NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

6 December 2023

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 1 November.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - Nov 2023 - 5 CFO.pdf
- 8.1.1 CFO Commentary M7.pdf
- 8.2 COO Report.pdf
- 8.3 IPR.pdf
- 8.3.1 WUTH IPR SPC Dashboard - Nov 2023 - Intro.pdf
- 8.3.2 WUTH IPR SPC Dashboard - Nov 2023 - 1 COO.pdf
- 8.3.3 WUTH IPR SPC Dashboard - Nov 2023 - 2 MD.pdf
- 8.3.4 WUTH IPR SPC Dashboard - Nov 2023 - 3 CN.pdf
- 8.3.5 CN Commentary - Oct figs for Dec 2023 BoD - final.pdf
- 8.3.6 WUTH IPR SPC Dashboard - Nov 2023 - 4 CPO.pdf
- 8.3.7 CPO Commentary - for Nov BoD final.pdf
- 8.4 BAF November December 2023.pdf
- 8.5 Productivity and Efficiency Update.pdf
- 8.6 Quarterly Maternity Report.pdf
- 8.7 Guardian of Safe Working Report.pdf

- 8.8 Freedom to Speak 6 Month Report.pdf
- 9 NHS Prevention Pledge.pdf
- 10 Review of Standing Financial Instructions (SFI's).pdf
- 10.1 Appendix 1 SFI November 2023 update.pdf
- 11 WUTH Charity Annual Report and Accounts 2023-24.pdf
- 11.1 Appendix 1 WUTH Charity Annual Report and Accounts 2023-24.pdf
- 12 Communications and Marketing Strategy November 2023.pdf
- 12.1 Appendix 1 Comms and Marketing Strategy.pdf
- 13 Annual Review of Terms of References.pdf
- 13.1 Charitable Funds V3.pdf
- 13.2 FBPAC V4.pdf
- 13.3 Estates and Capital - V4.pdf
- 13.4 Remuneration V2.pdf
- 13.5 People V4.pdf
- 13.6 Audit and Risk V4.pdf
- 13.7 Quality V3.pdf
- 14 CQC Urgent and Emergency Care Patient Experience Survey Results 2022.pdf
- 15 CQC Adult In Patient Survey Results 2022.pdf
- 16 National Cancer Patient Experience Survey Results 2022.pdf
- 17.1 Quality Committee.pdf
- 17.3 Charitable Funds Committee.pdf
- 17.4 Audit and Risk Committee.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 December 2023
Time	09:00 – 11:00
Location	Hybrid

Agenda Item		**Lead**	
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	
Items for Decision and Discussion			
5.	Patient Experience Strategy Story	Vic Peach	
6.	Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
7.	Chief Executive Officer Report	Janelle Holmes	
8.	Board Assurance Reports		
	8.1) Chief Finance Officer Report	Mark Chidgey	
	8.2) Chief Operating Officer Report	Hayley Kendall	
	8.3) Integrated Performance Report	Executive Directors	
	8.4) Board Assurance Framework	David McGovern	
	8.5) Productivity and Efficiency Update	Hayley Kendall	
	8.6) Quarterly Maternity and Neonatal Services Report	Vic Peach	Jo Lavery
	8.7) Guardian of Safe Working Report	Dr Nikki Stevenson	
	8.8) Freedom to Speak 6 Month Report	Debs Smith	Tracy Nolan
9.	NHS Prevention Pledge	David McGovern	
10.	Standing Financial Instructions (SFIs)	Mark Chidgey	
11.	WUTH Charity Annual Report and Accounts 2023/24	Mark Chidgey	
12.	Comms and Marketing Strategy	Debs Smith	
13.	Annual Review of Terms of References	David McGovern	Cate Herbert
Wallet Items for Information			
14.	CQC Urgent and Emergency Care Patient Experience Survey Results 2022	Vic Peach	

15.		CQC Adult In Patient Survey Results 2022	Vic Peach
16.		National Cancer Patient Experience Survey Results 2022	Vic Peach

Committee Chairs Reports

17.	17.1	Quality Committee	Dr Steve Ryan
	17.2	People Committee – **Verbal**	Lesley Davies
	17.3	Charitable Funds Committee	Sue Lorimer
	17.4	Audit and Risk Committee	Steve Igoe

Closing Business

18	Questions from Governors and Public	Sir David Henshaw
19	Meeting Review	Sir David Henshaw
20	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 24 January 2024, 09:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 1 November 2023
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Dr Steve Ryan	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Professor Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
MC	Mark Chidgey	Chief Finance Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
EH	Eileen Hume	Deputy Lead Public Governor
RT	Robert Thompson	Public Governor
JB	John Brace	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. No apologies were received.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 4 October were **APPROVED** as an accurate record.	

4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story from a Volunteer who was a forces veteran and volunteering in the Patient Experience Team. The video story described his experience of joining the Trust and the important contribution veterans can provide through volunteering. DS commented that it was positive the new volunteer felt included at the induction day, which also included other new members of staff. DS added a Volunteer event was being held on 13 November to celebrate and thank volunteers for their contribution. DH queried the number of Volunteers at the Trust. DS stated there was around 180 Volunteers at the Trust who volunteered in a variety of roles across the organisation. MC stated the Trust had signed the Armed Forces Covenant to show our commitment towards the Armed Forces communities. DH requested the Board pass on its thanks to Mick and other volunteers for their contribution. The Board **NOTED** the staff story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted the Trust had not been inspected by the Care Quality Commission (CQC) in 5 years and was keen to be inspected. DH added the Annual Members Meeting in October took place and went well. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH gave an industrial action update and summarised the latest position relating to Consultant and Junior Doctors, as well as the ongoing dispute with Clinical Support Workers (CSWs) regarding retrospective re-banding, noting further strike action was planned between 6-17 November for CSWs. JH stated the Trust declared no serious incidents in September and three Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS). JH highlighted that, following Board approval in October to move to a new regional Laboratory Information Management System	

	(LIMS), the Diagnostics and Clinical Services Division has been engaged with the process, and further assurance on the mobilisation and implementation of the new system has been sought. JH reported the MRI Department had been selected as the North West Region Team of the Year 2023 in the Society of Radiographers 2023 Radiography Awards and would go forward to be judged for the overall UK award. JH referenced the public hearings for module 2 of the UK Covid-19 Inquiry began on 3 October and would conclude on 14 December and explained that module 2 was focused on core political and administrative governance and decision-making for the UK. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board on 6 October and the Place Based Partnership Board (PBPB) on 19 October. RM queried the new Urgent Response Centre proposal from Cheshire and Wirral Partnership (CWP). JH stated that demand for mental health assessment in ED regularly outweighed the capacity of the mental health unit. Capacity is further compromised when there was a delay in egress to mental health in patient beds which were regularly escalated to CWP. JH added the new Urgent Response Centre would provide additional collocated space for patients in mental health crisis or waiting mental health admission. NS stated this area remained a challenge for patients and staff and the prevalence of mental health in Wirral was higher than the national average. NS added the Chief Nurse had formed a Mental Health Transformation Group which included Wirral system partners to address the problem. TF highlighted upon arrival at the mental health unit in ED triage was undertaken promptly and where possible patients were diverted to alternative services to further manage overall capacity and demand. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC highlighted at the end of September 2023, Month 6, the Trust reported a deficit of £13.4m against a plan of £13.6m, the resultant variance of £0.2m was a deterioration on the M5 position. MC added the position assumes £3.2m of income to mitigate lost	

	activity caused by industrial action, noting this was based on guidance from NHSE and the ICB but had yet to be finalised. MC provided an update on the month 6 statutory financial targets and the RAG rating for each, highlighting that financial stability, agency spend, financial efficiency, capital and cash were all rated green, and financial sustainability was red. MC explained the key drivers, mitigations, and corrective actions for each as well as the forecasted RAG rating. MC sought approval to increase the capital budget from £26.842m to £26.948m due to increase in Public Divided Capital, which had been considered by the Estates and Capital Committee in October. SL noted progress had been made with Barclays in enabling access to the bank account for the Charity and commented this was positive news. The Board: • **NOTED** the report; and • **APPROVED** the increase in capital budget from £26.842m to £26.948m, which had been reviewed and endorsed by the Estates and Capital Committee. **8.2) Chief Operating Officer Report** HK highlighted in September the Trust attained an overall performance of 96% against plan for elective outpatients and an overall performance of 85% for elective admissions. HK stated the reason for underperformance related the impact of large scale cancellations from medical industrial action as well as underutilisation of Cheshire and Merseyside Surgical Centre by other regional Trusts. HK stated cancer performance for 2 week waits at the end of September was 89.9% and the Faster Diagnosis Standard was 73.37% against a national target of 75% by March 2024. DM01 performance in September was 93.94% against a national target of 90% by March 2024. HK reported type 1 unscheduled care performance was 47.15% which was below the 4hr improvement trajectory, noting September was a significantly challenged month with high level of demand from both walk-in attendances and ambulance conveyances. HK summarised the risks to performance for elective and unscheduled care continued to be the impact of industrial action, and specifically mental health demand and the gap in provision in the ED going into winter.	

	SR commented about the continued reduction in the number of inpatients not meeting the criteria to residue and if the Trust was capturing the benefits for patients being at home. HK stated Home First had been capturing the experience of patients and the Trust was considering asking Healthwatch Wirral to seek feedback from patients. HK also stated that the contract between Prometheus (mental health transport provider) and the ICB was due to expire on 31 October and that a different provider would cover the gap in service until a new contract and provider could be procured from April. The Board **NOTED** the report. **8.3) Monthly Maternity Report** TF provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise this month. TF stated there was one serious incident and Maternity and Newborn Safety Investigation (MNSI) case declared in September. TF summarised the additional reports, noting these which are a requirement to be reported to the Board of Directors and will be part of the evidence submitted within the MIS submission. SR commented he attends the monthly Maternity Champions meeting and noted the strong attention to detail and clinical engagement to gather evidence for MIS Year 5. DH commented the Chair of the ICB visited the Trust in October and walked around Maternity Services. DH added the Chair fed back about the positive culture and team working in Maternity. The Board: • **NOTED** the report; and • **NOTED** the additional reports and updates included within the report required to be reported to the Board of Directors in November 2023 **8.4) Board Assurance Framework (BAF)** DM summarised the BAF covering strategic risks and scores for the period October/November. DH highlighted that changes have been made in relation to the frequency of BAF reporting across all fora. The Board: • **NOTED** and **APPROVED** the changes to the BAF; and • **NOTED** the changes in the frequency of BAF reporting across all fora	

	8.5) Integrated Performance Report DS reported staff turnover in month was above threshold and was due to staff leaving to start further education. DS stated the Trust was exploring how to retain staff while supporting them to undertake further education. DS also reported sickness absence in month was above threshold and continued to be driven by short term absence. DS added anxiety was an increasing theme and Occupational Health would provide additional support. NS explained a new Head of Research and Innovation had been appointed and would start in November and the focus was on recruiting to NIHR studies. NS stated the Patient Safety Incident Response Framework had launched in September and an update including feedback would be provided to a future meeting. The Board **NOTED** the report	
9	**Winter Operational Plan** HK outlined the Trust's winter plan and highlighted robust plans were in place to deal with expected winter pressures, and recent peaks in demand suggest planning for a worst case scenario, noting there would be 3 months where demand outstrips capacity available. HK added there remained concerns around corridor care and handover times due to potential high levels of occupancy as well as significant risks for mental health given the current challenges and demands in ED. JH stated at the recent Unscheduled Care Board a request was made of members to review all Wirral provider winter plans and feedback to the ICB Place lead any areas of concern prior to sign off. DH commented it was positive to see Divisional winter plans which demonstrated good connectivity and joint working. DH requested the Board's thanks be shared with Divisions for their work on this. SR commented on the robustness of the winter plans and suggested exploring mental health street triaging. HK stated the local mental health provider had limited resources but agreed to raise at their next meeting. SR also queried if the launch of the new OPEL framework as well as the wider system response. HK stated the Trust declared OPEL 4 on Monday and the new framework had been delayed by 6 weeks to update the thresholds.	

	SL queried the funding available for the winter plan. MC stated funding for the winter plan was already within the forecasted position and would be reviewed by the Executive Team next week. The Board **NOTED** the report.	
10	**Committee Chairs Reports** **10.1) Estates and Capital Committee** The Board **NOTED** the report. **10.2) Finance Business Performance Committee** The Board: • **NOTED** the report; and • **RATIFED** the Aseptic Services business case **10.3) Council of Governors** The Board **NOTED** the report.	
11	**Questions from Governors and Public** RT queried if there was no capacity for mental health services in the region or if it was due to a lack of engagement with the mental health provider. JH stated locally Cheshire and Wirral Partnership (CWP) were engaged but the issue of inpatient mental health capacity was a national issue. JH added in Wirral she understood that the risks were related to both bed numbers and the recruitment of staff. NS stated the population of Wirral had a higher hospital admission for mental health, noting this was 215 patients per 100,000 in comparison to 80 patients per 100,000 for England. DH requested a deep dive on mental health risks and mitigations due to the higher number of patients per 100,000. No questions were raised.	Tracy Fennell
12	**Meeting Review** DH thanked LD for accommodating the meeting at the Cheshire College Ellesmere Port Campus. Members commented about the rich conversations that took place in the Board Away session regarding collaboration and	

	partnerships. DH added Governors would be updated in due course regarding this. No comments were made.	
13	**Any other Business** No other business was raised.	

(The meeting closed at 13:50)

Action Log
Board of Directors in Public
6 December 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 July 2023	8.1	To provide a breakdown of the number of open studies to understand the totality and spread	Dr Nikki Stevenson	In progress. An update will be provided to Board following the next meeting of the R&I Committee.	January 2024
2.	1 November 2023	11	To provide a deep dive on mental health risks and mitigations	Tracy Fennell	In progress. To be presented to Quality Committee in January 2024 and will be a Board Seminar topic in March.	March 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
6 December 2023

Title	Chief Executive Officer 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 November. It is recommended that the Board of Directors: • Note the report

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

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

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

1	**Narrative**
1.1	**Industrial Action Update** The national pay dispute relating to Consultants and Junior Doctors is on-going, although there has been no further strike action since early October 2023 whilst talks have been on-going. In relation to the Consultant's dispute, an offer has been made by the government, which trade unions will put to members for a vote.

	In a separate matter, the UNISON industrial dispute relating to retrospective re-banding for Clinical Support Workers continues. In October 2023 UNISON agreed to the Trust's request to enter into ACAS conciliation and meetings have taken place on four separate occasions, to discuss the Trust's third offer. The third offer includes agreement on UNISON's key demand, specifically a backstop date of April 2018 for any retrospective regrading. For retrospective re-grading to be awarded, the duties that individuals have been undertaking must be sufficient to change the banding of the role. The Trust position on this matter is based on the national NHS framework. Talks have stalled because parties are unable to agree on what constitutes the difference between a band 2 CSW and a band 3 CSW. UNISON asked the Trust to seek national advice on our position. The Trust did so, and the advice confirmed that the Trust position is in line with the national NHS framework. Unfortunately, UNISON have not accepted this position and therefore further strike action will take place on the following dates: • 7am Monday 4th December to 8:15am Saturday 9th December 2023 • 7am Monday 11th December to 8:15am Saturday 16th December 2023 • 7am Monday 18th December to 8:15am Saturday 23rd December 2023 As with any industrial action, planning and mitigating actions are in place via the Trust's EPRR route and impact across the Trust is carefully monitored.
1.2	**Accreditations and Awards** **Cheshire and Merseyside Surgical Centre achieves Getting It Right First Time (GIRFT) accreditation** The Cheshire and Merseyside Surgical Centre has achieved Getting It Right First Time (GIRFT) accreditation as part of the National Elective Surgical Hub Accreditation Programme. It follows a visit to the Centre on 25 September by GIRFT inspectors including Professor Tim Briggs who is Chair of the GIRFT programme and National Director for Clinical Improvement and Elective Recovery. **Endoscopy Team achieves JAG Accreditation** The Endoscopy Team has been awarded reaccreditation by the Joint Advisory Group (JAG) on GI Endoscopy by the Royal College of Physicians for the year. JAG accreditation is awarded to endoscopy services which have demonstrated they meet best practice quality standards. **Health Service Journal (HSJ) Awards** As Senior Responsible Officer for the Cheshire & Merseyside Elective Recovery and Transformation Programme, I was part of the winning team recognised within the Provider Collaboration of the Year category at the HSJ Awards ceremony on 16 November. In the same category, WUTH were also finalists for the collaboration with Countess of Chester Hospital on the Cheshire and Merseyside Surgical Centre at Clatterbridge.

	Cellular Pathology maintains United Kingdom of Accreditation Service (UKAS) accreditation to the international medical laboratory standard ISO15189:2012 The Cellular Pathology department has maintained United Kingdom of Accreditation Service (UKAS) accreditation to the international medical laboratory standard ISO15189:2012. It follows a visit to the department on 7 November by the UKAS assessment manger and peer assessor. This is a very rigorous standard to maintain, and accreditation is an internationally recognised reflection of the quality and technical expertise of the service. During this year's inspection the assessors were so impressed during their visit, that they raised no findings against the department and were full of praise for the service, its quality and the commitment, openness and dedication of all staff working in the department. **Pleural Team shortlisted for award** The Pleural Team have been shortlisted in the Macmillan Cancer Support Professionals Excellence Awards for a Whatever It Takes award. The Whatever It Takes award category aims to recognise individuals and teams that have truly gone the extra mile. The nominee should demonstrate values of heart, strength and ambition through compassion, kindness, and teamwork.
1.3	**Patient Safety Incident Investigations (PSIIs) and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** The Patient Safety Incident Response Framework (PSIRF) was launched in September and one PSII was opened in October in relation to a Never Event. The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance. There were three incidents reported to the Health and Safety Executive (HSE) in October. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.4	**Contract Award Updates** The Board of Directors in October approved a contract award to 4Ways Healthcare Ltd, which was negotiated by the Cheshire and Merseyside Radiology Imaging Network for the provision of outsourced out of hours radiology reporting services. The direct award of this contract is compliant with the Trust's Standing Financial Instructions and with the Public Contracts Regulations 2015 by utilising the NHSSC framework for Medical Diagnostic Reporting Services Reference 2018/S 2285 20138.
1.5	**Thirlwall Inquiry Terms of Reference** The Thirlwall Inquiry, tasked with the investigation following the sentencing of Lucy Letby, published its terms of reference on 30 October 2023. The inquiry will investigate 3 broad areas: • The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

	• The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:
	  ○ whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her
	  ○ the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust
	  ○ whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby
	• The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.
	
	Further information, including a non-exhaustive list of questions that may form part of the inquiry, can be found here: Thirlwall Inquiry: terms of reference - GOV.UK (www.gov.uk)

1.6	**UK Covid-19 Inquiry module 2 public hearings summary** The public hearings for module 2 of the UK Covid-19 Inquiry began on 3 October and will conclude on 14 December. During w/c 6 November the Inquiry heard from witnesses including Lord Mark Sedwill, former cabinet secretary and head of the civil service, Lord Edward Udny-Lister, a senior advisor to then prime minister, Rt Hon Boris Johnson, and Simon Ridley, who was director general of the Covid-19 Taskforce. The Inquiry heard evidence about the concerns that the NHS was going to be overwhelmed, the discharge of patients into care homes, decisions about lockdowns, and the Department of Health and Social Care's (DHSC) role in drafting regulations. During w/c 20 November the Inquiry heard from witnesses including Sir Patrick Vallance, Professor Sir Chris Whitty, and Professor Sir Jonathan Van Tam. The Inquiry heard evidence on the timing of lockdowns, difficulties in getting data on NHS capacity, and the interactions between government and its scientific advisors. W/c 4 December the Inquiry will hear from Rt Hon Matt Hancock MP, former secretary of state for health and social care, Rt Hon Michael Gove MP, now secretary of state for levelling up, housing and communities, and Professor Dame Jenny Harries, former deputy chief medical officer and now chief executive of the UK Health Security Agency (UKHSA).
1.7	**System and Place Updates** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 3 November and received two presentations related to the available data, emerging priorities and activities being coalesced within C&M related to digital and workforce.

The need to prioritise and to target activity was discussed as was the opportunity for Trusts to consider the best way to maximise effort, secure improvements and, if possible, to achieve efficiency. The Board welcomed the presentations and identified the need for a facilitated exploratory and prioritisation discussion on these subjects at its next meeting.

Elective Recovery and Transformation Programme

- There are now have less than 55,000 patients to clear before the end of March in order to achieve the target of no people waiting over 65 weeks. The average clearance rate has reduced slightly due to the high levels of industrial action and the summer holidays; however, more clearance is needed to reach the 65 week target at the end of March. Significant risks exist around winter, continued industrial action and covid.
- Theatre utilisation performance is improving again, although it remains in the 3rd quartile. Some trusts that perform well have not submitted data for this period, so it is believed the "real" performance is higher. Session utilisation has improved through August, and it is expected to continue when the September data is available.

Clinical Pathways

- An options paper has been prepared to consider future models for the dermatology service. The recommendation proposes that an independent evaluation of IT platforms is undertaken prior to procurement of system for 2024.
- Gynaecology collaboration workshop took place in September. 53 attendees from across Acute, Primary care, Place and Local Authority came together to agree priority areas for further improvement including development of women's health hubs and implementation of the Women's Health Strategy. The second phase of the Clatterbridge Elective Hub has now opened, and has been visited by Professor Tim Briggs, the clinical director for the national GIRFT programme. The team were highly commended by Professor Briggs on the quality of the facility, and the evident team working.

Finance, efficiency and value workstream

- The overall C&M Financial position has worsened in September (month 6) with an overall deficit of £128m against a £71.5m plan, £59m worse than plan. This deficit has slowed down compared to earlier months, but C&M remains the fourth highest deficit in England.
- It should be noted that once non-recurrent CIPs are adjusted for, the underlying deficit is £191m. At this stage C&M is forecasting a year end position in line with its overall plan (£51.2m deficit) – this is very high risk.

Place Based Partnership Board (PBPB) Update

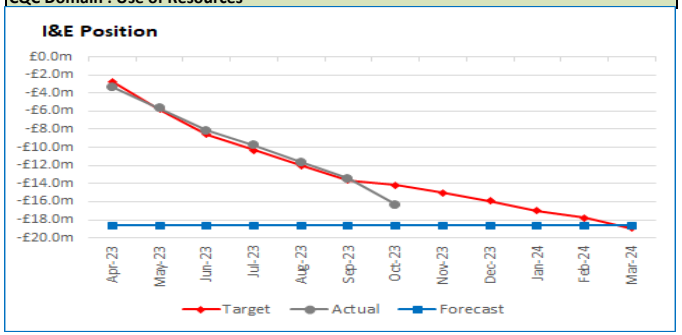
The Place Based Partnership Board (PBPB) met on the 23 November and discussed several reports, including quality and performance, finance, and risk reports from a Place perspective. Key among the reports was an update on developing the Wirral Health and Care Plan for 2024/25.

This will result in the refresh of the Wirral Health and Care Plan 2023/24 for 2024/25 thus aligning NHS, local authority, and wider Place priorities. The Board also received

	an update the Wirral Strategic Estates Group and NHS Cheshire and Merseyside Integrated Care Board (ICB) Dental Improvement Plan 2023-2025.

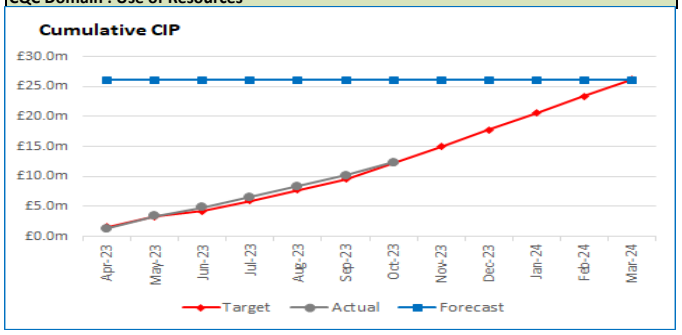
Chief Finance Officer

CQC Domain : Use of Resources



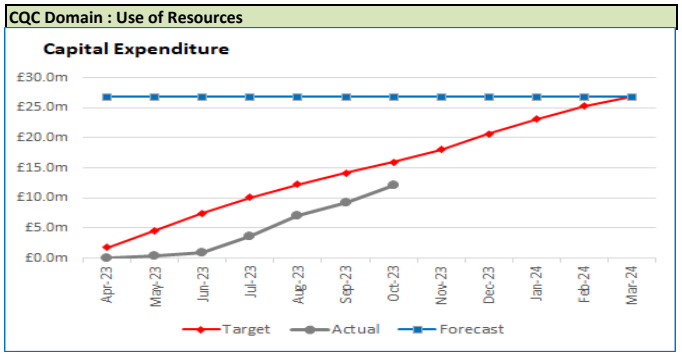
Oct-23
-£16.34m
Variance
Position worse than plan
Target
-£14.20m

CQC Domain : Use of Resources



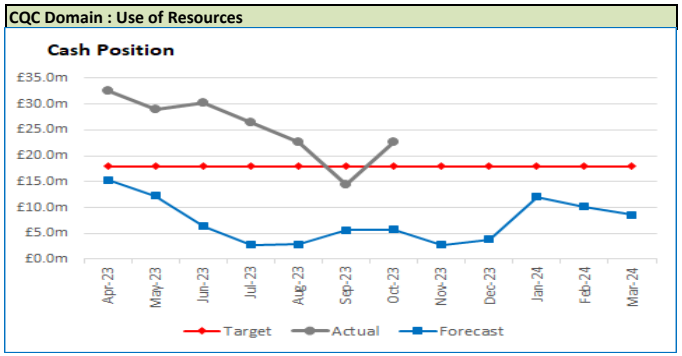
Oct-23
£12.31m
Variance
Position better than plan
Target
£12.28m

CQC Domain : Use of Resources



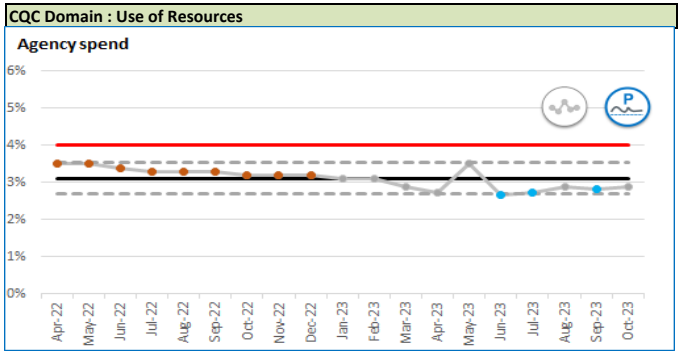
Oct-23
£12.2m
Variance
Position not worse than plan
Target
£16.0m

CQC Domain : Use of Resources



Oct-23
£5.7m
Variance
Position better than plan
Target
£22.6m

CQC Domain : Use of Resources



Oct-23
2.9%
Variance
Position better than threshold
Threshold
3.7%

Chief Finance Officer

Executive Summary

In summary, the Trust is forecasting, with risks, that the financial plan for 2023/24 will be achieved. The key internal risks are maximising elective activity, CIP achievement and overspends within Estates. The main external risks are the impact of continued strike action and underfunded national pay awards. Failure to achieve the financial plan would place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

As the Trust annual plan is a deficit of £18.9m, management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy approved by the Board in April 2023. Quarterly updates will be provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2023/24 are:

Statutory Financial Targets	RAG (M7)	RAG (Forecast)	Target Measure
Financial Stability			Achieve in-year financial plan
Agency Spend			Agency spend <= 3.7% of total pay
Financial Sustainability			Medium term financial recovery plan
Financial Efficiency			Variance from efficiency plan
Capital			Capital spend on track and within CDEL limit
Cash			Positive Trust cash balance

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

I&E Position

Narrative:

At the end of October 2023, Month 7, the Trust has reported a deficit of £16.3m against a plan of £14.1m, the resultant variance of £2.2m is a deterioration on the M6 position.

The M7 position includes assumed national funding and changes to contract terms to mitigate against additional expenditure and reduced income resulting from industrial action. During November NHSE has confirmed the actual levels of funding and required Trusts and ICBs to reset their plans on this basis. This work is ongoing, and an update will be provided to the Board of the impact on the forecast position and associated risks.

The table below summarises this I&E position at M7:

Month 7	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£37.6m	£35.9m	-£1.7m	£257.5m	£252.6m	-£4.9m
Other Operating Income	£3.1m	£3.4m	£0.3m	£22.8m	£22.4m	-£0.4m
Total Income	**£40.6m**	**£39.3m**	**-£1.4m**	**£280.3m**	**£275.0m**	**-£5.3m**
Employee Expenses	-£30.2m	-£30.5m	-£0.3m	-£207.7m	-£208.0m	-£0.4m
Operating Expenses	-£13.1m	-£13.5m	-£0.3m	-£95.3m	-£93.5m	£1.8m
Non Operating Expenses	-£0.5m	-£0.3m	£0.2m	-£3.7m	-£2.3m	£1.4m
CIP	£2.7m	£2.1m	-£0.6m	£12.3m	£12.5m	£0.2m
Total Expenditure	**-£41.2m**	**-£42.2m**	**-£1.0m**	**-£294.5m**	**-£291.3m**	**£3.2m**
Total	**-£0.6m**	**-£2.9m**	**-£2.3m**	**-£14.2m**	**-£16.3m**	**-£2.2m**

Key variances within the position are:

Clinical Income – £4.9m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners and underperformance against the elective plan in Surgery. There has also been a reduction in PbR excluded drugs, but this is offset by operating expenses.
Operating expenses – The underspend mirrors the variances within clinical income.
Non-operating expenses – our PDC dividend payable was lower than expected and interest payable has increased.
CIP – CIP was lower than plan in M7 and whilst it is still ahead of the year to date position the full target level will not be met recurrently.

It is confirmed that the Trust's agency costs were 2.9% of total pay costs compared to a maximum target of 3.7%.

Risks to position:
The main risks to the I&E position are:

- The Trust fails to fully deliver the recurrent Cost Improvement Programme (see below).
- Continuation of strike action, with a consequential impact on both expenditure and income (elective activity).
- The overspend in Estates continues and/or the agreed mitigation plan is not fully achieved.
- That the reducing trajectory of patients with no criteria to reside is either not maintained and/or reverts to previous levels.

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Minimising the financial consequences of strike action whilst maintaining the safety of services.

Cumulative CIP

Narrative:

The Trust delivered more CIP in October than in any previous month but due to increases in the profile of the plan, M7 was the first month that we were behind target. The Trust is ahead of the year-to-date plan of £12.3m by £0.2m.

Risks to position:

- That the momentum on identification and delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:

- Continuation of the Productivity and Improvement Programme.
- Review of non-recurrent opportunities not currently included within our forecast.

Capital Expenditure

Narrative:

The Board approved changes to the capital plan in M6 as per the table below:

Description	Original budget	Reprioritisation	Revisions to Forecast	Revised budget
CDEL				
Internally Generated	£3.965m			**£3.965m**
Urgent Maintenance (ICB)	£2.920m			**£2.920m**
UECUP	£5.800m			**£5.800m**
UECUP - PDC	£10.000m			**£10.000m**
CDC - PDC	£4.108m			**£4.108m**
CDC - PDC P2			£0.106m	**£0.106m**
Diagnostics Digital - PDC	£0.049m			**£0.049m**
Confirmed CDEL	**£26.842m**	**£0.000m**	**£0.106m**	**£26.948m**
Total Funding for Capital	£26.842m	£0.000m	£0.106m	£26.948m
Capital Programme				
Backlog maintenance	£1.397m	£0.869m		£2.266m
Medical equipment	£1.818m	£0.096m		£1.916m
Heating and chilled water pipework replacement	£2.920m	-£0.900m		£2.020m
IT equipment	£0.750m			£0.750m
UECUP - Trust funding	£5.800m			£5.800m
Approved Capital Expenditure Budget	**£12.685m**	**£0.065m**	**£0.000m**	**£12.752m**
UECUP	£10.000m			£10.000m
CDC	£4.108m	£0.106m		£4.214m
Diagnostics Digital	£0.049m			£0.049m
Confirmed PDC	**£14.157m**	**£0.106m**	**£0.000m**	**£14.263m**
Total Anticipated Expenditure on Capital	£26.842m	£0.171m	£0.000m	£27.015m

At M7 the capital programme is £3.8m behind plan:

Scheme	Plan spend @ M7	YTD spend	Variance
Backlog maintenance	804	146	-658
Medical equipment and corporate schemes	1,368	751	-617
Heating and chilled water pipework	1,480	1,480	0
IT equipment	220	136	-84
UECUP - Trust funding	-	-	0
UECUP - PDC	8,085	6,990	-1095
CDC	4,003	2,610	-1393
Diagnostics Digital	49	-	-49
CDC - equipment	-	98	98
NHSE/I TOTAL CAPITAL PLAN 23/24	**16,009**	**12,211**	**- 3,798**

We do not anticipate any underspend against plan by year end.

The level of capital available for equipment replacement and infrastructure update is very limited and could be committed many times over. As a consequence, there is continued review of both schemes and prioritisation decisions. Monitoring of risks associated with delivery of capital schemes and the overall programme will continue to be reported through the Estates and Capital Committee.

Risks to position:

- That delays and increased costs of significant schemes, such as UECUP, result in the diversion of funding from equipment replacement and the update of infrastructure with a consequential impact on quality of care.

Actions:

- CFO, with executive team to continue to work with divisions to manage re-prioritisation of schemes within the agreed budget.
- Estates and Capital Committee to continue to monitor progress and risks from capital projects.
- Review and update the three year capital plan for 2023/24 to 2025/26.

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the end of October our cash balance was £19.9m. The significant capital programme and a planned deficit of £18.9m maintaining a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement will not be sustainable beyond the short-term but has avoided the need to request borrowing from NHSE.

The issue of access to the bank account for the Charity has now been resolved.

Risks to position:

- Achievement of the cash trajectory is placing delivery of the Public Sector Payment Policy at risk.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Ensuring that cash flow from the ICB for contractual payments is optimised.
- Monitoring and escalation of any aged debt delays.
- Confirmation of NHSE process should the Trust be required to request additional cash resource.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
6 December 2023

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, 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. The Board should note that industrial action has had a significant impact on the ability to deliver the elective plan and a high number of patients cancelled for planned care, with the year to date activity position being behind plan.

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

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

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

1	Introduction / Background
1.1	As a result of the large scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. There is national recognition of the significant disruption to elective services during that pandemic and more recently, the continued industrial action. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny from September 2023.

2	Planned Care
2.1	**Elective Activity** In October 2023, the Trust attained an overall performance of 97% against plan for outpatients and an overall performance of 87% against plan for elective admissions as shown in the table below:

2023/24 Plan			
Activity Type	Target for Oct	Actual for Oct	Performance
Outpatient New	12,909	12,310	95%
Outpatient Follow Up	31,765	30,945	97%
Total outpatients	**44,674**	**43,255**	97%
Day case	4,654	4,154	89%
Inpatients	808	605	75%
Total	**5,462**	**4,759**	87%

Underperformance against plan continues predominantly due to the impact of large-scale cancellations for industrial action. Underperformance relating to the under utilisation of Surgical Centre sessions also continues (relating to another NHS Trust), and two across medical specialities, both of which have recovery plans in place monitored by the Chief Operating Officer.

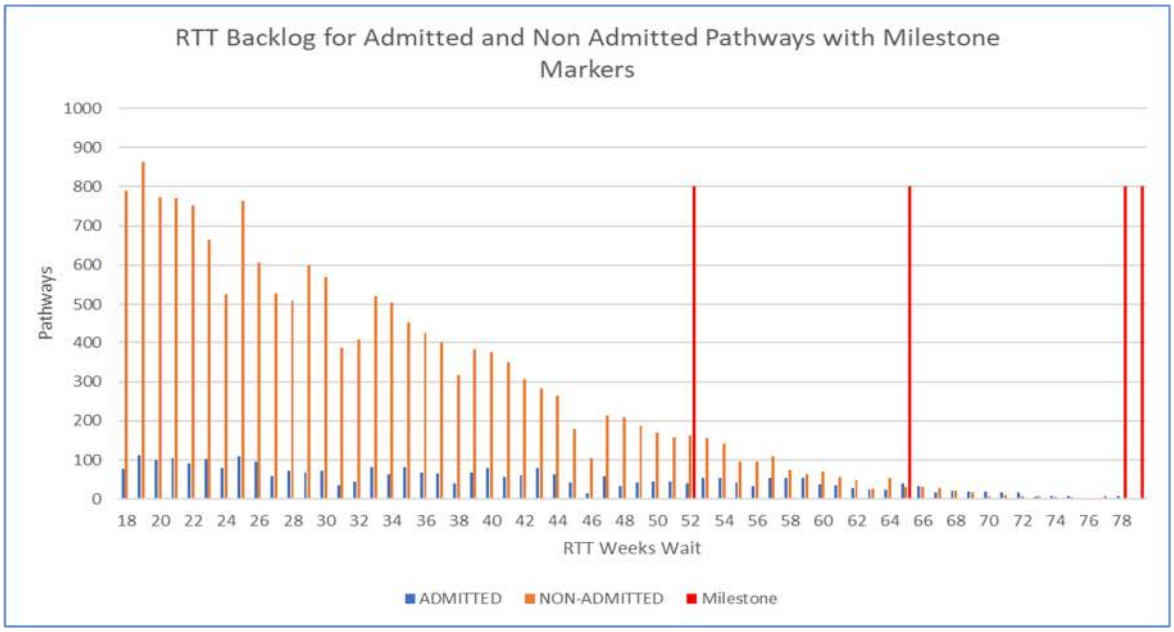
The Trust has submitted a revised financial forecast position that has a reduced level of elective activity included within it.

2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by March 2024. The Trust's performance at the end of October against these indicators was as follows:

- 104+ Week Wait Performance – 0
- 78+ Week Wait Performance – 4
- 65+ Week Wait Performance - 355
- 52+ Week Wait Performance - 1908
- Waiting List Size - there were 43,236 patients on an active RTT pathway which is higher that the Trust's trajectory of 38,916.

An in-depth analysis of waiting list size has been undertaken and key actions to address are underway across the divisions, including early escalation to clinical teams and proactively managing patient pathways ahead of breach dates.

The graph below illustrates current RTT Backlog for admitted and non-admitted patients at the key milestones of 52, 65, 78 and 104 weeks:



WUTH have continued to support neighbouring Trusts by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre and this will continue throughout the year. The Trust, via the new National PIDMAS system has also offered to provide mutual aid across two surgical specialities. The ICB has confirmed that treating these very long waiting patients will not affect the Trust's performance position.

2.3 Cancer Performance

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

- 2 Week Waits – This national standard has now been stood down. However, the Trust continues to measure performance internally to support the delivery of the Faster Diagnosis Standard. At the end of October 2WW performance was 84.3%.
- FDS – was 72.09% in September (latest available data) against a national target of 75% by March 2024. This standard has been impacted by industrial action and subsequent inability to maintain the 2WW standard.
- 31 day treatment numbers - above trajectory and expected to continue.
- 62 day performance is currently below trajectory with 173 patients against a plan of 176.

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09	02/10	09/10	16/10	23/10	30/10
Actual 23/24	177	193	193	194	182	175	175	182	203	191	162	155	158	161	163	165	167	176	191	183	196	201	184	175	164	170	154	168	177	173	167
Recovery Trajectory	210	210	210	210	205	205	205	205	205	200	200	200	200	194	194	194	194	194	188	188	188	188	182	182	182	182	176	176	176	176	176
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- 104 day long waiters – performance is above trajectory at 50 against a plan of 33 for September:

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09	02/10	09/10	16/10	23/10	30/10
Actual 23/24	65	68	59	55	54	49	58	58	64	56	46	48	59	57	57	56	47	42	43	41	45	48	54	57	50	57	57	58	57	53	50
Recovery Trajectory	55	55	55	55	52	52	52	52	52	49	49	49	49	45	45	45	45	45	41	41	41	41	37	37	37	37	33	33	33	33	33
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

As with all Trusts across C&M delivery of the 31and 62 day indicators remains a priority but given the increases in demand the recovery of performance against the targets remains a focus for 2023/24. The Trust is performing well when compared to other units but remains focussed on improving waiting times further for patient experience.

There continues to be a multi-disciplinary approach to improving the efficiency of cancer pathways and as expected is supporting decreased waiting times for Colorectal with a similar workstream commencing in Gynaecology.

2.4 DM01 Performance – 95% Standard

In October 93.65% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01. This is against the national standard of 95% and requirement for Trust's to achieve 90% by March 2024. ECHO and CT remain challenged, however have recovery plans in place.

The Trust has commenced providing mutual aid for neighbouring Trusts for patients waiting longer than 6 weeks for diagnostic tests.

2.5 Risks to recovery and mitigations

The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue.

The major risk to the delivery of the elective recovery programme is medical staff industrial action, given the significant volumes of patients cancelled during this action. On strike days, elective activity is being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, with a focus to keep patient cancellations to an absolute minimum.

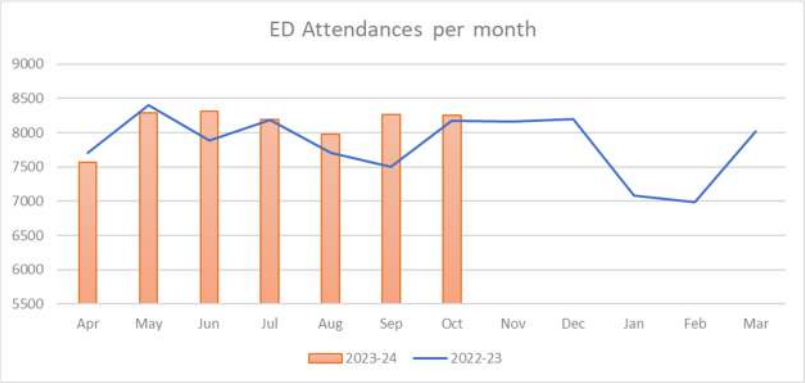
3.0 Unscheduled Care

3.1 Performance

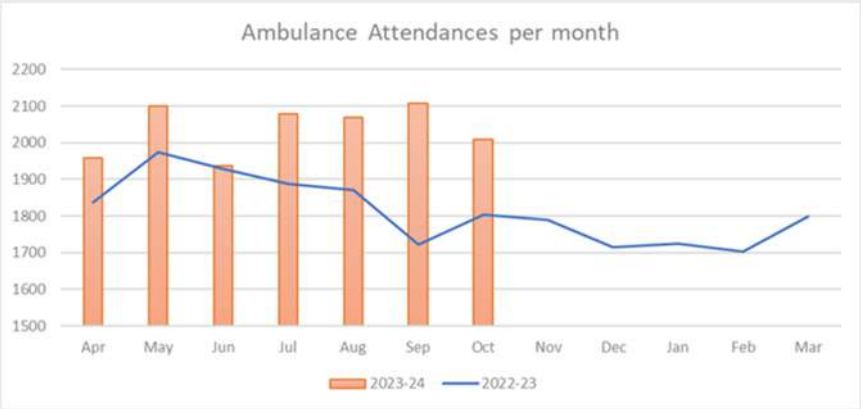
September Type 1 performance was reported at 48.50%, which is below the 4-hour improvement trajectory. The combined performance for the Wirral site was 75.08%:

Type 1 ED attendances:	Type 3 ED attendances:
• 8,264 in September (avg. 275/day) • 8,258 in October (avg. 266 /day) • 3% decrease from previous month	• 2,942 in September • 2,836 in October • 2% reduction from previous month

ED Attendances by month 2023/24 compared to 2022/23:



The number of patients self-presenting and the number of patient ambulance conveyances in October were higher than in the previous year, with the latter having the greatest impact on the flow within the department.

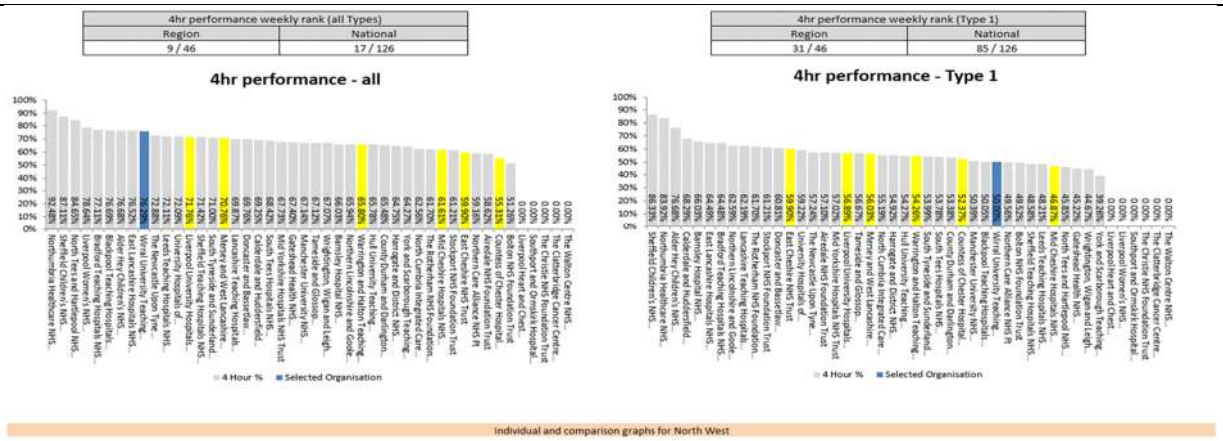
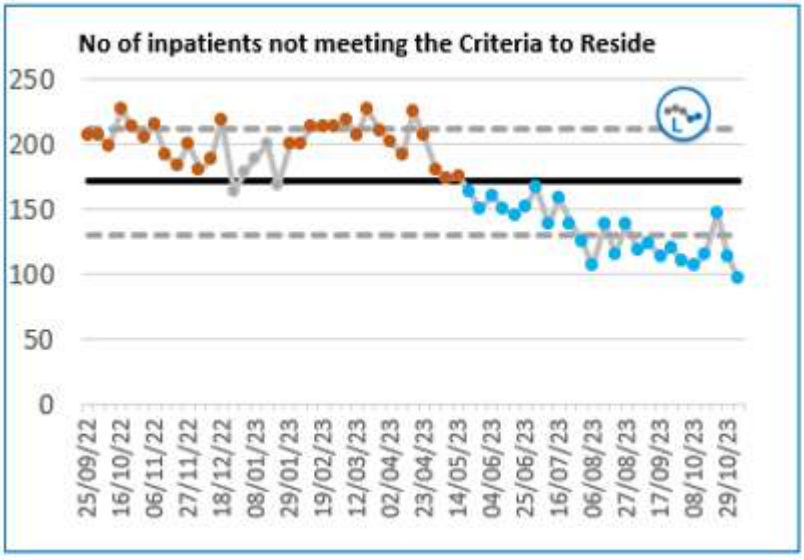


In October, compliance with the national standard for ambulance handovers had deteriorated. Improving ambulance handover times to release ambulance crews is a priority for the Trust. One of the main contributary factors to poor handover times is in relation to the expected 15 minutes to handover (ambulance crew arrives on site to the handover of the patient to our clinical team). Periods of high volumes of activity, both from ambulances and patients who self-present along with poor outflow of assessment areas contribute to limited trolley space and workforce preventing patients to be handed over to the department.

To improve the position, the Trust has met with colleagues from the Northwest Ambulance Service (NWAS) and PLACE partners and produced an action plan that is due to be implemented in November.

Some of the measures to improve handover times are included in the winter initiatives, which are to be implemented from mid-October. Measures include the expansion of the Home First service and the additional A&E nurse to enable staffing of the first corridor (to prioritise releasing of the ambulance crews). Building work on the winter escalation ward is also now complete, providing 16 additional beds to support with increased pressure in A&E.

The graphs below demonstrate Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in C&M (yellow bars) and Type 1 performance only:

	 There is now direct oversight each day by the COO and Deputy COO of site meetings and ambulance handover to ensure that performance improves. **Urgent & Emergency Care Upgrade Programme (UECUP)** The next phase of the UECUP work is scheduled to take place in February 2024. Operational plans are currently being developed to ensure that the impact on the running of the department is minimised. It is anticipated that with the move, the department will have access to part of the new department, including the new resus area, which will be used to make space for the next phase of construction.
3.2	**Transfer of Care Hub development and no criteria to reside.** The reduction of the number of patients with no criteria to reside continued into October, with the number reaching below 100.  This is a great success that has been achieved in a short space of time. This is a positive step both for our patients in hospital beds who need alternative support outside the hospital and to support patients waiting for a hospital bed in the emergency department. The Transfer of Care Hub (ToCH) will continue to focus on further reducing the number over the coming months, working closely with our colleagues in Social Care and the Community Trust.
3.3	**Mental Health**

	October saw an improved position with a reduction in the number of patients with mental health conditions waiting for a bed. This was accompanied with a further reduction in waiting times for a bed once referred. The Trust continues to work with the local mental health provider to ensure that any increase in demand is responded to promptly and that plans are in place to support A&E once the next phase of UECUP commences in February. Following concerns raised in September regarding the termination of the contract with Prometheus, who provide transport for patients brought into the Trust under a Section 136. It has been confirmed that a new contract has been awarded to one of the existing providers, ISL until the end of April 2024 – further development of plans is required pre this date.
3.4	**Risks and mitigations to improving performance** The increase in ambulance conveyances and the acuity of patients attending A&E continues to put pressure on the flow through the department. This in turn has a negative impact on performance against national standards for emergency care. The Trust has recognised recent UEC performance is not where expected, and additional actions and executive oversight are in place to address the pressures. Patient safety continues to be a priority by ensuring that patients waiting in the waiting room for triage do not have to wait longer than 15 minutes and that patients who are in the corridor following an ambulance transfer are assessed by a medic whilst remaining in the care of ambulance crew. Further industrial action would be a significant challenge to the capacity and flow of ED across the hospital. However, the Trust continues to ensure that robust plans are in place to ensure the safety of patients and staff vias the Emergency Preparedness and Preparation (EPRR) route.

4	Implications
4.1	**Patients** • The paper outlines challenges with waiting times for elective treatment longer than what the Trust would want to offer, but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced in November to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024.

5	Conclusion
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the Trust's Winter Plan to ensure that the increase in demand over the winter can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements have been seen in the 62 and 104 day wait cancer metrics and in achieving the FDS, but medical industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

06 December 2023

Title	Integrated Performance Report
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 October 2023

It is recommended that the Board:

- notes performance to the end of October 2023

Key Risks

This report relates to the key risks of:

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

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

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

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

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric. Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	3	4	7
Effective	0	1	1
Caring	3	1	4
Responsive	4	18	22
Well-led	3	0	3
Use of Resources	4	1	5
All Domains	17	25	42

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

Integrated Performance Report - November 2023

Approach

The metrics for inclusion have been reviewed with the Executive Director team.
Performance is represented in SPC chart format to understand variation, and a summary table indicating performance against standards.
The metrics are grouped into Executive Director portfolios, with individual metrics showing under their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	3	4	7
Effective	0	1	1
Caring	3	1	4
Responsive	4	18	22
Well-led	3	0	3
Use of Resources	4	1	5
All Domains	17	25	42

Key to SPC Charts:

Issues / limitations

SPC charts should only be used for 15 data points or more. Some of the reported metrics only apply from 2022, so will take time to build up.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

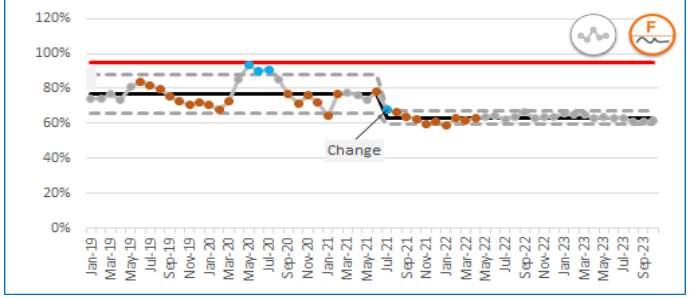
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	Threshold target for 2023/24 is now confirmed - maximum 71 cases for the year.
% Appraisal compliance	Likely change of the target threshold to 90% from Q3 2023/24

Chief Operating Officer (1)

CQC Domain : Responsive

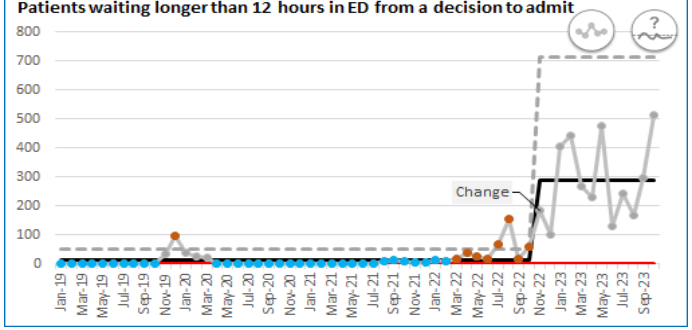
4-hour Accident and Emergency Target (including APH UTC)



Oct-23
61.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

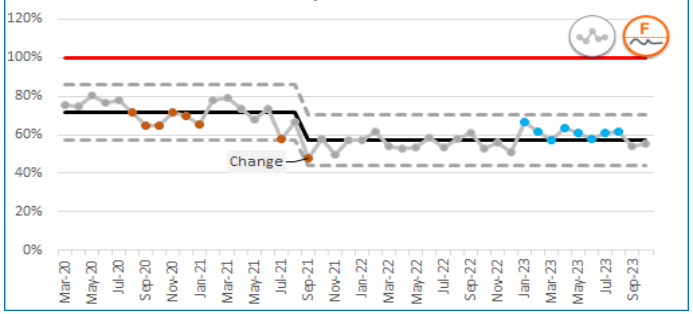
Patients waiting longer than 12 hours in ED from a decision to admit



Oct-23
512
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

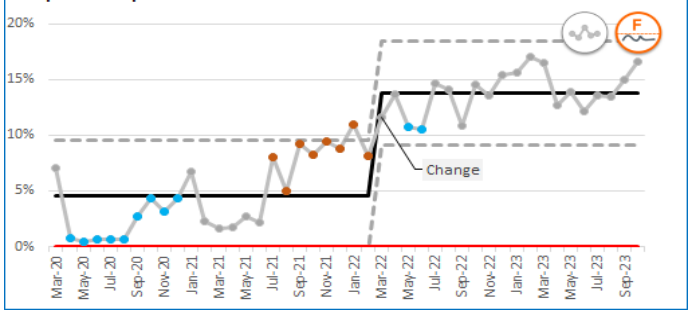
Time to initial assessment for all ED patients - % within 15 mins



Oct-23
55.6%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

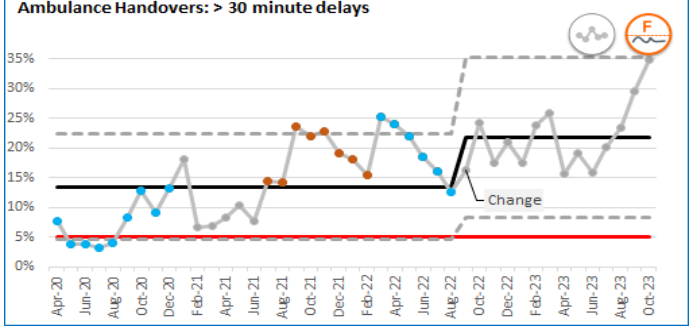
Proportion of patients more than 12 hours in ED from time of arrival



Oct-23
16.6%
Variance Type
Common cause variation
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: > 30 minute delays

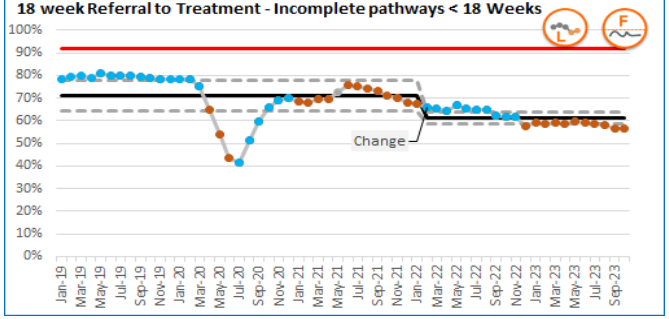


Oct-23
34.9%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

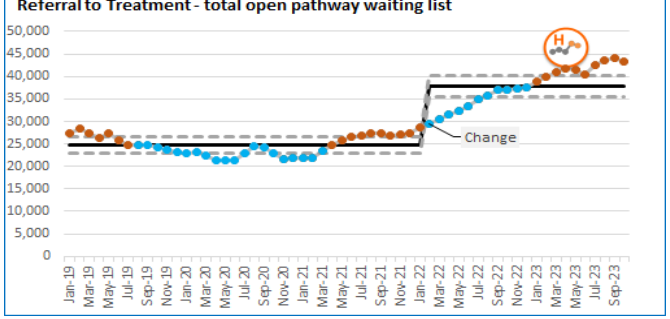
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Oct-23
56.61%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

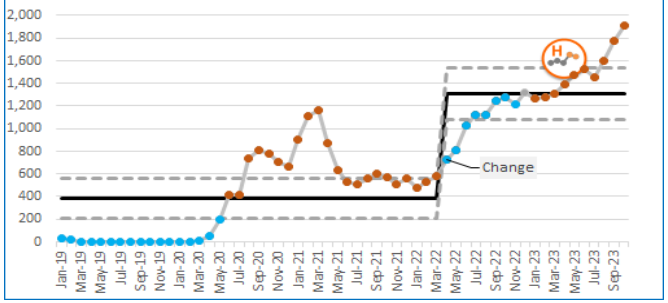
Referral to Treatment - total open pathway waiting list



Oct-23
44147
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

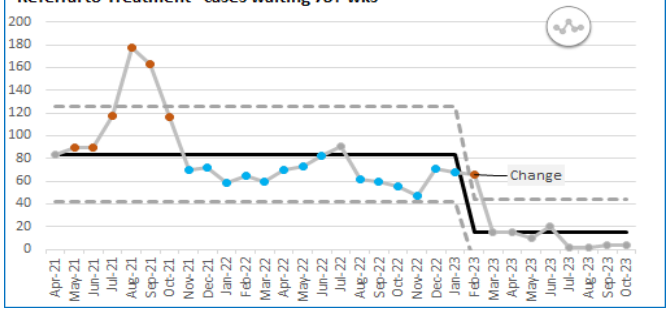
Referral to Treatment - cases exceeding 52 weeks



Oct-23
1908
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

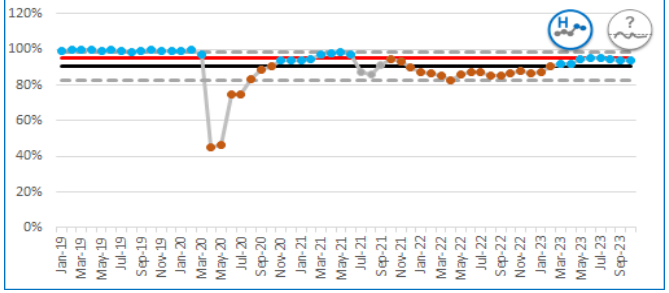
Referral to Treatment - cases waiting 78+ wks



Oct-23
4
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

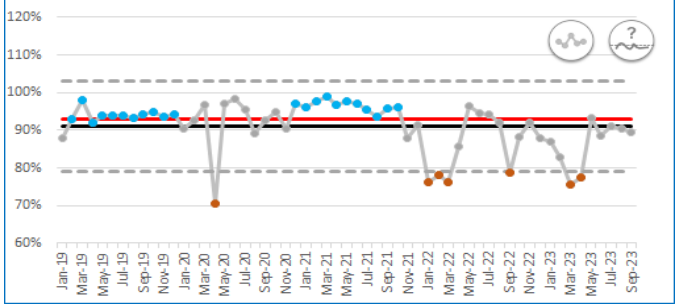


Oct-23
93.6%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

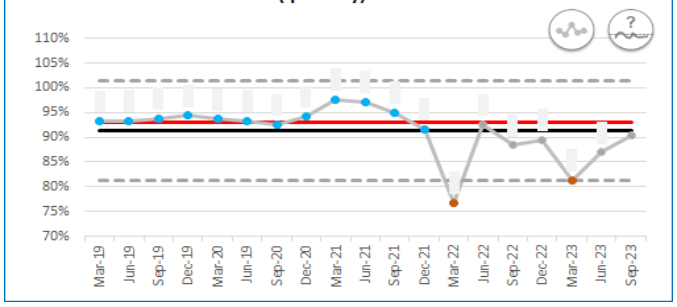
Cancer Waits - 2 week referrals (monthly)



Sept-23
89.6%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

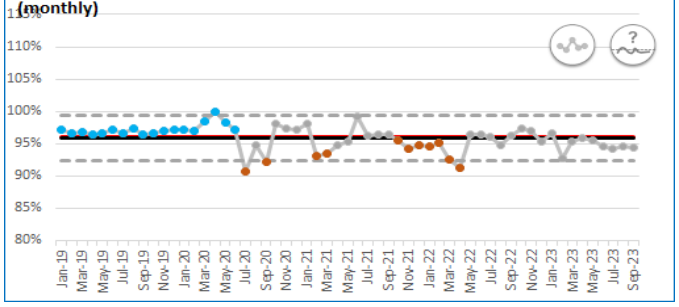
Cancer Waits - 2 week referrals (quarterly)



Sept-23
90.4%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

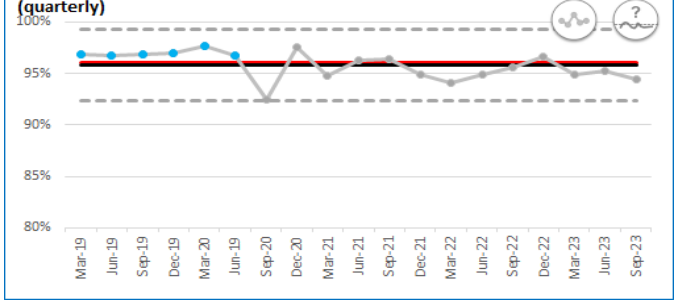
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Sept-23
94.5%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

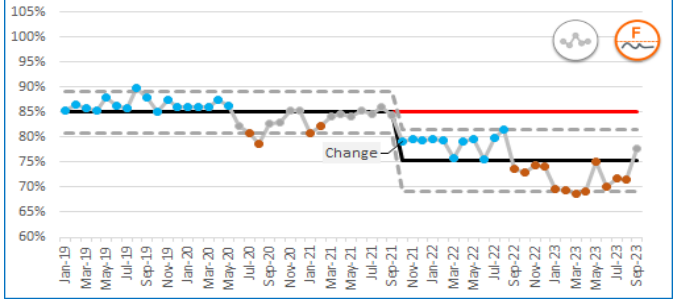
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Sept-23
94.4%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

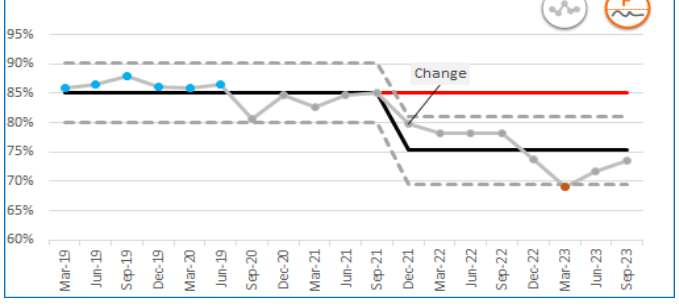
Cancer Waits - 62 days to treatment (monthly)



Sept-23
77.7%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

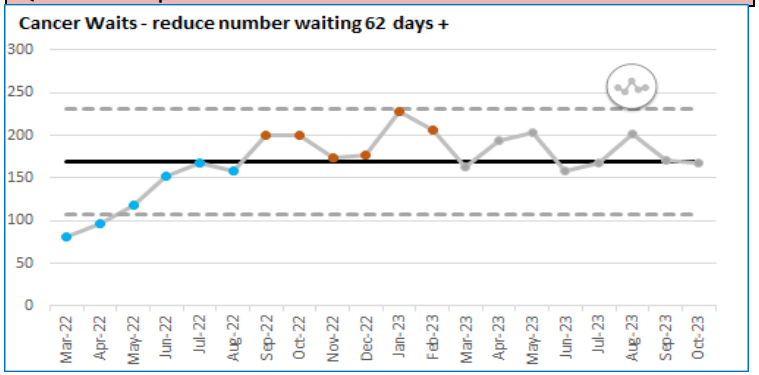
Cancer Waits - 62 days to treatment (quarterly)



Sept-23
73.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

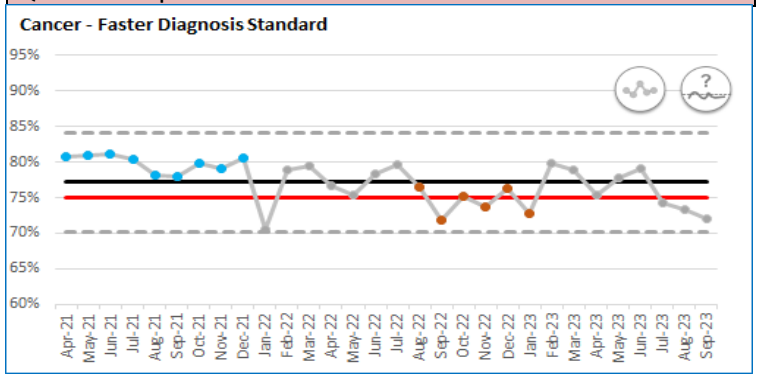
Chief Operating Officer (4)

CQC Domain : Responsive



Oct-23
167
Variance Type
Common cause variation
Threshold
176
Assurance
Trajectory target not appropriate for SPC Assurance reporting

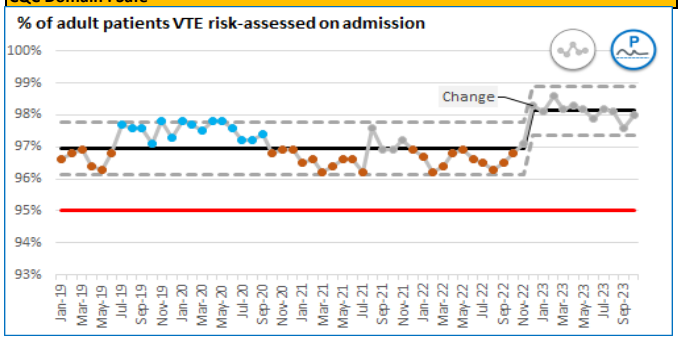
CQC Domain : Responsive



Sept-23
72.1%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

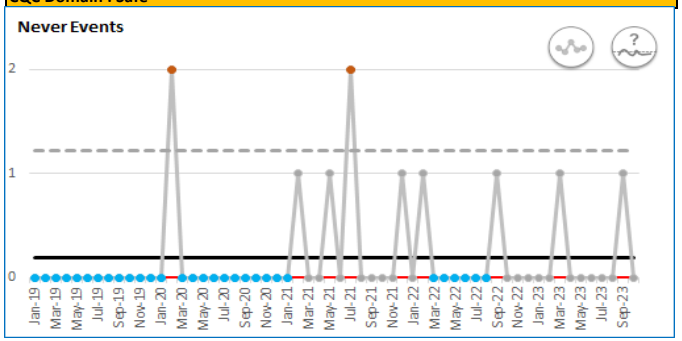
Medical Director (1)

CQC Domain : Safe



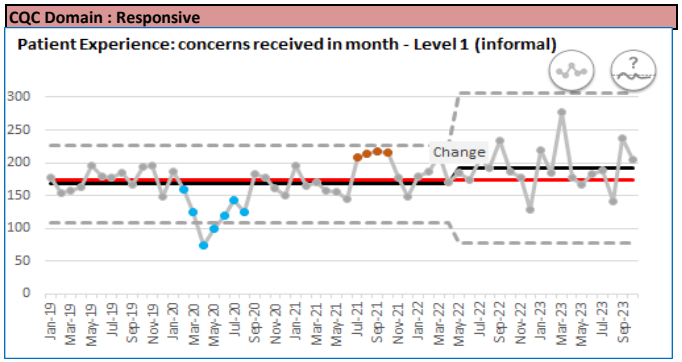
Oct-23
98.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



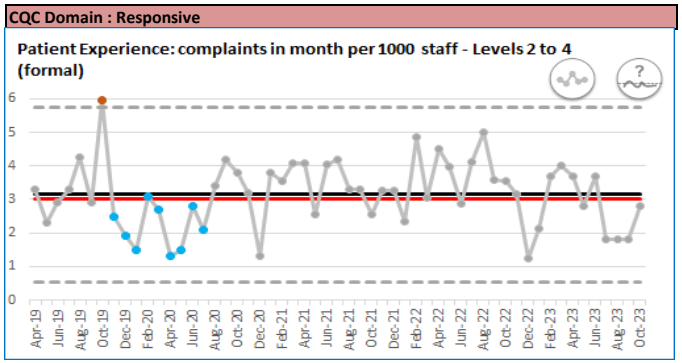
Oct-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



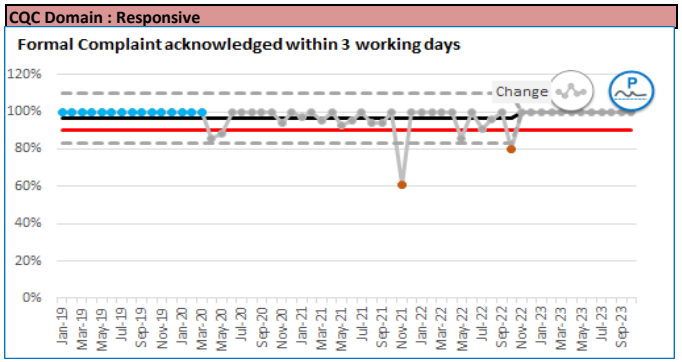
Oct-23
204
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



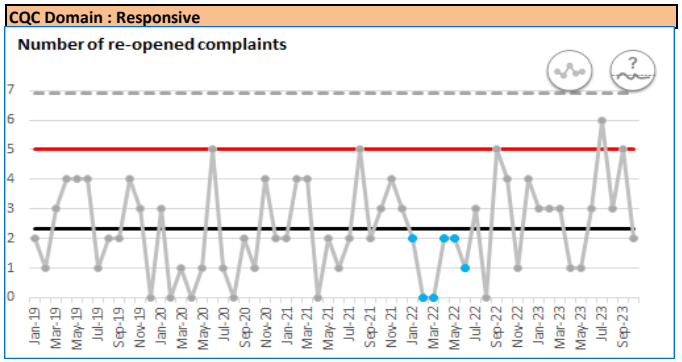
Oct-23
2.8
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Oct-23
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

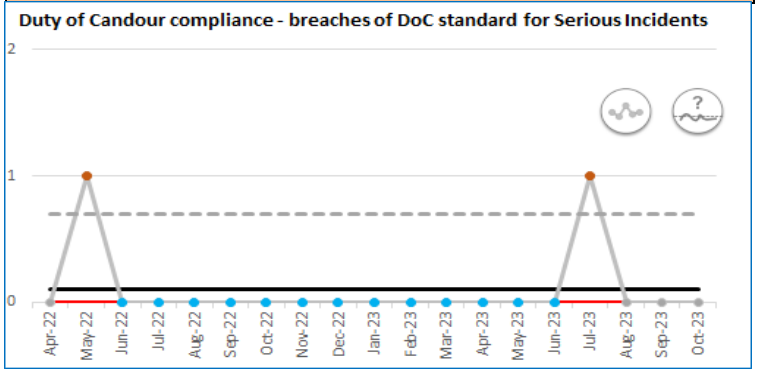
CQC Domain : Responsive



Oct-23
2
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

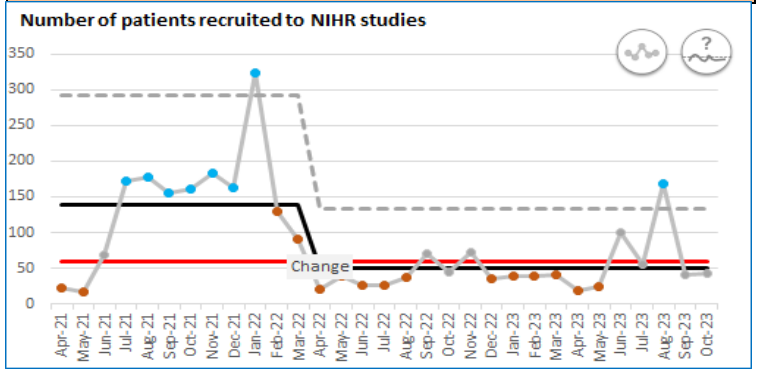
Medical Director (2)

CQC Domain : Well-led



Oct-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

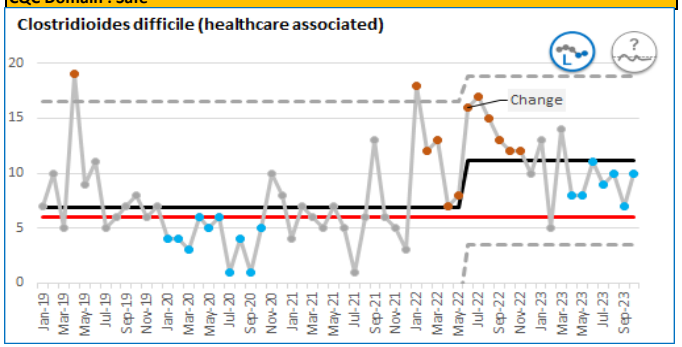
CQC Domain : Well-led



Oct-23
42
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

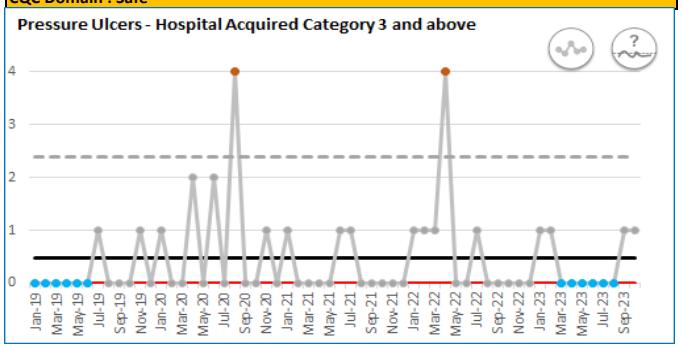
Chief Nurse

CQC Domain : Safe



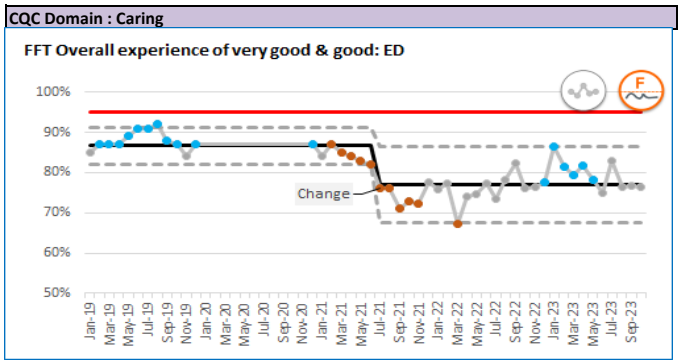
Oct-23
10
Variance Type
Special cause variation - improving
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



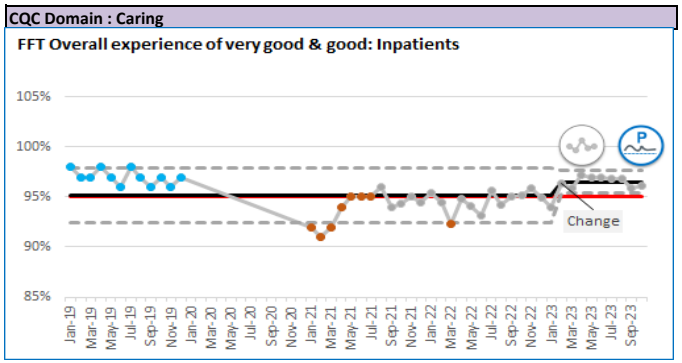
Oct-23
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



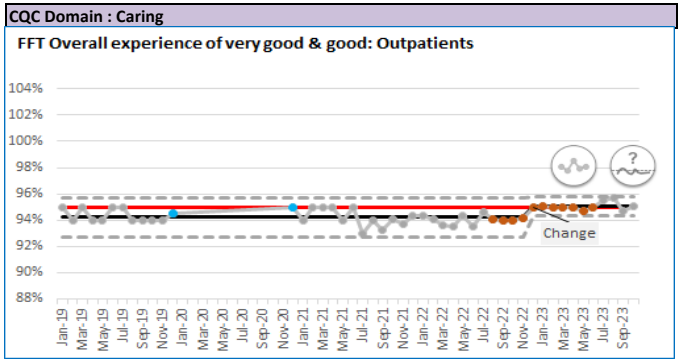
Oct-23
76.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring



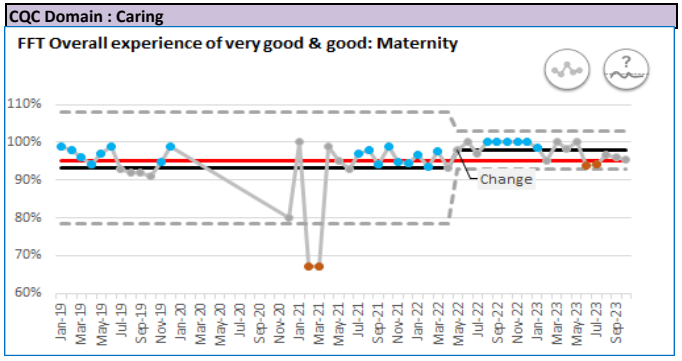
Oct-23
96.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Caring



Oct-23
95.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



Oct-23
95.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – for Dec 2023 BoD

Overall position commentary

The Trust exceeded its monthly *Clostridioides difficile* threshold by 4 in October 2023. This is a decrease of 23 cases when compared to 2022/23 and the downward trend in the number of positive cases reported over the past 12 months continues. In line with the IPC annual plan, the 5 key priorities identified, that underpin the Trust CDT priorities work plan, that aim to further reduce the incidence of CDT over the forthcoming months, is incorporated into the IPC communication and engagement strategy.

For Pressure ulcers, category 3 and above, that have developed in our care there was a single case in October 2023.

The Friends and Family Test (FFT) for Inpatients, Outpatients and Maternity have all exceeded the required threshold. Emergency Department (ED) has not achieved target in month at 76.5%, very similar to the previous two months. During August, all areas were above the national benchmark for FFT except for ED which was slightly below the national average. September's benchmarking data has not yet been released by NHSE.

***Clostridioides difficile* (healthcare associated)**

Narrative:

The NHS standard contract for 2023-24 identifies the *C.difficile* threshold for each trust; our threshold for 2023-24 is 71. To meet this, we have set internal monthly threshold of 5 or 6 each month. In October 2023 there were 10 patients diagnosed with CDT, exceeding the monthly threshold by 4.

Actions:

- Dynamic CDT improvement plan is in place, with mechanisms to cross reference learning from *C difficile* investigations to instigate actions from learning outcomes.
- A proactive and reactive decant programme has commenced to enable HPV cleaning of the whole site.
- Improved processes regarding the use of side rooms to enable prompt isolation.
- Priority focus on cleaning, decluttering, hand hygiene and re-introduction of the 'gloves off' campaign
- Use of newly developed IPC dashboard that incorporates local intelligence to highlight priority areas where targeted work can be focused to improve patient outcomes.

Risks to position and/or actions:

- Annual threshold may be exceeded.
- Bed occupancy levels may inhibit the ability to implement the HPV cleaning schedule and the rapid isolation of infected patients.

FFT Overall experience of very good and good.

Narrative:

The Trust monitors FFT experience across a range of care settings, with a target rating of a minimum 95% for good or very good.

Performance against the 95% threshold for October 2023 was:

- Emergency Department (ED) – 76.54% (below threshold) - slightly below the national average of 82% (using August's Benchmarking)
- Inpatients – 96.07% (above threshold) - above national average of 94% (using August's Benchmarking)
- Outpatients – 95.1% (above threshold) – above national average of 94% (using August's Benchmarking)
- Maternity 95.52% (above threshold) - above national average of 92% (using August's Benchmarking)

Actions:

- Continued focus on providing people with access to provide feedback via FFT: volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to feedback, making immediate rectifications when able to and encourage patient and carer participation through Patient Experience Promise groups.
- Continue coproduction with patients via Patient experience strategy

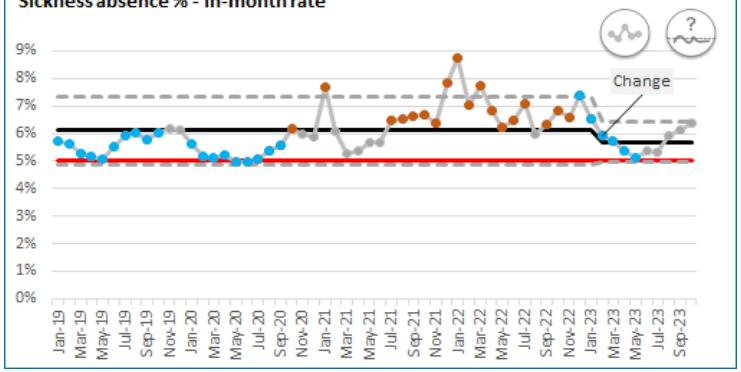
Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible.
- Car parking facilities impacting on patients' ability to easily access outpatients' appointments on time at the Arrowe Park Hospital site: Actions have been taken to address this.

Chief People Officer

CQC Domain : Safe

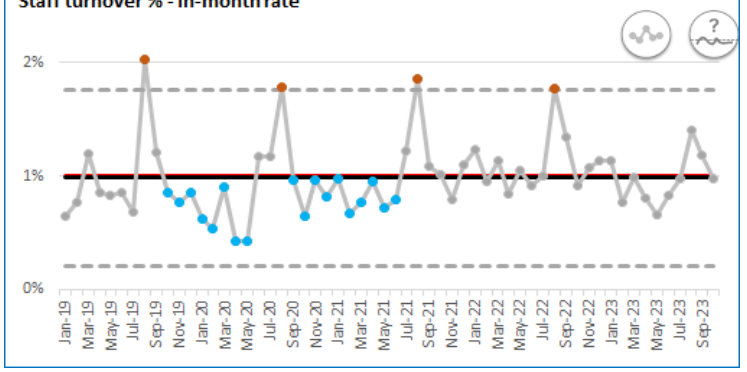
Sickness absence % - in-month rate



Oct-23
6.38%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

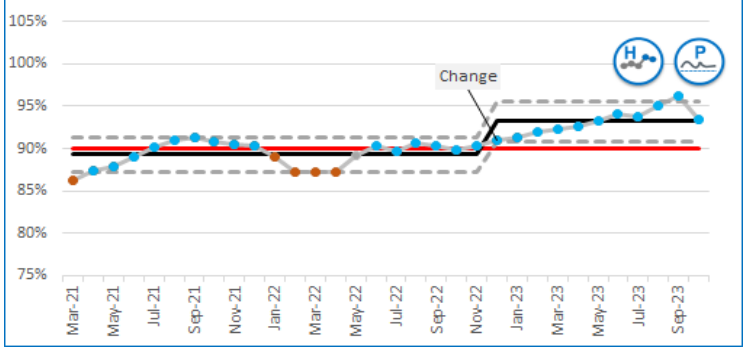
Staff turnover % - in-month rate



Oct-23
0.98%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

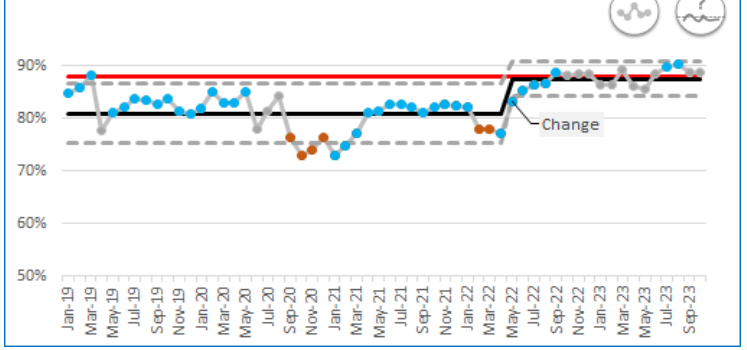
Mandatory training % compliance



Oct-23
93.34%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Oct-23
88.69%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Nov 2023 BoD

Overall position commentary

Mandatory training and appraisal compliance continues to be achieved.

Sickness absence has increased to 6.38%. Whilst turnover has reduced further this month, it remains slightly over target.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For October 2023 the indicator was 6.38% and demonstrates common cause variation.

The position is mainly driven by short term sickness absence, which accounts for 79% of absences across the Trust. Cold/flu, gastrointestinal problems and COVID are the most commonly occurring reasons for short term sickness absence. The most commonly occurring reason for long-term absence is anxiety/stress/depression, although occurrences have reduced by 3% in the last 3 months following the review of the psychological support provision within the Occupational Health Department.

Actions:

- HR Services continue to provide targeted support to areas of challenge, for example, additional support has been provided to the Neonatal Department, improving sickness absence over the last 2 months.
- Tailored training is being provided to managers, based on challenges in specific areas.
- The Staff Flu and COVID Vaccination Programme is ongoing via both drop-in clinics and roaming vaccinators.
- Annual patterns of absence over the Christmas period have been identified and shared with line managers, to facilitate proactive conversations with individuals and offer support to those who may need it.

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill-health and supporting people to balance work whilst minimising the impact of any ill-health symptoms, where possible. Managing attendance can also help control costs related to overtime, absenteeism and temporary staffing.

Work continues on the agreed year 2 deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes the development of the new flexible working brochure, which is available to all staff, and the implementation of WUTH Perfect Start as part of the Trust-Wide Strategic Retention Group.

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. In October 2023 the indicator decreased to 0.98%. This demonstrates a common cause variation.

Actions:

Focusing on how we can sustain a valuable workforce continues through the Strategic Retention Group. Examples of the work underway includes:

- Consideration of retention issues within the team job planning component for Medical and Dental staff 2024/25 job planning, monitored via monthly Job Planning meetings.
- Focus on trainee doctor experience continues, with oversight from the Medical Director.
- Listening events with band 6 nurses has identified themes that will support the training plan for the new band 6 aspirant role and support personalised development plans for current band 5 nurses.
- Focus on reward and recognition continues, with several workstreams to deliver this work, including a focus on sharing best practice from local reward schemes across the Trust.

Risks to position and/or actions:

The impact of the work outlined above will achieve a downwards trend towards the <10% turnover target, the number or % of staff leaving within the first 12 months and voluntary turnover.

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 also reduce as Turnover improves over time.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

November/December 2023

Item

Contents

1. Introduction

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

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

Baker Tilly 2021

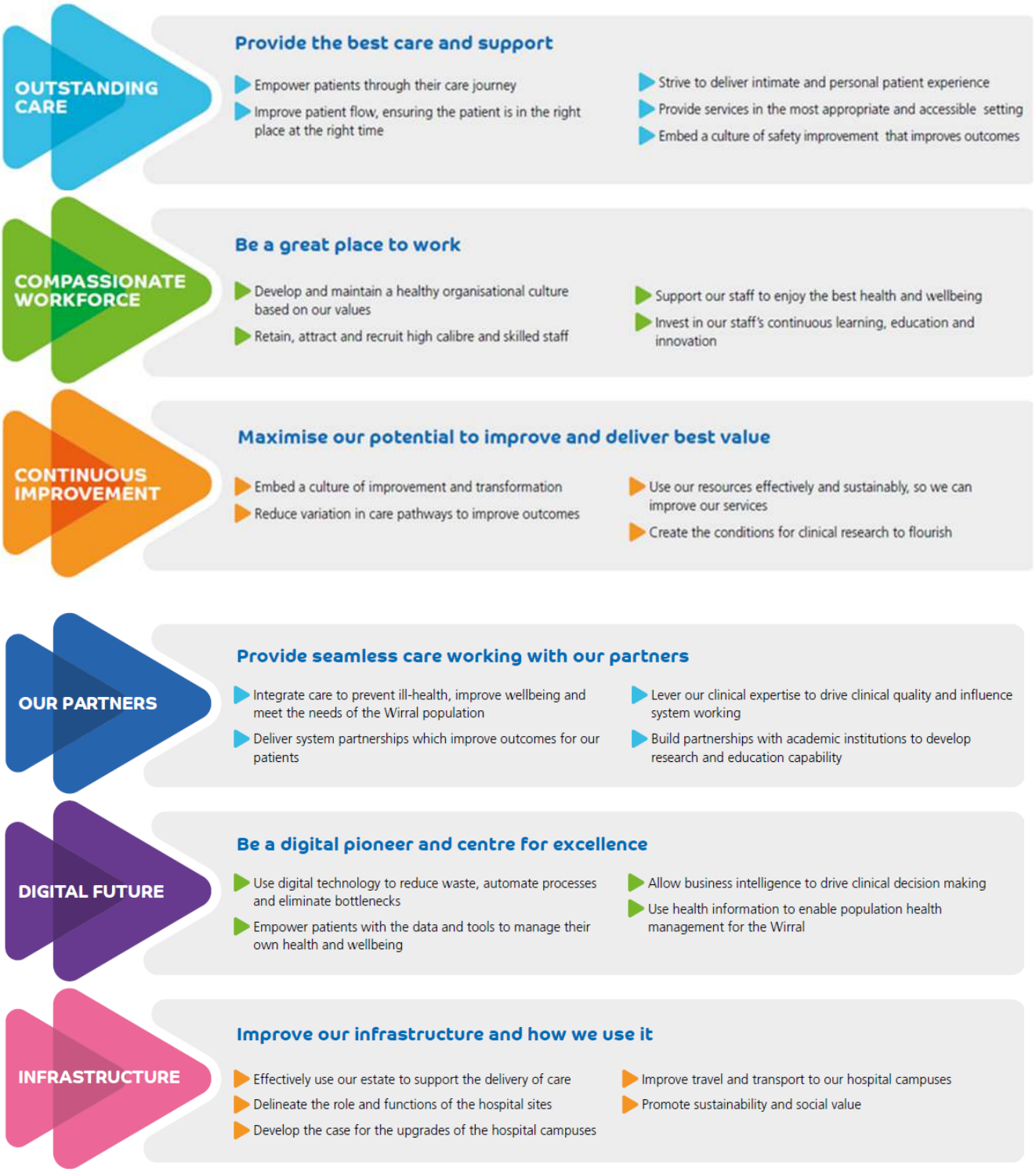
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

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

The Trust Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

The Trust's intention is to **minimise** the risk to the delivery of quality services in the Trust's accountability and compliance frameworks and maximise performance.

To deliver **safe, quality** services, the Trust will encourage staff to work in collaborative partnership with each other and service users and carers to minimise risk to the greatest extent possible and promote patient well-being. Additionally, the Trust seeks to minimise the harm to service users arising from their own actions and harm to others arising from the actions of service users.

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

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

		organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

4.2 Risk Categorisation

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

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be monitored as follows:

- Reports to the Board at each meeting.
- Reports to each meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every meeting of relevant Board Committees.
- Reporting to each meeting of the Trust Management Board
- Cyclical (at least yearly) Reporting to Divisional Boards for information and to raise awareness; and
- Reporting to each meeting the Risk Management Committee.

5.3 Annual Refresh

The Risk Management Strategy outlines that the BAF will be subject to full annual refreshment that will take place in March each year for approval in April along with the Risk Management Strategy.

6. Update Report

6.1 November/December 2023

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

The controls, assurance, and actions for each of the current strategic risks have been reviewed with Executive Team members and these changes will be reflected in the next iteration to Board.

6.2 Changes to the previous version

Following the last report, changes have been incorporated into the BAF where scorings have changed, or actions been completed/added.

It should also be noted that changes have now been made in relation to the frequency of BAF reporting across all fora.

6.3 Recommendations

Board is asked to:

- Note and approve the changes to the BAF.

Board Assurance Framework Dashboard							
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score 2022/23**	**Last Month**	**Current**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Quality and Board	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Quality and Board	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)
Outstanding Care **R, O, C, F**	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director	Quality	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O**	6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, F**	7	Failure to embed the Trust's approach to value and financial sustainability and Planning may impact on the achievement of the Trust's financial, service delivery and operational plans.	Chief Finance Officer	FBP	16 (4 x 4)	12 (4 x 3)	8 (4 x 2)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation and change.	Chief Strategy Officer and Chief Operating Officer	Board	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, S**	9	Failure to have strong leadership and governance systems in place.	Chief Executive Officer	Board	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)
Our Partners **R, S, F**	10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)
Digital Future and Infrastructure **R, O, C, F**	11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	FBP and Board	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Infrastructure **R, O, C**	12	Risk of business continuity in the provision of clinical services due to a critical infrastructure or supply chain failure therefore impacting on the quality of patient care.	Chief Strategy Officer	Capital, FBP and Board	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

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

Strategic Priority	Outstanding Care			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. • Business Continuity and Emergency Preparation planning and processes in place • Winter plan initiated that includes additional resource and capacity to aid strong UEC flows and performance • Full review of post take model to ensure sufficient resource is allocated to manage volumes	• Trust Management Board (TMB) Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway

Progress
Key Changes to Note • Additional action added relating to a system wide response required on delivering against the new national measures for improving urgent and emergency care, released in January 2023.

BAF RISK 2	Failure to meet constitutional targets, resulting in an adverse impact on patient experience and quality of care.

Strategic Priority	Outcomes Care			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	12 (3 x 4)

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

Gaps in Control or Assurance	Actions
• There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required. • National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets • Impact of industrial action	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients.

Progress
Key Changes to Note • Further gaps in controls identified relating to the impact of Industrial Action • Additional action added.

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

Strategic Priority	Outstanding Care			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from incidents. • Development and implementation of patient safety, quality, and research strategies. • Initiative-taking monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • WISE Accreditation Programme.	• Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Review of modified harm review Trust process Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • GIRFT and GIRFT Monitoring • Quality and Clinical audits • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF introduced – 14 month project plan from September PSIRF Governance • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • CQC Maternity inspection • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • Elective Hub

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts • Current operational impacts • Capital availability for medical equipment	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements • CQC preparedness programme and mock inspections • Appointment of patient safety champions

Progress
Key Changes to Note • Additional actions added.

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

Strategic Priority	Compassionate Workforce			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment. • E-rostering and job planning to support staff deployment. • Strategic Retention Group in place and year 1 programme delivered. • Retention Task and Finish Groups in place for all relevant staff groups. • Facilitation in Practice programme. • Training and development activity, including launch of leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy' have been delivered across the Trust. • Career clinics have recommenced within Nursing and Midwifery	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Talent management and succession planning framework is yet to be implemented.	• Monitor impact of retention and recruitment initiatives. • Retention working group action plan. • 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. • Roll out of clinical job planning. • Transfer of OH Services. • Actions from National Staff Survey. • Incorporation of NHS workforce plan into Strategy. • A 3-month pilot of the internal transfer for band 5 Registered Nurses and Clinical Support Workers has been launched • The electronic resignation and exit interview pilot have been completed and is in the process of review.

Progress
Key Changes to Note • N/A

BAF RISK 5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.

Strategic Priority	Compassionate Workforce			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Just and Learning Culture Group in place and year 1 programme of work delivered. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum.	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance	Actions
• The potential for national and local industrial action	• Just and learning Communications Plan. • Provision for mediation and facilitated conversations. • SOP for supporting staff affected by unplanned events. • Launch Patient and Syllabus Training. • Embed the new approach to coaching and mentoring • Embed new supervision and appraisal process • Develop and implement the WUTH Perfect Start • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool

Progress
Key Changes to Note • Addition of controls. • N/A

BAF RISK 6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.

Strategic Priority	Compassionate Workforce			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group.	• Workforce Steering board and People Committee oversight. • Internal audit.

Gaps in Control or Assurance	Actions
	• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Embed the WUTH LQF and associated development offer • Deliver year 2 of the flexible working programme • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Launch of new CEO Award • Launch 'Employee of the Month' and 'Team of the Month' awards • Development of staff stories library.

Progress
Key Changes to Note • Addition of controls.

BAF RISK 7	Failure to embed the Trust's approach to value and financial sustainability may impact on the achievement of the Trust's financial, service delivery and operational plans

Strategic Priority	Continuous Improvement			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 3)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • Recovery plan to achieve 23/24 financial plan and reset complete confirming no change to the plan. • Mitigations and Risk Plan Completed.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change. • Uncertainty of impact of industrial action	• CFO to present a full review of Forecasting to the FBPAC. • Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • Completion of submission of H2 plan to ICB.

Progress
Key Changes to Note • Change to overall scoring. • Additional actions identified.

BAF RISK 8	Failure to deliver sustainable productivity gains due to an inability to embed service transformation and Change.

Strategic Priority	Continuous Improvement			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Strategy Officer and Chief Operating Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress. • COO monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings with effect from October 2021. Monthly CIP report to FBPAC. • MIIA internal audit review of Cost Improvement Programmes, which highlighted an audit opinion of moderate assurance. • External audit report. • CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. • Historic estate infrastructure system working. • Lack of clarity on financial arrangements for 2022/23 period. • Historic estate infrastructure. • Ability to deliver system wide change across Wirral NHS organisations. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period, limits level of assurance in board and committee reports.	• Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. • Implementation of revised Cost Improvement approach. • Integration of Quality and Service Improvement function from 2024/25

Progress
Key Changes to Note • N/A

BAF RISK 9	Failure to have strong leadership and governance systems in place.

Strategic Priority	Continuous Improvement			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)

Controls	Assurance
• Board oversight and governance reporting. • Board Development Programme. • Well led and maturity assessments in place. • Board Appraisal and Development Plans. • Clear recruitment process. • NHS Code of Governance. • Forward plan and work programme.	• Board and Committee reporting. • Development Programme. • Assessment and Adoption of the NHS Code. • Internal Audit.

Gaps in Control or Assurance	Actions
• N/A	• Continuous review of Governance structure and reporting. • CQC Inspection readiness programme.

Progress
Key Changes to Note • N/A

BAF RISK 10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

Strategic Priority	Our Partners			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• WUTH senior leadership engagement in ICS. • Wuth Strategic intentions are aligned with the ICS, for example ensure master plans and decisions are taken as a system to optimise the way we use public estate across Wirral to deliver organisation and ICS objectives. • National guidance on PLACE based partnerships Legislation framework. • ICS design framework. • ICS Body governance. • Input of Trust CEO and Director of Strategy into Outline of the ICP Structure.	• CEO and Director of Strategy updates to Board and Executive Director meetings. • Chair, CEO and Chief Strategy Officer attendance at Healthy Wirral Partners Board. • Secondment of Head of Strategic Planning to develop ICP/Place operating model. • ICS Chair updates, ICS meetings, ICS Self-assessment submission. • CMAST CEO and Directors of Strategy meetings. • Healthy Wirral Partners Board.

Gaps in Control or Assurance	Actions
• Time to establish C&M ICS accountability and governance infrastructure, Delays in the consolidation of CCGs to ICS. • Place lead appointment for Wirral. • Function and role of C&M ICS working with the Trust and Formal.	• Development of PLACE governance arrangements with Wirral partners. • Completion of ICS and PLACE governance self-assessment. • Development of PLACE operating model.

Progress
Key Changes to Note • N/A

BAF RISK 11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience, and our ability to transform services in line with our aspiration to be a leader in our ICS.

Strategic Priority	Digital Future and Infrastructure			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Finance Officer and Chief Strategy Officer	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Assessment of Capital requests. • Capital bid process. • Capital Contingency. • Risk management via Ulysses. • Reporting to Capital and Estates Committee.	• Funding approvals. • Scale of projects versus resources. • Capital Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance.

Gaps in Control or Assurance	Actions
• N/A	• Continue to track delivery of 23/24 schemes through Capital Management Group and Capital Committee • Prepare for 24/25 capital schemes as part of 3 year capital programme • Further develop reporting to Capital Committee • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Continual reassessment of requests through Capital Management Group

Progress
Key Changes to Note • Change in Score. • Additional Assurance added.

BAF RISK 12	Risk of business continuity and the provision of clinical services due to a critical infrastructure supply chain failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure			
Review Date	01/11/23	Initial Score	Last Month	Current
Lead	Chief Strategy Officer	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy. • Agreed 3 year Capital Programme. • Business Continuity Plans. • Stock capital process. • Procurement and contract management. • Bespoke digital healthcare team. •	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Independent review of risks carried out

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance.	• Develop Arrowe Park master plan and Prioritisation of estates improvements. • Asset audit. • Implementation of the new Capital Assets and Facilities system. • Heating and ventilation programme. • Replacement of generators. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Development and review of EPPR plans across all areas.

Progress
Key Changes to Note • Additional actions identified.

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

Use table 1 to determine the consequence score(s) (C)
Use table 2 to determine the likelihood score(s) (L)
Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
Assign grade of risk according to risk score.

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

Risk Grading	Risk Score
Low risk	1 to 3
Moderate risk	4 to 6
High risk	8 to 12
Significant risk	15 to 25

Appendix – Risk Appetite Scoring Matrix

Risk levels ▶ / Key elements ▼	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
06 December 2023

Item 8.5

Title	Productivity and Efficiency Update
Area Lead	Hayley Kendall, Chief Operating 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 the current 2023/24 Productivity and Efficiency Programme and identified plans to date, along with the ongoing work to identify further schemes to deliver a programme that supports the financial sustainability of the organisation.

This report will provide an update on the nine transformation programmes and the Cost Improvement Position (CIP) year to date. This report will also provide an update on the approach to identifying a CIP for 2024/25.

The Board is asked to note the report for information purposes.

Key Risks

This report relates to these key risks:

- Delivery of a sustainable financial position

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	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
	For 2023/24, the Trust has a CIP of £26m. As at month 7, £21.795m has been transacted out of budgets recurrently, with a forecast outturn of £22.993m recurrently. Table 1 below details the divisional split against the target set:

Table 1

Transacted CIP @M7									
Division	M1	M2	M3	M4	M5	M6	M7	YTD	Transacted 23/24
Medicine	£15	£280	£301	£306	£313	£569	£474	£1,784	£4,032
Acute	£4	£12	£11	£8	£15	£70	£182	£119	£1,282
Surgery	£256	£320	£579	£459	£660	£487	£509	£2,762	£5,542
DCS	£73	£318	£218	£354	£311	£330	£317	£1,605	£3,455
W&C	£42	£132	£87	£287	£137	£137	£137	£822	£1,644
Corporate	£774	£827	£58	£89	£108	£115	£200	£1,971	£2,804
Estates	£18	£84	£83	£148	£122	£144	£166	£600	£1,555
COVID	£123	£123	£123	£123	£138	£138	£128	£770	£1,481
Total	**£1,305**	**£2,097**	**£1,460**	**£1,775**	**£1,805**	**£1,990**	**£2,113**	**£10,432**	**£21,795**

Table 2: In month 7, the Trust delivered £2.113m against a target of £2.700m with the main variances being detailed in the following table:

	Month 7		
Division	In Mnth Target	In Mnth Delivered	Variance
Medicine	£753	£474	-£280
Acute	£197	£182	-£15
Surgery	£636	£509	-£128
DCS	£450	£317	-£133
W&C	£234	£137	-£97
Corporate	£93	£200	£107
Estates	£214	£166	-£48
COVID	£122	£128	£6
Trust	**£2,700**	**£2,113**	**-£587**

This is the first month where there is a significant variance to target in month, recognising the target has stepped up in month 7.

Table 3: The year to date transacted position at month 7 is detailed in table 3 below:

	Month 7		
Division	YTD Target	YTD Delivered	Variance
Medicine	£1,237	£2,258	£1,022
Acute	£642	£301	-£341
Surgery	£3,021	£3,270	£250
DCS	£1,859	£1,922	£63
W&C	£960	£959	-£1
Corporate	£1,986	£2,171	£185
Estates	£1,725	£766	-£959
COVID	£875	£865	-£10
Trust	**£12,304**	**£12,512**	**£208**

Summary

There has been a significant effort from all areas of the hospital to achieve the year to date position of £12.5m transacted recurrently from budgets with the in year effect of that being £21.8m, equivalent to 84% of the in year target. In addition there is a plan to

	deliver an additional £1m non-recurrently in year to bridge a previous month detioration of £1m in year.

2 Waste Activity Value Efficiency (WAVE): Best value. Best care. Best WUTH.

For 2023/24, transformation workstreams have been established, with the aim of leading and supporting the delivery of major change and cost saving projects across several areas, within the Trust. The WAVE programme is nine workstreams designed to meet the increasing demand for our services, whilst driving value for money throughout the Trust and being the best at making things better.

The four aims of WAVE are:

- Embed "Zero Waste" culture and empower everyone to challenge waste.
- Maximise elective activity through improved productivity.
- Focus our expenditure on services that add value for patients.
- Improve efficiency and drive down costs wherever possible.

Table 4: The position across the workstream is detailed in table 4 below:

Part Year Effect					
Workstream	**Red**	**Amber**	**Green**	**Blue**	**Total Identified**
Diagnostics	£0	£0	£20	£1,461	**£1,481**
Medicines Optimisation	£0	£214	£439	£491	**£1,144**
Non PBR Income & SLA Management	£18	£0	£49	£1,491	**£1,558**
One Patient Record	£250	£4	£59	£505	**£818**
Patient Flow	£0	£0	£0	£3,534	**£3,534**
Procurement	£0	£14	£15	£2,816	**£2,845**
Space Utilisation	£0	£2	£0	£365	**£367**
Think Big	£0	£0	£26	£3,394	**£3,420**
Workforce	£10	£54	£25	£7,740	**£7,829**
Total	**£278**	**£289**	**£632**	**£21,796**	**£22,995**

Full detail of each work programme is discussed and monitored monthly through the Programme Board chaired by the Chief Executive Officer.

3 Governance

The governance and reporting of cost improvement and productivity has been enhanced, with workstream reporting and overall CIP programme reporting on a fortnightly basis to the CIP Assurance Group and monthly to Programme Board.

CIP Assurance Group

To ensure that the work programmes deliver against the target a fortnightly CIP meeting was introduced, chaired by the Chief Operating Officer, with attendance from Deputy Chief Finance Officer, Divisional Directors, Associate Director of Prod/Eff &PMO and all Corporate support leads. This monitor's weekly project progress report produced by the PMO, weekly finance updates from the operational financial management team and a

focused discussion on overdue milestones, key project risks and issues and escalations to Programme Board.

Divisional meetings and Workstream meetings

Fortnightly Divisional CIP meetings are in place with attendance from divisional leads, PMO, finance and corporate support services.

Programme Board

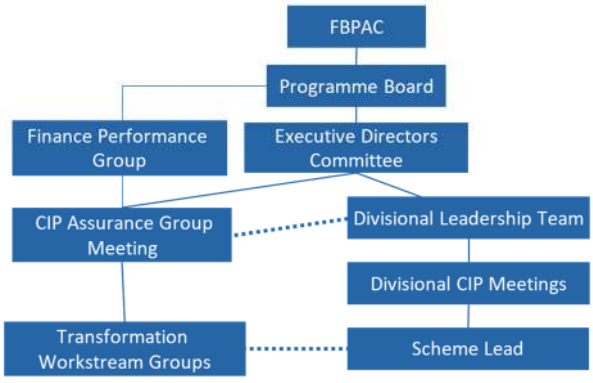
Taking place monthly the Programme Board, chaired by the Chief Executive Officer, receives assurance from each workstream detailing both programme level schemes and divisional CIP projects. High level summaries are provided with divisional updates includes against each of the trust wide workstreams. This forum receives escalations, risks and issues from the CIP Assurance Group.

Reporting

To ensure accurate capture and consistency of reporting, the Finance Team carry out all aspects of CIP reporting, completed through the Finance Business partners aided by a CIP transaction tracker. Project management reporting is completed by the PMO and Divisions via Smartsheets.

Diagram 1 below details the governance structure.

Diagram 1: Productivity Structure



4 2024/25 Planning

Building on the success of the CIP delivery in this financial year, early planning has started on the 2024/25. CIP principles have been developed through a core team of the COO, Chief Finance Officer and their teams that are built around the following:

- An assumption that the CIP target for all teams will be in line with the target assigned for 2023/24.
- If the full year effect of CIP delivered in 2023/24 for any Division exceeded target, then the value of this difference will be carried forward into 2024/25 and deducted from the 2024/25 target.
- If the full year effect of CIP delivered in 23/24 was less than target, then the value of this difference will be added to the 24/25 target.

	• Productivity gains will be considered as part of CIP. However, given the uncertainty over recoverability of additional income then focus should be on schemes that remove expenditure. • We do not expect any "invest to save" schemes to be included in CIP plans unless this results in a direct and immediate reduction in cost. Key Dates: • 1st cut CIP included in the 1st cut planning submission - **10/11/23** • Uncosted 23/24 carry over schemes to be costed and presented at CIP Assurance Group - **24/11/23** • 2nd cut CIP included in the 2nd cut planning submission - **11/12/23** • 2nd CIP to be presented at FBPAC **- 20/12/23** Workstreams have been drafted for 2024/25 and will be developed through with the executive leads and presented at the Programme Board. **Next Steps:** • Executive leads assigned to workstreams • PMO to work with executive leads to identify key delivery aims in each workstreams • Divisions to submit 2nd CIP cut • Review of non-core spend reduction based on capacity plans and alignment to job plans • Review of productivity opportunities based on activity plans • Indicative targets and opportunities identified against each workstream

5	Implications
5.1	**Patients** • The CIP and WAVE programmes have been established with a full Quality and Impact Assessment (QIA) process to ensure impacts on patient care / inequalities are assessed and review with every major workstream across the two programmes.
5.2	**People** • The QIA process considers all potential impact included on people. There is a Project Management Office (PMO) team supporting both CIP and WAVE who ensure strong governance is wrapped around any scheme.
5.3	**Finance** • The CIP and WAVE programmes provides a key element of the Trust's Financial Strategy and sustainability and positive impacts on its delivery.
5.4	**Compliance** • This paper positively supports the Trust's financial position and thus its regulatory and statutory performance.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

06 December 2023

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2023 and extended monthly report in October and November 2023, with the following paper providing a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

This paper provides a specific update regarding Year 5 of the Maternity Incentive Scheme (MIS), together with an update on Saving Babies Lives (SBLv3) one of the ten safety actions included in the MIS, together with an update Three Year Delivery plan, Maternity Continuity of Carer (MCoC) and the most recent Maternity and Neonatal Voices Partnership (MNVP) annual report 22/23.

Included in the paper is the CNST scored card and annual legal services report for information.

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (October 2023) key quality and safety metrics.

It is recommended: -

- Note the report.
- Note the progress of the Trust's position with Year 5 of the Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the update to the Continuity of Carer model of maternity care and the Trusts position to implement this model as a default model of care subject to approval to improving the midwifery establishment.
- Note the Maternity and Neonatal Voices Partnership (MNVP) annual report.
- Note the Trusts CNST scorecard and annual legal services report.

Key Risks

This report relates to these key Risks:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Dec 2023	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
Dec 2023	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Maternity Incentive Scheme (MIS) Year 5
	A detailed MIS update is included to Board of Directors Quarterly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 1 February 2024. Now in its fifth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The Women's & Children's Division has continued with its work to progress the 10 safety actions based on the previous requirements. At the September Board of Directors, it was updated WUTH was on track to meet the requirements of each safety action and since the revised version a gap analysis has been completed **(Appendix 1**) following the publication for Year 5. The compliance has been monitored via a monthly Divisional Quality Assurance Meeting and to provide the Board of Directors an update on the position to meet the requirements of each safety action. The Local Maternity and Neonatal Service has been delegated responsibility by the Integrated Care Board (ICB) in reviewing the uploaded evidence for Safety Actions 3, 4, 5, 7, 8, 9 to the Future NHS Platform for MIS Year 5. The Trust has received confirmation that WUTH has reached the compliance for all the reviewed safety actions.

	Safety action 2 relating to the MSDS data has been confirmed compliant in October 2023 reviewing July 2023 data. Safety Actions 1 and 10 evidence will be included in the presentation to the Board of Directors in January 2024. A full report and presentation will be included in the January 2024 Maternity update to seek board declaration of MIS Year 5 compliance for submission by 1 February 2024.

2	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. The Three-Year Delivery Plan for Maternity and Neonatal Services also sets out that providers should fully implement Version 3 of the SBLCB by March 2024. An implementation tool was developed nationally to support its implementation. Maternity services and commissioners completed a baseline assessment of current practice for WUTH in September 2023 and since then a review of the 300 pieces of evidence has taken place by the LMNS along with feedback given. As at November 2023 all outstanding audits and requested evidence have been submitted to the NHS Future platform and will be reviewed in December 2023 by the LMNS. There is a requirement by NHSE to report the implementation tool to the Board of Directors evidencing the Trusts compliance position in December 2023, included at **Appendix 2**. Current self-assessment compliance is 94% overall and the requirement is >70% overall, and at least 50% compliance for each element.

3	Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in April 2022 and updates have been provided quarterly. The gap analysis is included at **Appendix 3** and remains in the same RAG rated position as fully compliant.

4	Three Year Delivery Plan – Maternity and Neonatal
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 4** and is RAG rated accordingly.

	The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales.

5	Implementing a Continuity of Carer Model of Maternity Care
	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 (CoC) 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. As a provider WUTH has six maternity continuity of carer teams and in line with upskilling programs and safe staffing levels, further teams are anticipated in 2024. A comprehensive review of MCoC is being undertaken that will be presented to the Board of Directors in January 2024 and data is being collated on the outcomes for women that will be presented to the Board of Directors at the next quarterly report.

6	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 5** and provides an overview of the latest (October 2023) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting, this data is reported as of June 2023. On review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers.

7	Serious Incidents (SI's) & Maternity and Newborn Safety Incidents (MNSI)

	Serious incidents (SI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). SI's 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 were no serious incidents and Maternity and Newborn Safety Investigation (MNSI), previously HSIB cases declared in October 2023 for maternity services. There were no serious incidents declared in October 2023 for Neonatal services.

9	Maternity and Neonatal Voices Partnership (MNVP)
	As reported to the Board of Directors in the last report in October 2023 and in line with the Maternity Incentive Scheme (MIS) Year 5 included at **Appendix 6** is the annual report (22/23) of the Maternity and Neonatal Voices Partnership.

10	Conclusion
	The next BOD paper will continue to update on the delivery of safe maternity and neonatal services to include a presentation evidencing compliance with all 10 safety actions with the Maternity Incentive Scheme Year 5. The process will request the Board of Directors agreed the sign of compliance on behalf of the Chief Executive Officer (CEO) with the LMNS and ICB present for that part of the meeting.

11	Implications
11.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
11.2	**People** • The proposals particularly around compliance with MIS Year 5 outline the safety action we aim to meet in order to deliver high quality care and demonstrate all safety measures. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.
11.3	**Finance** • In order to meet the compliance of MIS Year 5 and deliver Maternity Continuity of Care as the default model, investment into the maternity and neonatal workforce is required and funding options are being explored.
11.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.7**

06 December 2023

Title	Guardian of Safe Working Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director and Deputy CEO
Author	Alice Arch, Guardian of Safe Working
Report for	Information

Report Purpose and Recommendations

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

This report covers the period 1st June to 30th September 2023 (Q2 2023_24) and outlines the following:

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

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

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	No

Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

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

1	Narrative

Dr Alice Arch has been successful in her appointment as Guardian of Safe Working and commenced in post on 1st November 2023.

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

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total):	283 (271.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total):	283 (271.6 WTE)
Amount of time available in job plan for guardian to do the role:	1 PA/4 hrs per wk
Admin support provided to the guardian (if any):	Access to 1.0 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	5	5	0
General Medicine	0	94	79	15
General Surgery	0	13	13	0
Special Surgery	0	1	1	0
T&O	0	0	0	0
Women & Children's	0	3	2	1
Total	0	116	10	16

Exception reports by grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	92	77	15
F2	0	2	2	0
SHO	0	21	20	1
SPR	0	1	1	0
Total	0	116	100	16

Exception reports by Rota

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E 20% Fellow	0	2	2	0

A&E F2 LIFT Weeks	0	1	1	0
A&E SHO	0	2	2	0
DCT Rota	0	1	1	0
Gen Paeds SpR 0.6 WThF	0	1	1	0
Gen Paeds T1	0	1	0	1
Medicine F1	0	73	58	15
Medicine F1 LIFT MT	0	4	4	0
Medicine F1 LIFT WF	0	2	2	0
Medicine IMY2	0	3	3	0
Medicine SHO	0	4	4	0
Medicine SHO LIFT MT	0	1	1	0
Medicine SHO 0.8 MTWTh	0	4	4	0
Medicine T1 General	0	1	1	0
Renal	0	2	2	0
Paediatrics Basic Hours	0	1	1	0
Surgical F1	0	10	10	0
Surgical F1 LIFT WF	0	3	3	0
Total	0	116	100	16

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	17	20	14	17	9	15
F2	1	0	0	1	0	0
SHO	3	3	8	2	4	1
ST3-8	1	0	0	0	0	0
Total	22	23	22	20	13	16

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Total	0	0	N/A	0

Work schedule reviews

There have been no work schedule reviews this quarter.

Vacancies

This are a number of vacant shifts which occur, for example, due to sickness or parental leave gaps on rotas and which can contribute to exception reports. The majority of these vacant shifts were within the Emergency Department. Vacancies are covered by doctors on flexible contracts and via the collaborative bank to minimise risks to patients or doctors in training. Medical staffing reviews are underway in several specialities.

Fines

There have been no fines issued this quarter.

2 Implications

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.8**

22 November 2023

Title	Freedom to Speak Up Report – 6 Month Report
Area Lead	Deb Smith, Chief People Officer/Executive Lead for FTSU
Author	Tracey Nolan, FTSU Guardian/Just and Learning Culture Lead
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide Board of Directors with a 6 monthly update of Freedom to Speak Up (FTSU) 23/24. The activity outlined within this report pertains to Q1 and Q2 2023/24.

It is recommended that the Board note the content of the report.

Key Risks

This report relates to these key Risks:

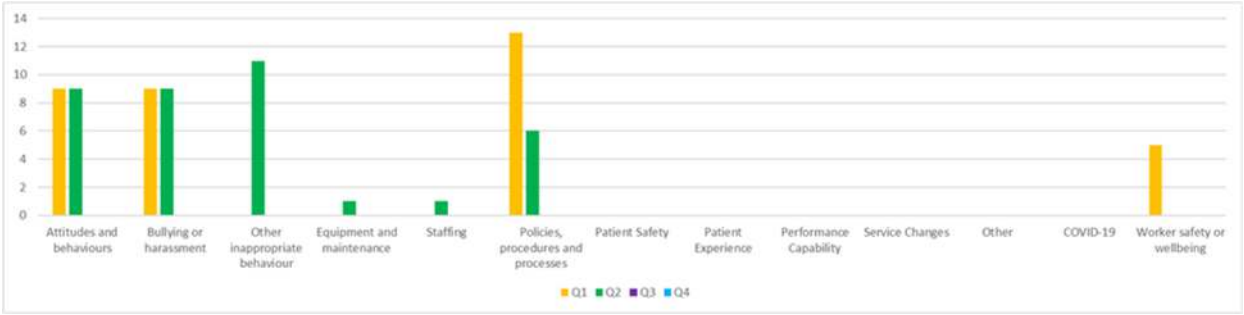
- Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary. There are no FTSU risks escalated as part of this report.

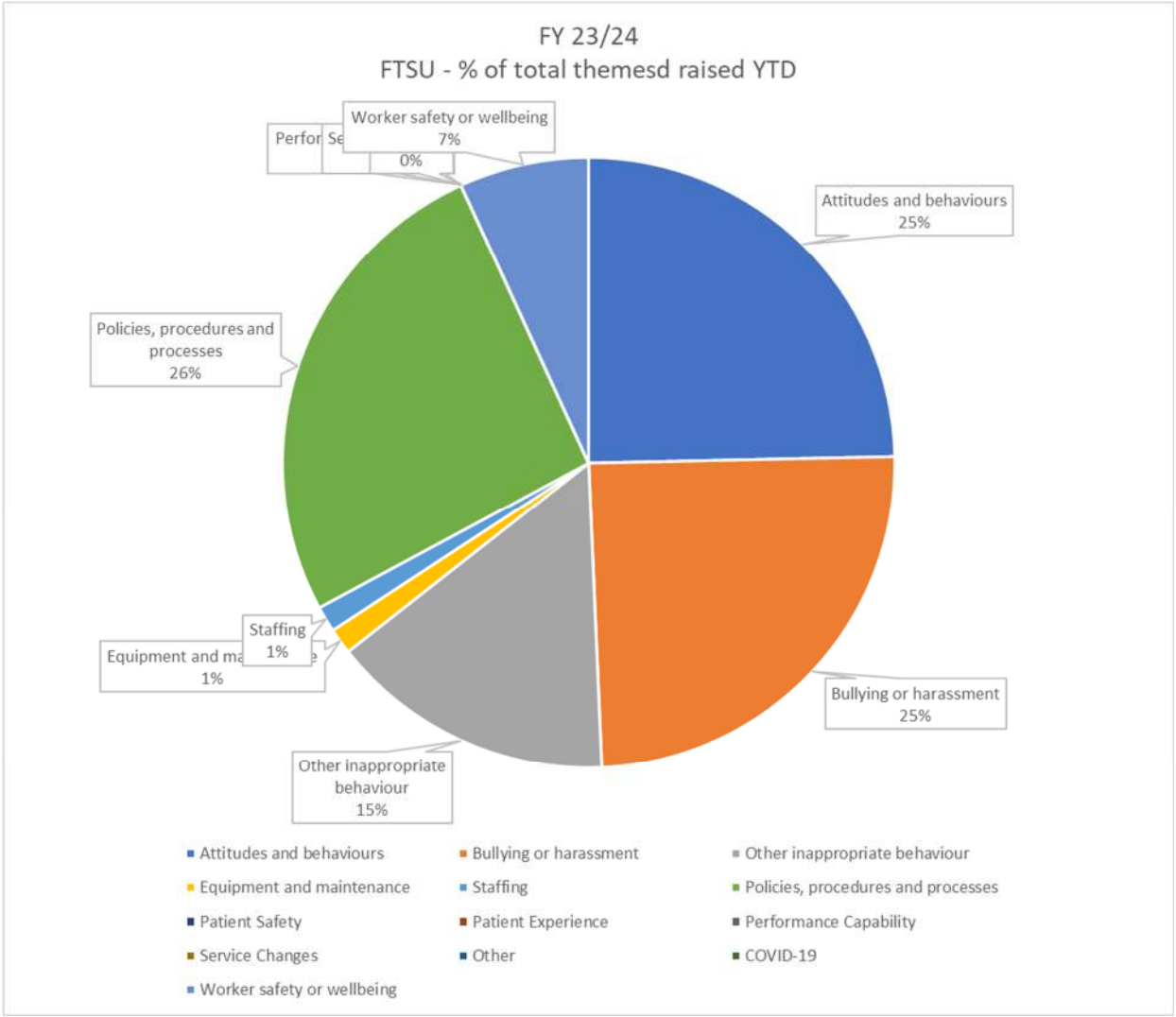
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

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

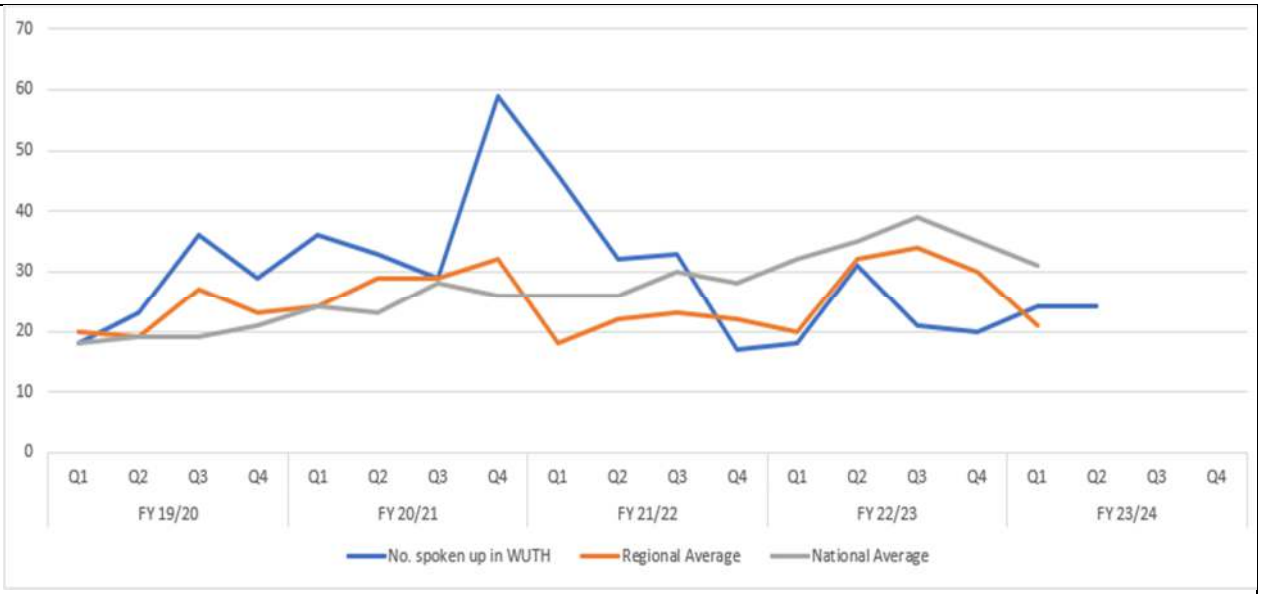
Governance journey

Date	Forum	Report Title	Purpose/Decision
22 November 2023	People Committee	As above	Information

1	Narrative
1.1	Revised NGO guidance for 2022 (“Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services” 2022) highlights that reporting activity should now be on a bi-annual basis and therefore this report seeks to meet those requirements and outline FTSU activity for 2023/24. This report provides an overview of activity data for 6 months 2023/24 and work undertaken to progress the agenda in line with national policy and best practice guidance. Data is presented in a way that maintains the confidentiality of individuals who speak up.
1.2	**Concerns Raised by Theme** The table below sets out the concerns raised during Q1 and Q2 by theme. Bullying and harrasment concerns have increased from this time last year along with concerns raised around process. It is important to note that concerns can often span numerous themes. To provide some context on the themes the staff that raised concerns around process often felt devalued, bullied and felt that communication and the way that processes were managed has been a contributory factor in them feeling bullied. New NGO reporting guidance (Recording Cases and Reporting Data, 2022), requires organisations to update the themes recorded and monitored, using new data from 1 April 2022. **Concerns raised by theme**  Data requirements changed last year to include the following 2 categories: Introduction of • “Other inappropriate behaviour” category • Worker safety or wellbeing Other inappropriate behaviour is defined in the new guidance as: • Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute bullying or harassment. This can be a current or past matter and may identify risks or be about actual events • where the person raising the case believes there is an element of other inappropriate attitudes or behaviours to be interpreted broadly. • The focus should be on the perceptions of the person bringing the case. Examples of other inappropriate attitudes or behaviours may include: • Actions contrary to an organisation's values • Incivility

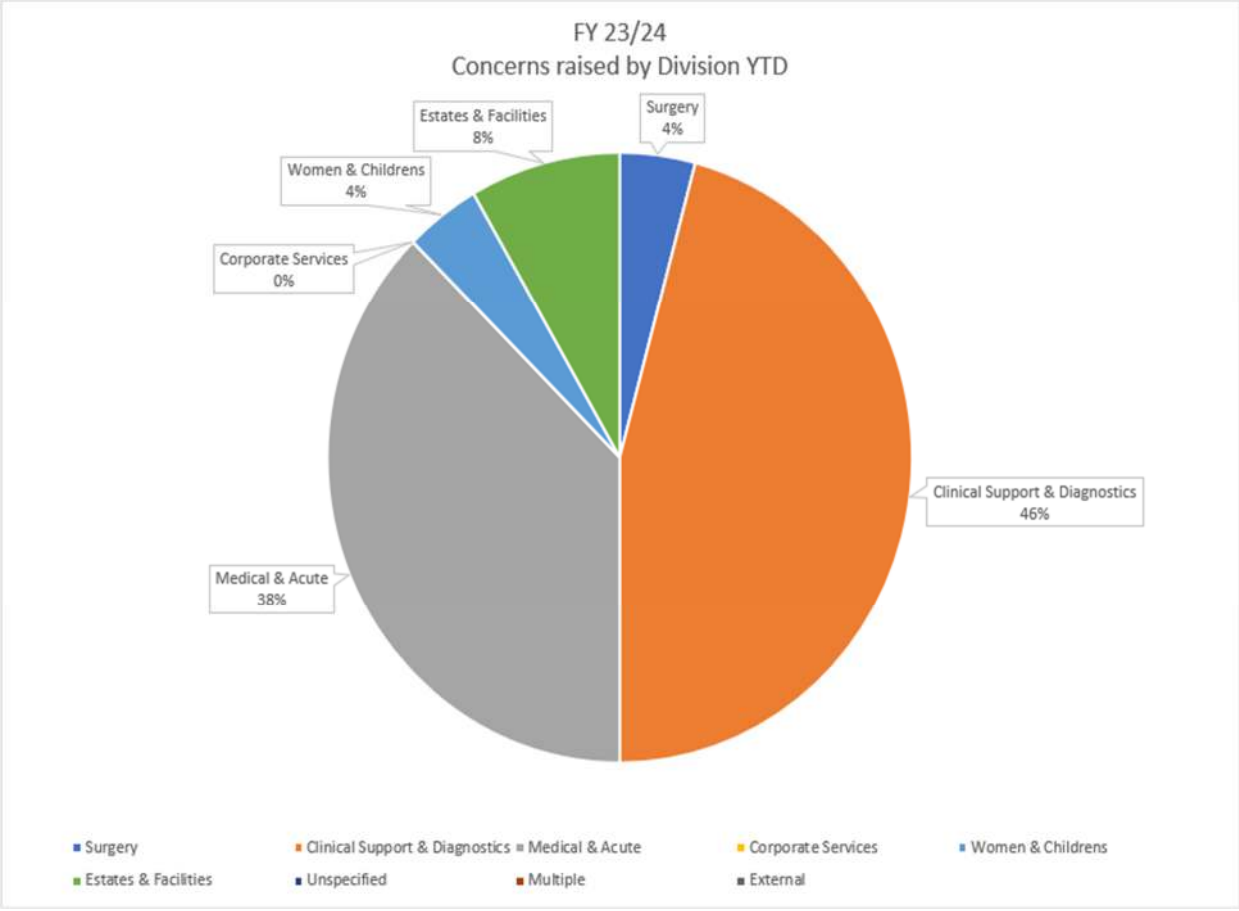
	WUTH had already been monitoring wellbeing and worker safety as separate themes, however will now combine for the purposes of national reporting.
1.3	WUTH had already been monitoring wellbeing and worker safety as separate themes, however will now combine for the purposes of national reporting. **% of total themes raised**  **Note:** Many concerns have more than one theme so the numbers in the chart will not correlate with the number of cases raised. The last 6 months demonstrate that attitudes and behaviours along with bullying and harassment are the highest reported theme which account for 49% of all concerns raised. Policies, procedures, and processes account for 26% of concerns raised. Inappropriate behaviour accounted for a further 15% of cases across the 6-month period. It is important to note that as per the NGO guidance, “bullying or harassment” is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National

	Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case. "Bullying" was reported in 25% of cases across the 6-month period. There are initiatives in place to tackle bullying/inappropriate behaviour. These include: • Leadership development – The Trust has invested significantly in leadership development and manager training programmes; all of which are underpinned by the WUTH Leadership Qualities Framework (LQF). Further to this, the OD Team have recently developed an electronic self-assessment tool which has been launched as part of the annual leadership conference. This new tool allows individuals to complete a undertake self-reflection by assessment their behaviour against the LQF and identify areas for development to improve their leadership practice. • Respect at Work Level 1 (Staff) and Respect at work Level 2 (Managers) e-learning packages. These training packages are identified as role essential training for all Trust staff and have a compliance of – 85% for level 1 and 95% for level 2 (data as of 30th Sept 2023). • Values and behaviours sessions – monthly sessions in which individuals can opt in or be advised to attend. In some cases, this workshop can be provided to teams as part of addressing team challenges. • Kindness and civility group – This staff led group is developing a kindness campaign that will kindness and civility across the Trust with the idea that through acts of kindness a 'just and learning culture' can develop. • Just and Learning delivery plan continues to be implemented as a multi-year project. There are four objectives of the project that aim to promote and embed a just and learning culture, evolve people policy and processes to reflect a just and learning culture and to develop support for staff when an unplanned event occurs. It is anticipated that through successful delivery of the project staff will psychological safety to speak up, raise concerns and embrace learning from unplanned events.
1.4	**FTSU Patient Safety Data** The graph below highlights the % of cases concerning patient safety for the 6-month period compared to the regional and national average. No Freedom to speak up concerns were raised about patient safety, this is lower than both regional and national average, although regional and national data is unavailable for Q2.



Concerns Raised by Division

The chart below shows the concerns raised Q1 and Q2 by division.

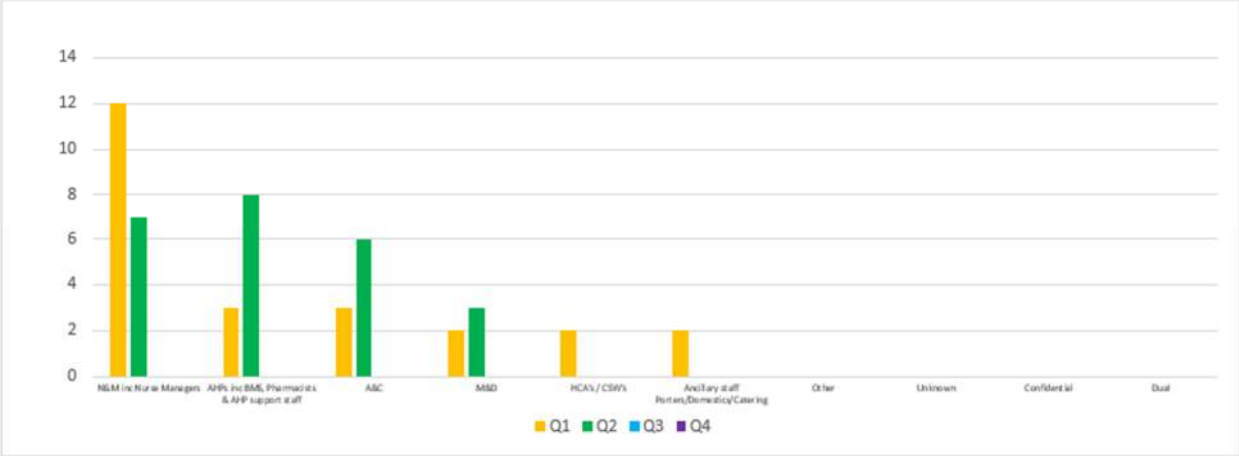


Clinical support and diagnostics have seen a significant increase in staff speaking up by 160% from Q3 and Q4 2022/23 to Q1 and Q 2 of this year, this has prompted further investigation and HR are working closely with the Divisional Management Team. Medical and Acute divisions will be split in future reports; all concerns raised during Q1 and Q2 period are from Medicine Division, no concerns raised from Acute.

Concerns Raised by Professional Group

The following table highlights the concerns raised by professional group with new categories identified in new NGO guidance.

Themes raised by professional group.



The highest group of staff raising concerns across the 6-month period are from Nurses and Midwives along with Allied Health professionals and pharmacists, this is a change to the previous year when the highest reporters were staff from administrative and clerical roles. CSWs remain a low staff group for raising concerns with only two concerns raised over the last 6 months. The FTSU guardian is planning to undertake some proactive engagement with CSWs in coming weeks to further promote FTSU and ensure this staff group are aware of the role should they wish to raise concerns. Further to this, information to determine if this is a theme in other Trusts is being sought from regional colleagues.

Anonymous Concerns

One anonymous concern was received in Q1 2023/24 regarding a bullying allegation against a colleague. Anonymous reporting continues to remain low which is a very positive indication that the FTSU process at WUTH is considered a psychologically safe process. Staff are encouraged in the first instance to discuss their concerns with their line manager where possible and support is offered by the FTSU guardian to assist them in doing this where required.

Disadvantageous or Demeaning Treatment as Result of Speaking Up

There was no reports of disadvantage or demeaning treatment reported across the last 6-month period.

Time Taken to Close Cases
The average time taken to close cases across the year was 3 days – most cases are resolved quickly resulting in staff feeling satisfied with an outcome. It is the experience of the FTSU Guardian that WUTH managers are responsive and receptive to the concern being raised, working swiftly to resolve.

Lessons Learned

Mental Health
Staff continue to struggle with their mental health and continue to, at times feel unable to communicate their concerns directly with line management. Cases have been received whereby staff have felt that they have not been sufficiently supported and at times have suffered a detriment because of their mental health.

Staff have also raised concerns this month around lack of understanding around their neuro diverse conditions which has resulted in them feeling bullied.

Mental health awareness and a willingness to try and understand the diverse needs of others is critical for staff experiencing stress and burnout.

Progressing the FTSU Agenda

Significant development of the FTSU agenda has been led nationally via the National Guardians Office (NGO) in 2022 with both national guidance and policy being updated and relaunched by NHS England. This included:

- National Guardian Reporting and Recording Guidance – February 2022
- FTSU Guidance - June 2022
- FTSU Reflection and Planning Tool for Trust Boards – due for completion
- Updated FTSU Policy – June 2022

To support the development of these a gap analysis was undertaken to develop a FTSU development plan that not only ensures that the Trust remains aligned to national FTSU requirements, but also continues to improve and provide a quality FTSU service at WUTH. In addition to the above documents the gap analysis also incorporated CQC requirements, findings from an internal review and learning from NGO case reviews. The following objectives were identified as part of an annual action plan.

1. **Review Governance and reporting structures for FTSU Guardians** – Through this objective reporting and oversight arrangements have been strengthened to ensure robust Board assurance. In addition, a process for triangulating FTSU cases with employee relations cases and patient safety incidents has been established in line with Trust Just and Learning Culture. There is work to complete in recruiting champions and to look at the guardian's role, time appears to be a significant factor holding staff back from fully committing to the champion or guardian role.

2. **Ensure the Trust is up to date with national and local guidance, policy and best practice** – In addition to the gap analysis undertaken to inform an action plan which addresses the gaps, this work also includes implementation of NGO reflection and planning tool for Board. Actions associated with this objective also included a review of the FTSU Champion and Guardian roles to ensure they were operating within the guidance launched in April 2021. This has been completed and

	WUTH is in line with recommendations made. Completion of the reflection and planning tool is in hand. 3. **Raise awareness of FTSU Guardians, Champions, and Speak Up Agenda across the organisation** – Following the national rebranding of FTSU the Trust have updated all the branding and promotional campaigns to reflect the national programme. The new posters have been placed around the hospital. New pull up banners have been purchased and are used for induction and other key events. The importance of speaking up and the FTSU service is included within the Trust welcome event for new starters along with managing teams and leading teams, with the FTSU Guardian promoting key messages and holding a stall as part of the World Café event. FTSU Guardian has delivered numerous bespoke Speak Up sessions to various staff to promote the importance of speaking up and the support available. Regular walk abouts are undertaken in both Arrowe Park as well as Clatterbridge to promote the importance of speaking up and being visible to staff. The Bromborough laboratory is also included in walk about calendars. 4. **Identify groups potentially facing barriers to speaking up and work towards addressing those barriers** – This objective seeks to engage staff from minority groups who are potentially less likely to speak up. Within the last 12 months FTSU champions are present within all the staff networks. The work of the FTSU champions is particularly important to promote the FTSU agenda and to further champion the agenda amongst staff with protected characteristics. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. 5. **Review effectiveness of FTSU process** – Continuous improvement is paramount to developing a FTSU culture. A survey tool has been developed to provide a feedback loop following the closure of FTSU cases the data identified by this feedback survey will also be incorporated into future reporting from April 2023 onwards. Refer to Appendix A for an overview of the FTSU process.

2	Implications
2.1	**Patients** When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience. Our staff are the eyes and ears of an organisation; their views and concerns can act as a valuable early warning system that a policy, process or decision is not playing out as anticipated or could be improved. A speaking-up culture benefits staff satisfaction and performance, too which in turns impacts on the care our patients receive.
2.2	**People** The number of people speaking up to FTSU Guardians has increased in Q1 and Q2 when compared with the number of concerns raised in from Q3 and Q4 2022/23.

	Considerable work has been undertaken during the year to implement national FTSU policy and guidance, development of an annual action plan and establishment of new policy and processes that triangulate FTSU cases with employee relations and patient incidents to determine themes and opportunities for learning. Work continues to enhance reporting and provide board assurance of the FTSU agenda. Merseyside Internal audit have recently completed an audit of Freedom to Speak Up at WUTH. The results of which demonstrate significant assurance. Recommendations will be added to the FTSU action plan and progress reported via this bi-annual report. The FTSU guardian/Just and Learning culture Lead continues to build and develop the role, promoting the service, regular walkabouts to ensure visibility and membership within key groups such as Lessons Learnt forum, and Patient Safety Incident Response Framework meeting (PSIRF) and will ensure that the FTSU agenda continues to be heard and the FTSU agenda continues to be promoted across the Trust.
2.3	**Finance** A speaking-up culture benefits staff satisfaction and performance, too. When people feel that their opinions matter and are valued and acted on, they become more committed, and performance and retention improve.
2.4	**Compliance** We are compliant with all reporting requirements to the National Guardians office. Training compliance is as follows: • Respect in the Workplace Level 1 - 85.47% • Respect in the Workplace Level 2 - 95.48% Mersey Internal Audit Authority (MIAA) undertook an audit of FTSU during October 2023. They have recently reported 'Substantial Assurance'. The report is due to be presented at the next Audit Committee in due course.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

06 December 2023

Title	NHS Prevention Pledge – Cheshire and Merseyside
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs
Report for	Approval

Report Summary and Recommendations

This report provides an outline of the work being carried out in Cheshire and Merseyside to oversee the adoption of the NHS Prevention Pledge at regional and Trust level.

It is recommended that the Board:

- Note the contents of the report;
- Note and confirm the adoption of the Pledge and associated commitments; and
- Note the proposals for future monitoring and reporting of progress.

Key Risks

This report relates to these key risks:

- Failure of the Trust to have the right culture and organizational conditions/structure to deliver our priorities for our patients and service users.
- Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.
- Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.
- Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

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

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes

Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

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

1	Narrative
1.1	Background The NHS Prevention Pledge is a prevention framework - underpinned by 14 commitments - that has been developed for NHS Provider Trusts to embed prevention of ill health within core service delivery, wider Trust environments and with partner organisations at Place. A key workstream within the C&M Population Health Programme – works closely with other workstreams, in particular All Together Fairer, All Together Active, C&M Anchor Institute Charter. The Framework has been developed by public health charity Health Equalities Group through comprehensive consultation phase in 2019 including Trusts, primary care, public health, researchers, voluntary sector. All 17 provider Trusts in C&M are now engaged in adoption of the NHS Prevention Pledge, with work started recently on a model for primary care.
1.2	Rationale The rationale for Pledge is set out as follows: • Meets ambitions/commitments set out in the NHS Long-term Plan; • Supports NHS Trusts to develop as local 'anchor institutions'; • Supports 'Core20 PLUS 5' programmes for adults & CYP; • Supports other prevention programmes within sub-region (e.g. treating tobacco dependency); • Drives a cultural shift towards embedding prevention in business as usual and empowering staff, patients & public.
1.3	The Commitments The Pledge is based on the achievement of 14 Commitments as follows: • Embedding prevention in governance structures • Quality improvement • Work with partners at place to address health equalities • Utilisation of common prevention pathways across Trusts • Establish key anchor institution practices • Systematically adopt and embed a 'MECC approach' (Making Every Contact Count) • Referral to non-clinical support through social prescribing • Support workforce development • Ensure a smoke-free environment & link to stop smoking support • Workplace health & wellbeing programs for NHS staff

	• Review food and drink provision across all our NHS buildings • Increase public access to fresh drinking water on NHS sites • Support the sub-regional physical activity strategy • Support the 'Prevention Concordat for Better Mental Health for All' • Monitor progress of the Pledge against all commitments In adopting the Pledge providers are asked to choose an initial 7 commitments to work towards prior to the commencement of work on all commitments. Our initially chosen commitments are highlighted in yellow above.
1.4	<u>Action Planning</u> Whilst a number of the commitments reflect work that is already being undertaken in the Trust an action plan has been developed against those commitments and support is ongoing via colleagues in the Health Equalities Group. Some of the initial actions identified are as follows: • Embedding prevention in governance structures - Established Exec Responsibility - Establishing Board Reporting - Commenced work on Health Inequalities Strategy • Quality improvement - Refreshed QI methodology - Project on deteriorating patients - QI training in place - AQUA status with training • Ensure a smoke-free environment & link to stop smoking support - Smoke free site - Smoking assessment questioning on admission - Promotional materials - Smoke free lead in place - Maternity focus and support • Workplace health & wellbeing programs for NHS staff - People Strategy focus - Programs and information in place • Review food and drink provision across all our NHS buildings - Trust adoption of NHS National Food & Drink Standards Nov 2022 - Nutrition and Hydration Group established - Gap Analysis against NHS National Food standards • Increase public access to fresh drinking water on NHS sites - Review of provision of water stations • Monitor progress of the Pledge against all commitments - Board reporting requirement - Reporting on a bi-annual basis with action plan included.
1.5	<u>Monitoring</u>

	Progress against and information relating to the Pledge will be reported to the Board on a bi-annual basis. An up-to-date action plan will be presented to the meeting of the Board in March 2024. Further information in regard to the pledge can be found here https://www.cheshireandmerseyside.nhs.uk/about/sustainability/nhs-prevention-pledge/

2	Implications
2.1	**Patients** • Understanding the effect of prevention on 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.
2.2	**People** • No direct implications for staff, though learning supports a culture of openness, and good patient care.
2.3	**Finance** • No direct implications from a financial perspective.
2.4	**Compliance** • Independent scrutiny helps in the supporting of good practice.

Board of Directors in Public **Item 10**

06 December 2023

Title	Review of Standing Financial Instructions
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Jillian Burrows, Assistant Director of Finance – Financial Services and Improvement
Report for	Approval

Executive Summary and Report Recommendations

Following on from the Internal Audit Capital Governance review, this report summarises the proposed changes to the Standing Financial Instructions (SFIs) in line with the recommendation. It is recommended that the Board:

- Approves the amendments.

Key Risks

This report relates to these key Risks:

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

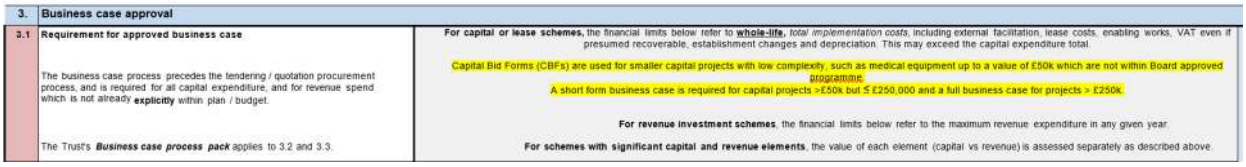
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
Better quality of health services for all individuals	No
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
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
Audit and Risk Committee	23 November 2023	As above	Approval

1 Narrative

1.1	**Proposed amendments** The Internal Audit report issued in relation to Capital Governance recommended a change to the SFIs to reflect current practices in relation to business cases and other documentation required for capital schemes.
1.2	There is a process in place for the development and approval of the annual capital plan and as such there are no SFI changes required. Therefore, these proposed changes cover: • Capital schemes that are a draw on any contingency within the annual plan or require a change in prioritisation. • Capital schemes where the Trust is required to bid for external funding.
1.3	The proposed changes to the SFI document are as follows: 7.2.3 Any item of capital expenditure which is not already **specifically** itemised in the approved capital plan will require either a capital bid form (CBF) or a form of business case. The type of documentation required will depend on the value of the proposed scheme and this is set out in Appendix 2 - Matrix of Financial Limits. Every item or scheme should have been approved through the CBF or business case process at some point prior to procurement. This section of the SFIs has been amended to: • Remove the reference to uncommitted capital funding as the annual plan now runs with a small level of contingency. • Reference to the need for a business case depending on the value of the scheme.
1.4	The proposed changes to Appendix 2 – Matrix of Financial Limits are as follows:  This section now refers to the thresholds for capital items as follows: • The CBF value of £50k is the delegated responsibility of the CFO. • The £250k threshold mirrors the delegated FBPC approval limit. • Greater than £250k is in line with capital approvals outside of the annual plan which require Board approval.

2	**Implications**
2.1	**Finance** • The revised SFIs now align with the thresholds set out in the scheme of delegation. • The requirement for short form business cases/full business cases will provide further governance ensuring that both capital and revenue implications are considered when scheme proposals are put forward.

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 either a capital bid form (CBF) or a form of business case. The type of documentation required will depend on the value of the proposed scheme and this is set out in Appendix 2 - Matrix of Financial Limits. 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.

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.

8.13.1 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.

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

Wirral University Teaching Hospital NHS Foundation Trust

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.								
	Approval for payment of consignment goods [3] d. 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).							
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					**Section 7**
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 **whole-life,** *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 up to a value of £50k which are not within Board approved programme. A short form business case is required for capital projects >£50k but ≤ £250,000 and a full business case for projects > £250k. **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.							Section 4
		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 FBPC	≤ £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 FBPC	≤ £250,000 CEO or DoF						
3.3b	**Approval of capital or lease [6] business cases not within Board-approved capital programme.**	> £250,000 Board [5] ≤ £250,000 FBPC	≤ £50,000 CEO or DoF						
		[5] **Business cases / schemes need additional NHSE / DHSC approval** if 'significant transactions' 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

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.							
	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						**Section 12 & Section 13 & Section 18**
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

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 FBPC	DoF only						**Section 5 & Section 16**
	b. Approving charges for new services	Notified to FBPC	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

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	

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

Board of Directors in Public **Item 11**

06 December 2023

Title	WUTH Charity Annual Report and Accounts 2023-24
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Peter Jardine, Financial Accountant
Report for	Information

Executive Summary and Report Recommendations
This report provides an overview of the 2022/23 Annual Report and Accounts for the Trust's Charity. It is recommended that the Board: • Note the report.

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
27 November 2023	Charitable Funds Committee	As above	Approval

1	Narrative
1.1	**Charitable Funds Annual Report and Accounts 2022/23** The draft annual report and accounts for the Charity were presented to the July meeting of the Charitable Funds Committee for review and comment prior to the commencement of the Independent Examination. The examination took place from July 2023 through to October 2023 with two presentational changes being identified and amended. A meeting was held on 27th November 2023 to approve the accounts and these will now be submitted to The Charity Commission in accordance with the governance process.

2	Implications
2.1	**Patients** • None
2.2	**People** • None
2.3	**Finance** • None
2.4	**Compliance** • The Charity's Annual Report and Accounts is required to be formally approved and then submitted to The Charity Commission by 31 January 2024.

Trustee's Annual Report & Financial Statements

For the Year to 31 March 2023

Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund also known as 'WUTH Charity'.

WUTH Charity

Registered charity no. 1050469

WUTHCharity wuthcharity.org

WUTH Charity

Annual Report and Accounts for the year ended 31 March 2023

Contents

Report of the Trustee for the year ended 31 March 2023

Foreword by Sue Lorimer, Chair of charitable funds committee of WUTH Charity

1. Welcome to our annual report for 2022/23. The Corporate Trustee is pleased to present the Annual Report of Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund ('the Charity', also known as 'WUTH Charity') together with the independently examined financial statements for the year ended 31 March 2023. Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity, as its gross income is below a statutory threshold.

2. This 'Annual Report and Accounts' document has been prepared by the Corporate Trustee in accordance with the *Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland* (FRS 102), *Accounting and reporting by charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)* (effective 1 January 2019), Charities Act 2011 and Charities (Accounts and Reports) Regulations 2008 (see Note 1 to the accounts). It addresses all the separately established funds for which Wirral University Teaching Hospital NHS Foundation Trust ('the Corporate Trustee', 'the Trust', or 'WUTH') is the major beneficiary.

Acknowledgement

3. The activities of the Charity have been achieved through the support and generosity of the local people of Wirral and the surrounding areas, and by the tireless efforts and resources of volunteers and active fundraisers in the community, and the Trust's staff. Many of our donors have contributed during times of personal difficulty. We would like to take this opportunity to extend sincere thanks, on behalf of the patients and Trust staff, to everyone who kindly gave to the Charity, as well as any supporters who gave their time and effort. Their contributions, imagination and enthusiasm are greatly appreciated.

Public interest benefit

4. The Corporate Trustee ensures that the *public benefit* criteria, as detailed in the Charities Act 2011, are met by demanding that each funding application is critically assessed against those criteria. This process is achieved through compliance with the Charity's *Expenditure Guidance* policy document. Applications are prioritised and rejected or pursued based on the availability of funds, compliance with the *Expenditure Guidance*, and the quality of the application – *'how much benefit is generated for each pound spent?'*

   Where possible, funds are used to provide benefit to a wide range of patients. Further descriptions of purchases made by the Charity during the year under review are included in *Achievements in 2022/23*

Ways to donate.

There are a number of ways to make a donation in confidence to WUTH Charity.

- **Over the Phone**

Credit and debit card payments can be received over the phone by calling the Charity Office, at Arrowe Park Hospital on 0151 482 7788.

- **JustGiving**

Donors a can create a personal JustGiving fundraising page for their own fundraising, or pay securely through the Charity's own page, with the option to consent to Gift Aid for both single donations and regular giving.

- **Standing order**

Regular donors can submit a *standing order form* (website, or by request) to the Charity Office.

- **Bank transfer**

Direct transfers can be made into the WUTH Charity bank account.
Sort code: 60 – 70 – 80
Account number: 10029753

- **Cash**

Cash donations can be received at the Trust's cash offices at the Arrowe Park or Clatterbridge sites, or be paid to the Charity through a local bank or post office, with account details as above.

- **Cheque**

Cheques can be posted or handed in to the Charity Office or cash offices, made payable to **WUTH Charity.** The postal address of the Charity Office is on page 11.

- **Gift Aid**

Gift Aid forms are available (website, or by request) to accompany any donation to WUTH Charity. The form seeks consent from the donor for the Charity to reclaim tax amounts that the donor has paid as a UK tax payer, maximising the power of a donation.

Who we are.

5. Wirral University Teaching Hospital NHS Foundation Trust Charity (WUTH) is a registered charity (registered number 1050469). We exist to raise funds and receive donations for the benefit of the our key partner organisation Wirral Universiry Teaching Hospital NHS Foundation Trust, their patients and their staff. By securing donations, legacies, and sponsorship, WUTH Charity can help upgrade and improve existing services while working to support and improve patient experience.

6. Having support from our local community is crucial to our work so please read on to learnabout our work what we have achieved and the difference we have made.

What we aim to do: our objectives and activities.

7. Income received by the Charity is accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 2006. These funds are held on trust by the Corporate Trustee.

8. On an everyday basis, the Charity exists to support the Trust. The Trust delivers patient care at Arrowe Park Hospital, Clatterbridge Hospital, and Wirral Women and Children's Hospital, as well as at several community locations throughout Wirral.

Mission Statement

9. WUTH Charity's Mission Statement, adopted in 2016, is as follows.

   "To further improve the quality of WUTH's patient care, by issuing grants for the purchase of medical equipment, improvement of Trust facilities and for the direct enhancement of the patient experience in other imaginative ways. This is achieved through the spontaneous generosity of the public and by fundraising activities, events and appeals."

10. This Mission Statement is the cornerstone of the Charity's *Expenditure Guidance* policy and explains the Charity's main activities.

Individual funds' purposes and decision-making

11. Decision-making is governed by the Charity's Expenditure Guidance policy, with compliance managed by the Trust's Financial Services Department on behalf of the Charitable Funds Committee. Within this framework, fund-holders are involved in delegated decision-making for the purposes of each individual fund's specialty area, or, in the case of Patient Wish, for the general purposes of the Trust.

12. For Patient Wish, the fund-holder is the Trust's Director of Nursing and Midwifery (Chief Nurse), who receives, considers and approves applications. For the other specialty funds, this is undertaken by the relevant senior Trust team comprising the most senior divisional clinician, nurse and manager. Any member of staff can apply for consideration.

13. In decision-making, there is always due regard for legal trusts imposed. Moreover, staff do attempt to acknowledge any non-binding 'expressions of wish' from donors about the area, function, department or specialty which should ideally benefit from their generosity.

Statute

14. The Charity is committed to spend in line with the statutory public interest benefit criteria, discussed in the previous section. It is additionally guided by its objects, below.

Objects

15. The principal objects of WUTH Charity as set out in the Declaration of Trust deed as follows.

To provide 'for any charitable purpose or purposes relating to the National Health Service.'

16. WUTH Charity's strong governance measures have been put into place so that donors and grantors can be assured that every pound spent generates the highest standards of public benefit, and so that the Trust and the Charity can be proud of each, and every project undertaken.

Fund structure

17. The Charity has one unrestricted Patient Wish general fund and eight specialty funds which includes the Tiny Stars Neonatal Appeal fund which was established in 2019/20.

18. During 2020/21 the Charity also set up a time restricted COVID-19 fund which benefited from successful grant applications from the national appeal organised by NHS Charities Together as well as the Charity's own COVID-19 appeal launched and championed by the Wirral Globe which resulted in significant contributions from the public. This fund was earmarked for and spent on staff welfare.

19. Designation (earmarking) is merely a record of the Corporate Trustee's intention at a point in time. It is not the same as a legal restriction on the funds, as this is a legal trust imposed on how and where the funds are spent. The Charity held no designated funds in 2022/23 or 2021/22 but the Corporate Trustee periodically considers earmarking.

20. Further fund details are included in Note 17 to the accounts.

Patient Wish fund

Respiratory fund

Breast Care fund

Critical Care fund

Heart Care fund

Cancer fund

Children's fund

Stroke fund

Tiny STARS Neonatal Appeal

Governance and management

Corporate Trustee

21. The sole trustee of WUTH Charity is Wirral University Teaching Hospital NHS Foundation Trust. This is a 'corporate trustee', and the Charity's primary beneficiary; the public is the ultimate beneficiary. The address of the Trust's principal office is the same as that of the Charity.

22. The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for ensuring that the NHS body fulfils its duties in managing the charitable funds. Members of the Trust Board are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. They fulfil the Trustee's legal duty by ensuring that funds are spent in accordance with objects and in pursuit of patient benefit, and independently determine the Charity's strategy through meetings of the Charitable Funds Committee.

23. The voting members of the Board of Directors of the Corporate Trustee ('Trust Board') who served during the financial year were as follows:

Chairman	Sir David Henshaw
Chief Executive	Janelle Holmes
Chief Finance Officer	Mark Chidgey (from June 2022)
Interim Chief Finance Officer	Robbie Chapman (to May 2022)
Deputy CEO / Medical Director	Dr Nicola Stevenson
Chief Operating Officer	Hayley Kendall
Chief Strategy Officer	Matthew Swanborough
Chief People Officer	Debs Smith
Chief Nurse	Tracy Fennell
Non-Executive Director	Steve Igoe
Non-Executive Director	Chris Clarkson
Non-Executive Director	Sue Lorimer
Non-Executive Director	John Sullivan (to June 2022)
Non-Executive Director	Lesley Davies (from May 2022)
Non-Executive Director	Rajan Madhok (from July 2022)

24. All the members were in post for the 12-month period to 31 March 2023 except where indicated.

Charitable Funds Committee

25. This is a Committee of the Trust Board, established to ensure that the Corporate Trustee's duties are discharged.

26. The formal purposes of the Charitable Funds Committee can be summarised as follows.

    i. To agree the purpose, strategy, and policies of the Charity.
    ii. To oversee the Charity's financial and treasury management processes.
    iii. To control expenditure from the funds.
    iv. To control fundraising initiatives.
    v. To recommend an Annual Report and Accounts to the Corporate Trustee, outlining all of the Charity's key achievements.

27. Decisions are made and approved at meetings of the Charitable Funds Committee, in which only Charity business is conducted. Board members do not receive any additional remuneration or payment for expenses whilst serving on the Charitable Funds Committee.

28. The Charitable Funds Committee is continuously improving the objectives and effectiveness of WUTH Charity. This activity includes ongoing review of the following areas.

    - Governance arrangements.
    - Expenditure compliance and effectiveness - value for money.
    - Income generation strategy.
    - Risk management arrangements.
    - Investment and reserves review.

29. The members of the Charitable Funds Committee who served during the financial year were as follows:

Non-Executive Director and Chair of Committee	Sue Lorimer
Chief Finance Officer	Mark Chidgey[1]
Interim Chief Finance Officer	Robbie Chapman[2]
Medical Director	Dr Nicola Stevenson
Chief People Officer	Debs Smith
Chief Nurse	Tracy Fennell
Non-Executive Director	Steve Ryan
Non-Executive Director	Lesley Davies[3]

[1] from June 2022
[2] to May 2022
[3] from May 2022

30. All the members were in post for the 12-month period to 31 March 2023 except where indicated. When unable to attend, a nominated deputy is expected to attend. The Trust's Chair and all non-executive directors have a right to attend the Committee. The Chief Finance Officer is the Executive Lead for the Committee.

Corporate Trustee's appointments

31. Non-executive directors of the Trust Board are appointed by the Trust's Council of Governors. Executive directors are recruited by the Trust Board. Further details regarding appointment to the key governance roles within the Trust Board and the Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2022/23 and are contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained by contacting the Trust (see Reference and administrative details), and the Trust's Annual Report and Accounts can be viewed on the Trust website.

32. Trust staff including executive and non-executive directors, are required to complete a corporate induction programme, which includes a briefing on Charity responsibilities. Directors are encouraged towards continuous professional development through the Trust's on-going performance management arrangements, and they are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

33. Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Trust Board, Charitable Funds Committee and governors all have had the benefit of access to advice from the Board Secretary and the Assistant Director of Finance – Financial Services, who were responsible throughout 2022/23 for ensuring that the Corporate Trustee's procedures are followed, and that applicable regulations are complied with.

Constitution of the Charity - *including the reservation and delegation of the powers of the Corporate Trustee*

34. The unrestricted general umbrella fund was established using the Charity Commission's model Declaration of Trust, dated 18 October 1995. This Declaration of Trust was amended by Supplemental Deed, dated 1 November 2007, which reflected the Trust's new status as an NHS foundation trust. A number of 'special purpose trusts' were individually registered with the Charity Commission as constituent/subsidiary charities in 1997 and were 'linked charities' under the Charity's single registration number. WUTH Charity applied for full dissolution of all linked charities within 2017/18 and Charity Commission records have been amended accordingly.

35. Any member of Trust staff can make a grant application. Delegated 'fund-holders' for each fund may approve an application, up to a specified financial limit. Above this limit, further approvals are required by the Corporate Trustee. The Trust's Financial Services department is responsible for the financial administration of the Charity and undertakes the 'technical approval' of all applications, ensuring compliance with the *Expenditure Guidance* policy and charity law on behalf of the Corporate Trustee.

36. Although the Corporate Trustee has delegated some day-to-day decision-making in terms of grant approvals, the Corporate Trustee and its Charitable Funds Committee reserve the power to apply any funds to any purpose in any area of the Trust's hospitals in accordance with the Health Service Act 2006, subject to any imposed restrictions.

37. The full current name of the Charity is Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund. It is also known as 'WUTH Charity', which is a registered 'working name'. The Charity's registration number is 1050469.

Risk management

38. The Charity's key systems are designed and implemented by Wirral University Teaching Hospital NHS Foundation Trust, and the Charity therefore benefits from the Trust's robust internal control framework. Risks to which the Charity is exposed are identified, and mitigating actions are considered, in meetings of the Charitable Funds Committee.

39. As at 31 March 2023, the Corporate Trustee has determined that the Charity did not have any significant residual risks.

What have we achieved: highlights from the activities undertaken in year?

40. As a grant-giving charity, WUTH Charity's aims and objectives are expressed through purchases made for the benefit of the Trust's patients and their careers. Details of some key funds' activities and achievements are set out below.

Charity funded projects.

41. There have been several projects funded this year, all of which have significant impact on our patients and their loved ones. A significant project to support staff was also funded via the COVID-19 fund, the Retreat restaurant and Wellbeing room. Some key stories are described below together with highlights of the fundraising activities.

The Retreat restaurant and wellbeing room £417,000

42. The Charity was pleased to support the refurbishment of the restaurant at Arrowe Park Hospital and the creation of a new wellbeing space with a significant investment of over £400,000. Funds were raised during the COVID-19 pandemic through the appeal launched and supported by the Wirral Globe, local donations, grants secured from the national charity NHS Charities Together and WUTH. The Retreat, named by staff opened in May 2022. Over 115,000 customers have been served in the new restaurant in the first twelve months. The refurbishment has resulted in a modern and comfortable space for staff to visit during their breaks.

43. "When planning the refurbishment of the Retreat, it was important that this space was not only a great place for staff to come and eat, but also a space that promoted staff wellbeing. It has been great to see how well received the area has been by all staff groups in the organisation, and it is not only used at mealtimes, but by staff having informal meetings in the area during the day as well. The Trust has seen a significant increase in how much the facility is now being used. It supports the Trust's goal to be a Great Place to Work. Thanks to the Charity team, Wirral Globe and NHS Charities Together for their support in funding such a great space."

Tom Lloyd Head of Soft Facilities Management

Reminiscence Interactive Therapy Activities - 'RITA' System £23,400

44. RITA is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery.

45. Used primarily for elderly patients with cognitive impairments, such as dementia, the user-friendly technology has shown to be effective in calming distressed or anxious patients.

46. "The reminiscence computer (RITA) has been widely used within the Department of Medicine for the Elderly (DME) Wards and especially on ward 22 at Arrowe Park Hospital. In addition, the reminiscence apps and films other activities on the system include karaoke, bingo, quizzes, and jigsaws. The system is an excellent addition to our resources that support patients especially those with dementia, delirium, or other cognitive impairments, and has proven to be an effective tool in managing behaviours that are challenging and in reducing boredom for patients on the wards. We would like to thank WUTH Charity and their supporters for funding the equipment which has supported many patients this year and will continue to do so in the future".

Tony Probbing, Associate Director of Allied Health Professionals & Divisional Lead for Corporate Nursing

Sensory Suite Surgical Elective Admissions Lounge (Seal Unit) £1,700

47. With a specialist visual and sound facility such as a colour changing wall panel, a plinth with fibre optic lights, wall projector and interactive sound panel and special soft furnishings, the suite offers a relaxed environment to relieve the stress of visiting the hospital for adult patients with additional needs.

48. Christine McGuinness, TV personality and autism campaigner, visited the hospital to officially unveil the suite. Christine has been extensively raising awareness after her three children were diagnosed with autism and following her own diagnosis of autism as an adult.

49. Christine said: "I am so pleased to open this sensory room that will help adults on the autistic spectrum to feel calmer during the stressful time before having surgery. Seeing organisations like hospitals support those with autism by designing appropriate environments - especially for adults - is a real step forward and thank you to Arrowe Park Hospital for making this possible. I hope other hospitals will follow suit."

50. Sensory Suite has been funded by WUTH Charity and the Seal Unit staff through various challenges such as the Virtual London Marathon and parachute jumps. Ward Sister Becky Brumpton lead the project and the teams fundraising.

51. “This has been such an important project to me from a personal perspective and it is a much-needed facility. Having a facility like this can make a huge difference to patients. It helps to keep them calm at what would usually be a very stressful experience for them and for their families. This is about offering a holistic approach to caring for patients with additional needs and I’m really proud to have this facility now up and running.”

Becky Brumpton Ward Sister Surgical Elective Admissions Lounge

52. The Charity has also funded a range of other projects including, gifts for patients in hospital on Christmas Day, special wheelchairs for the Children’s Ward and décor improvements for the Harmony Suite, which supports parents experiencing baby loss. The Charity is extremely grateful for the support it has received this year which has a direct benefit to patients, their loved ones and staff.

Head of Fundraising Annual Review

53. Following the continued restrictions of last year, the Charity team were pleased to resume fundraising activity this year, whilst at times continuing to support staff, particularly as part of the Trust’s winter wellbeing plans. Below are some of the highlights of the year for both the Charity team and our supporters.

Tri4Life Everest Summit Expedition

54. In April a group of lifelong friends, the Tri4Life team from Wirral began their expedition to retrace the famous steps of George Mallory in a centenary celebration of the 1922 British Mount Everest expedition. Tri4Life, a Wirral based charitable enterprise raises funds to support charities close to their hearts and promotes active, healthy lifestyles to today's youth. This year the Tiny Stars Neonatal Appeal is one of their chosen causes to support.

55. Martin Pritchard- Howarth, a consultant Geriatrician at Wirral University Teaching Hospital (WUTH) and Tri4Life member commented prior to the challenge; “As young boys we ran and played in the same streets as our childhood Everest Heroes, Mallory and Irvine who lived in Birkenhead. It will be a huge honour to follow in their footsteps exactly one hundred years since their pioneering endeavour. We have been seeking the next challenge to mark our 20th anniversary and given Mallory and Irvine's local Wirral connections and the approaching Centenary of their fateful journey, have settled upon this attempt to scale Everest! None of us are from a climbing background, many of us are above the age of 50, but all of us have a drive and passion to inspire others and raise money for good causes along the way.

56. We all hope that this effort will massively boost the funds of our chosen charities, including the Tiny Stars appeal. In May the whole team returned safely home following the successful summit attempt by three of the group.

Wirral Coastal Walk

57. Over 30 participants took part in the scenic walk along the Wirral coastline. Starting at the Floral Pavilion the twelve-mile route ended at Thurstsaton Country Park. Participants included members of the public, staff members and families who had received can from the Neonatal Unit.

It's a Knockout

58. The Charity team added this new event to the calendar in July. Thirteen teams took part in this nostalgic inflatable assault course. Teams included staff s from the Executives, Eye department and Porters. They were joined by local companies and community groups including SP Energy Network and many other WUTH Supporters. Alongside the event was a family fun day with a selection of stalls and activities for all to enjoy.

Arrowe Park Abseil

59. Returning for a third year there was a great turn out for this year's Arrowe Park Abseil. A huge £26,000 was raised by the 125 participants taking part, including staff, local businesses and former patients who wished to say thank you for the care they have received. The event was supported by Santander who were on hand to volunteer on the day. WUTH Charity supporter WBO cruiserweight world champion Tony Bellew also took part.





Virtual Marathon

60. 13 participants who took part in this year's Virtual London Marathon and raised over £4000 for the Tiny Stars Neonatal Appeal. It was a great event with staff and the local community taking part in this 26.2-mile challenge.

Wirral Winter Ball

61. WUTH Charity Ambassador Mandy Molby organised Ball in aid of the Tiny Stars Neonatal Appeal. Raising over £30,000 for the Tiny Stars Neonatal Appeal. 280 people attended and enjoyed entertainment from Britain's Got Talent winners Boogie Storm and George Michael tribute act Rob Lambardi.

62. Mandy has expressed her thanks to the Charity team for their hard work and praised how well the event was organised again. She has confirmed her support again in November 2023.





Carol Service Christ Church Port Sunlight

63. The voices of Cantemus at Caldy and the Hand bell ringers of Port Sunlight supported the Charity with a beautiful service in Christ Church Port Sunlight. Joined by 100 friends of the Charity they helped to raise £2,000 for the Tiny Stars Neonatal Appeal.

Santa Express

64. Stagecoach turned one of their fleet of buses into a 'Santa's grotto' for the Christmas season to help raise money for the Tiny Stars appeal. Thank you the support and festive cheer you brought over the last month supporting WUTH Charity and for raising a fantastic £2500 with your Santa's Grotto Bus.

Elf Run

65. The elf run returned for a second year with almost 3000 pupils from schools around the Wirral taking part in our much loved 'Elf and fitness challenge. Thank you to all the children everyone who took part helping to raise over £4000 for the Tiny Stars Neonatal Appeal.

Cycle 75

66. To start off the celebrations for the NHS turning 75 in 2023 the Charity team organised a static bike challenge in which participants would cycle for seventy-five hours over a seven-day period. The event was a huge success with over one hundred and twenty people taking part including, members of the public, staff and local community groups. The final event for the financial year raised over £7,000.

67. The team would like to thank everyone who has supported this year. The team would like to give special thanks to our volunteers who regularly support the team at events and in our day-to-day activities and our ambassadors.

68. Mrs Mandy Molby, Sing Me Mersey's Billy Hui and Wendy Williamson. Their continued support is exceptional and gratefully received.

69. I would also like to personally thank our volunteers who have supported the team throughout the year, their support is invaluable. Our community and events fundraisers Joanne Roberts and Phil Crawford have worked incredibly hard to deliver excellent, safe, and enjoyable events. I would like to thank them for their hard work again this year.

70. A full event calendar is planned for 2023 and the Charity team are excited and optimistic to implement a new three-year Charity Strategy supported by a development grant successfully applied for from NHS Charities Together. We look forward to sharing our events and developments throughout the year.

71. Looking to our year ahead, the team have a full calendar of events planned. Our main fundraising focus for the year will continue to be the Tiny Stars Neonatal Appeal. With architects commissioned to begin the consultation and planning for the refurbishment we look forward to being able to share more detailed plans for the Neonatal Unit with our supporters.

72. A new three-year strategy has been developed and with the support of the NHS Charities Together £30,000 development grant various new activities are planned to strengthen the Charity.

73. These include the introduction of a temporary pop-up gift shop, refreshed branding, new website, and increased branding around the hospital sites.

74. Additional training and improvements to improve the quality of WUTH's patient and staff experience. We will continue to share our events and developments throughout the year with our stakeholders and supporters.

Reserves policy

Background

75. In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold a minimum reserve balance. This is to allow freedom to initiate expenditure when required, in advance of donations, and to mitigate the impact of any unforeseen circumstances.

76. Conversely, the Charity Commission asserts that charities should not hold substantial unspent reserves as a matter of course. The Corporate Trustee recognises its statutory obligation to ensure that funds should be spent effectively and promptly.

Level of reserves

77. As at 31 March 2023, the Charity did not have any staff-based obligations or large ongoing projects, which might generate significant unforeseen obligations, and the Charity has the ability to reactively scale back expenditure to trivial levels, as discussed in the Charity's *Going concern* policy (page 27). Therefore, the Corporate Trustee cannot identify any need to hold high levels of reserves to March 2023.

78. Reserves are that part of a charity's unrestricted funds that is freely available to spend on any of that charity's purposes. The actual level of reserves held is usually calculated as the total funds of a charity, less restricted funds and any other funds earmarked against, or committed to, future projects.

79. The Charity's restricted funds have narrower objects than those of the Charity and so are not 'freely available'. However, they still have broad objects within their own areas, are subject to the apportionment of overheads, and are not often subject to very narrow restrictions from imposed trusts. This means that, for internal management purposes only, an 'operational reserves' figure might be alternatively broadly expressed as the total funds held. It could be argued that this represents a high level of 'operational reserves', given the very low risk of unforeseen obligation, and the growing needs of the Charity's beneficiary trust.

80. The Corporate Trustee is committed to ensuring that high fund balances are not held unnecessarily, and that the Charity's funds are put to prompt and prioritised use for the benefit of the Trust's patients.

81. The Charitable Funds Committee has established a reserves policy as part of its plans to provide long term support to WUTH Charity.

82. The Charitable Funds Committee calculate the reserves as that part of the charity's unrestricted income funds that is freely available after taking account of designated funds that have been earmarked for specific projects.

83. Because, with the exception of one fund, the funds held are classed as restricted, the actual reserves figure for WUTH Charity at 31 March 2023 was £318k (2021/22 £380k). This level of reserves is consistent with the reasoning above and is calculated as follows:

Total unrestricted funds of	£318,000
Less designated funds of	0
Total free reserves	**£318,000**

Investment policy

Background

84. By law, the Charity must ensure it spends any income received within a 'reasonable time of receipt'. Charities should not hold substantial unspent reserves as a matter of course. However, where NHS charitable funds have surplus monies not needed to fund immediate charitable activities, the Corporate Trustee may elect to invest some (or all) of this surplus to generate additional income to fund future activities.

85. All investment decisions

    must comply with the Trustee Act 2000 and have regard to the Act's standard investment criteria; and
    must be informed by appropriate professional investment advice.

86. The Charity avoids investments involving alcohol, arms and tobacco.

87. The overriding objective, as expressed through the Charity's Treasury Management Policy, is to safeguard the Charity's assets and minimise risk, whilst maximising returns net of administrative expense.

Investments summary

88. The Charity has no investment assets.

89. In 2022/23 investment income of £9k (2021/22 £1k) was earned. This income solely relates to bank interest.

Reference and administrative details

Registration

90. Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund ('WUTH Charity'), registered charity number 1050469, was entered onto the Register of Charities on 8 November 1995. Registered administrative details and overview are available on the Charity Commission website: www.charitycommission.gov.uk

Principal office Donations & fundraising

WUTH Charity Office
Arrowe Park Hospital
Arrowe Park Road
Wirral
CH49 5PE
wuth.charity@nhs.net
0151 482 7788
WUTHCharity wuthcharity.org

Administration and records

91. The accounting records and day-to-day administration of the funds are handled by the Trust's Financial Services department, located at Willow House, Clatterbridge Hospital, Bebington, Wirral CH63 4JY.

Advisors

The following services were retained by the Charity during 2022/23.

Banks
Barclays Bank PLC
Leicester
LE87 2BB

Government Banking
Services
National Westminster Bank
PLC
280 Bishopsgate
London EC2M 4RB

Nationwide Building Society
Kings Park Road
Northampton
NN3 6NW

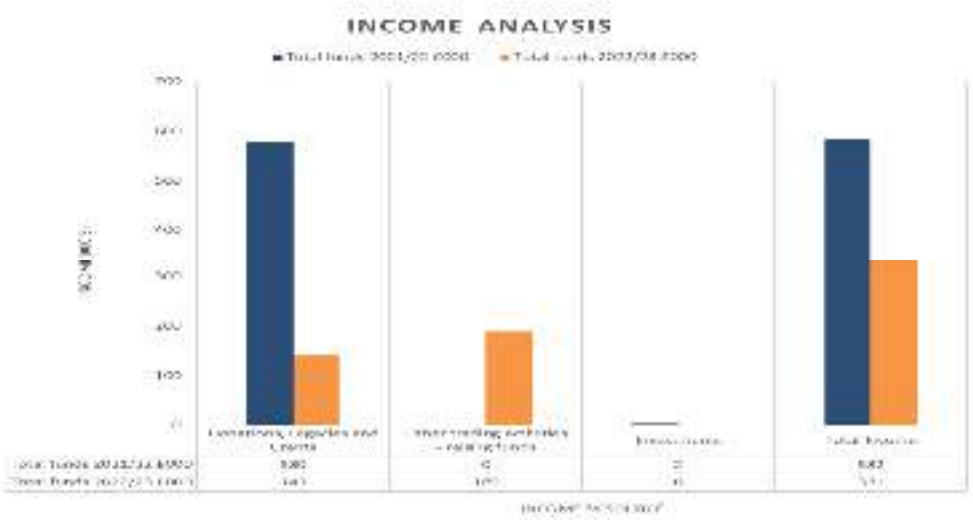
Independent Examiner
Azets Audit Services
6th Floor Bank House
Cherry Street
Birmingham
B2 5AL

Legal Advisor
Hill Dickinson LLP
No. 1 St Paul's Square
Liverpool
L3 9SJ

Finance and performance review

Income summary

92. The Charity relies upon donations and legacies as its main source of income. Total income for 2022/23 was £331k (2021/22 £582k). The following chart analyses this year's income by source.



Donations - £111k

93. Many of our on-site donors give to the Charity in times of personal difficulty, whilst other donors may be motivated to say 'thank-you' after returning home from an experience as a patient or carer, which leads to postal donations, JustGiving collections and external (third party) fundraising events.

94. Fundraising activities and events are a wonderful way for the local community to contribute and get involved. They are usually more effective if undertaken with the knowledge and approval of the Corporate Trustee, and the Charity's fundraising team (page 4) can offer advice and help.

95. We thank all donors for their kindness and effort.

Grants - £30k

96. This development grant was awarded by COIF Charities Deposit Fund late in March 2023.

Legacies - £2k

97. We are very fortunate to be remembered through wills by kind legacy donors, and we extend our thoughts and thanks to their families and friends.

Other trading activities - £179k

98. The income relates to income received in exchange for supplying goods and services to raise funds for the Charity. This was primarily generated by both internal and external fundraising events. Additional funds were generated through lottery activity, Just Giving and Gift Aid income.

99. Historically event income was categorised under donations, this has been reclassified here in line with charity objectives.

Investment income - £9k

100. To maximise the benefit of every penny donated, the Charity seeks to invest any funds which are not likely to be used in the short-term subject to the requirements of the Reserves Policy. Recent investment market conditions are such that investment income was modest in 2022/23. All investment income generated during 2022/23 was through bank interest.

101. Investment opportunities are subject to ongoing review.

Expenditure analysis

102. Of the total expenditure of £693k (2021/22 £342k), £413k (2021/22 £122k) was spent on charitable activities across a range of programmes for patient benefit.

103. The allocation of support costs to these charitable activities is detailed in Note 7 to the accounts.

Patient comforts and welfare - £4k

104. This is shown as a £4k benefit to the charity rather than expenditure. During 2022/23 the Charitable Funds Committee decided to review the Charitable Grant Application process and all live grant applications were put on hold. The impact of this was the reversal of 2021/22 accrued expenditure.

Staff education and welfare – (£8k)

105. We continue to fund initiatives to train the staff who care for patients. Ensuring staff are well trained and supported benefits the quality of care they provide. Additionally, we support wellbeing programmes established to help maintain and improve the physical wellbeing of staff in their demanding roles.

Medical equipment and Patient Appliances - (£3k)

106. This expenditure represents tangible benefits to patients which will be felt for years to come. The Charity has provided an array of modern and innovative equipment to be used in the direct delivery of healthcare in recent years. Expenditure for 2022/23 has been impacted by the decision to review the grant application process.

107. 2022/23 expenditure included the purchase of a medical ward refrigerator to be housed in the delivery suite at Arrowe Park Hospital.

Buildings and Refurbishment - (£400k)

108. As part of the COVID support grants received, the Charity contributed towards the refurbishment of the staff restaurant. The new facilities include a wellbeing hub as well as break out areas and meeting spaces.

Other Commitments - (£6k)

109. This represents funding paid over to external charities as part of the joint Tri4Life Everest Challenge.

Raising funds - (£250k)

110. This category includes budgeted fundraising services and resources, which will underpin future income growth.

Deferred Income - (£30k)

111. This development grant was awarded by COIF Charities Deposit Fund late in March 2023. The income has been deferred to match expenditure which will be incurred in the 2023/24 financial year.

Future Plans

112. The Trust, as a body operating within the NHS, is subject to uncertainty due to changes in government policy, departmental and regulatory reforms, and local developments. The Corporate Trustee is therefore committed to flexibility in the Charity's spending decisions, to accommodate the changing needs of its major beneficiary.

113. **The Charity therefore did not require or compile comprehensive future spending plans in 2022/23.**

114. As the Charity grows, this position will adapt to incorporate the spending plans associated with appeals schemes.

115. As a rule, the Corporate Trustee is committed to utilising funds as soon as is practical, based on patient benefit priorities. Other future plans for the development of the Charity's activities and incomes are outlined in the Head of Fundraising's review of the year (page 11).

Corporate Trustee's responsibilities in relation to the financial statements

116. The Corporate Trustee is responsible for preparing the Trustee Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) including the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102).

117. The law applicable in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently.
- observe the methods and principles in the applicable Charities SORP.
- make judgements and estimates that are reasonable and prudent.
- state whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.
- prepare the financial statements on the *going concern* basis unless it is inappropriate to presume that the Charity will continue in operation; keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations (see Note 1 to the accounts) and the provisions of the trust deed; and safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

118. The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements (including notes) set out on pages 25 to 41 have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

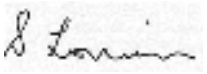
119. The Corporate Trustee is responsible for the maintenance and integrity of the general and financial information included on the Charity's webpages. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement as to disclosure to our independent examiners

120. So far as the Corporate Trustee is aware, at the time of approving this Annual Report and Accounts, there is no relevant information of which the Charity's independent examiner is unaware. The Corporate Trustee has taken all the steps that it ought to have taken to make itself aware of any relevant information and to establish that the Charity's independent examiner is aware of that information.

By delegated authority on behalf of the Corporate Trustee:

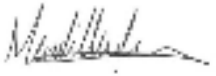
Sue Lorimer



Date xxx

Chair - Charitable Funds Committee / Non-Executive Director of the Corporate Trustee

Mark Chidgey



Date xxx

Executive Lead - Charitable Funds Committee / Chief Finance Officer of the Corporate Trustee

Independent examiner's report to the corporate trustee of Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund

I report to the charity Trustees on my examination of the accounts of the charity for the year ended 31 March 2022.

Responsibilities and Basis of Report

As the Trustees of the Charity, you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the 2011 Act'). You are satisfied that the accounts of the charity are not required by charity law to be audited and have chosen instead to have an independent examination.

I report in respect of my examination of the charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act.

An independent examination does not involve gathering all the evidence that would be required in an audit and consequently does not cover all the matters that an auditor considers in giving their opinion on the accounts. The planning and conduct of an audit go beyond the limited assurance that an independent examination can provide. Consequently, I express no opinion as to whether the consolidated accounts present a 'true and fair' view, and my report is limited to those specific matters set out in the independent examiner's statement.

Independent Examiner's Statement

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the Act. I confirm that I am qualified to undertake the examination because I am a member of the Association of Certified Chartered Accountants, which is one of the listed bodies.

I have completed my examination. I can confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the 2011 Act: or

2. the accounts do not accord with those records; or

3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination: or

4. the accounts have not been prepared in accordance with the methods and principles of the Statement of Recommended Practice for accounting and reporting by charities.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in other to enable a proper understanding of the accounts to be reached.

Use of this report

This report is in respect of an examination carried out under section 145 of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

SIGNATURE

Name: Laura Hinsley FCCA

Association of Certified Chartered Accountants

Azets Audit Services
6th Floor Bank House
8 Cherry Street
Birmingham
B2 5AL

Date: XXXX

Statement of Financial Activities

For the year ended 31 March 2023

	Note	Unrestricted Funds		Restricted Funds		Total funds	
		2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
		£000	£000	£000	£000	£000	£000
INCOME from							
Donations, Legacies and Grants	3	55	242	88	338	143	580
Other trading activities - raising funds	4	14	2	165	0	179	2
Investments	5	2	0	7	1	9	1
Accrued income	12	2	0	0	0	2	0
Total Income		**73**	**244**	**260**	**339**	**333**	**583**
EXPENDITURE on							
Raising Funds	6	(84)	(82)	(166)	(138)	(250)	(220)
Charitable activities							
Patient comforts and welfare	7	4	(97)	0	(2)	4	(99)
Staff comforts and welfare	7	(8)	0	0	0	(8)	0
Building and refurbishment	7	0	0	(400)	0	(400)	0
Patients Appliances : Purchase	7	(2)	0	0	0	(2)	0
Furniture And Fittings	7	0	0	0	0	0	0
Purchase of medical equipment	7	(1)	(21)	0	(2)	(1)	(23)
Other expenditure	7	0	0	(6)	0	(6)	0
Defered Income		(30)	0	0	0	(30)	0
Total Expenditure		**(121)**	**(200)**	**(572)**	**(142)**	**(693)**	**(342)**
Net realised gains / (losses)on investments		0	0	0	0	0	0
NET INCOME / (EXPENDITURE)		**(48)**	**44**	**(312)**	**197**	**(360)**	**241**
Transfers between funds		(13)	0	13	0	0	0
Balance sheet adjustment		1	0	8	0	9	0
Net Movement in Funds		**(60)**	**44**	**(291)**	**197**	**(351)**	**241**

Balance Sheet
As at 31 March 2023

	Note	Unrestricted Funds		Restricted Funds		Total funds	
		2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
		£000	£000	£000	£000	£000	£000
Current Assets							
Debtors	12	(1)	0	0	0	(1)	0
Cash and cash equivalents	13	525	457	1,155	904	1,680	1,361
Total Current Assets		**524**	**457**	**1,155**	**904**	**1,679**	**1,361**
Liabilities							
Creditors falling due within one year	14	(76)	(75)	(187)	11	(263)	(64)
Accruals	14	(12)	0	(428)	0	(440)	0
Defered Income	14	(30)	0	0	0	(30)	0
Net Current Liabilities		**(118)**	**(75)**	**(615)**	**11**	**(733)**	**(64)**
Total assets less current liabilities		**406**	**382**	**540**	**915**	**946**	**1,297**
NET ASSETS		**406**	**382**	**540**	**915**	**946**	**1,297**
Total funds of the charity:							
Restricted Funds				540	915	540	915
Unrestricted Funds		406	382			406	382
TOTAL CHARITY FUNDS		**406**	**382**	**540**	**915**	**946**	**1,297**

The notes on pages 27 to 41 form part of these accounts.

Approved by the Corporate Trustee and signed on its behalf:

Sue Lorimer xxx
Chair of the Charitable Funds Committee
Non-Executive Director of the Corporate Trustee

Mark Chidgey xxx
Executive Lead for the Charitable Funds Committee
Chief Finance Officer of the Corporate Trustee

Notes to the accounts

1. Accounting policies

a. Basis of preparation

121. Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund ('the Charity') is a public benefit entity.

122. The Charity's financial statements have been prepared under the going concern basis and historical cost convention as modified by the revaluation of assets, and in accordance with applicable United Kingdom accounting standards and Accounting and reporting by charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 1 January 2019 ('Charities SORP (FRS 102)'), its published updates and amendments pertaining to small entities, the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102), Charities (Accounts and Reports) Regulations 2008, and Charities Act 2011.

123. The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Charities SORP (FRS 102) issued on 1 January 2019, rather than Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005, which has since been withdrawn.

b. Going concern

124. The Corporate Trustee has satisfied itself that there are no material uncertainties about the Charity's ability to continue as a going concern for a period of at least 12 months from the date these financial statements are approved. This is because the Charity's expenditure and obligations are with Wirral University Teaching Hospital NHS Foundation Trust. The Charity has the ability to scale costs back, in line with available cash / funds. There are no contractual staff obligations, and no long-term programmes or projects to create unfunded obligations. Grants are committed after assessing fund balances, and grant commitments can, in certain circumstances, be reversed, are short-term, and are non-recurrent in nature.

125. The Corporate Trustee has therefore adopted the going concern basis of accounting in preparing the financial statements and a material uncertainty is not considered to exist in relation to going concern.

c. Fund structure

126. Unrestricted income funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the charitable objects. After a significant restructure, as at 31 March 2018, the Charity has a single unrestricted general purpose (Patient Wish fund), and seven restricted specialty funds. Restricted funds are to be used in accordance with their specific restrictions, which could be imposed by the donor through a written trust, or through 'appeals' fundraising.

127. The major funds held are disclosed in Note 17.

d. Income

128. All income is recognised once the Charity has entitlement to it, it is probable that it will be received, and its monetary value can be measured with sufficient reliability.

129. Given the absence of a reliable measurement basis, the significant voluntary contribution of Trust staff members is not included as Charity income in these accounts.

must be more likely than not that a transfer of cash will occur, and the amount of the obligation must be able to be measured or estimated reliably.

e. Income from legacies

130. Legacy sums notified but not received at year end will be recognised as in-year income if their receipt is considered to be 'probable' (more likely than not), in line with d., above.

131. Therefore, legacies are accounted for as income upon cash receipt, or where the receipt of the legacy meets each of the following 'probable' criteria.

- Confirmation has been received from the representatives of the estate(s) that probate has been granted.
- The executors have established that there are sufficient assets in the estate, after settling liabilities, to pay the legacy.
- All of the conditions attached to the legacy have been fulfilled or are in the control of the Corporate Trustee, and payment is unlikely to be challenged.

132. If the Charity is notified of a legacy after the reporting date but before the accounts are authorised for issue, then the legacy is accrued as income within the accounting period only if it can be shown that the 'probable' criteria are met as at the reporting date, and the legacy can be reliably measured.

133. If there is uncertainty as to the amount of the legacy (for example, if it is challenged) and it cannot be reliably measured by the date on which the accounts are authorised for issue, or there are unmet conditions not wholly within the control of the Charity, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

f. Expenditure

134. All expenditure is accounted for on an accrual basis and is recognised once there is a legal or constructive obligation, as a result of a past event, committing the Charity to the expenditure. In addition, settlement must be 'probable' – that is, it

135. When transacting directly with third parties, contractual obligations are recognised as goods or services are supplied to the Charity. When funding Trust expenditure, constructive grant obligations are recognised by the Charity when the conditions of each grant are met. Grant conditions for day-to-day transactions are deemed to be satisfied when the Trust fully completes the purchase transaction correctly and promptly, and the details of the purchase can be demonstrated to match the original grant claim, which has itself been approved by the Corporate Trustee or delegated officer(s).

136. Extraordinary grants may be issued in advance of grantee expenditure. Such grants are only issued if they are contractually required and/or are directed by the Corporate Trustee.

g. Expenditure on irrecoverable VAT

137. Irrecoverable VAT is charged against the same category of resources expended as the underlying purchases.

h. Expenditure on raising funds

138. These are costs associated with generating incoming resources and are recognised as per the Charity's other expenditure. The costs of budgeted fundraising services and resources have been included. Unless directly attributable to a particular fund, such costs are split across the Charity's 10 funds.

i. Charitable activities and apportionment

139. The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity.

140. Charitable activities costs comprise the direct and grant-funding expenditures of charitable projects, and all overheads (administration and governance costs), charged directly to funds. The apportionment of the overheads ('support costs') across the different categories of charitable activity is usually then achieved using the value of expenditure transactions undertaken within the financial year in each category.

141. Governance costs comprise the costs of independent examination and the element of the administration fee which is deemed attributable to supporting the Charitable Funds Committee and for providing policies, papers, advice and recommendations, in addition to the creation of this Annual Report and Accounts.

142. The apportionment of support costs across the different categories of charitable activity is disclosed in Note 7.

j. Fixed asset and current asset investments.

143. Any investments held would be stated at market value as at the Balance Sheet date. The Statement of Financial Activities would include the net gains and losses arising on revaluation and disposals throughout the year. The Charity held no investments within 2022/23 or in the prior year.

k. Realised gains and losses from investment.

144. All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and market value at the start of the year (or purchase cost if bought in year). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or purchase cost if bought in year).

145. In line with the principles of fund accounting, all gains (or income) and losses (or expenditure) pertaining to treasury activity are allocated back to each individual 'originating' fund.

146. The Charity had no such gains/losses in 2022/23 or in the prior year.

l. Financial instruments.

147. Financial assets and financial liabilities are recognised when the Charity becomes a party to the contractual provisions of the instrument. All financial assets and liabilities are initially measured at transaction price (including transaction costs). The Charity's financial instruments comprise balances from across the Balance Sheet: Debtors, cash and creditors.

148. The Charity's financial assets and financial liabilities qualify as 'basic financial instruments. These basic financial instruments are initially recognised at transaction value and are subsequently measured at amortised cost which equates to settlement value.

m. Contingent assets and liabilities.

149. A contingent asset is a possible asset that arises from a past event, but which is not recognised in the Charity's Balance Sheet as its existence can only be confirmed by future events which are not within the Charity's control.

150. If receipt of a legacy is probable, but it cannot be reliably measured by the date of compilation of these accounts, then the legacy is shown as a contingent asset until all the conditions for income recognition are met.

151. A contingent liability is either a possible but uncertain obligation, or a present obligation that is not recognised in the Charity's Balance Sheet because.

- a transfer of economic benefit to settle the possible obligation is not probable; or
- the amount of the obligation cannot be estimated reliably.

152. Grants approved in principle but with unmet application or performance conditions are disclosed as contingent liabilities.

n. Critical accounting judgements and key sources of estimation uncertainty

153. In the application of the Charity's accounting policies described above, the Corporate Trustee is required to make judgements, estimates and assumptions about carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and any other factors that are relevant. Actual results may differ from these estimates.

154. In assessing whether conditions have been met such that a grant claim is formally fully agreed and therefore recorded as expenditure, judgement is applied by delegated officers of the Corporate Trustee. Similarly, when applying the Charity's accounting policies to the recognition of legacies, judgement is required to assess the circumstances surrounding each legacy. The Corporate Trustee's going concern judgement is discussed in section b.

155. The Corporate Trustee does not consider that there are any other significant judgements, nor has it identified sources of estimation uncertainty, which present a significant risk of causing a material adjustment to the accounts within the next reporting period.

2. Related party transactions

156. The Charity is a subsidiary of Wirral University Teaching Hospital NHS Foundation Trust and the Trust is therefore a related party. The Trust's 'place of business' is Trust Headquarters, as detailed in the Reference and administrative details section of the Annual Report. The Trust is a public benefit corporation established under the NHS Act 2006 and is both the Corporate Trustee and the primary beneficiary of the Charity. The Charity's ultimate parent is HM Government.

157. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. All of the Charity's non-treasury expenditures, other than the costs of independent examination, bank charges and JustGiving fees, are with the Trust. During the year, the Charity made cash payments totalling £0k (2021/22 £193k) to Wirral University Teaching Hospital NHS Foundation Trust.

158. At 31 March 2023, the Charity owed the Wirral University Teaching Hospital NHS Foundation Trust £263k (2021/22 £52k) for support services delivered but not yet paid. All transactions entered into during the year were conducted on an arm's length basis.

159. During the year, none of the members of the Trust Board, Charitable Funds Committee or senior Trust staff, or parties related to them, were beneficiaries of the Charity, and none of these individuals have undertaken any material transactions with the Charity or received honoraria, emoluments or expenses in the year which were funded by the Charity.

160. Board members, and other senior staff, take decisions on both Charity and Trust matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public. The Corporate Trustee purchases Directors and Officers liability insurance which covers both the Charity and the Trust under a shared limit, and separate trustee indemnity insurance has therefore not been deemed necessary.

161. Prior to 31 March 2013, NHS charitable funds considered to be subsidiaries were excluded from accounts consolidation ('group accounts'), in accordance with a Treasury accounting direction issued by Monitor (now NHS Improvement). This dispensation is no longer available and NHS foundation trusts need to consolidate any material NHS charitable funds.

162. The Trust reviewed the figures contained in the single-entity financial statements within this Annual Report and Accounts and has determined that they are immaterial to the 'Trust group'. Consolidation has therefore not occurred in 2022/23 nor did it occur in any previous year.

3. Income: Donations and legacies

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Donations from individuals	20	190	54	329	74	519
Corporate donations	4	0	33	0	37	0
Grants	30	0	0	0	30	0
Legacy	1	52	1	9	2	61
Total donations and legacies	**55**	**242**	**88**	**338**	**143**	**580**

163. Donations from individuals are gifts from members of the public, relatives of patients and staff. This income is usually collected through “In Memory Of” donations as well as general gifts.

164. Corporate donations are gifts from organisations that have supported WUTH Charity during the past year, for example £12k donated via the Mayor’s Special Charity Appeal and The Restaurant Group.

4. Income: Other trading activities - raising funds

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
WUTH Event Ticket Sales	0	0	28	0	28	0
WUTH Event Additional Fundraising	2	0	79	0	81	0
Fundraising by Individuals	3	0	23	0	26	0
Other Fundraising Income	0	2	28	0	28	2
Lottery	4	0	0	0	4	0
Other Just Giving & Gift Aid	5	0	7	0	12	0
		0		0		0
Total other trading	**14**	**2**	**165**	**0**	**179**	**2**

165. This income category only includes raised income for which there is an exchange; for example, monies collected due to ticket sales for official events, or the selling of goods.

166. This figure therefore does not capture the flow of income generated by the ongoing and ad hoc representation of the Charity to patients and visitors by Trust staff, or the donations collected at any of the Charity's many events held in 2022/23, which would be included under Donations in Note 3.

5. Income: Investments

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Fixed asset investments	0	0	0	0	0	0
Bank Interest	2	0	7	1	9	1
Total	**2**	**0**	**7**	**1**	**9**	**1**

167. To maximise the benefit of every penny donated, the Charity seeks to invest any funds which are not likely to be used in the short-term subject to the requirements of the Reserves Policy. Recent investment market conditions are such that investment income was modest in 2022/23. All investment income generated during 2022/23 was through bank interest.

168. Investment opportunities are subject to ongoing review.

6. Expenditure: Raising funds

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Fundraings services / resources	(83)	(80)	(164)	(132)	(247)	(212)
Just Giving fees, kicenses and related charges	(1)	(2)	(2)	(6)	(3)	(8)
Total	**(84)**	**(82)**	**(166)**	**(138)**	**(250)**	**(220)**

169. The Corporate Trustee has approved the recharge of service and resource costs from the Trust to the Charity, on a recurring basis.

7. Expenditure: Charitable activities

	Grant Funded Activity		Charitable Contributions		Support Costs		Total	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000	£000	£000
Unrestricted Funds								
Patient education and welfare	4	(97)	0	0	0	0	4	(97)
Staff education and welfare	(8)	0	0	0	0	0	(8)	0
Building and refurbishment	0	0	0	0	0	0	0	0
Furniture And Fittings	0	0	0	0	0	0	0	0
Patients Appliances : Purchase	(2)	0	0	0	0	0	(2)	0
Purchase of medical equipment	(1)	(21)	0	0	0	0	(1)	(21)
Other expenditure	0	0	0	0	0	0	0	0
Total unrestricted funds	(7)	(118)	0	0	0	0	(7)	(118)
Restricted Funds								
Patient education and welfare	0	(2)	0	0	0	0	0	(2)
Staff education and welfare	0	0	0	0	0	0	0	0
Building and refurbishment	0	0	(400)	0	0	0	(400)	0
Furniture And Fittings	0	0	0	0	0	0	0	0
Patients Appliances : Purchase	0	0	0	0	0	0	0	0
Purchase of medical equipment	0	(2)	0	0	0	0	0	(2)
Other expenditure	0	0	(6)	0	0	0	(6)	0
Total restricted funds	0	(4)	(406)	0	0	0	(406)	(4)
Total	(7)	(122)	(406)	0	0	0	(413)	(122)

170. The Charity grants funding to support Wirral University Teaching Hospital NHS Foundation Trust, through the purchase of goods and services for the Trust, consistent with the charitable objects of the Charity.

171. Support costs (overheads) comprise the Charity's administration fee, which is explained in Note 9, legal fees and the costs of independent examination, detailed in Note 10.

172. Support costs can be split between administration costs and governance costs, which have been separately disclosed below. The basis for the apportionment of overheads is detailed in Note 1.

173. Further details regarding expenditure due to charitable activities are included in the Achievements in 2022/23 and Finance and performance review sections of the Annual Report.

8. Analysis of grants

174. Grants are made to support Wirral University Teaching Hospital NHS Foundation Trust in its purchase of revenue goods or services and fixed assets. This expenditure is described in Note 7, and in the descriptions of management arrangements and performance reporting within the Annual Report.

175. The Charity does not make grants to individuals or third parties.

9. Analysis of staff costs

176. The Charity does not directly employ staff. Instead, the resources of Wirral University Teaching Hospital NHS Foundation Trust are used, and an administration fee is levied by the Trust in order that the Trust can recover estimated costs incurred. This administration fee is subject to the approval of the Charitable Funds Committee.

177. The staff who perform administrative and fundraising functions work within Trust policy and under Trust direction, with identical terms and conditions to all other Trust staff, and their workload may be covered by colleagues interchangeably. These points would all suggest that these staff have not been seconded into the Charity, and that the supply is one of service, not of staff.

178. The Charity therefore does not require separate staff costs disclosures, and the service expenditure (administration fee) is contained within Note 6. The fundraising service charge is additionally disclosed in Note 6.

10. Costs of independent examination

179. The independent examiner's fee of £5,760 (21/22 £5,280) including VAT relates solely to the independent examination of these accounts. No other additional services have been provided by the independent examiner. This fee is included wholly within Charitable activities in the Statement of Financial Activities, through the apportionment of governance costs within total support costs (Note 6).

11. Fixed asset and current asset investments

180. No fixed asset or current asset investments have been held by the charity during the financial year, or prior year.

181. There have been no direct investments made outside the UK by the Charity, and further details of the Charity's treasury activity are contained within the Investment policy section of the Annual Report.

12. Current assets: Debtors

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Accrued income	2	0	0	0	2	0
Other debtors	(3)	0	0	0	(3)	0
Total	**(1)**	**0**	**0**	**0**	**(1)**	**0**

182. Due to the balance and nature of the Charity's debtors, exposure to credit risk is negligible. No debts are past due or impaired.

183. There is a modest amount of Accrued Income relating to future fundraising events.

13. Current assets: Cash

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Natwest/RBS	347	324	79	-121	426	203
Barclays	93	48	1,076	1,024	1,169	1,072
Nationwide	85	85	0	0	85	85
Total	**525**	**457**	**1,155**	**903**	**1,680**	**1,360**

184. The carrying value of financial assets measured at amortised cost is measured as the total of balances in Notes 12 and 13.

14. Current liabilities: Creditors

	Unrestricted Funds		Restricted Funds		Total Funds	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000
Creditors						
Due to Wirral University Teaching Hospital NHS FT	(76)	(75)	(187)	11	(263)	(64)
Defered Income	(30)	0	0	0	(30)	0
Accruals - Creditors	(12)	0	(428)	0	(440)	0
Total	**(118)**	**(75)**	**(615)**	**11**	**(733)**	**(64)**

185. Amounts owed to Wirral University Teaching Hospital NHS Foundation Trust relate to unpaid obligations for services delivered, and grants issued but not yet paid. The carrying value of financial liabilities measured at amortised cost equates to the accruals row above.

15. Contingent assets and liabilities

186. If receipt of a legacy is probable at 31 March, but it cannot be reliably measured by the date of compilation of these accounts, then the legacy is disclosed as a contingent asset until all of the conditions for income recognition are met. The Charity had no contingent assets as at 31 March 2023 and 2022.

187. Grants approved in principle but with unmet application or performance conditions are disclosed as contingent liabilities. If the conditions are not met within six months, the conditional approval expires. As at 31 March 2023 the estimated contingent liability was £0k (2021/22 £0k).

16. Commitments

155. The Charity has no other undisclosed commitments.

17. Analysis of material funds

The objectives of all of the Charity's funds are disclosed in the Aims and objectives section of the Annual Report. A summary of 2022/23 fund movements is as follows.

A summary of 2022/23 fund movements is as follows:

	Fund balance B/Fwd		Income		Expenditure		Transfers		Adjustments		Fund Bal/Cfwd		Gains and Losses for the year	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breast Care Fund	60	70	7	5	(16)	(15)	0	0	1	0	52	60	(8)	(10)
Cancer Fund	7	15	5	7	(15)	(15)	0	0	1	0	(2)	7	(9)	(8)
Childrens Fund	15	28	5	5	(17)	(18)	0	0	1	0	4	15	(11)	(13)
COVID Fund	387	236	0	152	(400)	(1)	13	0	0	0	0	387	(387)	151
Critical Care Fund	18	28	15	5	(17)	(15)	0	0	1	0	17	18	(1)	(10)
Heart Care Fund	9	20	1	3	(16)	(14)	0	0	1	0	(5)	9	(14)	(11)
Respiratory Fund	33	46	2	3	(16)	(16)	0	0	1	0	20	33	(13)	(13)
Stroke Fund	9	12	7	11	(15)	(14)	0	0	1	0	2	9	(7)	(3)
Tiny Stars Neonatal Appeal	379	262	221	148	(61)	(31)	0	0	1	0	540	379	161	117
Total restricted funds	**917**	**717**	**263**	**339**	**(573)**	**(139)**	**13**	**0**	**8**	**0**	**628**	**917**	**(289)**	**200**

b) Analysis of unrestricted fund movements

	Fund balance B/Fwd		Income		Expenditure		Transfers		Adjustments		Fund Bal/Cfwd		Gains and Losses	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Patient Wish Fund	380	339	70	243	(120)	(202)	(13)	0	1	0	318	380	(62)	41
Total unrestricted funds	**380**	**339**	**70**	**243**	**(120)**	**(202)**	**(13)**	**0**	**1**	**0**	**318**	**380**	**(62)**	**41**
Total	**1,297**	**1,056**	**333**	**582**	**(693)**	**(341)**	**0**	**0**	**9**	**0**	**946**	**1,297**	**(351)**	**241**

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

06 December 2023

Title	Communications and Marketing Strategy
Area Lead	Debs Smith, Chief People Officer
Author	Debs Smith, Chief People Officer
Report for	Approval

Executive Summary and Report Recommendations

A proactive and dynamic approach to communications and marketing are vital to the delivery of the Trust strategic objective. The draft Communications and Marketing Strategy sets out this approach and is underpinned by a detailed operational plan.

It is recommended that the Board:

- Approve the draft Communications and Marketing Strategy

Key Risks

This report relates to these key risks:

- BAF Risks 1,2,3,5,6,7,8,9,10,11,12.

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

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

Governance journey

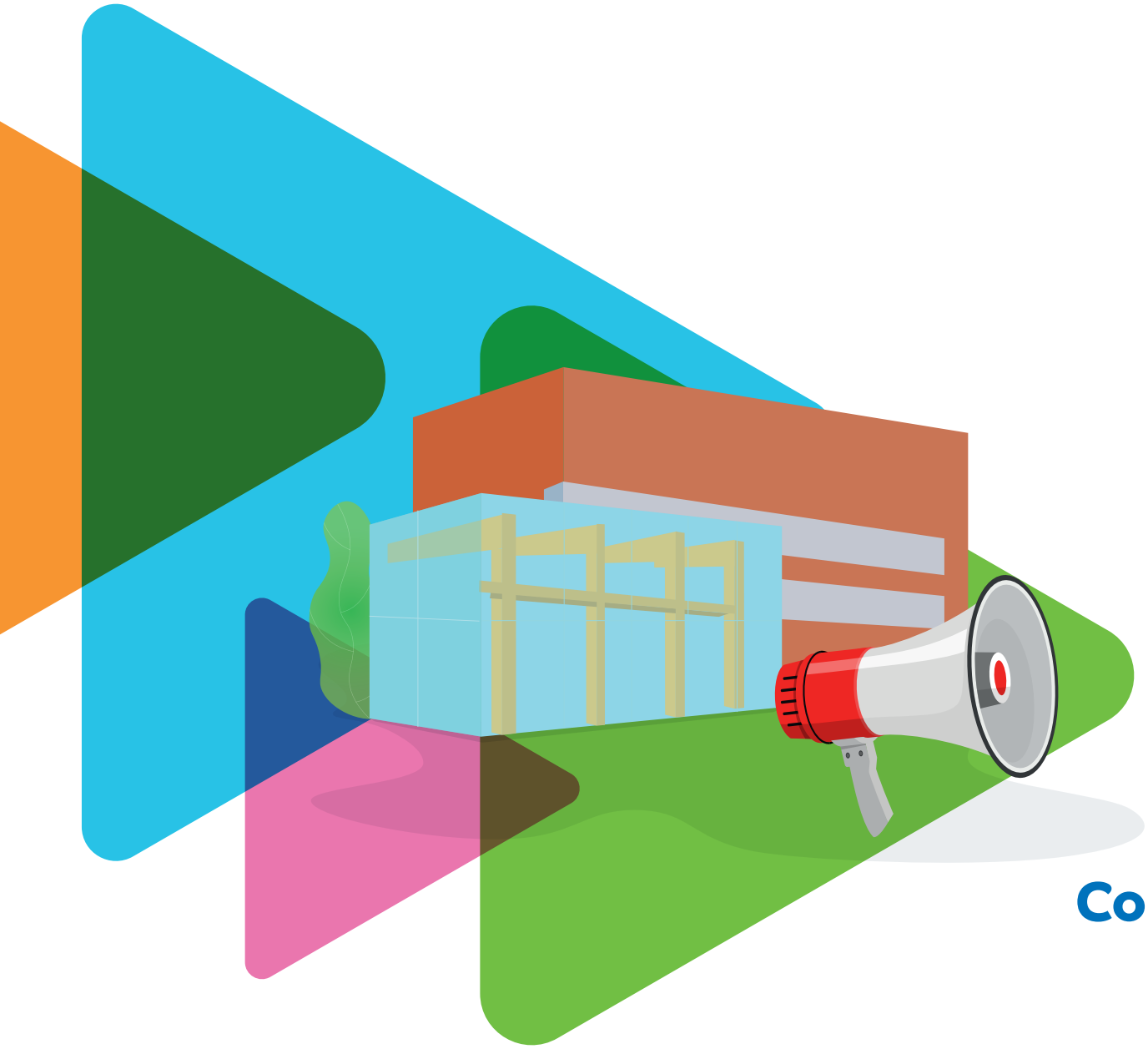
Date	Forum	Report Title	Purpose/Decision
This is the first report on this topic to the Board.			

1	Narrative
1.1	A proactive and dynamic approach to communications and marketing are vital to the delivery of the Trust strategic objectives. To this end, the newly drafted Communications and Marketing Strategy mirrors our overarching strategy, ensuring that patients, families, staff and the wider community are aware of the significant number of innovations and initiatives that are taking place, so they can be part of our pursuit to becoming an 'Outstanding' organisation. The draft Communications and Marketing Strategy at Appendix 1 sets out this approach and is underpinned by a detailed operational plan. Delivery of the strategy and success measures will be overseen by Trust Management Board.

2	Implications
2.1	**Patients** This strategy sets out how communications and marketing play a vital role in promoting hospital services, innovations, community involvement and health promotion campaigns. Above all, they help patients, carers and families to access the services they need and we support broader priorities such as reducing health inequalities.
2.2	**People** This strategy sets out how colleagues are kept informed and aligned with the Trust's mission and values through newsletters, staff website updates, emails, digital communications, video and social media.

together we will

NHS
Wirral University Teaching Hospital
NHS Foundation Trust



Marketing and Communications Strategy

2023 - 2026

Foreword

As Wirral's largest employer with 6,500 employees, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is the thriving heart of the local community.

Comprising Wirral's only Emergency Department, we are one of the biggest and busiest acute NHS Trusts in the North West.

We worked with our stakeholders, staff and patients to develop our strategic road map, producing our 2021-2026 Trust-wide Strategy, which sets out specific objectives aimed at delivering our goals and improving the health of the communities we serve.

This Communications and Marketing Strategy therefore mirrors our overarching strategy, ensuring that patients, families, staff and the wider community are aware of the significant number of innovations and initiatives that are taking place, so they can be part of our pursuit to becoming an 'Outstanding' organisation.

Contents

Introduction

The WUTH Communications and Marketing team plays a vital role in promoting hospital services, innovations, and community involvement, reaching both external and internal audiences.

Externally, we promote new services, healthcare initiatives and health promotion campaigns through both traditional and social media, website content and community outreach programmes, as well as other activities. Above all, we help patients, carers and families to access the services they need and we support broader priorities such as reducing health inequalities.

Our Trust services are rooted in our community and are fundamentally important to the people of Wirral. Communications and marketing help to raise awareness amongst our community, so that the Trust's services are well-received, used appropriately and understood by the public. In communicating with the public, our partners and our staff, we strive to personalise our communications and reach our audiences in a manner that suits them best, taking account of inclusion, accessibility and addressing health inequalities.

Internally, we keep our colleagues informed and aligned with the Trust's mission and values through newsletters, staff website updates, emails, digital communications, video, social media and face-to-face meetings.

These efforts collectively enhance public confidence, employee involvement, and the overall standing of the Trust within the healthcare landscape and Wirral as a 'Place' in the NHS and social care system..

We also team up with other marketing and communications partners in Cheshire and Merseyside, finding smart ways to work together, share best practices, support our patients' choices, and be more efficient.

Where we are today

Following a challenging period caused by the COVID-19 pandemic and recovery, and even during the pandemic, the Trust has been able to move forward and bring a raft of exciting new developments, investments and innovation to fruition.

This has provided the Communications and Marketing team with a wealth of good news stories that have been shared through all our channels of communication, including our website, newsletters and press releases to the local media, as well as social media.

In July 2023, we celebrated the 75th anniversary of the NHS, showcasing our staff and their achievements.

We are promoting capital developments in the tens of millions- from our new Urgent and Emergency Care Upgrade project to the ground-breaking Cheshire and Merseyside Surgical Centre, which is providing capacity for an extra 6000 operations for our patients.

We've innovated in every area of our work – from our Green Plan, to apprenticeships, our unique Leadership Qualities Framework – 'Leadership for All', our staff health and wellbeing offer, in how we strive for a just and learning culture, delivering best practice equality, diversity and inclusion for our staff experience and patients, clinical research excellence and much more…

Recent highlights

Our Trust is a recognised leader in many areas, winning national awards in everything from dermatology to dementia care, patient safety to patient experience, and innovation to staff engagement. Here are a few of our achievements in recent years.

2021

- **Launch of new 5-year strategy**
  The Trust is aiming to achieve CQC 'Outstanding' by 2026.
- **Cardiac Catheter Lab, Arrowe Park Hospital**
  £1.2m state-of-the-art laboratory for heart patients.
- **High Dependency Unit, Arrowe Park Hospital**
  Upgraded to include six specialist side rooms, enhanced infection prevention and control measures and a new ventilation system.
- **ExactVu ultrasound imaging, Arrowe Park Hospital**
  First Trust to use this imaging aid to help diagnose prostate cancer.
- **Clatterbridge Diagnostics, Clatterbridge Hospital**
  One of the first UK's community diagnostics centres; treating 50,000 patients by March 2023.

Recent highlights

2022 - 2023

- **The Retreat -new restaurant and changing rooms for staff, Arrowe Park Hospital**
  Modern light and airy restaurant space, serving healthy food, built with WUTH Charity support and incorporating staff wellbeing rooms.
- **Cheshire and Merseyside Surgical Centre, Clatterbridge Hospital**
  £25m for new elective surgical hub with 4 new operating theatres (two opened Oct 2022, plus two in Oct 2023), plus £2m Da Vinci robot for robotic surgery.
- **Dialysis Unit, Arrowe Park Hospital**
  £2.8m relocation and upgrade with new ward spaces, side rooms, and waiting areas.
- **Maternity Services at Arrowe Park and Seacombe Birth Centre**
  Rated Good, with areas of outstanding practice, by the Care Quality Commission (CQC).

2023 - 2025

- **Urgent and Emergency Care Centre**
  £37m redevelopment of Emergency Department and Urgent Care Centre at Arrowe Park Hospital - state-of-the-art facility, more ambulance receiving bays, greater privacy and dignity for patients, plus special provisions for children's Emergency Department and mental health patients.

...deliver the best quality and safest care to the communities we serve

Our Strategic Focus 2023-26

Our vision and values

Together we will: '**deliver the best quality and safest care to the communities we serve**', through our values of '**caring for everyone**', '**embracing teamwork**', with '**respect to all**' and 'committed to improvement'.

To support the Trust's vision, we have identified four communications' objectives which link back to our Trust-wide objectives.

These communications' objectives each have their own workstreams, and a detailed plan will be created annually incorporating a calendar of activities.

These will include regular milestones such as disease awareness days or employee celebration days for different healthcare professions, annual/regular major events such as the Annual Members' Meeting and Staff Awards, plus specific activities in any given year, such as facility openings.

Trust-wide objectives

OUTSTANDING CARE

Provide the best care and support

OUR PARTNERS

Provide seamless care working with our partners

COMPASSIONATE WORKFORCE

Be a great place to work

DIGITAL FUTURE

Be a digital pioneer and centre for excellence

CONTINUOUS IMPROVEMENT

Maximise our potential to improve and deliver best value

INFRASTRUCTURE

Improve our infrastructure and how we use it

Communications' objectives

OUTSTANDING CARE
Illustrate outstanding patient care and support

CONTINUOUS IMPROVEMENT
Showcase how the service is continually improving

OUR PARTNERS
Demonstrate and support ongoing partnership success

COMPASSIONATE WORKFORCE
Highlight how the Trust offers a great place to work

DIGITAL FUTURE
Describe research, innovation and digital excellence

INFRASTRUCTURE
Explain the benefits of new buildings, equipment and services

Communications' priorities

Outstanding Care

Illustrate outstanding patient care

- Successful patient outcomes
- 32 clinical specialties
- New services or facilities
- Advanced equipment
- Health promotion campaigns
- Voice of the patents and carers
- CQC inspections
- External awards
- Arrowe Park Urgent and Emergency Care upgrade
- National campaigns
- Healthy Wirral
- Winter plan
- Vaccinations
- Reduced health inequalities

Communications' priorities

Compassionate Workforce

Highlight how the Trust is a great place to work

- Staff success and achievements
- Staff awards
- Training and career development
- Staff voice and experience
- Equality, diversity and inclusion
- PRIDE month
- Armed forces support
- Apprenticeship scheme
- Staff environment improvements
- Widening participation
- Education and trainee feedback
- NHS Staff Survey
- People Pulse survey
- Health and wellbeing
- People Strategy
- Leadership development
- People promise and People Plan
- Recruitment events
- Volunteer workforce
- WUTH Charity involvement
- International recruitment

Communications' priorities

Continuous Improvement

Showcase how the service is continually improving

- 'Best Care for Everyone' delivery
- Research and Innovation, including 60+ research projects
- Research authors and papers
- Innovative treatment and services
- Artificial Intelligence (AI) in diagnostics
- Personalised medicine and genomics
- Digital Foundations, Innovation, Education, Intelligence
- Quality Improvement
- One Patient Record
- Patient Portal
- Meeting sustainability goals
- Remote monitoring/ telecare
- Data snapshots
- Awards and accreditations
- WAVE (Waste Activity Value Efficiency)
- Service improvements

Communications' priorities

Our Partners

Demonstrate ongoing partnership success

Initiatives

- Our role as an Anchor Institution in Wirral
- Local, regional, national contribution
- Joined-up integrated patient journey
- Visits by local and national NHS professionals and politicians
- Businesses and supply chain
- Green Plan partnerships
- Social value delivered through construction projects
- Apprenticeship Levy transfer

Partnerships

- NHS Cheshire and Merseyside Integrated Care Board (ICB)
- Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST)
- Wirral Place and Partners
- GPs / health clinics/Primary care links
- Wirral Council
- MPs
- Governors
- Education providers
- The Bridge Forum
- Healthwatch Wirral
- Wirral Maternity and Neonatal Voices
- Mencap
- Macmillan/Maggie's/League of Friends

Measurement & Evaluation

This highlights the key measures for our marketing and communications' activities:

External communications

- Media enquiries – number of inbound calls
- Press releases issued – number, including those relating to comms objectives
- Media coverage – print articles, radio interviews, TV interviews. Tone of coverage
- Website data – visits, visitors, top pages
- Social media – number of followers, posts, engagement
- Online activities – podcasts, blogs, videos – engagement and sharing content
- Public involvement and advocacy through social media and patient feedback

Internal communications

- Staff InTouch Bulletin – number of recipients / feedback
- Leaders in Touch – video views
- Website data

Stakeholder communications

- Stakeholder newsletter (quarterly) – number of recipients
- Stakeholder briefings
- Survey stakeholder feedback

Other activities

- Campaigns
- Metrics for patient uptake e.g. patient portal sign ups
- Support with award submissions – awards shortlisted/won
- Increases in referrals, patient uptake
- Correlation of public information campaigns with uptake e.g. vaccinations

Appendix 1:

Audiences and channels of communication

General communications

- Annual strategy
- Website
- Brand guidelines and corporate messaging
- Website
- Annual Members' Meeting

General communications

- Staff InTouch Bulletin (twice weekly) - Email/ staff website
- Staff InTouch magazine (quarterly) - Email/ staff website
- Leaders In Touch Forum (monthly) - Face-to-face, Teams, cascade
- Stakeholder newsletter (quarterly) - E-newsletter
- Board meeting summary (monthly) - Email staff

Public

- Traditional media - Newspapers, radio, TV
- Social media (daily) - Facebook, Instagram, X, LinkedIn, YouTube
- Trust website updates (daily) - Trust website
- Patient leaflets (daily) - In hospital
- Flu and COVID-19 campaigns (annual) - All channels

Measurement & Evaluation

Audiences and channels of communication

Stakeholder communications

- Together We Will - Quarterly newsletter
- Stakeholder update TBC - Monthly
- Stakeholder briefings - Face-to-face

Departments and Divisions (may require support)

- Safety bulletin
- Clinical advisory bulletin
- Staff noticeboards
- Recruitment

Events/ Campaigns/ Projects

- Leadership for All conference
- Staff Awards/ long service certificates
- Posters
- Digital projects, including Patient Portal
- External awards e.g. Health Service Journal (HSJ)
- Leveraging the contribution of WUTH Charity and supporting fundraising

Ad Hoc

- Wall art
- Screensavers
- Posters
- Urgent staff emails
- Incidents
- Unplanned media enquiries
- Reactive issues

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park Hospital, Arrowe Park Road,
Birkenhead, Wirral CH49 5PE

Telephone: 0151 678 5111

www.wuth.nhs.uk

@wuthnhs

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13**

06 December 2023

Title	Annual Review of Terms of References
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the final Terms of References for approval for Board Assurance Committees following the annual review. All major amends are highlighted on the appended documents.

The Terms of Reference for Research and Innovation Committee remains outstanding and will be approved at the next meeting in December and forwarded to the Board in January for approval.

It is recommended that the Board:

- Approve the Terms of References 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.

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	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**
Charitable Funds Committee	22 November 2023	Draft Committee Terms of Reference	Approval
Finance Business Performance Committee	19 October 2023	Draft Committee Terms of Reference	Approval
Estates and Capital Committee	18 October 2023	Draft Committee Terms of Reference	Approval
Renumeration Committee	4 October 2023	Draft Committee Terms of Reference	Approval
People Committee	27 September 2023	Draft Committee Terms of Reference	Approval
Audit and Risk Committee	20 September 2023	Draft Committee Terms of Reference	Approval
Quality Committee	7 September 2023	Draft Committee Terms of Reference	Approval

1	Narrative
1.1	**Terms of Reference** An annual refresh has been undertaken on the Terms of References for Board Assurance Committees. These were provided to each Committee for feedback and all the requested amendments have been made. The Board are asked to approve the appended Terms of Reference. As with all other Terms of Reference, these will continue to be live documents and will be reviewed annually in line with good governance practice. The Terms of References will also be uploaded the website.

2	Implications
2.1	Clear terms of reference will support effective decision making and good governance.

Wirral University Teaching Hospital NHS Foundation Trust

Charitable Funds Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution** **Charities Acts** **Trustee Acts** **Charity Treasury Management Policy**

Review Date: September 2024
Issue Date: October 2017
Version: 3.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure that the Trust's duty as Corporate Trustee of its Charitable Funds has been discharged. Its purpose is to oversee management, investment, and use of charitable funds within regulations provided by the Charity Commission and ensures compliance with charity law, including responsibility for the charity's fundraising activities. It does not remove from the Board the overall responsibility and legal obligation for this area but provides a forum for a more detailed consideration of charitable matters.

The Charitable Funds Committee has delegated responsibility, from the Corporate Trustee, within the limits set out in these Terms of Reference, the charitable funds sections of the Scheme of Reservation and Delegations and Standing Financial Instructions for the efficient governance and running of the Wirral University Teaching Hospital (WUTH) Charity.

2. Authority

The Charitable Funds Committee has delegated authority from the Corporate Trustee 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 request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. The Committee has delegated authority from the Board to:

i) Maintain the Charity's governing document and registration with the Charity Commission.

ii) Review and advise on those aspects of Standing Orders and Standing Financial Instructions that appertain to the charity and its operation.

iii) Apply all charitable funds in accordance with the NHS Acts, Charities Acts and good practice (including but not limited to WUTH Charity Expenditure Policy) and ensure that decisions on the use of investments of such funds are restricted to the explicit conditions or purpose of each donation, bequest, or grant.

iv) Make decisions involving the use of charitable funds for investments subject to the powers laid down in the "Declaration of Trust" and with regard to the Trustee Acts and any subsequent legislation.

v) Consider the appointment of investment advisors and monitor the performance of the charitable fund portfolio and consider changes when deemed necessary.

vi) To oversee the Investment Policy of the Charitable Funds as required by the Trustee Acts and the NHS Acts.

vii) Act as the control mechanism for any approved fundraising appeals which may be initiated and to be aligned to the Charity Income and Fundraising Guidance Policy. Appointment and control of fundraisers will be in line with the Charities Acts.

viii) Oversee and monitor the functions with regards to the investment, accounting and reporting on the use of charitable funds.

ix) Receive Annual Accounts and Annual Reports of the Trust's charitable funds for consideration and recommendation for final approval to the Board of Directors.

x) To develop the strategy, policies, and objectives for the Charity for consideration and approval by the Corporate Trustee.

3. Objectives

Act as the Committee that discharges the Board's responsibilities (as sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

3.1 Risk

3.1.1 To ensure that unacceptable risks and inadequate levels of assurance related to financial performance of the Charitable Fund or associated investments are reported to the Board for consideration.

3.2 Statutory duties

3.2.1 Ensure the approval and submission of statutory returns, annual accounts, and Trustee's Report in accordance with the Charity Commissions Statement of Recommended Practice.

3.2.2 Invest and apply the income, funds, and property of the Charity in accordance with the governing document and complies with all legal relevant requirements including the Charities Acts and agreed expenditure policy.

3.2.3 Maintain the solvency and continuing effectiveness of the Charity.

3.2.4 Safeguard permanent endowments.

3.3 Strategy

3.3.1 To review the Charity Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.

3.4 Other Duties

3.4.1 Invest and review the investment funds not needed for immediate applications, in accordance with the Charity's investment objectives and the principles outlined in the Treasury Management Policy.
3.4.2 Monitor the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.
3.4.3 Review and monitor the effectiveness derived from grants of money and property to the Trust.
3.4.4 Operate a visible and transparent decision making process for grants of money and property.

3.5 Governance

3.5.1 Ratify and review policies and procedures required for effective management of the Charity. This will incorporate oversight of associated compliance arrangements such as those required by the Charity Commission.
3.5.2 Ensure the Charity Treasury Management Policy including any other applicable policies are adhered to when considering related actions.
3.5.3 Give the Board assurance on an annual basis that the systems, policies, and procedures they have put in place to deliver Charitable Funds plans are operating in compliance with appropriate standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
3.5.4 Consider, interpret, and disseminate guidance from relevant bodies including the Charity Commission and other regulatory/advisory bodies relating to the Charitable Funds agenda.
3.5.5 Approve the establishment, work plans, duration and effectiveness of sub-committees and working groups.
3.5.6 To review and respond to any areas escalated from the Trust Board or its Committees.

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:

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Finance Officer
- Chief People Officer

6. Attendance

Meetings of the Committee may be attended by:

- Assistant Director of Finance (Financial Services)
- Head of Fundraising
- Director of Communication and Engagement
- Director of Corporate Affairs
- The Medical Director or Chief Nurse, or their deputy
- A Governor to observe

A nominated lay person, with appropriate experience, may attend upon invitation by the Chair.

Other officers of the Trust will be invited to attend on an ad-hoc basis to present papers or to advise the committee. Professional advisors regarding investments may be invited to attend, when deemed necessary.

The Trust Chair and all Non-Executive Directors have a right to attend 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 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, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be three members, to include the Chair (or nominated deputy) and one Executive Lead/member of the Senior Management Team.

The Committee will meet at least four times a year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The Committee will report to the Board following each meeting via a Chair's report and will present a comprehensive annual report to the Corporate Trustee.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The are no groups reporting to this Committee.

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.

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 2024
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 Financial Management and Assurance

3.1.1 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.

3.1.2 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.

3.1.3 Consider the robustness of the M12 and year-end out turn ahead of review of the Annual Accounts by the Audit and Risk Committee to provide assurance on the reliance of these.

3.1.4 To review and recommend business, operational, and financial plans to the Board of Directors.

3.1.5 To seek assurance of effective due diligence in respect of business cases, including alignment to Trust strategies, approving those within the financial limits delegated and referring those in excess of delegated limits to the Board with recommendations. The limits currently set out in the Standing Financial Instructions, as approved in October 2022 are:

- Approval of revenue only business cases: up to £250k
- Approval of Capital or leave business cases within Board approval capital programme: up to £1m
- Approval of capital or lease business cases from contingency funds: up to £250k

3.1.6 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.

3.1.7 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.

3.1.8 To monitor and seek assurance on provider to provider and third party contractor SLA's that present a material risk to the organisation.

3.1.9 To review and seek assurance on the development, implementation, and clinical engagement in the Service Line Management (SLM) process through Divisional representation.

3.1.10 To seek assurance on the Trust overall cash management position

3.1.11 Review proposed new investments, undertake due diligence, and make recommendations to the Board for approval in line with scheme of delegation.

3.2 Performance and Improvement

3.2.1 To monitor the operational financial performance and agree, as necessary, corrective action.

3.2.2 To instigate investigation into any aspect of performance that gives cause for concern, providing exception reports to the Board of Directors.

~~3.2.3 To monitor and seek assurance on digitalisation agenda and associated action plans as pertains to its financial implications.~~

~~3.2.4 To monitor and seek assurance on compliance against the procurement strategy.~~

3.2.5 To monitor and seek assurance on compliance with the Agency Cap focussing particularly on recurrent risks and resource utilisation.

3.2.6 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.

3.2.7 To monitor the implementation of the Trust efficiency programme, and to receive assurance that any potential impact of that programme has been risk

assessed with mitigations identified. Any areas of impact that are considered a concern may be referred to another relevant Board Committee for further assurance.

3.2.8 To monitor delivery and seek assurance of the CIP.

3.2.9 To review and seek assurance on the capital programme and expenditure as required.

3.3 Strategy

3.3.1 To review the Trust's Finance Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.

3.4 Risk

3.4.1 To review any areas of specific risk or assurance highlighted within the Board Assurance Framework and make recommendations for amendment if required.

3.4.2 Receive assurance on all aspects of the effective outturn delivery of financial, specified operational performance targets and significant variances to planned levels of achievement.

3.4.3 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.

3.5 Governance

3.5.1 To review and seek assurance on compliance against relevant legislation.

3.5.2 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 and Risk 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

Meetings of the Committee may be attended by:

- Deputy Chief Finance Officer
- A senior clinical representative e.g., the Medical Director or Chief Nurse, or their deputy.
- A Governor to observe

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.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

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

Estates and Capital 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 2024
Issue Date: October 2020
Version: 4.0
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 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 Performance

3.1.1 To receive, monitor and seek assurance on risks relating to capital, estates, and estates related safety management, as set out in the BAF and 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 and compliance 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 To review the Trust's Estates Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.
3.2.3 Approval of the Campus Master Plans and strategies for estates and capital
3.2.4 To keep under review the land holdings of the Trust, advise the Board on acquisitions and disposals, and monitor progress against schemes.

3.1 Health and Safety

3.1.1 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.
3.1.2 To approve the Trust's Health and Safety plan, recommending it to the Board for final approval.
~~3.1.3 To monitor health and safety reviews to the annual health and safety plan.~~
3.1.4 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.
3.1.5 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.

3.2 Capital Programme

3.2.1 Review proposed new developments and investments, undertake due diligence, and make recommendations to the Board for approval in line with scheme of delegation.
3.2.2 Ratify and review policies and procedures required for effective management of capital programme.
3.2.3 Receive assurance on all aspects of the delivery of capital programme and significant variances to planned levels of achievement.
3.2.4 To monitor the development of capital commercial opportunities across the Trust.
3.2.5 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.

3.2.6 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.
3.2.7 To monitor capital delivery against 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 Facilities
- Deputy Director of Estates, Facilities & Capital Planning
- Associate Director of Estates, Engineering and Capital Delivery
- Director of Corporate Affairs
- ~~Head of Health and Safety~~
- A Governor to observe

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.

Where members are unable to attend, they should send a designated nominated deputy.

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

Remuneration 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 2024
Issue Date:
Version: 2.0
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 Executive Director and other Executive Team Member appointments, succession planning and the remuneration of the same.

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 contractors working on behalf of the Trust) are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources.

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 Appointments – Executive Directors and other Executive Team Members:

3.1.1 To be responsible for identifying and appointing candidates to fill all Executive Director positions on the Board and for determining their remuneration and other conditions of service. When appointing the Chief Executive, the committee shall be the committee described in all relevant legislation.

3.1.2 To monitor and review the composition of Executive Directors and other Executive Team members in terms of size and balance of experience, skills and qualifications.

3.1.3 Consider and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

3.1.4 To ensure compliance with the terms of the Trust's constitution and best governance practice with regard to the processes for making Executive Director and other Executive Team Member appointments to the Board of Directors.

3.1.5 To authorise release dates following resignation/removal of an Executive Director or other Executive Team Member from office, where these are earlier than completion of the contractual notice period, having regard to a full risk assessment of the circumstances, including consideration of potential 'Acting Up' arrangements.

3.1.6 To keep under review Executive Team Member development and succession planning.

3.1.7 To review and approve any interim Executive Director appointments in accordance with relevant guidance.

3.1.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.1.9 Ensure that all relevant appointees are subject to a full Fit and Proper Persons test prior to commencement.

3.1.10 Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

3.2 Remuneration

The Committee has delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee should also recommend and monitor the level and structure of remuneration for senior management (normally the first layer of management below board level) however decisions regarding the remuneration for individual senior managers should be made by the Executive Directors (subject to the proviso outlined in section 3.2.3 below).

3.2.1 To decide and review the terms and conditions of service of the Trust's Executive Directors and other Executive Team Members in accordance with all relevant Trust policies, including:

- All aspects of salary (including and performance-related elements/ bonuses).

- Provisions for other benefits, including pensions and cars.
- Allowances.

3.2.2 To monitor and evaluate the performance of individual Executive Team Members.

3.2.3 To review and decide on proposals relating to the remuneration of the other Executive Directors and senior managers on locally determined pay e.g. VSM.

3.2.4 To adhere to all relevant laws, regulations, and NHS policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors / other Executive Team Members whilst remaining cost effective.

3.2.5 To approve contractual arrangements for Executive Directors and other Executive Team Members, including but not limited to termination payments.

3.2.6 To consider these items in respect of all staff where the Trust has discretion in respect of Terms of Service and/or benefits (e.g. discretionary bonuses).

3.2.7 To formulate and review any relevant policies.

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:

- The Trust Chair (who will Chair the Committee) – nominated deputy is the Deputy Chair;
- All Non-Executive Directors; and
- The Chief Executive (in the appointment of Executive Directors other than the Chief Executive).

6. Attendance

Meetings of the Committee may, at the request of the Chair, be attended by:

- Chief People Officer;
- Director of Corporate Affairs (to advise on constitutional matters);
- Any other person who has been invited to attend the Committee so as to assist in deliberations.

No officer shall be present for discussions about his/her own remuneration.

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. In the case of this Committee, no member or attendee may send a deputy without permission of the Chair.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, the Chief Executive will through the nature of his/her role, be deemed to have an interest in the following matters:

i) The appointment and removal of the Chief Executive
ii) The remuneration of the Chief Executive

It will be for the Chair of the Committee to determine whether or not it is appropriate for the Chief Executive to be in attendance to advise on these matters. In such circumstances where the Chief Executive 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 three Non-Executive Directors (including the Chair or Deputy Chair).

Meetings shall be held as necessary. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to receive the outcome of Executive Team appraisals, any recommendations on remuneration and to review the Executive Team succession plan.

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 also update the Council of Governors on recent Committee activity via the appropriate template.

The are no groups reporting to this Committee.

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

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: September 2024
Issue Date:
Version: 4.0
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, including medical education. 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 and Risk 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 reports relating to staff engagement and employee voice, including 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 any relevant reports as required by guidance or regulation.

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
- Deputy Medical Director – Professional Standards

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:

- Medical Director
- Deputy Chief People Officer
- Equality and Diversity Lead
- Assistant Director of OD
- Director of Communications and Marketing
- 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 three members, including two Non-Executive Directors, and the Chief People Officer (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.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

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

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 2024
Issue Date: October 2022
Version: 4
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 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.

3.1.6 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.

3.1.7 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.

3.1.8 To monitor and seek assurance on compliance against the procurement strategy.

3.1.9 To monitor and seek assurance on the digitalisation agenda, along with the controls in place specifically relating to digital controls and cyber security.

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 Board 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 Counter Fraud

3.4.1 To review the adequacy of policies and procedures for all work related to counter fraud and as required by NHS Counter Fraud Authority, as well as reviewing the outcomes of counter fraud work.

3.4.2 To review the adequacy of annual plans / reports from the Local Counter Fraud Specialist and the Local Security Management Specialist.

3.4.3 To satisfy itself that the organisation has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work.

3.5 Other Assurance Functions

3.5.1 The Committee shall review the findings of other assurance functions, both internal and external to the organisation, and consider any governance implications.

3.5.2 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 Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

3.5.3 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.

3.5.4 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.

3.5.5 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.

3.5.6 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.

3.6 Annual Accounts Review

3.6.1 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.

3.6.2 To annually review the accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.6.3 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.

3.6.4 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.

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
- A Governor to observe

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 and Risk 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 and Risk 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 Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The Trust's Annual Report shall include a section describing the work of the Audit and Risk 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.

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 2024
Issue Date: TBC
Version: 3.0
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 and serious incident learning); 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:

3.1.1 To review the policies and practices that relate to patient safety and experience, clinical health and safety, and quality governance.

3.1.2 To review and approve the Trust's Quality Strategy and Patient Experience Strategy, recommending them to the Board for final approval, and to seek assurance that the associated actions are being implemented.

3.1.3 To provide scrutiny of the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with fundamental standards of care, and learning effectiveness.

3.1.4 To provide scrutiny of the frameworks and processes in place for managing patient safety and quality governance. This may include reviewing operational challenges, resourcing, clinical audit programmes, and other key areas of quality control.

3.1.5 To consider and seek further assurance regarding any potential quality impact arising from Trust activities, as referred by other Committees.

3.1.6 To receive relevant reports as required by guidance or regulation and any other matters referred by the Patient Safety Quality Board, including Divisional quality performance.

3.1.7 To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis.

3.1.8 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.

3.1.9 To monitor and review the BAF in accordance with the Risk Management Strategy, in particular the risks associated with patient safety, quality governance.

3.1.10 To consider any findings of major investigations of internal control over safety critical matters, clinical effectiveness, patient concerns, or clinical health and safety matters and agree subsequent actions required to keep residual risk under prudent control.

3.1.11 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.

~~3.1.12 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.~~

~~3.1.13 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.~~

3. 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.

4. Membership

The Committee shall consist of:

- Three Non-Executive Directors, one of whom shall be appointed the Chair
- 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.

5. Attendance

Meetings of the Committee will generally be attended by:

- Deputy Director of Quality Governance
- Director of Corporate Affairs
- A Governor to observe

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.

6. 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.

7. 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.

8. 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 also update the Council of Governors on recent Committee activity via the appropriate template.

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.

9. 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.

10. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

11. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 14**

06 December 2023

Title	CQC Urgent and Emergency Care Patient Experience Survey Results 2022
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs, Director of Infection Prevention and Control
Author	Johanna Ashworth-Jones, Programme Developer, Patient Experience and Nurse Quality Indicators
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide an overview summary of the CQC Urgent and Emergency Care UEC Patient Experience Survey results 2022.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	No
Our partners: provide seamless care working with our partners	No
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
9 November 2023	Quality Committee	As above	Information

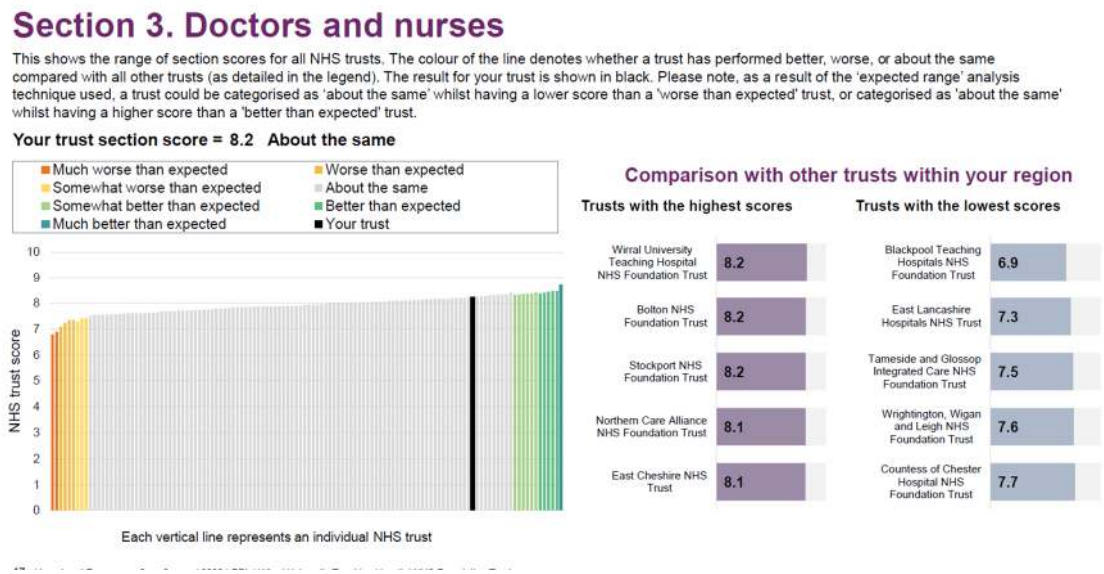
1	Narrative
1.1	The 2022 survey of people who used UEC services involved 122 NHS Trusts with a Type 1 accident and emergency department. Responses were received Nationally from 29,357 people who attended a Type 1 department, with a response rate of 23%. WUTH had a total of 258 responses with a response rate of 21%. Patients were eligible for the survey if they were aged 16 years or older and had attended UEC services during September 2022. The Care Quality Commission use results from the survey to build an understanding of the risk and quality of services, CQC will use the results alongside other sources of data on people's experience to inform targeted assessment activities. Trusts have differing demographic profiles of people who use their services, demographic factors can influence a Trust's survey results, so to account for this, CQC use a 'standardise' technique to make direct comparison fair. For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the Trust is performing. **CQC Banding** CQC use a banding system of "Better", "Worse" and "About the same as" to compare Trusts nationally. Within this banding system the "Better" and the "Worse" Bandings have a sliding scale of better and worse bandings as follows: Better: • Much "Better" than most • "Better" than most • Somewhat "Better" than most Worse • Much "Worse" than most • "Worse" than most • Somewhat "Worse" than most WUTH did not have any indictors or sections banded as "Worse". There was a total of 8 indicators banded as "Better" detailed below and the section on Care and treatment was also banded as "Better" "Better" than most • Did you have confidence and trust in the doctors and nurses examining and treating you? • Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you? • Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E? • After leaving A&E, was the care and support you expected available when you needed it? Somewhat "Better" than most

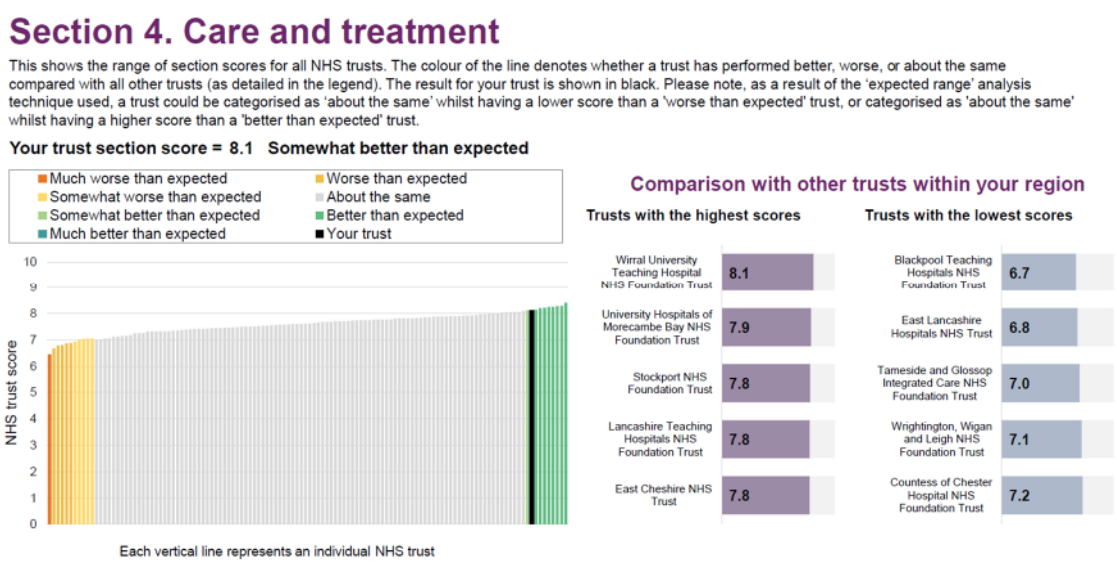
- Did you have enough time to discuss your condition with the doctor or nurse?
- If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did staff give you enough information to help you care for your condition at home?

Regional Benchmarking

CQC provide Trust's with a regional benchmarking position using the overall questionnaire section scores. Of the 9 section scores WUTH were highlighted as the top performing Trust regionally for 5 of the 9 sections and within the top five Trust's regionally for the remaining 4 as detailed in the comparative graphs below.

Sections where WUTH was highlighted as Top regionally:

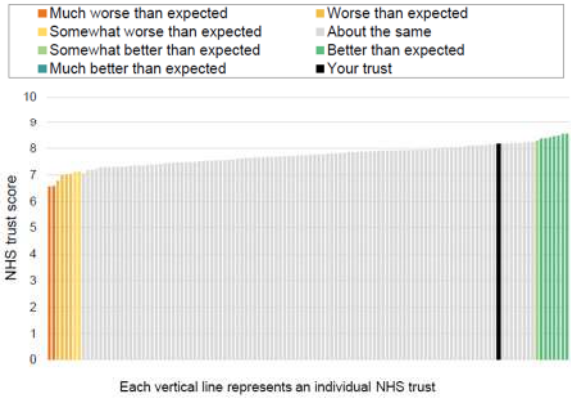


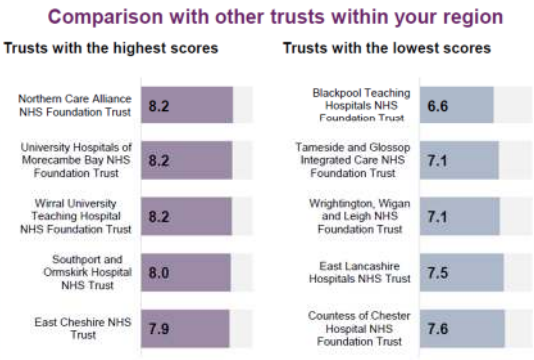


Section 5. Tests

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.2 About the same

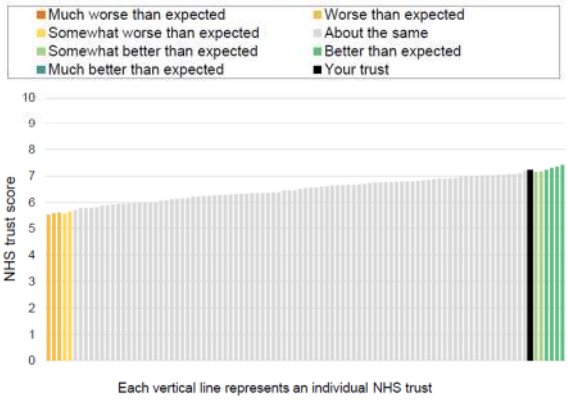


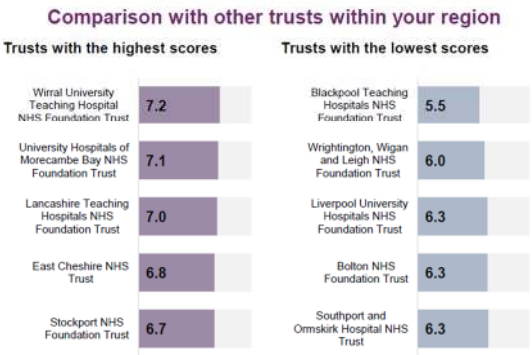


Section 7. Leaving A&E

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.2 About the same

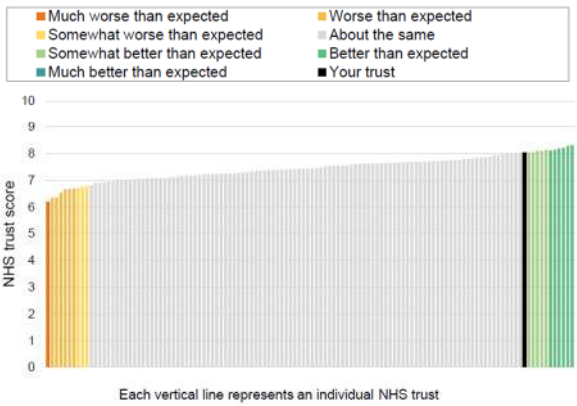




Section 9. Experience overall

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 About the same

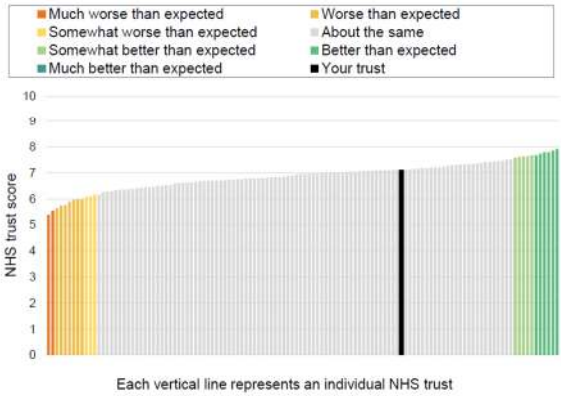


Sections where WUTH was highlighted in the top 5 regional Trusts

Section 1. Arrival at A&E

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.1 About the same



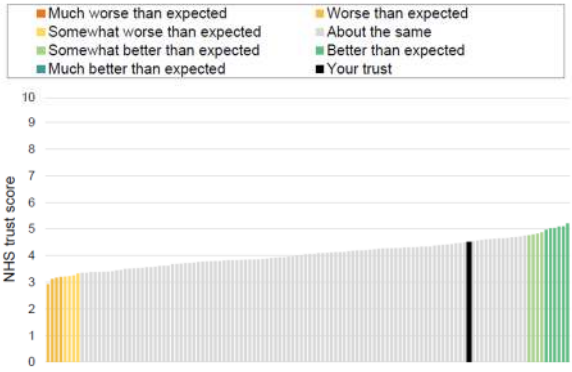
Each vertical line represents an individual NHS trust

Comparison with other trusts within your region

Section 2. Waiting

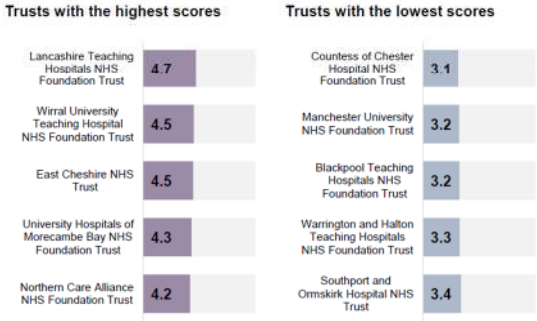
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 4.5 About the same



Each vertical line represents an individual NHS trust

Comparison with other trusts within your region



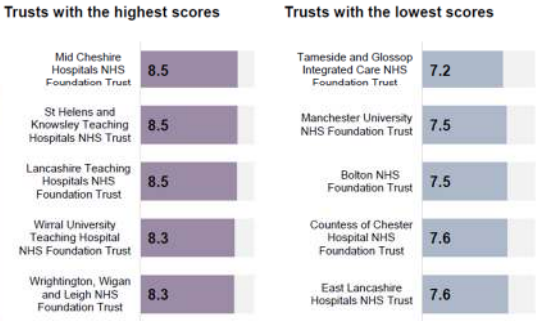
Section 6. Environment and facilities

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.3 About the same

Each vertical line represents an individual NHS trust

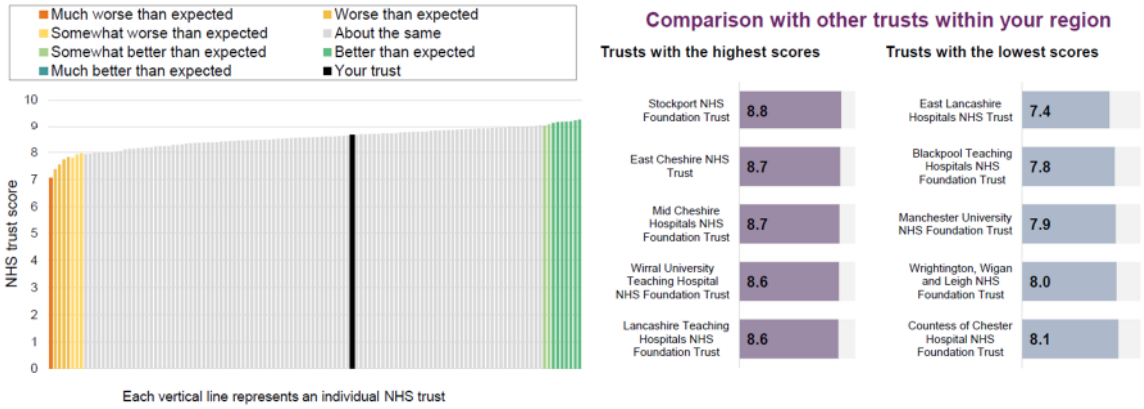
Comparison with other trusts within your region



Section 8. Respect and dignity

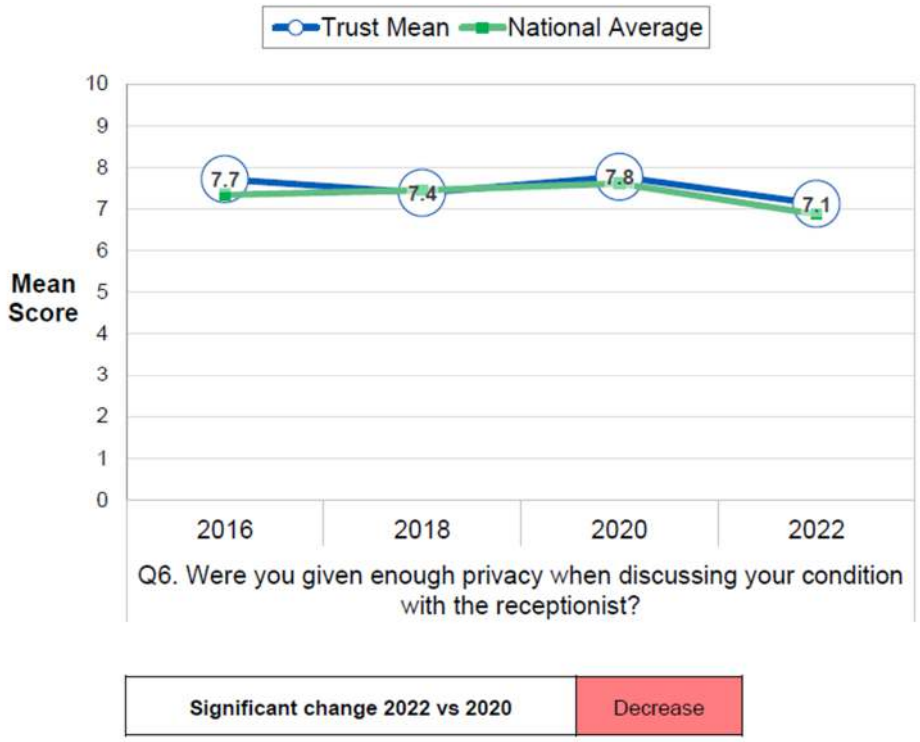
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

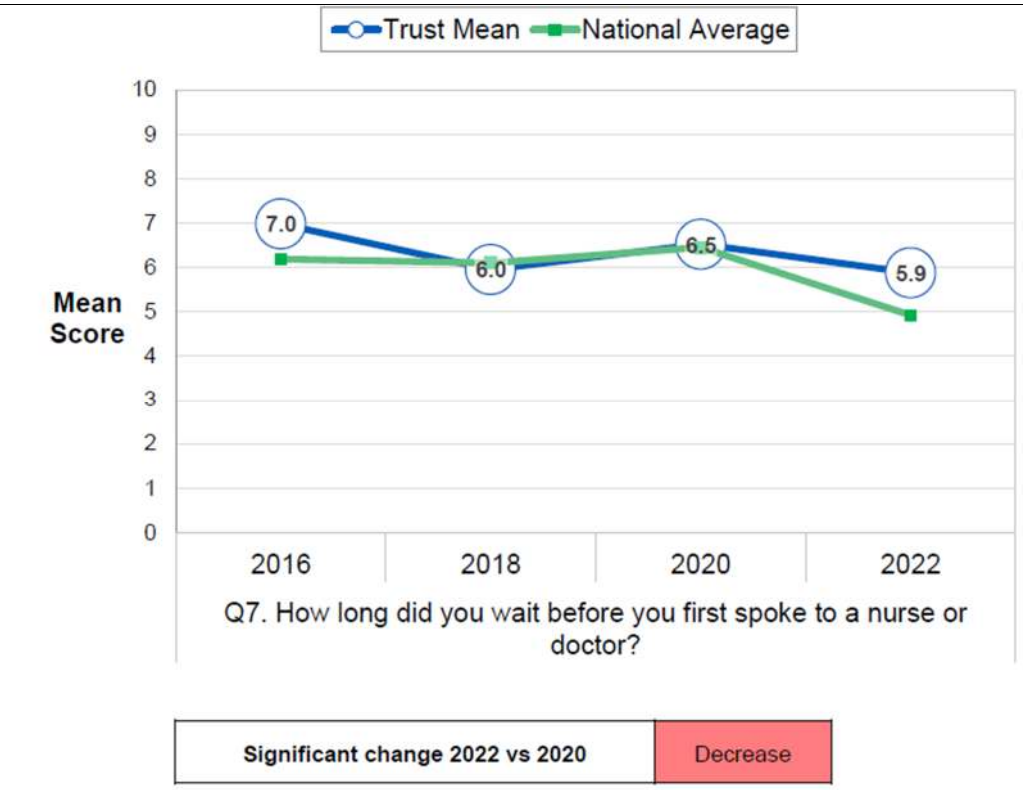
Your trust section score = 8.6 About the same



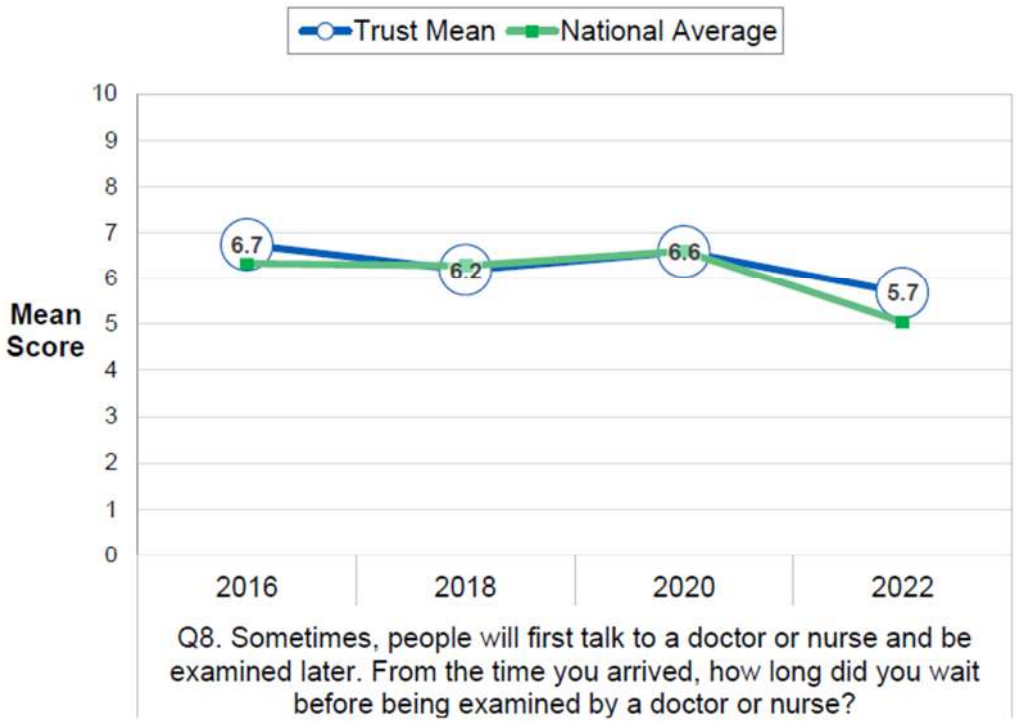
Areas for improvement

Out of the 37 questions within the survey, 7 questions were highlighted as significantly worse based on a year-on-year comparison with WUTH's own data. Whilst these question areas will form part of the overarching improvement action plan it is important to acknowledge that 6 of these 7 were still above the national average. The question where there was a decrease and a score below the national average was in relation to how long the overall time in ED lasted and which is a recognised area of improvement focus for the Trust.

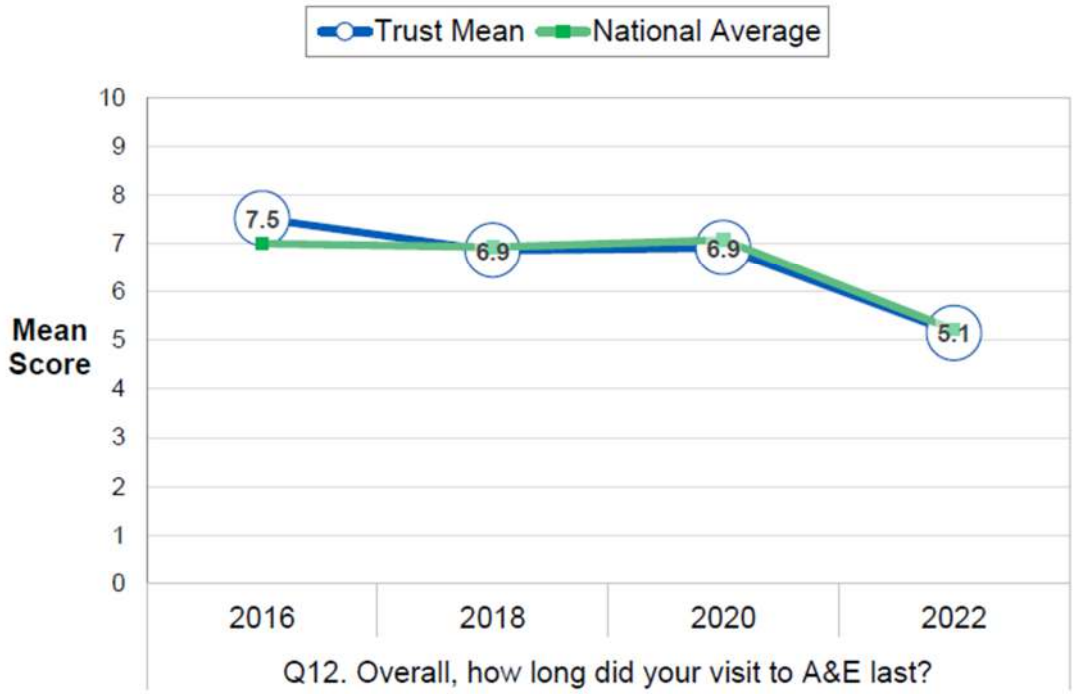




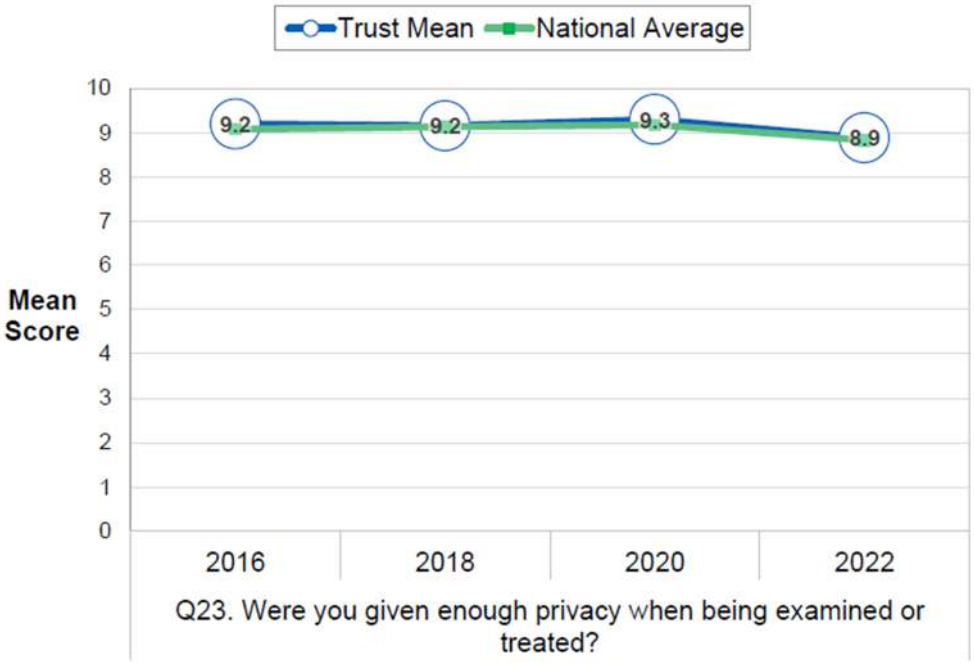
Significant change 2022 vs 2020	Decrease



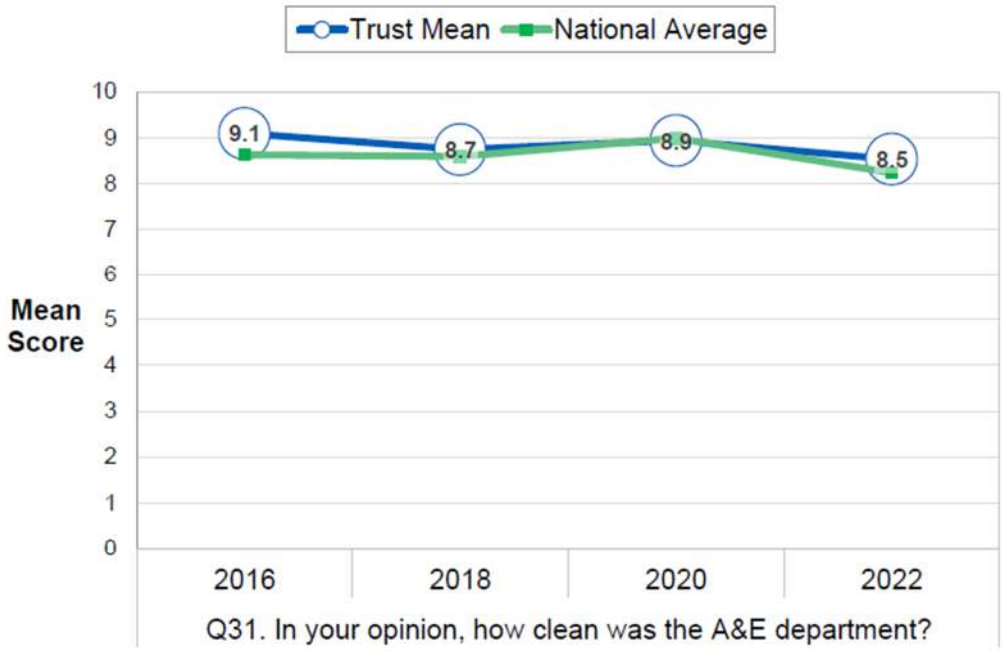
Significant change 2022 vs 2020	Decrease



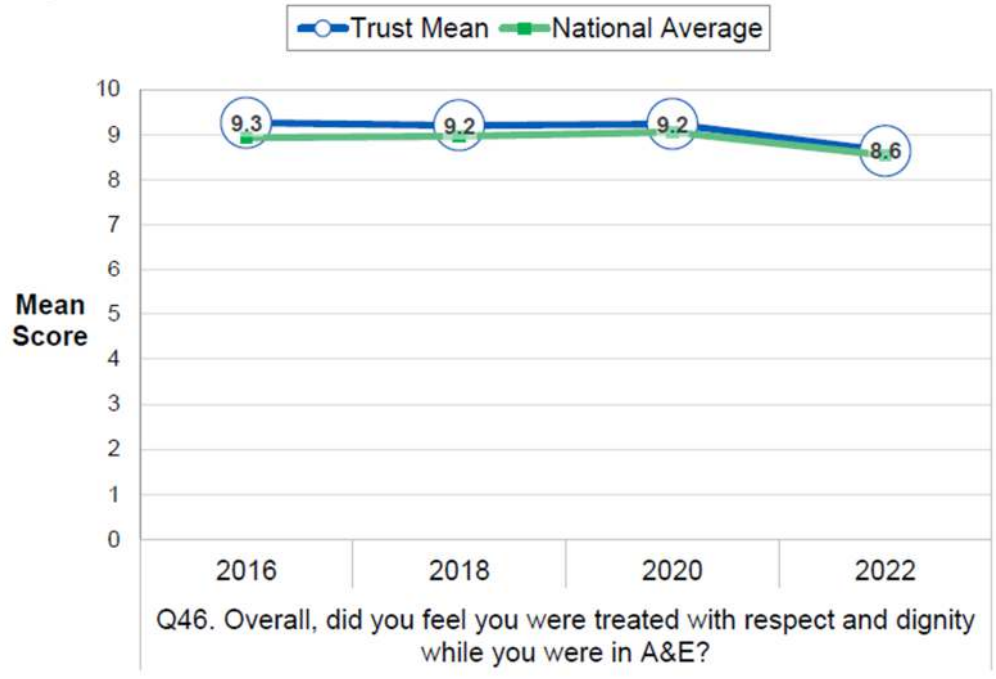
Significant change 2022 vs 2020	Decrease



Significant change 2022 vs 2020	Decrease



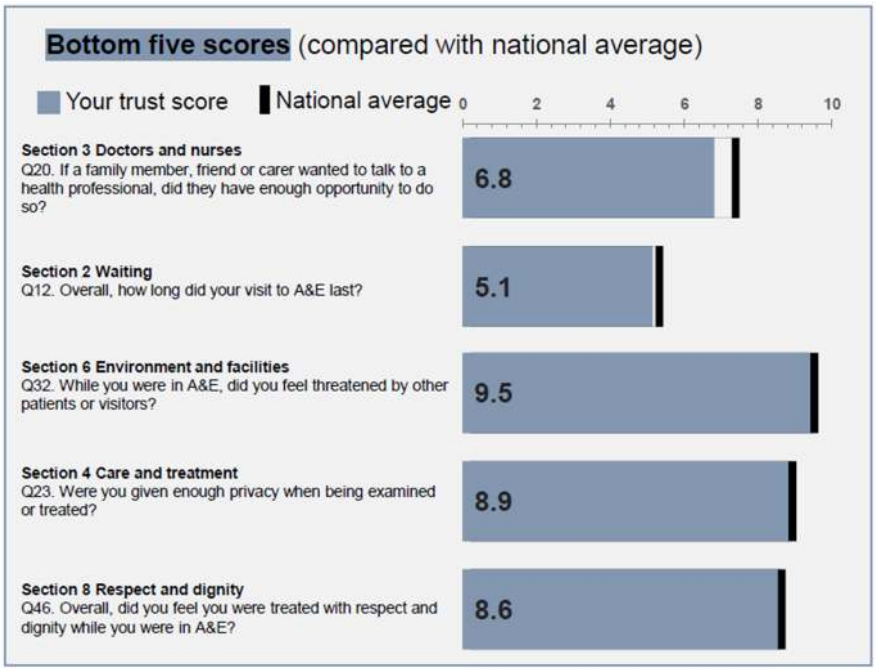
Significant change 2022 vs 2020	Decrease



Significant change 2022 vs 2020	Decrease

Answered by all

CQC also highlights to Trusts the individual questions that are classed as the five bottom performing questions for the organisation, this is based on the Trust's score compared with the national average. 3 of the 5 questions highlighted are actually high-performance scoring e.g. above a standarised score of 8. Three questions have also

	been highlighted within this report in the WUTH specific data year of year decrease comparison. All of these will be included in the overarching action plan.  This report demonstrates that WUTH have performed exceptionally well both regionally and nationally in this latest CQC patient experience survey. This achievement is even more significant when acknowledged against the regular operational challenges faced within the Trust and the significant building work that is being undertaken as part of the Urgent and Emergency Care Upgrade Programme UECUP. An action plan that provides details of how the success within this report will be circulated and presented within the organisation will be monitored via the Patients Family Experience Group. The action plan will include areas that have been highlighted for additional improvement and which have been mapped against current workstreams to ensure that there is no duplication.

2	Implications

2.1	**Patients**
	• The impact of the CQC patient experience programme on patients falls into three main positive impact areas:
	  ○ The publication of results provides confidence in the quality of care and experience appraised by CQC
	  ○ The formulation of the action plan based on the patient feedback and results will have a positive impact in improving patient care, quality, and experience
	• National patient experience survey's allow patients the opportunity to feedback on their care centrally

2.2	**People** • Publication and recognition of areas of celebration identified by an external monitoring body such as CQC, supports increased staff morale and internal and external recognition

	• Results provided by external organisations recognising areas for improvement can support staff in escalation and progression of existing workstreams and reinforce improvement focus
2.3	**Finance** • Compliance with the participation of the CQC patient experience survey programme requires a financial commitment by the Trust. Further work is currently underway to evaluate the most appropriate approved company for WUTH to use
2.4	**Compliance** • CQC are a regulatory body of WUTH, compliance with the survey programme is part of these regulatory requirements

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 15**

06 December 2023

Title	Care Quality Commission (CQC) Adult Inpatient Survey 2022
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Johanna Ashworth-Jones, Programme Developer Victoria Peach, Deputy Chief Nurse
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide an overview summary of the CQC Adult Inpatient Patient Experience Survey results 2022.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

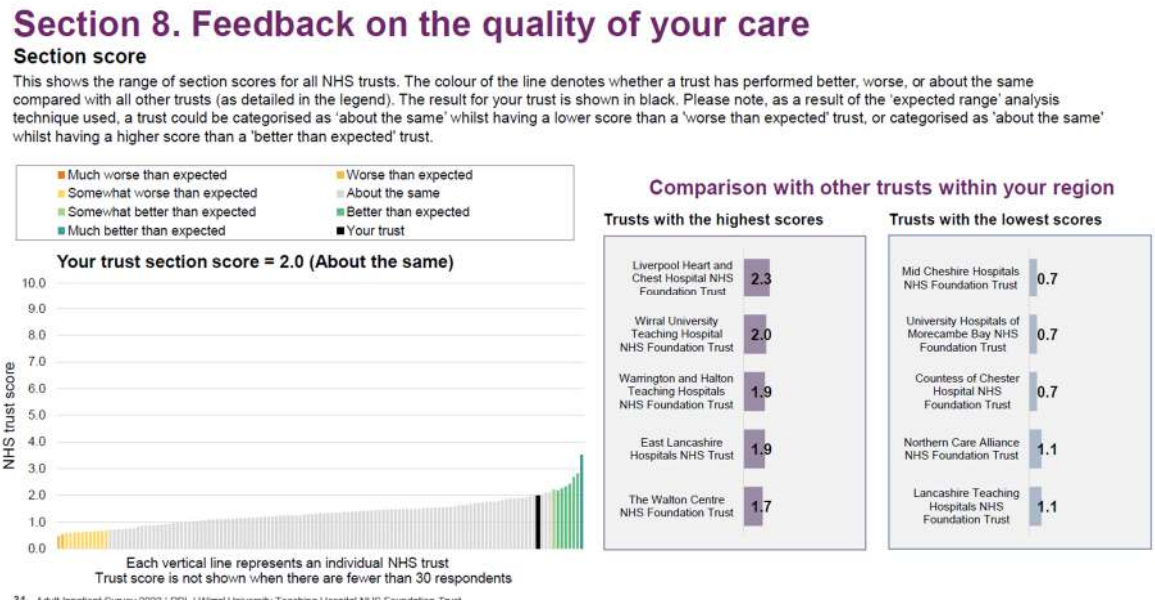
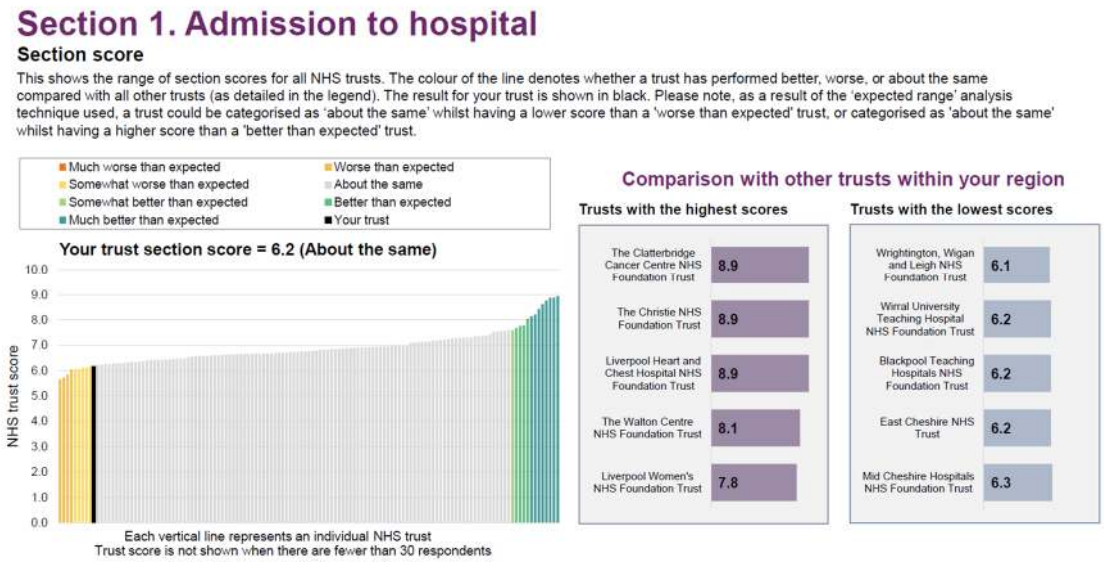
Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
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
9 November 2023	Quality Committee	As above	Information

6 October 2023	Patient Family Experience Group	As above	Information

1	Narrative
1.1	The CQC Adult Inpatient Survey was conducted using a push to web methodology which means participants were offered either an online methodology or a paper copy. A total of 133 Trusts took part in the survey with a national total of 63,224 patients taking part and a national response rate of 40.2%. WUTH had a response rate 33% with 396 patients responding. The CQC use results from the survey to build an understanding of the risk and quality of services. The results alongside other sources of data regarding people's experience are used by the CQC to inform targeted assessment activities. Trusts have differing demographic profiles of people who use their services, demographic factors can influence a Trust's survey results. To account for this CQC use a 'standardise' technique to make direct comparison possible and fair. For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score for each question, the better the Trust is performing. WUTH have not been banded as 'worse' nationally in any of the sections and questions. For most of the questions and sections WUTH has scored as about the same as. Areas of required improvement are aligned to existing WUTH priorities such as reducing waiting list times and waiting times within the Emergency Department to be admitted. The 2 areas of celebration align to areas of trust wide improvement work: ensuring patients, relatives and carers have enough information when preparing to leave hospital; and the launch of the patient experience strategy (April 2022) which has strengthened the number of methodologies that patients can provide feedback. WUTH need to ensure progression against the action plan in preparation for the next sample period November 2023 to improve upon the 2022 data.
1.2	**CQC Banding** CQC use a banding system of "Better", "Worse" and "About the same as" to compare Trusts nationally. Within this banding system the "Better" and the "Worse" Bandings have a sliding scale of better and worse bandings as follows: Better: • Much "Better" than most • "Better" than most • Somewhat "Better" than most Worse • Much "Worse" than most • "Worse" than most • Somewhat "Worse" than most

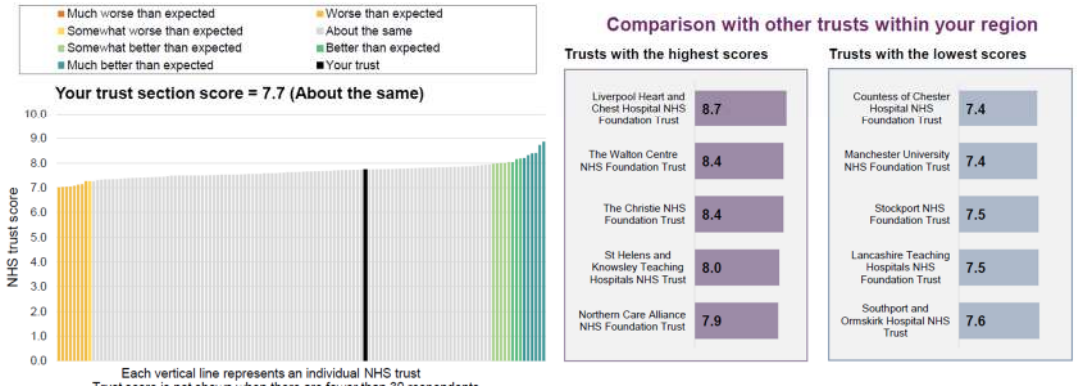
	WUTH had 1 question that was banded as better than most this was in relation to: *To what extent did you understand the information you were given about what you should or should not do after leaving hospital?* WUTH were not banded as "worse" for any indicators or sections and were therefore banded as "about the same" for all other indicators.
1.3	**Regional Benchmarking** CQC provide Trust's with a regional benchmarking position using the overall questionnaire section scores. WUTH were identified: • in the top 5 regional organisations for 1 section in relation to feedback on the quality of care; and • highlighted as 1 of the lowest scoring hospitals regionally for 1 section in relation to admission to hospital. WUTH highest scoring regional comparative section  WUTH lowest scoring regional comparative section 

All other sections are classed as “about the same” as displayed in the slides below.

Section 2. The hospital and ward

Section score

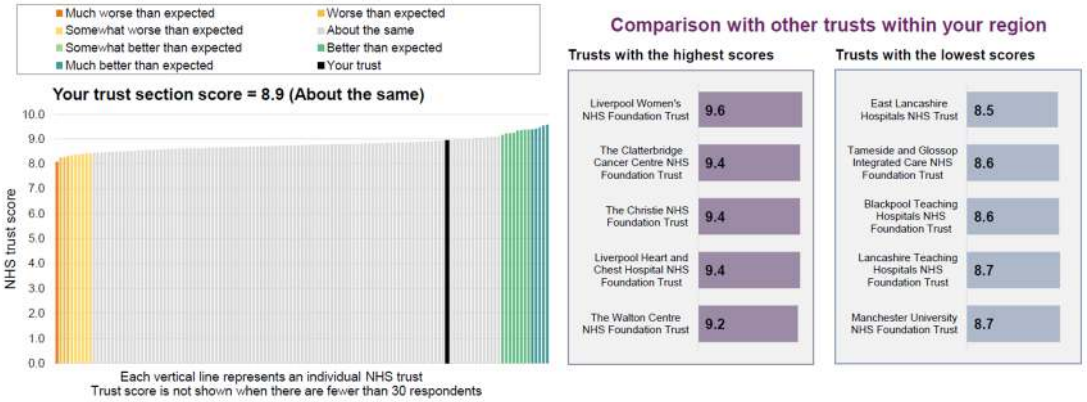
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Section 3. Doctors

Section score

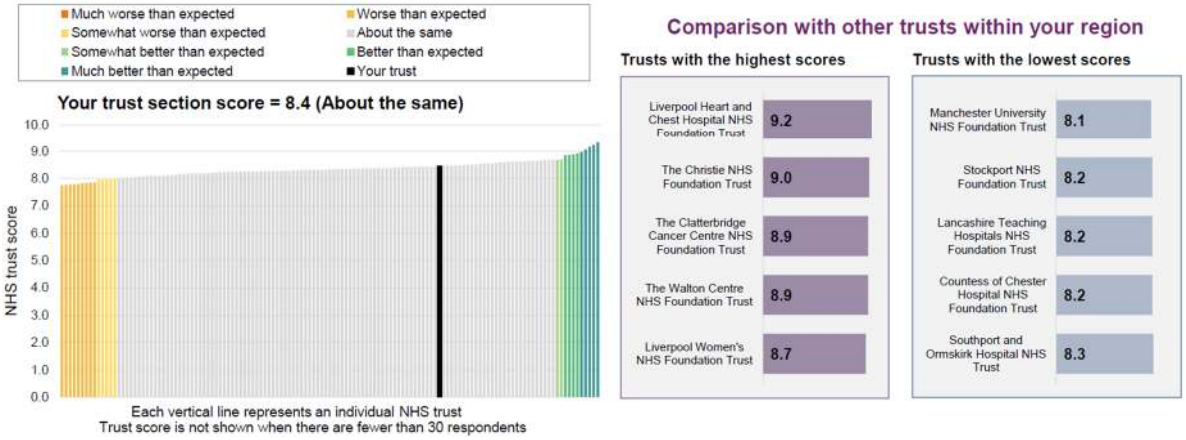
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Section 4. Nurses

Section score

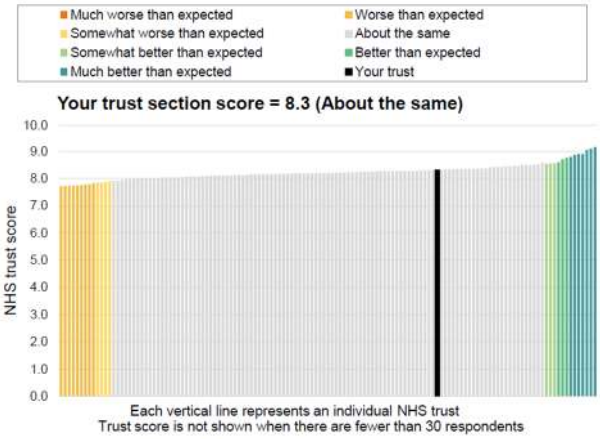
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



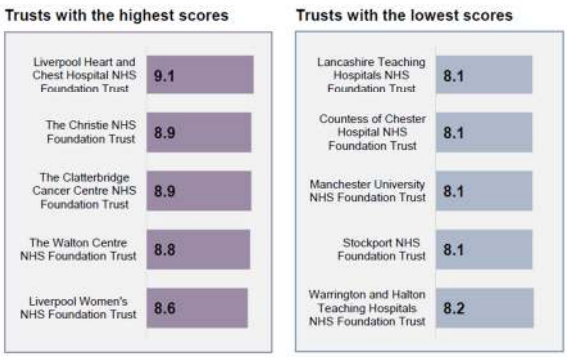
Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



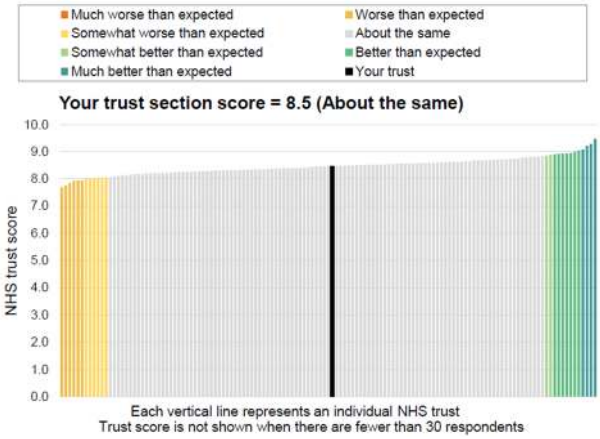
Comparison with other trusts within your region



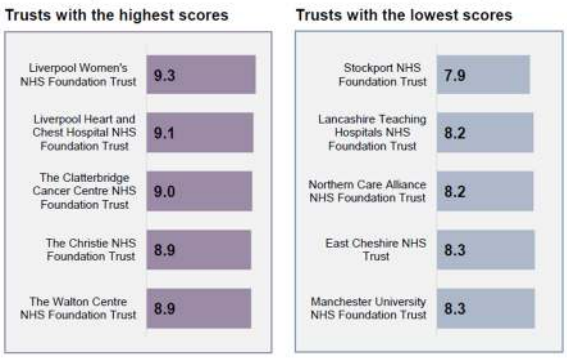
Section 6. Operations and procedures

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



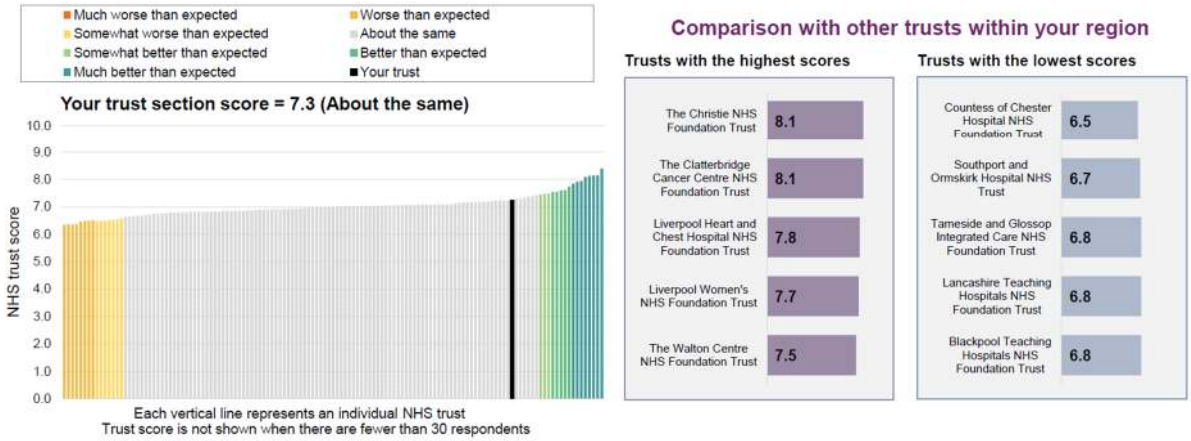
Comparison with other trusts within your region



Section 7. Leaving hospital

Section score

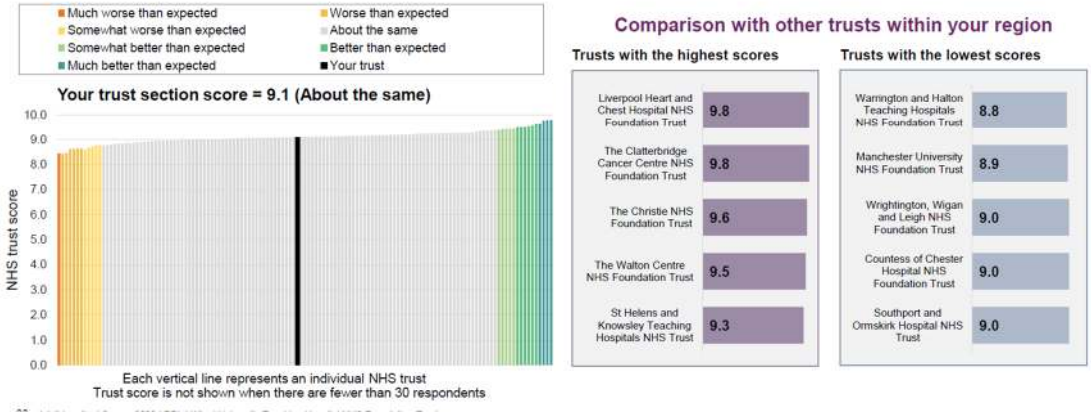
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Section 9. Respect and dignity

Section score

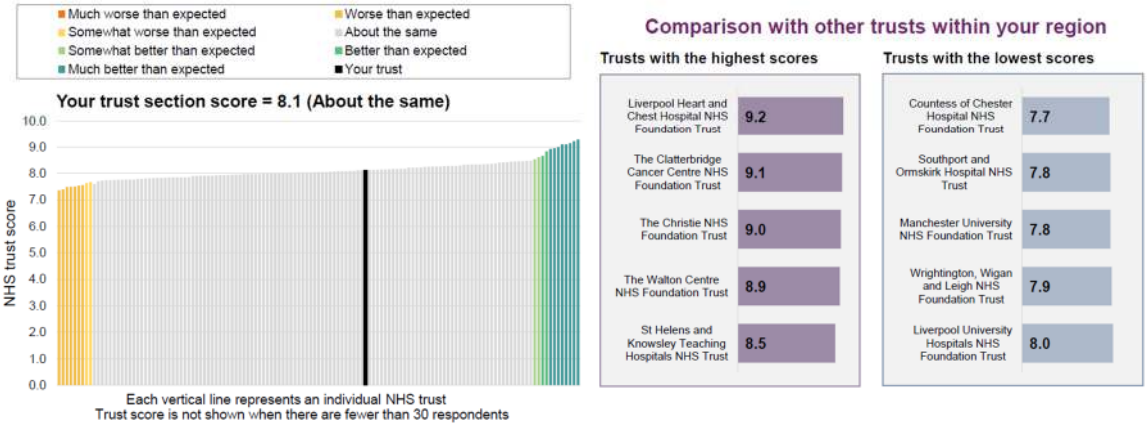
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

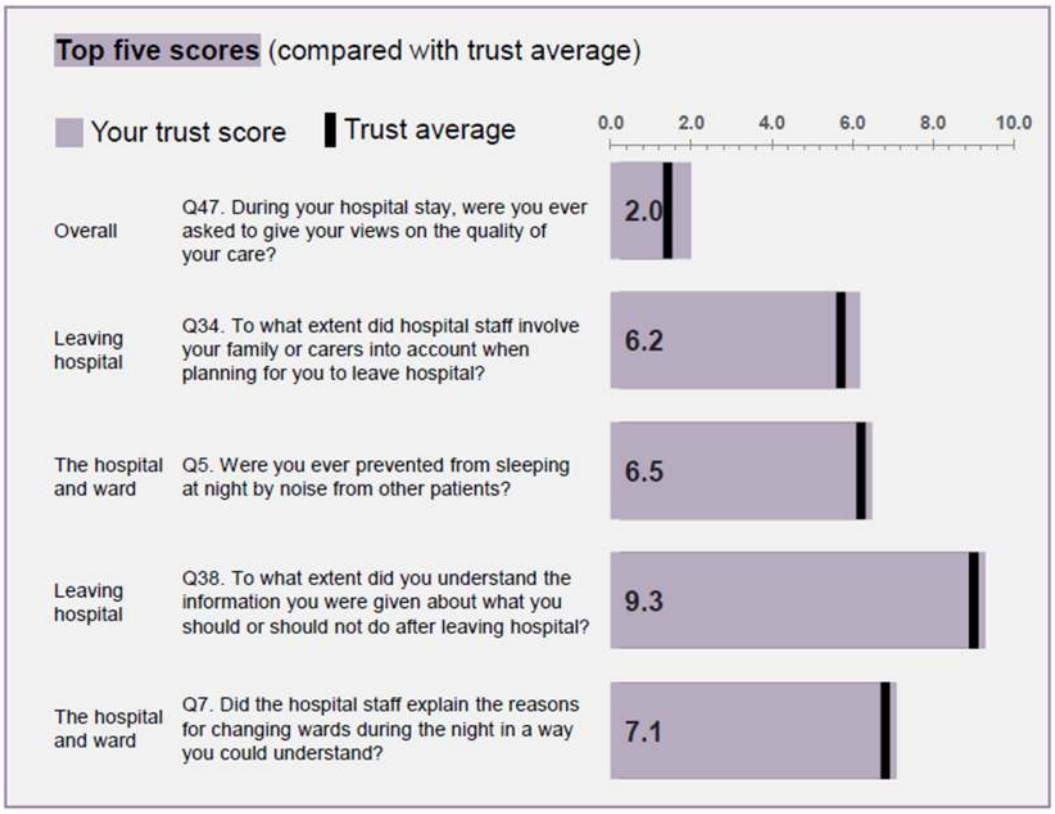


1.4 **Areas of Celebration**

As highlighted earlier in the report WUTH were:

- banded as “better” than other organisations nationally in relation to information on leaving hospital.
- highlighted as in the top performing hospitals regionally in relation to feedback mechanisms.
- No questions or sections have been banded as ‘worse’.

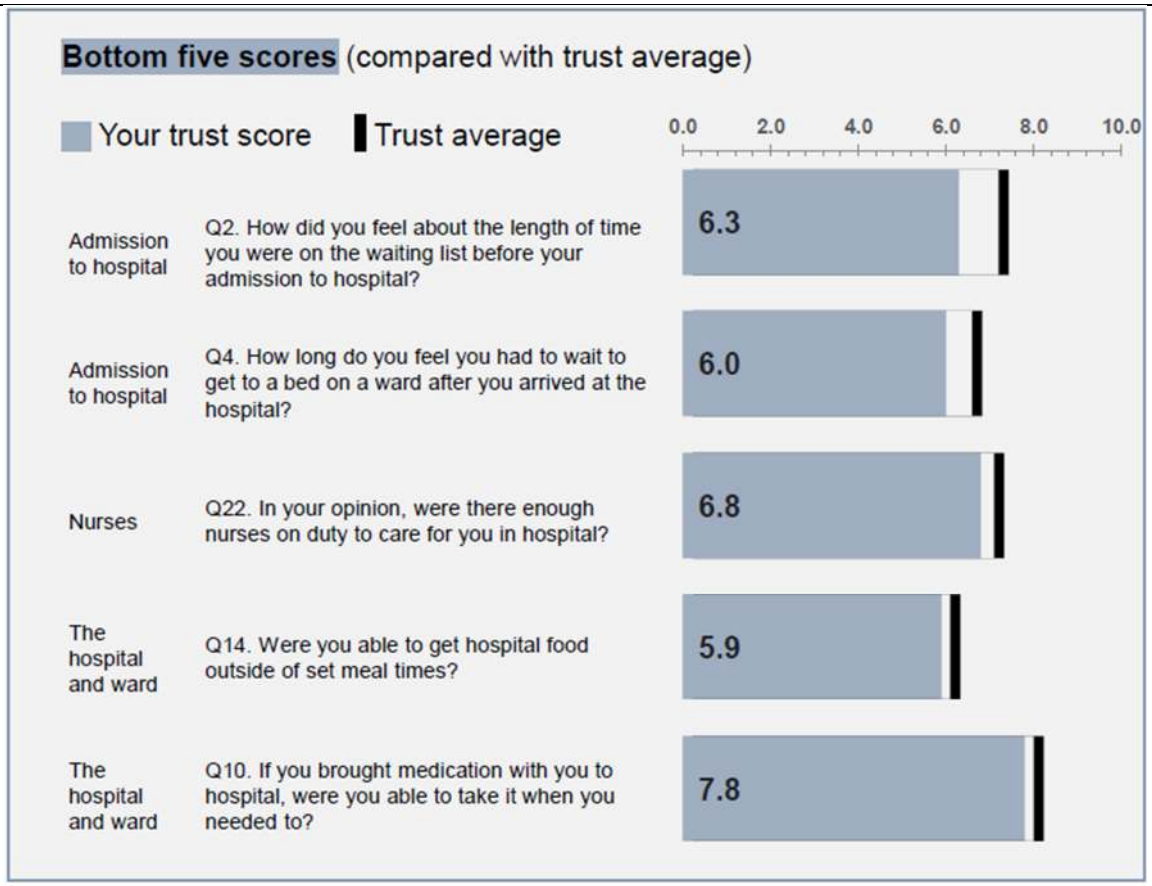
The following questions are those highlighted by CQC as the Trust’s Top 5 scores compared with Trust average:



1.5 **Areas for Improvement**

CQC have highlighted 4 indictors as having a significant decline in comparison to 2021 data. All areas of identified decline or required improvement are captured within the CQC Adult Inpatient Survey action plan.

Significant Decrease	Point change
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	-0.9
Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	-0.6
Q29. Were you able to get a member of staff to help you when you needed attention?	-0.4
Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	-0.4



1.6 Next Steps

All results have been shared with divisional and specialist lead areas for review. An action plan highlighting areas of celebration for sharing and areas highlighted as requiring improvements based on the following criteria, has been developed. Each area has been cross referenced with any existing workstreams already in place to minimise duplication and maximise resource implementation.

Criteria that determine areas that have been included within the action plan:

- Sections or questions banded as "Worse" *(none within this survey)*
- Questions highlighted as having a significant decline by CQC based on the comparison between standardised data year on year.
- Questions identified by CQC as the lowest performing 5 questions in comparisons with Trust average scores.
- Questions where raw data demonstrates a significant decline year on year.
- Any question with a standrised score of below 8.

Divisional Nurse Directors will take the lead on behalf of each Divisional Triumvirate in relation to ensuring actions are implemented within their areas. Monitoring will be undertaken at the Patient Family Experience Group (PFEG) where CQC action plans are a standing agenda item.

2 Implications

2.1 Patients

- The impact of the CQC patient experience programme on patients falls into three main positive impact areas:

	○ The publication of results provides confidence in the quality of care and experience appraised by CQC ○ The formulation of the action plan based on the patient feedback and results will have a positive impact in improving patient care, quality, and experience ○ National patient experience survey's allow patients the opportunity to feedback on their care centrally
2.2	**People** • Publication and recognition of areas of celebration identified by an external monitoring body such as CQC, supports increased staff morale and internal and external recognition • Results provided by external organisations recognising areas for improvement can support staff in escalation and progression of existing workstreams and reinforce improvement focus
2.3	**Finance** • Compliance with the participation of the CQC patient experience survey programme requires a financial commitment by the Trust. Further work is currently underway to evaluate the most appropriate approved company for WUTH to use
2.4	**Compliance** • CQC are a regulatory body of WUTH, compliance with the survey programme is part of these regulatory requirements

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 16**

06 December 2023

Title	National Cancer Patient Experience Survey Results 2022
Area Lead	Tracy Fennell – Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
Author	Dawn Miller, Macmillan Lead Cancer Nurse
Report for	Information

Executive Summary and Report Recommendations

The National Cancer Patient Experience Survey (NCPE) 2022 is the 12th iteration of the survey, having ran annually since 2010 (NCPE did not take place in 2020 due to the pandemic hence no report was published in 2021). The survey is an important part of the national NHS Cancer Programme, and it has been designed to monitor national progress on cancer care, to drive local quality improvements, and to inform to assist commissioners and providers of cancer care.

When asked to rate their care on a scale of zero (very poor) to 10 (very good), WUTH received an average rating of 9.2 (national average of 8.9)

WUTH scores above, below, and equal to the National average

Total 60 questions 2022	
Number of questions **above** National average	45
Number of questions **equal** to National average	7
Number of questions **below** National average	8
Number of questions 5% or more below National average	3

Respondents by Tumour group

Responses for questions with less than 15 respondents are suppressed to because uncertainty around the result is too great.

Breast	44
Haematology	43
Urology	38
Skin	21
Colorectal	18
Prostate	17
Total	198

It is recommended that the Board of Directors:

- Note the report

Key Risks
This report relates to these key risks: • BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
9 November 2023	Quality Committee	As above	Information

1	Narrative
1.1	The NCPES 2022 took place across 134 acute hospital NHS Trusts providing cancer services. The survey sampled all patients (aged 16 and over) with a primary diagnosis of cancer who were admitted to an NHS hospital as an inpatient or day case patient, and who had been discharged between April, May, and June 2022. Nationally out of 123,632 people 61,268 responded to the survey resulting in 53% response rate compared to WUTH who had 198 respondents out of 368 patients, resulting in a 56 % response rate. All respondents reported their ethnicity as White British Following a review of the NCPE the questionnaire was amended and divided into the following domains: • Support from you GP practice • Diagnostic tests • Finding out that you had cancer • Support from a main contact person • Deciding the best treatment • Care Planning • Support from hospital staff • Hospital care

- Your Treatment
- Immediate and Long-term side effects
- Support while at home
- Care from your General Practice
- Living with and beyond cancer
- Your overall NHS care

The Care Quality Commission (CQC) standard for reporting comparative performance is used based on calculation of “expected ranges”. This means that Trusts will be flagged as outliers only if there is statistical evidence that their score deviates (positively or negatively) from the range of scores that would be expected for Trusts of the same size

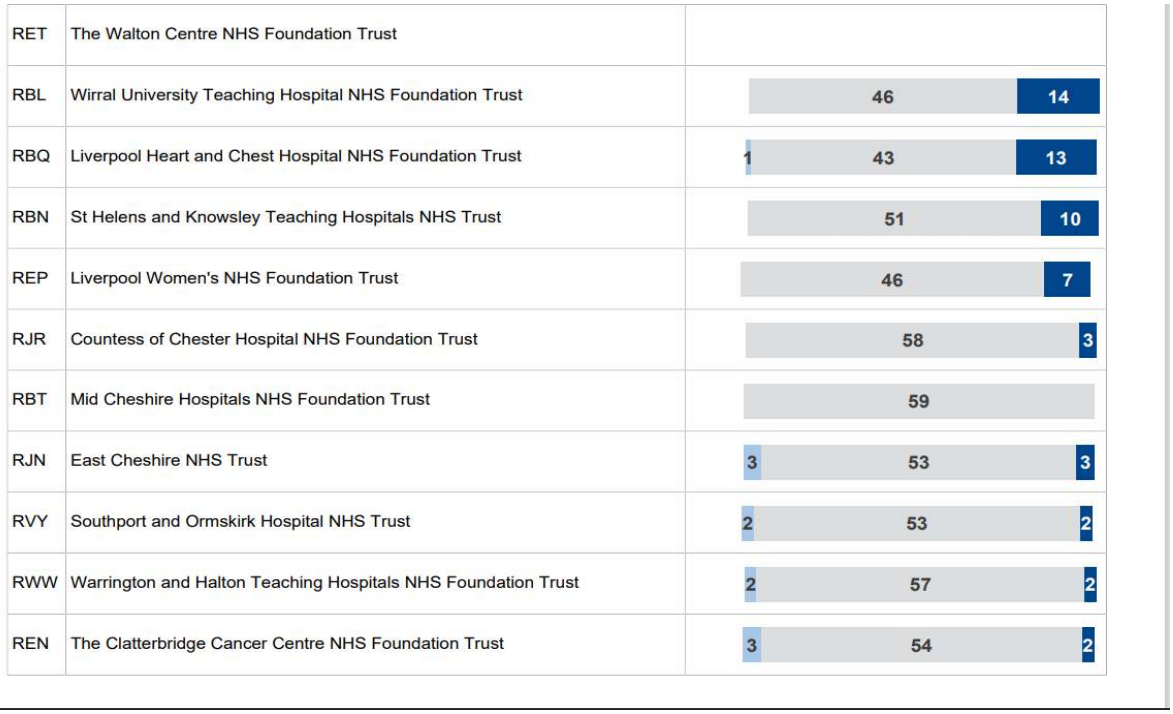
In 2022 14 questions scored above the expected range, compared to 6 questions in 2021 and one question in 2019.

There were no questions scoring below the expected range.

Question		WUTH % 2022	Lower expected range	Upper expected range	National Average	% Above N/A
<u>Above the expected range</u>						
Q6	Diagnostic test staff appeared to have all the information needed about the patient	**89%**	78%	89%	**83%**	**+6%**
Q8	Diagnostic test results were explained in a way the patient could understand	**86%**	72%	85%	**78%**	**+8%**
Q9	Enough privacy was always given to the patient receiving the diagnostic test	**99%**	91%	98%	**95%**	**+4%**
Q13	Patient was told sensitively they had cancer	**83%**	67%	80%	**74%**	**+9%**
Q14	Cancer diagnosis explained in a way the patient could understand	**84%**	70%	82%	**76%**	**+8%**
Q16	Patient was told they could go back for more information about their diagnosis	**91%**	78%	89%	**84%**	**+7%**
Q20	Treatment options were explained in a way the patient could understand	**90%**	76%	88%	**82%**	**+8%**
Q21	Patient was always able to discuss fears and worries with hospital staff	**80%**	58%	76%	**67%**	**+9%**
Q41.2	Beforehand patient had enough understandable information about chemotherapy	**95%**	76%	94%	**85%**	**+10%**
Q42.1	Patient had enough understandable information about progress with surgery	**92%**	79%	91%	**85%**	**+7%**

Q43	Patient felt the length of waiting time for clinic and day unit for cancer treatment was about right	**92%**	69%	87%	**78%**	**+14%**
Q45	Patient was always offered practical advice on dealing with the immediate side effects of treatment	**77%**	62%	77%	**69%**	**+8%**
Q57	Administration of care was very good	**93%**	81%	92%	**87%**	**+6%**
Q59	Patients average rating of care scored from poor to very good	**9.2**	8.6	9.1	**8.9**	**+0.3**

From a Regional perspective WUTH had more questioning scoring above the expected range than any other Trust in Merseyside and Cheshire cancer Alliance.



Areas showing significant improvement and have scored 10% or more compared to 2021

	2021	2022	Improvement
Q32 Patients family or someone close was definitely able to talk to a member or the team looking after the patient in hospital	60%	86%	**+16%**
Q41.2 Beforehand patient completely had enough understandable information about chemotherapy	85%	95%	**+10%**
Q42.2 Patient completely had enough information about progress with chemotherapy	70%	87%	**+17%**
Q49 Care team gave family or someone close to them all the information needed to help care for the patient at home	55%	67%	**+12%**

Q51Patient definitely received the right amount of support from their GP practice during their treatment	40%	54%	**+14%**

Key Issues/Gaps in Assurance

Number of questions scoring 5% below the N/A by tumour group requiring an action plan

Tumour Site	Number of Questions answered	Number of questions 5% or more below	Average Rating of care
Breast	57	1	9.5
Colorectal	48	2	9.6
Haematology	50	8	9.3
Skin	35	2	9.7
Urology	52	18	8.7
Prostrate	44	8	9.1

WUTH questions scoring 5% or more below National Average 2022

Questions 5% or more below N/A	2022 score	National average%	% below National average
Q42.3 Patient completely had enough understandable information about progress with radiotherapy. *WUTH do not provide this treatment.	75%	81%	-6%
Q41.5 Beforehand patient had understandable information about immunotherapy	73%	84%	-11%
Q29 Patient was offered information about how to get financial help or benefits	62%	67%	-5%

Two areas scored more than 10% less compared to 2021

	2021	2022	Decline
Q41.5 Beforehand patient completely had enough understandable information about chemotherapy	91%	80%	-11%
Q53 After treatment, the patient could get enough emotional support at home from community or voluntary services	53%	39%	-14%

The areas in 2021 that scored 5% or more below the National Average have demonstrated significant improvements in 2022 following action plan. *One question pertained to radiotherapy which is not a treatment WUTH deliver

Question	**2021 score**	**Adjusted National average**	**2021 % Below National**	**2022 Score**	**Increase**

			Average		
Q42.2 Patient completely had enough understandable information about progress with chemotherapy.	69	79	-10%	87%	+18%
Q42.3 Patient completely had enough understandable information about progress with radiotherapy. *WUTH do not provide this treatment	74	80	-6%	N/A	N/A
Q58 cancer research opportunities were discussed with patient	34	44	-10%	41%	+7%

The free text comments from this year demonstrate examples of very positive feedback in relation to their experience at WUTH.

My care and treatment have been exemplary. the staff administering my chemotherapy are very efficient and always friendly. A free car park close to the ward is also provided. I cannot find any fault with this department at APH. Well done and thank you.

The care I received was excellent in all aspects from my diagnosis to my surgery and aftercare. The treatment I received from the surgical staff at APH was outstanding with my welfare being top priority throughout my stay.

My cancer was detected on a routine mammogram. from diagnosis to completion of treatment I had 1st class care, my experience was fast, caring, sympathetic, expert, knowledgeable & informative care. could not be faulted.

My stay in hospital was during covid restrictions and therefore no family /friends could visit, which I feel would have supported recovery to a greater extent. However, at no time did I feel neglected by the medical and nursing staff – I appreciate all the care and support given to me.

There were other free text comments that highlighted areas for improvement.

I was moved wards three times just because beds were needed for other people and then there were no specialists to help me with the new stoma nd use of ileostomy bags. Nurses on the ward tried their best but didn't have the correct knowledge.

The care was excellent. however, the delay waiting for my prescription from the pharmacy ay APH was woeful, 8 hours taking up a bed waiting for tablets, nursing staff urgently needed by bed. I did complain to the sister.

There have been significant delays to surgery, 2 operation dates cancelled, and I have had to chase dates at every stage. I was given timescales but none of these were achieved, and I was told on more than one occasion that dates were not available.

Communication between the 3 hospitals I had appointments at was not great.

Next *Steps*

	Each of the tumour groups who are included within the NCPE will be asked to reflect on their individual performance and develop improvement plans based on areas scoring 5% below the National average. Progress made against these actions will be monitored within the division. The report will be shared internally at PFEG and Cancer Steering Group meeting. The report will be approved internally by PQSB prior to presenting at Wirral CCG Clinical Quality Performance Group (CQPG) meetings. **Conclusion** There have been improvements in the cancer patient experience following the implementation of the 2021 Action Plans. However, it has previously been reflected in the comments we have received that there can be an element of confusion for patients who are asked to complete the survey as we are so close geographically to the Clatterbridge Cancer Centre (CCC) and patients consider the feedback to be related to their oncology treatment at CCC. This must be considered when reviewing the findings.

2	Implications
2.1	**Patients** • This report impacts on patient safety in that demonstrates the learning and recommendations for improved patient care that have derived from patient safety incident investigations • There is neutral impact on EDI
2.2	**People** • There is no impact on people. • There is neutral impact on EDI • There is positive impact on stakeholders – both internal and external from the assurance gained from this report in the management of patient safety incidents and adherence to Duty of Candour
2.3	**Finance** • There is no financial impact from this report
2.4	**Compliance** • This supports statutory and/or regulatory compliance with adherence to Duty of Candour and the 2015 SI Framework which is now the Patient Safety Incident Response Framework

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 17.1**
6 December 2023

Report Title	Committee Chairs Reports – Quality Committee
Author	Dr. Steven Ryan, Chair of Quality Committee

Items for Escalation/Action

- Timeliness of completion of Mental Capacity Act Assessments (MCAs) and Deprivation of Liberty Safeguards (DoLS) had been identified as an issue from a number of sources in the high quality Patient Safety Intelligence Report. These are complex assessments & requirements, typically undertaken during attendance and admission of patients, especially during unscheduled care episodes. Underlying causal factors were highlighted and include high clinician workload, complexity of care, delays due to high numbers of admissions, as well as clinician knowledge and confidence. There has been a focus on improving education and training, led by the Safeguarding Team and colleagues from Cheshire and Wirral Partnership Trust. The Committee has requested a more detailed review of this area.

- Progress continues to be made with the CQC Action Plan and completion of all but one remaining "should do" actions is expected within this financial year with a reasonable level of confidence. The outstanding action relates to the physical estate of the neonatal unit, which cannot be completed this year due to capital funding constraints. Part of the mitigation is funding from charitable donations, which aims to improve family experience. Design work is continuing pending that funding being released.

- The Quality and Patient Safety Intelligence report also highlighted that there was a backlog in ensuring all clinical guidelines were up to date. High levels of clinical workload compounded by industrial action have reduced clinician time to be able to be able to input into the guidelines. A risk-based approach has been taken, so that focus can be placed on guidelines that require the earliest attention, where changes are required. This includes modifying clinician duties were appropriate. In many guidelines there are no major changes at the time of updating. The Governance Support Unit continues to work with Divisions and Services to improve this position. Methods & resources have been developed that have seen the backlog in policy updates being substantially reduced and will be applied to this issue. The Committee will continue to monitor this.

- An issue has been identified in relation to the interaction between the Patient Safety Incident Response Framework methodology and that which has been previously been developed for maternity services by the national Maternity and Newborns Safety Investigations Programme. The issue is around the principle of moving away from detailed investigation of individual incidents towards thematic reviews (including learning from non-harm incidents). This issue has the risk of adding complexity to processes as well as duplication. The Trust's Chief Nurse has alerted the Chief Nurse at the Cheshire and Merseyside Integrated Care Board about this. In the interim the Committee was assured that investigation, learning and action is continuing.

- The Chief Nurse advised that there was an impending update of the NHS national pressure ulcer definition and measurement framework. This will likely impact the numbers of patients in the numbered categories (1-4 with 4 being the most sever). At go-live an explanation of any changes will be provided.

New/Emerging Risks

- No new risks were identified

Overview of Assurances Received

- The Committee received an update on the Quality and Safety Strategy (based on the principles of insight, involvement and improvement) and were assured to see the development of key performance indicators (KPIs) to provide assurance on the impact of the strategy. The KPIs will be monitored through the Committee.

- Assurance was received from 2 CQC (Urgent and Emergency Care, and Adult Inpatient), as well as the National Cancer, patient experience surveys. These surveys were all reported for the calendar year 2022. The reports will be shared with the Board. All three showed a benchmarked high level of patient satisfaction – a testament to the skills and attitude of our staff dealing with the Covid pandemic and its after effects. Indicators where there had been some deterioration (but still above the national benchmark) included prolonged waiting times for unscheduled care, an issue which is well known to the Trust and subject to on-going oversight and action (see Chief Operating Officer's report).

- The Cervical Screening Annual Report provided gave assurance on the quality of the service and also detailed how risks around lack of some digital informatics functions were mitigated. The report also outlined the services approach to identifying and responding to inequalities in non-attendance. The Committee suggested that further detail on this be provided in future reports.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 17.3**
6 December 2024

Report Title	Committee Chairs Reports – Charitable Funds Committee
Author	Sue Lorimer, Chair of Charitable Funds Committee

Items for Escalation/Action

- The Head of Fundraising gave an update to the Committee regarding the cyber security of Harlequin, the charity's donor database. She explained that the Trust owns the data, and it is held on a secure server. She added that Information Governance had undertaken a review of Harlequin and no concerns were raised.
- The Chief Strategy Officer and Director of Estates, Facilities & Capital Planning provided a presentation on plans for the update of the Neonatal Unit which will be funded from the Tiny Stars appeal and Incubabies, a separate charity. They said that Incubabies had been kept informed and would receive the same presentation. A full reprovision of the unit would cost circa £4m -£5m but the charitable funds would amount to £1m at most so the Chief Finance Officer stressed the importance of understanding what could be achieved with that budget. The Committee was assured that there had been good clinical engagement in the plans.
- The Committee received a report from the Head of Fundraising. Results for the year to date were a little disappointing at £9k after costs. The "It's a Knockout" event had to be cancelled due to the weather and the team was short of one of their members for some months. However, more recent events had been successful, a £50k legacy had been notified and the charity shop was exceeding income expectations. The Committee noted that the League of Friends charity and shop had closed and requested that Chief Finance Officer follow up whether there were any funds to transfer to the trust.
- The Committee agreed to defer the implementation of the "Pennies from Heaven" scheme pending the transfer to a new payroll provider.
- The Committee approved the rollout of the new grant approval process following testing within the trust.
- The Committee received the finance report for the charity and noted the very welcome news that the Barclays Bank account has now been released to the charity.
- The Committee received a presentation on mitigating actions to enable the charity to make good some of the shortfall in funds raised to date. The Committee agreed the importance of achieving as close to the target as possible in order to maximise funds for the Neonatal Unit.
- The annual report and accounts were approved for recommendation to the Board of Directors. The charity's auditor confirmed that they had found no issues with the report. The Committee also received the Independent Examination Report and the Letter of Representation. There were no issues raised. The Committee commented on how engaging they found the annual report.

New/Emerging Risks

- The Committee received the news that Head of Fundraising has been successful in securing a more senior fundraising post elsewhere in the NHS. The Committee thanked her for all of her hard work and noted that her departure would present a risk to the fundraising programme. It was also noted that the Director of Communications and Engagement was retiring so it was important that focus on fundraising should not be lost.

Overview of Assurances Receive

- The Committee were assured to receive the various reports from Finance and Fundraising and a clear Independent Examination report on the charity.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 17.4**
6 December 2023

Report Title	Committee Chairs Reports - Audit and Risk Committee
Author	Steve Igoe, Chair of Audit and Risk Committee

Overview of Assurances Received

This report updates on the work of the Audit Committee at its meeting on 23rd November 2023.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.

Items for Escalation

There are no items for escalation from the Committee to the Board.

Updates on issues raised at the Meeting on 20th September 2023

The Committee received briefing updates on:

- Blood Transfusion service disruption due to ageing interface hardware issues, and,
- Assurances in relation to delayed transfers of care.

These papers updated the Committee and closed off actions from the previous meeting.

Internal Control and Risk Management

The Committee discussed the Chair's report from the Risk Management Committee. Many of the items raised in the report were the subject of debate and discussion by the Committee in other items and indeed the Estates risks and mitigations were the subject of a substantial briefing later on the agenda and discussion given the number of risks in the Trust's risk register. It was however noted that there is a strong risk management culture in the Trust, and this was evident in the report and responses.

A detailed review of the Board Assurance Framework took place (BAF).Potential discrepancies in scoring were noted although it was recognised that tis is a subjective process. It was also recognised that the BAF will undergo a full refresh along with Risk Appetite as part of the Trust's ongoing annual review mechanisms.

A deep dive took place into Estates risks and mitigations. It was recognised that oversight of these issues at a Governance level rests with the Trust's capital Committee who themselves had recently undertaken such a deep dive .In recent years much work had taken place for the trust to fully understand its exposure to these risks most of which clearly arise as a result of substantial underspending over many years on infrastructure issues. Estates colleagues identified the many mitigations in place to deal with a multitude of risks however it was recognised that these would never fully resolve the challenges as substantial capital expenditure would be needed to do so. That is not going to happen in the short to medium term given the state of NHS finances and the strict control placed on such spend by the centre via the CDEL limited. There therefore remains a not inconsiderable level of residual risks in a number of areas that the Trust is managing albeit on a prioritised basis.

The Committee was updated on procurement spend controls and waivers. It was noted that the Trust continues to perform strongly against NHS benchmarks. A detailed analysis of waivers was presented and discussed with the vast majority of spend related to specific capital projects and specialist staffing requirements. This was the first of a more focussed report format which was welcomed by the Committee. The Committee were assured that the Trust in relation to these waiver items was achieving value for money and that due consideration had been given to the relevant and appropriate levels of financial scrutiny and authorisation alongside the use of framework agreements and measured term contracts.

The Committee scrutinised the standing report on financial losses and special payments. Much of these losses were immaterial. The Committee was updated on the ongoing discussions with WBC relating to a substantial amount of unpaid debt. The Director of Finance confirmed that there was ongoing movement in relation to this and that he would further update the Committee at its next meeting in January.

An updated set of SFI's relating to capital schemes was presented to the Committee arising from recommendations made during a recent internal audit review. The Committee approved the proposed changes.

The Chief Information Officer introduced reports on recent work relating to Digital Maturity and Cyber Security. Whilst recognising the ongoing risks the Committee were comforted by the level of detail and performance set out in the documents. The Committee also considered the locus of ownership in Governance terms for the new Information Assurance Group (IAG). It was agreed that the IAG would report into the Audit Committee.

Anti-Fraud Progress Report

MIAA provided their regular update on Anti-Fraud issues and work being undertaken. The trust reported 12 green outcomes against the 12 return standards. A positive position.

The AFS reviewed the detailed documentation in relation to Conflicts of interest and confirmed to the Committee that there were no areas of significance to bring to the Committees attention.

Work continues on the National Fraud Initiative matching process which must be completed by the end of the current financial year.

Internal Audit

MIAA provided an overview of recent activity undertaken across the Trust.

Two reviews were reported to the Committee both receiving Substantial Assurance, namely Managing conflicts of interest and freedom to speak up.

A request to change the Audit work plan to defer the audit of medical staffing was agreed however only on the basis that the work must be done during Q1 24/25.The outstanding action tracker highlights issues in relation to this area dating from 2019/20 and it is therefore a matter of urgency that this work is done and the issues identified resolved.

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. There was strong evidence of items whose previous completion dates had slipped being actively completed. The Committee were assured that the final few items related to people issues would be completed by various policy ratification processes to be completed by

the end of the month. The outstanding work no medical staffing as highlighted above must be done by the end of Q1 24/25.

Emergent risks and Assurances

All such matters are included in the body of the report on the deliberations of the Audit Committee as set out above.