Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC - 3RD APRIL 2024

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3 April 2024

10:00 GMT+1 Europe/London

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1. BOARD OF DIRECTORS IN PUBLIC - 3RD APRIL

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 3 April 2024
Time	10:00 – 12:00
Location	Hybrid

Page	Agenda Item			Lead	Presenter
	1.		Welcome and Apologies for Absence	Sir David Henshaw	
	2.		Declarations of Interest	Sir David Henshaw	
5	3.		Minutes of Previous Meeting	Sir David Henshaw	
16	4.		Action Log	Sir David Henshaw	
	Items for Decision and Discussion				
	5.		Staff Story	Debs Smith	
	6.		Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
17	7.		Chief Executive Officer Report	Janelle Holmes	
	8.		Board Assurance Reports		
21		8.1)	Chief Finance Officer Report	Mark Chidgey	
29		8.2)	Chief Operating Officer Report	Hayley Kendall	
39		8.3)	Integrated Performance Report	Executive Directors	
53		8.4)	Board Assurance Framework	David McGovern	
65		8.5)	Monthly Maternity Report	Dr Nikki Stevenson	Jo Lavery
	9.		Employee Experience – **Presentation on the day**	Debs Smith	
145	10.		Emergency Preparedness, Resilience and Response (EPRR) Core Standards Update	Hayley Kendall	
175	11.		Risk Management Strategy	David McGovern	
198	12.		Corporate Governance Manual	David McGovern	Cate Herbert
	Committee Chairs Reports				
253	13.	13.1)	Finance Business Performance Committee	Sue Lorimer	
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258		13.3)	Quality Committee	Dr Steve Ryan	
		13.4)	People Committee – **Verbal**	Lesley Davies	

Closing Business

14.	Questions from Governors and Public	Sir David Henshaw
15.	Meeting Review	Sir David Henshaw
16.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 1 May 2024, 09:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 6 March 2024
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Dr Steve Ryan	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
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
CM	Chris Mason	Chief Information Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.6
RMe	Dr Ranj Mehra	Deputy Medical Director – item 8.7
AA	Dr Alice Arch	Guardian of Safe Working – item 8.8
PM	Paul Mason	Director of Estates, Facilities & Capital Planning – item 9
CJ	Clare Jefferson	Associate Director of Estates, Facilities and Capital Governance and Sustainability – item 9
EH	Eileen Hume	Deputy Lead Public Governor
RT	Robert Thompson	Public Governor
TC	Tony Cragg	Public Governor

Apologies:

LD	Lesley Davies	Non-Executive Director
SI	Steve Igoe	SID & Deputy Chair

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 24 January were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** Due to offsite technical problems the video story was not played.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted NHS Cheshire and Merseyside had commissioned a Wirral System Review into the collaboration and integration opportunities across health and care in Wirral. DH added there was a Steering Group meeting to review progress every 2 weeks. SR highlighted he attended the national Chairs' meeting on behalf of DH and provided a summary of key points discussed, notably the increase on productivity, the introduction of NHS IMPACT and Martha's Rule. MS highlighted members of the team had attended NHS IMPACT events and proposed presenting the Trust's improvement approach following the launch of NHS IMPACT. NS explained one of the requirements to participate in the trial of Martha's Rule was access to a 24/7 Critical Care Outreach Team. NS added the Trust had this and planned to express an interest to be part of the first phase of Martha's Rule programme. The Board **NOTED** the update.	Matthew Swanborough
7	**Chief Executive Officer's Report** JH gave an industrial action update and explained Junior Doctor strike action had taken place from 24 to 28 February 2024. The UNISON industrial action dispute relating to retrospective re-banding for Clinical Support Workers (CSWs) continues. Following a ballot, UNSION have received a further mandate for strike action. JH stated in January there was one Patient Safety Incident Investigations (PSIIs) opened under Patient Safety Incident Response Framework (PSIRF) and one Reporting of Injuries,	

	Diseases and Dangerous Occurrences (RIDDOR) reported to the Health and Safety Executive. JH noted the Leadership Competency Framework had been launched on 28 February and would be used in the 2023/24 Board member appraisal. JH explained the Together Awards for staff would take place on 22 March and would be an opportunity to celebrate the outstanding work of staff and teams throughout the past year. JH thanked everyone who nominated colleagues for awards and congratulated those who were nominated. JH highlighted phase 2 of the Fuller Inquiry has been launched and the Trust would comply with all requests made by the Inquiry. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board on 2 February and the Place Based Partnership Board (PBPB) on 22 February. SL noted UNISON was asking the Trust to step outside of the Agenda for Change framework and queried the implications of this. DS stated one implication was that it sets an expectation for future claims. DS added NHSE (NHS England), and NHS Providers have encouraged individual Trusts to resolve locally resulting in different approaches for each Trust. SL queried the system focus regarding the 3 to 5 factors that had greatest potential to reduce cost, supporting transformation, while improving system flow. JH stated this related to a range of transformational programmes developed and led by CMAST. MC explained an example of one transformational programme was the Cheshire and Merseyside Surgical Centre, which resulted in more patients being treated and reducing the overall system backlog. SL requested an update be provided regarding the transformational programmes at Wirral Place and Cheshire and Merseyside level. The Board **NOTED** the report.	Matthew Swanborough
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC highlighted at month 10 the Trust was reporting a deficit of £21.470m, an adverse variance against plan of £4.494m, and was	

	forecasting an outturn variance to plan of £4.494m which was subject to deterioration should there be further industrial action. MC provided an update on the statutory responsibilities and key financial risks, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency was amber and agency spend, capital and cash were green. MC summarised the key drivers of variance to plan and the mitigation and corrective actions. MC explained there were discussions at the ICB (Integrated Care Board) regarding the availability of funds to cover costs incurred by industrial action and this was to be determined. MC added the Trust was also not proposing to change the forecast position yet as any changes would be co-ordinated at ICB level. SL commented it was positive NHS partners were now utilising their sessions at the Cheshire and Merseyside Surgical Centre. HK agreed and explained clinical leads from both Trusts were meeting in March to discuss 2024/25 and a long-term plan. DH enquired about the structural deficit position. MC reported the amount of recurrent CIP transacted has been fundamental to improving the underlying position, but continued work involving transformation at Place and ICB level was required to improve this further. SR queried the underspend on backlog maintenance and medical equipment. MC stated it was expected spend would catch up by year end and the Estates, Facilities and Capital team had provided assurance regarding completion of planned projects. The Board **NOTED** the report. **8.2) Chief Operating Officer Report** HK highlighted in January the Trust attained an overall performance of 101% against plan for outpatients and an overall performance of 98% against plan for elective admissions. HK explained underperformance continued to be related to the impact of large-scale cancellations for industrial action. HK summarised referral to treatment and cancer performance. HK reported type 1 unscheduled care performance was 46.82% which was below the 4hr improvement trajectory. HK explained there was an improvement plan in place which was being monitored closely.	

	HK stated compliance with the national standard for 15-minute ambulance handovers continued to remain a challenge with an average daily handover of 92 minutes. HK added there was also an increase in the number of patients receiving corridor care. HK highlighted in January the Trust saw an increase in demand for patients attending the ED (Emergency Department) with mental health conditions. Although demand increased, there was not as long a wait for admission to a specialist mental health bed as last winter. SR noted one of the main areas of concern in delivering 65 weeks by the end of March 2024 was in gynaecology and referenced the launch of Women's Health Hubs as a mechanism to reduce the backlog for non-cancer patients. HK stated the Trust was ensuring the prompt triage of new referrals was being undertaken so that patients did not need to wait unnecessarily for treatment. HK added some patients had been referred to their GP with appropriate guidance. Continuous flow had also been implemented, with a three times daily push of patients through the hospital, which has initially made significant improvements, and Aqua has been engaged to further support the department. A feedback report on this, and the impact on unscheduled care risks, will be provided to Quality Committee. DH noted ambulance handover time had initially started to improve and queried if this was being sustained. HK stated improvements were being sustained for ambulance handovers under 30 minutes. HK added the Trust was also working closely with NWAS to ensure the appropriate procedures were being conducted in a timely manner. The Board **NOTED** the report. **8.3) Integrated Performance Report** NS highlighted there had recently been a Never Event, the patient did not suffer any harm and an investigation had started under the Patient Safety Incident Response Framework. NS explained C Diff remained a focus, as the Trust had exceeded the national threshold, and outlined the number of hospital and community acquired C Diff cases. NS added FFT was in line with or above average but had requested Women and Children provide an update in their Divisional Performance Review regarding the reduced score for Maternity. SR queried the Never Event and if there was any feedback from the rapid evaluation.	

NS stated initial findings indicate the event occurred because of process error.

SR commented it was positive the Trust achieved its target for the number of patients recruited to NIHR studies.

NS agreed and reported the Trust continued to focus on recruiting to commercial studies.

DS reported mandatory training continued to meet threshold as well as staff turnover. DS explained there were also fewer staff who left in the last financial year compared to previously. DS highlighted appraisal compliance had not met Trust target and there had been a focus on the improving the quality of discussions, a new approach had been implemented and an update would be provided to People Committee in March. DS highlighted sickness absence continued to be driven by short term sickness absence and the new Attendance Management Policy launched on 1 March.

DH queried how the Trust was progressing tracking the retirement of staff.

DS explained there was a new workforce planning tool that Divisions have undertaken as part of 2024/25 operational planning which would include upcoming workforce changes. DS explained an update on this would be provided to People Committee in May.

The Board **NOTED** the report.

8.4) Productivity and Efficiency Update

HK highlighted the year to date position was £18.483m delivered against a year to date target of £20.556m. HK added CIP had an adverse variance against plan of £2.083m and was now forecasting under delivery of £2.992m in year against target of £26.172m. HK explained that the full year effect of the schemes will be in line with the target.

SL congratulated the team for delivery of CIP schemes. SL commented the Finance Business Performance Committee received a presentation on CIP schemes from the Divisional Director for Medicine and it was noted about the positive and engaging process. SL queried how the Trust had lower turnover, but more was being spent on pay costs.

DS stated this related to premium costs on agency/bank staff and the Executive Team had asked Trust Management Board Divisional Directors to provide an update on their individual agency spend for the next meeting.

	CC queried how the CIP target for 2024/25 would be allocated to each Division. HK stated that it was instead based on the areas of opportunity and that it was open to discussion with triumvirates. RM queried if there were any new schemes for 2024/25 or if schemes were continuous. HK stated some themes in workforce would continue into 2024/25 and there were some new schemes, for example admin and clerical and the implementation of digital dictation and voice recognition. JH commented some schemes were part of a multi-year programme and the Trust was a key player driving forward transformational schemes across Wirral Place. The Board **NOTED** the report. **8.5) Board Assurance Framework (BAF)** DM summarised the BAF covering high level and strategic risks within the Trust for February, explaining the annual refresh of strategic risks was being undertaken in March for Board of Directors approval in April with the Risk Management Strategy. The Board **NOTED** the current version of the BAF. **8.6) Quarterly Maternity and Report** JL introduced the report and gave an update on Year 6 of the Maternity Incentive Scheme (MIS), noting guidance was expected in the spring. JL also gave an update on the Saving Babies Lives, the three-year delivery plan for the service and progress regarding implementing a Continuity of Carer Model. JL referenced the 2023 Maternity CQC (Care Quality Commission) Survey, explaining overall results indicate Maternity Services have been providing quality care to expectant and new mothers. JL summarised the maternity and neonatal research and innovation opportunities, noting there were several initiatives in progress. JL also 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. JL added there were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in January 2024 for maternity services.	

NS thanked JL for the report and commented about the large amount of work required to provide assurance to the Board and other regulators. NS added the Trust continued to receive good feedback from the LMNS regarding this.

DS queried the perinatal culture and leadership programme as part of MI5 Year 5 and how this triangulated with the staff survey results for Women and Children's Division.

JL stated workshops with staff were being organised to understand this further.

The Board **NOTED** the report.

8.7) Learning from Deaths Report Q2 2023/24

RMe summarised the report, highlighting the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) was within the expected range of mortality data.

RMe reported deaths in the diagnostic groups for pneumonia and sepsis had increased during the quarter and work was ongoing around these deaths to better understand and improve care. RM also reported Wirral had a higher percentage of deprivation.

NS highlighted she, RMe and the Deputy Director of Quality Governance meet regularly with the coroner who is satisfied with the Trust's approach to improving end of life care.

SL noted only 30% of patients in the diagnostic group for pneumonia were believed to have pneumonia and queried this.

RMe stated this related to the initial coding on arrival at the hospital and the patient will have subsequently died from another illness. RMe added it was important to ensure clinicians code correctly and that this may impact on the overall SHMI.

SR queried the upcoming changes to the coding.

RM explained the changes including removing palliative care coding and adding deprivation and comorbidities. RMe added because Wirral had greater level of deprivation, it is expected that HSMR may increase.

The Board **NOTED** the report.

8.8) Guardian of Safe Working Report Q3 2023/24

AA highlighted the number of exception reports and vacancies covering the period 30 September to 31 December 2023, noting

	many exception reports were in Medicine and from junior doctors regarding working hours. DH noted several junior doctors raised exception reports due to covering the hour change on 27 October and queried this. DH also queried the fines. NS stated when the hour changes again this was an additional hour worked and fines money received from fines were used towards projects to improve environment for junior doctors. DS noted the number of exception reports relating to training/academic issues was zero and queried this. NS stated there had been challenges rostering in training/academic time but agreed to speak with the Deputy Medical Director regarding this. The Board **NOTED** the report.	
9	**Green and Sustainability Plan** CJ gave an overview of progress to date, noting the action plan progress between 2022/21, 2021/22 and data for 2022/23 would take place in January 2024. In 2021/22 16 actions were complete or ongoing, 61 start or partially completed and 51 not started/limited progress. CJ also provided a summary of the key updates across staff engagement, energy, travel and transport/medial gases, greenspace/biodiversity, and external engagement. CJ highlighted the plan for 2024/25 which included the launch of heat decarbonisation plan and waste management plan. Members thanked CJ for the presentation and commented on the good progress so far. The Board **NOTED** the report.	
10	**Accountable Officer Controlled Drugs Annual Report** NS explained she was presenting the report on behalf of the Director of Pharmacy & Medicines Management. NS gave an overview of the report, highlighting there were 211 incidents involving controlled drugs in 2022-23 and that no patients came to harm. NS added the Trust was considered by the Controlled Drug Local Intelligence Network team to be a high number, low harm reporter indicative of an open reporting culture. NS summarised the recommendations to continue to support improvements in compliance with legislation, patient experience,	

	and safety, and monitoring of usage trends to highlight potential diversion. CC commented about the continued increase in controlled drug incidents and queried if there was an improvement plan to reduce the number of incidents. NS stated there was a set of recommendations put in place to reduce the number of incidents along with enhanced scrutiny of controlled drugs. DH commented about the importance of sharing lessons learnt as the type of incident related were avoidable. NS stated lessons learnt were captured routinely by the Medicines Safety and Optimisation Group and discussed at Patient Safety Quality Board. The Board **NOTED** the report and recommendations.	
11	**Transfer of Care Discharge Hub** HK outlined the pathway improvements that have been delivered through the Transfer of Care Hub, noting there has been a significant improvement in reducing the number of patients occupying a hospital bed who do not have a criteria to reside. DH commented about the good progress made and suggested including a Housing Officer in the Hub. DH also explained there were several lessons learnt that would be a valuable for other NHS providers. HK agreed that a Housing Officer would be considered. JH stated members from the Department of Health and Social Care had used Wirral to pilot the new categorisation framework around discharge and fed back how impressed they were with the teams integrated approach to reducing discharge delays. SR queried how the Hub would be operated moving forward. HK explained the Hub had now transferred to a Division and a permanent Discharge Director had been recruited. HK added the next step was to ensure there were below 50 patients in the hospital who did not have criteria to reside and ensuring all patients had a ready for discharge date. The Board **NOTED** the demonstrable progress made in the development of the Transfer of Care Hub and receive future updates as required.	
12	**Committee Chairs Reports**	

	12.1) People Committee The Board **NOTED** the report. **12.2) Quality Committee** The Board **NOTED** the report. **12.3) Estates and Capital Committee** The Board **NOTED** the report. **12.4) Council of Governors** The Board **NOTED** the report.	
13	**Questions from Governors and Public** Governors commented the meeting was positive and the reports were comprehensive.	
14	**Meeting Review** Members commented there was a variety of discussions with a good mix between operational and strategic business.	
15	**Any other Business** DH thanked Edge Hill University for their hospitality. No other business was raised.	

Action Log
Board of Directors in Public
3 April 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	6 March 2024	6	To present the Trust's improvement approach following the launch of NHS IMPACT	Matthew Swanborough	Complete. Scheduled for June Board Seminar.	June 2024
2.	6 March 2024	7	To provide an update regarding the transformational programmes at Wirral Place and Cheshire and Merseyside level	Matthew Swanborough	Complete. Scheduled for June Board Seminar.	June 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
3 April 2024

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

Executive Summary and Report Recommendations
This is an overview of work undertaken and important recent announcements in March. 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** Board members are aware of the ongoing dispute with UNISON in relation to the Clinical Support Worker (CSW) banding. On 4th March 2024 UNISON issued notice of a further 23 days of strike action throughout March and April. A further period of prolonged strike action creates a risk to patient care that we cannot allow. Following

	discussions with Board, the Trust has entered into further discussion with UNISON and reached a compromise on the outstanding matters in dispute. UNISON have advised that the Trust's revised offer will be put to a vote of their members, and whilst this consultation takes place, strike action due to take place week commencing 25th March and 1st April 2024 has been paused. UNISON will advise the Trust of the outcome of the vote, and therefore their intentions to take strike action during the week commencing 8th April 2024, on or before 3rd April 2024.
1.2	**Patient Safety Incident Investigations (PSIIs) and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There was one Patient Safety Incident Investigation (PSII) opened in February under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance. There was one RIDDOR reportable event reported in February. All RIDDOR reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.3	**CQC Unannounced Visit to Urgent Care** The Urgent & Emergency Care Department (ED) received an unannounced visit from the CQC on the 14th March, with a further unannounced follow up visit on the 21st March. The inspectors observed the activity in the department and spoke with a number of medical & nursing & non clinical staff members, patients & the departmental leadership Triumvirate. No immediate safety concerns were raised at the end of each visit during the high level feedback sessions. The team acknowledged the department was busy & praised the staff. They were complimentary of the staff engagement, cultural changes witnessed & confirmed, positive patient feedback. They were also pleased to see that the , the Paediatric ED was now open 24/7 which was an action from the last visit. Following further correspondence in relation to this review, an update will be provided at the Board meeting in Private.
1.4	**Visit from National Director for Primary Care and Community Services** On 21st March, Amanda Doyle, the NHSE Director for Primary Care and Community Services, visited the Trust as part of a wider visit to Wirral System. She met with the Trust senior team including myself and colleagues from the Community Trust and the Council. The visit was arranged by the ICB in order that the significant improvement work around the reduction in the numbers of 'no criteria to reside' patients following the establishment of the transfer of care hub could be shared. Ms Doyle also visited the UECUP site, and the Transfer of Care Hub, before travelling to Wirral Community Health and Care Foundation Trust to continue her tour of the system. It was a great opportunity to showcase the collaborative efforts ongoing on the Wirral, and the impact it has on the demand for the hospital's services.

1.5 **The Together Awards**

Held on the 22nd March, the Together Awards 2024 was a fantastic evening celebrating the achievements of our staff. Awards were given out for excellence, innovation, improvement, and many others. All the staff nominated were strong examples of the categories they represented, and for the first time ever, our Patient Choice Award had three winners.

Congratulations to all winners and all those nominated, and thank you for all your efforts in making the Trust a better place.

The winners are listed below:

Team Excellence Award – Patient Care The Pleural Team	**Employee of the Year – Support Services** Simon Turner
Team Excellence Award – Support Services Clatterbridge Maintenance Team	**Learner of the Year** Liam Whitaker
Research and Innovation Award Digitally Supported Arthroplasty Team	**Equality, Diversity and Inclusion Award** The STAR Team
Improvement Award Service Improvement Team, Transfer of Care Hub	**Waste Activity Value Efficiency Award** Dr Annette Cooper
Volunteer of the Year Carol Taylor	**Patient Choice Award (pictured above)** Mark Buchanan Becky Brumpton Mr Mustafa Sadiq and the Foetal Medicine Department
Employee of the Year – Patient Care Lauren Knight	

1.6 **System and Place Updates**

Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update

The CMAST Leadership Board met on 1 March in a meeting which included Chairs and CEOs. The focus of discussions related to a review of programmes' delivery for 2023/4 and projected year end milestones.

Significant progress was reported and acknowledged across all programmes. The Board also noted the planned closure of the CMAST workforce programme and intentions for development of CMAST Programme commitments and delivery approach for 2024/5.

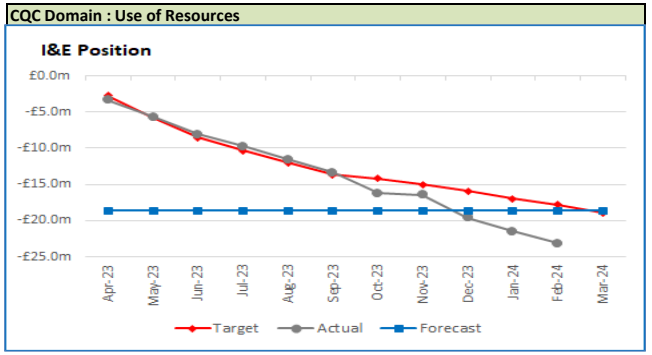
It is expected that a draft Annual Plan for 24/25 will be discussed by the Leadership Board from May onward before sharing with the ICB. The Board also noted the continued impact of UEC pressures and hospital flow on acute performance.

Place Based Partnership Board (PBPB) Update

	The PBPB met on the 21 March and discussed several standing reports on Place Quality and Performance, Finance and Unscheduled Care. Key among the reports was the quarterly Place Delivery Assurance Framework which gave an overview of the system management of key strategic risk and changes to risk scoring since the last report in December 2023. PBPB also noted there were revisions to the Risk Management Framework that were due for ratification by NHS Cheshire and Merseyside in March 2024 and work had commended to develop a Place Risk Register.

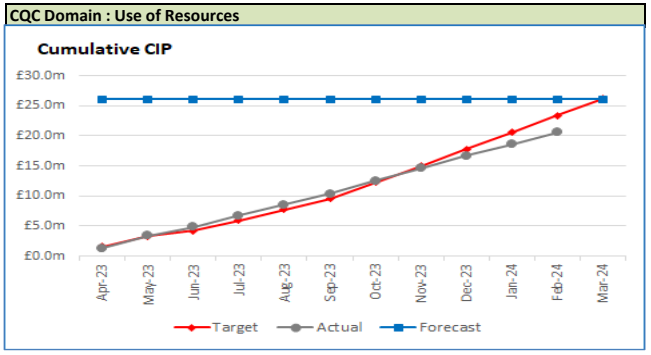
Chief Finance Officer (1)

CQC Domain : Use of Resources



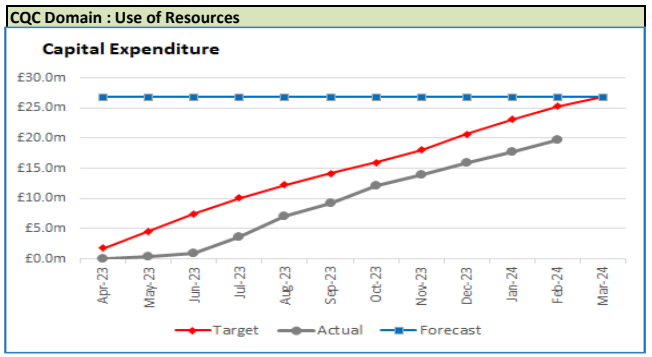
Feb-24
-£23.1m
Variance
Position worse than plan
Target
-£17.8m

CQC Domain : Use of Resources



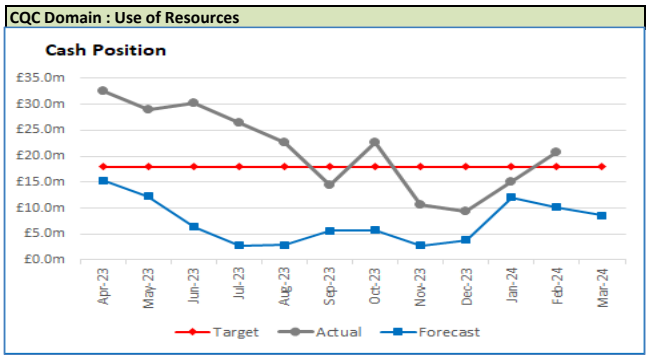
Feb-24
£20.61m
Variance
Position worse than plan
Target
£23.36m

CQC Domain : Use of Resources



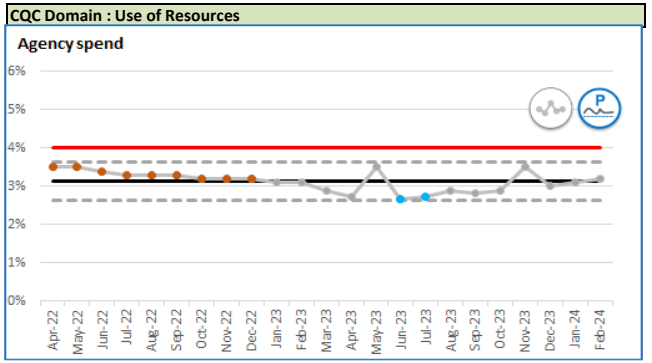
Feb-24
£19.76m
Variance
Position not worse than plan
Target
£25.2m

CQC Domain : Use of Resources



Feb-24
£20.70m
Variance
Position not worse than plan
Target
£18.0m

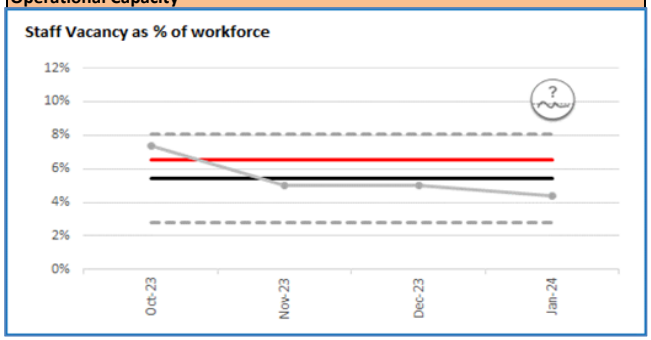
CQC Domain : Use of Resources



Feb-24
3.2%
Variance
Position better than threshold
Threshold
3.7%

Chief Finance Officer (2) - Digital Healthcare Team

Operational Capacity



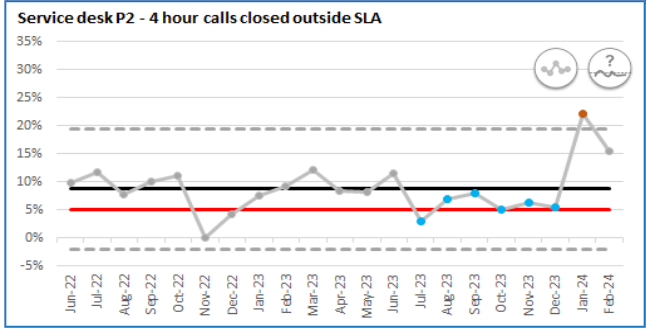
Feb-24
3.15%
Variance Type
Not enough data points yet
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Strategic Delivery

Projects completed against plan - definition TBC

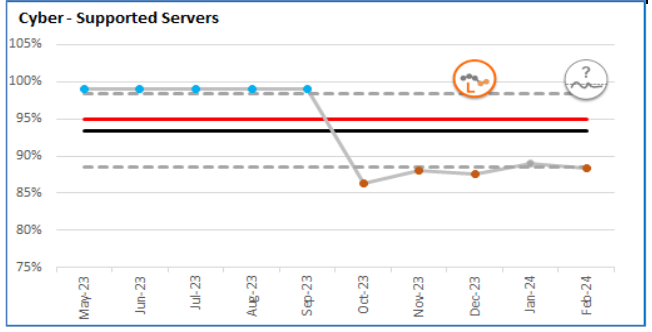
Feb-24
Variance Type
Common cause variation
Threshold
Eg <=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



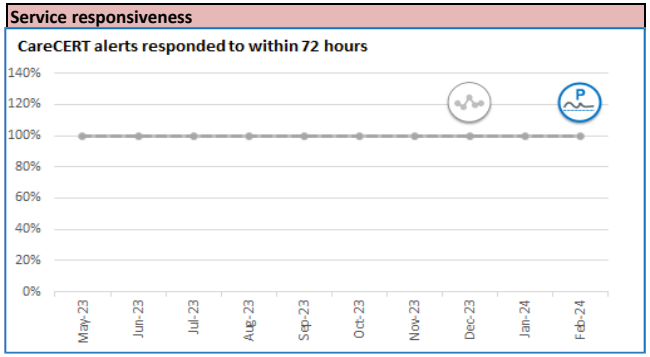
Feb-24
15.4%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



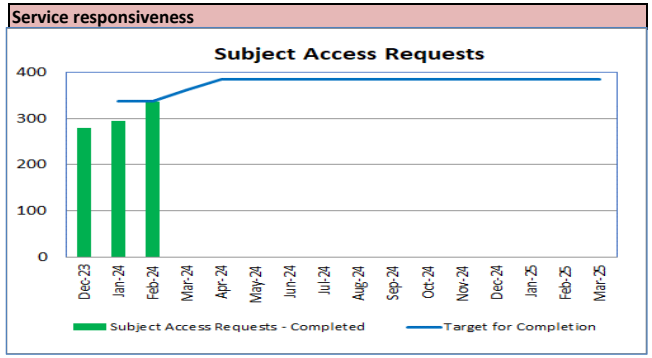
Feb-24
88.4%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Feb-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



Feb-24
337
Variance
Not yet applicable
Target
337

Chief Finance Officer

Executive Summary

The key internal elements of risk to achievement of plan are shortfalls in the value of elective activity, CIP achievement and overspends within Estates. The main external risks are the impact of continued strike action and under-utilisation of elective capacity by NHS partners. Failure to achieve the financial plan places significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

At M11, the Trust has reported a deficit of £23.1m against a plan of £17.8m. This £5.3m adverse variance relates to the unmitigated impact of Industrial Action. The Trust continues to work internally and externally to secure mitigations such that the 23/24 forecast deficit of £18.9m is not exceeded.

As the Trust annual plan is a deficit, 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 are 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 (M11)	RAG (Forecast)	Section within this report / associated chart
Financial Stability			I&E Position
Agency Spend			I&E Position
Financial Sustainability			N/A (quarterly update)
Financial Efficiency			Cumulative CIP
Capital			Capital Expenditure
Cash			Cash Position

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

The Board is asked to:

- Note the assurance that mitigations are in place to manage financial targets other than Financial Stability.
- Note that for financial stability all internal and external risks referenced have been fully mitigated with the exception of the impact of Industrial Action.

I&E Position

Narrative:

At the end of February 2024, M11, the Trust has reported a deficit of £23.1m against a plan of £17.8m, the resultant variance of £5.3m is a deterioration on the M10 position (£4.50m). The position includes all expected mitigations against additional costs and reduced income because of industrial action. Any further costs incurred, or income lost will result in a corresponding deterioration in our financial position.

The table below summarises this I&E position at M11:

Month 11	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Car	£37.5m	£37.6m	£0.1m	£407.5m	£398.0m	-£9.5m
Other Operating Income	£3.3m	£3.8m	£0.5m	£36.6m	£38.0m	£1.4m
Total Income	**£40.8m**	**£41.4m**	**£0.6m**	**£444.1m**	**£436.0m**	**-£8.2m**
Employee Expenses	-£29.6m	-£30.1m	-£0.5m	-£325.3m	-£327.1m	-£1.7m
Operating Expenses	-£14.2m	-£14.5m	-£0.3m	-£154.0m	-£152.7m	£1.3m
Non Operating Expenses	-£0.5m	-£0.4m	£0.1m	-£5.9m	-£3.8m	£2.1m
CIP	£2.8m	£2.1m	-£0.7m	£23.3m	£20.6m	-£2.7m
B/S Release	£0.0m	£0.0m	£0.0m	£0.0m	£3.9m	£3.9m
Total Expenditure	**-£41.6m**	**-£43.0m**	**-£1.4m**	**-£461.9m**	**-£459.0m**	**£2.9m**
Total	**-£0.8m**	**-£1.6m**	**-£0.8m**	**-£17.8m**	**-£23.1m**	**-£5.3m**

Key variances within the position are:

Clinical Income – £9.5m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners prior to M10 and underperformance against the value of elective plan in Surgery. There has also been a reduction in PbR excluded drugs which is offset by operating expenses.
Operating expenses – The £1.3m underspend is partially due to the corresponding reductions in elective activity. However, this is offset by adverse variances in Estates.
Non-operating expenses – PDC dividend payable was lower than expected and interest payable has reduced.
CIP – CIP is £2.7m behind plan at M11 and outturn is forecast to be £3.0m below plan. With remaining schemes unlikely to be transacted in M12, this will mean a shortfall of £1.2m against the full year effect of the £26.2m target.

The Trust's agency costs were 3.8% of total pay costs in M11 compared to a maximum target of 3.7%, although the figure for the year remains below target at 3.2%. A plan has been agreed with Executives to reduce agency costs from 1st April.

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 and separate agenda item).
- Continuation of strike action, with a consequential impact on both expenditure and income (elective activity).

- The overspend in Estates continues and failure to implement mitigations.

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 £2.1m CIP in M11 which is an adverse variance to plan of £0.7m. The YTD position is £20.6m against a target of £23.3m and the forecast for in year effect of CIP is £23.2m, £3.2m below target. The full year effect of the schemes is now £25m, £1.2m short of target.

Risks to position:
- That the momentum on 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.
- Non recurrent measures to mitigate the recurrent shortfall.

Capital Expenditure

Narrative:
There have been four changes in respect of the capital plan provided at M10:

- Changes in the proposed model of delivery for the system-wide LIMS with reduced capital costs and funding (PDC) in 23/24.
- An additional PDC allocation of £0.047m for screening
- The bringing forward of the CDEL for pipework for 2024/25 into 2023/24
- IFRS16 funding support for a lease arrangement for the Durley Storage Unit.

Description	M10 position	Reprioritisation	Revisions to Forecast	Revised budget
CDEL				
Internally Generated	£3.965m			**£3.965m**
Urgent Maintenance (ICB)	£2.920m		£2.920m	**£5.840m**
UECUP	£5.800m			**£5.800m**
UECUP - PDC	£10.000m			**£10.000m**
CDC - PDC	£4.108m			**£4.108m**
CDC - PDC P2	£0.146m			**£0.146m**
Diagnostics Digital - PDC	£0.049m			**£0.049m**
LIMS - PDC PROJECT DELAYED	£3.258m		-£3.258m	**£0.000m**
Endoscopy	£0.775m			**£0.775m**
Breast screening	£0.072m			**£0.072m**
Screening			£0.047m	**£0.047m**
IFRS16 - lease capitalisation			£0.159m	**£0.159m**
Confirmed CDEL	**£31.093m**	**£0.000m**	**-£0.132m**	**£30.961m**
Total Funding for Capital	**£31.093m**	**£0.000m**	**-£0.132m**	**£30.961m**
Capital Programme				
Backlog maintenance	£1.366m		£0.159m	£1.525m
Medical equipment	£1.916m			£1.916m
Heating and chilled water pipework replacement	£1.422m		£2.920m	£4.342m
Fire prevention works	£0.900m			£0.900m
IT equipment	£0.810m			£0.810m
UECUP - Trust funding	£5.800m			£5.800m
Contingency	£0.471m			£0.471m
Approved Capital Expenditure Budget	**£12.685m**	**£0.000m**	**£3.079m**	**£15.764m**
UECUP	£10.000m			£10.000m
CDC	£4.254m			£4.254m
Diagnostics Digital	£0.049m			£0.049m
LIMS - PDC PROJECT DELAYED	£3.258m		-£3.258m	£0.000m
Endoscopy	£0.775m			£0.775m
Breast screening	£0.072m			£0.072m
Screening			£0.047m	£0.047m
Confirmed PDC	**£18.408m**	**£0.000m**	**-£3.211m**	**£15.197m**
Total Anticipated Expenditure on Capital	**£31.093m**	**£0.000m**	**-£0.132m**	**£30.961m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

At M11 the capital programme is £5.4m behind plan and is forecast to be on plan by year end:

Scheme	Plan spend @ M11	YTD spend	Variance
Backlog maintenance	1.3	1.1	- 0.1
Medical equipment and corporate schemes	1.8	1.0	- 0.8
Heating and chilled water pipework	2.7	2.7	0.1
IT equipment	0.7	0.2	- 0.4
UECUP - Trust funding	4.7	0.7	- 4.1
UECUP - PDC	10.0	10.0	-
CDC	4.1	3.9	- 0.2
Diagnostics Digital	0.0	-	- 0.0
CDC - equipment	-	0.1	0.1
PDC - Ultrasound equipment	-	0.1	0.1
Endoscopy	-	0.0	0.0
NHSE/I TOTAL CAPITAL PLAN 23/24	**25.2**	**19.8**	**- 5.4**

We do not anticipate any underspend against plan at 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.

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 February the cash balance was £20.7m. The large capital programme and a planned deficit of £18.9m means that a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement is not sustainable but does mean the Trust does not need to draw upon additional borrowing from NHSE in 2023/24.

Risks to position:

- Achievement of the cash trajectory will place 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.
- 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**
3 April 2024

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Deputy Chief Operating Officer Kate Cooper, Directorate Manager Planned Care
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 continues to have 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

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 ongoing and prolonged 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. The Trust has a strong elective recovery position within the region. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover.

2	Planned Care
2.1	**Elective Activity** In February 2024, the Trust attained an overall performance of 98.08% against plan for outpatients and an overall performance of 99.38% against plan for elective admissions as shown in the table below: Underperformance against plan continues for inpatients, predominantly due to the impact of large-scale cancellations for industrial action. Underperformance relating to the under-utilisation of Surgical Centre sessions also continues but has improved (relating to another NHS Trust). The Trust has submitted a revised financial forecast position that has a reduced level of elective activity included within it for H2.

Activity Type	Target for Feb	Actual for Feb	Performance
Out pt New	12360	12865	104.09%
Out pt Follow up	30351	30679	101.08%
Total Out pts	42711	43544	98.08%
Day case	4455	4610	103.48%
Inpatients	776	589	75.90%
Total	5231	5199	99.38%

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 February against these indicators was as follows:

- 104+ Week Wait Performance – 0
- 78+ Week Wait Performance – 14
- 65+ Week Wait Performance - 363
- 52+ Week Wait Performance – 1,839
- Waiting List Size - there were 41,440 patients on an active RTT pathway which is higher that the Trust's trajectory of 37,124

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.

WUTH have continued to support Trusts across the North West by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 3 to date:

Quarter	4
Period	01/01/2024 - 31/03/2024

Target	Indicator	Threshold	January-24		February-24		March-24		Quarter 4	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	GP or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	88.14%	N/A	N/A	N/A	N/A	N/A	88.14%	N/A
31 Day Wait	Decision to Treat/Earliest Clinically Appropriate Date to Treatment	96.00%	90.97%	N/A	N/A	N/A	N/A	N/A	90.97%	N/A
62 Day Wait	GP Urgent Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	71.29%	N/A	N/A	N/A	N/A	N/A	71.29%	N/A

Sub Targets (Not National Standards):

Target	Indicator	Threshold	January-24		February-24		March-24		Quarter 4	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	Breast Expected to be >=90%	90.00%	93.44%	N/A	N/A	N/A	N/A	N/A	93.44%	N/A
28 Day Wait	Skin Expected to be >=90%	90.00%	88.12%	N/A	N/A	N/A	N/A	N/A	88.12%	N/A
62 Day Wait	Trust Position Expected to be >=70% by End March 2024	70.00%	71.29%	N/A	N/A	N/A	N/A	N/A	71.29%	N/A

- 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 January 2WW performance was 83.8%.
- FDS – was 73.36% in December (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, creating a risk for the delivery of 75% by the end of March.

- 62 day performance is currently below trajectory with 150 patients against a plan of 156 for January. The year end target is to have no more than 140 patients waiting over 62 days.

	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	06/11	13/11	20/11	27/11	04/12	11/12	18/12	25/12	01/01	08/01	15/01	22/01	29/01	05/02	12/02	19/02	26/02	04/03	11/03	18/03
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	145	137	154	149	164	143	153	191	191	174	175	168	150	148	147	144	144	125	105	111
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	170	170	170	170	163	163	163	163	156	156	156	156	156	149	149	149	149	143	143	143
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	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

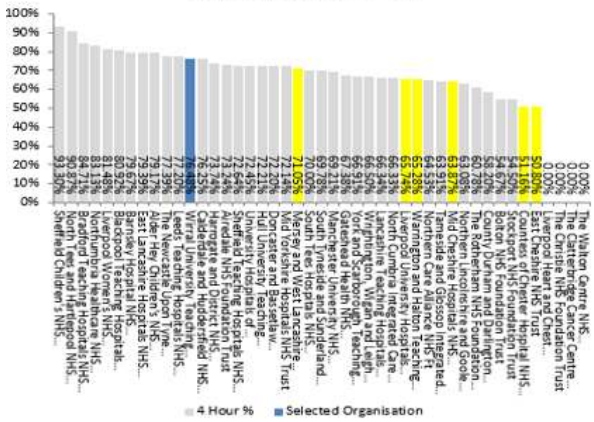
	• 104 day long waiters – performance is above trajectory at 42 against a plan of 18 for January.  The Trust is achieving the National requirement to achieve 70% for 62-day waiters (by March 2024) and remains focussed on reducing the total number of 62 and 104 day long waiters to pre-covid levels. The continued multi-disciplinary approach to improving the efficiency of cancer pathways is working well and is being rolled out across the most challenged tumour groups.
2.4	**DM01 Performance – 95% Standard** At the end of February 97.61% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, a pronounced increase on last month's position of 94.419%. This is against the revised national standard of 95% and requirement for Trust's to achieve 90% by March 2024. WUTH remains on track to achieve 95% by March 2024 and has one of the strongest performance positions of all hospitals in the region. The Trust has commenced providing mutual aid for a neighbouring Trust for endoscopy given the shorter waiting times at WUTH and significant waits elsewhere.
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 has been medical staff industrial action, given the significant volumes of patients cancelled during strike 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 a minimum. The main area of concern in delivering 65 weeks by the end of March 2024 is Gynaecology which is the specialty that has taken the longest to recover from the pandemic, this has been flagged to the ICB as an area of concern and there will be challenges with delivering zero 65 week waits in Upper GI and Lower GI.

3.0	**Unscheduled Care**
3.1	**Performance** February Type 1 performance was reported at 49.12%, with the combined performance for the Wirral site at 74.70%:

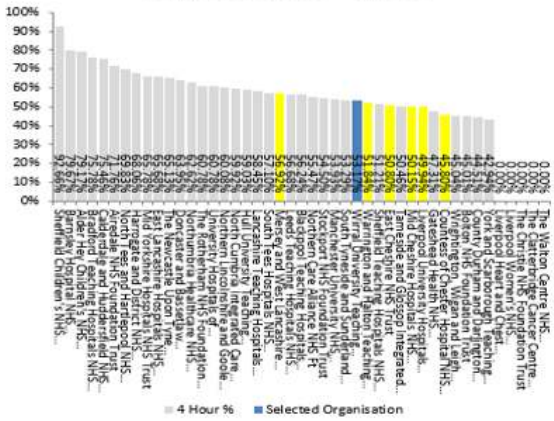
Type 1 ED attendances:	Type 3 ED attendances:
• 8,035 in January (avg. 259/day) • 7,384 in February (avg. 256/day) • 1.7% decrease from previous month	• 3,484 in January • 3,149 in February • 9.6% decrease from previous month

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:

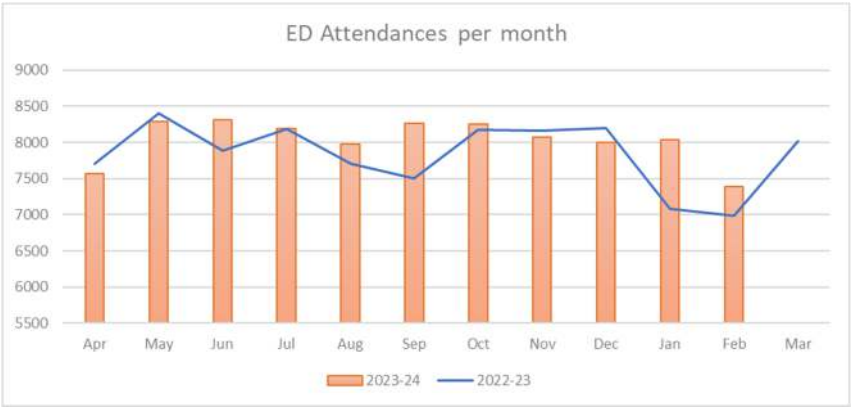
4hr performance weekly rank (all Types)	
Region	National
12 / 45	35 / 127



4hr performance weekly rank (Type 1)	
Region	National
28 / 45	86 / 127



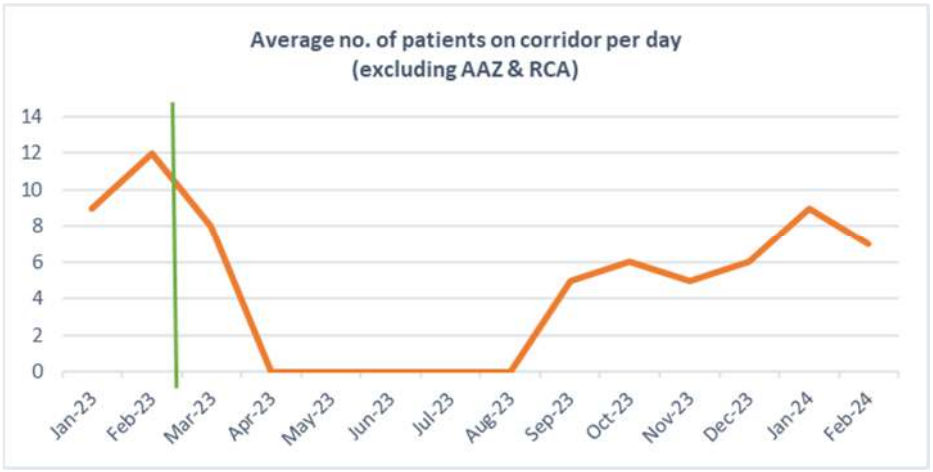
A&E type-1 attendances saw a slight reduction in February compared to previous month however attendances continually remain higher than 2023-24. The Trust has experienced weeks where attendances per day have exceeded 300, in a department that on average sees 260-270 patients. This causes significant flow issues and take a days to recover from.



In February, compliance with the national 15-minute ambulance handover standard improved from 92 minutes to 61 minutes compared to January, however this remained above the Cheshire and Mersey average of 51 minutes handover time. However, mid-month the Trust saw a significant improvement to 24 minutes. One of the actions that led to an improvement in performance was the implementation of the continuous flow policy (19th February), where an additional patient is allocated to each ward before a patient is discharged. This improves timely flow to A&E, spreads the risk across the

Trust and leads to earlier discharge from the wards and encourages an increase in the use of the Discharge Hospitality Lounge.

In February, the Trust saw an slight decrease with the average number of patients experiencing corridor care.



Opening of AAZ (12 ambulance spaces permanently staffed by ED)

This is in addition to the 12 spaces in Ambulance Arrivals Zone (12 spaces) and in the reverse cohort area (6 spaces). The ED continues to offer additional bank shifts to temporarily increase the staffing levels for the corridor with a plan to attempt to staff an additional 12 spaces on the corridor as assurance to deliver timely handover.

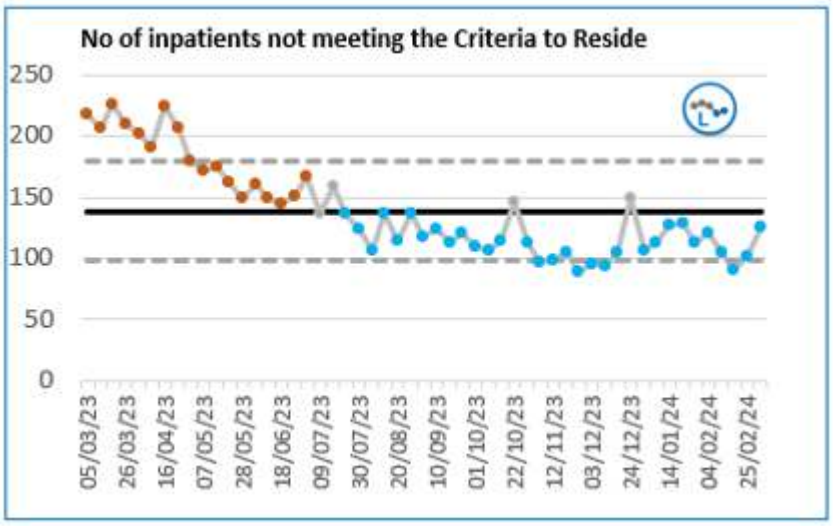
The Trust began working with AQuA in February to improve ambulance handover. Two programmes of work have been agreed and are currently underway. The focus is on the handover process between the Trust and Northwest Ambulance Service (NWAS), followed by a project to review the pathway for patients who have a fall, out of hospital. A group has been formed with representatives from Place partners, including commissioners and the third sector, to look at what is currently in place to avoid transfer to hospital where possible and what is in place to support a patient on discharge to prevent falls in the future.

Initial feedback from the handover review has suggested some improvements which have now been incorporated into the Urgent and Emergency Care Improvement Plan. The actions are to implement a process to ensure that the ambulance IT portal is updated when crews leave site to ensure that the correct times are documented and also to enhance our fit2sit offer. An audit has recently taken place to quantify the number of patients that could potentially be transferred from a trolley to a chair; the Trust is currently awaiting the outcome.

A summary of both projects is expected by the end of April 2024.

Urgent & Emergency Care Upgrade Programme (UECUP)

Due to some delays in the overall project, the handover of phase 2 is now scheduled for mid-May 2024. Operational plans remain in place to ensure that the impact on the running of the department is minimised, with a focus on avoiding delays to both ambulance handover and flow within the department. Preparatory work has not been delayed and is currently being undertaken in the current Emergency Department and is progressing on time.

3.2	**Transfer of Care Hub development and no criteria to reside.** The number of patients not meeting the criteria to reside rose again at the end of February, with an increase in the number of patients on pathway 2. The Trust has seen an increase in several more complex patients and an increase in demand for step-down beds.  The Transfer of Care Hub continues to work with Place, with weekly escalation meetings and a review of patients with the longest length of stay. The Transfer of Care Hub continues to work with the Department of Health and Social Care (DHSC) on the implementation of the new national coding system. The DHSC are keen to review the processes implemented by the Trust and visit the site to understand how the teams operate. A visit is planned for the end of March. It is extremely positive for the Trust that the Hub is being recognised as a best practise service.
3.3	**Mental Health** The demand for mental health beds remained constant in February compared to previous months, however the department saw an increase in the number of patients requiring admission to acute mental health beds. The increase in demand was seen across Cheshire which at times led to delays in discharge. The department continues to work with the local mental health provider for support when the ED is experiencing high demand and requires rapid de-escalation. Right Care Right Person will be in place by the end of April. The Trust is working closely with Merseyside Police and CWP to ensure that Trust policies are amended to reflect the change in national guidance and to ensure that the policy change is fully shared and understood by staff.
3.4	**Risks and mitigations to improving performance** The Trust continues to make progress in implementing the actions from the improvement plans for each of the urgent and emergency care quality standards. The action plans have been shared with AQuA and it is anticipated that the plans will be updated once the recommendations from the AQuA review are available.

	The risk remains that winter pressures continue with the high level of acuity of patients attending the ED. Added to this is the increase in sickness levels at a time when additional staff are required to support any corridor waits or to open short-term escalation beds.

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced 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. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in 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 significant pressures across urgent and emergency services with attendances remaining higher than previous years. Given the focus on ambulance handover and delivery of the four hour target improvements have been implemented resulting in improved performance but this does continue to be a challenge. Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

03 April 2024

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 February 2024 It is recommended that the Board: • notes performance to the end of February 2024

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**
April 2022	Board Seminar – Development Session	Proposed 2022/23 Quality and	Discussion on results of review and agreement on next steps

		Performance Dashboard	
April 2023	Executive Director Team	Proposed Integrated Performance Report	Further discussion on metric inclusion and format of report
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:** Further metrics under the CFO have been added showing performance related to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	3	4	7
Effective	0	1	1
Caring	2	2	4
Responsive	5	18	23
Well-led	2	1	3
Use of Resources	3	2	5
All Domains	15	28	43

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.

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

Integrated Performance Report - March 2024

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
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Responsive	5	18	23
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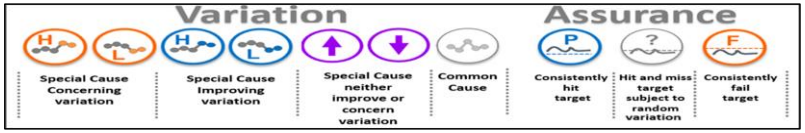
All Domains	15	28	43

Key to SPC Charts:



Issues / limitations

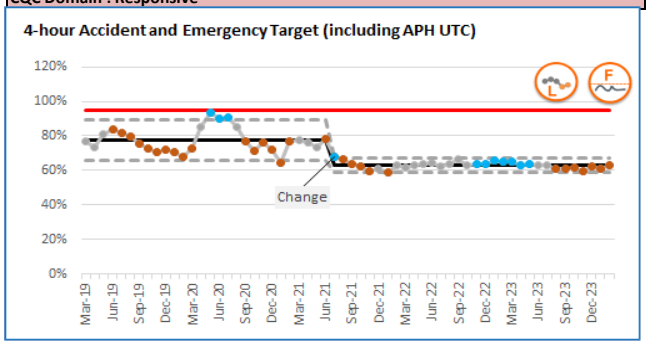
SPC charts should only be used for 15 data points or more. Some of the reported metrics only apply from 2022, so will take time to build up.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included 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
Ambulance handover	Metric calculation amended to show % within time-band
Metrics added under CFO in relation to the Digital Healthcare Team	

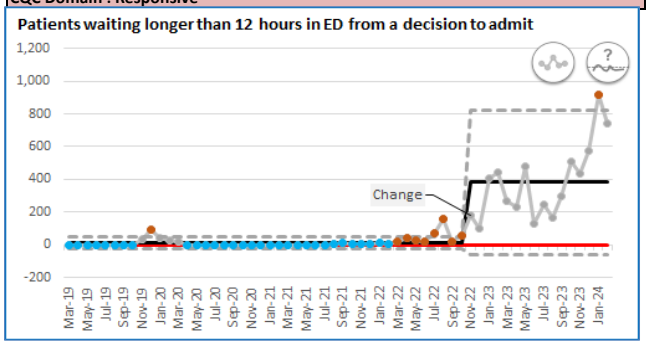
Chief Operating Officer (1)

CQC Domain : Responsive



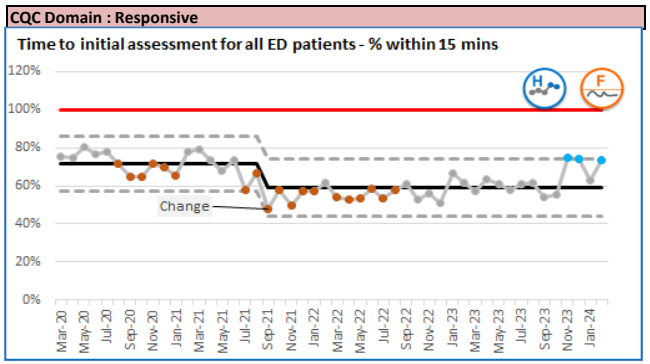
Feb-24
63.0%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



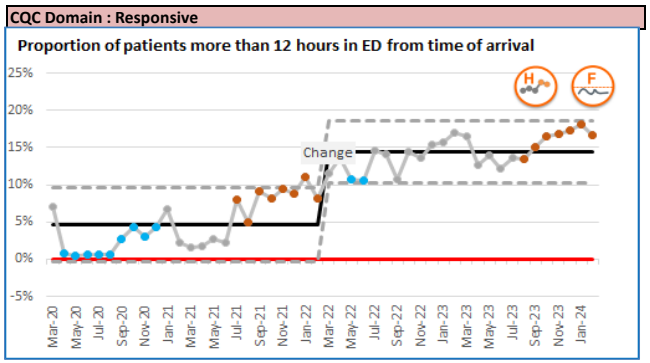
Feb-24
741
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



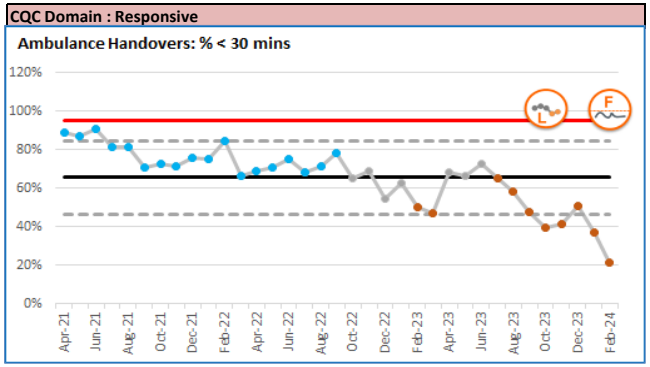
Feb-24
73.3%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



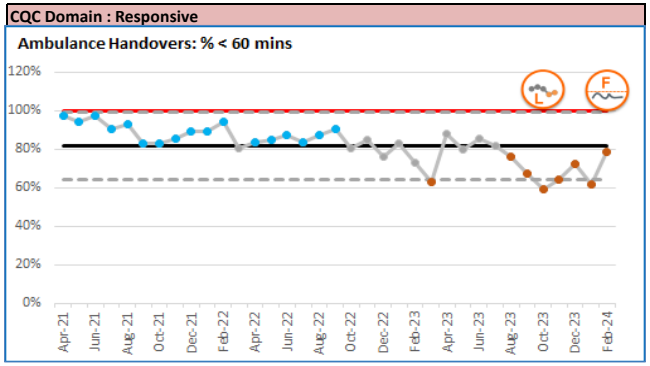
Feb-24
16.7%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



Feb-24
21.2%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

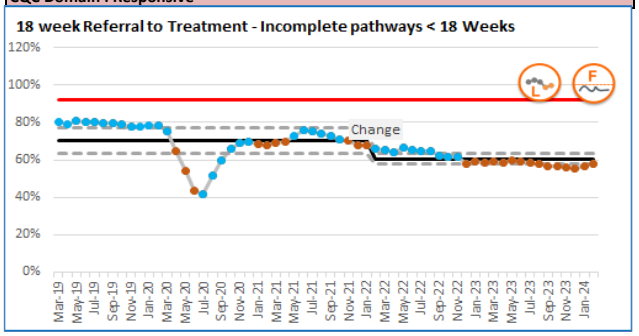
CQC Domain : Responsive



Feb-24
78.8%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target

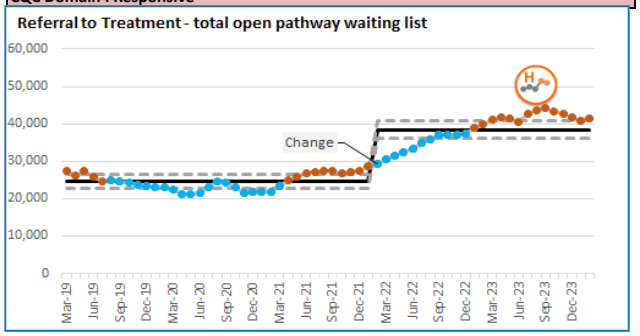
Chief Operating Officer (2)

CQC Domain : Responsive



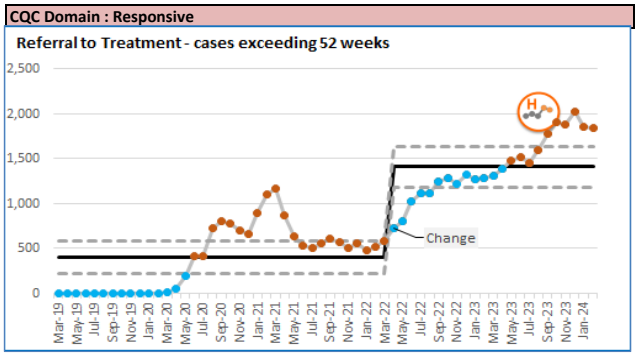
Feb-24
58.07%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



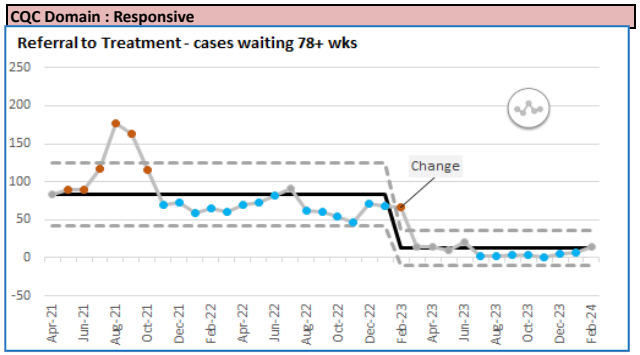
Feb-24
41400
Variance Type
Special cause variation - concerning
Threshold
≤ 37322
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



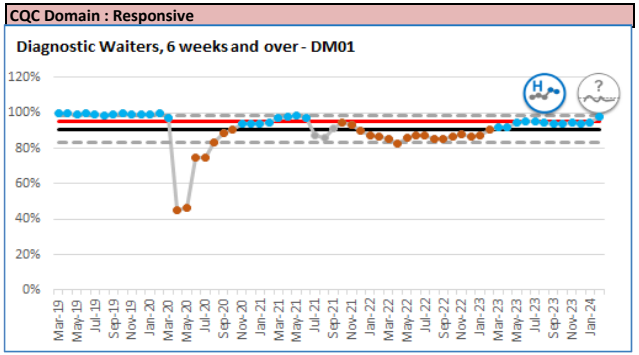
Feb-24
1839
Variance Type
Special cause variation - concerning
Threshold
1060
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Feb-24
14
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

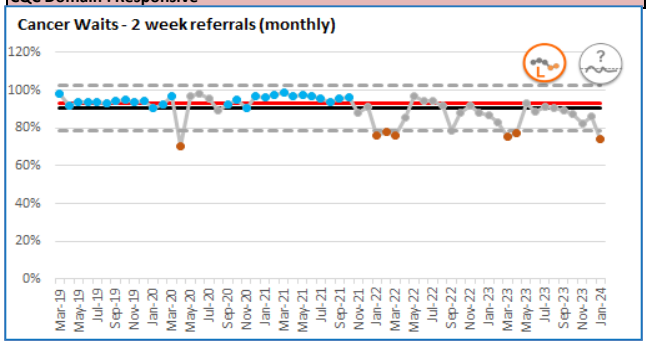
CQC Domain : Responsive



Feb-24
97.6%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

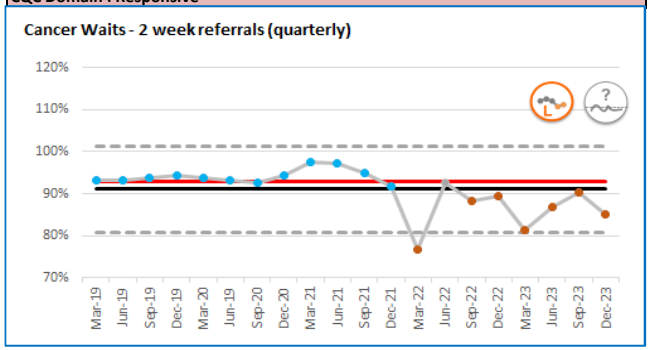
Chief Operating Officer (3)

CQC Domain : Responsive



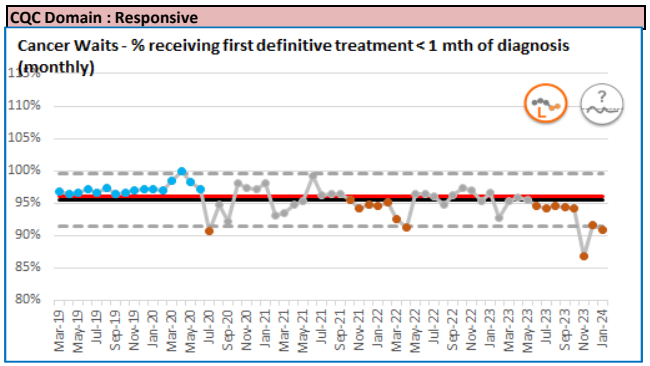
Jan-24
74.4%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



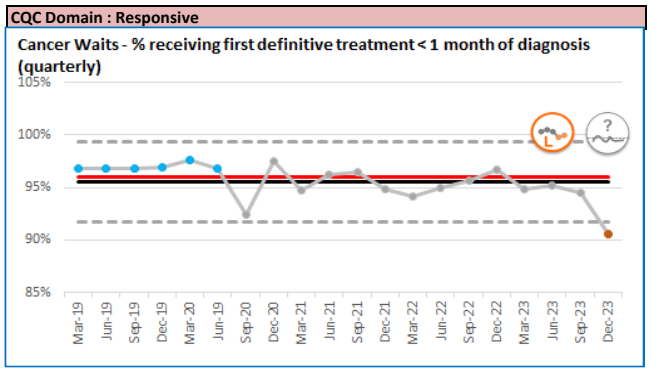
Dec-23
85.1%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



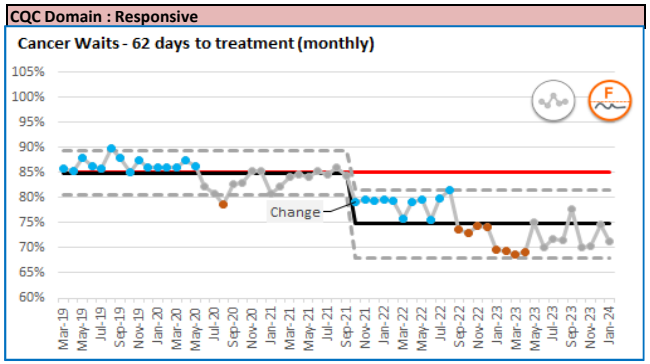
Jan-24
90.9%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



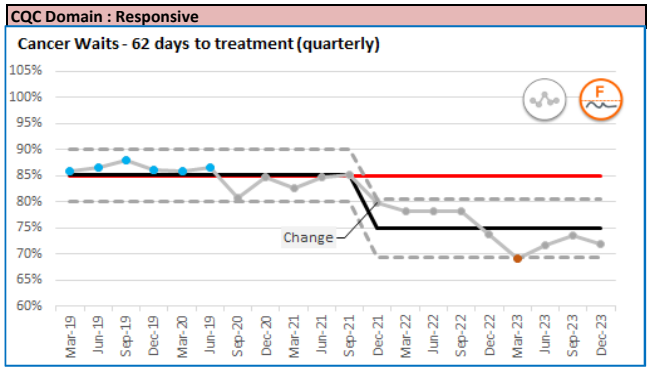
Dec-23
90.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Jan-24
71.3%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

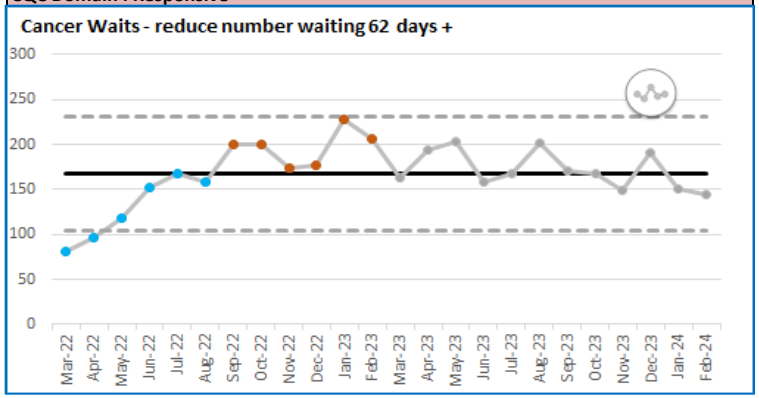
CQC Domain : Responsive



Dec-23
71.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

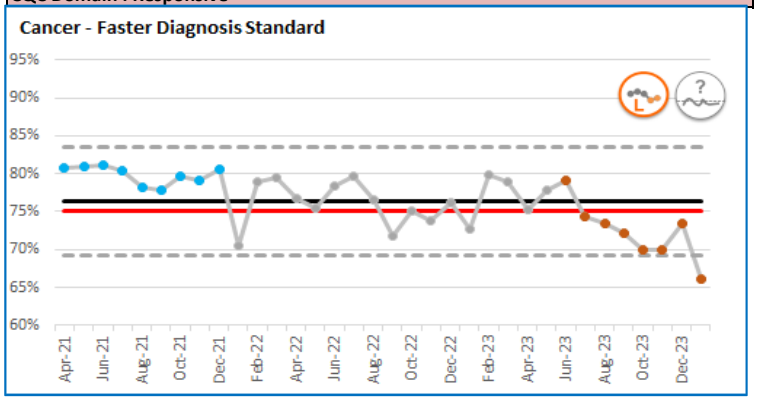
Chief Operating Officer (4)

CQC Domain : Responsive



Feb-24
144
Variance Type
Common cause variation
Threshold
149
Assurance
Trajectory target not appropriate for SPC Assurance reporting

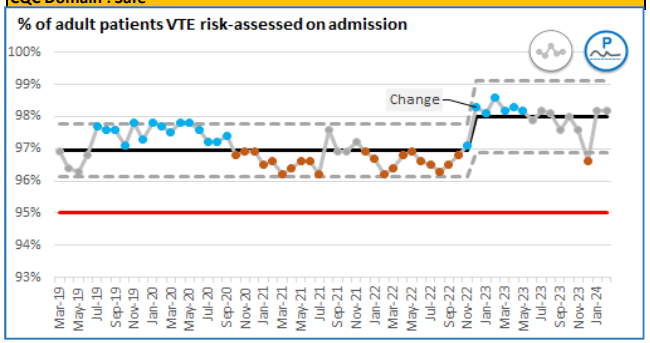
CQC Domain : Responsive



Jan-24
66.1%
Variance Type
Special cause variation - concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

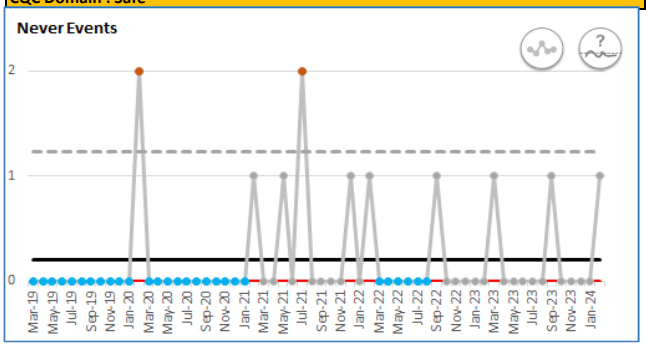
Medical Director (1)

CQC Domain : Safe



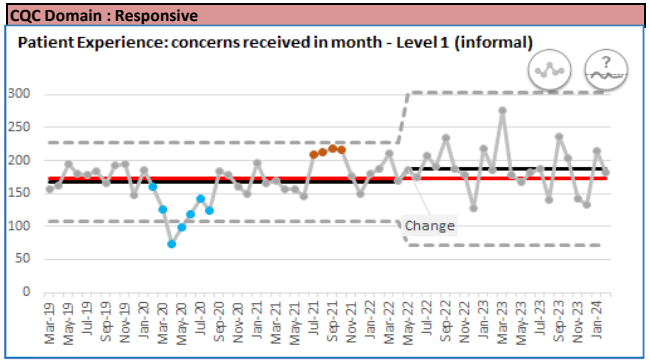
Feb-24
98.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



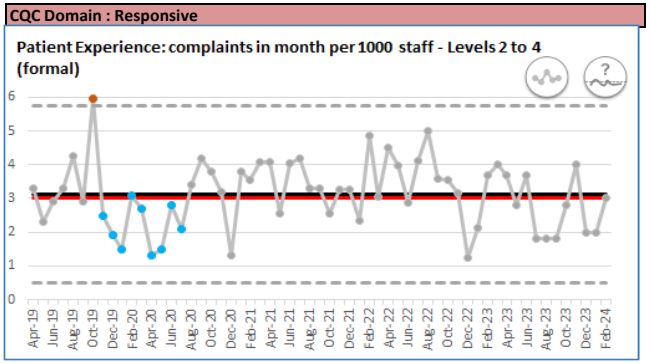
Feb-24
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



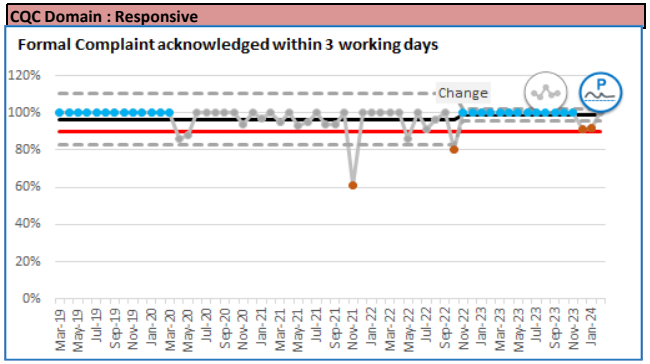
Feb-24
182
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



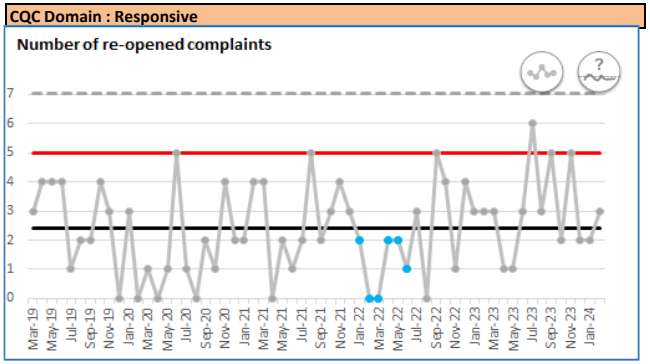
Feb-24
3.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Feb-24
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

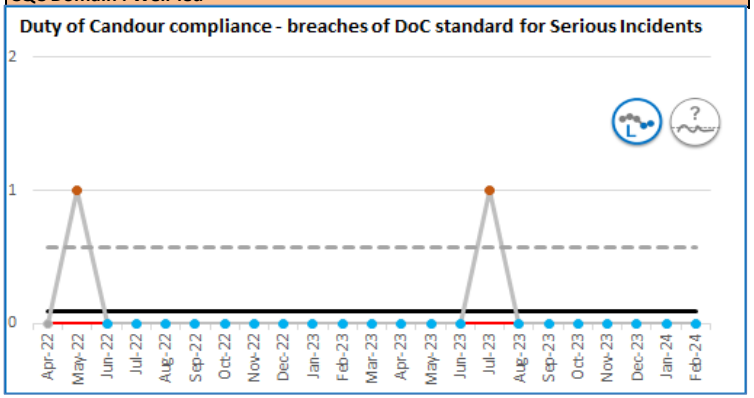
CQC Domain : Responsive



Feb-24
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

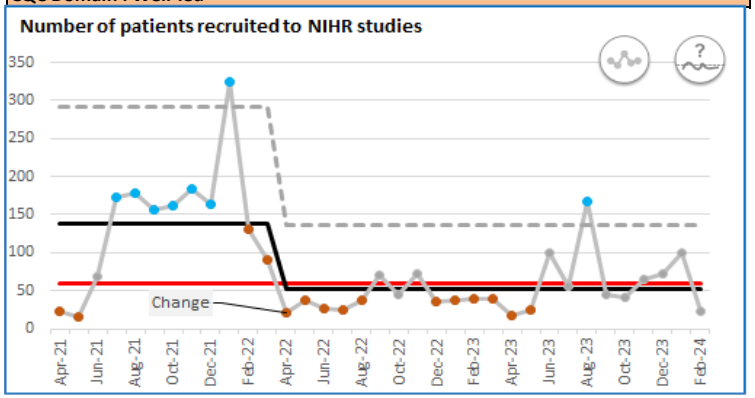
Medical Director (2)

CQC Domain : Well-led



Feb-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

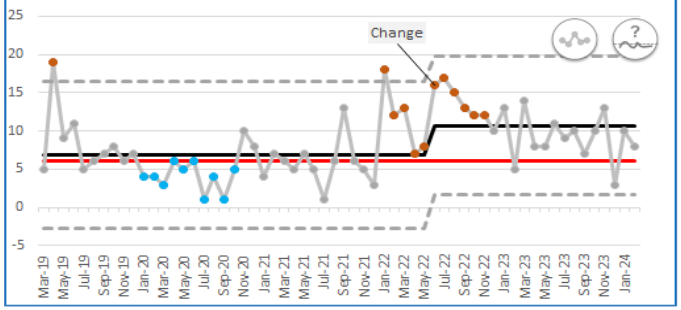


Feb-24
23
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

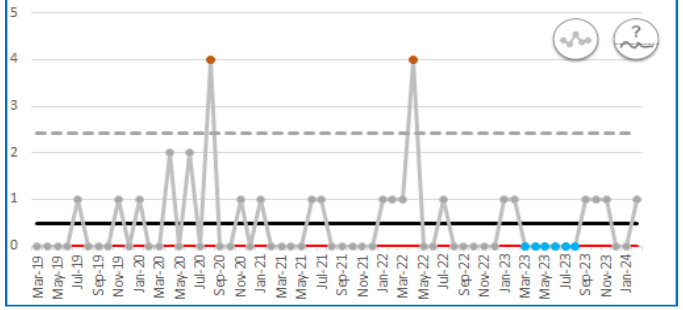
Clostridioides difficile (healthcare associated)



Feb-24
8
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

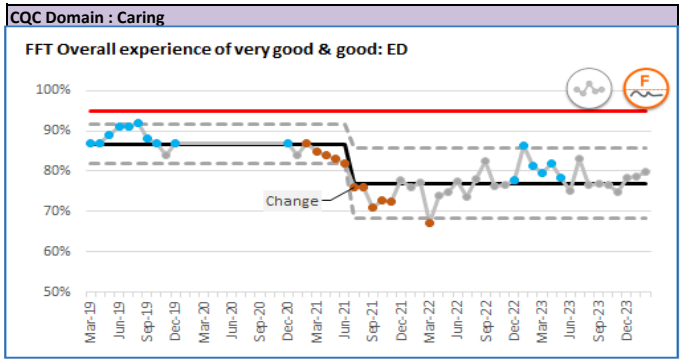
Pressure Ulcers - Hospital Acquired Category 3 and above



Feb-24
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

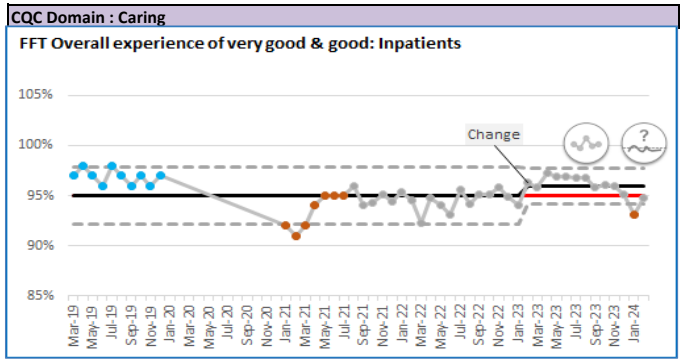
FFT Overall experience of very good & good: ED



Feb-24
79.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

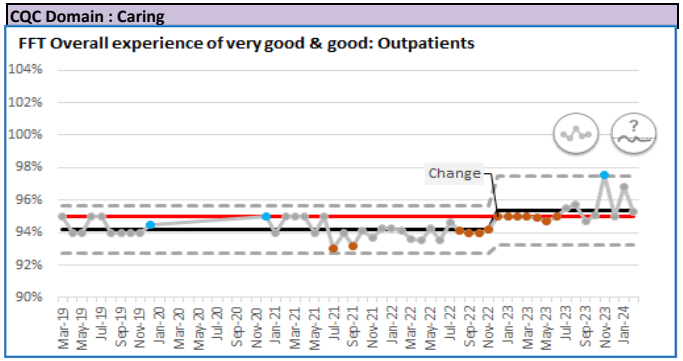
FFT Overall experience of very good & good: Inpatients



Feb-24
94.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

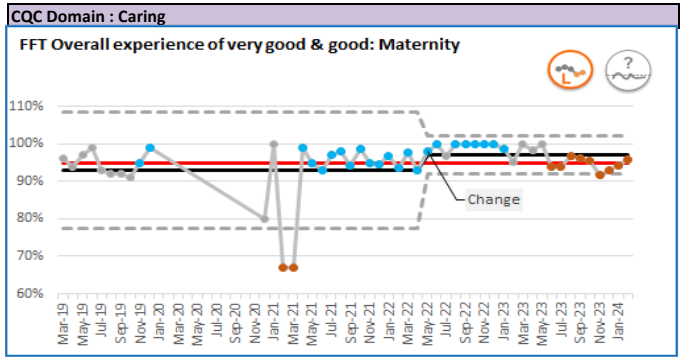
FFT Overall experience of very good & good: Outpatients



Feb-24
95.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Feb-24
95.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – Feb 2024 data

Overall position commentary

A local threshold of 6 *Clostridioides difficile* per calendar month has been set to achieve the year end ambition. In February this was exceeded by 2, having reported 8. Whilst this is 26 infections reported over the year end threshold it is a decrease of 31 when compared to the same period last year.

The 5 key priorities identified that underpin the CDT improvement work continue to be communicated weekly in The Trust bulletin with monthly related themes and newsletters to improve awareness to staff as per the agreed IPC communication and engagement strategy. The theme for February was hand hygiene with emphasis on the 'Gloves are off' campaign.

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.

Actions:

- The Bi-weekly DIPC MDT CDT improvement group continues with learning from *C difficile* rapid evaluations of care discussed and learning disseminated to the divisions.
- Yellow cards have been developed which are handed out to staff who are seen to be not following the trust Hand hygiene policy, the cards detail the principles of the policy and reminds staff that effective hand hygiene helps to keep patients safe by protecting them from infection.
- A presentation was given to the Cheshire & Mersey AMR/IPC group regarding the work we are doing to reduce our rates of CDI which received very good feedback and acknowledgment of all the hard work that is taking place.

Risks to position and/or actions:

- Annual threshold has been exceeded by 26.
- Bed occupancy intermittently inhibits the ability to implement the HPV proactive and reactive 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.

Analysis of the patient comments for inpatient services indicates that their reasons for providing a negative response is linked to their initial experience within ED, highlighting waiting times, delays and communication, these are also the reasons highlighted for negative responses in ED.

Actions:

- Continued focus on providing people with access to provide feedback via FFT:
- 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.
- Whilst car parking continues to be a theme of negative feedback this has shifted from a subcategory of the inability to find a car parking space to frustrations related to pay machines and parking charges. These comments have been shared with the Capital Estates and Facilities Division

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired HA Pressure Ulcers category 3 and above. During February there was one HA Category 3 pressure ulcer reported. A Rapid Evaluation of Care REC has been completed however is awaiting presentation, initial findings suggests that regular skin checks were not in place due to IA which was incident reported. The patient had a learning disability and was reported to be self-mobile however may have benefited from an air mattress at an earlier stage.

Actions:

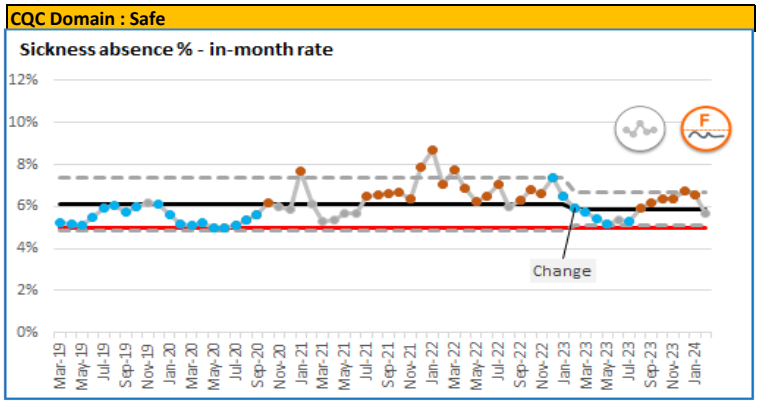
Increase awareness on the importance of timely skin inspections to be shared at the safety huddle.
Trust wide implementation of Purpose T as its Pressure ulcer risk assessment will replace Braden from the 1st April 2024.
The Trust has an overarching Trust Pressure Ulcer improvement plan with Divisional specific improvement plans identifying divisional themes and trends.
Review underway in relation to documentation provisions with Cerner system to streamline documentation.

Risks to position and/or actions:

Changes to national reporting for wound classification will be implemented from 1st April 2024 which will remove the classification of Unstageable. These historical unstageable will automatically be classified as a Cat 3 which will result in an increased prevalence for the Trust.

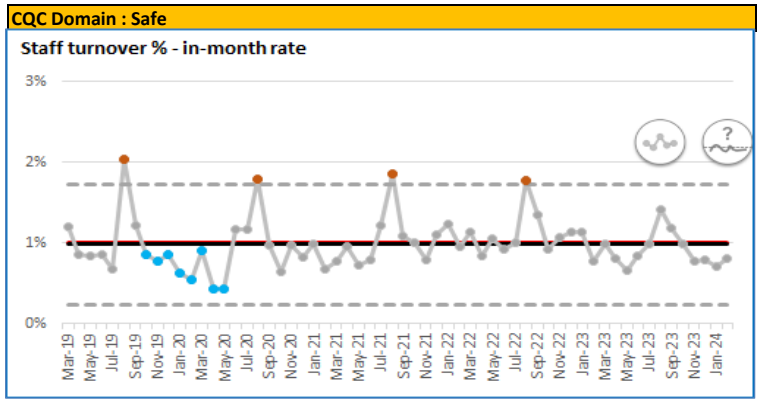
Chief People Officer

CQC Domain : Safe



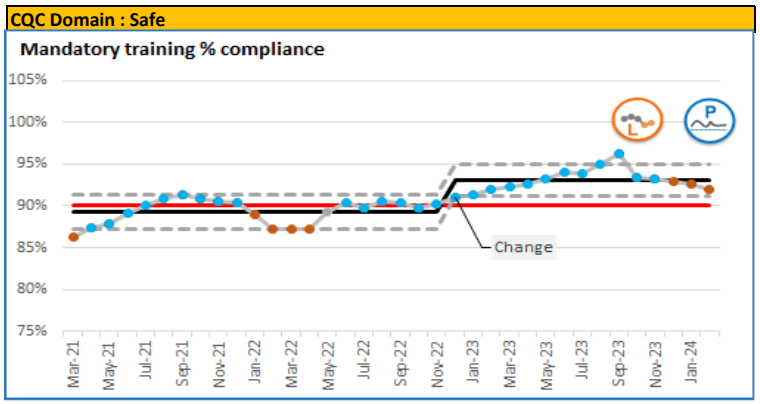
Feb-24
5.64%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



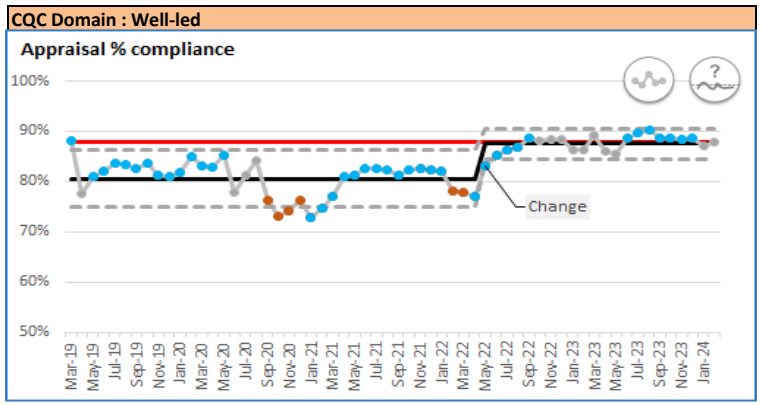
Feb-24
0.81%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Feb-24
91.99%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Feb-24
87.85%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for March 2024 BoD

Overall position commentary

Despite seasonal pressures and strike action, the Trust's People KPIs for mandatory training and turnover remain on target and continues to be achieved.

Appraisal compliance has been adversely impacted by strike action and remains slightly below target. Sickness absence also remains above target although there has been a significant improvement in month.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For February 2024 the indicator improved and is at 5.64%, which is an improvement of 0.9% from the previous month.

The improvement in the position is still mainly driven by a decrease in short term sickness absence, and significant improvements in Estates and Facilities Directorate and Medicine Division.

Focus remains on supporting the health and wellbeing of our staff. A number of measures are in place to offer enhance support, boost morale, support mental and physical wellbeing, and help build resilience.

Actions:

- Health Surveillance policy and programme re-launched Trust wide.
- Attendance Management Policy awareness sessions delivered as part of the new policy launch.
- Flu Vaccination programme continues and will conclude at the end March 2024.
- Division led engagement events held throughout March to share staff survey results and enable teams to shape plans for improvement.
- Ongoing promotion of the Trust's EAP has resulted an increase in utilisation up to 26%.
- Occupational Health referral and treatment times have improved.
- Increased Psychotherapy sessions have been made available.
- Occupational Health and Wellbeing staff now deliver sessions at induction, Managers Essentials and the Preceptorship Programme.
- Seasonal absence pattern letters will be issued by HR Services ahead of the Easter period.
- 18-24 March is Neurodiversity celebration week and a calendar of free events are taking place.
- Building Emotional Resilience sessions continue. New sessions start in April focusing on Low Mood, Social Anxiety, PTSD and Health Anxiety.

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 promotion 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. Work has commenced on refining year 3 deliverables which will include delivering against the Grow OH and Wellbeing strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of February 2024 compliance remains below the threshold at 87.85%, demonstrating common cause variation. Acute Care Division (84.20%) and Medicine Division (83.35%) are the only divisions below target.

- Whilst the introduction of the new appraisal approach (launched in April 2023) has had a positive impact upon appraisal compliance, a drop in compliance from January 2024 can be attributed to the impact of industrial action. Divisional leaders have committed to restoring compliance by April 2024.

Actions:

- Divisional leaders and HR continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team contacts all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and ‘on-demand’ learning resources that brief staff and managers on the new process.
- A new appraisal ‘portlet’ has been developed in collaboration with the national ESR Team. This makes recording appraisal easier for managers with a short step by step video to assist them in recording appraisals.

- The Learning and Development Team have offered short-term interim support to divisions to support with recording of appraisals during periods of significant system pressures and ongoing industrial action.

Risks to position and/or actions:

- Ongoing system pressures and industrial action continues to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness sessions for teams / services that are particularly lower in compliance.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
Annual Review
April 2024

Contents

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

1. Introduction

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

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

Baker Tilly 2021

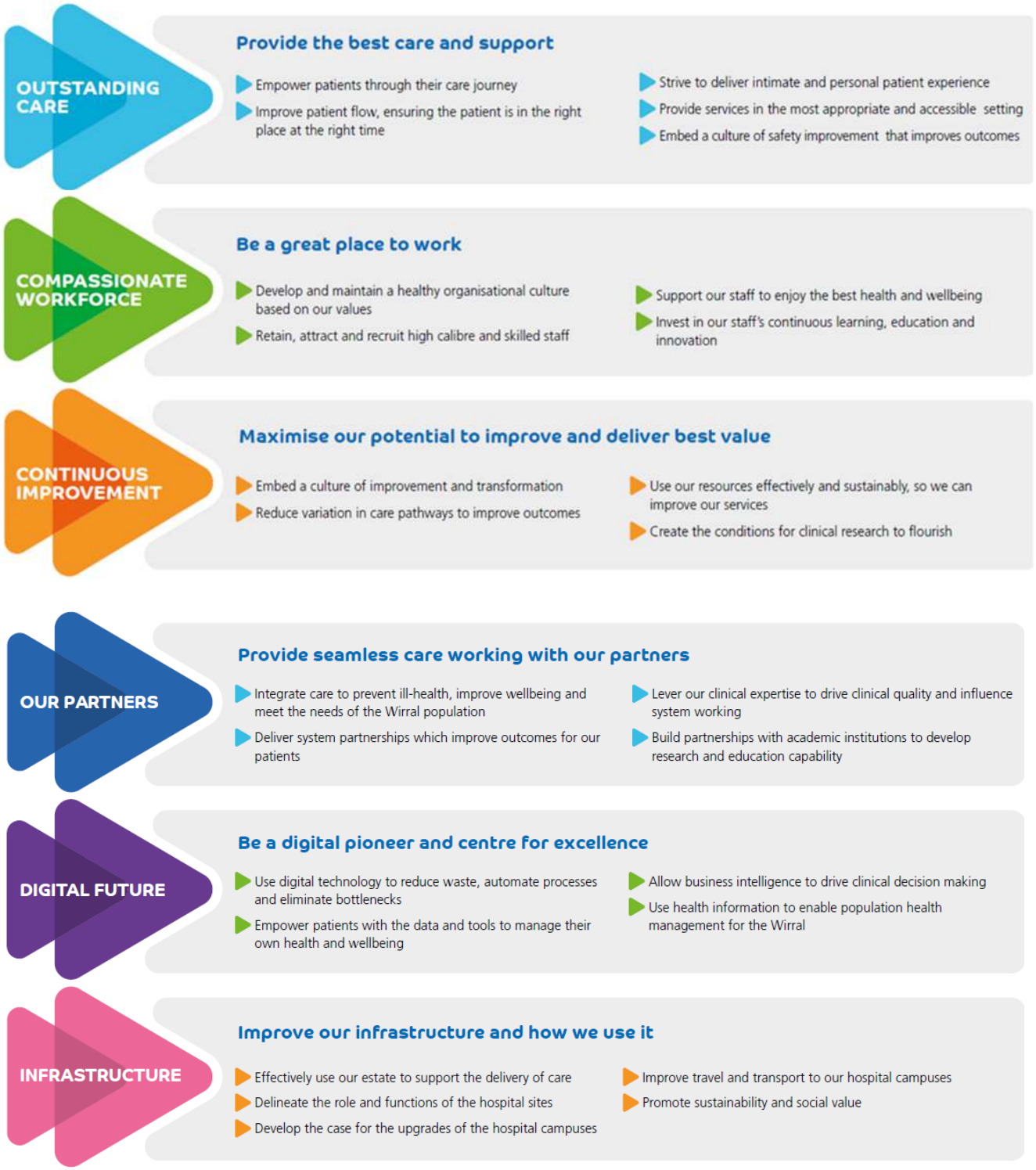
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

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

The Trust 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. The BAF is updated on a bi-monthly basis and subject to a full refresh on an annual basis.

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) circulation to Divisional Boards for information and to raise awareness; and
- Reporting to each meeting the Risk Management Committee.

5.3 Annual Refresh 2024

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.

The timeline for this refreshment has been as follows:

- Initial review by the Executive Team – 12th March;
- Presentation to Divisional Boards – Ongoing throughout February and March;
- Initial consideration by Risk Management Committee – 12th March;
- Committee consideration throughout March;
- Board review and approval (along with the Risk Management Strategy) – 3rd April.

6. Update Report

6.1 Annual Review

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 review, changes have been incorporated into the BAF as part of this annual refresh. This has included the addition of new risks, the removal of 1 risk and the merging of current risks.

The key changes are as follows:

- Old risks 5 and 6 in relation to Compassionate Workforce have been merged.
- Refreshed risk 6 has been updated to incorporate CIP.
- New Risk 7 has been added to ensure a single risk in relation to Digital Planning and Infrastructure.
- Risk 10 has been refreshed to separate out Digital from Estates Infrastructure.
- Risk 11 has been updated to ensure a single risk in relation to Business Continuity.
- Risk 12 is a new risk included to highlight the increasing agenda around Health Inequality.

Work will now be completed to set current scores and future targets for each risk. This will be fully reported for approval to the next Board meeting in May.

6.3 Risk Appetite and Risk Maturity

The report includes the current position of the Trust in relation to Risk Appetite and Maturity.

A separate workshop is currently being arranged to enable the Board to consider the up to date position in regard to future risk appetite and current levels of maturity.

6.4 Recommendations

Board is asked to:

- Consider and Approve the proposed changes to the BAF for 2024;
- Note the current position in regard to Risk Appetite and Risk Maturity;
- Note the process for rescoring risks which will be reported from the next meeting.

Board Assurance Framework Dashboard							
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score (I and L)**	**Current (I and L)**	**Target (I and L)**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unreasonable 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)	
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 (4 x 3)	
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 and Board	16 (4 x 4)	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)	
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users. **MERGED RISK.**	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	
Continuous Improvement **R, O, F**	6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans. **UPDATED RISK.**	Chief Finance Officer	Finance	16 (4 x 4)	12 (4 x 3)	
Digital Future **R, O, F**	7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience. **NEW RISK.**	Chief Finance Officer	Finance			
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains quality and service improvements 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)	
Our Partners **R, S, F**	9	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)	
Infrastructure **R, O, C, F**	10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience. **UPDATED RISK.**	Chief Strategy Officer	Capital and Board	16 (4 x 4)	12 (4 x 3)	
Infrastructure **R, O, C**	11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care. **UPDATED RISK.**	Chief Strategy Officer	Finance and Board	16 (4 x 4)	12 (4 x 3)	
Our Partners **R, O, C, F**	12	Failure to reduce health inequalities across the Wirral population by working in partnership with stakeholders to achieve the aims of the Joint Forward Plan. **NEW RISK.**	TBD	Board			

Removed Risk: "Failure to have strong leadership and governance systems in place".

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

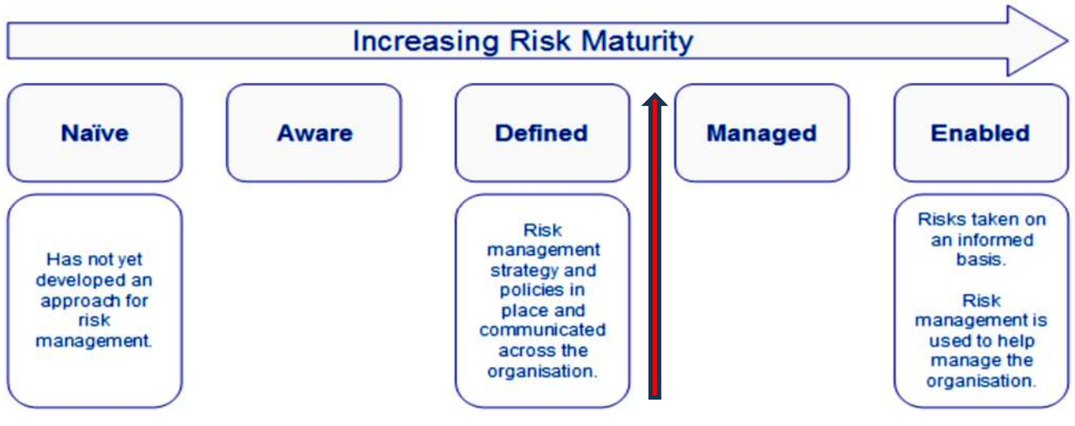
Use table 1 to determine the consequence score(s) (C)
Use table 2 to determine the likelihood score(s) (L)
Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
Assign grade of risk according to risk score.

	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

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.



Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

03 April 2024

Title	Monthly Maternity and Neonatal Services Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director, Deputy Chief Executive Officer (CEO)
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 March 2024, 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).

The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard.

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (February 2024) key quality and safety metrics.

It is recommended that the Board:

- 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

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**
March 2024	Maternity & NNU Assurance Board	Monthly Maternity and Neonatal Services Report	For information

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (February 2024) 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. The Maternity Services Data Set publications have a lag of circa three months. 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. Maternity has initiated in addition to Maternity and Newborn Safety Investigations (MNSI) an external review initiated there were three term still births in the later end of 2023. An update will be provided at the next quarterly Maternity and Neonatal Services report to the findings. Maternity and Neonates has initiated a thematic review following six neonatal deaths in the postnatal period. An update will be provided at the next quarterly Maternity and Neonatal Services report to the findings.

2	Serious Incidents (SI's) & Maternity and Newborn Safety Incidents (MNSI)
	Patient Safety Incident Investigations (PSSI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in February 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date fice cases are undergoing review.

	There were no Patient Safety Investigation Incidents (PSII's) declared in February 2024 for Neonatal services.

3	Implications
3.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
3.2	**People** • MIS Year 5 compliance has been met against all 10 safety actions demonstrating evidence delivering high quality care. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.
3.3	**Finance** • In order to meet the compliance of MIS Year 6 and delivery of Maternity Continuity of Care as the default model, investment into the maternity and neonatal workforce is required and funding options are being explored. • Funding that has been awarded for specific initiatives has bene committed to and improvements programmes in progress.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report Feb 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	Yes	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to October 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate.
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; thematic review requested as 6 NN deaths from Dec 2023 - March 2024
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	na	No PSSI's reported in February 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and ambition to achieve 100% compliance by 31/3/24
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	All vacacnies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. Current vacancy rate <2.5%, likely to rise between April - October 2024 as recruitment will rely on newly quaified midwives
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024; Awaiting Year 6 publication due April 2024; Letter sent to advise what will not be included but no detail on additions
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 6 teams in total and two approach model in place; comparison data / research underway
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in January 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

NHS Maternity Services Survey 2023 Benchmark Report

Wirral University Teaching Hospital NHS Foundation Trust

NHS

Care Quality Commission

Ipsos

Contents

1. Background & methodology
2. Headline results
3. Benchmarking
   - Section 1. Antenatal care
   - Section 2. Labour and birth
   - Section 3. Postnatal care
4. Trends over time
   - Section 4. Antenatal care
   - Section 5. Labour and birth
   - Section 6. Postnatal care
5. Appendix

Background and methodology

This section includes:

- explanation of the NHS Patient Survey Programme
- information on the 2023 Maternity Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2023 Maternity Survey will be the tenth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The 2023 Maternity Survey

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 63,271 people who used maternity services were invited to participate in the survey across 121 NHS trusts.

Completed responses were received from 25,515 maternity service users, an adjusted response rate of 41%.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2023. If there were fewer than 300 people within an NHS trust who gave birth in February 2023, then births from January were included.

In larger trusts, all eligible individuals from ethnic minority backgrounds, who had a live birth between 1 and 31 January and 1 and 31 March 2023 were invited to participate. A full list of eligibility criteria can be found in the survey sampling instructions.

Fieldwork took place between May and August 2023.

Trend data

In 2021, the Maternity Survey transitioned from a solely paper based methodology to both paper and online. This dual approach was continued in 2022 and 2023.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2022 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2022 data.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and methodology (continued)

Antenatal and Postnatal data

The Maternity Survey is split into three sections that ask questions about:

- antenatal care
- labour and birth
- postnatal care

It is possible that some maternity service users may have experienced these stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 121 NHS trusts that took part in the survey.

Trusts were asked to carry out an "attribution exercise", where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2023, 121 of the 121 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Limitations of this approach

Data is provided voluntarily. In 2023, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in profiles between trusts. For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity service users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10 (except for questions B3 and D8). A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive, and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C3). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to). This is to prevent individual responses being identifiable.

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into **five** sections:

1. Background and methodology – provides information about the survey programme, how the survey is run and how to interpret the data.

2. Headline results – includes key trust-level findings relating to the service user who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

3. Benchmarking – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/ or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

4. Trends over time – includes your trust's mean score for each evaluative question in the survey. This is either shown as a historical trend chart or a significance test table, depending on the availability of longitudinal data.

Where possible, significance testing compares the mean score for your trust in 2022 to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.

Historical trends are presented where data is available, and questions remain comparable for your trust. Trends are presented only where there are at least five data points available to plot on the chart. Historical trend charts show the mean score for your trust by year, so that you can see if your trust has made improvements over time. They also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not.

Significance test tables are presented where there are less than 5 data points available, and questions remain comparable between 2022 and 2023.

5. Appendix – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

Using the survey results (continued)

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: http://www.cqc.org.uk/maternitysurvey
- National and trust-level data for all trusts who took part in the 2023 Maternity Survey: https://nhssurveys.org/surveys/survey/04-maternity/year/2023. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors services: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

300 invited to take part

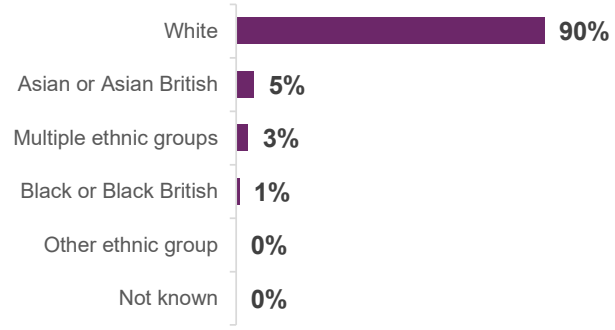
115 completed

39% response rate

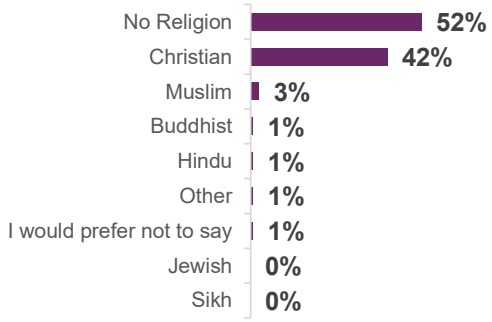
41% average trust response rate

43% response rate for your trust for 2022

ETHNICITY



RELIGION



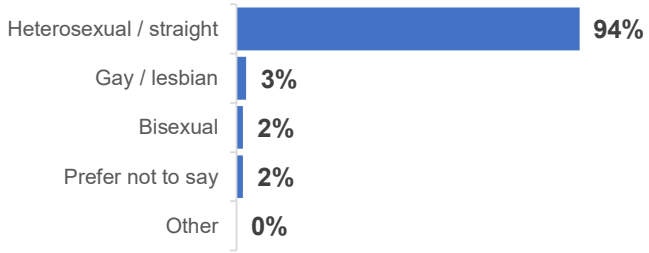
PARITY

How many babies have you given birth to before this pregnancy?

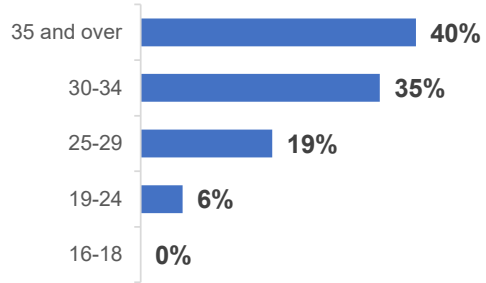
of respondents gave birth to **their first baby.**

SEXUALITY

Which of the following best describes how you think of yourself?



AGE

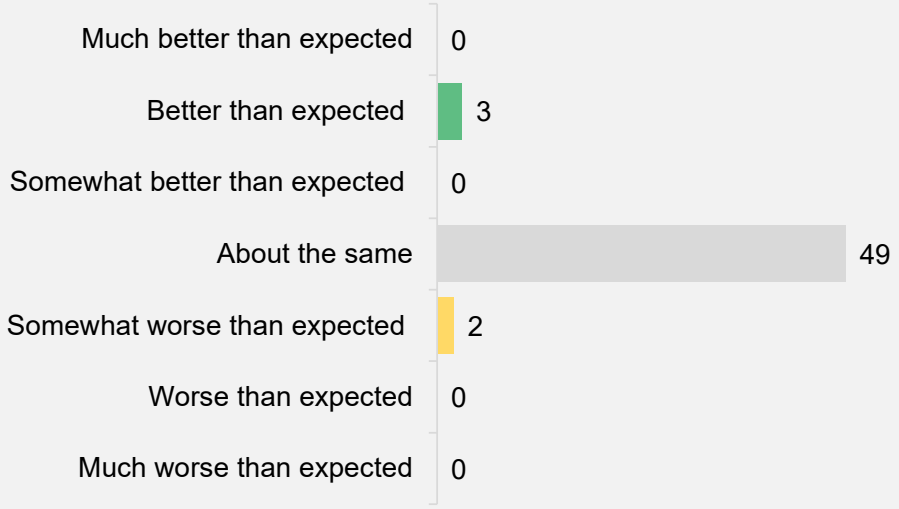


Please note that demographic information is unweighted.

Summary of findings for your trust

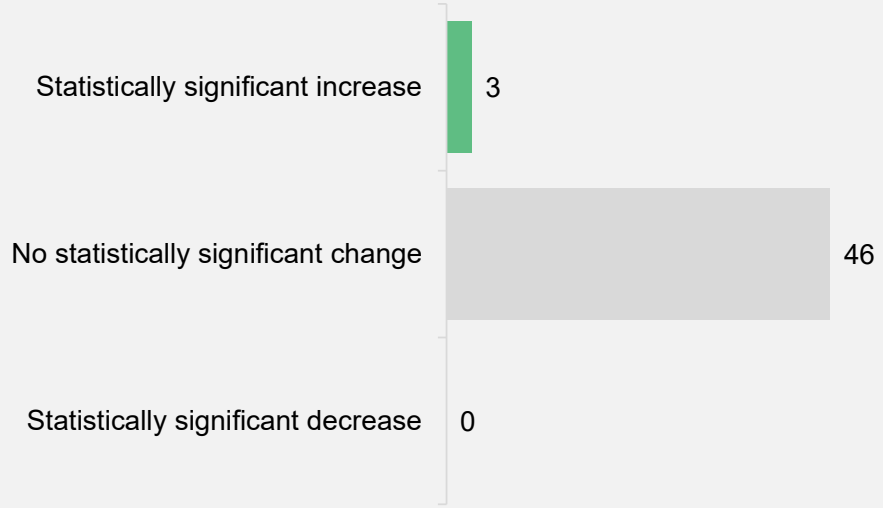
Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.



Comparison with results from 2022

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2022 results.



For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

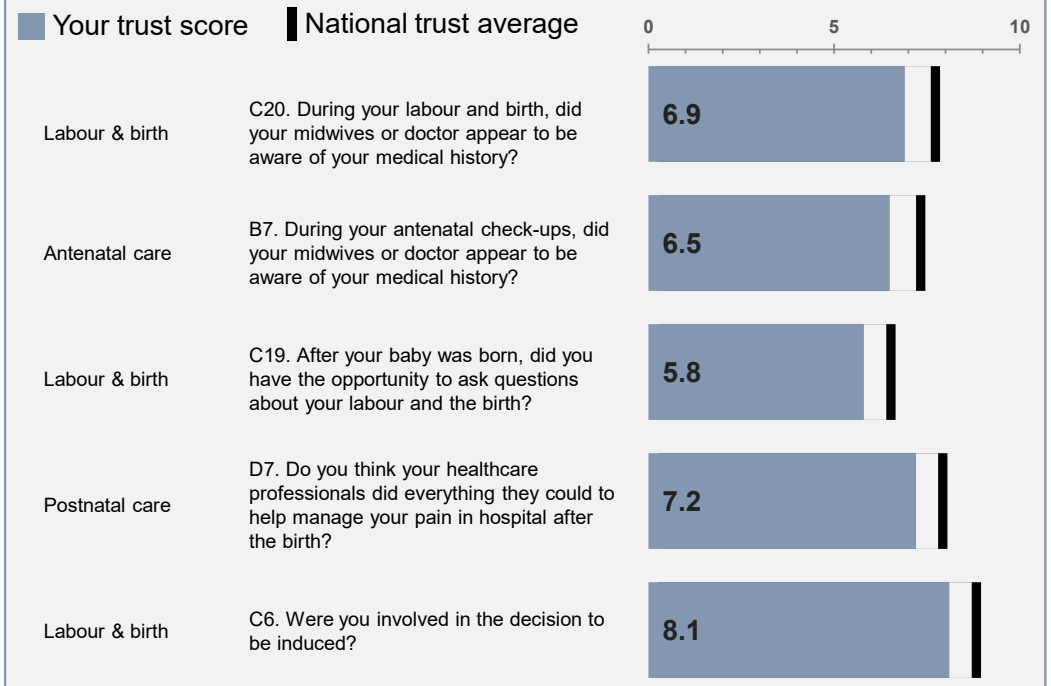
Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with average trust score across England)

Bottom five scores (compared with average trust score across England)



Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts
- for more guidance on interpreting these graphs, please refer to the appendix

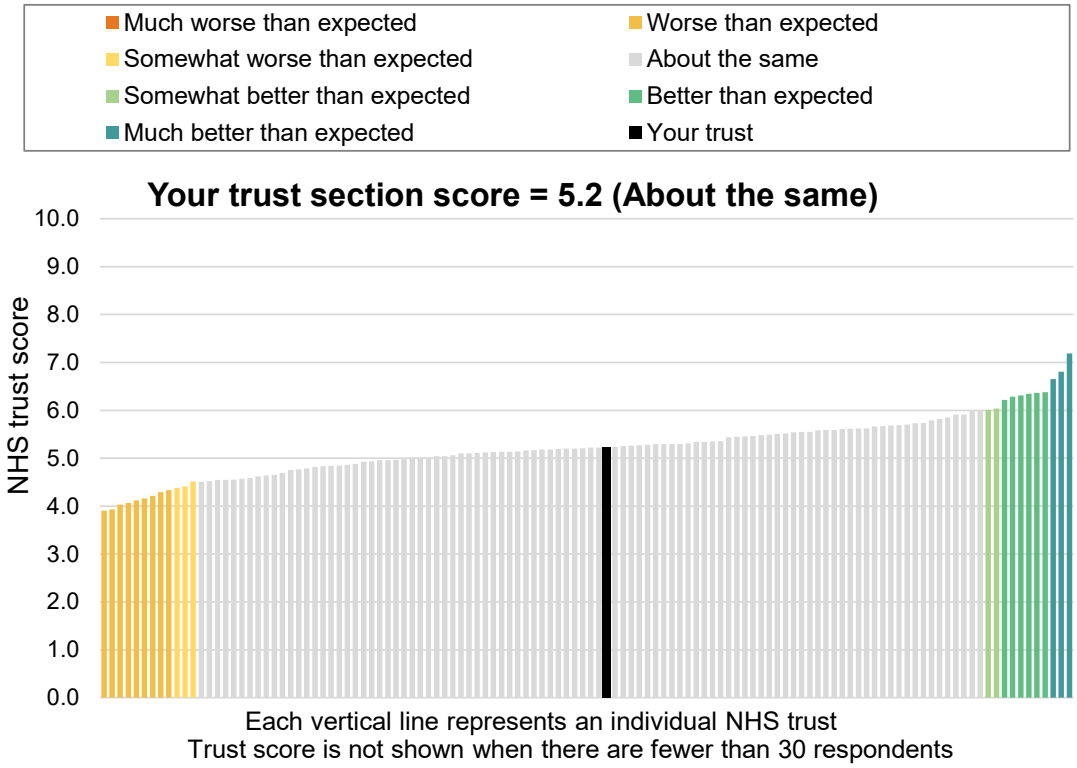
Benchmarking

Antenatal care

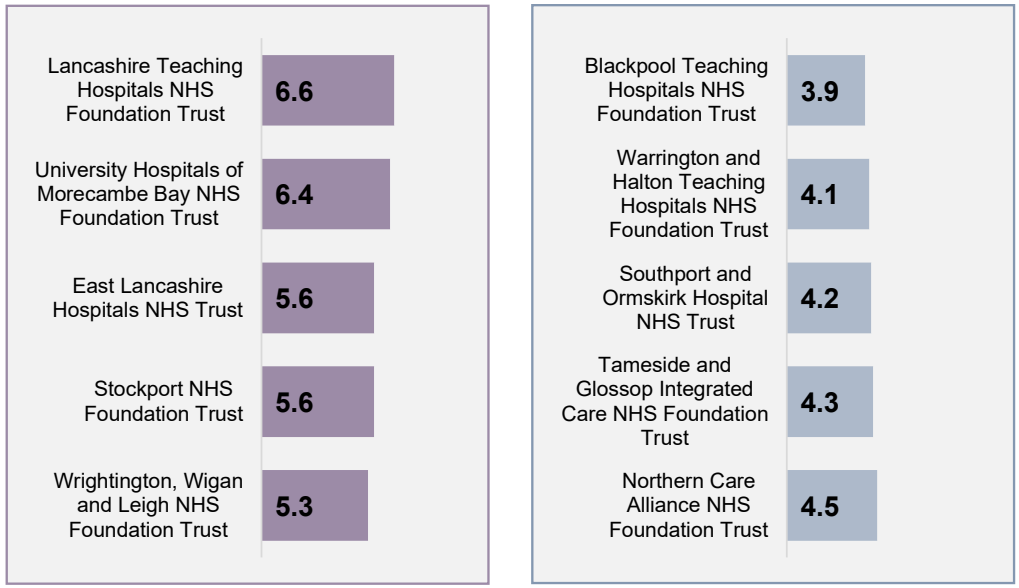
The start of your care during pregnancy

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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

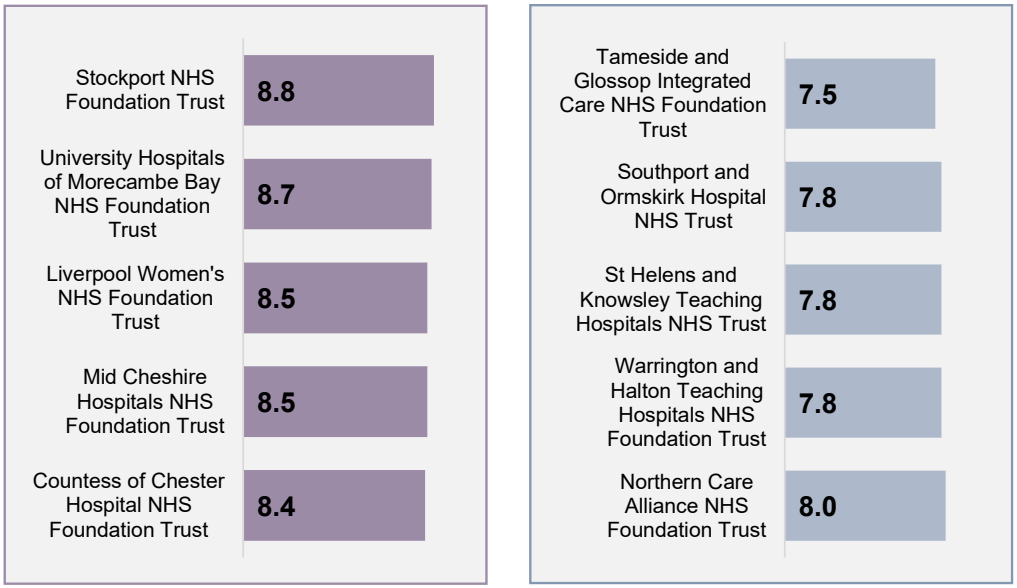


Antenatal check-ups

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B7 to B10. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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

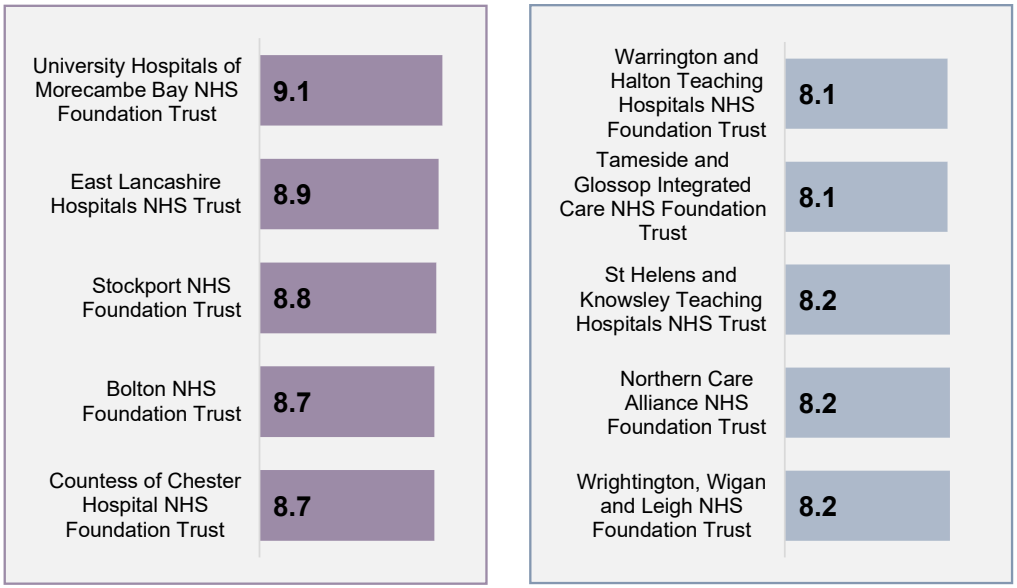


During your pregnancy

Section score

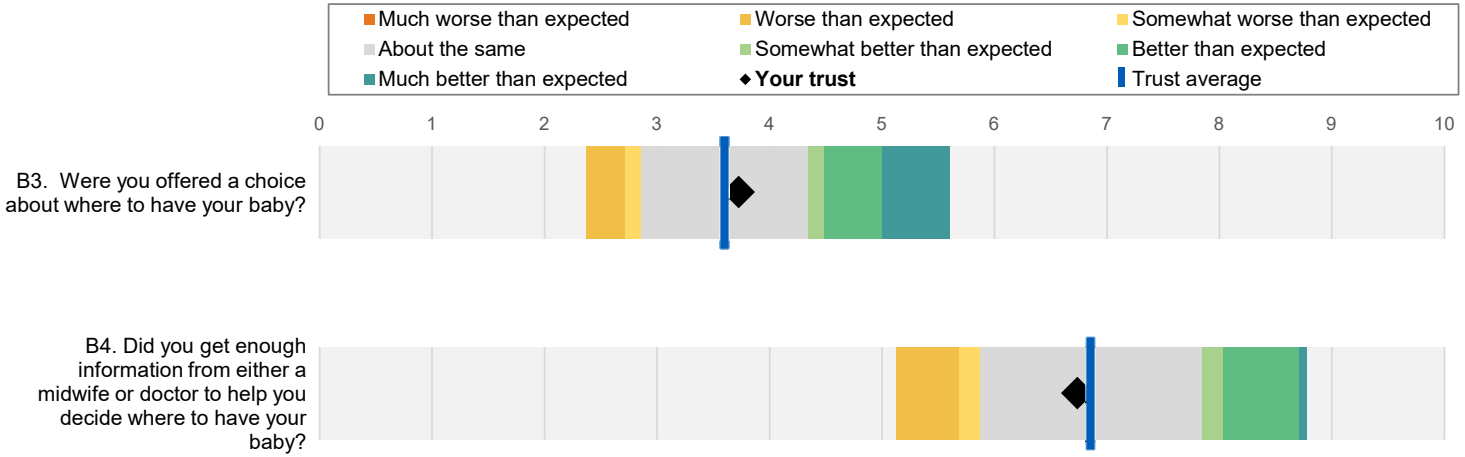
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B11 to B18. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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



Benchmarking - Antenatal care

Question scores: Start of your pregnancy

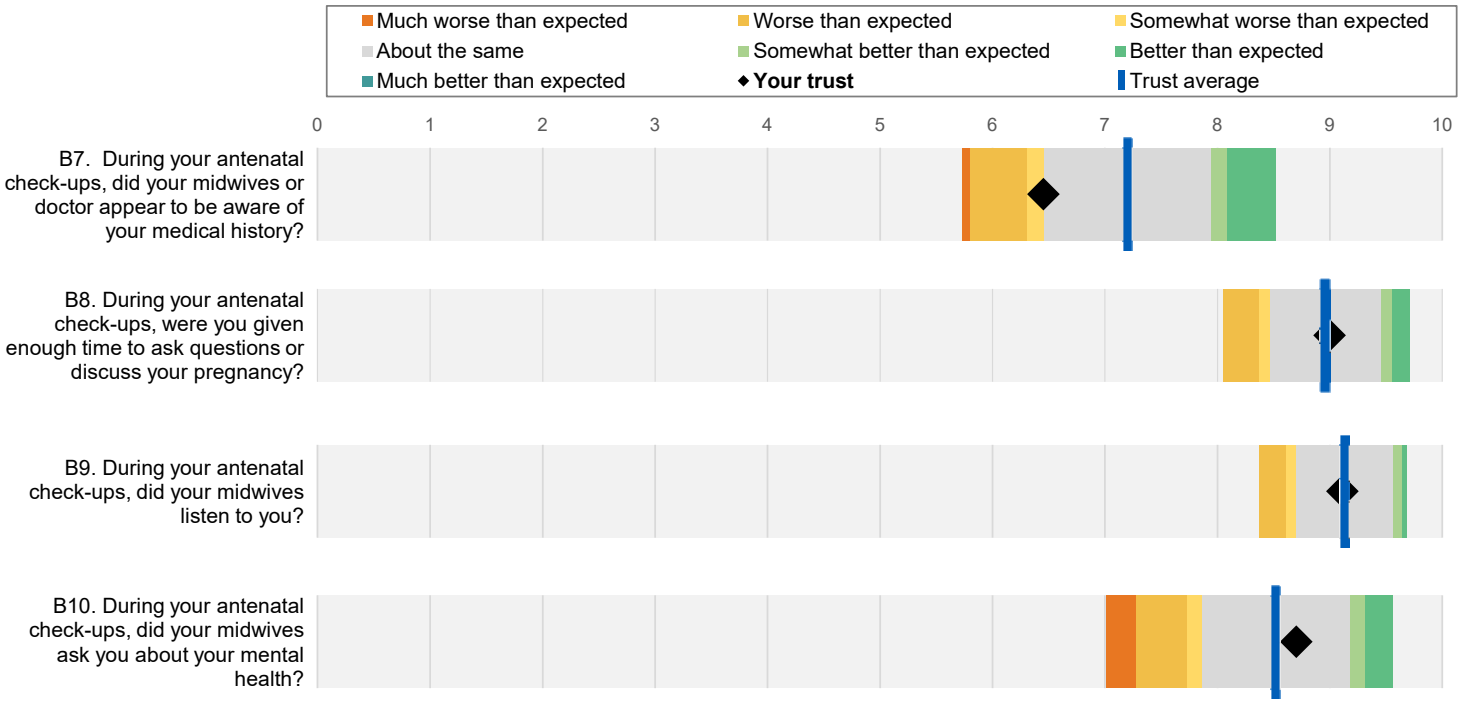


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
99	3.7	3.6	2.4	5.6
105	6.7	6.9	5.1	8.8

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: Antenatal check-ups



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	106	6.5	7.2	5.7	8.5
B8. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	111	9.0	9.0	8.1	9.7
B9. During your antenatal check-ups, did your midwives listen to you?	111	9.1	9.1	8.4	9.7
B10. During your antenatal check-ups, did your midwives ask you about your mental health?	111	8.7	8.5	7.0	9.6

Somewhat worse

About the same

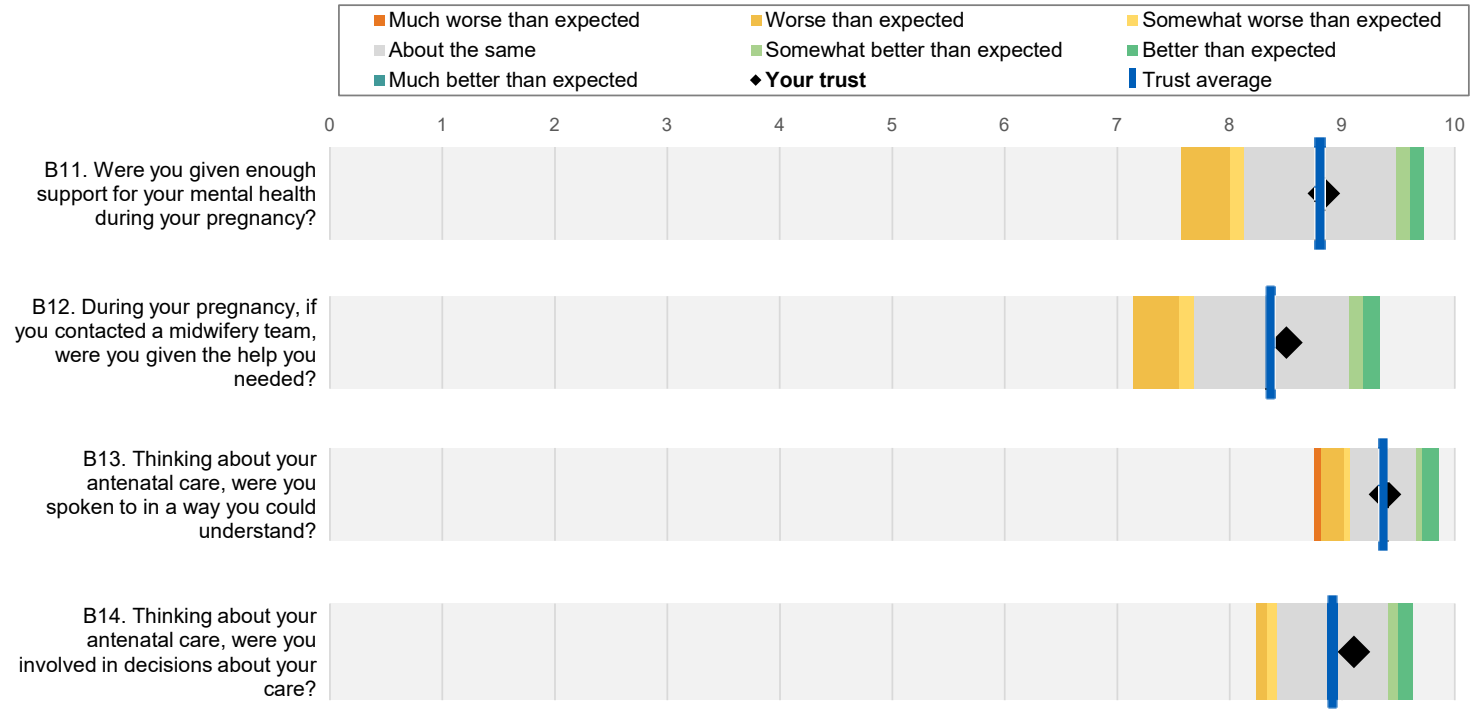
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	74	8.8	8.8	7.6	9.7
About the same	103	8.5	8.4	7.1	9.3
About the same	112	9.4	9.4	8.8	9.9
About the same	109	9.1	8.9	8.2	9.6

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy

		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B15. During your pregnancy did midwives provide relevant information about feeding your baby?	110	6.6	7.1	5.2	8.6
B16. Did you have confidence and trust in the staff caring for you during your antenatal care?	112	8.6	8.4	7.1	9.4
B17. Thinking about your antenatal care, were you treated with respect and dignity?	112	9.3	9.3	8.3	9.9
B18. If you raised a concern during your antenatal care, did you feel that it was taken seriously?	72	8.4	8.8	7.4	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

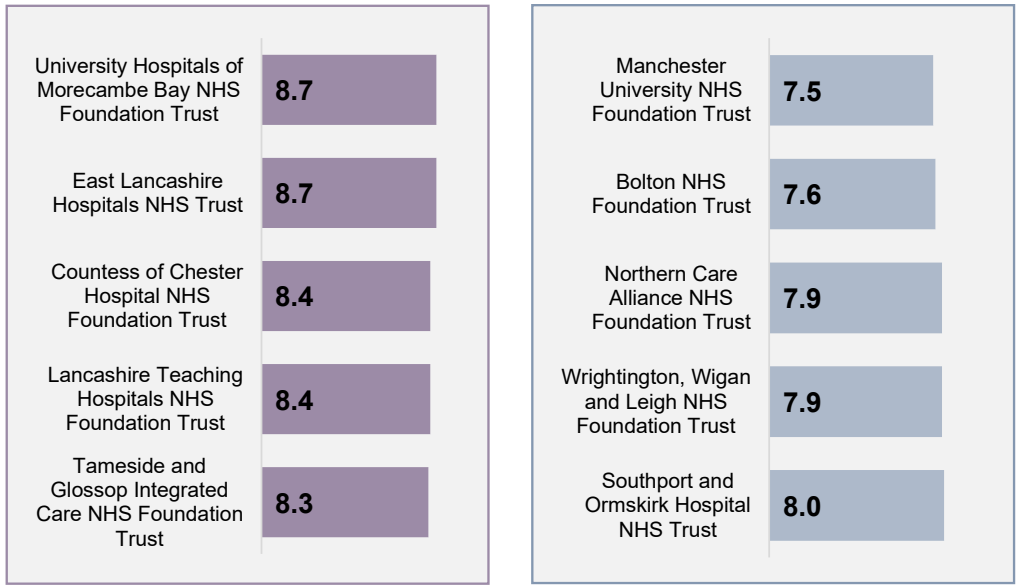
Labour and birth

Your labour and birth

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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

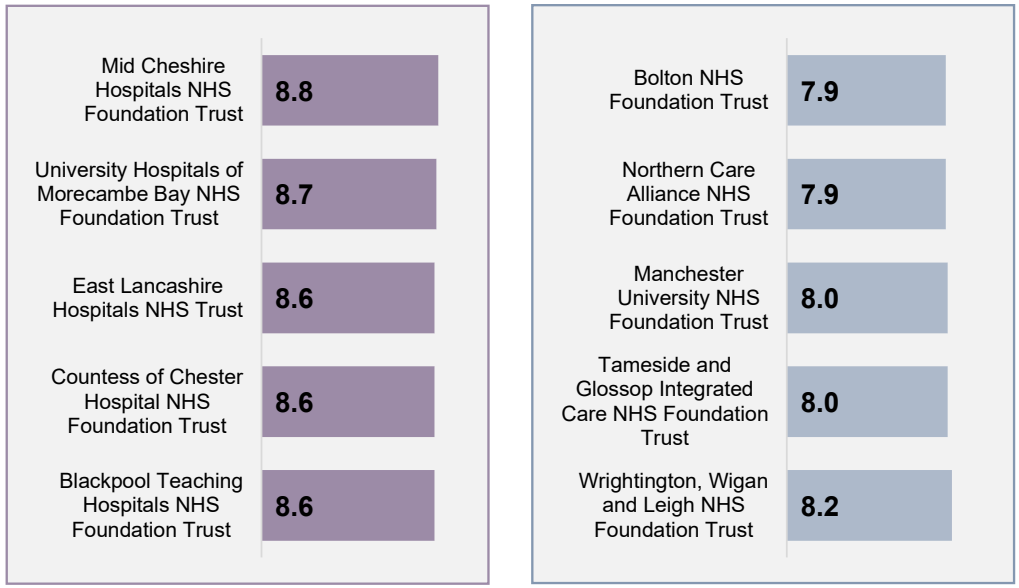


Staff caring for you

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 and C12 to C21. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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.

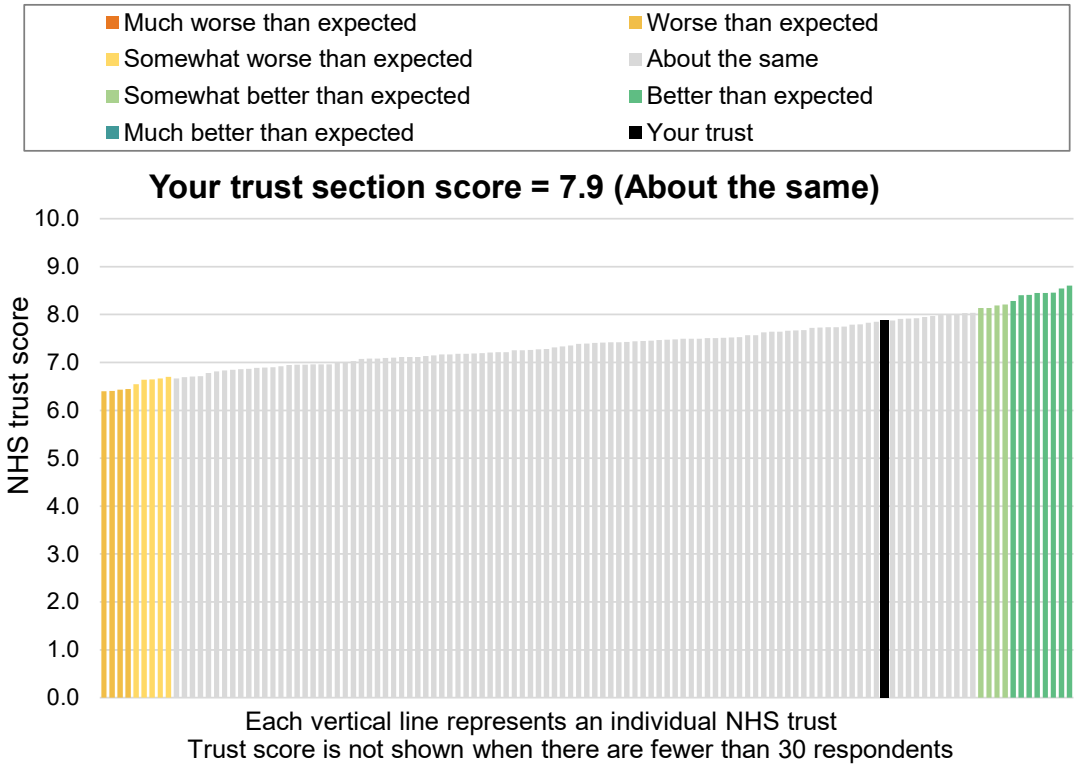
Comparison with other trusts within your region



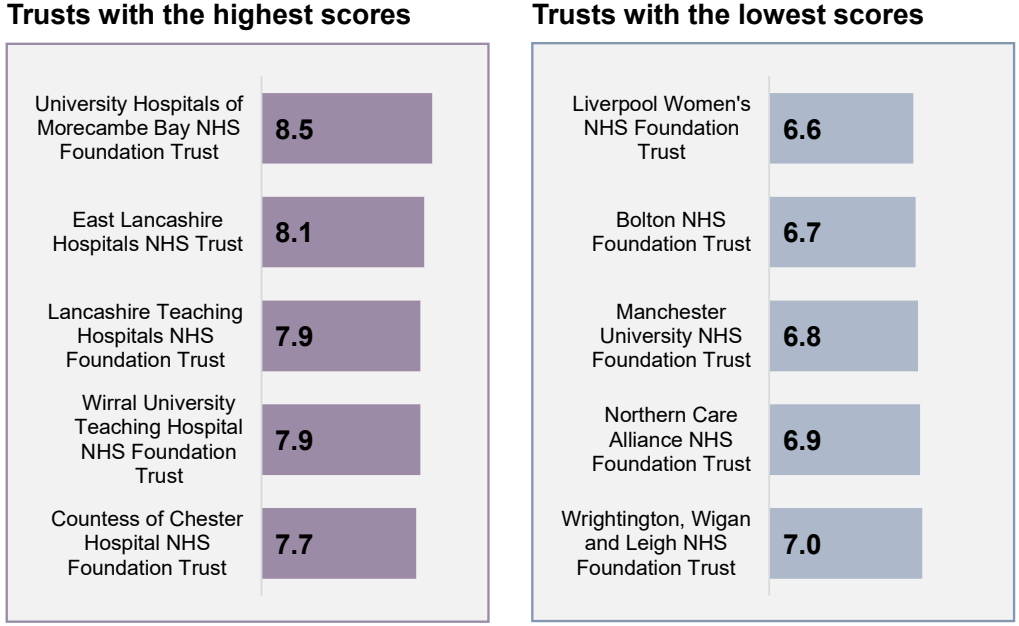
Care in the ward after birth

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D8. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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.

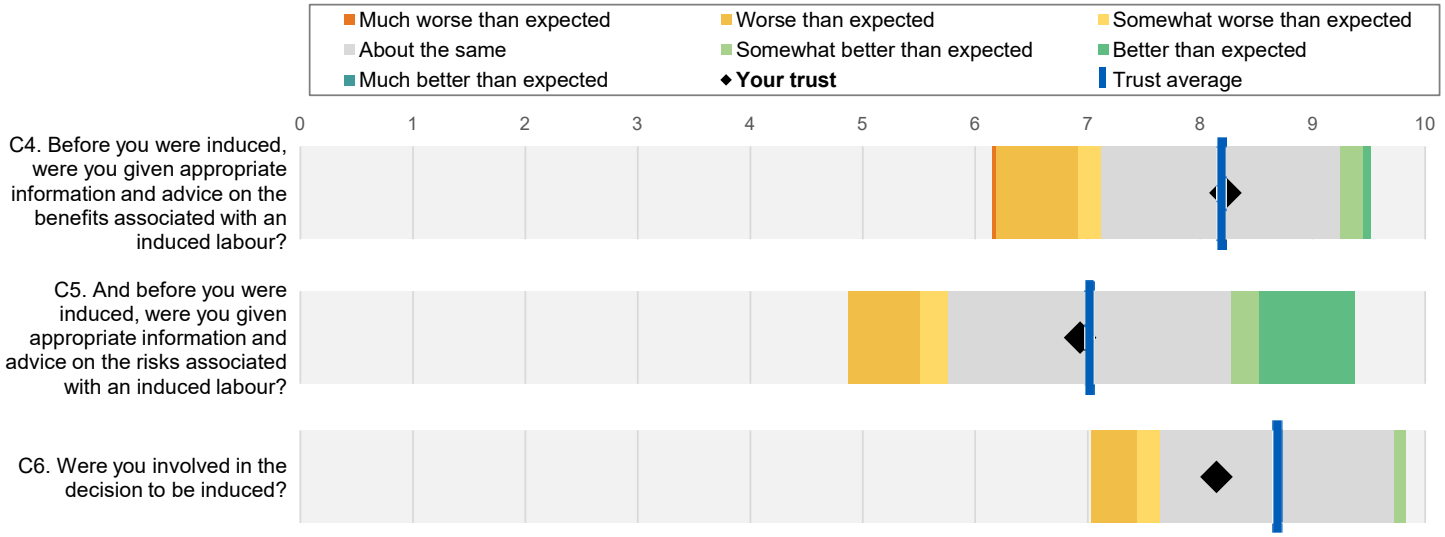


Comparison with other trusts within your region



Benchmarking - Labour and birth

Question scores: Your labour and birth



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C4. Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour?	42	8.2	8.2	6.1	9.5
C5. And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	42	6.9	7.0	4.9	9.4
C6. Were you involved in the decision to be induced?	42	8.1	8.7	7.0	9.8

About the same

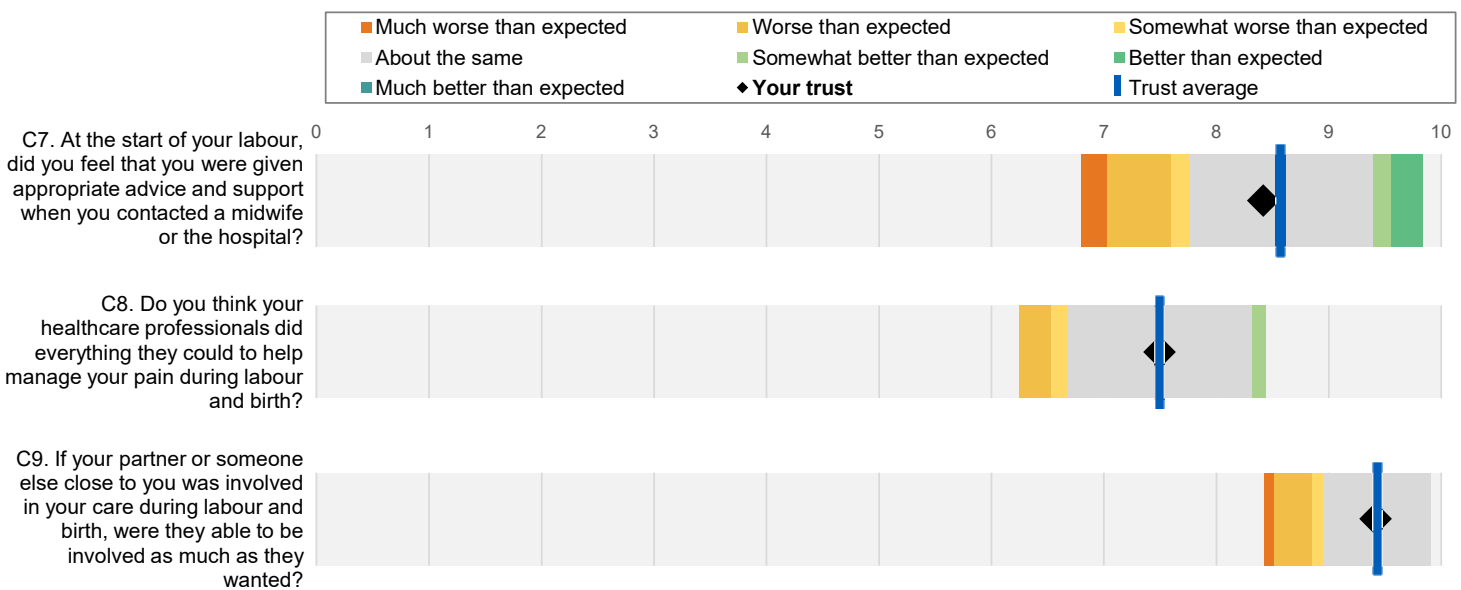
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Your labour and birth

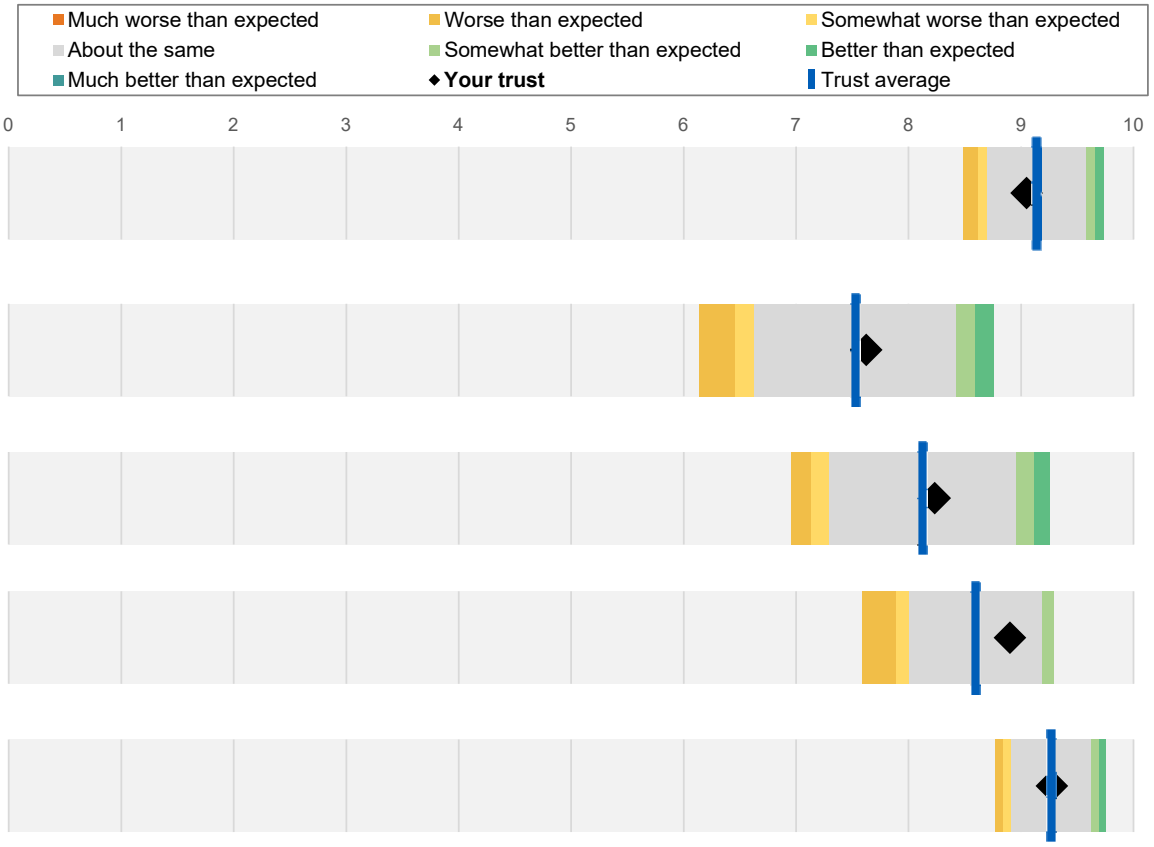


			All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	71	8.4	8.6	6.8	9.8	About the same
C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	84	7.5	7.5	6.2	8.4	About the same
C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	114	9.4	9.4	8.4	9.9	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



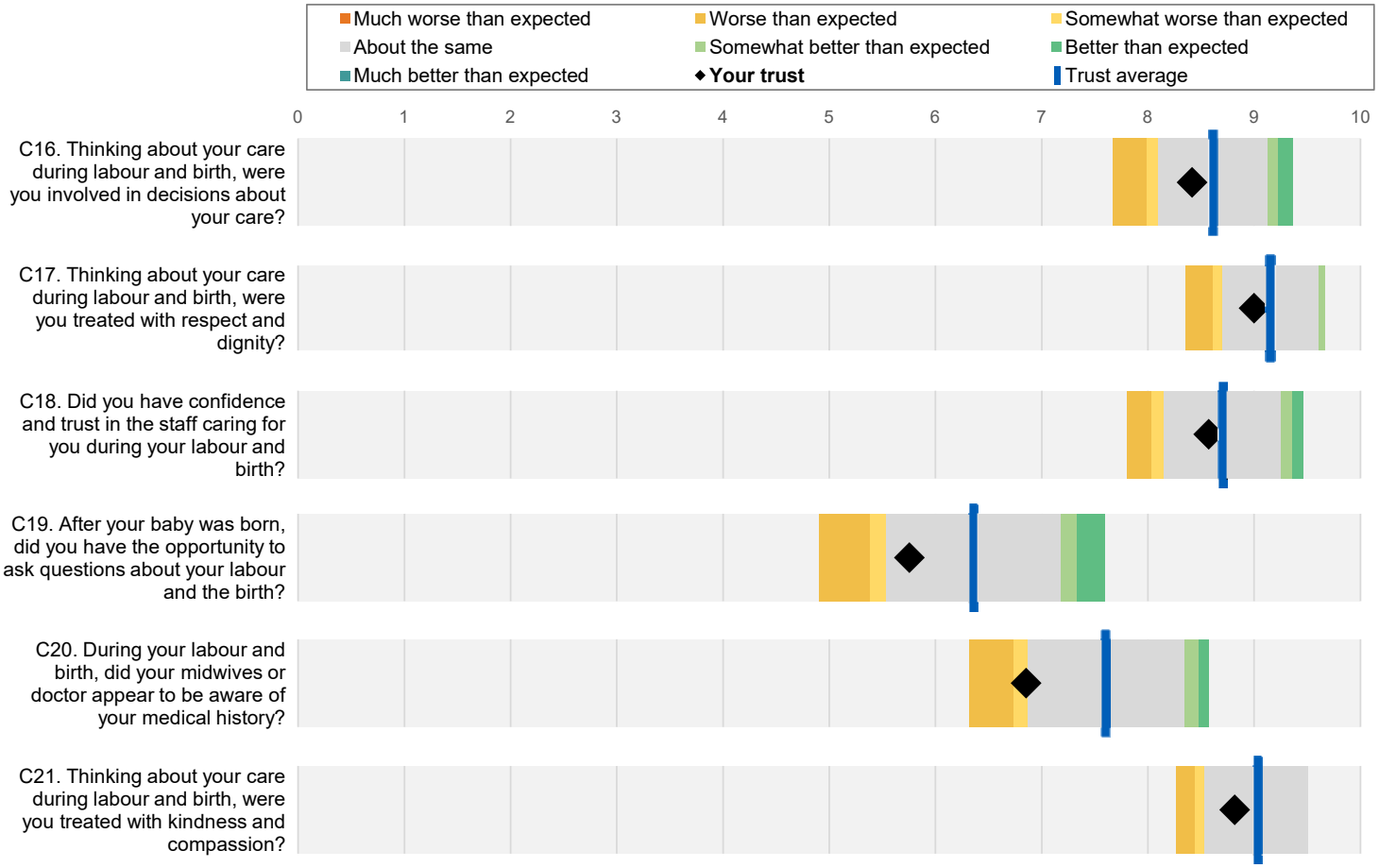
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C10. Did the staff treating and examining you introduce themselves?	112	9.0	9.1	8.5	9.7
C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	115	7.6	7.5	6.1	8.8
C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?	72	8.2	8.1	7.0	9.3
C14. During labour and birth, were you able to get a member of staff to help you when you needed it?	111	8.9	8.6	7.6	9.3
C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	115	9.3	9.3	8.8	9.8

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



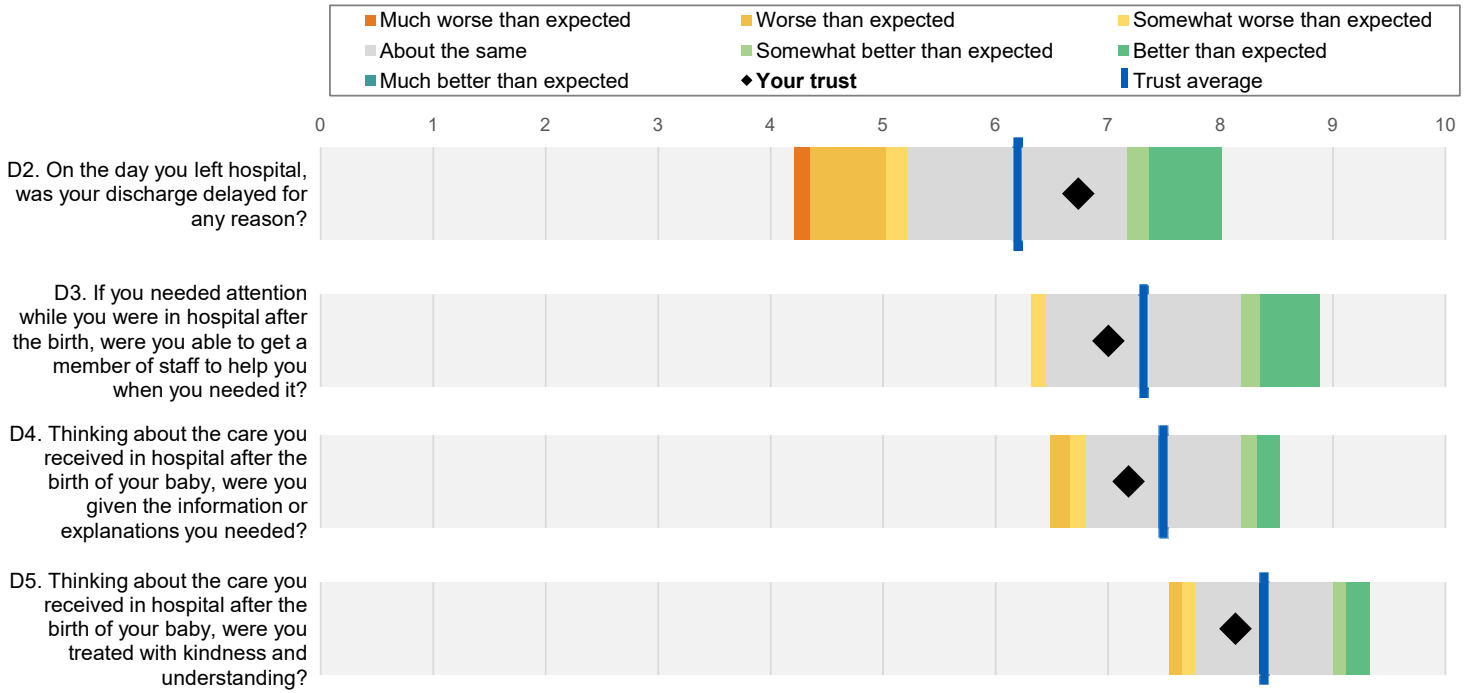
		All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?	111	8.4	8.6	7.7	9.4
C17. Thinking about your care during labour and birth, were you treated with respect and dignity?	115	9.0	9.2	8.4	9.7
C18. Did you have confidence and trust in the staff caring for you during your labour and birth?	115	8.6	8.7	7.8	9.5
C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	104	5.8	6.4	4.9	7.6
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	104	6.9	7.6	6.3	8.6
C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?	115	8.8	9.0	8.3	9.5

About the same | About the same | About the same | About the same | Somewhat worse | About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth

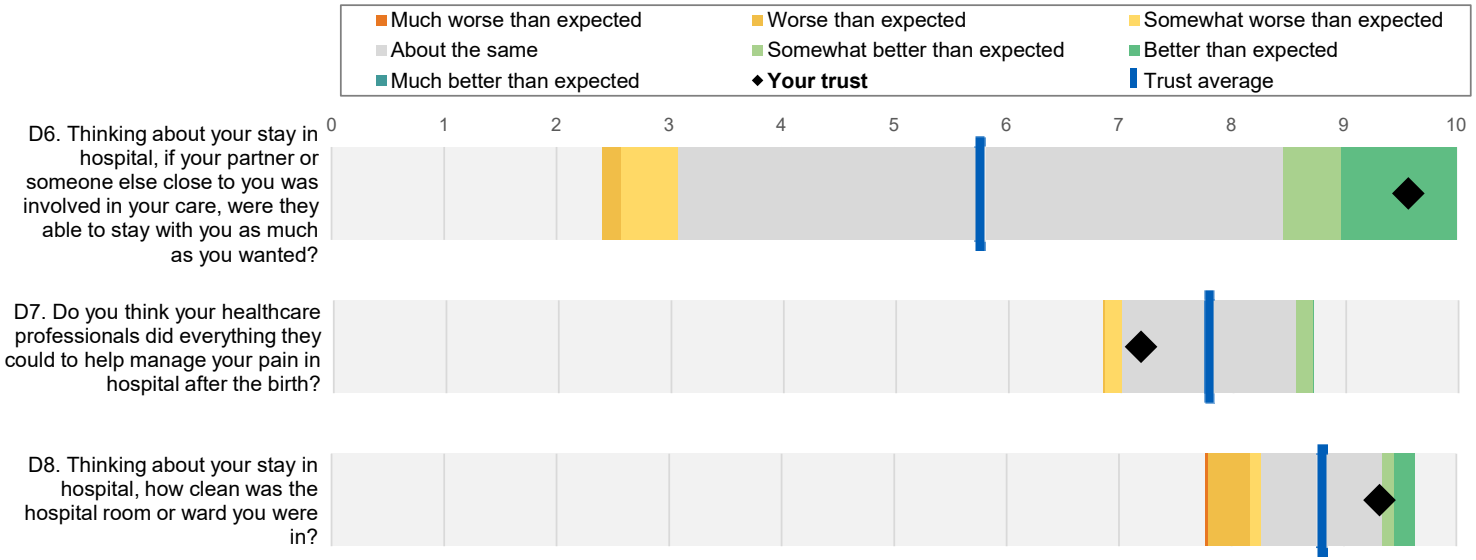


			All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
D2. On the day you left hospital, was your discharge delayed for any reason?	114	6.7	6.2	4.2	8.0	About the same
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	102	7.0	7.3	6.3	8.9	About the same
D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	113	7.2	7.5	6.5	8.5	About the same
D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	114	8.1	8.4	7.5	9.3	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	106	9.6	5.8	2.4	10.0
D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?	111	7.2	7.8	6.8	8.7
D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	114	9.3	8.8	7.8	9.6

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

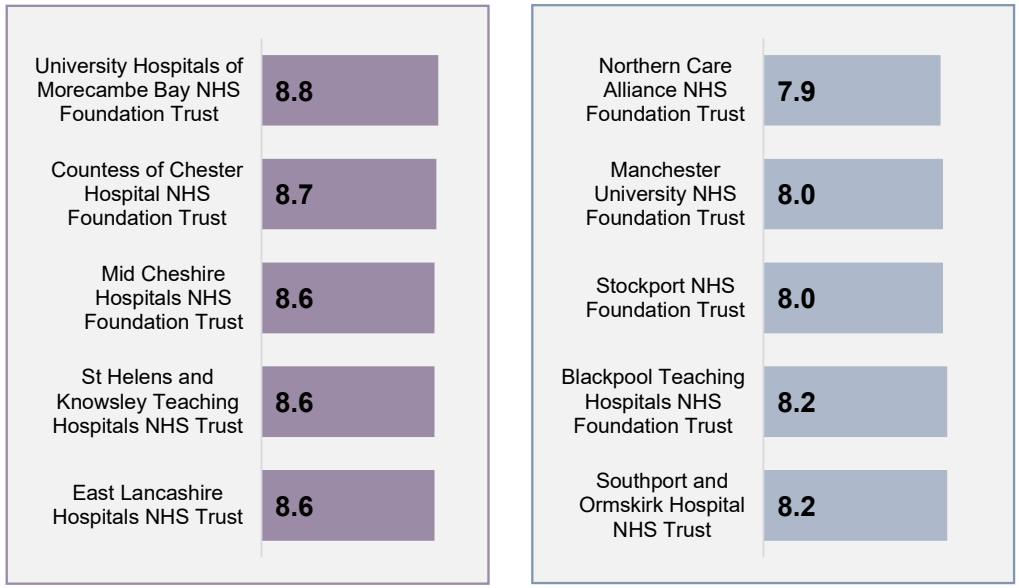
Postnatal care

Feeding your baby

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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.

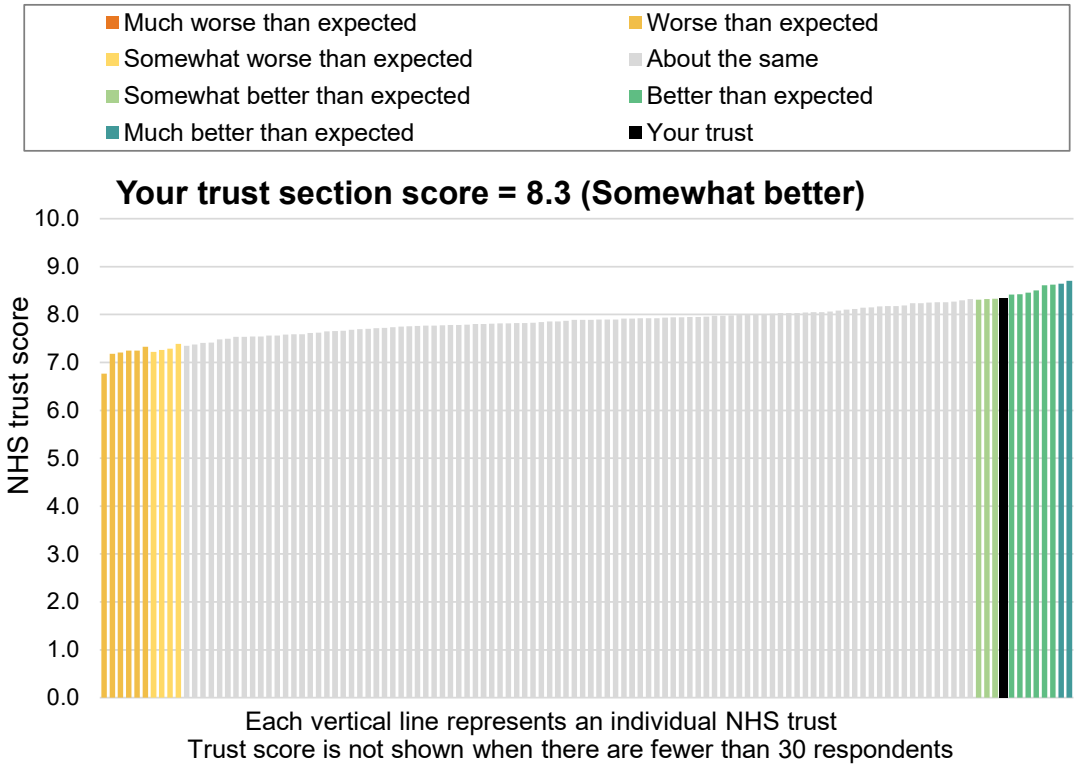
Comparison with other trusts within your region



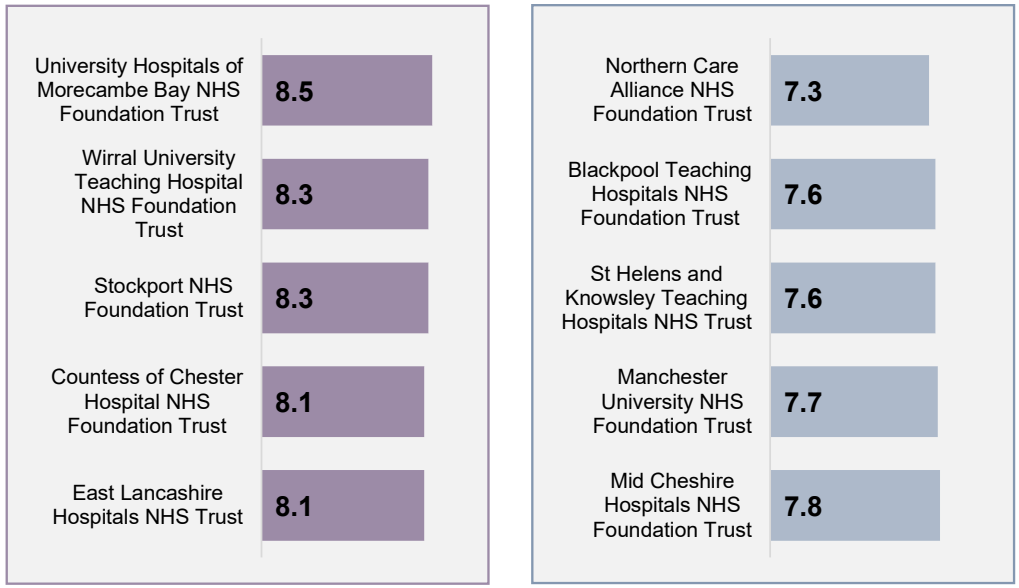
Care at home after birth

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F5 to F9 and F11 to F17. 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. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, 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.

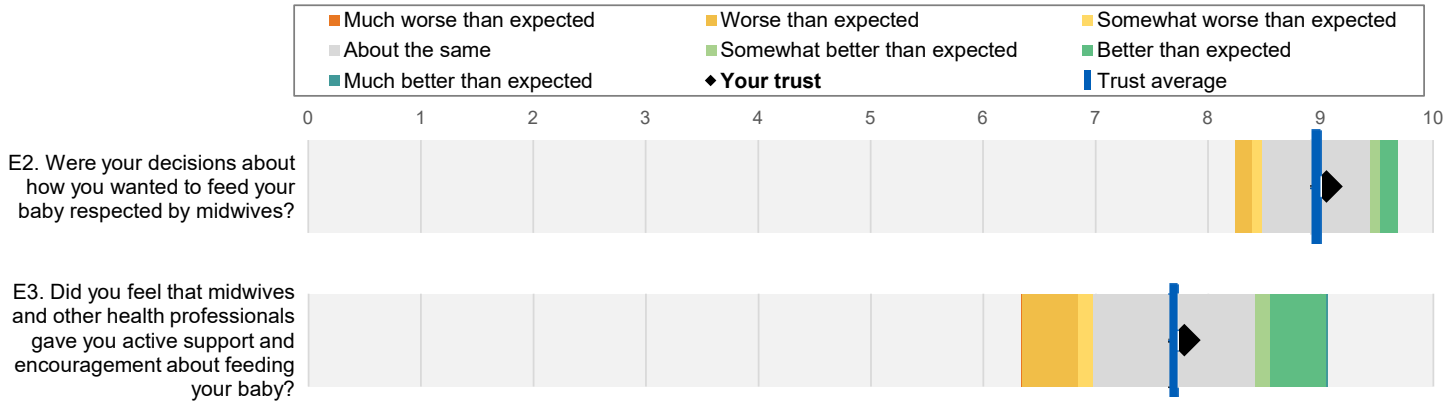


Comparison with other trusts within your region



Benchmarking - Postnatal care

Question scores: Feeding your baby

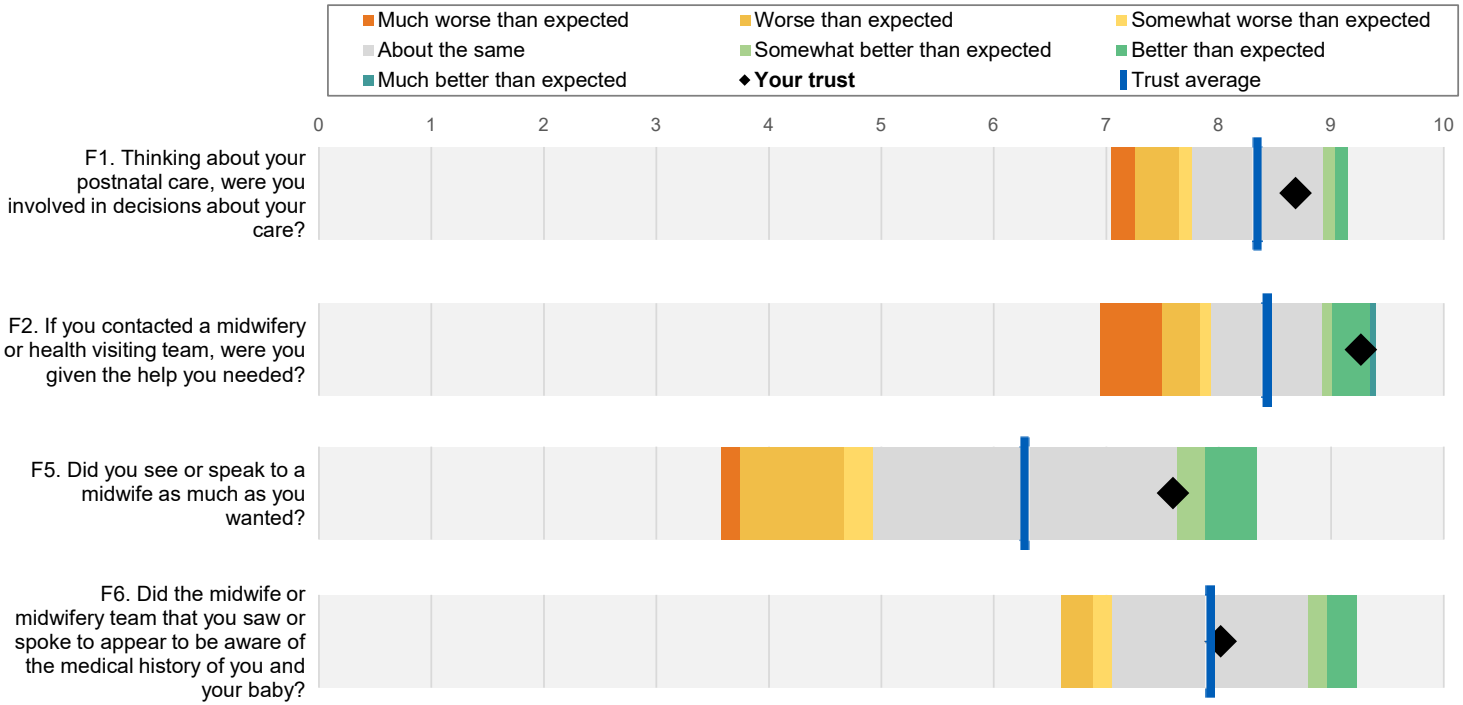


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
97	9.1	9.0	8.2	9.7
94	7.8	7.7	6.3	9.1

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	92	8.7	8.3	7.0	9.1
Better	79	9.3	8.4	6.9	9.4
About the same	97	7.6	6.3	3.6	8.3
About the same	84	8.0	7.9	6.6	9.2

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

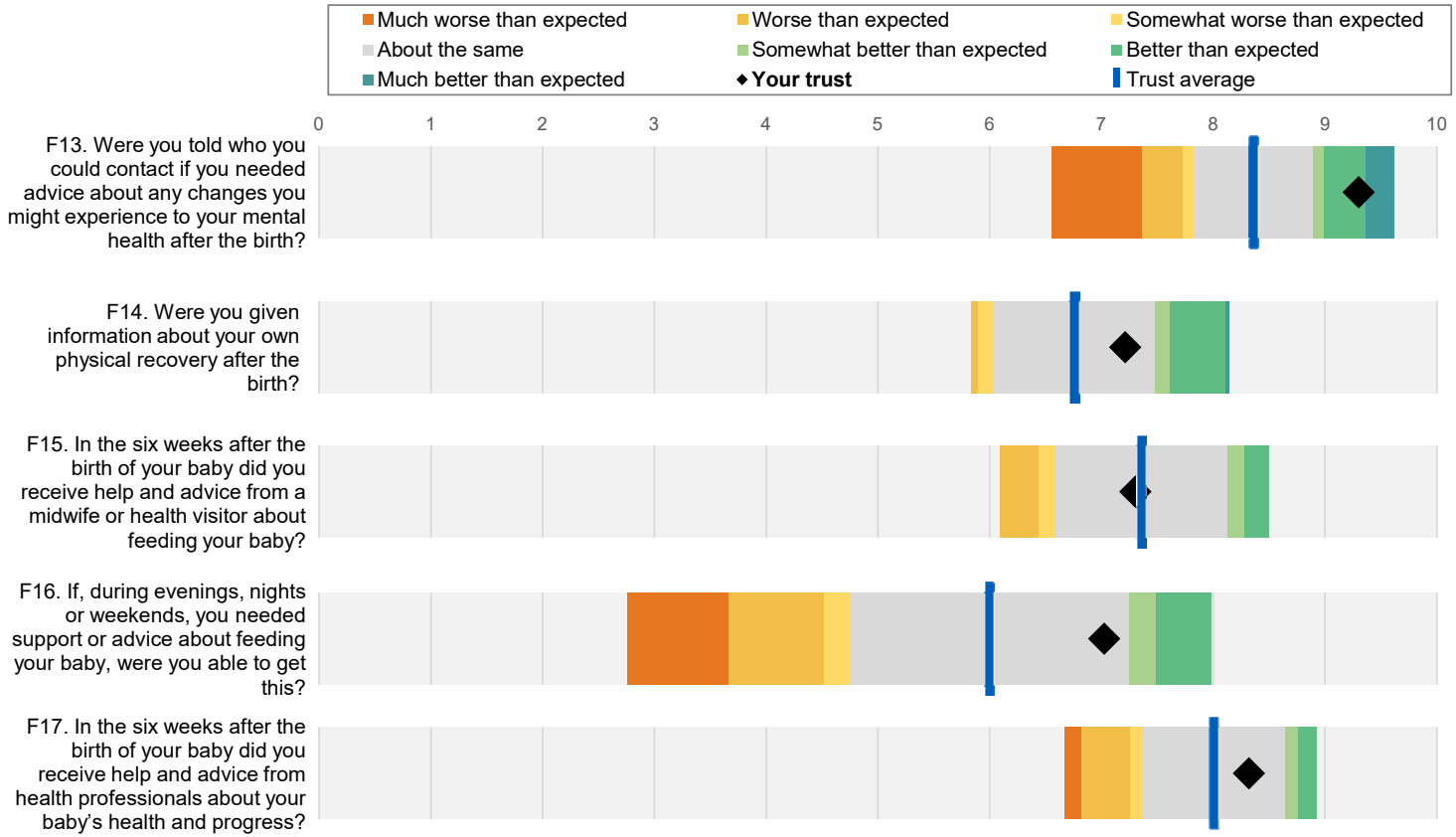
Question scores: Care at home after birth

	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	97	9.1	8.7	7.8	9.6
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	91	8.6	8.5	7.4	9.5
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	96	8.7	8.4	7.5	9.2
F11. Did a midwife or health visitor ask you about your mental health?	97	9.8	9.7	8.8	10.0
F12. Were you given information about any changes you might experience to your mental health after having your baby?	95	7.9	7.4	6.2	8.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



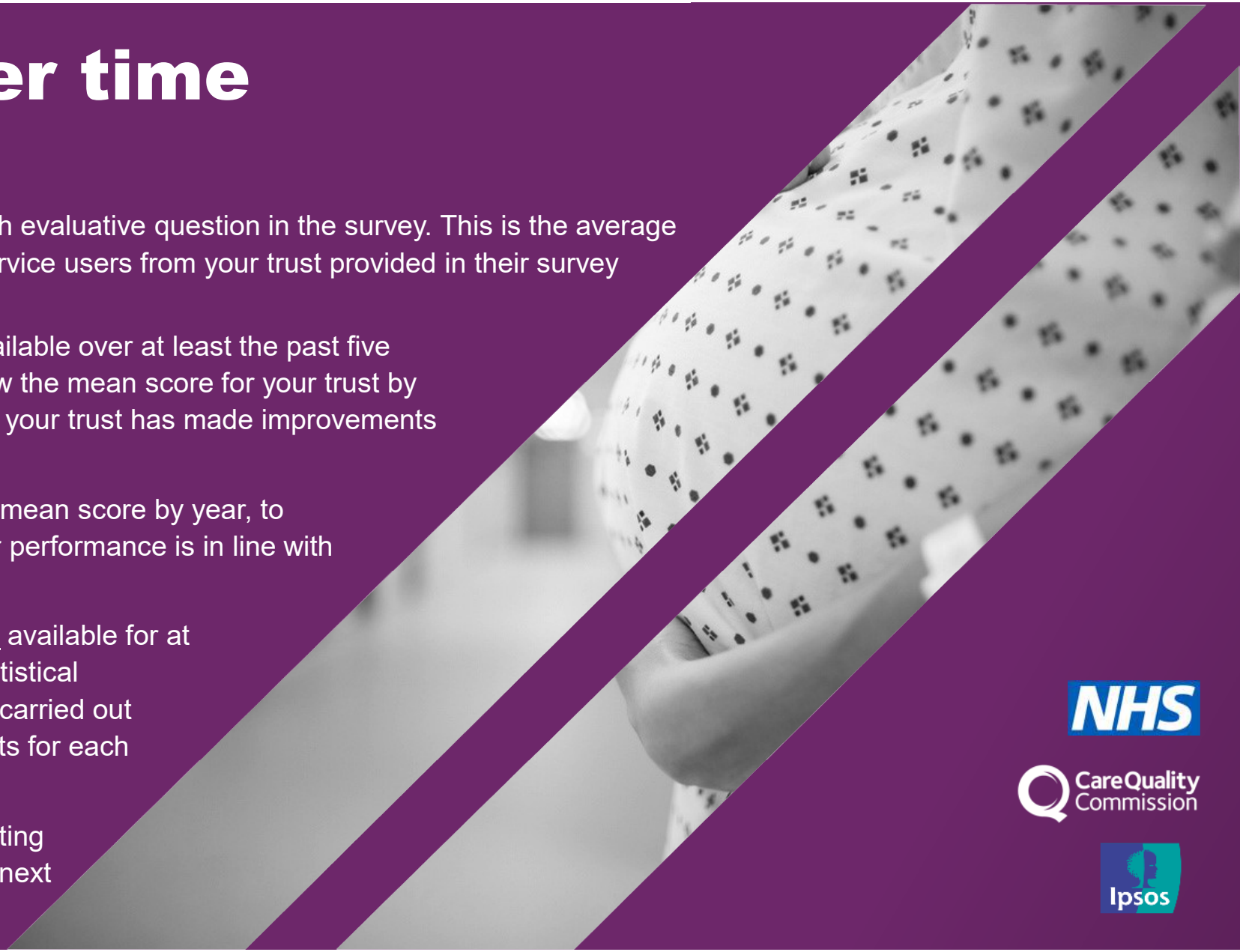
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Better	88	9.3	8.4	6.6	9.6
About the same	96	7.2	6.8	5.8	8.1
About the same	87	7.3	7.4	6.1	8.5
About the same	39	7.0	6.0	2.8	8.0
About the same	90	8.3	8.0	6.7	8.9

Trust score is not shown when there are fewer than 30 respondents.

Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey. This is the average of all scores that maternity service users from your trust provided in their survey response
- where comparable data is available over at least the past five surveys, the trend charts show the mean score for your trust by year. This allows you to see if your trust has made improvements over time
- they also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not
- where consistent data are not available for at least the past five surveys statistical significance testing has been carried out against the 2022 survey results for each relevant question
- for more guidance on interpreting these graphs, please see the next slide



Trends over time

The following section presents comparisons with previous survey results. Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted to show where there is meaningful change between years.

Historical trend charts are presented when there are at least five data points available to plot on the chart. Five data points may not be available due to:

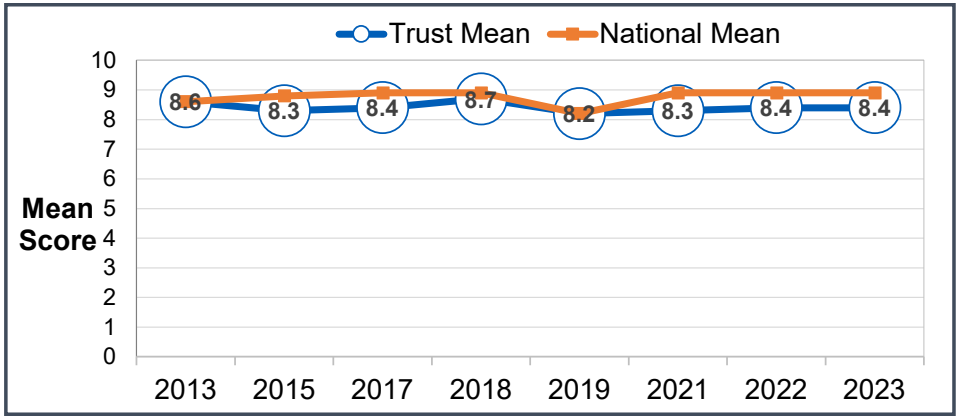
- changes to the questionnaire mean that a question is no longer comparable over time;
- organisational changes which impact comparability of results over time; or,
- historical errors with sampling or issues with fieldwork which impact comparability.

Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted. These are carried out using a two sample t-test. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a filled green circle, and significant decreases are in red.

Where comparable data is not available, statistical significance test tables are provided. Statistically significant changes in your trust score between 2022 and 2023 are shown in the far right column 'Change from 2022 survey', significant increases are indicated with a green arrow and significant decreases are indicated with a red arrow.

The following questions were new or changed for 2023 and therefore are not included in this section: B18, C4, C8, C21 and D7.

Historical trend chart example



Significance test table example

		2023 Trust Score	2022 Trust Score	No. of respondents	Change from 2022 survey
The start of your care in pregnancy					
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	4.3	7.1	178	▼

Trends over time

Antenatal care

Trends over time - Antenatal care

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
The start of your care in pregnancy											
B3.	Were you offered a choice about where to have your baby?							3.7	3.5	99	
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?							6.7	6.3	105	
B7.	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?							6.5	6.0	106	

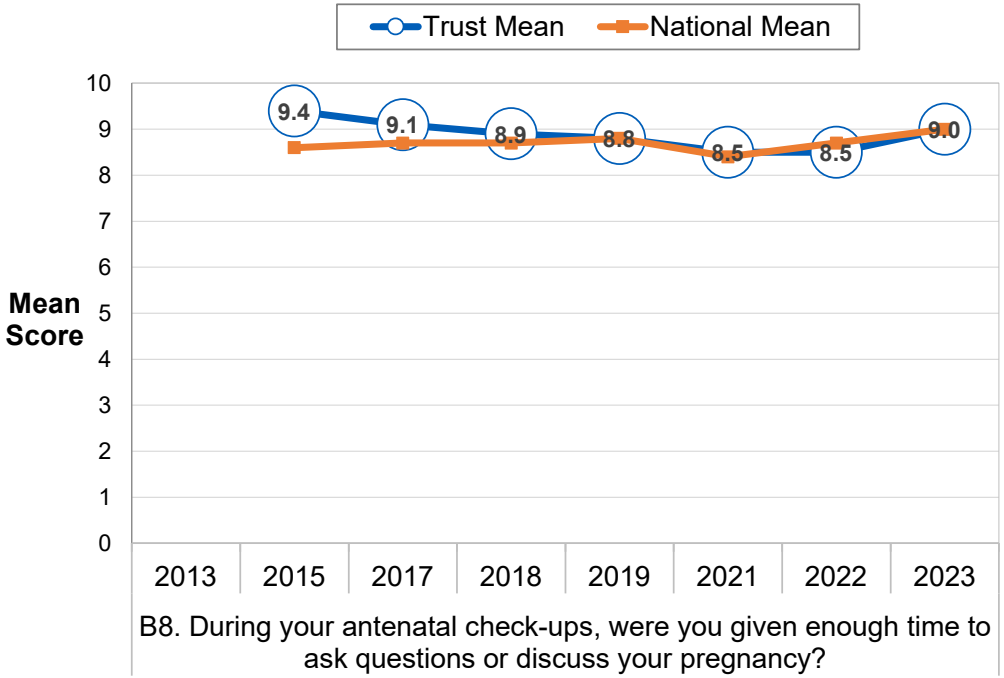
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Antenatal care (continued)

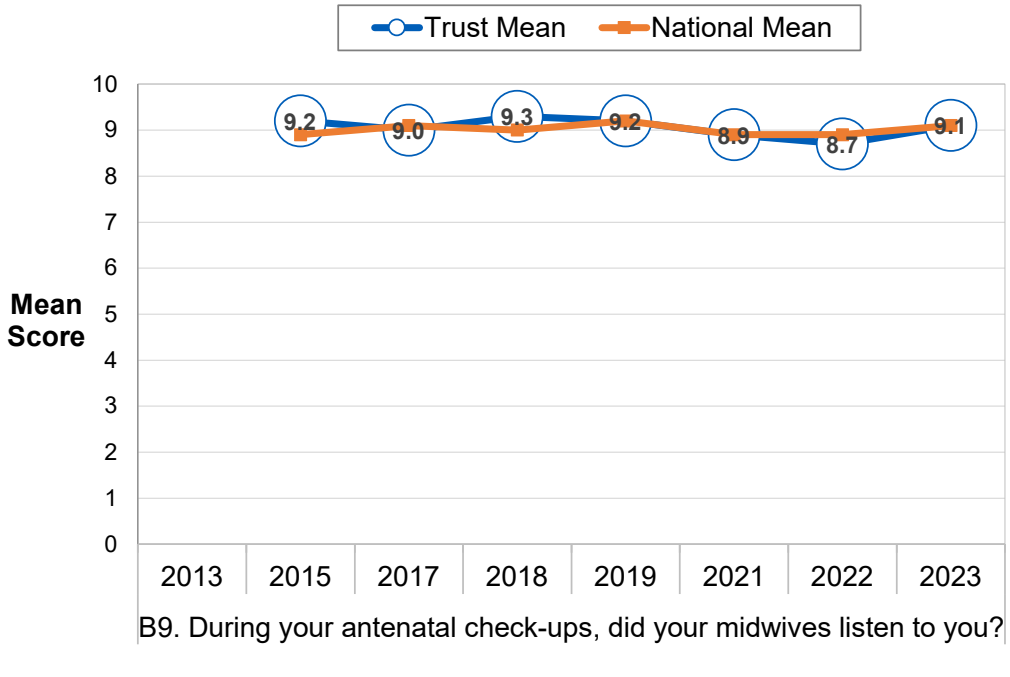
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Antenatal check-ups



B8. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Please note: *no data available for some years*



B9. During your antenatal check-ups, did your midwives listen to you?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Antenatal check-ups										
B10. During your antenatal check-ups, did your midwives ask you about your mental health?							8.7	7.0	111	▲

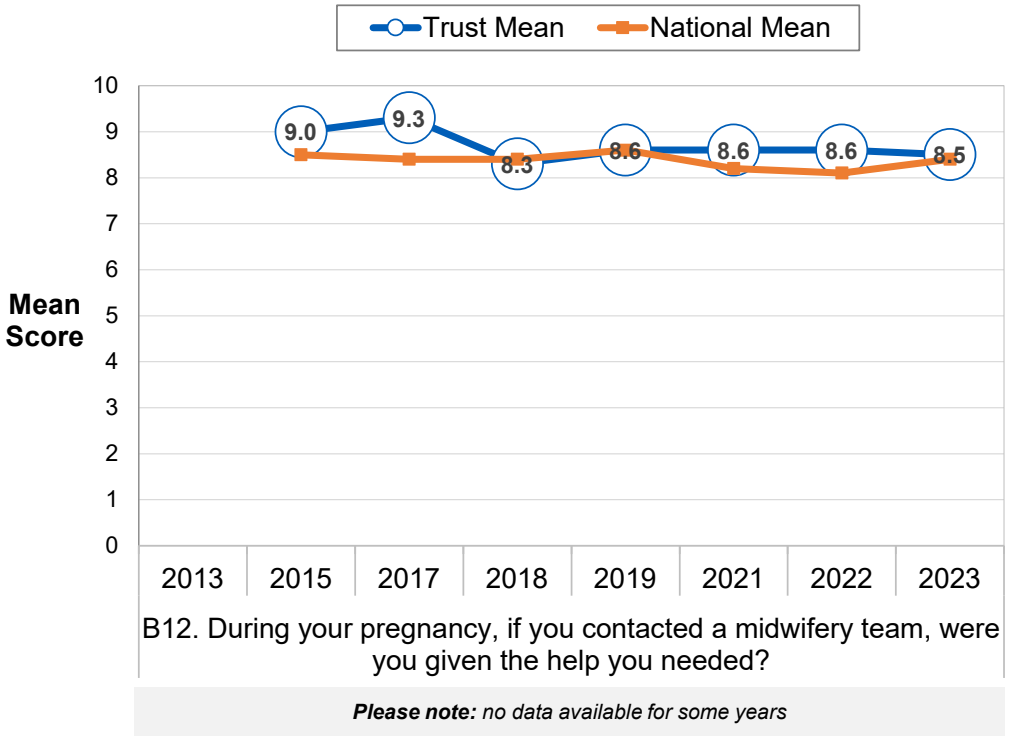
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Antenatal care (continued)

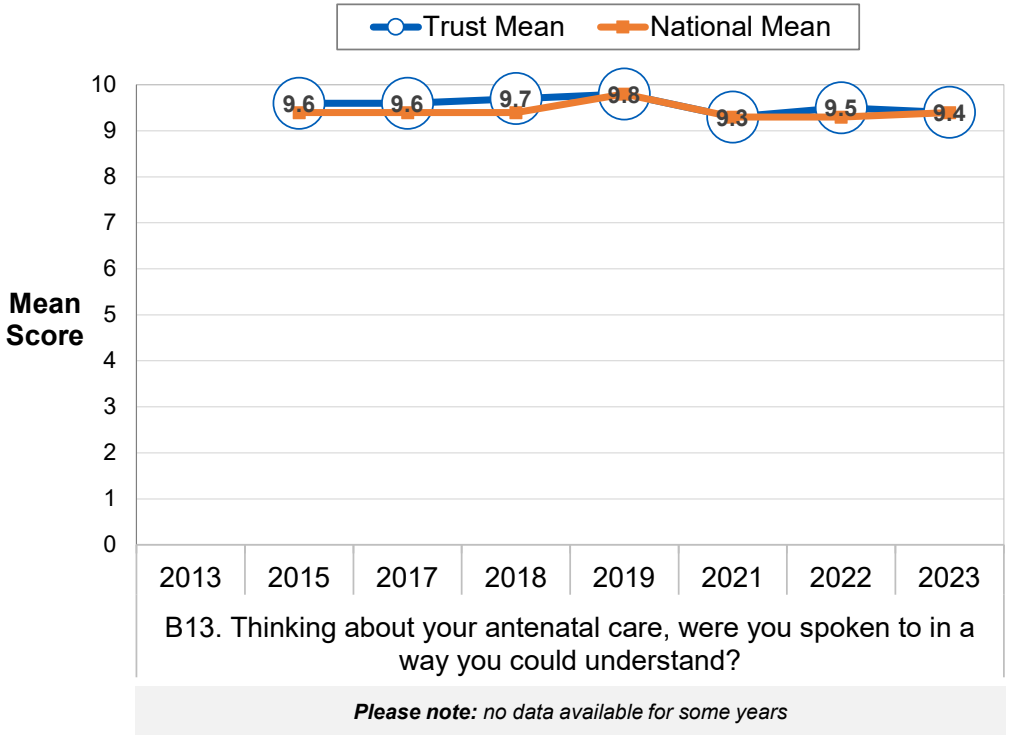
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

During your pregnancy



B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

Please note: *no data available for some years*



B13. Thinking about your antenatal care, were you spoken to in a way you could understand?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
During your pregnancy					
B11.	Were you given enough support for your mental health during your pregnancy?	8.8	7.5	74	▲
B14.	Thinking about your antenatal care, were you involved in decisions about your care?	9.1	8.7	109	
B15.	During your pregnancy did midwives provide relevant information about feeding your baby?	6.6	6.0	110	
B16.	Did you have confidence and trust in the staff caring for you during your antenatal care?	8.6	8.2	112	
B17.	Thinking about your antenatal care, were you treated with respect and dignity?	9.3	8.9	112	

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time

Labour and birth

Trends over time - Labour and birth

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Your labour and birth										
C5.	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?						6.9	5.9	42	
C6.	Were you involved in the decision to be induced?						8.1	7.7	42	

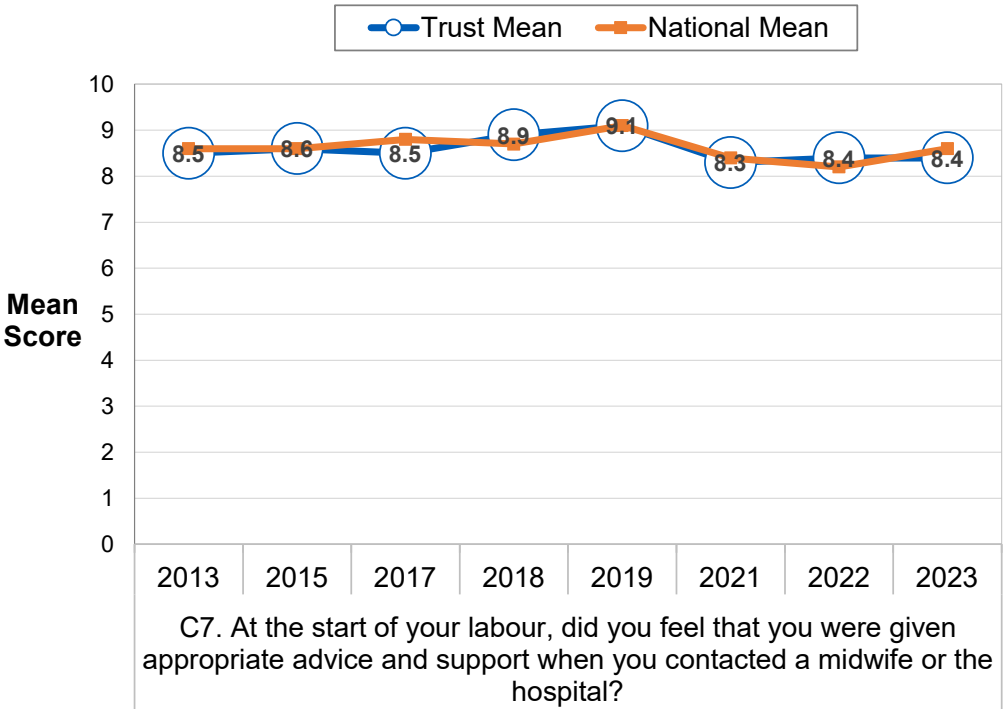
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

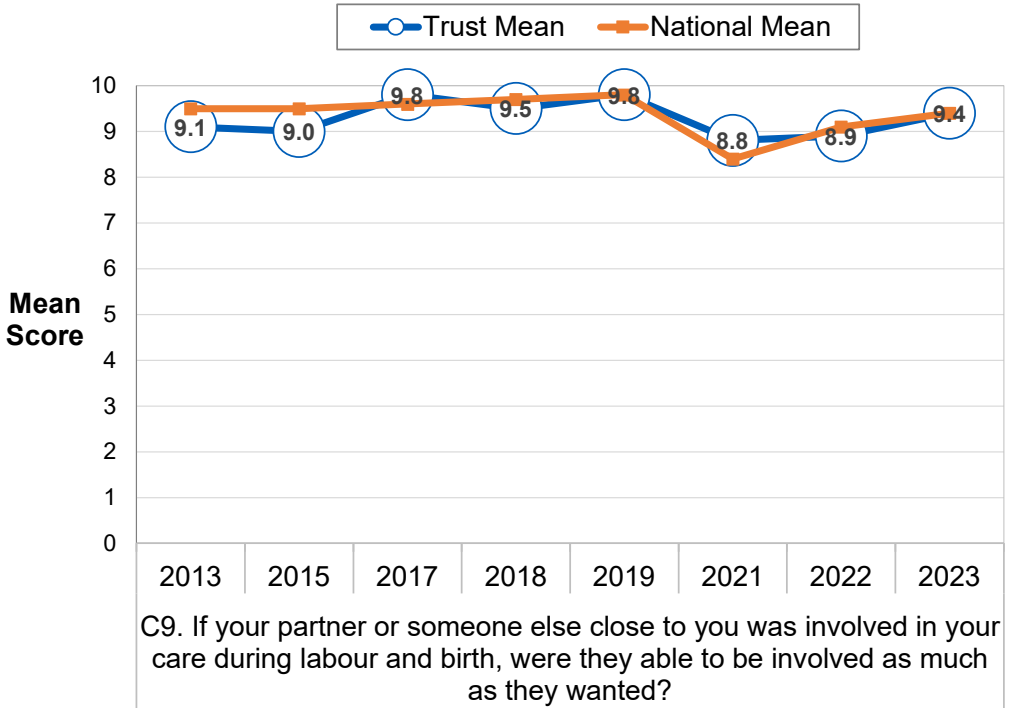
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Your labour and birth



C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?



C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

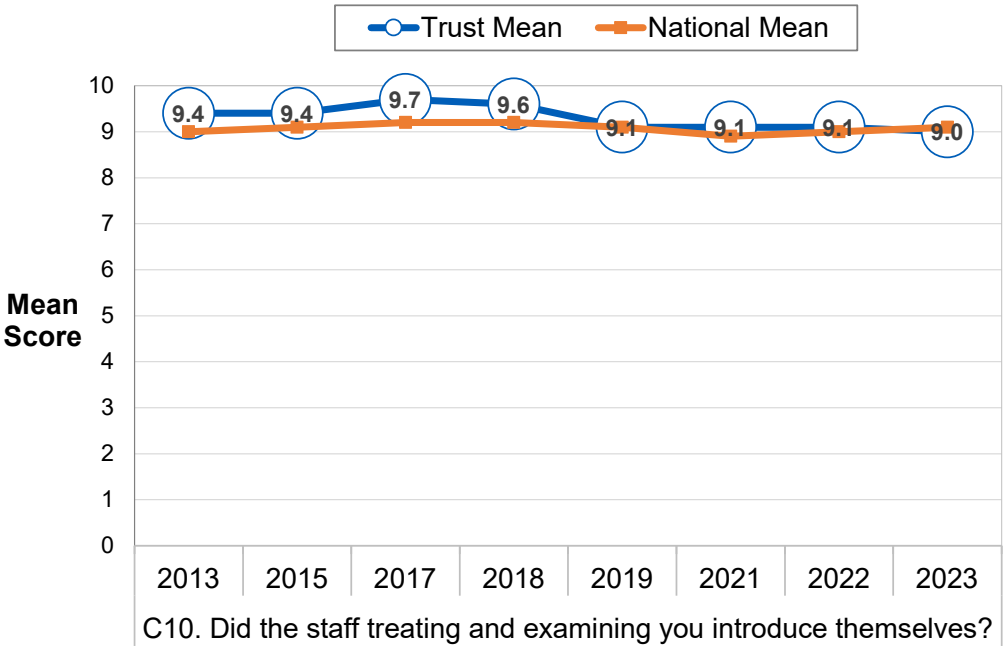
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

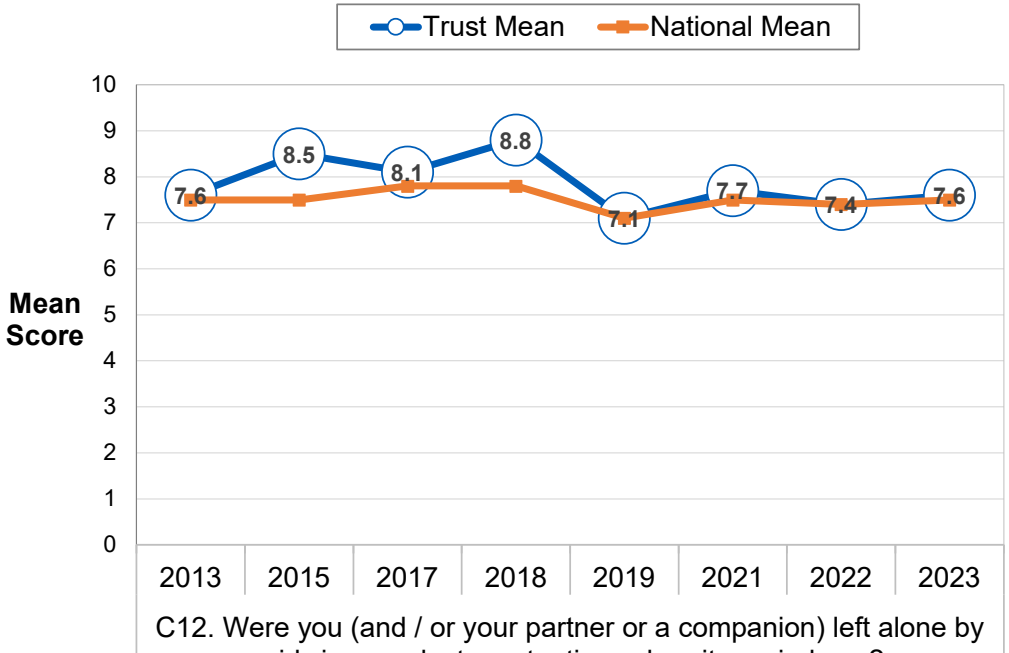
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C10. Did the staff treating and examining you introduce themselves?



C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

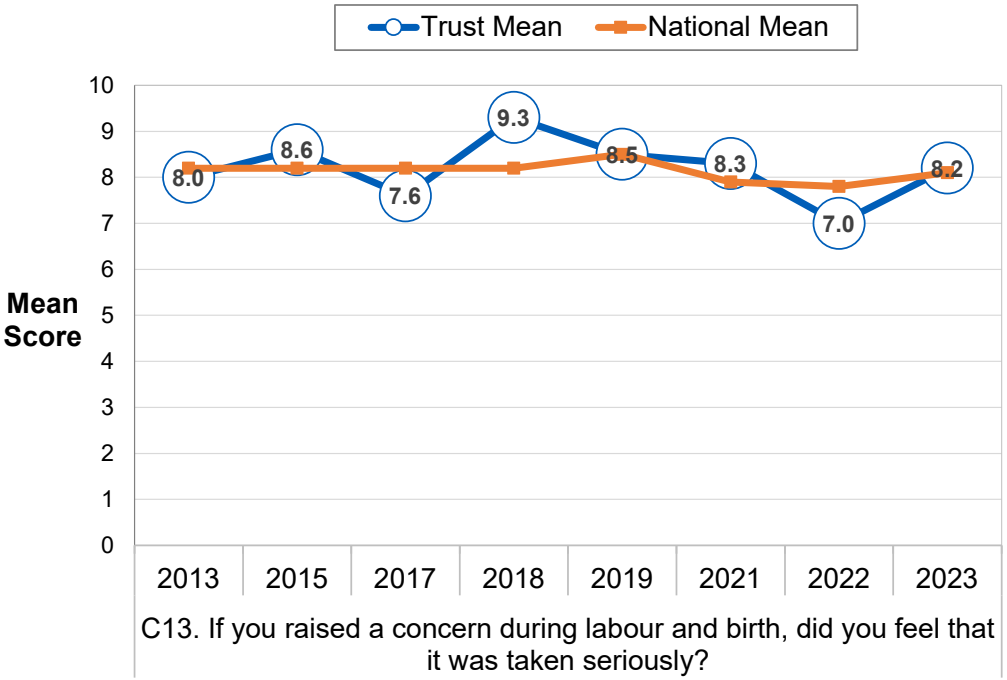
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

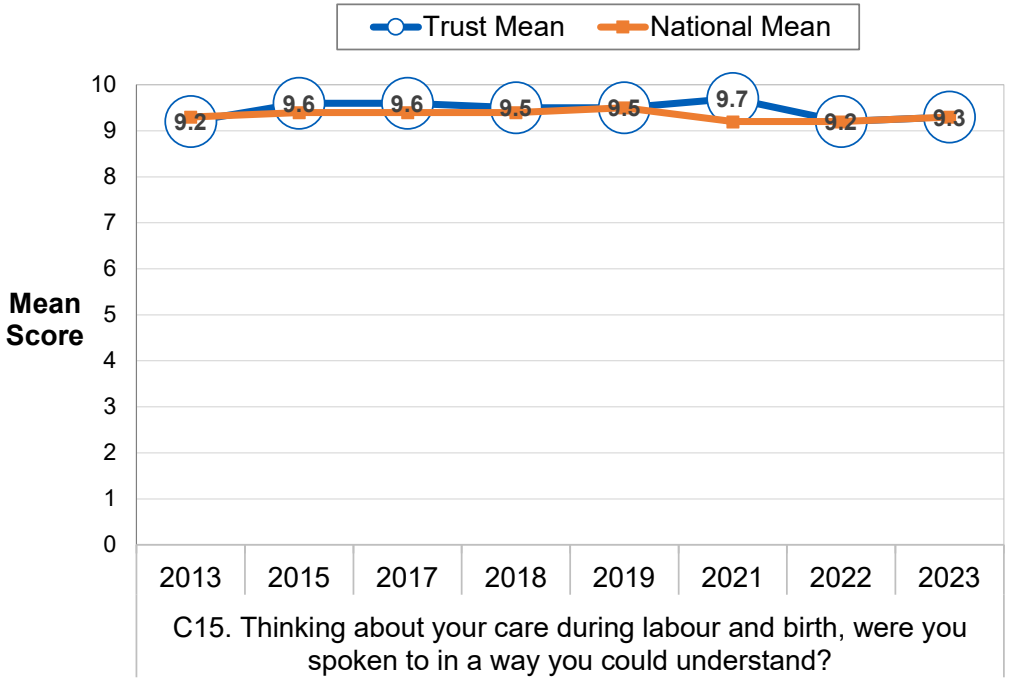
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?



C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Staff caring for you											
C14.	During labour and birth, were you able to get a member of staff to help you when you needed it?							8.9	8.5	111	
C16.	Thinking about your care during labour and birth, were you involved in decisions about your care?							8.4	8.4	111	

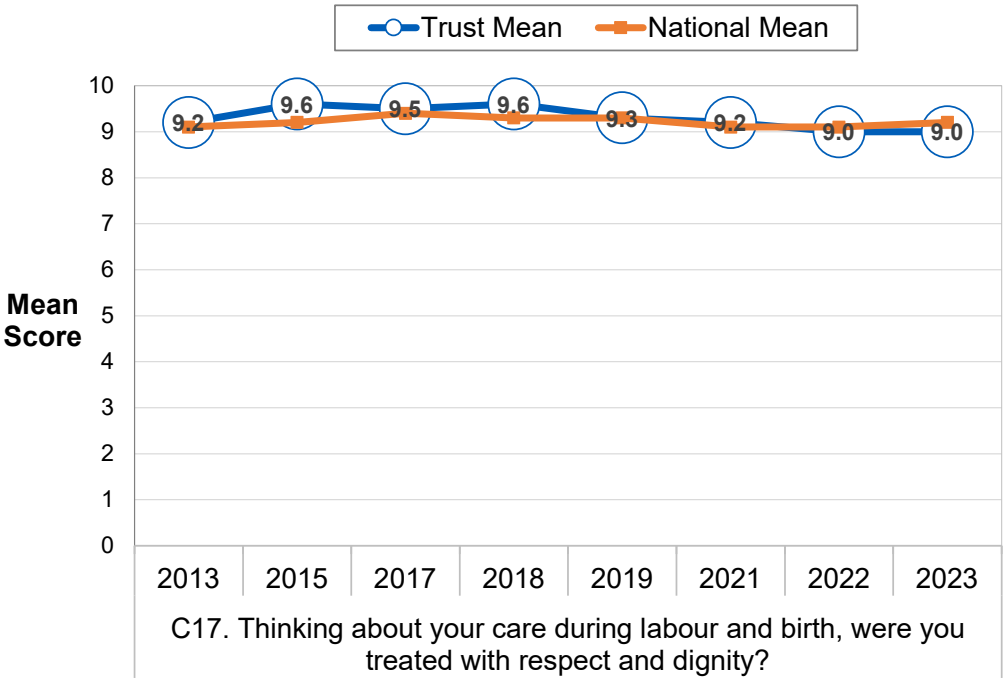
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

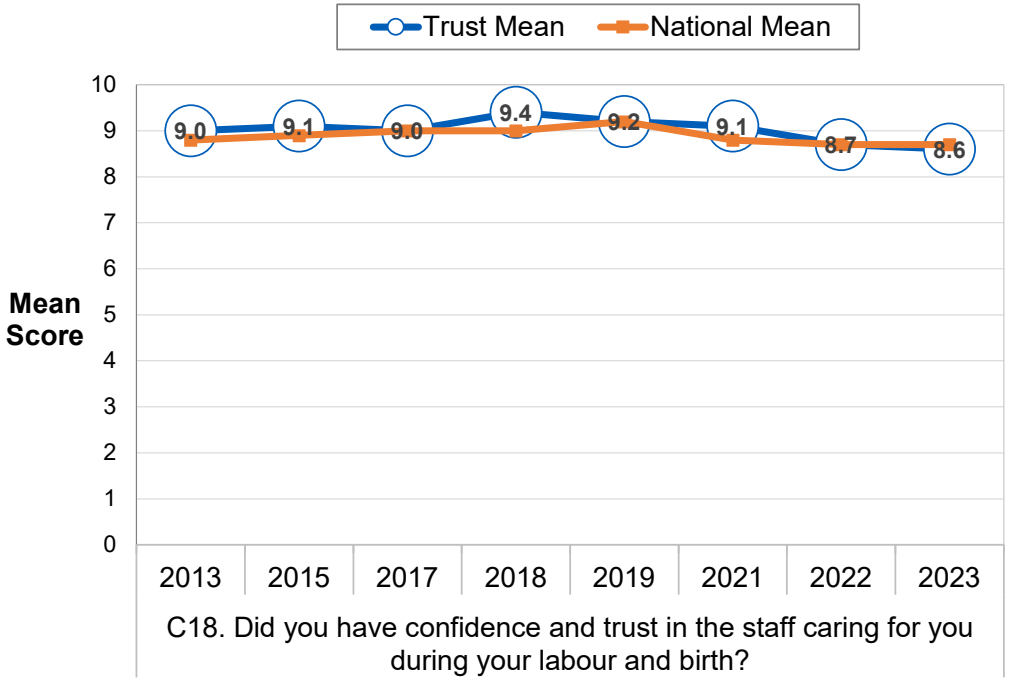
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C17. Thinking about your care during labour and birth, were you treated with respect and dignity?



C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Staff caring for you										
C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?							5.8	6.6	104	
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?							6.9	7.4	104	

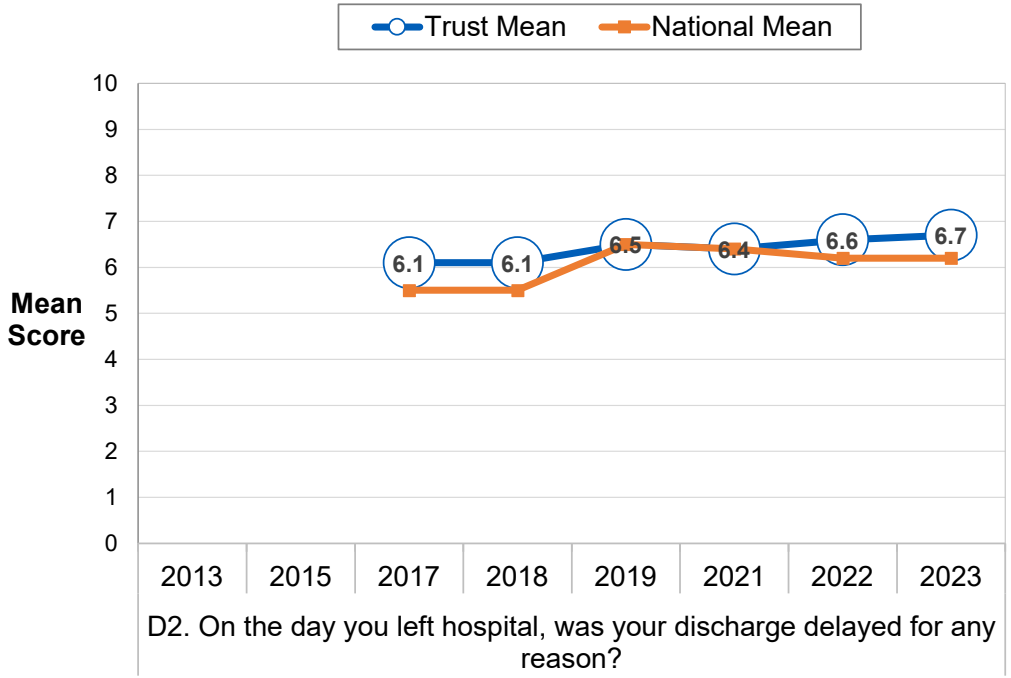
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care in the ward after birth											
D3.	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?							7.0	6.8	102	

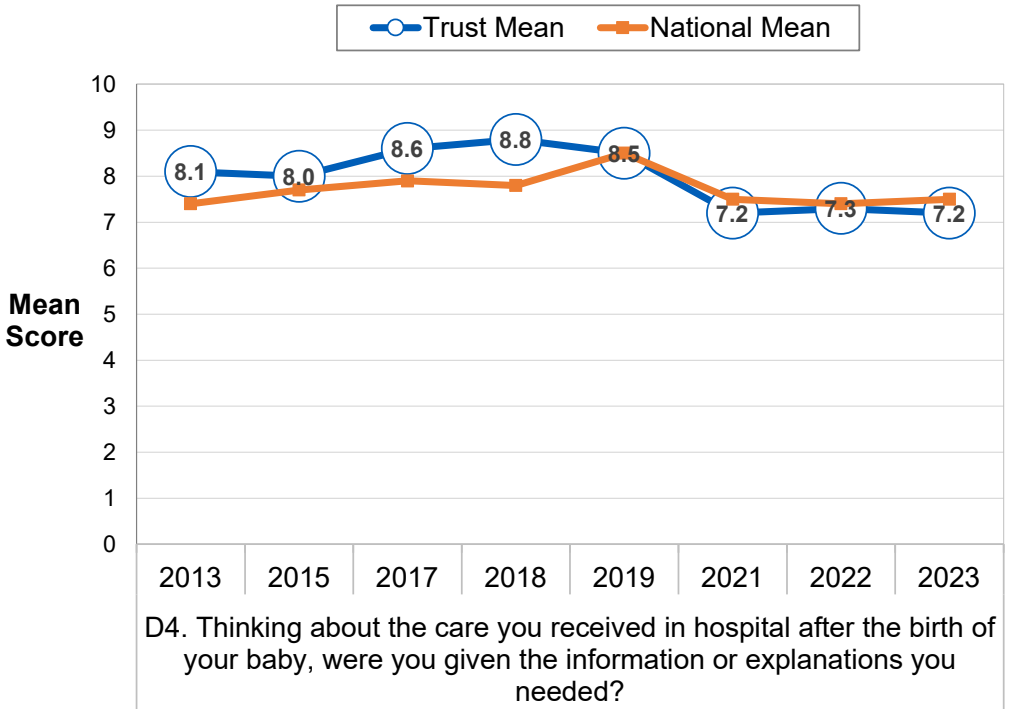
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

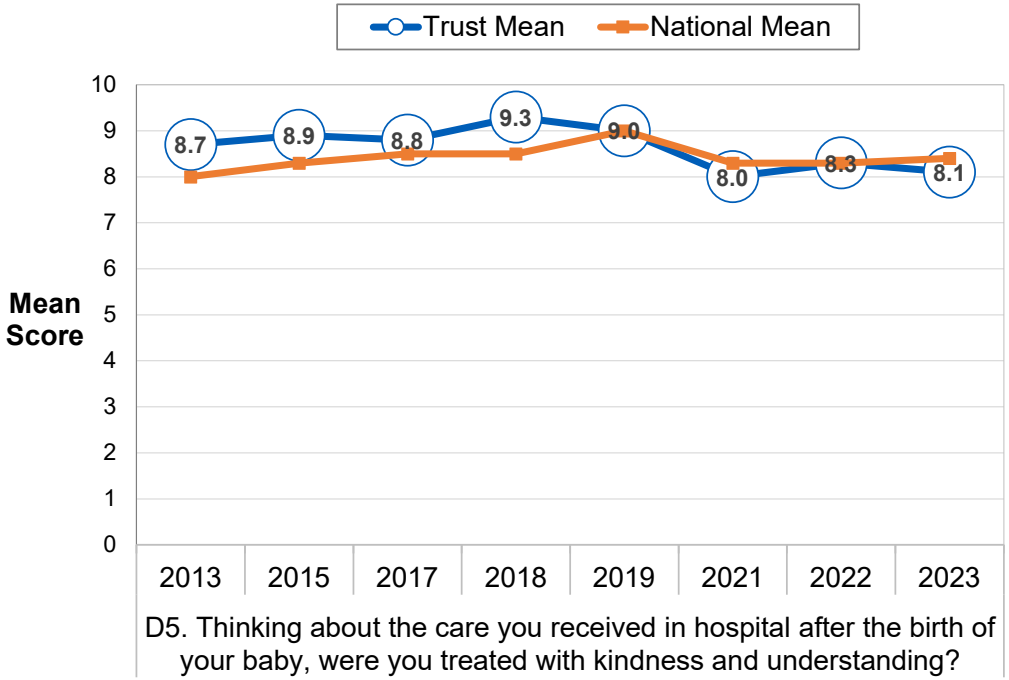
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?



D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

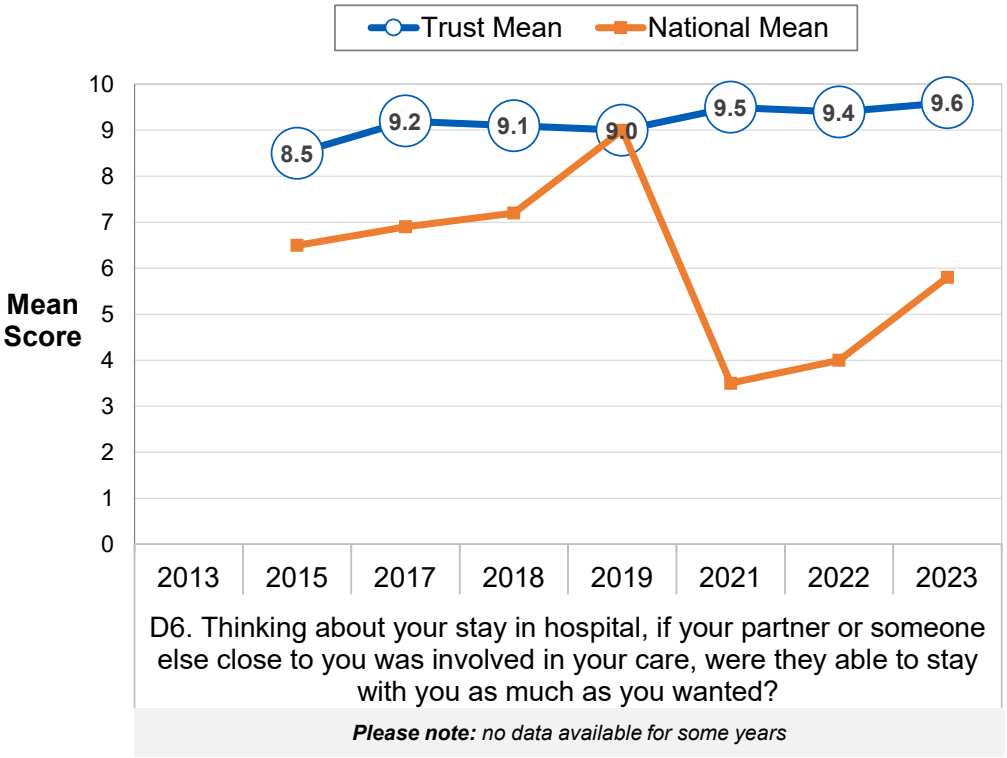
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

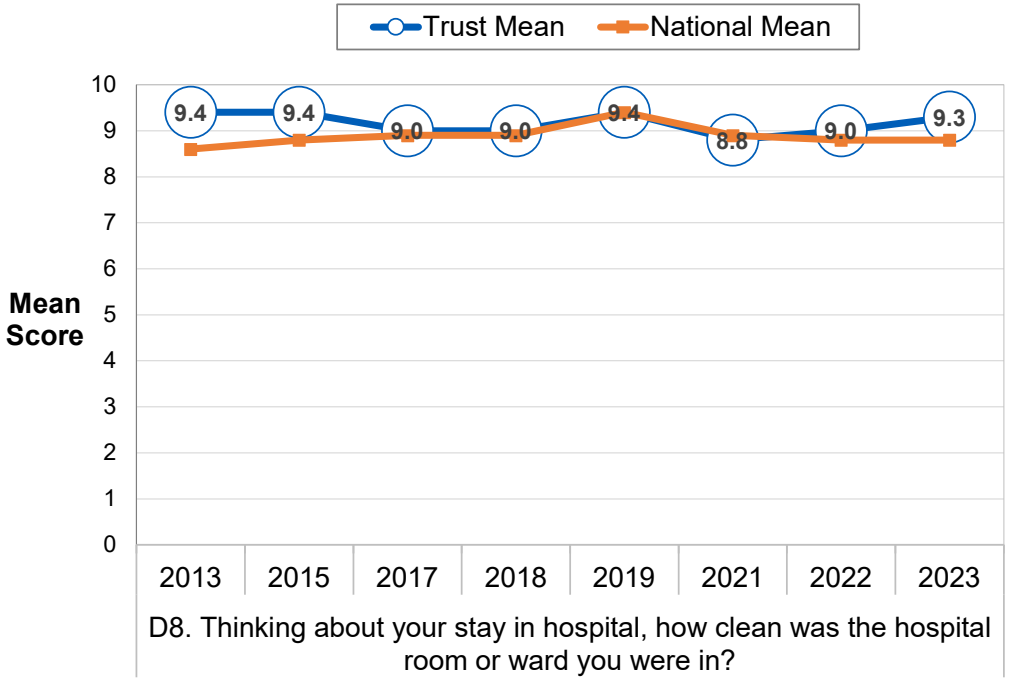
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Please note: *no data available for some years*



D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

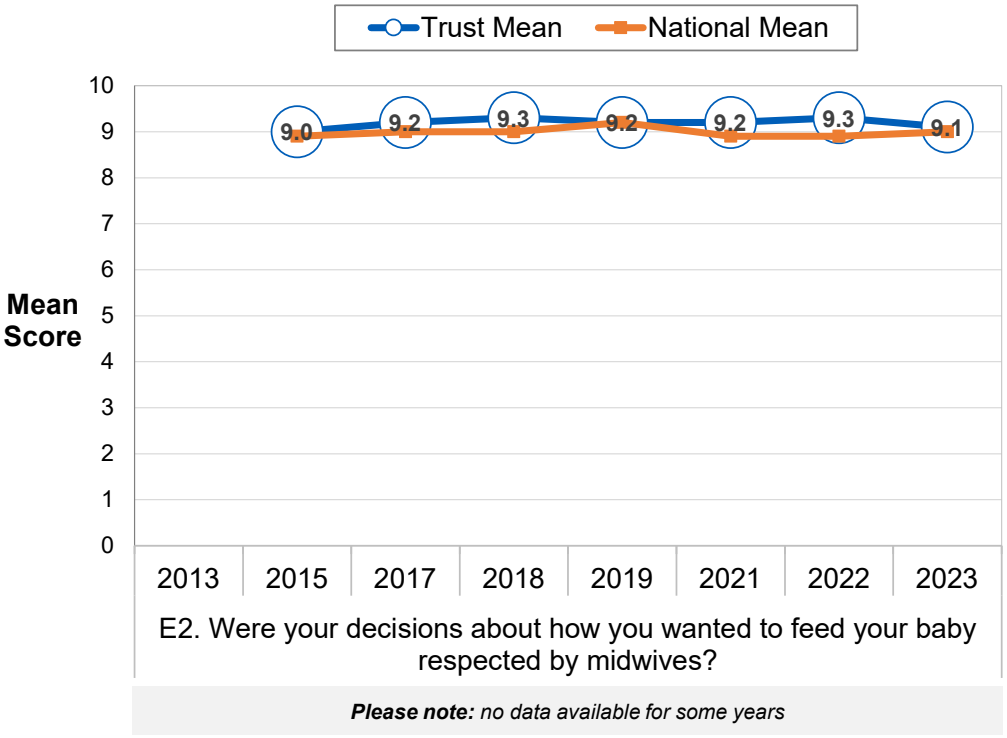
Trends over time

Postnatal care

Trends over time - Postnatal care

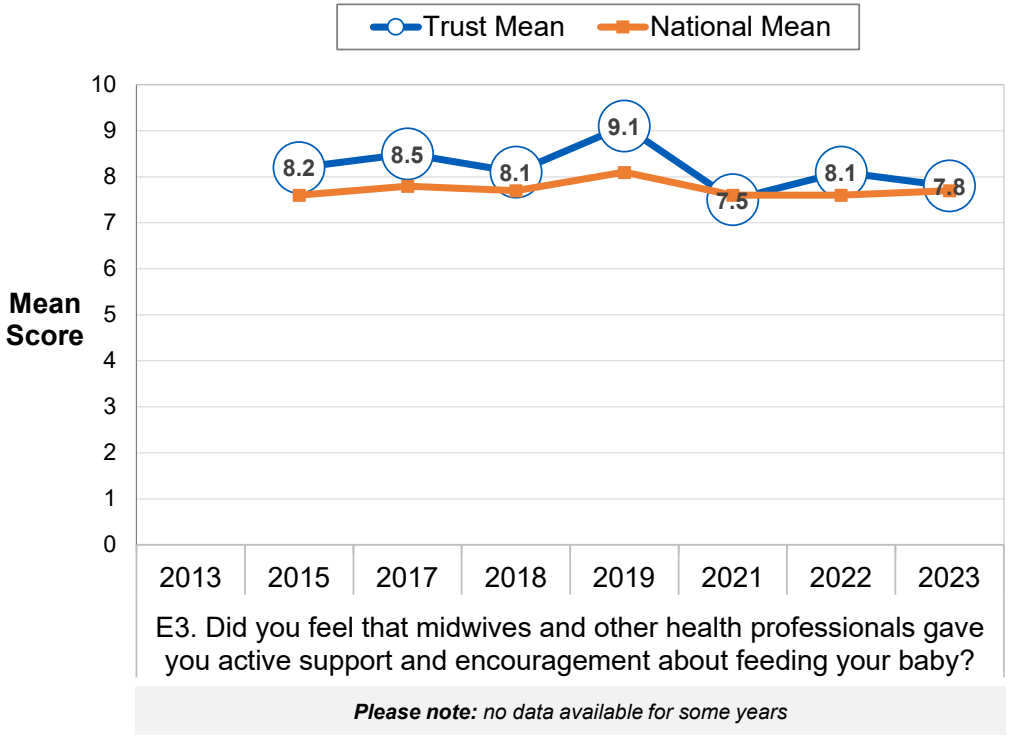
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Feeding your baby



E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Please note: *no data available for some years*



E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth											
F1.	Thinking about your postnatal care, were you involved in decisions about your care?							8.7	8.5	92	
F2.	If you contacted a midwifery or health visiting team, were you given the help you needed?							9.3	8.8	79	

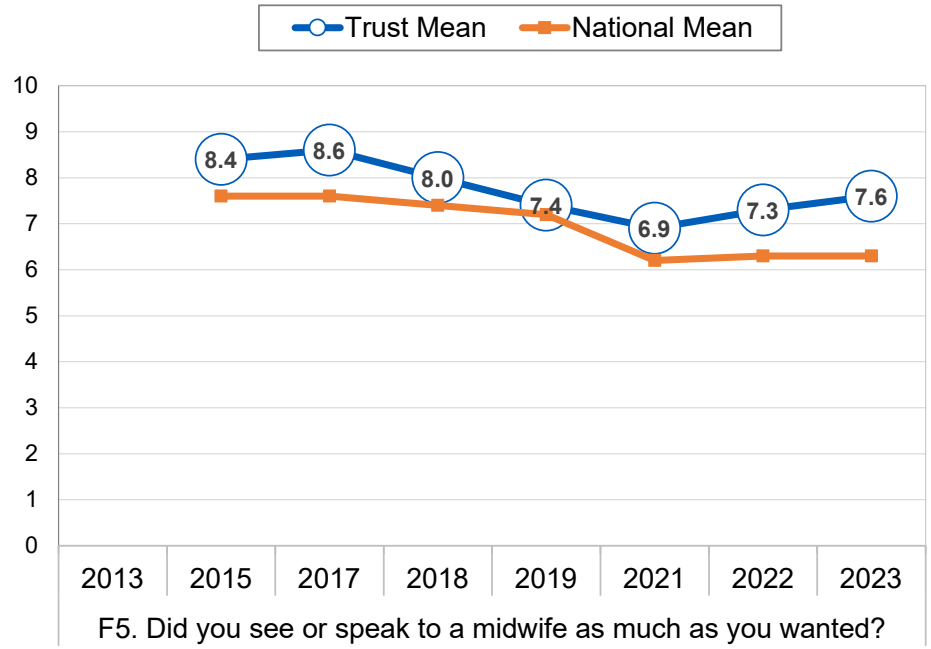
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time – Postnatal care (continued)

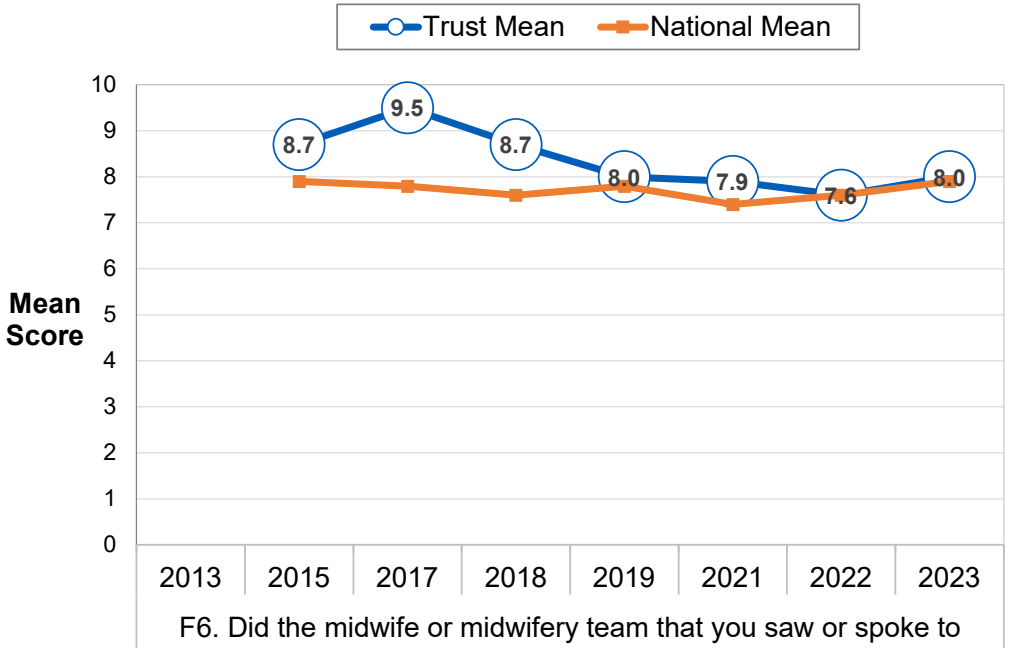
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F5. Did you see or speak to a midwife as much as you wanted?

Please note: *no data available for some years*



F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

Please note: *no data available for some years*

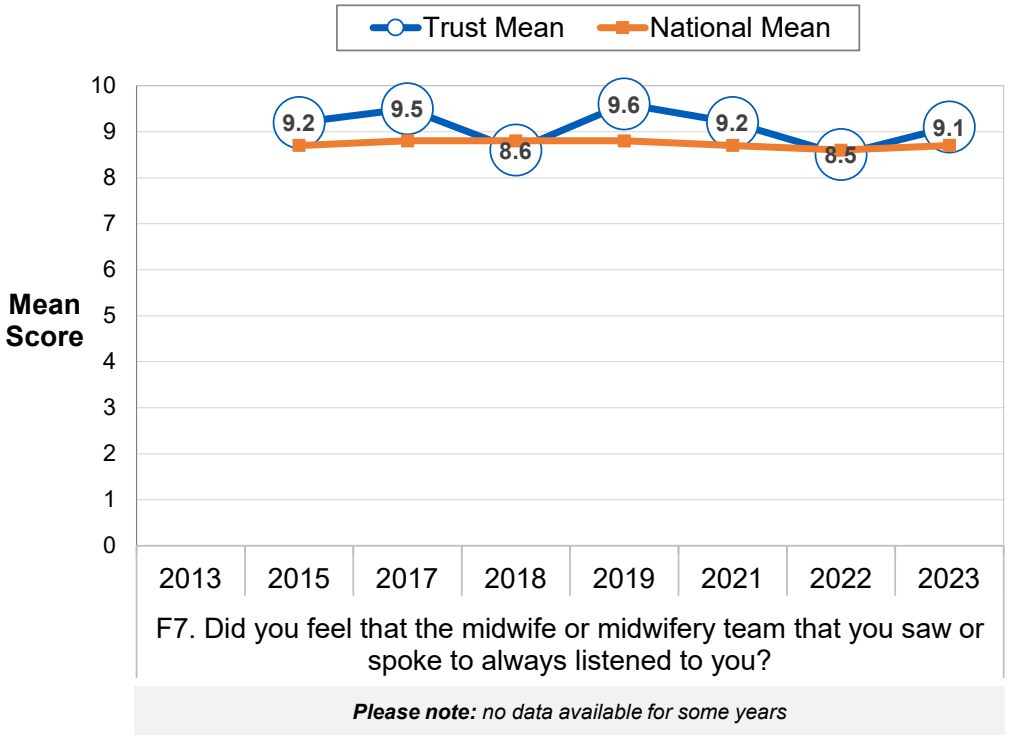
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

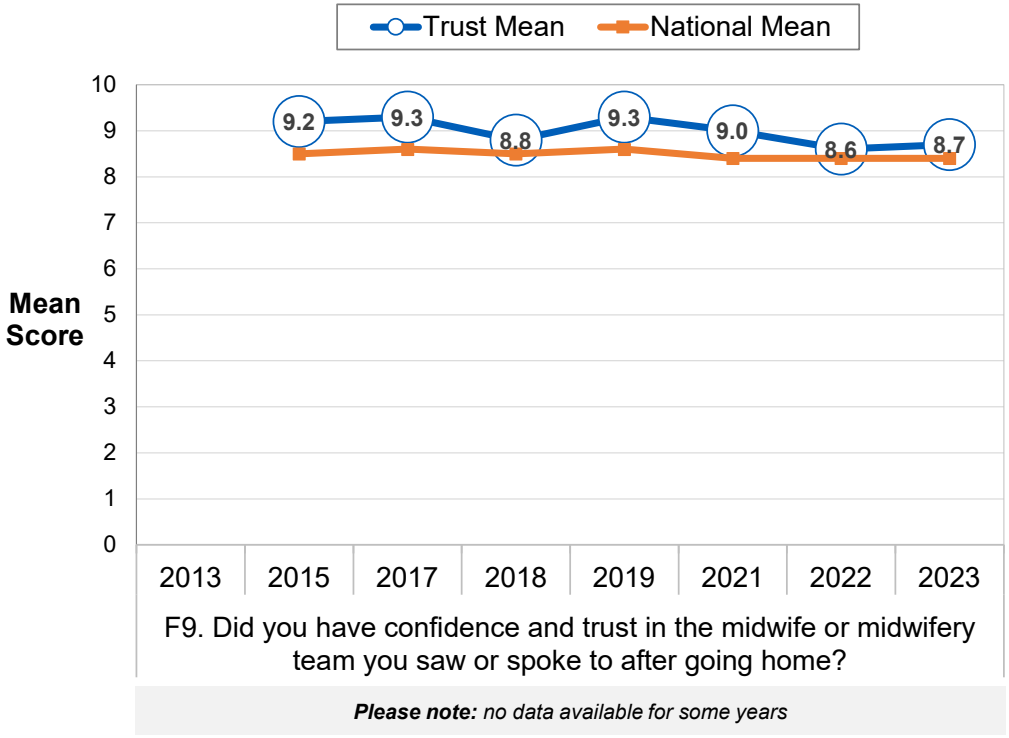
Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



Please note: *no data available for some years*



Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth											
F8.	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?							8.6	8.5	91	
F11.	Did a midwife or health visitor ask you about your mental health?							9.8	9.6	97	
F12.	Were you given information about any changes you might experience to your mental health after having your baby?							7.9	7.1	95	

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth					
F13.	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	9.3	7.5	88	▲
F14.	Were you given information about your own physical recovery after the birth?	7.2	6.9	96	
F16.	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	7.0	5.9	39	

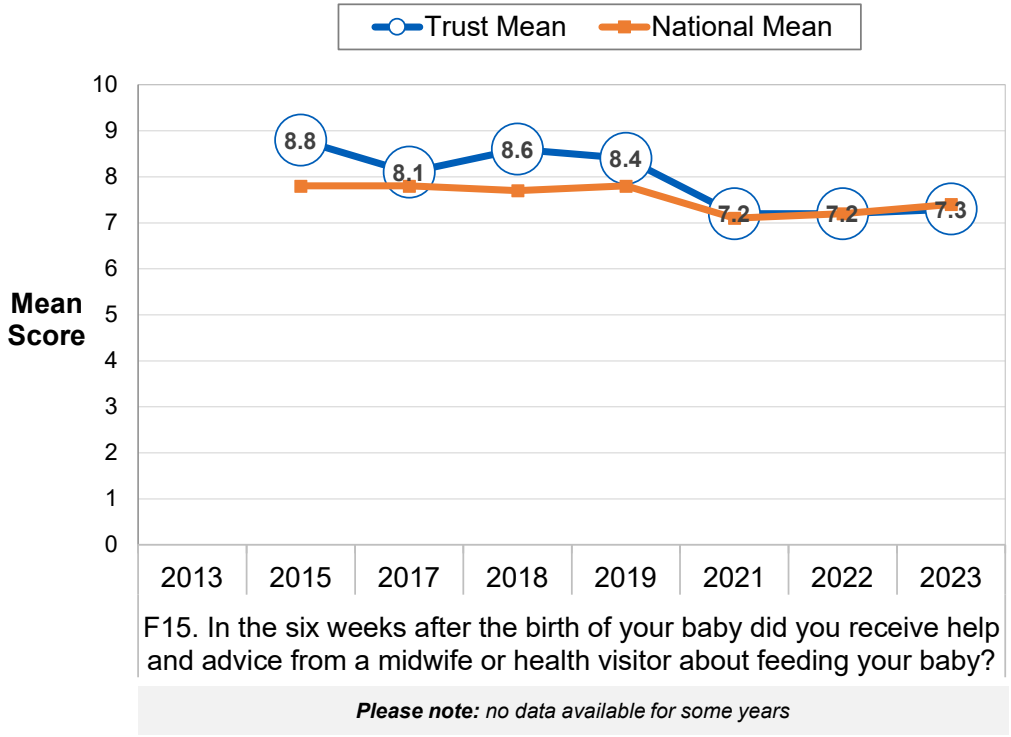
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Please note: *no data available for some years*

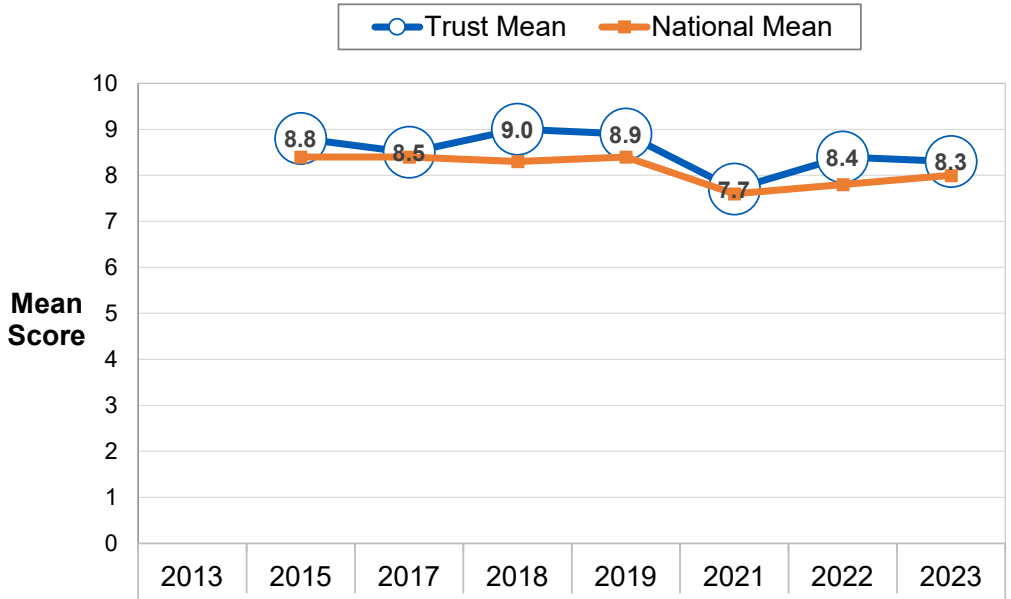
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



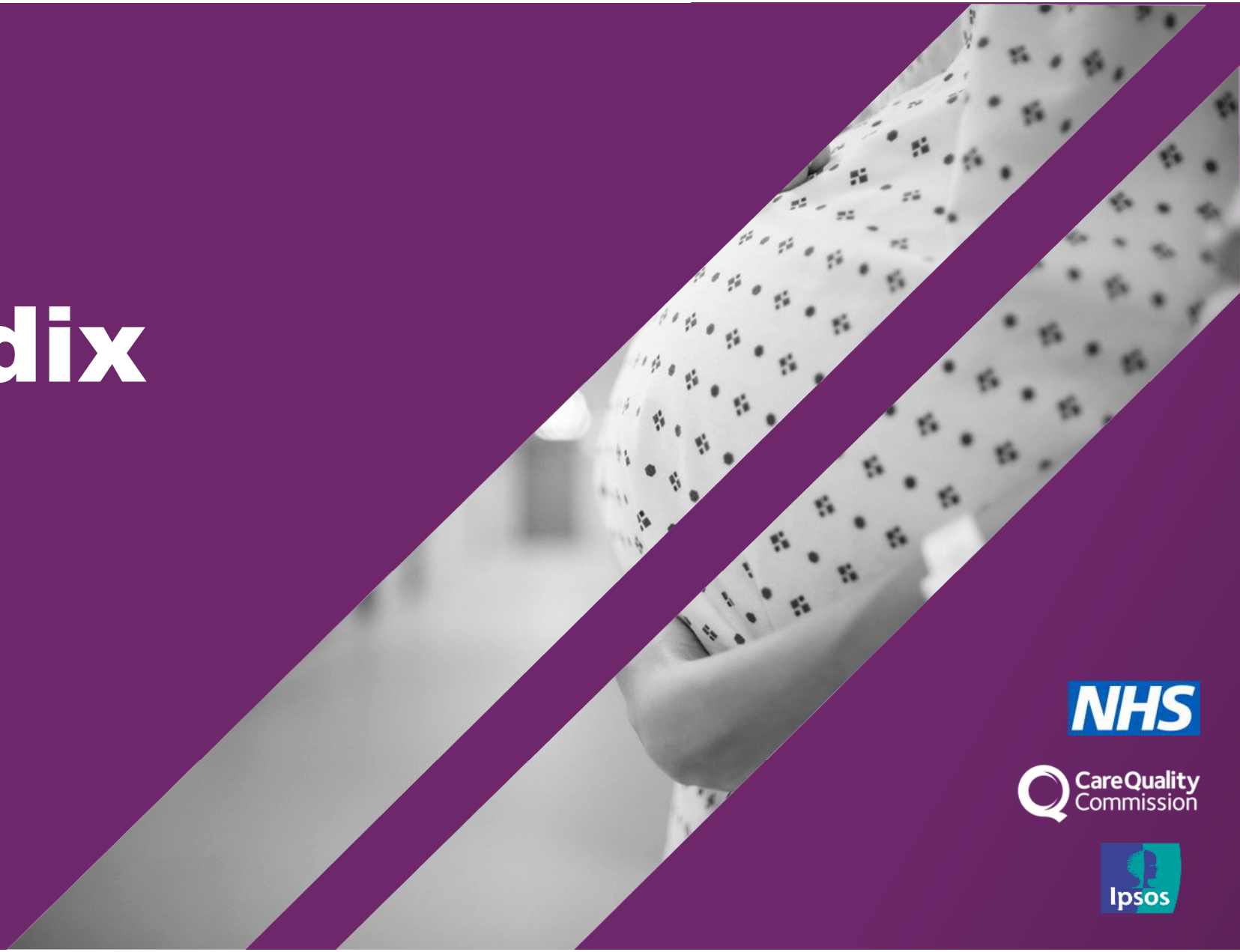
F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Appendix



Comparison to other trusts

The questions at which your trust has performed worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• Your trust has not performed “worse than expected” for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat better or worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? • C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	• Your trust has not performed “somewhat better than expected” for any questions.

Comparison to other trusts

The questions at which your trust has performed better compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Better than expected	Much better than expected
• D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? • F2. If you contacted a midwifery or health visiting team, were you given the help you needed? • F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	• Your trust has not performed “much better than expected” for any questions.

NHS Maternity Survey 2023

Results for Wirral University Teaching Hospital NHS Foundation Trust

Where maternity service users' experience is best

- ✓ Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- ✓ Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- ✓ Maternity service users being given the help they need when contacting a midwifery or health visiting team after the birth.

Where maternity service users' experience could improve

- ○ Midwives or doctors appearing to be aware of the medical history of the service user during labour and birth.
- ○ Midwives or the doctor appearing to be aware of service users' medical history during antenatal check-ups.
- ○ Maternity service users having the opportunity to ask questions about their labour and the birth after the baby was born.
- ○ Maternity service users feeling that healthcare professionals did everything they could to manage their pain in hospital after the birth.
- ○ Maternity service users being involved in the decision to be induced.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where maternity service users experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where maternity service users experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

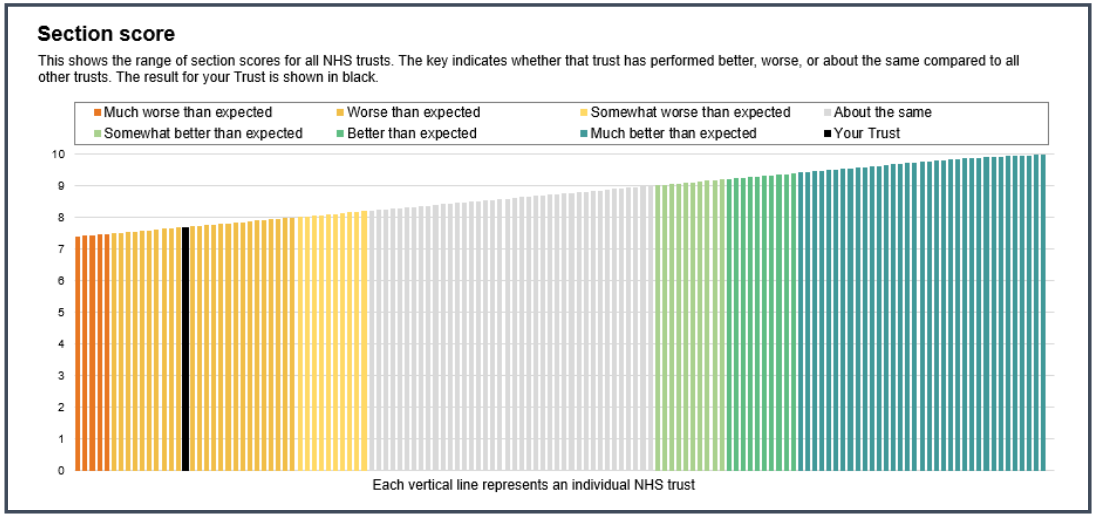
This survey looked at the experiences of individuals in maternity care who gave birth between January and March 2023 at Wirral University Teaching Hospital NHS Foundation Trust. Between May and August 2023, a questionnaire was sent to 300 individuals. Responses were received from 115 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

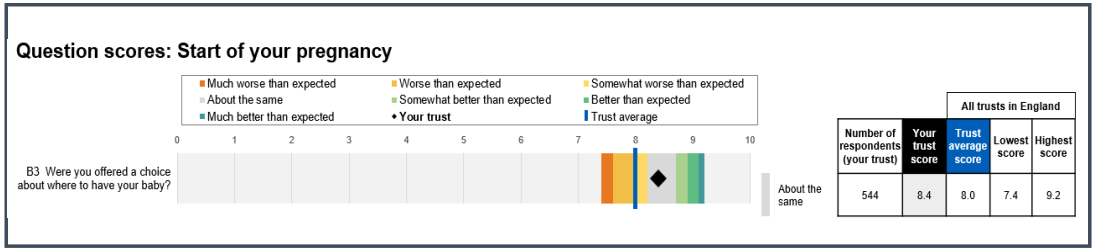
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, 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. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Please note, the benchmark bandings were updated for the 2021 survey to provide a greater level of granularity in the expected range score. The 2023 survey uses the same approach.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the experience of people who use maternity services could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B7 "During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of the people who use maternity services experiences.

Calculating the trust score for each question

The weighting mean score for each trust, for each question, is calculated by dividing the sum of the weighting scores for a question by the weighted sum of all eligible respondents to the question for each trust. Weighting is explained further in the quality and methodology report.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

For further information

Please contact the Coordination Centre for Mixed Methods at Ipsos.

MaternityCoordination@ipsos.com

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 10**

03 April 2024

Title	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Update
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Povey, Head of EPRR
Report for	Information

Report Purpose and Recommendations

The Board received a report in October 2023 that outlined the annual self-assessment against the national EPRR core standards and the submission reported a self-assessment score of 82% which was in line with previous submissions. Following submission to NHS England, through a new process that was being tested across Cheshire and Merseyside, there was a significant deterioration in the compliance score against the standards resulting in the Trust receiving a rating of partially compliant with more standards being scored as partially compliant compared to fully compliant. The Trust challenged NHS England on the change in process, as did the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) and all other acute hospitals within the region, given the volume deterioration across all organisations.

The Board is asked to note the update and the change in levels of compliance and receive a future update on the action plan progress to improve the number of standards to full compliance. It should be noted that the action plan is governed through the Risk Management Committee.

Key Risks

This report relates to these key risks:

- BAF Risk 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.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
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**
31/10/23	Executive Leadership Team	EPRR Core Standards Feedback	Information

1. Background

On an annual basis the Department of Health and Social Care and NHS England require all Trusts to undertake an annual assessment of their Core Standards for EPRR. This takes the form of a self-assessment against each applicable standard and requires a response to be documented and evidenced and an action plan for any standard that is not fully compliant put in place to achieve that compliance.

To assist with compliance, for 2023 guidance was provided on the expectations for each standard to achieve full compliance. The guidance is very prescriptive about what must be in place for each standard and the Midlands trial in 2022 saw most Trust's compliance rating drop in a process being described as 're-setting the baseline'. The process so far has identified some new or additional requirements for some of the standards which will see the Trust rating drop whilst additional requirements move to the action plan.

The Trust submitted the self-assessment and supporting papers by the required deadline.

2. Self-assessment scoring and movement

The Trust submitted the following self-assessment score which was in line with previous years:

Self-Assessment assurance rating	Partially	Percentage compliance	82%
Core standard position after organisation self-assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	51	11	0

NHS England undertook their new assessment process and returned the following compliance position:

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	1	61	0

	Although the category of compliance has not changed from partially compliant, there was a movement of 50 standards that moved from fully compliant to partially compliant through the NHS England review. Attached at appendix one is the site-specific letter for the Trust that has been utilised to develop an improvement plan that will be monitored through the Risk Management Committee. Attached at appendix two is the detailed gap analysis and action plan. There was significant concern across C&M as all hospitals received a compliance score of 50% less than the self-assessment that was submitted. There were a number of meetings with the C&M ICB and NHS England and Chief Operating Officers to challenge the position and despite the challenge no scores were changed. There is a letter attached at appendix three from NHS England for Boards explaining some of the movements from previous assessments demonstrating the widespread deterioration. It should be noted that the Trust's EPRR was tested significantly through the COVID-19 pandemic with strong assurance internally that there are the processes and governance in place to ensure the Trust is in a good position to respond to significant events. In addition, there was a live test of the Major Incident policy and response with the unfortunate M53 incident.

3.	**Recommendation**
	The Board should note the movement in the self-assessment position and the detailed action plan included with clear timescales for improving compliance against the standards. Progress against the delivery of the action plan will be managed through the Risk Management Committee and reports provided to Board as required.

4	**Implications**
4.1	**Patients** • Maintaining robust EPRR plans supports patient safety and ensures service provision can continue in the event of a crisis or other business continuity scenario.
4.2	**People** • EPRR, and the training required by the new guidance, supports staff's ability to continue to provide services in an emergency scenario and provides a structure for a measured response and ensure for their own health and safety.
4.3	**Finance** • Currently, there is no impact on the Trust's financial position, however ensuring plans are in place will support cost aversion in the event of an EPRR event.
4.4	**Compliance** • This report is in line with the NHSE Guidance and supports compliance with EPRR requirements.

To:
Hayley Kendall
Accountable Emergency Officer (AEO)
Wirral University Teaching Hospital NHS Foundation Trust

Date: 6th November 2023

Dear Hayley,

As you will be aware NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the EPRR Annual Assurance process, and for 2023/24 we described how we would further enhance our assurance arrangements using the EPRR Core Standards, by introducing an evidence-based check and challenge process, whereby organisations would be required to submit evidence which supported their self-assessment.

Check & Challenge findings.

For the 2023/24 period, your organisation submitted a provisional self-assessment of –

Self-Assessment assurance rating	Partially	Percentage compliance	82%
Core standard position after organisation self-assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	51	11	0

Colleagues from the North West have now completed a full review of evidence submitted through both primary and supplementary submission periods.

Following completion of the check and challenge process, and review of any supplementary evidence we have identified the following proposed assurance position –

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	1	61	0

The final findings of the check and challenge review, along with the rationale and specifics of any challenges raised, are detailed within this letter, and subsequently

confirms whether the check and challenge team “accept” or “challenges” your organisations provisional self-assessment.

Final Assurance position

Upon receipt of this letter, Accountable Emergency Officers are requested to re-assess their self-assessment scoring based on feedback and any residual challenges. A copy of their final self-assessment and statement of compliance should be returned to your ICB and copied to the regional team (england.eprrnw@nhs.net) within 10 days of receipt of this letter.

For your organisation this means that your final submission self-assessment and annual statement of compliance should be received by close of play on 15th November 2023.

Governance via Local Health Resilience Partnerships

Once your final self-assessment and statement of compliance has been completed, these are required to be signed off by your Board by 31st December 2023.

Your ICB will liaise with you to agree a schedule for Local Health Resilience Partnership (LHRP) meetings, where the normal schedule of confirm and challenge sessions will take place.

At these sessions each organisation will be required to outline their overall compliance level and an action plan for any partially or non-compliant standards.

Where an agreement has not been reached in support of an assurance rating, or where an organisation chooses to submit a higher level of assurance than has been identified through the check and challenge review, a strong rationale must be discussed with peers and their lead ICB as part of the LHRP session, and ahead of a final assurance discussion at the Regional Health Resilience Partnership (RHRP).

Continuous Improvement Cycle - Governance

As with previous years, organisations will be required to provide updates against their EPRR Assurance action plans through their LHRP. The schedule for these updates is linked to the final level of compliance reported by the organisation and in line with our revised approach, the ongoing governance for continuous improvement will require ICBs to review evidence submitted against the organisation’s assurance action plan as part of this process –

- Fully compliant – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- Substantially compliant – formal updates against action plan every 6 months.
- Partially compliant – formal updates against action plan every 3 months.

- Non-compliant - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

Continuous Improvement Cycle – Collaborative Working

We recognise and understand the significance of undertaking the evidence-based review process this year, and the demands and challenges this has placed across the system.

We will be looking to schedule debrief sessions for AEO's and EP leads following completion of the assurance process in order to –

- Identify what elements worked well and could be used in future assurance processes or as part of continuous improvement throughout the year.
- Identify what elements need improvement and require further review and amendment ahead of next year's assurance cycle.
- Identify areas of good practice which can be shared across the system in order to improve our collective resilience and
- Identify where there are consistent themes and trends across domains and services to explore opportunities for collaborative work to enhance collective resilience and reduce burdens on individual agencies.

We hope that colleagues have found the process a useful opportunity to reflect on areas which would further enhance their organisations own preparedness, as well as opportunities to work collaboratively with partners to address common areas of concern.

Finally, we want to again take the opportunity to thank you, and your EPRR lead(s), not only for your engagement in the amended assurance process, but in your support through another challenging year in the world of resilience, and amidst a backdrop of a number of concurrent issues and incidents, not least the prolonged planning and response to the ongoing industrial action.

Kind Regards

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions
NHS England

Cc Anthony Middleton, AEO, Cheshire & Merseyside Integrated Care Board
Beth Warburton, Head of EPRR, Cheshire & Merseyside Integrated Care Board
Steve Povey, EPRR Lead, Wirral University Teaching Hospital NHS foundation Trust

NHS England North West

Appendix 1 – Organisations summary sheet

Organisation name	Wirral University Teaching Hospital			2022/23 Assurance Rating (and % compliance)	Partially – 86%	
Initial self-assessment rating (2023/24)	Partially			If the organisations accept the challenges identified in the check & challenge process their compliance rating would be -	Non-Compliant	
Initial self-assessment percentage compliance	82%			Check & challenge percentage compliance	2%	Variance (-) – 80%

CS	Domain	Standard	Detail of standard	Self-assessment rating	Check & Challenges rating	Accepted or challenged	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	A	Challenged	EPRR policy is a draft. JD does not explicitly refer to COO as AEO
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	A	A	Accepted	
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	Challenged	No evidence of public board meetings detailing the required elements of training & exercising; incidents since last report; lessons & learning

4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	Challenged	Work programme does not demonstrate clear evidence of being driven by risk assessments/registers
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	G	A	Challenged	Evidence submitted does not provide detail to demonstrate that board are satisfied that there is sufficient and appropriate EPRR resource to fully discharge the organisations EPRR duties.
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	A	Challenged	Debrief report submitted as additional evidence is from 2021 and is therefore not recent evidence of continuous improvement. Major Incident Plan is over 12 months old. The section on debriefs does not refer to debriefs being facilitated by trained independent facilitators or lessons identified being tracked through to them being lessons learned.
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	A	Challenged	Evidence submitted does not meet the following compliance requirements: Evidence of EPRR risks on the organisations risk register(s) and review sequence for these Clear evidence of alignment of assessments from the LHRP risk register and community risk registers, and how these are used to update risks
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	A	Challenged	Evidence submitted does not meet the following compliance requirements: Process describing who is responsible for raising risks to the Local Health Resilience Partnership and/or Local Resilience Forum Policy documents explicitly state how EPRR only risks will be managed Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	Challenged	Evidence submitted does not demonstrate collaborative planning by the Trust on EPRR arrangements. Evidence submitted does not meet the following compliance requirements: Organisational plans have undergone a clearly described consultation process (within Policy or management system) Organisations should be able to demonstrate membership and

							engagement within planning groups and how these groups are used to identify stakeholders to engage and consult with Records should be maintained of those consulted with or consultations participated within Any changes to plans as a result of consultations should be clearly documented and outlined as part of the sign off process Where the organisation chooses not to implement consultation feedback this rationale should also be included when signing off the document
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	Challenged	Plan submitted as evidence has not been reviewed in the last 12 months. The content of the plan does not align with current national guidance and contains out of date references and terminology.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	Challenged	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	A	Challenged	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	G	A	Challenged	Comments from Trust noted however previous feedback remains. Pandemic plan is out of date and still refers to PHE actions rather than UKHSA. Also contains factual inaccuracies that police would host the multi-agency SCG. No details of ethics processes in the event of capacity limitations. No details of PPE stock level monitoring.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	G	A	Challenged	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	Challenged	Escalation policy submitted as evidence is for operational pressures and not incidents. The content of the policy is also out of date as new OPEL guidance has been issued and CCGs are no longer in existence. Although the major incident plan, which is out of date, references the national conops it doesn't detail the Trust arrangements to increase capacity.

16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	G	A	Challenged	2 versions of fire safety submitted as supplementary evidence. This doesn't meet the requirements as the evacuation plan doesn't reflect the NHS evacuation & shelter guidance published in May 2023.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	G	A	Challenged	Trust state lockdown policy is currently under review therefore cannot be considered as current. Version submitted as initial evidence did not meet the compliance criteria.
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	G	A	Challenged	
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	G	A	Challenged	Although evidence has been provided of the Trust involvement in multi-agency planning evidence does not include Trust planning documents detailing arrangements for responding to mass fatalities or excess deaths.
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	A	Challenged	
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	A	Accepted	
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	A	A	Accepted	
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	A	Challenged	

24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	A	Challenged	
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	Challenged	
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	G	A	Challenged	
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	A	Challenged	Comments from Trust noted however not evidence of access to hard copies of polices and how these are managed has been provided.

28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	Challenged	
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	A	Challenged	Evidence submitted does not meet the following compliance requirements: Templates/log books meeting the required legal standard should be available for logging Clear process for calling out Loggists in organisation in place, this should be able to operate 24/7 Organisation has identified the number of Loggists required based on assessment of need and potential organisational demand and this is actively monitored Arrangements make reference on how to work with Loggists, sign off logs etc Roles indicate who will work with the Loggists and their function There is reference to the records retention periods for logs and records associated with incident response and routine on call Call out of Loggists should be part of the communications exercises testing response staff Arrangements are clear on log sign off processes – including where electronic logs have been used
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	Challenged	
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	G	A	Challenged	
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	G	A	Challenged	

33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	Challenged	
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Challenged	
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	Challenged	
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	A	Challenged	
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	Challenged	No evidence that AEO has attended an LHRP meeting in the last 12 months. No evidence that AEO or suitable director level rep has attended 75% of LHRP.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	Challenged	Evidence submitted does not meet the following compliance requirements: Clear governance arrangements for the Local Resilience Forum documented in Policy Governance arrangements for the organisation demonstrate how will be represented in multiagency forums (e.g. by ICB) and if participating as an invited member of any LRF groups
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	G	A	Challenged	

43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	A	Challenged	
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	A	Challenged	
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	A	A	Accepted	
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	A	Accepted	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	A	A	Accepted	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	Challenged	Trust comments noted. However, the Covid response is not an adequate test of all BC arrangements.

49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	G	Accepted	
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Accepted	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A	A	Accepted	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Accepted	
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	Accepted	
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	A	Challenged	
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	G	A	Challenged	

57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	Challenged	
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	G	A	Challenged	
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	G	A	Challenged	
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist:	G	A	Challenged	

			https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf				
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	G	A	Challenged	
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	A	Challenged	

63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	G	A	Challenged
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	A	Accepted
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	Challenged
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	G	A	Challenged

	Action Plan			Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	In accorance with the NHSE EPRR Framework, the Trust has asspointed Hayley Kendall, Chief Operating Officer as the Accountable Emergency Officer. Details of the responsibilities associated with the role are in Section 3 of the Trust EPRR Policy including LHRP Representation.	Partially Compliant	Policy due March 2025 but will be refreshed earlier.	S Povey	Mar-24	EPRR Policy amended to include reference to COO being AEO, even though it is clearly included in the job description. Completed
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust EPRR Policy, last reviewed May 2022, contains the roles and responsibilities for key positions and references its approval to the Trust Risk Management Committee and Trust Board. Note that the Trust does not have a dedicated Emergency Planning Committee as the EPRR portfolio refers through to the Risk Management Committee. Section 6.1 of the Policy references the BCM process for departments internally and also for utility and consumable providers	Partially Compliant	Amend policy to include more indepth governance arrangements, make specific mention of Trust objectives and specifically mention 'owners' of core standards 3 to 9.	S Povey	Sep-24	Action ongoing
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	EPRR Annual Report and Core Standard Assurance Statement approved at Risk Management Committee and noted in Chair's RMC Report to Board of Directors in March 2022. Standard achieved The EPRR Annual Report must go to the Trust Board (Public Board) and also a statement appear in the Trust Annual Report & Accounts.	Partially Compliant		S Povey	Sep-24	23/24 Board Report will have consistent terminology following transistion of EPRR functions to 'Head of EPRR'. Arrangements in place for this to go to Trust Board via RMC.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an Annual Work Plan that is published each year and updated throughout the year.	Partially Compliant	The LHRP Risk Register has not been updated since pre-covid. ICB are currently asking for volunteers to sit on the Risk Register Working Group, SP has offered as he was part of the last review to offer continuity. Regional Risk Register made available to Trusts late January 2024, Trust risks and common risks to be included in trust policies.	S Povey	Jun-24	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Major Incident Plan (reviewed March 2022) and action cards describe resourcer and roles and responsiblities. The Trust CBRNE & HAZMAT Response Plan (Reviewed March 2022) is also relevant. The response for decontamination events is suitable resourced and is included in the new build ED plans to provide permanent connections and a designated area for wet decontamination. Current arrangemnts are in place utilising a generator and temporary water supply. Items are services in accordance with the manufacturers requirements. the Trust has a two tier On Call System with Hospital Managers supported by a Manager on Call and Director On Call who are available 24/7.	Partially Compliant	Query that policies aren't signed off by board. Correct they are not, there is an establsihed structure for policies in the trust that does not have to be approved by Board. Roles are in section 3 of policy 347 and were available for assessors, this will be an explicit part of future responses. Ongoing discussion with ICB on NHSE expectations v trust reality	S Povey	Jun-24	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The Trust has in place; Major Incident Plan,, Annual Report, Risk Register entries, Debriefs from exercises and incidents which detail learning. Learning from debriefs following training, exercising or a live incident are documented and have an action owner. Where appropriate lessons are sahred with partners at L:HRP Meetings.	Partially Compliant	We have not had anything to debrief since then. This Standard needs to cover this eventuality or accept the last completed debrief. Given we have been in a national level 4 incident we have evidence of lessons learned from Covid. We have now debriefed afollowing the M53 bus incident and are currently undertaking a lessons learned exercise for the first 6 months of CSW action which can in included as part of the 2024 response.	S Povey	Jul-24	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The Trust has a Risk Management Policy and EPRR Risks are included on the trust risk register. Signifcant/major incidents are recorded on the trust BAF. Trust attendance at LHRP Strategic and Practitioner meetings where EPRR risks are considered and recorded. Trust EPO is part of the working group for the LHRP Risk Register.	Partially Compliant	LHRP Risk Register is out of date and last worked on when NHSE were in charge of it. ICB are currently forming a working group to update. Trusts do not attend Local Resilience Forums, ther are represented by NHSE and/or ICB. See also Core Standard 4 update. ICB action required	S Povey	Jun-24	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR policy references the Trust risk management policy and risks are reviewed on a monthly basis. AEO and Head of EPRR attends Risk Management Committee.	Partially Compliant		S Povey	Dec-24	This will require a partial re-write of the Trust Risk Management Policy to specifically mention EPRR, it currently is generic. Coversations required with Trust Risk Management,ICB and NHSE to see how practical and relevant this is EPRR Policy to be amended with process to escalate EPRR Risks to LHRP and beyond to LRF via the LHRP which will be specifically mentioned within the trust EPRR Policy now that this structure is in place. Ongoing as of Feb 2024.
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The Trust Policy structure sees all policies apporved at local level and then sent to a parent committee (Risk Management for EPRR), all policies are then published fro consultation before being formally approved.The Trust liaises with other Acute Networks and with other trusts, ICB and NHSE via the LHRP structure at both Practitioner and Accountable Director level	Partially Compliant		S Povey	Mar-24	Evidence sent (Trust Policy 000) does not seem to satisfy the requirmeent despite appearing to be in line with the requirement. Under discussion with ICB.
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plans reviewed 3 yearly in line with EPRR framework. WUTH has been involved in several major incidents in previous years. No significant command issues highlighed by the subsequent debriefs and command framework has been used for pandemic response.	Partially Compliant		S Povey	Mar-24	Trust Policy is for a 3 yearly update of policies unless identified specifically otherwise. The current policies submitted were within date according to Trust policy. This is a new requirement and has never been challenged/mentioned before. SP will discuss to see if the 3 year policy window can include a x.1 and x.2 policy check in years 1 and 2 after introduction prior to a full x.0 in the third year. Ongoing as of Feb 2024.

11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has a Severe Weather Plan in place which was reviewed in March 2022. The plan references hot and cold weather extremes and also covers flooding. The trust has a MoU with North West 4x4 to assist in extreme conditions. Communications arrangements are in place that utilise internal and external communications. the trust has a group set up for |CLimate Adaptation Planning with its first meeting being scheduled.	Partially Compliant		S Povey	01/03/2024	This Policy has followed the Trust 3 year review process, in addition a new plan has been received from UKHSA and there has been insufficient tiime to review this polcit, make changes to the Trust Policy and go through the review, consulatation and aproval process to update the current trust version in time for it to be concluded in this years Core Standards. This may be a repeating process depending on when UKHSA release updates. SP will discuss and escalate to ICB as there will need to be a 'Received by' cut off date to allow trusts to integrate revisions into their own plans. This also would require anannual x.1 and x.2 reviews ahead of the 3 yearly main check. Feb 2024 - As per Standard 10
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Policies and procedures as detailed in the health & Social care act. COVID Board assurance framework IPC Team Outbreak policy Fit testing service PPE policy Isolation policy Ongoing surveillance Infection Prevention & Control Group that is chaired by the DIPC and signs of all relevant policies and procedures Annual work plan 3 yr IPC strategy Trust intranet has current guidelines	Partially Compliant		S Povey	Apr-24	This covers work done by Pharmacy, IPC and Occupational Health Teams, which is subject to scrutiny elsewhere. Whilst some responses to outbreaks are pre-determined and already exist, the response to Covid should be considered in that pre-determined processes were not used and the mass vaccination of the population was done using a newly created model. Conversations are required to look at the relevance of including such detail in an EPRR response as whilst being under the broader umbrella of EPRR some of the comments are referring to work in other areas. Whilst this does need to dovetail in, we need to ensure that we are not duplicating workstreams as the Trust has this covered under IPC under the Director of Infection Prevention and Control. Feb 2024 - Under discussion with ICB
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fit testing service for FFP3 masks Local COVID policy reflecting national guidelines. Local monkey pox plan Weekly Clinical Advisory group that oversees all new and emerging pandemics Trust intranet has current guidelines IPC COVID BAF Collaborative flu preparedness meetings	Partially Compliant		S Povey	Mar-24	The UKHSA has not yet produced a Pandemic Flu Plan, the last version exists under the previous PHE guise, therefore, there are no UKHSA actions to refer to. Ppe Stock level monitoring is a wider process within IPC and to a lesser extent procurement. The Policy is not out of date and is within the Trust prescribed timescales, however, other points will be reviewed as part of a wider policy review. This again would appear to need the trust to look at an x.1, x.2 approach inside the 3 year review period. Feb 24 - Trust plan to be updated but may need further update after UKHSA review the national plan.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	MOU in place between our community/partner organisations to work in collaboration as and when needed. Monthly collaborative meetings between partner organisations Nerve agent information and other resources in an emergncy details in MS Teams On Call Group and within ED.	Partially Compliant		S Povey	Mar-24	This is being looked at centrally via the ICB as no Trust achieved this standard.In addition a SitRep process would be identifed within the EPRR Policy/Major Incident Plan. PGD processes are done within the Pharmacy Department.
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	NHS England Concept of Operations for managing Mass Casualties incorporated into the Trust Major Incident Plan. Patient identification included in the ED major incident plan/action cards. Mass casualty action card (Plato Action Card) included in the Hospital on-call booklet and Major Incident Plan. NWAS regional casualty allocations agreed with ED and agreed by AEO. Full Capacity Protocol available to assist onboarding and discharge. Plan in place for unidentified patients.	Partially Compliant		S Povey	Complete	Trust Escalation Policy has been updated and is now available and indate to meet this standard. We believe we are now compliant.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation Plan in place. NHSE Evacuation and Shelter guidance incorporated into plane. Shelter is the responsibility of the Local Authority Evacuation Policy review undertaken with NWAS & MFRS Evacuation Workshop held with On-call managers, Hospital Clinical Coordinators & Executive Directors on-call	Partially Compliant		S Povey	Mar-24	The revised Evacuation and Shelter Guidance was published in 2023, Wirral Health Resilience Group have yet to meet since this was published to discuss any changes. This is a group containing representation from local authorities whose remit Evacuation and Shelter comes under. The Trust plan will be updated when all stakeholders are in agreemenet of the process to follow. Feb 24 - Final amendments awaiting final advice from ICB Evac & Shelter Task & Finish Group.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy in place, currently under review following incient at CGH site that required multi agency response. Alternative ICC nominated. Staff communications route updated following incidnet at CGH. Plan is scalable dpending on locaation and risk.	Partially Compliant		S Povey	May-24	Trust Estates are currently reviewing the Trust Lockdown Policy with Trust EPRR involved in the process.

18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referred to in the Major Incident Plan. Referred to the Communications Plan.	Partially Compliant		S Povey	May-24	Needs to be incorporated into Trust policies.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust engages and contributes to the LHRP via the Deaths Management Working Group and Mersyside Mass Fatalities Plan. Mortuary Action Card details storage arrangements for Major Incident/Mass Caualty Incident, wider Merseyside plan activated when capacity reached, in accordance with ICB/NHSE.	Partially Compliant		S Povey	Jun-24	Further information from Mortuary, potentiallly look at developing a Mortuary Escalation Action Card. Document regional role and Mortuary Managers Meeting and Excess Deaths Group.
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	24/7 Manager & Executive Director level on-call in place, SPOC via Trust switchboard 24hr/7 days Major Incident Plan Switchboard cascade In & out of hours plan in place, tested every 6 months On-call booklet in place for all managers and directors WUTH has been involved in 3 major incidents with no significant issues highlighted • Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff."	Partially Compliant		S Povey	Jun-24	Review of major incident policy to ensure alingment with the EPRR policy.
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	1st and 2nd On Call staff are undertaking Principals of Health Command Training on an ongoing basis delivered centrally by NHSE. Internal training for on call and training checklist. Sessions throughout the year for new staff and existing staff as a refresher. All staff transferring to NHSE Portfolios, final versions received late July. Training being formulated to meet this requirement.	Partially Compliant	Training Portfolios being introduced alongside Principles of health Command Training and rolling plan of courses needed to comply updated which will involve internally and externally delivered training.	S Povey	Sep-24	This relates to the new requirement for formal training and training portfolios. Exect to have all oncall staff up to date with a documented portfolio by the end of quarter two.
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning. Transfer to NHSE Training Portflios under Principles of Health Command to take place from Q4 2023 onwards. Record of 1:1 induction checklist sent to delegate Certificate of attendance for training sent to delegates for their portfolios Attendance sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintaing centrally by Emergency Planning • Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for all on call staff, new requirement and will be delivered through the year	Partially Compliant	Training programme to update on call training to meet Principles of Health Command requirements in development, it is anticipated that this may take an extended time period to introduce and maintain.	S Povey	Aug-24	Training programme to update on call training to meet Principles of Health Command requirements in development, it is anticipated that this may take an extended time period to introduce and maintain. Feb 24 - ongoing, discussions also taking place with ICB for centralising some training and also for centralised contract negotiation with external suppliers.
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely" test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidenced in EPRR Annual Report Debrief Reports produced and shared at LHRP for shared learning • Exercising Schedule • Evidence of post exercise reports and embedding learning. Exercising administration to be updated to include aims/objectives in planning stage, link with ICB for local COMAH Participation. CBRN traning and exercise commencing following re training of trainers in July 2023. EMERGO course in planning stage for new ED Department opening.	Partially Compliant		S Povey	Jun-24	The Trust Training and Exercisisng Programme was submitted, however it has not previously referenced the Trust EPRR risks when planning exercises and there have been no EPRR risks specifically recorded. This is addressed with Core Standard 7. All future exercising will use a planning template which documents aims, objectives and references trust, regional or national risks it aims to prepare for. Feb 24 - Risk Registers published end of January, the trust can now cross reference current riaks and include them inpland and trust risk assesments.
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning Record of 1:1 induction checklist sent to delegate Certificate of Attendance for training sent to delegates for their personal portfolios. Attendance Sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintained centrally by Emergency Planning - Training records - Evidence of personal training and exercising portfolios for key staff. - Personal portfolios to be included in PADR process for On Call staff.	Partially Compliant		S Povey	Sep-24	Training Needs Analysis has not been a previous requirement in this format, the adoption of the on call portfolios and explicit improvements to Trust policies such as Major Incident will identify specific responder functions and associated training needs. Reference to historical training indicates when some aspecte were last refereshed. Feb 24 - On Call portfolios and Risk registers will inform the training needs analysis.
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	On call and key responder staff receive training for their specific rsponse roles. All staff receive introductory induction training on the role of EPRR. Incident action cards are clear on roles.	Partially Compliant		S Povey	Jul-24	Training has not taken place since pre-Covid and therefore needs to re-commence, The NHS National/Regional Incident in response to Covid-19 was stepped down in May 2023 following which Trusts began to look at training and execising again, as we are doing at WUTH. It is fair to say that the Trust processes are in place given the successful response to the national emergency. Feb 24 - On Call Portfolios will educate some training, identified training also to be programmed in to new training matrix.

26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Radiology Conference Room is the Major Incident Room The Boardroom is the back up room All on-call forums and 1:1 inductions are held in the Major Incident Room to ensure on-call are clear on where the room is and what is available in the room Site Maps, action cards and plans etc are in a locked cupboard in the room. The key located and door codes for Radiology are described on the on-call major incident action card which is inlcuded in the on-call booklet. Major Incident Room used a number of times for major and critical incidents etc and no significant issues highlighted.Resilient phone lines in Radiology Conference Room.	Partially Compliant		S Povey	Apr-24	Action Cards for opening/operating were provided. Terminology will be made consistent across plans and policies but is a minor point. The resilience of telephones is not mentioned and should be. Trust opinion is that this needs to be centrally led across the NHS. Feb 24 - Trust pushing resilient telecomms on the regional and national agendas. Major Incident Plan under current review to ensure consistent terminology.
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	All polices are verision controlled under the Trust document control processes. Digital copies are available vis MS Teams and Resilience Direct with hard copies present in the Major Incident Room. External partners are issued with digital versions but will be replaced in future with access to Partners page on Resilience Direct.	Partially Compliant		S Povey	Jun-24	EPRR Policies distrubution management needs to be added into the EPRR main policy along with locations of hard copies and document/version control arrangements for these. Feb 24 - Development of Resilience Direct pages for partner organisations underway.
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity response plans in place and available on the Emergency Planning Intranet page. Trust is moving to the recently issued NHSE Business Continuity Toolkit and has commenced training within Directorates.	Partially Compliant		S Povey	Aug-24	The Trust has adopted the new NHSE Business Continuity Toolkit and is rolling out training and support. All Divisions, departments will be required to follow this model. The launch of this is being scheduled which is following the adoption by a number of areas as a trial. Feb 24 - Further departments have had training ahead of mass roll-out.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	List of volunteers for trainined Loggists kept in the Major Incident Room (out of hours)and the Quality & Safety Department (in hours) Request of Loggist included in the Commander's action card (out of hours) and Quality & Safety Action Card (in hours) Record of training maintained centrally by Emergency Planning. Trust has a supply of MI Log Books in the MI Room. • Documented processes for accessing and utilising loggists • Training records	Partially Compliant		S Povey	Jun-24	The Log books and Pocket Log Books used by the trust meet legal requirements and are bought in from an aproved supplier. The trust is currently recruiting additional Loggits for either the blended UKHSA on line course or training by the Head of EPRR who is an Approved Loggist Trainer. Part of the On Call Training for Managers and Directors is attendance at the 'Working With Your Loggist' course which includes all arrangements for sign off etc. Communications Exercises to feature call out of Loggists going forward.
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	METHANE Template inlcuded in the on-call booklet and MS Teams Groups for On Call Managers and Directors Information Team, Infection Control Team and Emergency Preparedness able to upload SitReps via Strategic Data Collection Service (SDCS).	Partially Compliant		S Povey	Apr-24	Sign off process for SitReps is within the Command & Control Structure. This will be documented in the main EPRR/MI Policy. As part of the processs for the upgrading of Core Standards documentation the On Call Handbook have a major update and review of format.
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance Specific guidance on nerve agents, EPRR blood transfusion guidance are available on the On Call Teams groups	Partially Compliant		S Povey	Apr-24	The Guidance mentioned is accessible to On Call Staff through the On Call Teams Groups for Managers and Directors. This has not been accepted by NHSE. Trust to look at the availability for electronic and hard copies across the trust sites.
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Trust CBRN policy ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance	Partially Compliant		S Povey	Apr-24	The Guidance mentioned is accessible to On Call Staff through the On Call Teams Groups for Mangers and Directors. This has not been accepted by NHSE. Trust to look at the availability for electronic and hard copies across the trust sites.
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Trust communications and media policy Major Incident Plan Social Media Policy Inclusion of communicaitons Lead in the Command Team Information tracking sheets held in the Major Incident Room WUTH has been involved in 4 major incidents in the past 4 years that have been noted as being well managed	Partially Compliant		S Povey	Jun-24	Trust Policy is out of date. Liaising with Communications Team about general policy and whether we need an EPRR Communication Strategy separately from the main Comms Policy.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Trust communications and media policy Major Incident Plan Social Media Policy Inclusion of communicaiton lead in the Command Team Information tracking sheets held in the Major Incident Room Action Card in place for Comms Suppport including Out Of Hours SPOC via On Call System	Partially Compliant		S Povey	Jun-24	As response to Core Standard 33

35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Trust communications and media policy Major Incident Plan Section 5 Social Media Policy Inclusion of communicaitons lead in the Command Team Information tracking sheets held in the Major Incident Room MRF Contacts Directory in On Call Teams Group to ensure latest partnet contact detils are available.	Partially Compliant		S Povey	Jun-24	As response to Core Standard 33
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust Major Incident Plan details the forms of response during a business continuity/major incident, in particular Section 5. Trust executive team has recently completed media training to ensure a good pool of people available as spokespeople.	Partially Compliant		S Povey	Jun-24	As response to Core Standard 33
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The Trust AEO attends LHRP Strategic Meetings, in their absence, another Director or the Trust EPO will attend with delegated authority. The Trust EPO is a member of the Energy Resilinence Group and ha soffered to continue on the Risk Register Group.	Partially Compliant		S Povey	Jul-24	LHRP Meetings were hosted by NHSE and transferred to the ICB. NHSE have not provided any attendance lists, ICB attendances were supplied but as they do not cover 12 months the full picture was not available. NHSE have this evidence themselves. Going forward the trust has requested that the LHRP Practitioners Group receive a report at the summer meeting closest to Core Standards that contains the attendance matrix for LHRP Strategic and Tactical Meetings..
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The Trust is represented at both the Cheshire and Mersey Resilience Forums by the ICB with support from NHS England. LRF business is fed through the LHRP meetings.	Partially Compliant		S Povey	Apr-24	NHSE & ICB attend this meeting and feed back down to trusts, they are asking to be sent their own agenda and minutes. The trust will document with its own policy that they are represented by NHSE and the ICB and that escalations will go through EPRR and/or Risk Committee and be escalated through the LHRP Strategic and Tactical meetings. NHSE have confirmed that non AEO attendance must be deputised by another Executive Director, a deputy or the trust EPO standing in will be recorded as non-compliant.
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual Aid arrangements are contained in Section 3 of Major Incident Plan. Muitual Aid requests would be made by the COO, Deputy COO or On Call Manager. A MACA Request would be made via the On Call Director to NHSE with a request for the appropriate form. Mutual aid is coordinated via the C&M SCC structure.	Partially Compliant		S Povey	Jun-24	The Trust needs to look at and refresh any agreements that are in place. PRPS to be take to next LHRP Mereting as this should be centrally co-ordinated, MACA requestes are done via NHSE. Need to look at voluntary groups and check any agreements . Feb 24 - NW 4x4 agreement being renewed and ICB are co-ordinating the refresh of an NHSE document to be signed by all trusts.
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Major Incident Plan Code of Conduct - handling personal identifiable information Information Governence Policy Information Security Policy EPRR data sharing protocols with Trust IG Lead. Data Protection and sharing information in emergencies guidance is available in the On Call Teams Groups	Partially Compliant		S Povey	Jun-24	Need to include formally within the Major Incident policy and EPRR policy.
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trust EPRR Policy is in place, however, this is to be reviewed as a result of the Trust adopting the NHSE Business Continuity Toolkit, thereofre, all policies are to be re-written to follow this format.	Partially Compliant		S Povey	Complete pending Policy Approval	Revised Policy includes this statement.
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	This is included in revised BCP Policy currently being rolled out, the existing policy is in place whilst the new training is rolled out and meets the requirements. The Trust is expected to be compliant once the policy has been re-written.	Partially Compliant	Trust are currently rolling out the NHSE Business Continuity Toolkit to Divisions and Departments	S Povey	Dec-24	Initial launch to departments by end of calendar year followed by divisions and departments updating all BIA AND BCP documents which is expected to take until June 2024 and then be placed on a rolling refresher programme.

46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	EPRR policy BIAs available on the Trust intranet, the response to Covid-19 resulted in plans being used in earnest and a review is now required as part of the opeartional debrief.	Partially Compliant	BIA documents will be improved via adoption of the NHSE Business Continuity Toolkit and these documents will then replace the existing ones on the Trust EPRR intranet pages and into the on-call Microsoft Teams channels.	S Povey	Jun-24	BIA Documents will be improved via adoption of the NHSE Business Continuity Toolkit and these documents will then replace the existing ones on the Trust EPRR intranet pages and into the on-call Microsoft Teams channels.
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCPs available on the Trust intranet Policies are available for departments but reviews range from 2019 to 2022. BCPs are currently being reviewed against the new guidance and thus it would no tbe possible for the Trust to be compliant given the timescales since the new guidance was released. Review needed to ensure that column D subjects are covered by all plans.	Partially Compliant	BCP Documents will be improved via adoption of the NHSE Business Continuity Toolkit and these documents will then replace the existing ones on the Trust EPRR intranet pages and into the On Call Microsoft Teams channels.	S Povey	Jun-24	BCP Documents will be improved via adoption of the NHSE Business Continuity Toolkit and these documents will then replace the existing ones on the Trust EPRR intranet pages and into the on-call Microsoft Teams channels.
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Testing and Exercising elements are included in the re-writing of the BC Plan following the adoption of the NHSE Business Continuity Toolkit. To date the Trust has tested its BCPs under digital downtime, COVID-19 and power outage.	Partially Compliant		S Povey	Dec-24	All testing and exercising was stood down during Covid response as a genuine incident was taking place. The National/Regional stand down to this took place in May 2023. Following this the Trust have adopted the new NHSE Business Continuity Toolkit which is being rolled out across the Trust and following all areas revising their plans a series of testing will take place. This will be completed through to the end of the calendar year.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the Board.	• Business continuity policy • BCMS • performance reporting • Board papers	The trust has in place policies and regular Board Reports and an Annual Report. This is to be fully updated following the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant	The trust BCMS is being improved by the adoption oof the NHSE Business Continuity Toolkit, the use of Plan, DO, Check, Act going forward is integral to the training being provided.	S Povey	Jun-24	The trust BCMS is being improved by the adoption of the new NHSE Business Continuity Toolkit, the use of Plan, Do, Check, Act going forward is integral to the training being provided.
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	EPRR policy Annual Report Major Incident debriefs The Trust has reviewed its own performance via the completion of Core Standards	Partially Compliant	The process for audit is being developed alongside the adoption of the NHSE Business Continuity Toolkit. Going forward this will include Core Standards Self Assessment & Peer Review, and potentially external auditors and ICB/NHSE.	S Povey	Jul-24	The process for audit is being developed alongside the adoption of the NHSE Business Continuity Toolkit. Going forward this will include Core Standards Self Assessment & Peer Review, and potentially external auditors and ICB/NHSE. Feb 24 - Questions as to what NHSE deem acceptable for internal/external raised across the region. ICB seeking clarification.
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	EPRR Policy Ref debrief Millennium - during Covid regular reporting and testing BCPs postponed in line with national policy. Trust re-establish the annual planned reviewed of the effectiveness of the BCMS and the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant	The trust has always debriefed and produced Action Plans and Learning from any incident and this will continue to take place whilst utilising the approach in the NHSE Business Continuity Toolkit	S Povey	Dec-24	The trust has always debriefed and produced action plans and learning from any incident and this will continue to take place whilst utilising the approach in the NHSE Business Continuity Toolkit
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Procurement Department seeks assurance from suppliers, this process will be re-inforced by the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant	Assurance has tradiotionally been sought via the Procurement department. As part of the revised BCP process we will be looking at centrally procured items, Trust procured items and divisionally procured items. Contingency for loss of supply including for single supplier items will be part of this process.	S Povey	Sep-24	Assurance has traditionally been sought via the Procurement department. As part of the revised BCP process we will be looking at centrally procured items, Trust procured items and divisionally procured items. Contingency for loss of supply including for single supplier items will be part of this process. Feb 24 - this is being linked into Business Continuity Plans.

55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	CBRN Plan Major Incident Plan, additional training completed for PRPS trainers with a revised training plan being implemented	Partially Compliant		S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires update so to bring everything back into date and ensure that the content is all in place. Feb 24 - currently being refreshed.
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	CBRN Plan ED Training Trust Waste Policy	Partially Compliant		S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. Feb 24 - currently being refreshed.
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Rotas are available in ED. Each shift has at least one trained member of staff: Shift Leader/ Band 6. More trained staff are needed to strengthen capability. The Trust ED has indicated that more training is eeded including train the Trainer for staff cascade	Partially Compliant		S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. Feb24 - currently being refreshed.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to	Equipment checklist is wall mounted within external container at the front of ED. Equipment held is reviewed against the checklist annually	Partially Compliant		S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. Feb - 24 Currently being refreshed.
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Completed and available in the ED external container at the front of ED. PRPS suits serviced as per manufacturers requirements.	Partially Compliant	Check ED Policy & CBRN Plan, we need to check alignment with partner plans e.g. NWAS	S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. Live exercise undertaken in February to test the equipment available which went well with an update to Execs in March 2024.
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Suits Serviced 22nd September 22 full check, Generator serviced September 2022. Arrangements in place to replace expired or contaminated/used suite.	Partially Compliant		S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. PRPS suits are centrally supplied but information on the showers, tents and equipment is required and has been commenced.Feb 24 - Decon facility test took place in February.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	PPM in place. Suit Serviced 22nd September 2023	Partially Compliant	Need to check policy/SOP for the maintenance and checking of suits	S Povey	Jun-24	The current HAZMAT/CBRN Policy has not been updated recently (Pre-Covid) and requires doing so to bring everything back into date and ensure that the content is all in place. Feb 24 - Equipment check took place in February with a successful trial.

62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	NHSE guidance followed. Kit destroyed in line with NHSE guidance. In the event of wet decontamination, water stored pending disposal, new ED decon area has drain interceptor requested by EPRR	Partially Compliant		S Povey	Jun-24	Disposal is via either NWAS or Trust Estates, activation details need to be in the revised Trust plan. Feb 24 - ongoing via NWAS & Estates.
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	6 x staff have undertaken a PRPS Train the Trainer course to allow full roll out of training across staff.	Partially Compliant		S Povey	Jul-24	Training records included for the July 2023 Train the Trainer session for PRPS suit use. Trust are currently planning the ongoing training of ED staff. Risk Assessment to be revised for current ED and to be in place for new ED upon completion. Feb 24 - new training programme currently being scheduled.
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Training programme commencing and Policy around training to be updated.	Partially Compliant	Lack of trainers and turnover of staff have resulted in a back log of training, this has now been corrected with six newly trained trainers who are rolling out training to all relevant staff. The expectation is that this will be completed by mid 2024 with a regular programme in place. There is the potential for key staff to have this included as mandatory training within ESR.	S Povey	Sep-24	Lack of trainers and turnover of staff have resullted in a back log of training, this has now been corrected with six newly trained trainers who are rolling out training to all relevant Staff. The expectation is that this will be completed by mid 2024 with a regular programme in place. There is the potential for key staff to have this included as mandatory training within ESR although this is to be discussed. Feb 24 - additional TtT session has been proposed for the trust to host, being discussed with NWAS at the time of writing.
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Records maintained by CBRN leads in ED. 6 staff are trained decontamination trainers. Fit Test training available via IPC	Partially Compliant		S Povey	Jun-24	This was not included as it is IPC work which has its own assurance process rourtes to follow. Trust have queried whether this should be an EPRR assurance question when it is dealt with by another function. Trust EPRR will reference IPC and await confirmation on future requirements.
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	CBRN Plan and ED action cards. Training for new staff and refresher training taking place with wet decontamination exercise planned for post strike period	Partially Compliant		S Povey	Jun-24	Compliance will be achieved when new staff training and refresher training is completed.
DD1	**EPRR Training**	**EPRR TNA**	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	EPRR TNA are fed from the requirements within the Principles of Health Command National Occupational Standards and the individuals portfolio. The trust is putting into place a series of sessions and course to ensure that all health commanders have the opportunity to meet the requirements.	Partially Compliant	Training required for Portfolios for responssible staff to be timetabled with refresher training built in to the timetable according to the requirements under NOS	S Povey	Jul-24	Feb 24 - this is being considered across all areas o
DD2	**EPRR Training**	**Minimum Occupational Standards**	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	All on call staff are required to attend Principles of Health Command Training, in house training and ongoing training is available which is being increased to enable on call staff to meet the requirements within their portfolios. Difficulty in acheiving compliance with this given the timescales of release of the training requirements.	Partially Compliant	Ongoing process on call staff have dates to attend training for Principlpes of Health Command and in house training delivered before they are permitted on call. Awaiting confirmation that all have attended Principles Training.	S Povey	Dec-24	This was originally communicated as the regional team passing information back to trusts but lately has been notified as atrust exercise. Trust EPO need to apply for all certificates. MS Teams form to be sent to all on-call staff confirming their attendance, completion, feedback sent and certificate receipt.
DD6	**EPRR Training**	**Training Data**	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	The trust has not received data from the Principles of Health Command Course as was stated would happen. Therefore work is required to update this information and see which staff have received their certificates. This is outwith the Trust's influence to ensure compliance with.	Partially Compliant	Trust to investigate with On Call Managers whether they have attended and received their certificate for inclusion in portfolios.	S Povey	Dec-24	
DD7	**EPRR Training**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	EPRR training is included in the EPRR Quarterly Report and referenced in the Annual Report. Given the new standards the Trust is partially compliant given the timescales from the release of the new standards.	Partially Compliant	Training compliance to be included in quarteyly EPRR report to Risk Management Committee and the Annual EPRR Report to the Board	S Povey	Feb-24	Scheduled EPRR Quarterly report due in February following action completion date.
DD8	**EPRR Training**	**JESIP doctrine**	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	The trust training does not include JESIP awareness at present	**Non Compliant**	JESIP Sessions to be included as part of Portfolio required training courses.	S Povey	Aug-24	Courses commencement by March 2024, dates for training and attendance to be agreed/confirmed.
DD10	**EPRR Training**	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	The Trust has not recently had their training independently evaluated.	**Non Compliant**	When all portfolio required training is in place, ICB or NHSE will be invited to look and evaluate at the trusts training provision for EPRR.	S Povey	Nov-24	Feb 24 - Ongoing

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL November 2023

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

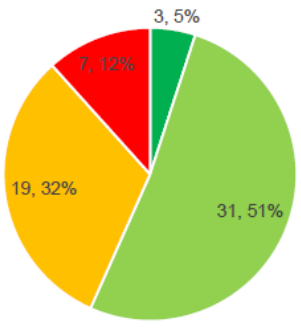
This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

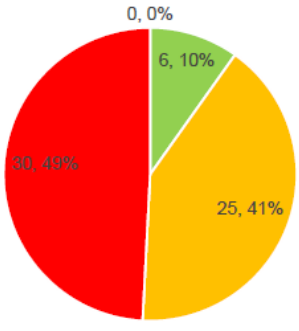
Levels pre and post confirm and challenge

Pre confirm and challenge



- Organisations declaring full compliance
- Organisations substantially compliant
- Organisations Partial Compliance
- Organisations Not Compliant

Post confirm and challenge



- Organisations declaring full compliance
- Organisations substantially compliant
- Organisations partial compliance
- Organisations non compliant

The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

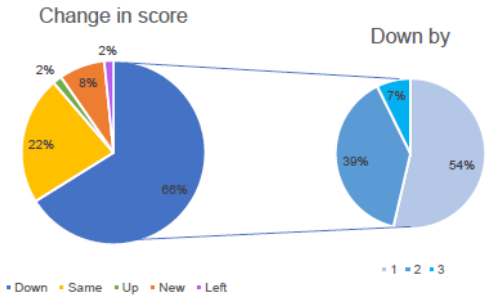
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year's assurance cycle.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

03 April 2024

Title	Risk Management Strategy – Annual Review
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide a refreshed version of the Risk Management Strategy.

Following recommendation from the Audit and Risk Committee, it is recommended that the Board:

- Approve the annual refresh of the Strategy

Key Risks

This report relates to these key risks:

- Ensuring robust processes and compliance with probity and transparency requirements.

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

Contribution to 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
29/02/2024	Audit and Risk Committee	As above	Approval

1	Narrative
1.1	The Risk Management Strategy was last refreshed and approved in November 2022 and was noted to be subject to a further review on a future April to April cycle. One year on from the fuller review in 2022/23 the strategy has been updated with minor changes and corrections regarding governance processes. Consideration has also been given to the current Risk Appetite Statement and it is not proposed that there are any changes at this time. The Risk Management Strategy has been updated with the new Risk Matrix as agreed through the Trust Risk Management Committee and supporting alignment to latest guidance from NHS Providers Good Governance Guide. The Risk Management Strategy is attached as an appendix to this report and any changes have been highlighted in the document.

2	Implications
2.1	**Patients** • No direct implications
2.2	**People** • No direct implications
2.3	**Finance** • No direct implications
2.4	**Compliance** • A clear strategy and strong processes on Risk Management are key for the Trust, and undertaking the frequent and individual emails is also serving to raise awareness in the Trust. Together this will underpin the principles of good governance and probity which will form part of the requirements of the well-led review.

Wirral University Teaching Hospital
NHS Foundation Trust

Wirral University Teaching Hospital Trust

Risk Management Strategy

2022 - 2025

Document Reference No.	V.5
Target audience	Trust Wide
Author	Director of Corporate Affairs
Group responsible for developing document	Audit and Risk Committee
Status	Approved
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1. INTRODUCTION

1.1. Wirral University Hospital Trust NHS Foundation Trust is committed to providing high quality services in an environment where patient and staff safety is paramount. However, healthcare provision has an inherent level of risk that cannot always be eliminated.

1.2. The Trust Risk Management Strategy provides a framework for the identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

- Identify actual or potential risks.
- determine how best to treat them.
- apply the treatment.
- monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

1.3. Every member of staff is responsible for effective risk management.

1.4. The Trust promotes a just, responsible culture that fosters learning, improvement, and accountability. It intends that all staff are able to raise issues of concern and be listened to.

1.5. The Trust Board recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

1.6. The Trust Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

2. PURPOSE

2.1. The Risk Management Strategy is a framework for the continued development of the risk management process, building on our and plans linked to the Board Assurance Framework (BAF) and meeting requirements of Regulators such as CQC, along with national priorities.

2.2. The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the “Ward to Board” accountability and devolved governance structure.

3. STRATEGIC OBJECTIVES

3.1. This strategy supports the delivery of the Trust’s Strategic objectives from the 2021-2025/26 period outlined below.

3.2. The Trust Strategic objectives will be delivered through the following enabling strategies:

- Clinical Service Strategy
- Workforce Strategy
- Estates Strategy
- Digital Strategy
- Patient Experience Strategy
- Risk Management Strategy
- Research and Innovation Strategy
- Quality and Safety Strategy

3.3. The delivery of this Risk Management Strategy will support the embedding of an infrastructure that ensures robust identification and management of risks that may prevent the achievement of Trust objectives.

3.4. The Board will approve and monitor the delivery of these strategies and mitigations of associated risks through its Board Committees.

3.5. The work plan of each Board committee will incorporate agenda items which will ensure risks to the delivery of our strategies are identified and managed as appropriate.

3.6. Section 8 provides more detail on Board Committees and their specific responsibilities.

4. OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1. The objectives of the Risk management strategy are:

*4.1.1. To **proactively identify**, manage and monitor significant risks that the Trust is exposed to during the delivery of its objectives*

4.1.2. To ensure that risks that can materially impact on the Trust's key statutory objectives and terms of authorisation as a Foundation Trust are identified, assessed and managed

4.1.3. To enhance the risk maturity of the Trust.

4.2. The Strategic Objectives of the Trust evidence the Board prioritising patient safety, quality of care, staff wellbeing and development, and achievement of national standards.

4.3. The Trust Performance and Risk Management Frameworks are integrated, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality.

4.4. At an operational level, the Trust will apply a proactive risk management approach to identify risk through analysis of performance data and an Early Warning Trigger Tool, described in detail in section 11.10.

4.5. A quality impact assessment tool will be used to identify possible risks to quality and safety arising from service re-design productivity & efficiency initiatives or variations in service delivery, such as patient flow pressures.

4.6. Themes from a number of quality and safety indicators including patient safety incidents, mortality reviews, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are managed appropriately.

4.7. The Trust will also use learning from experience as a risk mitigation approach.

4.8. This is covered in more detail in section 12.5.

Objective 3: *To increase the risk maturity of the Trust from Risk Aware to Risk Enabled*

Figure 2: Risk Maturity scale

4.10. Figure 2 above shows the different levels of risk maturity that the Trust can achieve as risk management becomes further embedded in the organisation.

4.11. The Board will annually review its risk maturity, appetite and Board Assurance Framework.

4.12. The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit and Risk Committee will monitor the implementation of any recommendations arising from this audit.

5. RISK APPETITE

5.1. Risk appetite is the total level of risk exposure, or potential adverse impact, that the Trust is willing to accept in pursuit of its objectives.

5.2. The pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy.

5.3. The Board recognises the importance of a robust and consistent approach to determining risk appetite to ensure:

5.3.1. The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic risk taking, or an overly cautious approach which may stifle growth and innovation.

5.3.2. Trust Managers will know the levels of risk that are legitimate for them to take, and opportunities appropriate to pursue, to ensure service improvements and patient outcomes are not adversely affected.

5.4. To value and compare the relative merits and weaknesses of different risks, the Trust Board will determine the level of risk the organisation is willing to tolerate in different areas.

5.5. The Trust has put systems in place to manage risk to an acceptable level within its agreed risk appetite levels.

5.6. Via reporting and the BAF Executive Directors will provide on-going assurance to the Board that existing controls are sufficient to mitigate risks.

5.7. Target risk ratings shall be set for all risks on the Risk Management System. A target risk rating is the estimated residual risk following the application of reasonable mitigating controls.

5.8. The target risk rating is the lowest level of risk acceptable or tolerable for particular risks.

5.9. Some risks tolerance levels will require the approval of the Board (Via the BAF), particularly where the application of controls is restricted by external factors. Where this is the case, it will be outlined clearly in the BAF cover report, which is expanded on in section 6.

5.10. Risks that have reached the agreed target rating will also be treated as tolerated risks.

5.11. Risks should be accepted as tolerable only when the mitigation plan has been implemented as far as reasonably practical and there is assurance that controls are effective.

5.12. The Trust regards risks that fall into the red 'high' category as significant and actions to control the risk must be taken immediately.

5.13. RISK APPETITE STATEMENT

5.14. 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.

5.15. 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.

5.16. 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.

5.17. 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.

5.18. The Trust wishes to maximise opportunities for developing 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.	OPEN	The Trust Board recognises that in order to provide outstanding care and patient experience there may be a need to accept a short-term impact on quality outcomes to achieve longer term rewards and innovations for our patients.
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.

6. THE BOARD ASSURANCE FRAMEWORK (BAF)

6.1. An effective Board Assurance Framework gives the Board a simple comprehensive tool for effective and focused management of the principal risks to meeting its objectives.

6.2. It provides a structure for the evidence to support the Annual Governance Statement disclosure. It simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

6.3. The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Trust strategy, whilst evaluating the effectiveness of controls, and the monitoring of action plans.

6.4. The Board Assurance Framework (BAF) is be based on six key elements:

6.4.1. Clearly defined principal objectives aligned to clear lines of responsibility and accountability.
6.4.2. Clearly defined principal risks with an assessment of potential impact and likelihood.
6.4.3. Key controls by which these risks are being and can be managed.
6.4.4. Reports identifying those risks are being reasonably managed and objectives being met, together with the identification of any gaps in assurances and in control.
6.4.5. Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

6.5. The BAF cover report is aligned to support assurances to support the Chief Executive's Annual Governance Statement Disclosure.

6.6. Specifically, BAF assurance reports to the Board will reflect:

- New or amended risks added since the last meeting
- Changes in risk ratings
- Updates on delivery of action plans, at points in which they fall due
- Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.
- Recommendations for remedial actions that require detailed board review

Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.

6.7. The BAF will be refreshed at least annually considering:

6.7.1. Risks which may prevent the Trust from achieving the Strategic Objectives will be set out in the Board Assurance Framework and assessed annually.
6.7.2. Each year, the Board will collectively review the BAF, to identify the risks significant to the delivery of the organisation's strategic objectives.

6.8. The Executive Directors will approve risks proposed for inclusion on the BAF, on the basis of strategic impact, prior to inclusion on the BAF.

6.9. Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the Board as they arise.

6.10. Each risk in the BAF will be scored using the Trust's Risk Scoring Matrix and monitored in accordance with the frequency set out.

6.11. The Board Assurance Framework will be reviewed at each meeting by the Trust Board and Bi-Monthly by the relevant Board Committees.

7. RISK MANAGEMENT DUTIES

7.1. Chief Executive

7.1.1. As Accounting Officer of the Trust, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's objectives, whilst safeguarding public funds and assets

7.1.2. The Chief Executive will ensure that executives have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

7.1.3. The Chief Executive will ensure that there are robust arrangements for business continuity planning.

7.1.4. The Chief Executive is responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively, in accordance with the Accounting Officer Memorandum.

7.2. Executive Directors

7.2.1. The Executive Directors are accountable to the Chief Executive for all areas of risk and assurance in respect of areas in their remit, including the maintenance of live risk registers which are monitored regularly.

7.2.2. Executive Directors are collectively accountable for risk management and ensuring risk management arrangements are embedded in their areas of responsibility.

7.3. Medical Director

7.3.1. The Medical Director has delegated overall strategic responsibility from the Chief Executive for the management of risk in the Trust and is the Executive Lead Director for devising, implementing and embedding all risk management processes throughout the organisation.

7.3.2. The Medical Director will provide advice on risk management to the Executive Directors and Board and will recommend the inclusion of risks on the Board Assurance Framework.

7.3.3. The Medical Director will ensure the risk register is reviewed monthly at the Risk Management Committee, with remedial actions put in place to address non-compliance.

7.4. Director of Corporate Affairs

7.4.1 The Director of Corporate Affairs is responsible for:

- Drafting and refreshing the risk management strategy.
- Maintaining, updating and communicating the BAF, whilst ensuring timely submissions are made to the Board and Assurance Committees as appropriate.
- Ensuring the Annual Governance Statement requirements pertaining to risk management are met on an annual basis.

7.5. Chief Nurse

7.5.1. The Chief Nurse will ensure nursing and allied healthcare staff comply with all safety and risk management procedures, providing assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

7.6. Chief Finance Officer

7.6.1. The Chief Finance Officer is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

7.6.2. The SIRO oversees the development of an Information Risk Management Strategy and related policies and procedures; ensures that the Trust's approach to information risk is effectively resourced and executed and provides a focal point for resolution of information risk issues.

7.6.3. The SIRO will act as an advocate for information risk on the Board and in internal discussions and will provide written advice to the Accounting Officer on the content of the annual Governance Statement in regard to information risk.

7.6.4. The Chief Finance Officer has responsibility for ensuring that the Trust operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

7.6.5. The Chief Finance Officer is accountable to the Board for the delivery of the financial plan and digital strategies, and for managing associated risk.

7.7. **Chief Strategy Officer**

7.6.1 The Chief Strategy Officer is jointly responsible (with the Director of Corporate Affairs) for putting in place an infrastructure of ensuring risks deemed significant to the delivery of the Trust Strategies are identified and mitigated as part of the drafting of the Strategy.

7.6.2 In the role of Security Management Director, the Chief Strategy Officer will oversee delivery of the Local Security Management Specialist Services (LSMS), receiving assurance on the management of security risks and reporting to Audit Committee as appropriate

7.6.3 As Executive lead for Health and Safety, the Chief Strategy Officer is responsible for ensuring the timely identification and mitigation of risks to Health and Safety

7.8. **Chief People Officer**

7.8.1 The Chief People Officer is responsible for ensuring risks deemed significant to the delivery of workforce objectives are met, with assurance reports feeding into the People Committee, Board, and elsewhere as appropriate.

7.9. **Chief Operating Officer**

7.9.1 The Chief Operating Officer is responsible for ensuring the delivery of the Trusts 'Outstanding Care' objectives whilst mitigating associated risks, such as risks to delivery of targets being achieved. In discharging this duty, the Chief Operating Officer will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated

7.10. **All Staff**

7.10.1. All staff have a responsibility to:

7.10.1.1. Familiarise themselves with and comply with Trust Risk Management Policy and processes.

7.10.1.2. Attend appropriate risk management training deemed necessary to enable them to undertake their duties.

7.10.1.3. Mitigate risks over which they have control in their daily work.

7.10.1.4. Proactively escalate concerns in instances where gaps in risk management training are identified, as soon as reasonably possible to their line manager.

7.10.1.5. Report breaches of compliance as outlined within the risks management strategy, whether by others or by themselves.

7.10.1.6. Report actual or potential risks in the delivery of safe care to patients, or risks to staff.

8. GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT

8.1. **Trust Board**

8.1.1. The role of the Board includes the identification, treatment and monitoring of risks signification to the delivery of the organisation's strategic objectives, which is aided by the use of a Board Assurance Framework (BAF).

8.1.2. The BAF document has been established by the Board and is reviewed Bi-Monthly.

8.1.3. The Executive Directors retain operational ownership and maintenance of the BAF. Its key elements include:

8.1.3.1. Identification of the principal risks that may threaten the achievement of Board identified strategic objectives.
8.1.3.2. Identifying the design of controls to manage these principal risks.
8.1.3.3. Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk.
8.1.3.4. Identifying assurances and are gaps in controls and / or assurances.
8.1.3.5. Instigating corrective plans where gaps in control have been identified.
8.1.3.6. Dynamic risk management including a well-founded risk register.

8.1.4. The Board is responsible for monitoring the internal control arrangements in each financial year to support the Annual Governance Statement Disclosure declaration.
8.1.5. As part of the delivery of this strategy, the Board will:

8.1.5.1. Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda.
8.1.5.2. Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.
8.1.5.3. Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions.

8.2. **Board Committees**
Each Committee of the Board has specific responsibility for seeking on going assurance on the effectiveness of the arrangements for managing key risks.
8.3. The Board will review the effectiveness of each Committee annually to support the review of the system of internal control.
8.4. Board Committees all have responsibility for elements of the risk management system, with the Audit Committee providing assurance on its effectiveness

8.5. **Audit and Risk Committee**
8.5.1. The Audit and Risk Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The Committee will seek assurance that the Trust's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.
8.5.2. Non-Executive Committee members of the Committee will play a key role in the internal control assurance processes, by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Trust risk register.
8.5.3. To aid this assurance, the Committee's work plan incorporates a review of the organisation's risk management processes, and associated risk registers, from divisional to corporate level on a cyclical basis, to gain assurance that systems in place are effective.
8.5.4. The Committee will monitor action plans associated with the delivery of this strategy.
8.5.5. The Committee will provide assurance to the Board on the effectiveness of the system of internal control through:

8.5.5.1. Regular monitoring of significant corporate and strategic risks on behalf of the Board
8.5.5.2. Monitoring of the implementation of the internal audit plan, and of associated internal audit recommendations, requesting further assurance on internal audits with limited assurance opinion
8.5.5.3. Monitoring the effectiveness of the information risk management arrangements through the Senior Information Risk Owner (SIRO) reports and chair assurance reports from the Information Governance Group

8.5.5.4. Receiving assurance on the management of security risks via updates on the delivery of the Local Security Management Specialist services action plan, and annual reports

8.5.5.5. Formally reviewing the system of internal control annually taking assurances from Board Committees on management of detailed risks.

8.6. **Risk Management Committee**

8.6.1. The Risk Management Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition, the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy.

8.6.2. The Risk Management Committee will meet at least six times a year and will review significant risks with a Trust wide impact and the BAF at each other meeting.

8.6.3. As part of its role the Risk Management Committee will seek detailed assurance reports on significant risk areas identified through the aggregation of incidents, complaints, never events and claims.

8.6.4. The Committee will report to the Board via a Chair's assurance report.

8.6.5. The Risk Management Committee will review all risks with a residual rating of 10-25

8.6.6. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will review and monitor progress against mitigation of key risks at each meeting on a bi-monthly basis.

8.6.7. As part of the implementation of this strategy the Risk Management Committee will:

8.6.7.1. Review assurances on learning and how it is embedded in divisions to manage risks. The Committee will consider the EWTT indicator relating to recurring themes from incidents, complaints and Sis.

8.6.7.2. Request detailed reports on the top strategic risks as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports.

8.7. **Quality Committee**

8.7.1. As part of its remit, the Committee has a responsibility to monitor the delivery of the Clinical Strategy and associated risks. The Quality Committee meets at least six times a year and will review significant quality and patient safety risks and the BAF at each other meeting

8.7.2. The Quality Committee will review current and future risks to quality and safety, which extend to risks identified by Divisions and corporate departments of the Trust.

8.7.3. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will discuss risks at each meeting on a bi-monthly basis.

8.7.4. As part of the implementation of this strategy the Quality Committee will:

8.7.4.1. Review assurances on learning and how it is embedded in divisions to manage risks.

8.7.4.2. Request detailed reports on the top strategic risks to quality as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports.

8.8. **Finance, Business Performance Committee**

8.8.1. As part of the delivery of this strategy the Committee will:

8.8.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item.

8.8.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports.

8.8.1.3. Monitor the implementation of the financial plan and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

8.9 **People Committee**

8.8.2. As part of the delivery of this strategy the Committee will:

8.8.2.1. Review significant workforce and education risks that fall in its remit as a standing agenda item.

8.8.2.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports.

8.8.2.3. Monitor the implementation of key action plans and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

9. APPROACH TO RISK

9.1. Risk Identification

The risk management process is outlined in detail within the Risk Management Policy.

As part of the implementation of this strategy, the Trust will put in place proactive and reactive approaches to the identification of risks, primarily through the risk assessment processes which assess the potential to cause any of the following:

- Injury
- Complaint
- Litigation
- Damage to the environment or property
- Failure to maintain services and/or the quality of services provided by the Trust,
- Failure to meet national and organisational targets loss of reputation and financial loss etc.

9.2 Sources of risk identification

9.2.1 There are internal and external sources of risk:

- Internal risks are identified, in the course of strategic and business planning, adverse incidents, complaints, claims, noncompliance with statutory duties and guidance, enquiries and clinical/nonclinical hazards identified for any Trust activities.
- External sources of risk are identified in the course of risk alerts, hazard warnings and recommendations received by the Trust from a recognised external source – e.g., information from the Medicines & Healthcare Products Regulatory Agency (MHRA), Care Quality Commission, National Institute for Health and Care Excellence (NIHCE), Health and Safety Executive (HSE), inquiries and other bodies. These will be communicated immediately and applied as appropriate in the Trust.

In implementing this strategy, the Trust's goal is to ensure that the effect of any risk is reduced to an acceptable level or negated completely. In practice, this will be executed by using internal and/ or external advice to decide on the most appropriate options to treat risk and by sharing best practice and learning from other organisations.

Sources of advice include the CQC, NHS Resolution, NHSR, National reporting & Learning System (NRLS), Health and Safety Executive, Internal Auditors.

Risk treatment (means of addressing risks) can be broken down into the following:

- Avoid - some risks may only be managed by terminating the activity (i.e., avoiding the risk by not undertaking the activity that could lead to the risk occurring)
- Control - preventative controls are measures currently in place when a risk is identified to control the risk i.e., directive controls or policies and processes, clear labelling of packages, checking a patient's identity before a procedure. If existing controls are shown

not to be adequate, e.g., gaps are identified, an action plan should be produced to ensure the risk is mitigated with additional controls. Action plans will be approved initially by a division as per the risk reporting arrangements

- Transfer - for some risks, the best method of control is to transfer them to a third party to reduce the exposure to the Trust or because another organisation will manage the risks more effectively e.g., financial risks can sometimes be transferred by effecting insurance (NHSR). However, this process needs to be carefully managed and audited to ensure the Trust's exposure is minimised.
- Tolerate - the exposure to the risk may be tolerable/accepted without any further controls

In assessing any mitigating actions associated with a risk there should also be an assessment of the impact of such actions.

All managers have authority for risks in their areas of responsibility in line with their resources available to them to eliminate or control the risk. Where the manager does not have suitable or sufficient resources, they should refer the issue to their line manager.

10. RISK MANAGEMENT PROCESS

The Risk Management process is summarised in figure 4 below and incorporates a proactive and reactive approach.

10.1. Risk assessment is an iterative process, and all risks will be periodically reviewed and re-assessed in view of contextual changes.

10.2. Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

10.3. The trust will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Trust risk register, and evidence considered as to whether residual risks are acceptable or not.

10.4. All strategic risks will be reviewed on a bi-monthly basis by the Executive Directors who confirm their management through the content of the BAF in preparation for presentation to the Board.

10.5. All moderate and significant risks (current risk score 8-25) will be reviewed by the Executive Directors who will confirm their approach to mitigation through the content of the Trust risks register operationally at the Risk Management Committee on an alternate basis in preparation to the Board for their consideration

10.6. All lower level risks (with a current risk score less than 6) are reviewed and managed locally by the Divisional management in their Governance meetings.

10.7. Risks which are not considered acceptable at a local level will be escalated as appropriate and managed through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

10.8. Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Trust's risk registers.

10.9. The current process and scoring matrix is attached to this strategy at the appendix.

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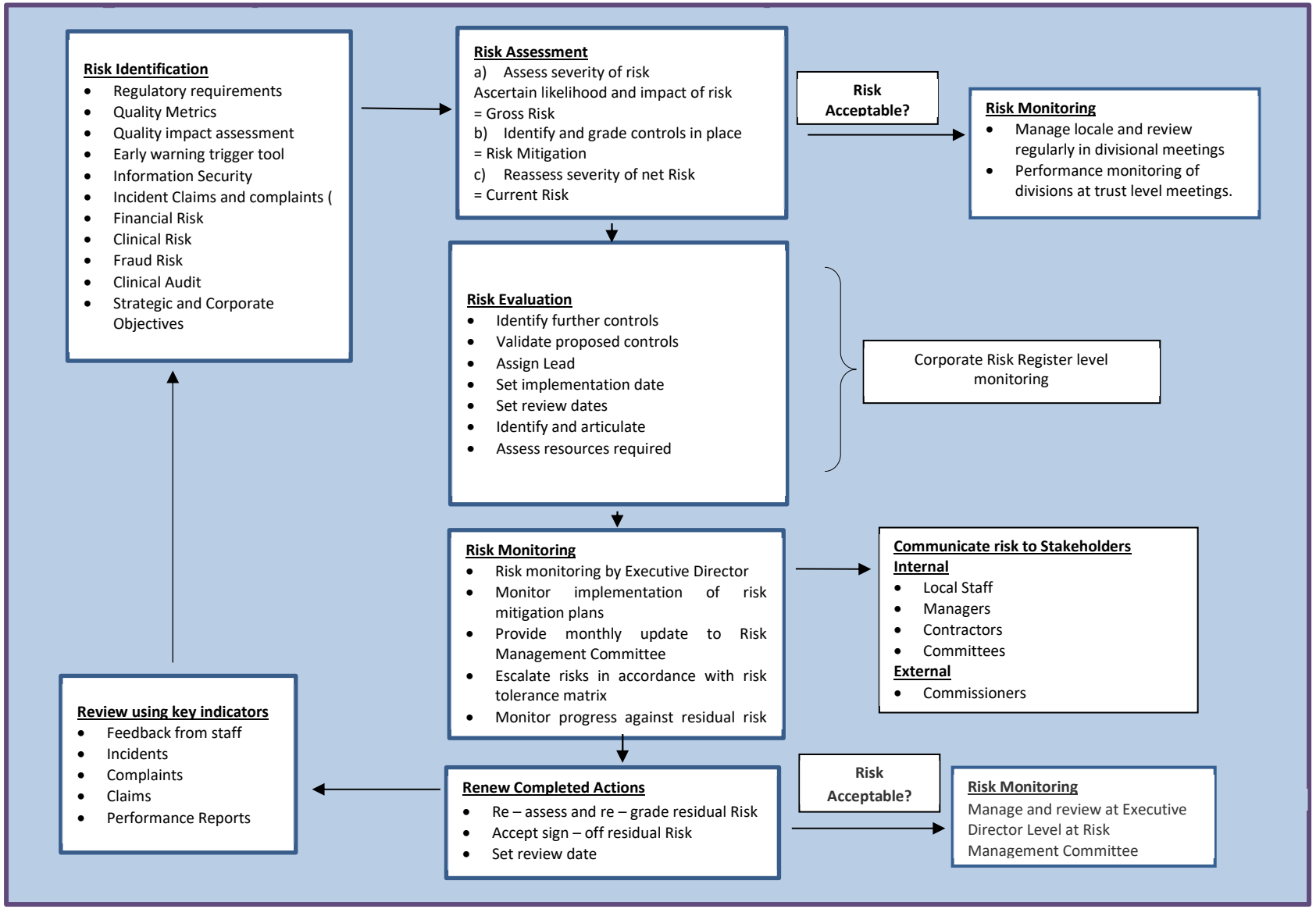
Figure 4: Risk Management process



10 PROACTIVE RISK MANAGEMENT APPROACH

10.5 Internal inspections/reviews and assessments

10.6 Risks will be identified, assessed and mitigated through internal inspections or reviews, e.g.:

- 10.6.1 CQC internal self-assessment
- 10.6.2 Delivery of clinical audit plan
- 10.6.3 Health, safety and fire inspections
- 10.6.4 Internal infection control visits
- 10.6.5 CQC Peer reviews
- 10.6.6 Internal audit reviews
- 10.6.7 Internal assessment of risks

10.7 Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.

10.8 **Learning from external sources**

10.8.1 The Trust Board will put in place a Development Programme that incorporates learning from various sources, such as coroner interventions and inspections by the Care Quality Commission for example.

10.8.2 Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.

10.8.3 The Trust ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy.

10.8.4 The Executive Directors will instigate a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans which are reviewed regularly by the Risk management Committee.

11 REACTIVE RISK MANAGEMENT APPROACH

11.5 As part of delivering this strategy, the Trust will identify risks arising from serious incidents, claims, complaints and incidents and form action plans to reduce risks to a tolerable level.

11.6 The Trust operates a fair, Just culture to ensure staff feel able and confident to report events or concerns.

11.7 Risks arising from complaints will be entered on the Risk Register.

11.8 Claims scored using the Trust's Risk Scoring Matrix and those rated 9) or above) will be entered on the Trust Risk Register and are escalated in accordance with the Trust's risk escalation process.

11.9 The Deputy Director of Patient Safety and Governance will review reports produced by Internal and External Audit with an audit opinion of limited assurance ensuring risks are identified and placed on the risk register as appropriate.

12 REGULATORY COMPONENTS OF RISK MANAGEMENT

12.5 In delivering this strategy the Trust will consider the following aspects of statutory compliance, and the management of associated risks.

12.5.1 Health and Safety Legislation

12.5.1.1 The Trust will discharge its statutory responsibilities under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to 'evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment'.

12.5.2 Care Quality Commission

12.5.2.1 In undertaking its statutory obligations under the Health and Social Care Act 2008, the Trust will maintain compliance with the regulation within the Act that governs its activity.

12.5.2.2 In delivering this strategy the Trust will identify and mitigate associated risks relating to CQC compliance.

12.5.3 Statutory Annual Governance Statement Disclosure

12.5.3.1 The Trust will put in place robust arrangements to comply with requirements from the Annual Reporting Manual in relation to the production of an annual Governance statement disclosure which is assured by an effective risk management system.

12.6 **Monitoring the Implementation of this Strategy**

12.6.1 The implementation of this strategy will be monitored by:

- Routine monitoring of the risks by the Quality Committee, and independent assurance updates to the Audit and Risk Committee and the Risk Management Committee.
- The Trust's progress against its strategic and corporate objectives.
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented.
- Annual updates to the Board as part of the year-end review
- An external review of governance and leadership every three years.

Appendix A – Risk Scoring

Table 1 – Consequence scores.

Consequence scores can be used to assess actual and potential consequences: -

- The actual consequence of an adverse event e.g., incidents, claims and complaints.
- The potential consequence of what might occur because of the risk in question e.g., risk assessments, and near misses.

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Patient	Reputational	Financial	Workforce	Legal / Regulatory*
Catastrophic	**Prolonged failure or severe disruption** of **multiple** services Multiple deaths caused by an event**; major impact** on patient experience	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability. Hospital closure	**>£5m** directly attributable loss / unplanned cost / reduction in change related benefits	Workforce experience / engagement is **fundamentally undermined** and the Trust's reputation as an employer damaged	Breach of regulation Trust put into Special Administration / Suspension of CQC registration. Civil/Criminal **Liability > £10m**
Severe	**Prolonged failure or severe disruption** of a **single** patient service Severe permanent harm or death caused by an event. **Significant impact** on patient experience	**Prolonged** adverse social / local / national media coverage with **serious impact** on patient trust and public confidence	**£1m - £5m** directly attributable loss / unplanned cost / reduction in change related benefits	**Widespread material impact** on workforce experience / engagement	Breach of regulation likely to result in enforcement action. Civil/Criminal **Liability < £10m**
Moderate	**Operation of a number** of patient facing services is disrupted Moderate harm where medical treatment is required up to 1 year. Temporary disruption to one or more CSUs Resulting in a poor patient experience	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**£100k - £1m** directly attributable loss / unplanned cost / reduction in change related benefits	**Site material impact** on workforce experience / engagement	Breach of regulation or other circumstances likely to affect our standing with our regulators. Civil/Criminal **Liability < £5m**
Minor	**Operation of a single** patient facing service is disrupted. Minor harm where first aid required up to 1 month. **Temporary service restriction** **Minor impact** on patient experience	**Short lived** adverse social / local / national media coverage which **may impact** on patient trust and public confidence in the short term	**£50k - £100k** directly attributable loss / unplanned cost / reduction in change related benefits	**Department / CSU material impact** on workforce experience / engagement	Breach of regulation or other circumstances that may affect our standing with our regulators, with minor impact on patient outcomes. Civil/Criminal **Liability < £2.5m**.
Limited	**Service continues with limited/no patient impact**	**Short lived** adverse social / local / traditional national media coverage with **no impact** on patient trust and public confidence	**£Nil - £50k** directly attributable loss / unplanned cost / reduction in change related benefits	**Material impact** on workforce experience / engagement for a **small number of colleagues**	Breach of regulation or other circumstances with limited impact on patient outcomes. Civil/Criminal **Liability < £1m**.

Table 2 – Likelihood

The likelihood score is a reflection of how likely it is that the adverse consequence described will occur. Likelihood can be scored by considering:

- Frequency (how many times will the adverse consequence being assessed actually be realised?) or

- Probability (what is the chance the adverse consequence will occur in a given reference period?).

NPSA recommend, if possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.

	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Likelihood score	**1**	**2**	**3**	**4**	**5**
Frequency (time based)	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

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**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

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

Differing Risk Scenarios
In most cases the highest degree of severity (i.e., the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

03 April 2024

Title	Corporate Governance Manual
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Executive Summary and Report Recommendations

This report provides the latest review of the Corporate Governance Manual, and requests specific approval of two documents – the Scheme of Reservation and Delegation and the Board Code of Conduct.

This manual will be reviewed annually going forward with any amends brought to Audit and Risk Committee and then the Board.

In line with the recommendation from the Audit and Risk Committee, it is recommended that the Board:

- Approves the Scheme of Reservation and Delegation;
- Approves the Board Code of Conduct;
- Approves and the complete Corporate Governance Manual inclusive of the introductory document.

Key Risks

This report relates to these key risks:

- Ensuring the Trust has robust and appropriate governance mechanisms in place.

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	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
29/02/2024	Audit and Risk Committee	As above	Approval

1	Narrative
1.1	The Corporate Governance Manual is a term used in the NHS to describe a suite of key governing documents, which set out how the organisation is run. This suite of documents is usually updated as each individual element is updated i.e. the Standing Financial Instructions, Terms of Reference. WUTH's Corporate Governance Manual is consists of: - An Introductory Document (Revised) - The Constitution - The Accountable Officer Memorandum - Standing Financial Instructions - Scheme of Reservation and Delegation (Revised) - Board Code of Conduct (Revised) - Governors Code of Conduct - Terms of Reference for the Board, Council of Governors, and Committees.
1.2	Specific Documents for Approval There are three documents written for this refresh which are provided for specific approval. The Introductory document was re-written in its entirety, and the SORD and Board Code of Conduct have been updated since their last iterations. The SORD has also had several formatting changes to make this more easily understandable. Given these three are the only documents which have been specifically drafted for this Manual, they have been attached to this cover report for approval. The full Corporate Governance Manual will be provided as a separate pack due to its size, however the Board is requested to approve the Manual in full. The Corporate Governance Manual will then be uploaded to the website.
1.3	Going forward, it is proposed that the Corporate Governance Manual will be reviewed on an at least annual basis, though this will not prevent the review of individual elements as they fall due.

2	Implications
2.1	**Patients** • No direct impact on patients.
2.2	**People** • No direct impact on people
2.3	**Finance** • No direct impact on finance
2.4	**Compliance** • This suite of documents is a key part of ensuring the Trust is governed appropriately, and supports the requirements of well-led.

Introduction

Corporate Governance in Foundation Trusts

Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity.

Wirral University Teaching Hospital (WUTH) is an NHS Foundation Trust, which means it is a public benefit corporation as constituted under the NHS Act 2006. Foundation Trust Boards have financial and strategic decision making autonomy, with accountability to NHS England and to its membership via a Council of Governors elected from that membership. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to support that autonomy and accountability, and to achieve its clinical, quality and financial objectives.

Corporate governance is largely about how the Board conducts its business and is separate from day-to-day operational management carried out by the executive directors and senior management team. Fundamental to this is having the means to verify the effectiveness of strategic direction and control achieved through independent review and assurance.

Corporate Governance Manual

The Corporate Governance Manual is the term used by NHS and other organisations to encompass the key governance documents that, in conjunction with key legislation, form the framework the Trust operates against.

The Health and Social Care Act 2022 enhances and amends the Health and Social Care Act 2012 Act, setting out the legal framework within with the Foundation Trust operates.

The Manual includes the following documents:

- Constitution (including Standing Orders for practice and procedures of the Board of Directors and the Council of Governors);
- The Accountable Officer Memorandum;
- The Codes of Conduct;
- Standing Financial Instructions as a framework for financial governance,
- Scheme of Reservation and Delegation which describe the powers reserved to and delegated by the Board

These documents together provide a regulatory framework for the business conduct of the Foundation Trust.

It is essential that all employees and members know of the existence of these documents and are aware of their responsibilities included there within. To this end all directors, governors, consultants, senior managers and heads of department have been issued with this manual (e-link) and it is incumbent upon them to ensure that all staff in their charge are advised of its existence.

The Council of Governors and Board of Directors shall at all times seek to comply with the Trust's Codes of Conduct for Governors and Directors. There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

Vision and Values

Our Vision and Values have been developed with the feedback of over 2,500 staff, patients and visitors who told us what matters most to them. Delivering the best quality and safest care requires teamwork. Within our organisation this means staff supporting each other to achieve our shared ambitions. Outside of our hospitals it's about working more effectively with other providers across the health and social care sector. Underpinning our vision and values and aligning to the Trust objectives and priorities are the foundations of Getting the Basics Right, Better and Best. This is reflected in the NHS Long Term Plan which emphasises the importance of health and social care organisations working more closely together.

Our Vision

Our Values

Additionally, WUTH is committed to upholding the Nolan Principles:

Selflessness

Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take; they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Strategic Objectives and Priorities

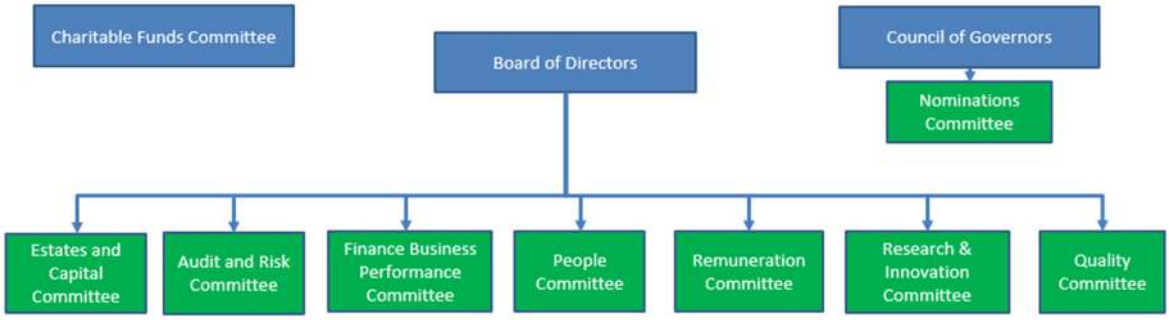
Our Strategic Objectives and Priorities have been derived from a process of reviewing national, regional and local contexts and detailed strategic analysis, as well as feedback from the series of strategy development workshops held with staff and stakeholders in 2020.

They are supported by our enabling Strategies, which are available on our website. Further information can also be found in our Trust Strategy 2021-26, which is also available on the website: WUTH Strategies | Wirral University Hospital NHS Foundation Trust

Our Strategic Objective and Priorities 2021-26 are as follows:

Corporate Governance at WUTH

WUTH is governed by a Board of Directors, and as a Foundation Trust, also by a Council of Governors. The Board has 7 Board Assurance Committees, and the Council of Governors has one.



Board of Directors

The Board of Directors is responsible for setting the strategy and culture of the Trust, monitoring operational performance/risks, and ensuring effective financial stewardship through value for money and financial controls. The Board has a number of key roles and approvals that it must take during the year, and it has delegated responsibility to a number of Committees to oversee specific areas of operations.

The Board is composed in line with the provisions of the Trust Constitution, section 20.

Further information on the current members of the Board can be found on our website: Board Members and Senior Management | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The Council of Governors

The Council of Governors is comprised of 21 seats, 13 of which represent the public, 5 which represent staff, and 4 which are directly appointed by partner organisations. The various constituencies and Governor election rules are laid out in the Trust's Constitution.

The Council of Governors has two responsibilities:

- Holding the non-executive directors individually and collectively to account for the performance of the Board of Directors; and
- Representing the interests of the members and the public as a whole

Further information on the current membership of the Council of Governors can be found on our website: Meet our Governors | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The Nominations Committee is constituted by and reports to the Council of Governors. This Committee oversees the appointment of Non-Executive Directors, and which approves their annual appraisal process/reviews the outcomes of that process. It is comprised of the Senior Independent Director and Governors, and is chaired by the Chair of the Board.

Board Committees

There are 7 Board Assurance Committees at WUTH, whose role it is to monitor and scrutinise operational performance, controls, and risks within their particular area. These Committees are:

- Estates and Capital Committee – Monitors the capital investment programme and other developments, estates-related health and safety, and risks/controls for both of these.
- Audit and Risk Committee – Monitors the internal audit programme, the external audit programme, approving the annual accounts, and monitoring the Board Assurance Framework and its strategic level risks. This Committee consists solely of Non-Executive Directors.
- Finance Business Performance Committee – Monitors monthly financial performance, financial controls, and approving significant business cases, as well as reviewing the performance information on access targets and recovery trajectories.
- People Committee – Monitors the delivery of the People Strategy, culture, the implementation of EDI/wellbeing initiatives, and the Freedom to Speak up updates.
- Remuneration Committee – Responsible for the appointment of Executive Directors, their remuneration, and has oversight of their performance appraisals.
- Research and Innovation Committee – Has oversight of the research initiatives in the Trust and monitors the growth of this agenda
- Quality Committee – Monitors patient care, clinical health and safety such as serious incidents, safeguarding, safe staffing, and ensuring the quality of clinical treatment and patient experience.

The Charitable Funds Committee sits outside this structure, as it is responsible for running WUTH charity and is therefore separate to the Board. However, the Trust is a trustee of the Charity, and therefore reports from the Charitable Funds Committee are taken regularly to Board, both to keep them updated of the ongoing work and to request approval where required for initiatives and/or strategy.

Risk Management

WUTH is committed to providing high quality services in an environment where patient and staff safety is paramount. The Trust Risk Management Strategy provides a framework for the identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

- Identify actual or potential risks.
- determine how best to treat them.
- apply the treatment.
- monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

The Trust promotes a just, responsible culture that fosters learning, improvement, and accountability. It recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

The Trust Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

Risk Management Strategy

The Risk Management Strategy is a framework for the continued development of the risk management process, building on our and plans linked to the Board Assurance Framework (BAF) and meeting requirements of Regulators such as CQC, along with national priorities.

The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the "Ward to Board" accountability and devolved governance structure.

The Board reviews the Risk Management Strategy at least annually.

Risk Appetite

The Risk Appetite Statement is included in the Risk Management Strategy at section 5, and is reviewed annually:

1.1. 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.
1.2. 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.
1.3. 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.
1.4. 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.
1.5. The Trust wishes to maximise opportunities for developing 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.	OPEN	The Trust Board recognises that in order to provide outstanding care and patient experience there may be a need to accept a short-term impact on quality outcomes to achieve longer term rewards and innovations for our patients.
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.

Board Assurance Framework

An effective Board Assurance Framework (BAF) provides the Board with a tool to manage its principal strategic risks, and a mechanism for identifying and assessing those risks and associated mitigations/actions.

The BAF is reported to alternate Board meetings and to every Audit and Risk Committee meetings, and risks owned by Board Assurance Committees are reviewed regularly by those Committees.

Accountability Framework

An Accountability Framework is in place to support the "golden thread" of accountability and responsibility through the organisation, both up from divisional/operational level to Board, and back down again. It sets out the requirements for divisional governance, to ensure a consistent and robust approach is implemented across each division.

Transparency and Probity

WUTH holds itself to the highest standards of transparency and probity, fostering a culture of openness and trust. A number of controls and policies are in place to support, several of which are highlighted in this section.

Fit and Proper Persons

The Fit and Proper Persons Test is a statutory and regulatory requirement which the Trust must carry out on all individuals on the Board, and anyone who falls within the definitions laid out in Regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) (Amendment) (Regulated Activities) Regulations 2014 (the "Regulations").

The Board of Directors has adopted and endorses the principles set out in the Fit and Proper Persons Test Framework, as published in August 2023.

The Director of Corporate Affairs is responsible for the correct and robust discharge of this test, and all completed tests are independently verified and signed off by the Senior Independent Director on the Board of Directors.

Managing Conflicts of Interest / Declaring Gifts and Hospitality

The Trust is required to maintain a register of interests for all decision making staff. WUTH has defined this as any member of staff band 7+. Anyone with a decision making responsibility, at any banding, is also required to submit an interest.

The processes and details required for submitted declarations of interest, and declarations of gifts and hospitality is set out in the Trust policy, Managing Conflicts of Interest, which is written in line with the NHSE Model policy.

The registers of interests, and of gifts and hospitality, are available via the online portal: Wirral University Teaching Hospital NHS Foundation Trust (mydeclarations.co.uk)

Internal Audit and External Audit functions

Part of the key controls are in place, both in terms of operational function and financial probity and responsibility, are the two audit functions.

Internal audit undertake audits of the controls in place in operational, and sometimes strategic, areas within the Trust. The recommendations made by Internal Audit are monitored by the Audit and Risk Committee.

External audit is essential for the production of the required Annual Accounts, and for ensuring robust systems are in place to manage the Trust's finances in a transparent, effective, and efficient manner. External Audit undertake the annual audit and ensure the Trust's annual accounts are correct and in line with guidance and other requirements.

Anti Fraud

The Trust receives Anti Fraud services, and has an independent advisor who leads on anti fraud efforts. The Anti Fraud advisor attends every Audit and Risk Committee to provide assurance on the current position, and on any risks or concerns that the Committee should consider.

Freedom to Speak Up

In line with guidance and NHSE requirements, the Trust operates a Freedom to Speak Up function, and employs a Freedom to Speak Up Guardian. There are champions in place across the Trust to encourage a culture of openness and disclosure.

The Board and the People Committee receive at least twice annual reports on the current position.

Use of the Seal

Authority to affix the seal to any document lies with the Chief Executive, who has delegated this to the Director of Corporate Affairs. The seal will be kept under key, and the Director of Corporate Affairs will ensure that the seal is affixed in line with contractual requirements, and that a register is kept of each usage.

Wirral University Teaching Hospital NHS Foundation Trust

Scheme of Reservation and Delegation

Effective from DD/MM/YYYY

Version 2

Version Log

Date	Version	Changes
2013	1	Original publication – further dates and amends unknown.
Date TBC once approved	2	Full review of document undertaken. This has included reformatting, addition of new requirements/removal of obsolete clauses, update of job titles and section references.

Introduction

This documents sets out the powers reserved to both the Board of Directors and the Council of Governors, and those delegated to the Committees, and key senior staff members. The document also sets out the financial delegation limits, which are then reflected in the Standing Financial Instructions (SFIs). The SFIs are therefore reviewed in conjunction with this document.

1. Decisions reserved to the Council of Governors

General enabling provision	• No decisions reserved
Regulations and control	• Decide whether the Trust's private patient work would significantly interfere with the Trust's principal. • Approve any proposal to increase by 5% or more the proportion of the Trust's total income in any financial year attributable to non-NHS activities. • Approve any "significant" transaction as defined in the Trust's Constitution. • Approve any application by the Trust to enter into a merger, acquisition, separation, or dissolution. • Amendments to the Trust's Constitution must be approved by the Board of Directors and the Council of Governors.
Appointments/dismissals	• Appoint, and, if appropriate, remove the Chair • Appoint, and if appropriate, remove the other Non-Executive Directors • Approve the appointment of the Chief Executive • Appoint, and if appropriate, remove the NHS Foundation Trust's auditor. • To appoint the Lead Governor of the Council of Governors • To decide the remuneration and allowances and other terms and conditions of office, of the Non-Executive Directors • Contribute to the annual appraisal of the Chairman (led by Senior Independent Director) • Receive the outcomes of the annual appraisals of the Non-Executive Directors
Policy determination	• Preparation and review of the Membership Strategy ensuring representation and engagement levels are maintained and increased as appropriate. • In preparing the NHS Foundation Trust's Forward Plan, the Board of Directors must have regard to the views of the Council of Governors
Audit	• Appoint, and if appropriate, remove the external auditor. • Review the performance of the external auditor, at least annually
Annual Report and Accounts	• To receive the Annual Report, Accounts and Financial Statements and any report of the External Auditor on them and the Trust's Annual Report

Monitoring	• To hold the Board of Directors collectively to account for the performance of the NHS Foundation Trust, ensuring that the Board acts so that the Trust does not breach its terms of authorisation. • Feeding back information about the NHS Foundation Trust, its vision and performance to the constituencies and the stakeholder organisations which appointed / elected them

2. Decisions reserved to the Board of Directors

General enabling provision	• The Board may determine any matter it wishes, for which it has delegated or statutory authority, in full session within its statutory powers
Regulations and control	• Approve the Trust's Corporate Governance Manual, the schedule of matters reserved to the Board, and Standing Financial Instructions for the regulation of its proceedings and business. • Approve, suspend, vary or amend the Standing Orders in accordance with the conditions in the Corporate Governance Manual • Ratify any urgent decisions taken by the Chairman and Chief Executive in accordance with the Corporate Governance Manual • Approve a scheme of delegation of powers from the Board to committees and from the Board to relevant officers as per the standing orders. • Require and receive the declaration of Board members' interests which may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. • Require and receive the declaration of officers' interests, which may conflict, with those of the Trust. • Approve arrangements for dealing with complaints. • Adopt the organisation structures, governance arrangements, processes, and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. This includes the detail of the structure of the Board, and its Committees. • Receive reports from committees, including those which the Trust is required by regulation to establish, and to take appropriate action thereon.

	• Confirm the recommendations of the Trust's committees of the Board where that Committee does not have executive powers, or where that Committee's level of delegated authority is insufficient. • Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. • Establish terms of reference and reporting arrangements of all committees and groups, which are established by the Board. • Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. • Authorise use of the seal • Ratify instances of failure to comply with the Corporate Governance Manual • Discipline members of the Board or employees who are in breach of statutory requirements or Corporate Governance Manual • Approve any amendments to the Trust's Constitution. These amendments must also be approved by the Council of Governors.
Appointments/dismissals	• Appoint and dismiss committees (and individual members) which are directly accountable to the Board. • Appraise and discipline executive directors in line with the Constitution. • Appoint, appraise, discipline, and dismiss the Board Secretary
Strategy, business plans and budgets	• Define the strategic aims and objectives of the Trust. • Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the NHS England • Ratify the Trust's strategy, policies, and procedures for the management of risk. • Approve Strategic Outline Cases, Outline Business Cases and Final Business Cases for Capital Investment per the SORD • Approve the medium term financial strategy and annual financial plan. • Approve Trust's organisational development plan. • Ratify proposals for acquisition, disposal or change of use of land and/or buildings. • Receive notification of all significant leases (annual rents exceeding £100,000) if not already under the Board's authority to approve.Approve the opening of bank accounts.

	• Approve proposals on individual contracts of a capital or revenue nature amounting to over £1,000,000 (inclusive of VAT) over a 3 year period, or the period of contract if longer. • Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be considered significant if it has a gross annual income or expenditure in excess of £1,000,000. • Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board. • Approve individual compensation payments in excess of £50K. • Approve proposals for action on litigation against or on behalf of the Trust in excess of £100k. • Approve any change to the use of the NHS risk pooling schemes or approve arrangements to self-insure
Policy determination	• Approve management policies including personnel policies incorporating the arrangements for the appointment, removal, and remuneration of staff
Audit	• Approval of external auditors' arrangements for the separate audit of funds held on trust • Review of the annual management letter received from the external auditor taking account of the advice, where appropriate, of the Audit and Risk Committee • Approve the appointment of the internal auditor, having regard to the recommendation of the Audit and Risk Committee (Note: the appointment of external auditors sits with the Council of Governors).
Annual Report and Accounts	• Receipt and approval of the Trust's Annual Report and Annual Accounts • Receipt and approval of the Annual Report and Accounts for funds held on trust
Monitoring	• Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. • Receive, and approve if required, reports providing assurance on the integration of equality, diversity, and inclusion throughout the Trust • Receive such reports and assurance as may be required by or informed by NHSE, CQC, or other regulatory bodies' guidance. • Continuous appraisal of the affairs of the Trust by means of the provision to the Board, as the Board may require from directors, committees and officers of the Trust as set out in management policy statements.

	• Receive reports from the Chief Finance Officer on financial performance against budget and the annual plan • Receive and drive action plans, by exception, where performance is below plan

3. Committee delegation

The Board of Directors may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board of Directors from time to time taking into account where necessary the requirements of the Regulator and/or the Charity Commission (including the need to appoint an Audit and Risk Committee and a Remuneration Committee).

The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with the Standing Orders committees of the Board of Directors may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

The Board of Directors have delegated decisions to the following committees:

- Audit and Risk Committee
- Estates and Capital Committee
- Charitable Funds Committee
- Finance Business Performance Committee
- Quality Committee
- People Committee
- Remuneration Committee
- Research and Innovation Committee

The full terms of reference for each Committee are maintained by the Board Secretary.

Committee	Delegated items
Audit and Risk Committee	The Committee is established 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 authorised by the Board of Directors to: • 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. • 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. • 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 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. • To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity, and accuracy. • Consider any activity within its terms of reference
Estates and Capital Committee	The Committee is established 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. The Committee is authorised by the Board of Directors to: • To approval Campus Master Plans and strategies for estates and capital. • To approve the Trust's Health and Safety plan, recommending it to the Board for final approval. • 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. • 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. • Consider any activity within its terms of reference

Charitable Funds Committee	The Committee is established 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. The Committee is authorised by the Board of Directors to: • Maintain the Charity's governing document and registration with the Charity Commission • Review and advise on those aspects of Standing Orders and Standing Financial Instructions that appertain to the charity and its operation. • 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. • 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. • Consider the appointment of investment advisors and monitor the performance of the charitable fund portfolio and consider changes when deemed necessary. • To oversee the Investment Policy of the Charitable Funds as required by the Trustee Acts and the NHS Acts. • 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. • Oversee and monitor the functions with regards to the investment, accounting and reporting on the use of charitable funds. • Receive Annual Accounts and Annual Reports of the Trust's charitable funds for consideration and recommendation for final approval to the Board of Directors. • To develop the strategy, policies, and objectives for the Charity for consideration and approval by the Corporate Trustee. • Consider any activity within its terms of reference.

Finance Business Performance Committee	The Committee is established to seek assurance about the Trust's financial and operational performance, delivery of the in-year plans and the development of future plans. The Committee is authorised by the Board of Directors to: • 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. • 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. • To review and recommend business, operational, and financial plans to the Board of Directors. • 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. • Consider any activity within its terms of reference
Quality Committee	The Committee is established 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 is authorised by the Board of Directors to: • To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis. • Consider any activity within its terms of reference.
People Committee	The Committee is established 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. The Committee is authorised by the Board of Directors to: • Consider any activity within its terms of reference.
Renumeration Committee	The Committee is established to ensure effective governance in respect of Executive Director and other Executive Team Member appointments, succession planning and the remuneration of the same.

	The Committee is authorised by the Board of Directors to: • 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. • 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. • To review and approve any interim Executive Director appointments in accordance with relevant guidance. • 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: o All aspects of salary (including and performance-related elements/ bonuses); o Provisions for other benefits, including pensions and cars; o Allowances • 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. • To approve contractual arrangements for Executive Directors and other Executive Team Members, including but not limited to termination payments. • Consider any activity within its terms of reference
Research and Innovation Committee	The Committee is established to ensure effective governance in respect of Research and Innovation activity across the Trust. The Committee is authorised by the Board of Directors to: • Consider any activity within its terms of reference

4. Scheme of delegation of powers from Standing Orders (SOs)

SO Ref	Delegated to	Duties delegated

1.1	Chair, advised by Chief Executive and Director of Finance	Final authority in interpretation of Standing Orders
4.11.1	Board of Directors	Suspension of Standing Orders
4.11.5	Audit and Risk Committee	Review suspension of Standing Orders
4.12.3	Board of Directors	Variation or amendment to Standing Orders
5.2	Chair and Chief Executive with two Non-Executives Directors	Emergency powers relating to the authorities retained by the Board of Directors
	All staff	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)

5. Scheme of delegation of powers from Standing Financial Instructions (SFIs)

Delegated matter	Delegated to	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
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 /	SFI 1.4.7
		Finance teams	
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	Chief Executive		SFI 3.1.1 / 3.1.4
account financial targets and forecast limits of available resources, to be forwarded to NHS England		Executive Directors	
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
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	SFI 3.3.2
		All budget holders	
• 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	Director of Finance	Director of Finance, advised by Assistant Director of Finance - Financial Services	SFI 7.2.8 / 7.2.9 / 7.2.10 / 7.2.11
• VAT recovery;		*Proposals should be forwarded to Financial Accounts in the first instance.*	
• leases / rentals, 'managed service' models, 'free asset' models;			
• collaborative working - joint ventures, joint operations, partnerships;			
• capital expenditure and revenue consequences			
• 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 Financial Limits	SFI 7.2.5 / 7.2.7 / 7.2.12
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
	Chief Executive / Director of Finance	Director of Finance (> £2m)	SFI 6.3.1 / 6.4.1

d) Negotiating contracts with commissioners, and establishing arrangements for extra-contractual services		Divisional Directors and corporate managers (< £2m)	
e) Signing income-related contracts	Chief Executive / Director of Finance	Refer to 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 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
• 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 Financial Limits	SFI 12.1.4
• Approving a capital requisition		Refer to 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
d) Accepting and authorising a quotation and the awarding of a contract		Refer to 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 Financial Limits	SFI 8.13.7 / 8.13.8
l) Signing expenditure-based contracts on behalf of the Trust		Refer to 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	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
● 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			
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
d) Approving requisitions and petty cash purchases (exceptional circumstances)		Refer to 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
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	All staff	All staff	SFI 2.6.3 / 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 be informed			
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			
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
● 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*	SFI 12.4.4 / 12.4.6

		Procurement in conjunction with the EBME Manager	
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
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 -	SFI 13.1.7

		Financial Services	
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 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	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
● 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			
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	Director of Finance	Director of Finance / Deputy Director of Finance / Assistant Director of Finance - Financial Services (PDC)	SFI 14.1.2 / 14.2.4 / 14.2.7

Loans > 1 month, including any working capital facility, and PDC must be approved by the Board in advance of drawdowns		Director of Finance / Deputy Director of Finance (loans)	
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
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
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
18. HR and pay			
Framework			
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	
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	
o) Completing and authorising payroll reporting forms (SVLs)	Chief People Officer	Matrons / Ward and departmental managers	SFI 19.4.5 / 19.5.3
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	Chief Executive	Line managers	
for AfC employees, this is granted in exceptional circumstances only, and only with written consent			
t) Approving time off in lieu	Chief Executive	General managers / departmental managers	
u) Approving	Chief Executive	General managers / departmental managers / Associate Medical Directors	
● 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			
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	
		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		
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	
	Medical Director	Post Graduate Tutor	
cc) Approving medical staff study leave (UK) - career-grade			
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	Chief People Officer	Associate Medical Director / Deputy Chief Nurse	
(no longer available for non-medical staff)		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	SFI 19.10
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 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	
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

6. Scheme of delegation of powers outside of SOs or SFIs

Delegated matter	Duties delegated	Delegated to	Operational responsibility
	Authorisation of Clinical Trials and Research Projects	Medical Director	Clinical Governance Group

Trials & Research Projects	Financial Management of Clinical Trials and Research Projects in accordance with all Trust financial policies and procedures	Chief Finance Officer	Deputy Chief Finance Officer with relevant clinicians and budget managers
	Authorisation of product trials	Chief Executive	Medical Director
Authorisation of New Drugs	Authorisation of new drugs	Chief Executive	Chief Pharmacist
Clinical Audit	Responsibility for clinical audit	Chief Executive	Medical Director
Complaints (Patients & Relatives)	Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Medical Director
	Responsibility for ensuring complaints relating to a division / department are investigated thoroughly	Chief Executive	Medical Director
Confidential Information	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Director of Informatics / Associate Medical Director
	Freedom of Information Act compliance code	Chief Executive	Chief Information Officer
	Data Security Arrangements	Chief Executive	Chief Information Officer
Data Protection Act	Review of Foundation Trust's compliance	Chief Executive	Chief Information Officer
Declaration of Interest	Maintaining a register of interests	Director of Corporate Affairs	Board Secretary
	To ensure Board of Directors / Senior Managers / Senior Clinicians / Department Heads / all senior staff have declared relevant and material interest.	Director of Corporate Affairs	Board Secretary
Environmental Regulations	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Director of Estates, Facilities and Capital Planning

Fire precautions	Ensure that the Fire Precautions and prevention policies and procedures are adequate, and that fire safety and integrity of the estate is intact.	Chief Executive	Director of Estates, Facilities and Capital Planning
Health and Safety	Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Director of Estates, Facilities and Capital Planning / Chief Pharmacist
Hospitality/Gifts	Keeping of hospitality register	Director of Corporate Affairs	Board Secretary
	Applies to both individual and collective hospitality receipt items. See Table B for limits.		All staff declaration required in Foundation Trust's Hospitality Register coordinated by the Board Secretary
Infectious Diseases & Notifiable Outbreaks	Responsibility for infectious diseases and notifiable outbreaks	Chief Executive	Director of Infection Prevention and Control
Legal Proceedings	Engagement of Foundation Trust's Solicitors / Legal Advisors	Chief Executive	Director of Corporate Affairs/Chief Finance Officer/Chief People Officer
	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Chief Finance Officer
	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Nominated Executive Director
Medical	Clinical Governance arrangements	Medical Director	Deputy Medical Director
	Medical Leadership	Medical Director	Deputy Medical Director

	Programmes of medical education	Medical Director	Deputy Medical Director
	Medical staffing plans	Medical Director	Deputy Medical Director
	Consultant Pay Progression (Schedule 15)	Chief Executive	Medical Director
	Medical Research	Medical Director	Deputy Medical Director
Nursing	Compliance with statutory and regulatory arrangements relating to professional nursing practice.	Chief Nurse	Deputy Chief Nurse / Matrons
	Matters involving individual professional competence of nursing staff.	Chief Nurse	Deputy Chief Nurse / Matrons
	Compliance with professional training and development of nursing staff.	Chief Nurse	Deputy Chief Nurse / Matrons
	Quality assurance of nursing processes.	Chief Nurse	Deputy Chief Nurse / Matrons
Patient Services Agreements	Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer
	Quantifying and monitoring out of area treatments	Chief Finance Officer	Deputy Chief Finance Officer
	Reporting actual and forecast income	Chief Executive	Chief Finance Officer
	Costing Foundation Trust Contract and Non Commercial Contracts	Chief Finance Officer	Deputy Chief Finance Officer
	Reference costing / Payment by Results	Chief Finance Officer	Deputy Chief Finance Officer
	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Deputy Chief Finance Officer
Risk Management	Ensuring the Foundation Trust has a Risk Management Strategy and a programme of	Chief Executive	Medical Director / Director of Corporate Affairs

	risk management		
	Developing systems for the management of risk.	Medical Director	Deputy Director of Quality Governance
	Developing incident and accident reporting systems	Medical Director	Deputy Director of Quality Governance
	Compliance with the reporting of incidents and accidents	Medical Director	All staff
Seal	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Affairs
	Attestation of seal in accordance with Constitution	In advance by Board / Director of Estates, Facilities and Capital Planning	Director of Corporate Affairs
	Property transactions and any other legal requirement for the use of the seal.	In advance by Board / Director of Estates, Facilities and Capital Planning	Director of Corporate Affairs
Medicines Inspectorate Regulations	Responsibility for review of regulations	Chief Executive	Medical Director/Chief Pharmacist

7. Delegated financial limits

All thresholds are inclusive of VAT irrespective of recovery arrangements and details of procurement thresholds are provided (net of VAT). 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.

Refer to the Standing Financial Instructions, Appendix 2 – Matrix of Financial Limits, for further authorisations.

Proposed Financial Limits (subject to funding available in budget)	**Financial Limit**	**Delegated Authority**
Requisitioning of all goods, works and services		
Approval of revenue requisitions Approval of capital requisitions Approval of annual call-off requisitions Approval for payment of consignment goods	Up to £1000	Deputy Department Managers/Ward Managers
	>£1000 - £5000	Department Managers/Matrons
	>£5000 - £10000	Directorate Managers/Assistant Managers
	>£10000 - £30000	Divisional Directors, Divisonal Medical Leads, Senior Corporate Managers
	>£30,000 up to the PCR2015 threshold	All Very Senior Managers or Deputy CFO
	Greater than the PCR 2015 threshold	CEO/COO/CFO or Deputy CEO
Drugs inventory and other Pharmacy purchasing		
	Up to £25000	Authorised pharmacy officers per a signatory list
	>£25000 - £50000	Pharmacy support services Operational Manager/Team Leader, Pharmacy Clinical Support Services
	>£50000 - £100000	Director of Pharmacy and Medicines Management/Deputy Director of Pharmacy
	>£100000	CEO or CFO
Authorisation of waivers		
Refer to Matrix of Financial Limits for requirements on tenders/procedures	Up to £30000	CFO or Deputy CFO
	>£30000	CEO & CFO

Proposed Financial Limits (subject to funding available in budget)	**Financial Limit**	**Delegated Authority**
Contract Award		
Refer to Matrix of Financial Limits for requirements on tenders/procedures	>£5000 - £30000	Budget manager, of a level higher than the opener
	>£30000 – EU Threshold	Budget Manager
	>EU threshold - £250,000	Deputy CFO
	>£250,000 - £500,000	CEO/CFO
	>£500,000 - £1,000,000	CEO
	>£1,000,000	Board
Approval of revenue only business cases		
	Up to £50,000	CEO or CFO
	>£50,000 - £250,000	Finance Business Performance Committee
	>£250,000	Board
Approval of capital or lease business cases within Board approved Programme		
	Up to £250,000	CEO or CFO
	>£250,000 - £1,000,000	Finance Business Performance Committee
	>£1,000,000	Board
Approval of capital or lease business cases NOT within Board approved Programme		
	Up to £50,000	CEO or CFO
	>£50,000 - £250,000	Finance Business Performance Committee
	>£250,000	Board

Proposed Financial Limits (subject to funding available in budget)	**Financial Limit**	**Delegated Authority**
Approval of any proposal or case involving management consultants		
	Up to £10,000	Executive Directors
	>£10,000 - £50,000	CEO or CFO
	>£50,000	Board with NHSE approval required
Charitable funds "bids"		
	Up to £30,000	CFO, or Fund holders if the spend is against their delegated fund
	>£30,000	Charitable Funds Committee
Petty Cash Withdrawal Approval		
	Up to £30	All managers
	>£30	Deputy CFO or CFO
Debt Write Offs		
	Up to £1000	Deputy CFO
	>£1000 - £10,000	CFO
	>£10,000	Audit Committee
Non-Clinical Negligence Payments (made on advice of NHSLR) *Limits below refer to net payments.*		
Employer liability	<£10,000	Legal Services Manager
Public liability	<£3000	Legal Services Manager
All other registered losses		

Proposed Financial Limits (subject to funding available in budget)	**Financial Limit**	**Delegated Authority**
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 to be notified in all cases.*	Up to £5000	CFO
	>£5000 - £10,000	CEO
	>£10,000	CEO & CFO
Litigation Claims		
Approval of payments following other legal advice that are patient-related *(Excluding non-clinical negligence payments)*	<£10,000	Legal Services Manager
	>£10,000	Associate Medicate Director
Approval of proposals for action on litigation against, or on behalf of, the Trust	<£100,000	Deputy Director of Quality Governance (and list determined by said role)
	>£100,000	Board
Income contracts		
Signing contracts *(Board consulted in advance for anything over £1m.)*	Up to £250,000	Deputy CFO
	>£250,000	CEO or CFO
Non Trading Income		
Approving non-clinical grant applications with divisional sign-off	Up to £50,000	Head of Fundraising
	>£50,000	CFO

Wirral University Teaching Hospital NHS Foundation Trust

BOARD OF DIRECTORS CODE OF CONDUCT

1. Introduction

The purpose of this code of Conduct ("the Code") is to provide clear guidance on the standards of conduct and behaviour expected of all Wirral University Teaching Hospital NHS Foundation Trust (WUTH) Board members, whether Executive or Non-Executive.

The Trust is an apolitical public benefit organisation that seeks to promote social inclusion. The promotion of any personal or political view that is at odds with this principle will be grounds for dismissal from the Board. Given the confidential, and often sensitive nature, of the issues considered by the Board, Directors both individually and collectively must always act with total discretion and integrity, and in the interests of the greater good of the Trust and the people who use its services.

This code, with the Code of Conduct for Governors and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the Code of Governance, the constitution and with Standing Orders. The code applies at all times when directors and employees are carrying out the business of the foundation trust or representing the foundation trust.

Any conflict between this code and the code of conduct for Executives as employees of the organisation will be superceded by the code for employees.

2. Seven Principles of Public Life

All directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take; they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

3. Corporate Values

In addition to the Seven Nolan Principles, WUTH has four values that underpin everything it does:

- **caring** for everyone
- **respect** for all
- embracing **teamwork**
- committed to **improvement**

WUTH Directors should exhibit these values in delivering their statutory duties and when representing the Trust.

4. General principles

Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all directors.

5. Confidentiality & access to information

Directors and employees must comply with the Foundation Trust's confidentiality policies and procedures. Directors and employees must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors and employees must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Foundation Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of

Information Act and other relevant legislation which will be followed at all times by the Board of Directors and all staff.

6. Conflicts of Interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the trust enters into the transaction or arrangement.

The Chair will advise directors in respect of any conflicts of interest that arise during board of directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Director of Corporate Affairs and/or the Board Secretary will provide advice on any conflicts that arise between meetings.

Directors are required to register all relevant interests on the Foundation Trust's register of interests in accordance with the provisions of the constitution, and the Managing Conflicts of Interest Policy. It is the responsibility of each director to update their register entry if their interests change, or to confirm each year that their interests have not changed. The register is available via the Declare portal, with details available from the Trust Secretariat.

Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

7. Bribery

The Board of Directors has a responsibility to protect both the Trust and the wider NHS from bribery or corruption.
Directors shall at all times comply with the Bribery Act 2010 and with the Trust's policy.
Directors will not request or receive a bribe from anybody, nor imply that such an act might be considered. This means not agreeing to receive or accept a financial or other advantage from any source as an incentive or reward to perform improperly the function or activities of WUTH.

8. Gifts & hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

The Board of Directors has adopted a policy on gifts and hospitality which will be followed at all times by directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy, and ensuring that an entry is completed in the Trust register.

9. Whistle-blowing

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature. The Board of Directors has adopted a whistle-blowing policy on raising matters of concern which will be followed at all times by directors and all staff.

10. Personal Conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

Specifically directors must:

- Act in the best interests of the Foundation Trust and adhere to its values and this Code of Conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors as a Board of Directors member in order for it to fulfil its role and functions.
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.
- Make every effort to attend meetings where practicable.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Foundation Trust, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

11. Training and Development

WUTH is committed to providing appropriate training and development opportunities for Directors to enable them to carry out their role effectively. Directors are expected to participate in training and development opportunities that have been identified as appropriate for them. Directors are required to participate in any review processes both in terms of their own contribution and the wider effectiveness of the Board.

12. Dealing with the Media

Non-Executive Directors should not engage with the media, or make any comments, over matters relating to WUTH, and any Non-Executive Director approached by the media for comment should immediately notify the Trust's Director of Corporate Affairs.

Executive Directors will engage with the media in line with corporate policy, in their roles as employees of the organisation.

13. Interpretation and Concerns

Questions and concerns about the application of the Code should be raised with the Director of Corporate Affairs. At meetings the Chair will be the final arbiter of interpretation of the Code.

14. Review and Revision of the Code

This Code has been agreed by the Board. The Director of Corporate Affairs will ensure that the Code is reviewed periodically, although it is for the Board to agree to any amendments or revisions.

15. Undertaking and Compliance

The members of the Board of Directors will satisfy themselves that the actions of the Board of Directors and Directors in conducting Board of Directors' business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code of Conduct.

16. Personal Declaration

I……. (Please print full name) have read, understood, and agree to abide by the Code of Conduct for the Board of Directors of WUTH FT

Signature …….

Date …….

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13.1**
3rd April 2024

Report Title	Finance & Business Performance Assurance Committee Report
Author	Sue Lorimer, Chair of Finance Performance Assurance Committee

Items for Escalation and Action

- The Committee noted that financial performance to month 10 had continued to deteriorate with a deficit of £21.5m achieved against a planned deficit of £17m, an adverse variance of £4.5m. Of this sum £2m relates to CIP underachievement with the balance related to industrial action and continued under-utilisation of surgical capacity by the Countess of Chester. The Committee was informed that the COCH has improved its utilisation in the current quarter and agreed in principle an SLA with the trust which should ensure better utilisation of their allocated theatre sessions for the remainder of 2023/24 and beyond. CIP is forecast to underachieve by £3m in year with full achievement in a full year.
  The adverse variance from plan for the year is forecast at £4.5m but this may be impacted by further industrial action.
  In response to questions from the Committee regarding medical agency staff HK said that a review of all agency medical staff was planned to be undertaken by the Trust Management Board and would be brought to the next meeting of the Committee.
- The Committee noted that capital expenditure was £5m behind plan. UECUP spend is forecast to remain behind plan at year end but schemes have been brought forward from 2024/25 to bridge the gap and the Committee was assured that the capital expenditure plan would be achieved in full. The cash balance was higher than plan at £15m but this continues to require close monitoring.
- The Committee received a presentation on progress of development of the 2024/25 financial plan. The draft income and expenditure plan showed a deficit of £27.9m. Cheshire and Merseyside ICB have stipulated that all plans comply with the following:
  - Improved performance on 23/24 plan – trust plan not compliant.
  - Reduction in staffing WTE – trust plan shows a 1% reduction in WTE's.
  - Increased productivity - trust plan shows increased productivity of 2.7%

  Inflation assumptions were 2.1% for pay and 1.9% for non-pay and a 5% CIP was included. The Committee gave its approval to the direction of travel of the plan but noted that it needed further improvement before final submission.
- The Committee received an update report on productivity and efficiency. The year to date achievement for CIP was £18.5m delivered with a further £4.7m forecast to the year end giving a total achievement of £23.2m against a plan of £26.2m. MC informed the Committee that while the trust's agency position was better than threshold it was an outlier for using off-framework agencies and this was an area for improvement.
- The Committee received a presentation from Alistair Leinster, Divisional Manager for Medicine on the divisional approach to delivery of CIP. The forecast for the division was achievement of £4.5m in-year and £5.1m full year which is 5% of the divisional budget. The Committee congratulated AL on the good performance despite the challenges within the division. AL stated that it will be more difficult to achieve this level of savings next year but the areas to be focussed on will be bed capacity, agency spend and medicines.
- The Committee noted the strong performance achieved in elective activity. Performance to reduce 65-week waiters was ahead of plan for all specialties except Gynaecology. Diagnostic performance was slightly behind the 95% target due to challenges in Cystoscopy

but is on plan to achieve 95% by the year end. Colorectal, Urology and Gynaecology remain the primary areas of concern across the cancer standards. The Committee were pleased to see the use of the trust's own infrastructure in delivering additional activity.

- The Committee were pleased to welcome Chris Mason, Chief Information Officer to his first meeting. He provided a set of KPI's for measuring the performance of the Digital Healthcare Team and the Committee noted that KPI's to measure strategic delivery were under development. CM informed the Committee that a Chief Clinical Information Officer had recently been appointed and this should help significantly with clinical engagement in developing the use of digital systems. The Committee looked forward to the continued attendance of CM at FBPAC meetings and to supporting him in the ongoing development of the digital agenda.
- The Committee received a preliminary report on private patient activity within the trust and noted progress on implementing previous internal audit recommendations. The Committee noted the new documentation and processes developed and looked forward to a further update in due course.
- The Committee gave retrospective approval to a contract with Wirral Community NHS Foundation Trust for MSK services.
- The Committee approved the award of a 2 year contract to Mersey Healthcare LLP under the Most Suitable Provider process.
- The Committee reviewed the Board Assurance Framework with no recommendations for change.

New/Emerging Risks

- Further improvement to the financial plan is required.
- The risk around elective performance and achievement of Cancer waiting times targets for Colorectal, Gynaecology and Urology are now significant due to continued industrial action.

Overview of Assurances Received

- Financial performance remains in line with commitments given to the ICB for H2
- Elective activity is performing well in general.
- The Medicine Division is well engaged in the CIP agenda

Other comments from the Chair

- The Committee continue to be assured by the quality of information received and the forward planning undertaken despite the continued operational pressures.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13.2**
3 April 2024

Report Title	Committee Chair's Reports - Audit and Risk Committee
Author	Steve Igoe, Non-Executive Director & Deputy Chair

Overview of Assurances Received

This report updates on the work of the Audit and Risk Committee at its meeting on 29 February 2024. The work of the Audit and Risk 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.

The action log confirmed all matters previously discussed at the Committee had been closed.

Internal Control and Risk Management

The Committee discussed the Chair's report from the Risk Management Committee.

The medical Director briefed the Committee on the ongoing management of risks and key issues being discussed and managed at an operational level. Following the previous Audit Committee meeting which discussed infrastructure issues, this time further discussion took place on capital equipment and the challenges of replacing old but key items such as the CT scanner. It was accepted that despite mitigations there was inevitably a degree of residual risk that remained with such items.

The Medical Director also highlighted challenges related to staffing and capacity. It was recognised that managing such issues was challenging and that whilst there was a command structure in place to deal with escalations, mitigating the risks from unscheduled care was often at the expense of elective activity which in turn has its own repercussions.

It was however noted that there is a strong risk management culture in the Trust, and this was evident in the report and responses.

The Committee reviewed the latest version of the Trust's Risk Management Strategy.The Strategy was last refreshed in November 2022, and at that point, it was noted that the refresh would be changed to April to April. There were no substantial changes to the Strategy, nor to the risk appetite statement. The Committee discussed the risks relating to Research and Innovation and where they would best be recorded alongside a discussion on place-based risks, noting these may well come more to the fore over the next 12 months. The Committee approved the Risk Management Strategy.

The Committee reviewed the latest version of the Board Assurance Framework noting this will be subject to a substantial review and refresh for the coming year.

A deep dive took place into Finance risks noting that Finance issues ran through many items on the BAF and Risk Registers.

The Deputy Director of Finance gave an overview of the four key high scoring risks, including the mitigations in place, the actions, and the monitoring process for each. The Director of Finance added that assurance can also be found via the internal audits which have been undertaken in year, and the accreditation which the team have achieved.

The Committee discussed the detailed Corporate Governance Manual which brings together a number of key documents in a single repository. The Committee approved the scheme of delegation and reservation, the Board code of conduct and recommended the same to the Board for final approval.

Procurement control and waivers

The Committee was updated on procurement spend controls and waivers. It was noted that the Trust continues to perform strongly against NHS benchmarks. Work is ongoing to create a robust procurement work plan to identify and reduce ad-hoc expenditure, and further efforts are being made to ensure awareness of the no PO, no pay policy.

The Deputy Director of Finance confirmed that the Procurement team are looking at changing the language in the SFIs to move away from “retrospective waivers” and start using “breach of SFIs.” Improvement in this area has stalled, and it is felt that there is a culture of simply using a waiver instead of having proactive conversations. There was some discussion about the cultural impact of such a change however the Committee the Committee agreed that this should be considered but that there should be a balance with the understanding that some retrospective waivers may not be in the individual’s control.

Financial Losses and Special payments

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 current position would appear to be that a number of these invoices will require to be written off although there will be no current year financial impact and they had been provided for in full.

The Committee noted the risk of salary overpayments during the payroll transition, and that drug costs seem to be increasing, both of which should be monitored.

Anti-Fraud Progress Report

MIAA provided their regular update on Anti-Fraud issues and work being undertaken. The AFS highlighted the strategic governance elements, including the Counter Fraud External Reporting Suite published by NHSCFA, and the review of the Anti-Fraud Policy. She also noted the investigations and referrals, including those carried forward from the previous period. The AFS introduced the 24/25 Anti-Fraud Plan which was approved by the Committee.

Internal Audit

MIAA provided an overview of recent activity undertaken across the Trust.

Two reviews were reported to the Committee, one in relation to Consultant incremental pay and the second relating to financial processing controls. The latter report receiving an opinion of substantial assurance.

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.

Internal Audit Pan 24/25

MIAA reported on the process undertaken to draft the internal audit plan, including the risks that have been considered, and indicated the proposals at section 6 and 7. It was noted that the process for approving the plan includes NEDs, and that this has worked well. The Committee approved the draft Internal Audit Plan 2024/25.

External Audit Plan for the Audit of theTrust accounts to 31 March 2024

Azets explained the auditor's responsibilities, as outlined in the report, and noted the general approach that will be undertaken to discharge these responsibilities. It was noted that there have been no major changes to the audit standards, unlike last year. The Auditor provided an overview of the significant risks that have been identified and the methods by which these would be reviewed and reported back to the Audit Committee. The Committee also noted the review of the Value for Money arrangements, which the auditors must also consider and assess. The Committee approved the External Audit Plan 2023/24 along with the proposed fees of £130,560 for the Trust and £4,800 for the Charitable Fund.

Year-end matters

A number of year end matters were then discussed and approved by the Committee. Specifically, the proposed going concern disclosure subject to any further requirements of the Foundation Trust Accounting and Reporting Manual 2023/24 (which is yet to be published) and the Accounting Policies to be used in constructing the year end accounts.

Emergent risks and Assurances

All such matters are included in the body of the report on the deliberations of the Audit and Risk Committee as set out above.

Wirral University Teaching Hospital NHS Foundation Trust

Meeting Name Trust Board in Public **Item No**
Date 3rd April 2024

Report Title	Chair's Report: Quality Assurance Committee 14th March 2024
Author	Dr. Steven Ryan

Items for Escalation/Action

- The annual trajectory for prevention of Clostridioides difficile cases for 2024/25 has been agreed with the Integrated Care Board at 108 cases. This upper limit is not now "artificially suppressed" by previous lower case levels, seen during the height of the pandemic. The number of cases seen in 2023/24 stands at 101 cases (with an annual trajectory of 71), a reduction of over 30 cases compared to the previous year. The Committee are assured of the continued diligence and oversight and leadership in place to prevent and control C diff. The relative lack of isolation facilities remains a challenge for the organisation.

- It was positively noted that there were trends in reduction of patients on the total open pathway waiting list from last summer, as well as the elimination of greater-than 78 week waits for patients. Given the fact that referral levels remain high, this is testament to the work undertaken to improve access for scheduled care in the face of disruption due to industrial action.

New/Emerging Risks

- No new risks were identified. However the Committee felt it would be useful to have a greater understanding of the potential impacts on, likelihood of and mitigations for, quality and safety related to restricted capital allocations for medical equipment. Relevant areas of the Board Assurance Framework were considered.

Overview of Assurances Received

- The implementation of the Patient Safety Incident Reporting Framework (PSIRF) continues and the Committee was assured of an active process with good clinical engagement and appreciation of the just and learning aims of this approach. Numbers of rapid evaluations of care proposed in month were higher than initially anticipated (65). Of these 35 showed no evidence of significant error or admission. Of these latter 35 reported 17 were stood down before panel consideration. This does indicate a culture of a high level of reporting of concerns, consistent with a health safety culture. Thematic learning around falls, tissues ulcers and infection control was identified.

- The Committee received assurance it had previously sought, that the Trust's patients seeking in-vitro fertilisation services could access such services, following a risk noted in the Quality and Patient Safety Intelligence report previously. The Trust is working with the regional lead service at Liverpool Women's Hospital to future-proof these services

- The Committee were assured that appropriate monitoring of key quality indicators (e.g. for falls, tissue ulcers and deterioration) was in place and that any adverse trajectories were identified in outcomes or processes. In the case of an adverse trajectory, divisions, supported by the central governance team took appropriate action.

- Through the work of a group of trainee doctors, a digital out-of-hours task list had been developed and implemented. This task list ensures that, particularly where other clinicians are needed to complete tasks, there is a robust system to support scheduling and completion of tasks. This ensures continuity of care. It also demonstrates an innovative and collaborative approach to quality and safety.

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. Additionally authors and area leads were able to respond to enquiries to assist the committee in formulating its opinion on assurance.