating to Financial Assurance and procurement spend controls. The Committee was assured on this latter item of the positive oversight of procurement, particularly in relation to Capital Expenditure. Work will continue to be undertaken to manage the number of waiver requests received although many of these relate to OEM suppliers where alternative provision is not available.
- The report concluded positively in relation to comparison with model health system metrics for spend control and process efficiency which are good indicators that compliance is being managed effectively. It also concluded that there is a robust system in place for requests to waive SFI's and authorisation for the same is at a senior level.

Internal Audit

- The Committee received its usual update in relation to the outcomes from Internal Audit work over the preceding period. The Committee was encouraged to see positive reports in relation to data security and protection. A further update was requested from the CFO in relation to the Trust's current position in relation to cyber preparedness.
- Moderate Assurance was received in relation to the outcome from the Tissue Viability Audit although the Committee was encouraged by the very positive way in which the recommendations had been addressed by the trust with only a couple remaining incomplete and being due for completion by the end of the calendar year.
- The final review was of the Trust's Risk Management processes which received Substantial Assurance. A very different place from where the Trust was a few years ago. The Chair suggested that now might be a good time for a risk maturity review.
- Audit plan changes were requested and approved in relation to:
    - A review of financial sustainability as requested by NHSE/I
    - A WISE ward accreditation review
    - IT medical devices
    - An alternate review to replace the Partnership and Governance review recognizing the infancy of the ICS and ICB

Tracking Outstanding Audit Actions

- Both the MIAA Audit Tracker and the Trust's own tracker report demonstrated good engagement with, and closure of, issues arising from Internal Audit reviews. This was confirmed orally by representatives from MIAA

External Audit

- The External Audit Partner confirmed he will present the findings from the 21/22 audit to the next Governors meeting. He was very complimentary about the work of the WUTH finance team in terms of preparation and management of the EA process holding the exercise out as an exemplar for other trusts to aspire to. The Committee thanked both Azets and the trust staff for an excellent outcome.

Review of Standing Financial Instructions (SFI's)

- An updated version of the Trust's SFI's was presented and approved. The significant changes related to:
    - Clarifying the charity expenditure approval process in the scheme of delegation
    - Updating the declaration of interest section

Board Assurance Framework

- The Committee discussed and approved current version of the BAF to be discussed by the Board at the next meeting. A small number of changes to the risk scoring criteria were noted reflecting the constantly changing and contemporary nature of the BAF. The chair suggested that the report might benefit from some further sophistication in relation to scores that had reached their target level but where still RAG rated red

Draft Terms of Reference

- The updated terms of reference were reviewed by the Committee and approved.

Managing Conflicts of Interest Policy Update

- An updated version of the conflicts policy was discussed and approved. The Committee then received an update on compliance and was assured by the Board Secretary of the Trust's stance in striving for 100% compliance which was supported by the Committee although recognizing the significant challenge that this presented. It was confirmed that a report on gifts and hospitality would be presented to the Committee later in the reporting cycle.

Other comments from the Chair

- The continued positive audit outcomes and reports further reinforce the trajectory of the Trust in terms of control environment and well led position. The positive opinions as to control environment and robust reports on Internal Control are significant in underpinning the trust and confidence regulators and the public can have in the safe, effective and efficient operation of the Trust.