NHS
Wirral Community Health and Care
NHS Foundation Trust

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

2 July 2025

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 WUTH Board of Directors in Public - 4 Jun.pdf
- 3.1 WCHC Board of Directors in Public - 4 Jun.pdf
- 4 Action Log - Public Board.pdf
- 6 Joint Chief Executive Officer Report.pdf
- 6.1 NHS Performance assessment framework.pdf
- 7 IPR.pdf
- 7.1 WUTH IPR Dashboard - June 2025 - Intro.pdf
- 7.2 WUTH IPR Dashboard - June 2025 - 1 COO.pdf
- 7.3 WUTH IPR Dashboard - June 2025 - 2 MD.pdf
- 7.4 WUTH IPR Dashboard - June 2025 - 3 CN.pdf
- 7.4.1 CN Commentary.pdf
- 7.6 WUTH IPR Dashboard - June 2025 - 4 CPO.pdf
- 7.6.1 CPO Commentary - for June BoD_.pdf
- 7.8 WUTH IPR Dashboard - June 2025 - 5 CFO.pdf
- 7.9 CFO Commentary M2 25-26 v3.pdf
- 8 WCHC IPR.pdf
- 9 Quality Comm.pdf
- 10 Audit and Risk Comm.pdf

11 People Comm.pdf

12 FBPAC.pdf

13 CFC.pdf

14 PCC Chair's Report June 2025_2.pdf

15. WCHT Finance Performance Chair's report meeting on 11th June 2025.pdf

17a. Cover Sheet Green Plan.pdf

17b. Green Plan.pdf

18a. SFIs cover sheet.pdf

18b. Standing Financial Instructions - amended to update to PA 2023 and DFLs.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community Health and Care NHS Foundation Trust

Notice of Meeting

This meeting will constitute both Boards of Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health & Care NHS Foundation Trust. The matters will be considered separately by both Boards and any decisions recorded as such.

Meeting	WUTH and WCHC Board of Directors in Public
Date	Wednesday 2 July 2025
Time	09:00 – 10:00
Location	Hybrid

Page		Agenda Item	Lead	Presenter
	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
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26	4.	Action Logs	Sir David Henshaw	
	Standing Items			
	5.	Joint Chair Update – **Verbal**	Sir David Henshaw	
27	6.	Joint Chief Executive Officer Report	Janelle Holmes	
44	7.	WUTH Integrated Performance Report	Executive Directors	
72	8.	WCHC Integrated Performance Report	Executive Directors	
	Chairs Reports			
100	9.	WUTH Quality Committee	Dr Steve Ryan	
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104	11.	WUTH People Committee	Lesley Davies	
106	12.	WUTH Finance Business Performance Committee	Sue Lorimer	
109	13.	WUTH Charitable Funds Committee	Sue Lorimer	
111	14.	WCHC People and Culture Committee	Meredydd David	

113	15.	WCHC Finance and Performance Committee	Steve Igoe	
	16.	WCHC Staff Voice Forum – **Verbal**	Alison Hughes	
	WCHC Strategic Objective: Place			
115	17.	Refreshed Green Plan	Tony Bennett	
129	18.	Revised SFIs and DFLs	Robbie Chapman	
	Governance and Assurance			
	19.	Fit and Proper Persons Update – **Verbal**	David McGovern/ Alison Hughes	
	Closing Business			
	20.	Questions from Governors and Public	Sir David Henshaw	
	21.	Meeting Review	Sir David Henshaw	
	22.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 3 September, 09:00 – 12:00			

Meeting	WUTH Board of Directors in Public
Date	Wednesday 4 June 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Dr Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
RM	Dr Ranj Mehra	Interim Medical Director
MS	Matthew Swanborough	Chief Strategy Officer
SW	Sam Westwell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer & Interim Deputy CEO
MC	Mark Chidgey	Chief Finance Officer

In attendance:

MD	Meredydd David	WCHC Non-Executive Director & SID
CB	Professor Chris Bentley	WCHC Non-Executive Director
ER	Emma Robinson	WCHC Associate Non-Executive Director
PS	Paula Simpson	WCHC Chief Nurse
TB	Tony Bennett	WCHC Chief Strategy Officer
RC	Robbie Chapman	WCHC Interim Chief Finance Officer
ER	Dr Eddie Roche	WCHC Interim Medical Director
JC	Dr Joanne Chwalko	WCHC Director of Integration
AH	Alison Hughes	WCHC Director of Corporate Affairs
CM	Chris Mason	Chief Information Officer
DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SH	Sheila Hillhouse	Lead Public Governor, WUTH
LC	Lynn Collins	Lead Public Governor, WCHC
TC	Tony Cragg	Public Governor, WUTH
HS	Haris Sultan	Observer

Apologies:

NS	Dr Nikki Stevenson	Medical Director & Deputy CEO, WUTH
SL	Sue Lorimer	Non-Executive Director, WUTH

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence**	

	DH welcomed members to the meeting, which was held jointly with the WCHC Board of Directors. Members of that Board are listed as attendees. 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 7 May were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story highlighting the experience of a patient who received care as part of the fragility same day emergency care (SDEC) service. The video story described their positive journey as part of the service and the high quality care received by staff. SW highlighted at the time of filming the patient story this was a pilot and had been so successful the service was being expanded into another bay within the ward. Members noted there was a Board Seminar in the afternoon on the Frailty SDEC. The Board **NOTED** the video story.	
6	**Joint Chair's Update** DH provided an update on recent matters and highlighted the challenging financial position in Cheshire and Merseyside and steps being taken address this. DH also stated the second meeting of the Integration Management Board took place on 2 June and there had been good discussions including agreeing the next steps regarding the integration. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH explained the two Cheshire & Merseyside provider collaboratives had come together to form the Cheshire and Merseyside Provider Collaborative (CMPC) from 1 May 2025.	

	JH summarised the first meeting of the CMPC in May, referencing the work being progressed by the ICB with NHSE on the system's financial plan. JH highlighted the Care Quality Commission (CQC) commenced an unannounced inspection of Arrowe Park Hospital on the 12 May for three days. The inspection focused on Urgent and Emergency Care and Medicine. JH added the Trust remained in inspection period until the first draft of the CQC report is received, expected on the 7 August 2025. JH summarised the outcome of the GIRFT Breast Surgery Gateway Review of the Cheshire and Merseyside Cancer Alliance, noting the Trust was a high performer for the 62-day cancer standard and having below average length of stay for implant-based reconstructions. JH reported a joint WCHC and WUTH neurodevelopment investment business case was developed in 2024/25 and submitted to the ICB for consideration during 2025/26 planning. JH added due to the current financial position across the NHS the business case had not been approved and work was underway to identify any further efficiencies. JH referenced Robbie Chapman took up the position of Interim Chief Finance Officer as of 1 May 2025. JH reported at WUTH in April there was one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and no Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH stated she undertook a visit to Community Nursing in May and further visits with the Chair were planned with other services across the Trust. JH explained WCHC and WUTH marked International Nurses Day on 12 May with celebrations across both Trusts, thanking the amazing nurses for their compassion, care, and dedication. Both Chief Nurse's provided a joint pledge which was shared with staff across both Trusts. JH highlighted the WUTH Team of the Month winner was the Children's Ward team including Emily Thomas and Dr Elizabeth Thompson. JH added the Employee of the Month – Support Services winner was Joshua Ang, Business Intelligence Support Assistant. JH highlighted the WCHC April Standout Winner was Cheryl Manning, Knowsley 0-25 North Team.	

	Members discussed the current delays to the neurodevelopment diagnostic pathway, including the lengthy delay and impact this has on patients and health inequalities. Members acknowledged pathway redesigns to the criteria for assessment were being made which had been approved by the local SEND Partnership Board, however this would take time to have an effect and there remained a large backlog of patients waiting assessment. Members also understood that a level of funding had been received and this was being used to create three additional posts which would help maximise productivity. PS agreed to provide an update at the next meeting regarding the neurodevelopment pathway, including the changes to manage demand and the timeframe to reduce the backlog. The Board **NOTED** the report.	
8	**WUTH Integrated Performance Report** RM highlighted the number of patients recruited to NIHR studies continued to be below trajectory and a new suite of indicators was being developed. RM added the Research and Innovation Team were focussed on high quality research studies and commercial research opportunities. SW stated there were 8 incidents of C Diff in April and 5 category 3 hospital acquired pressure ulcers. SW highlighted the Friends and Family Test for ED was 79%, Outpatients and Maternity exceeded the 95% of those that responded were either satisfied or very satisfied with the service. SW explained the number of level 1 concerns raised with the Trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff was below the agreed threshold. SW reported with the exception of CSW day fill rates, RN and CSW staffing fill rates were above the threshold of 90%. DS highlighted mandatory training was on target at 92.11%. Sickness absence had improved over recent months however it remains above target at 5.84% and an area of concern and focus. DS reported turnover was on target at 0.79%. DS stated appraisal had decreased to 86.60% and explained all Divisions had been requested to produce a 12 month plan to factor in periods of annual leave and demand. The Board **NOTED** the report.	

9	**WUTH Report from the Lead Governor** SH reported there had been a meeting of the Council of Governors on 1 May and summarised the updates provided by Board members. SH added the Council of Governors also approved the appointment of Robert Thompson as Deputy Lead Governor role. SH stated Governors would participate in the NHS Providers Governor Focus Conference in May and Governor elections were planned to take place over the summer. The Board **NOTED** the report.	
10	**WUTH Audit and Risk Committee** SI alerted members that there remained a risk as a result of challenges to timely clinical coding. SI added this was due vacancies and the impact of system downtime during the recent cyber incident. SI commented a short-term mitigation plan is being developed however the Committee were not assured that the potential financial and clinical risks have yet been mitigated. SR commented if clinical coding was not completed correctly and promptly, this would adversely impact on mortality rates. MC stated the mitigation plan was short term and did not suppress the risk fully but explained the coders were prioritising elective activity and deaths. JH explained this risk has been raised with the ICB and that clinical coding recruitment was a known issue regionally and nationally. SI summarised the various “Advise” and “Assure” matters from the Committee meeting on 22 April. The Board **NOTED** the report.	
11	**WUTH Finance Business Performance Committee** MC alerted members that the full year value of CIP identified to date was £27.2m against a target of £32m and after adjusting for risk the CIP reduces to £18.1m, a gap of £13.9m. MC also alerted members that cash continues to be an area requiring focus and currently it is forecast that cash support will be needed before Q3. MC alerted members regarding the loss of external income through the Aseptic Pharmacy which now presents an income risk	

	MC summarised the various “Advise” and “Assure” matters from the Committee meeting on 28 May. The Board **NOTED** the report.	
12	**WUTH Quality Committee** SR provided a verbal update and alerted members that the workforce capacity of the ophthalmology clinic has the potential impact to lengthen waiting times and treatment intervals for patients receiving repeated injectable therapy regimens. SR also alerted members that it has been necessary to reduce manufacturing capability of the pharmacy aseptic unit, resulting in the cessation of production for other organisations. Mitigation plans are developed for this. SR alerted members that there had been two Never Events in separate areas, and these would go through the usual governance processes.	
13	**Quarterly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise for April. JL stated there were no Patient Safety Investigation Incidents (PSIIs) declared for Maternity Services or Neonatal Services in April. JL added to date there are three active Maternity and Newborn Safety Investigations (MNSI). JL gave an update on Maternity Incentive Scheme (MIS) Year 7 and the ten safety actions, noting this was being routinely tracked through the Divisional Quality Assurance meeting. JL referenced the Perinatal Mortality Reviews Summary Report (PMRT) for quarter 3 and 4 2024/25 which summarised the number of perinatal deaths. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 91% compliance against the 6 elements based on evidence as of 31 December 2024. JL summarised the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services. JL also updated on progress regarding implementing a Continuity of Carer Model.	

	JL referenced the progress of the Maternity Portal Online Programme (MPOP), Maternity Self-Assessment Tool and the UNICEF accreditation of the maternity assessment. JL highlighted the Neonatal Operation Network annual visit on 6 December 2024 and the work underway in regard to the redevelopment of the Neonatal Unit. LD queried the impact on patients now that the Trust was not pursuing a 100% Continuity of Carer (CoC) staffing model. JL advised the national guidance had changed to provide this staffing model to women at risk and there was a sufficient number of midwives at the Trust to do this. JL added the 100% model would have required 10 additional whole time equivalent (WTE) and there were already challenges recruiting newly qualified midwives. The Board: • **NOTED** the report and associated appendices; • **NOTED** the Perinatal Clinical Surveillance Assurance report; • **NOTED** the position with the Maternity Incentive Scheme Year 6 and launch of Year 7 requirements; • **NOTED** the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI); • **NOTED** the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3; • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals"; • **NOTED** the PMRT reports; • **NOTED** the progress with the Maternity Portal Online Programme; • **NOTED** the position with the Maternity Self-Assessment Tool; • **NOTED** the progress with the UNICEF accreditation; and • **NOTED** the progress with the NNU expansion and visit held in December 2024.	
14	**Chief Finance Officer Report** MC reported at the end of April, month 1, the Trust is reporting a deficit of £0.89m which is in line with the month 1 plan. MC added in month 1 the Trust has transacted 13.3% of the annual CIP benefits. MC advised that as previously stated to the Board there were 4 key risks to the plan of which the primary risk was full delivery of CIP.	

	At this stage (M1) the risk was not mitigated as the risk adjusted annual forecast was below the required target. Other key risks were: - activity/case mix, - aseptic pharmacy income - Full delivery of the elective income plan MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability and cash were amber, agency and capital were green, financial sustainability and financial efficiency were red. **The Board:** • **NOTED** the report; • **NOTED** that the Trust's most immediate risk remains the cash position; • **NOTED** the risks to delivering the recurrent £32m CIP target; and • **APPROVED** the 3-year capital budget including £1.1m charitable funding for the Neonatal unit redevelopment scheme.	
15	**Chief Operating Officer Report** HK highlighted in April the Trust attained an overall performance of 104% against plan for outpatients and an overall performance of 105% against plan for elective admissions. HK summarised the referral to treatment standard and current performance against this, noting the Trust achieved trajectory for caseload, percentage of patient waiting 18 weeks or under, number and percentage of 52 week waiters in April 2025. HK set out the number of patients waiting 78+ and 65% weeks, noting this was primarily due to either mutual aid patients, patient choice, or Ophthalmology graft patients. HK explained the waiting list had decreased in size in April by -5.5% to 46,400 (-2,699 patients) due to the impact of the 'validation sprint'. HK further summarised cancer performance against trajectories and the Faster Diagnostic Standard. HK highlighted in March type 1 unscheduled care performance was 49.13% and remained below the planned improvement trajectory, however, the Trust was continuing to deliver a range of improvements across the pathway to support patient flow and improve the quality and timeliness of care. HK stated the number of patients not meeting the criteria to reside continued to reduce, currently at 11.9% and delivering the strongest performance in C&M.	

	SR queried the number of mutual aid patients and if treating this counted towards the Trust's on targets. HK stated these patients would be included on the waiting list and will count towards the Trust's on target, but the ICB elective recovery programme have confirmed these will not be viewed as Trust breaches in terms of elective performance. The Board **NOTED** the report.	
16	**WUTH Modern Slavery Statement** DM sought approval of the Trust's Modern Slavery Statement, noting it was a requirement to produce a statement on an annual basis and that the Board approves this. DM added it is provided retrospectively for the preceding financial year and has to be published within 6 months of the end of the financial year. The Board **APPROVED** the statement.	
17	**WUTH Board Assurance Framework (BAF)** DM set out the various key changes to the BAF following the Board Seminar in May, noting a number of risk descriptors had been updated as well as changes to the risk appetite statements. Members discussed the BAF and agreed the risks and controls appeared accurate and reflected the current position. The Board: • **APPROVED** the refreshed Risk Appetite statement included in this report; • **APPROVED** the rewording of Strategic Risks as outlined. • **NOTED** the current version of the BAF.	
18	**Questions from Governors and Public** No questions were raised.	
19	**Meeting Review and BAF Review** Members agreed it had been a good meeting with both Boards meeting together for the first time. Members also agreed it had been beneficial to understand the context from each Trust and there were opportunities to bring joint reports for several agenda items.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 12:10)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 4 June 2025
Location	Hybrid

Members present:

DH	Sir David Henshaw	Joint Chair
MD	Meredydd David	Non-Executive Director & SID
CB	Professor Chris Bentley	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
ER	Emma Robinson	Associate Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
JC	Dr Joanne Chwalko	Chief Operating Officer & Interim Deputy CEO
DS	Debs Smith	Joint Chief People Officer
PS	Paula Simpson	Chief Nurse
TB	Tony Bennett	Chief Strategy Officer
RC	Robbie Chapman	Interim Chief Finance Officer
ER	Dr Eddie Roche	Interim Medical Director
AH	Alison Hughes	Director of Corporate Affairs

In attendance:

RM	Dr Ranj Mehra	WUTH Interim Medical Director
MS	Matthew Swanborough	WUTH Chief Strategy Officer
SW	Sam Westwell	WUTH Chief Nurse
HK	Hayley Kendall	WUTH Chief Operating Officer & Interim Deputy CEO
MC	Mark Chidgey	WUTH Chief Finance Officer
SR	Dr Steve Ryan	WUTH Non-Executive Director
CC	Chris Clarkson	WUTH Non-Executive Director
LD	Lesley Davies	WUTH Non-Executive Director
CM	Chris Mason	WUTH Chief Information Officer
DM	David McGovern	WUTH Director of Corporate Affairs
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
SH	Sheila Hillhouse	Lead Public Governor, WUTH
LC	Lynn Collins	Lead Public Governor, WCHC
TC	Tony Cragg	Public Governor, WCHC
AJ	Alison Jones	WCHC Freedom to Speak Up Lead – item 15
MB	Mick Blease	Local Security Management Specialist – item 30

Apologies:

DMu	Dave Murphy	Chief Digital Information Officer, WCHC

Agenda Item	Minutes	Action

1	**Welcome and Apologies for Absence** DH welcomed members to the meeting, which was held together with the WUTH Board of Directors. Members of that Board are listed as attendees. 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 23 April were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log, the progress reported and the actions still open.	
5	**Patient Story** The Board received a video story highlighting the experience of a patient who received care as part of the fragility same day emergency care (SDEC) service. The video story described their positive journey as part of the service and the high quality care received from staff. SW highlighted at the time of filming the patient story this was a pilot and had been so successful the service was being expanded into another bay within the ward. Members noted there was a Board Seminar in the afternoon on the Frailty SDEC. The Board **NOTED** the video story.	
6	**Joint Chair's Update** DH provided an update on recent matters and highlighted the challenging financial position in Cheshire and Merseyside and steps being taken to address this. DH also stated the second meeting of the Integration Management Board took place on 2 June and there had been good discussions including agreeing the next steps regarding the integration of both Trusts. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer**	

	JH noted that two Cheshire & Merseyside provider collaboratives had come together to form the Cheshire and Merseyside Provider Collaborative (CMPC) from 1 May 2025. JH summarised the first meeting of the CMPC in May, referencing the work being progressed by the ICB with NHSE on the system's financial plan to reduce current system expenditure plans. JH highlighted that the Care Quality Commission (CQC) commenced an unannounced inspection of Arrowe Park Hospital on 12 May for three days. The inspection focused on Urgent and Emergency Care and Medicine. JH added that the Trust remained in inspection period until the first draft of the CQC report is received, expected on 7 August 2025. JH summarised the outcome of the GIRFT Breast Surgery Gateway Review of the Cheshire and Merseyside Cancer Alliance, noting the Trust was a high performer for the 62-day cancer standard and having below average length of stay for implant-based reconstructions. JH reported a joint WCHC and WUTH neurodevelopment diagnostic business case was developed in 2024/25 and submitted to the ICB for consideration during 2025/26 planning. JH added due to the current financial position across the NHS the business case had not been approved and work was underway with all system partners to identify alternatives. This was a risk on each Trusts' respective risk registers and was being actively discussed with other system partners. JH referenced Robbie Chapman took up the position of Interim Chief Finance Officer as of 1 May 2025 and formally welcomed his to the Executive Team. JH reported at WUTH in April there was one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and no Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH advised that she undertook a visit to Community Nursing in May and further visits with the Chair were planned with other services across the Trust. JH explained WCHC and WUTH marked International Nurses Day on 12 May with celebrations across both Trusts, thanking all nurses for their compassion, care, and dedication. Both Chief Nurse's provided a joint pledge which was shared with staff across both Trusts. JH highlighted the WUTH Team of the Month winner was the Children's Ward team including Emily Thomas and Dr Elizabeth	

	Thompson. JH added the Employee of the Month – Support Services winner was Joshua Ang, Business Intelligence Support Assistant. JH highlighted the WCHC April Standout Winner was Cheryl Manning, Knowsley 0-25 North Team. Members discussed the current delays to the neurodevelopment diagnostic pathway, including the lengthy delay and impact this has on patients and health inequalities. Members acknowledged pathway redesigns to the criteria for assessment were being made which had been approved by the local SEND Partnership Board, however this would take time to have an effect and there remained a large backlog of patients waiting assessment. Members also understood that a level of funding had been received and this was being used to create three additional posts which would help maximise productivity. PS agreed to provide an update at the next meeting regarding the neurodevelopment pathway, including the changes to manage demand and the timeframe to reduce the backlog. The Board **NOTED** the report.	Paula Simpson
8	**WCHC Integrated Performance Report** JC reported performance against the four-hour target in the Walk-in-Centre and Urgent Treatment Centre was 95% against a target of 97%. JC added the median length of stay in the Community Intermediate Care Centre (CICC) was currently 18 days (vs target under 21 days) and 19 patients currently met the no criteria to reside. JC noted that the Urgent Community Response Service had received a high number of referrals from GP out of hours and a deep dive had been requested to understand this further. DH reflected on the number of no criteria to reside patients and the similarities with WUTH, suggesting as private sector capacity reduces, the Trusts could explore this as an opportunity. JC commented about the various restrictions imposed by care home providers which affected domiciliary care availability and suitability for complex patients, and the importance of distinguishing between a patient able to go home and one requiring a care home.	

	JH stated MS provided a presentation to Board previously regarding the domiciliary care market and requested MS provide this at a future meeting. MS agreed. DS highlighted staff turnover was 6.5% and stipulated this was a reporting issue and likely to be lower due to the CIP establishment not having been removed. DS explained sickness absence was driven by long term absences in the community nursing and specialist medical staff group. A deep dive had been requested by the People and Culture Committee. PS reported the number of patient safety incidents remained in line with normal variation and the majority of reported incidents were categorised as no or low harm. PS noted an incident in May which involved a fall and resulted in moderate harm which was under review via the appropriate governance routes. PS added the Friends and Family Test remained high with 92% satisfaction. RC advised for M1 the Trust was reporting a £0.9m surplus against a planned deficit of £0.1m. Cost pressures were driven by estates but were offset by underspends in vacancies. RC highlighted in M1 £4.5 of CIP had been transacted and £6.0m had been identified as a full year effect. Members discussed the format of the Integrated Performance Report and commented about the importance of having a report in the pack with graphs and commentary. AH advised the Chief Digital Information Officer was progressing this and would be available for the next Public Board meeting. The Board received the report live from TIG and was **ASSURED** on the monitoring of performance across the Trust for M01, 2025-26.	Matthew Swanborough
9	**WCHC Report from the Lead Governor** LC highlighted the Remuneration Committee of the Council of Governors supported the recruitment of the first joint NED with WUTH and had successfully selected a candidate. LC reported there had been a meeting of the Council of Governors on 28 May and summarised the updates provided by Board members. LC stated expressions of interest were being sought for the Deputy Lead Governor role.	

	LC referenced the outcome of the 2024 PLACE assessment, noting the Trust came third in the country across the 8 assessed metrics, with an overall score of 98.22%. The Board **NOTED** the report.	
10	**WCHC Audit Committee** MD alerted members that the internal audit programme was progressing well and on track to be completed within agreed timeframe. MD also alerted members that the external audit of the 2024 annual report and accounts was progressing well and off to a good start. The initial headline financial and remuneration report had been submitted within agreed timeframe. MD summarised the various "Advise" and "Assure" matters from the Committee meeting on 30 April. The Board **NOTED** the report.	
11	**WCHC Quality and Safety Committee** CB alerted members that the Committee had been made aware of concerns raised through the SEND Partnership Board that 2/10 priority areas remained following the SEND inspection report and still require action. CB added the ICB had not approved the pathway business case, therefore a review of the impact and mitigations was underway. CB also alerted members that the triangulation of a range of strategic action plans identified weaknesses in the lines of assurance for some components of the operational programmes and plans were underway on how best to correct this. CB summarised the various "Advise" and "Assure" matters from the Committee meeting on 7 May. The Board **NOTED** the report.	
12	**WCHC Staff Voice Forum** AH provided a verbal update on the Staff Voice Forum held on 20 May and explained this focussed on the WCHC and WUTH integration. AH added that staff had the opportunity to ask questions regarding this and were encouraged to keep asking questions. SH queried the number of staff who had applied for the Mutually Agreed Resignation Scheme (MARS).	

	DS advised 80 and 120 had applied from WCHC and WUTH respectively, and explained the Executive led panel would meet in June to review and approve. The Board **NOTED** the update.	
13	**Learning from Deaths Report Q4 2024/25** ER gave an overview of the report, noting there was a total of 11 reported unexpected deaths including 6 child deaths all of which were reviewed using SUDIC methodology. During the period there were 0 deaths which met the criteria for StEIS reporting. Of the total deaths reported in period, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. The Board were **ASSURED** by the report and **APPROVED** Appendix 1 to be published on the public facing website.	
14	**Staff Survey Results 2024** DS gave an analysis of the results of the survey, noting the response rate was 51% which was lower than the average and was a decrease from 2023 (60%). A total of 927 staff completed the survey. DS highlighted the results showed the Trust maintained a steady position in all 7 themes and a decline in 2 themes, particularly in 'we are always learning' and 'morale'. DS noted when benchmarked against Community Trusts, the Trust had below average scores for 8 out of the 9 indicators. In comparison to the whole of the NHS, the Trust scored above average for 8 out of 9 indicators DS set out the corresponding actions to support delivery of improvements, notably an action plan and sharing the results with teams. DS added that the People & Culture Committee would receive assurance on the delivery of the action plan. The Board reviewed the analysis provided and were **ASSURED** on the outlined areas for priority focus and proposed actions.	
15	**Freedom To Speak Up (FTSU) Annual Report** AJ provided an overview of FTSU activity during 2024/25, noting 50 concerns were reported and this reflected a 47% increase from the previous year.	

	AJ added 36 concerns reported were either reported openly by staff members or confidentially, with 14 reported anonymously. AJ stated the highest number of concerns reported were from Community Response Directorate, with relationships and team dynamics being the predominant theme of concerns. JH explained this theme correlated with the most recent staff survey findings whereby team working had scored below average. DS stated a refreshed behavioural standards framework was being launched to provide further training and the standards of good behaviour. DS added the Organisational Development team had also produced a tool kit to support the integration of teams at a local level and this would include elements of team working, values and behaviours. JH also suggested incorporating the Trust values into the appraisal meeting which would provide an opportunity for staff to demonstrate how they have applied the values. DS agreed but stated this type of conversation was not taking place consistently during the appraisal and agreed to review the learning from WUTH. The Board **APPROVED** the Freedom to Speak Up Annual Report for 2024/2025.	
16	**Social Value End of Report 2024-25** TB summarised the areas of progress against the five social value themes and the We Will statements of the social value and partnerships section of the Strategy. TB stated positive areas of development relate to 'community engagement and support' and regarding the three 'We Will' statements, one has been assessed as 'Met' and two as 'Partially met'. The Board **AGREED** the draft Social Value Report for 2024/25.	
17	**WCHC Organisational Strategy Year 3 Report** TB provided an overview of key achievements against each of the 'We Will…' statements of the Strategy, noting the end of year three position showed significant achievement across every strategy area, delivering against all the 'We Will' statements planned for 2024/25. TB highlighted progress had been made in development of integrated teams for Population Health Management, extending the responsiveness and scope of admissions avoidance capacity with	

	Urgent Community Response's Call Before Convey and revised Virtual Frailty Ward model, and reshaping the Trust's Centralised Booking Service to improve efficiency and quality of service The Board were **ASSURED** regarding progress against delivery of the Organisational Strategy (2022 -2027).	
18	**WCHC Modern Slavery Statement** DS sought approval of the Trust's Modern Slavery Statement, noting it was a requirement to produce a statement on an annual basis and that the Board approves this. DS added it is provided retrospectively for the preceding financial year and has to be published within 6 months of the end of the financial year. The Board **APPROVED** the statement.	
19	**WCHC Board Assurance Framework (BAF)** AH summarised the strategic risks position following approval by the Board in April and the meeting of the Quality & Safety Committee in May, noting the scoring of the relevant risks was unchanged. AH noted that due to the change of date for this meeting, the Finance & Performance Committee and the People & Culture Committee had not met yet and would meet on 11 June where each of the relevant strategic risks will be discussed and updated to reflect the latest position. Members discussed the BAF and agreed the risks and controls appeared accurate and reflected the current position. The Board **RECEIVED** the update provided on the current position in relation to the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress.	
20	**WCHC Charitable Funds Annual Report** RC provided the latest published financial statements for the Trust's charitable funds for the financial year ending 31 March 2024), which were included within the funds of the Cheshire and Wirral Partnership (CWP) Charity. RC highlighted the closing fund balance on 31 March 2024 was £100,729. RC noted there were plans to promote and encourage donations and funding applications throughout the Trust. The Board were **ASSURED** on the financial reporting arrangements for the WCHC's charitable funds.	

21	**WCHC Emergency Preparedness, Resilience and Response (EPRR) Annual Report** JC summarised the Trust's EPRR activity for 2024/25, noting there were several key achievements and that the Trust also responded effectively to several significant incidents, including flooding, service disruption, and a cyber event. JC added 2024 Core Standards Self-Assessment confirmed 86% compliance ("Partially Compliant"), with a plan in place to achieve "Substantial Compliance" in 2025/26. JC highlighted a MIAA audit provided a 'Substantial Assurance' rating, with a recommendation that the Trust complete 2 'low risk' actions to strengthen EPRR delivery. The Board: • **NOTED** the report and the assurance provided through incident response, internal audit, and training activity; • **APPROVED** the revised Major Incident Plan (Appendix A) as part of the annual EPRR submission; • **APPROVED** the 2024 Core Standards Self-Assessment outcome (86% – Partially Compliant); • **NOTED** the findings of the 2025 MIAA audit (Substantial assurance, with two low-risk actions; • **ENDORSED** the 2025/26 EPRR Work Plan (Appendix G); and • **SUPPORTED** ongoing collaborative working with Wirral University Teaching Hospital to coordinate EPRR resources and, where possible, strengthen shared arrangements	
22	**WCHC Communications & Marketing Report Q4 2024/25** AH presented the report, highlighting the internal and external activity aligned with the Trust's strategic objectives and goals across "Populations", "People" and "Place". AH explained an internal communications review had been undertaken and the results noted overall positive results for staff engagement. AH referenced the new integration branding for WCHC and WUTH, highlighting this was "Better Together, for people in our care" - to support all integration messaging and communications, both internally and externally. AH set out the priorities for quarter 1 2025/26 and the various upcoming campaigns. The Board were **ASSURED** that the communications, marketing and engagement activity evidenced in this report for Q 4 - 2024-25 meets the aims of the Trust.	

23	**Questions from Governors and Public** No questions were raised.	
24	**Meeting Review and BAF Review** Members agreed it had been a good meeting with both Boards meeting together for the first time and conducting the relevant statutory business. Members also agreed it had been beneficial to understand the context from each Trust and there were opportunities to bring joint reports for several agenda items.	
25	**Any other Business** No other business was raised.	

(The meeting closed at 12:10)

Action Log
Board of Directors in Public
2 July 2025

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1.	5 March 2025	9	To incorporate as part of the integration programme the development of a one Wirral number telephony system for patients to access information by dialling one number	Matthew Swanborough	In progress. Due August 2025.	August 2025
2.	2 April 2025	8	To provide at a future Board Seminar different approaches to address sickness absence, taking examples from internal and external to the NHS	Debs Smith	Complete.	July 2025
3.	4 June 2025	9	To present the previously provided presentation to Board regarding domiciliary care	Matthew Swanborough	Complete.	July 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1.	4 June 2025	7	To provide an overview of the neurodevelopment pathway, to include the changes to manage demand and the timeframe to reduce the backlog	Paula Simpson	In progress. A verbal update will be provided at the July meeting.	September 2025

Board of Directors in Public **Item 6**
2 July 2025

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

Executive Summary and Report Recommendations
The purpose of this report is to provide members with an update on activity undertaken across Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health & Care NHS Foundation Trust (WCHC) since the last meeting and draw the Board's attention to any local and national developments. 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	**Performance**

	This month, the WCHC Board will receive a written version of the Integrated Performance Report (IPR), rather than reviewing a live dashboard, complimenting the 'live' dashboard in the Trust Information Gateway which is used by board members and staff across the Trust to track and monitor real-time performance live. Both Trusts will be evolving the format of their respective IPRs in line with the Insightful Board Guidance. These revised formats will be provided as part of the September Board reports. Operational performance at WUTH remains challenging and improvement plans are in place in all relevant areas. Whilst year to date financial performance remains on plan, there is a constant focus on CIP and other efficiencies to support the required year end position. The Trust is reporting 2 never events, and no duty of candour breaches. There have been 13 incidents of Clostridioides Difficile in month which is an improving position. At WCHC, there is good performance seen across the operational KPIs reportable to commissioners, and in month highlights include good occupancy at the Community Intermediate Care Centre (CICC), which is supported by the community Home First Service.. WCHC also continues to focus on its CIP programme to achieve its required financial positions, and the in-month position remains in line with plan. Across both Trusts I would like to recognise this performance and acknowledge the efforts of staff who contribute to this strong position and support those in our care.
1.2	**Local News and Developments** **Cheshire and Merseyside Provider Collaborative (CMPC) Update** The CMPC Leadership Board met on Friday 6 June and received an update on a number of system wide issues. Discussions took place with the focus on recent system recovery and financial improvement. In addition, the Leadership Board discussed the Elective Reform programme. The update covered changes in programme governance which embeds focus on the elective reform agenda and seeks to consolidate effort and opportunities by linking this agenda even more closely to clinical pathway improvement (previously two distinct programmes). Finally the Board discussed the definition and relaunch of its Community Improvement Programme including the need for Trust representation and participation at its upcoming first programme board meeting which would seek to specify and agree a work plan for the year ahead. Update papers were also provided on the following areas: • System financial report • System performance update

	WCHC Interim Medical Director From 1 July 2025, Dr Ranj Mehra, Interim Medical Director at WUTH, will take up a role of interim Joint Medical Director across both WUTH and WCHC. This is to maintain continuity across both organisations as Dr Eddie Roche, the Interim Medical Director at WCHC, has decided to return to his substantive role as Clinical Director in Urgent Care at WCHC from 1 July 2025. As an Intensivist and experienced Medical Leader, Dr Mehra has a passion for quality improvement and patient safety. I welcome Dr Mehra to this joint role and extend thanks to Dr Roche as he returns to the Clinical Director role. **WUTH and WCHC 2024/25 Annual Report and Accounts** Both WUTH and WCHC Annual Report and Accounts were approved by the respective Board of Directors and are due to be submitted on schedule for 30 June 2025. These will then be laid before Parliament. Once laid before Parliament, both Annual Report and Accounts will be sent to each Council of Governors at the Annual Member's Meetings, where they will "receive" the accounts, as per their statutory requirements.
1.3	**National News and Developments** **Consultation on the NHS Performance Assessment Framework** In May 2025 NHS England consulted on an updated NHS Performance Assessment Framework, proposing a new approach, methodology and metrics for the assessment of integrated care boards and NHS trusts and foundation trusts. It was noted that this Framework would support the process in relation to the National Oversight Framework and the assessment of providers future segmentation within that framework. The consultation sought the views of providers in relation to a set of recommendations for the future operation of the framework as follows: Proposal 1: Each ICB and provider is placed in a segment from 1 to 4 based on its performance against short- and medium-term NHS priorities. There will be an additional segment 5 for those in most need of support. Proposal 2: Segmentation decisions are based solely on delivery against the performance metrics set out in the NPAF. The capability ratings consulted on in 2024 no longer influence which segment an organisation is allocated but will be considered as part of NHS England's improvement response. Proposal 3: Providers will not have their scores adjusted to reflect wider system performance. Our segmentation decisions will be based solely on delivery against the performance metrics set out in the NPAF for each organisation type. Proposal 4: Any organisation reporting a financial deficit is limited to segment 3 (but may still be placed in segment 4 or 5). Proposal 5: Use of fewer metrics to calculate a segment decision. These will be focused on short-term priorities.

The consultation closed at the end of May with all organisations submitting a questionnaire outlining views.

In general there has been support for the proposals from national organisations with a synopsis of some responses below:

- Cheshire and Merseyside ICB
  - Broadly in agreement over proposals to introduce a consistent set of measures properly allotted to different providers.
  - Some concern that some providers (Acute Trusts and ICB's themselves) operate in a less stable financial environment and may be limited in segmentation.
  - ICB Metrics should only relate to the areas that they commission.

- NHS Providers
  - Broadly in agreement over proposals to introduce a consistent set of measures properly allotted to different providers.
  - A need to understand how "the extent to which providers are effectively collaborating" can be measured. It is important to recognise that collaboration is an important means of achieving specific outcomes, but it is not an end in itself.

- Trust Response (WUTH)
  - Broadly in agreement over proposals to introduce a consistent set of measures properly allotted to different providers.
  - Consideration needs to be given to the potential impact on the provision of Mutual Aid across regions and any dis-incentivisation that may occur as a result of the framework.

The proposed new framework is attached to this report for information and a further report will be provided to the Joint Board meeting when the outcome of the consultation and new framework is published.

Rapid National Independent Investigation Into Maternity Services

On 23 June 2025, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care. The independent investigation will conduct urgent reviews of up to 10 Trusts where there are specific issues between now and December 2025.

As this takes place, Boards with responsibilities relating to maternity and neonatal care are asked to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.
- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working,

	through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families. • Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both. • Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it. The Trusts will support any requests from this review, if required, and will continue to provide assurance to the Boards on the delivery of our maternity and neonatal care services.
1.4	**WUTH Health and Safety** There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in May. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There were two Patient Safety Incident Investigations (PSII) opened in May under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance.
1.5	**Published Reports of Interest** The following are some reports recently published and of interest to members of the Board, staff and public. • **UK Health Security Agency (HSA) - Health inequalities in health protection report 2025.** Health inequalities in health protection have a high human cost across people and places. They have a wider societal impact, including on health services and economic productivity. The causes of and solutions to addressing health inequalities are often systemic, structural and complex. This report sets out the extent of these health inequalities. It also sets out how the UK HSA aims to make health protection fair. Health inequalities in health protection report 2025 - GOV.UK • **NHS England - Integrated urgent care: key performance indicators 2025/26.** This document outlines the integrated urgent care (IUC) key performance indicators (KPIs) which commissioners must apply in relation to the service. It is for use by local commissioners, providers and NHSE. It must be read in conjunction with the Integrated urgent care aggregate data collection specification (2023/24) which provides each of the metrics used in the KPIs, and the current Integrated urgent care service specification which provides additional detail. This document seeks to clarify which organisations need to report against the KPIs listed and provides guidance to both commissioners and service providers on

	compliance. NHS England » Integrated urgent care: key performance indicators 2025/26 • **NHS Providers - Bold action: tackling inequalities in maternity care.** This briefing summarises the findings from a series of interviews with trust leaders where they described the barriers and enablers to improvement in maternity services, with a particular focus on health inequalities. Drawing on these conversations, and NHS Providers' longer-term work in this area, they have set out a number of calls to action. These look across improving access and preventative care, developing the workforce, working with women and communities, addressing race inequalities, streamlining reporting requirements and unlocking resource. Bold action: tackling inequalities in maternity care • **NHS Providers - Model ICB Blueprint**. NHSE has shared the first version of the Model ICB Blueprint with integrated care board leaders. ICBs need to produce plans to reduce their running costs by 50%. It sets out an initial vision for ICBs as strategic commissioners, and the role they will play in realising the ambitions of the 10 Year Health Plan. This briefing provides a summary of the blueprint document, highlighting the aspects most relevant to trusts, and includes NHS Providers' view. model-icb-blueprint-may-2025.pdf • **NHS Cheshire and Merseyside.** The 2024/25 annual report for Cheshire and Merseyside's Population Health Programme - Stronger Partnerships, Healthier Futures - has been published. This report focuses on the Four Pillars of Population Health (Social Determinants Programme, Supporting Healthy Behaviours Programme, Healthcare inequalities Programme, Screening, immunisation and health protection) and highlights a variety of successes each of these programmes have celebrated during 2024/25. Stronger Partnerships, Healthier Futures: Cheshire and Merseyside's Director of Population Health annual report - NHS Cheshire and Merseyside
1.6	**Communications and Engagement** **Better Together – Journey to Integration** All staff across WUTH and WCHC received a message from myself and the Chair on Thursday 12 June. The message detailed the launch of our Better Together - Journey to integration document which describes our strategic intention to become one organisation and the benefits we believe it will deliver for patients, staff, and our populations. In addition to outlining the benefits it also highlights the financial benefits, gives an overview of both organisations, the national and regional context, and our commitment to engagement on our joint strategy. **Joint Stakeholder Newsletter** We issued our first edition of a joint stakeholder newsletter which marked the launch of our *Better Together for People in Our Care* document. This newsletter also featured a range of articles highlighting the work of both Trusts including the collaborative work already underway across both organisations.

These included examples of integrated projects that are already improving patient outcomes and staff experience, and demonstrated how teams from WCHC and WUTH are working side by side with a shared purpose and commitment to better care.

Celebrating PRIDE month - June 2025

There has been lots of activity across both Trusts during June to recognise and celebrate PRIDE. In both organisations it has been a joyful and visible reminder of our shared commitment to inclusion, respect, and celebrating what makes each of us unique.

Whilst not until 9 August, WCHC and WUTH will once again be supporting Wirral Pride with a marketplace stall engaging with the community around all of our services and how we are working to be inclusive for all.

Carers Week – 9-15 June 2025

WCHC was proud to support Carers Week including welcoming the Wired minibus to St Catherine's Health Centre for patients and staff to drop in and find out more information and seek advice if they have unpaid caring responsibilities.

The Trust was also pleased to be represented at the Commitment to Carers conference held by Wirral Carers Alliance at the Floral Pavilion on 11 June 2025. The Trust had a marketplace stall at the event with representatives from across the Trust, including the Patient Experience Team, providing information and listening to carers about what they need from the Trust.

I would like to thank all those involved in supporting these activities and especially members of our Working Carers Staff Network.

WUTH and WCHC staff recognised at Royal Garden Party

Nicola Williams (community cardiology) and Farzana Chan-Cheema (urgent care) from WCHC and Lauren Knight (respiratory nurse specialist) from WUTH had been selected by NHS England to attend the Royal Garden Party for the NHS in May at Buckingham Palace.

Hosted by members of the Royal Family they were joined by 100s of NHS staff who enjoyed a sunny afternoon of celebration in the gardens of Buckingham Palace.

Congratulations to Nicky, Faz and Lauren, we are delighted that you had a memorable time representing your services, WUTH and WCHC.

Leaders In Touch and Get Together

These monthly all staff briefings in both Trusts continue to be well attended with invitations now extended to staff in both organisations to attend either or both briefings. At each meeting we are providing an update on integration and providing other key messages from the Board including updates on performance.

	At these briefing we also celebrate staff across each Trust by announcing our Employee of the Month and Stand out Winners. **WUTH Employee of the Month – Support Services Winner – Nigel Macleod – Executive Assistant** Nigel Macleod, Executive Assistant, has been recognised for his unwavering professionalism, kindness, and dedication. Always willing to help others and quietly celebrate their successes, Nigel is a true team player who leads with humility and care. **WUTH Employee of the Month – Patient Care Winner – Hannah Blake – Bereavement Midwife** Hannah has been recognised for the extraordinary compassion, empathy and dedication she brings to her role every single day. Providing specialist support to families facing the unimaginable loss of a baby, Hannah offers truly person-centred care with remarkable sensitivity and strength. **WCHC May Standout Winner – Claughton Community Nursing Team** “I am so proud of the dedication and commitment the team provide to our student nurses. As the NELP for students, recent feedback demonstrates the outstanding care that the team provides, not only to patients in the community, but also to student nurses on their learning journey. Beyond clinical excellence, the team’s commitment to education and empowerment stands out, fostering a culture a continuous learning. I am proud to be a part of this team”. – submitted by Helen Marie Chapple.

Consultation on the NHS Performance Assessment Framework

Wirral University Teaching Hospital NHS Foundation Trust

Proposal 1: We propose Each ICB and provider is placed in a segment from 1 to 4 based on its performance against short- and medium-term NHS priorities. There will be an additional segment 5 for those in most need of support.

- The approach is based on assessing performance against a balanced scorecard of metrics across 4 domains that relate to the 4 purposes of an ICS. Individual organisations (ICBs and acute, mental health, community and ambulance providers) are measured against a range of metrics that reflect their individual contributions to the delivery of NHS priorities. An organisation's overall score is derived by benchmarking its performance against targets or standards and their peers.
- Every ICB and provider will be allocated a segment. This indicates its level of delivery from 1 (high performing) to 4 (low performing).
- The March 2025 NPAF draft anticipated that organisations in segment 4 would receive a diagnostic to identify those with the most intense support needs and that those organisations would enter segment 5, equivalent to the existing Recovery Support Programme (RSP).

Proposal 2: We propose: Segmentation decisions are based solely on delivery against the performance metrics set out in the NPAF. The capability ratings we consulted on in 2024 no longer influence which segment an organisation is allocated but will be considered as part of NHS England's improvement response.

- The NPAF aims to bring a more objective, transparent and consistent approach to our segmentation decisions. The segmentation process we consulted on in 2024 included an assessment of the organisation's capability to improve without support.
- NHSE propose to assess capability separately, rather than making the capability rating a component of the segment score. This ensures that segmentation is based exclusively on performance against delivery, making it more objective, transparent and providing for greater public accountability.
- Any separate rating of 'capability' will be used to inform NHSE's improvement response in order to prioritise those organisations most in need of support or intervention.

Proposal 3: We propose: Providers will not have their scores adjusted to reflect wider system performance. Our segmentation decisions will be based solely on delivery against the performance metrics set out in the NPAF for each organisation type.

- Proposing removal of the previously suggested 'system adjustment' element from the provider scoring methodology. This is to ensure that providers are not held accountable for performance they may not control totally.
- This consideration is proposed to remain for ICBs.
- Total list of new NPAF Indicators are appended to this presentation.

Proposal 5: We propose: Any organisation reporting a financial deficit is limited to segment 3 (but may still be placed in segment 4 or 5).

- Proposal to add in a segmentation override such that any provider or ICB reporting a financial deficit cannot be allocated to a segment above 3. Organisations may still be placed in segment 4 or 5 based on their performance in other areas but may not in a segment higher than 3 unless they are delivering a surplus or breakeven position.

Proposal 5: We propose: Use of fewer metrics to calculate a segment decision. These will be focused on short-term priorities.

- Proposal to introduce fewer core measures that align with NHS priorities as well as a high-level view of quality of care. This will allow the NHS to focus this year on the stated recovery priorities. Longer-term transformation measures that align to the NHS 10 Year Plan and the redefined roles of ICBs and the centre will be introduced from 2026/27.
- Full list of proposed indicators appended to this presentation.

NHS Performance Assessment Framework (NPAF) Segmentations

NHS Cheshire and Merseyside

Segment / Theme	Description	Support	Improvement	Intervention
Segment 1 - High Performing Organisations	Consistently high-performing across all domains, with a track record of successful delivery	No specific support or intervention needs identified; expected to set up their own support plans.	Collaborates with NHS England to develop best practices and improvement initiatives.	Enforcement action is not usually expected but can be taken if necessary.
Segment 2 - Good performance with specific issues	Good performance across domains with specific issues in place that have the support of system partners.	Can diagnose and clearly explain support needs, predominantly supplied locally.	Works with NHS England to develop best practices and targeted support to improve specific pathways.	Enforcement powers are not common but may be used where specific issues call for this approach.
Segment 3 - Off-track in multiple areas	The organisation and/or wider system are off-track in a range of areas.	Support needs are between NHS England and the organisation, delivered through local support offers, national support programmes, and bespoke regional interventions.	Receives increased scrutiny targeted at delivering improvement in challenged performance areas.	NHS England may apply interventions and/or require the organisation to take action in specific areas of poor performance, including enforcement action if necessary.
Segment 4 - Significantly off-track	The organisation is significantly off-track in a range of areas. Application of the diagnostic did not identify a need to enter the Recovery Support Programme (RSP).	NHS England considers the organisation's challenges and support needs to inform appropriate support or intervention. Support needs are prioritised through local support offers, national support programmes, and bespoke regional interventions.	Receives significant scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed and proactively monitored.	NHS England may apply interventions and/or require the organisation to take broad actions or address specific concerns related to diagnosed issues, including enforcement action if necessary.
Segment 5 - Entry into Recovery Support Programme	Following a diagnostic, the organisation's entry into the RSP is considered necessary to address serious failures of patient safety, quality, finance, leadership, and/or governance.	NHS England appoints an improvement director to intensively support the organisation to meet improvement goals. The programme supports the ICB or provider in undertaking a full diagnostic to identify support needs and develop a full recovery plan in collaboration with system partners and agree transition criteria.	The organisation is subject to the highest level of NHS England scrutiny and performance management to meet agreed transition criteria demonstrating sustainable levels of improvement to leave the programme.	Alongside entry into the RSP, enforcement action may also be agreed through the relevant executive governance group if deemed necessary. Transition out of segment 5 requires transition criteria to be met.

PAF Metric list by Organisation

NHS
Cheshire and Merseyside

Theme	ICB	Acute	Mental Health / Community	Ambulance
Operating Priorities	• Growth in total waiting list size (%) • Proportion of cancers diagnosed at stage 1 and 2 (%) • Bed days per 100k population • Number of mental health bed days per 100,000 head of population • Growth in LDA inpatient numbers (%) • Health Insight Survey ease of making contact with GP (%) • Urgent dental activity vs target • Hypertension patients treated to target (%) • % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	• 18-week performance (%) • 52-week performance (%) • Estimated clearance time • 62-day performance (%) • 28-day performance (%) • >4 hours in dept (%) • <12 hours in dept (%)	• 52-week community performance (%) • Acute MH patients with length of stay >60 days at discharge (%) • CYP mental health access rate (%)	• C2 mean response time
Finance & Productivity	• Planned surplus / deficit • YTD surplus / deficit	• Planned surplus / deficit • YTD surplus / deficit	• Planned surplus / deficit • YTD surplus / deficit	• Planned surplus / deficit • YTD surplus / deficit
Quality & People	• Health Insight Survey % of patients able to see their preferred primary care professional • Staff survey safety culture score • Neonatal death/stillbirth rate • Average number of days between planned and actual discharge date • Proportion of patients to receive all eight diabetes care processes • Staff survey engagement score • Sickness rate	• CQC inpatient survey satisfaction rate • Staff survey safety culture score • CQC safe rating • Rates of c-difficile, E-coli and MRSA • Summary Hospital-Level Mortality Indicator • Readmission rate band • Average number of days between planned and actual discharge date • Staff survey engagement score • Sickness rate	• CQC community mental health survey satisfaction rate • Staff survey safety culture score • Restrictive Intervention rate • CQC safe rating • Crisis response - % of patients to receive face to face contact within 24 hours • Urgent Community Response two-hour performance • Readmission rate band • Staff survey engagement score • Sickness rate	• Staff survey - if a friend or relative needed treatment I would be happy with the care provided by this organisation • Staff survey safety culture score • CQC safe rating • See and convey rate • Staff survey engagement score • Sickness rate

Next Steps

Those who wish to participate in the consultation are encouraged to respond by completing the online questionnaire that asks the questions below.

1. Describe the organisation or group you belong to.
2. What is the name of your organisation?
3. To what extent do you agree or disagree that the proposed approach set out in the draft NPAF offers an objective and consistent approach to assessment?
4. To what extent do you agree that NHS England's assessment of ICB and provider capability should be used to inform how we support organisations to improve but that it should not influence segmentation?
5. To what extent do you agree that ICB segmentation should continue to consider system performance?
6. To what extent do you agree that segments 1 and 2 should be limited to organisations achieving financial balance (surplus or breakeven)?
7. To what extent do you agree a shorter list of measures for 2025/26 will simplify the framework and allow a clearer focus on operating priorities consistent with the reset agenda?
8. Do you have any comments about the proposal and the impact on advancing equalities and/ or reducing health inequalities?
9. Do you have any other comments?

The consultation is open from Thursday 12 May to 5:00pm on Friday 30 May 2025.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**

02 July 2025

Title	Integrated Performance Report
Area Lead	Executive Team
Author	Executive Team
Report for	Information

Executive Summary and Report Recommendations
This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of May 2025. It is recommended that the Board: • Note performance to the end of May 2025.

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

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.

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.

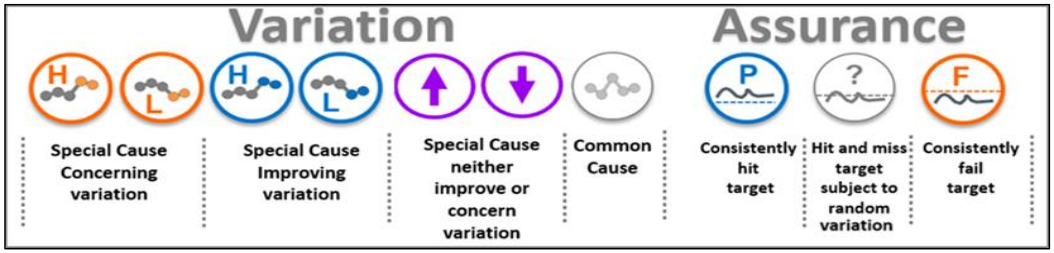
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - June 2025

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.

Key to SPC Charts:



Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	2	3	5
All Domains	16	27	43

Issues / limitations

SPC charts should only be used for 15 data points or more.
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.

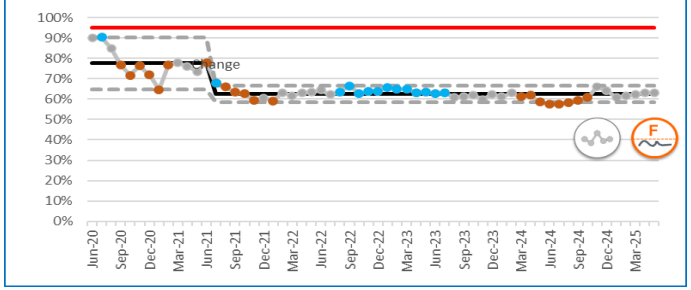
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	National threshold target for 2024/25 is not yet confirmed - internal maximum set at 108 cases for the year.

Chief Operating Officer (1)

CQC Domain : Responsive

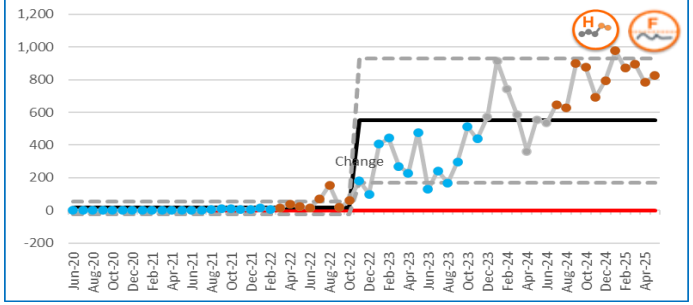
4-hour Accident and Emergency Target (including APH UTC)



May-25
63.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

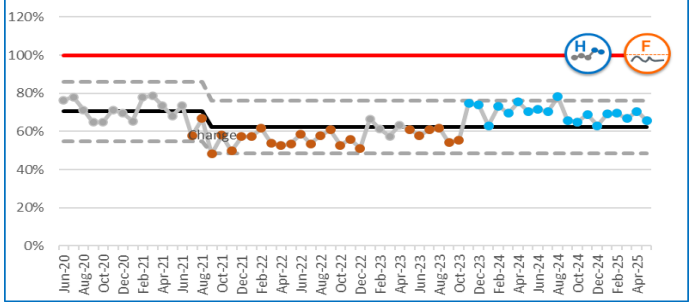
Patients waiting longer than 12 hours in ED from a decision to admit



May-25
827
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

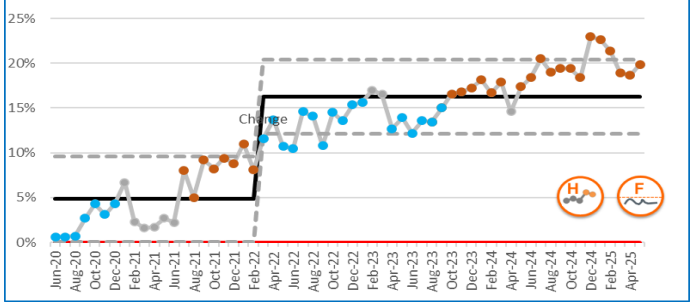
Time to initial assessment for all ED patients - % within 15 mins



May-25
65.7%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

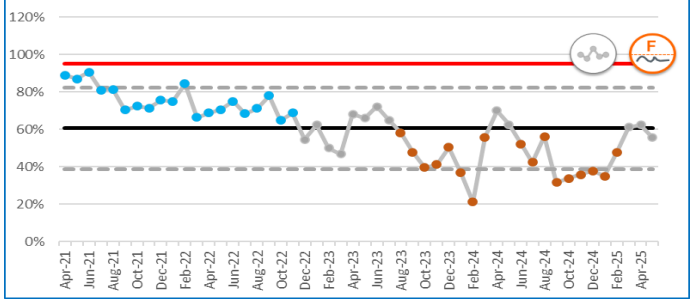
Proportion of patients more than 12 hours in ED from time of arrival



May-25
19.9%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

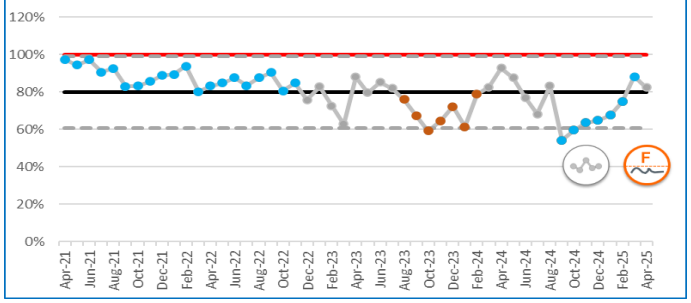
Ambulance Handovers: % < 30 mins



May-25
55.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

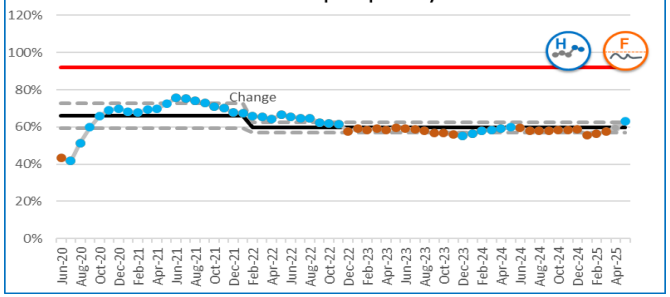


Apr-25
82.3%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

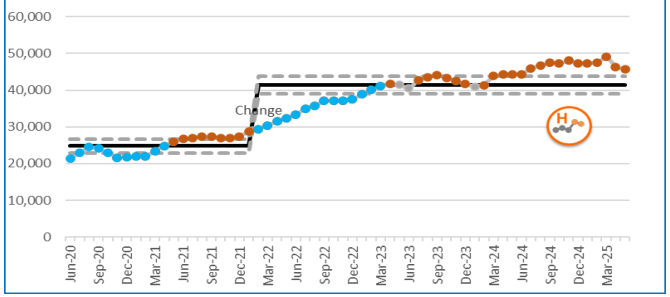
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



May-25
63.01%
Variance Type
Special cause variation - improving
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

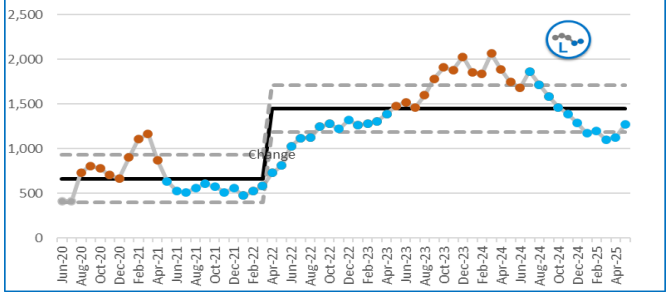
Referral to Treatment - total open pathway waiting list



May-25
45691
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

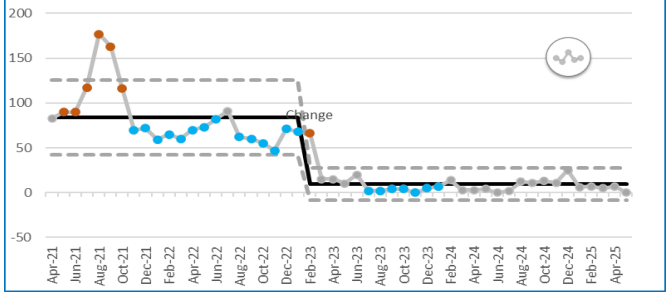
Referral to Treatment - cases exceeding 52 weeks



May-25
1272
Variance Type
Special cause variation - improving
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

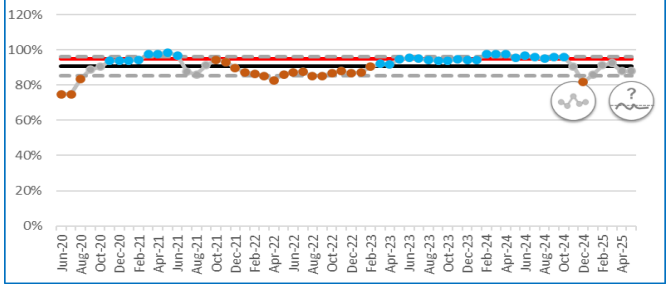
Referral to Treatment - cases waiting 78+ wks



May-25
0
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

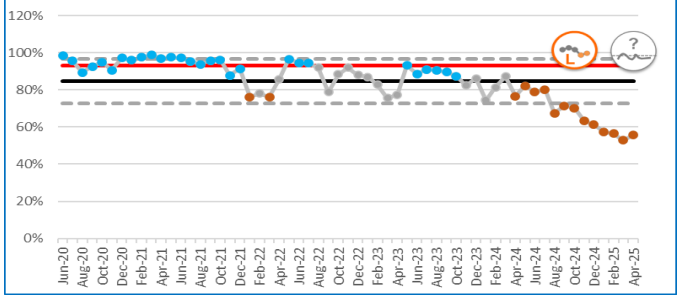


May-25
87.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

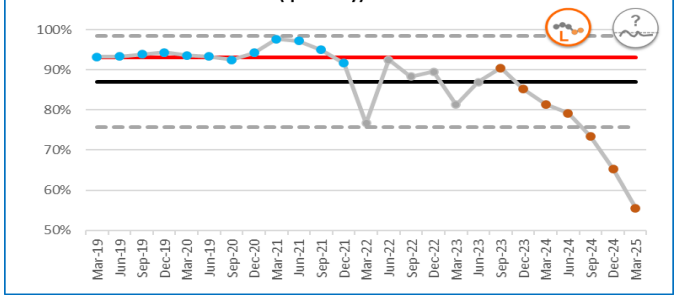
Cancer Waits - 2 week referrals (monthly)



Apr-25
55.9%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

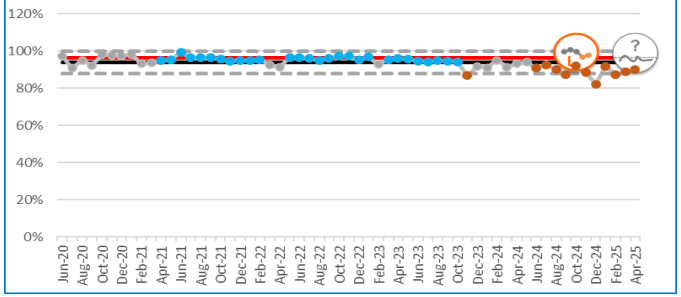
Cancer Waits - 2 week referrals (quarterly)



Mar-25
55.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

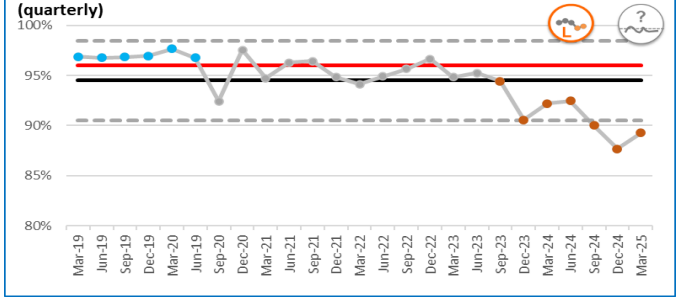
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Apr-25
90.1%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

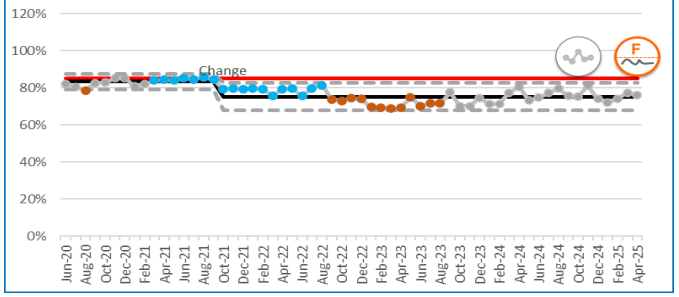
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Mar-25
89.3%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

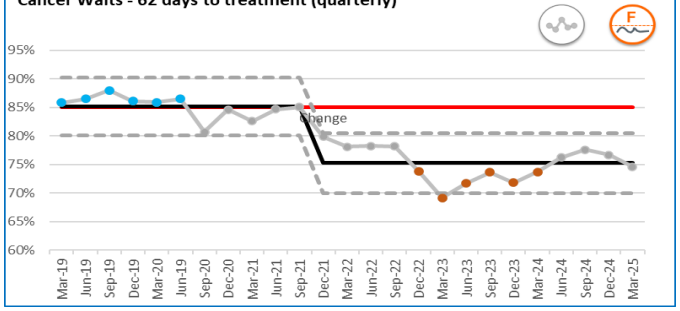
Cancer Waits - 62 days to treatment (monthly)



Apr-25
76.0%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Cancer Waits - 62 days to treatment (quarterly)

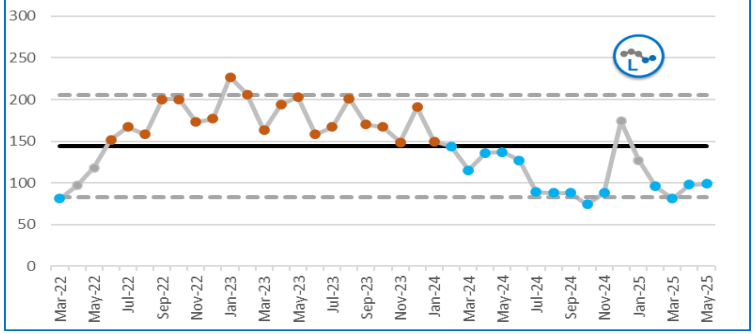


Mar-25
74.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (4)

CQC Domain : Responsive

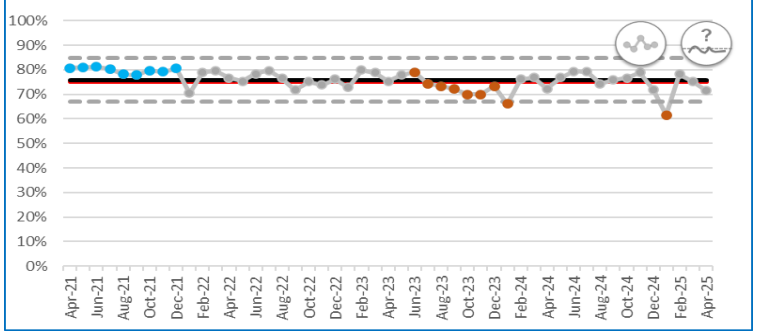
Cancer Waits - reduce number waiting 62 days +



May-25
99
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

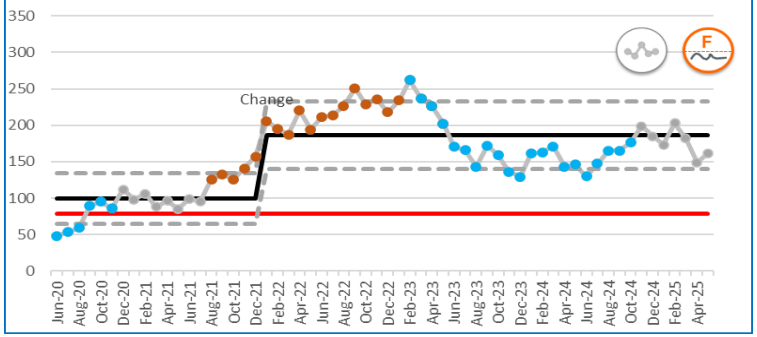
Cancer - Faster Diagnosis Standard



Apr-25
71.5%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

CQC Domain : Effective

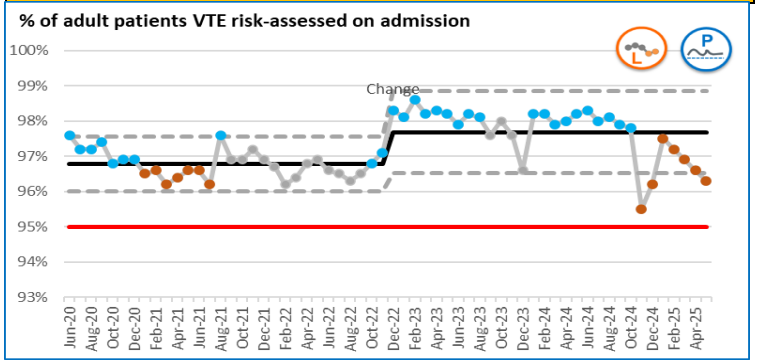
Long length of stay - number of patients in hospital for 21 or more days



May-25
161
Variance Type
Common cause variation
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

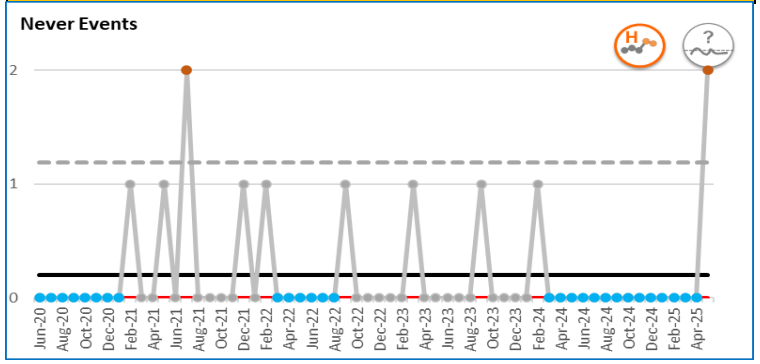
Medical Director

CQC Domain : Safe



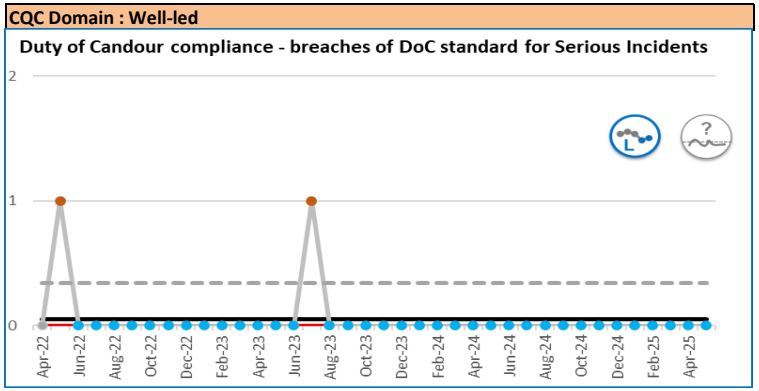
May-25
96.3%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



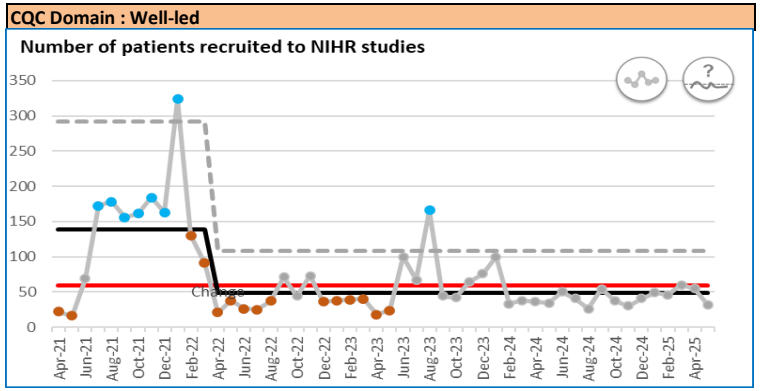
May-25
2
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



May-25
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

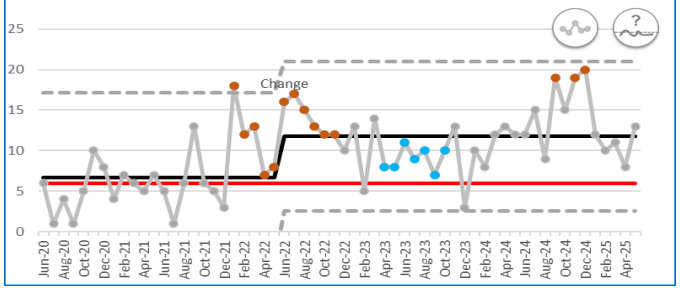


May-25
32
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

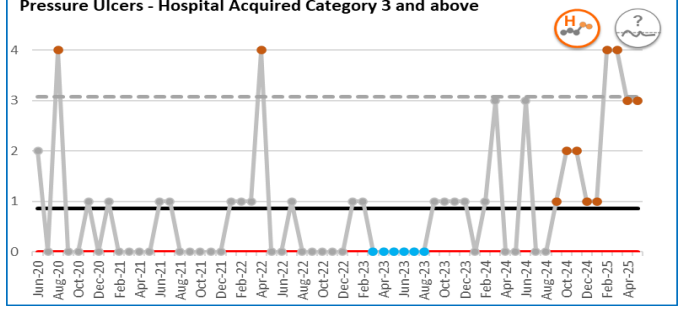
Clostridioides difficile (healthcare associated)



May-25
13
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

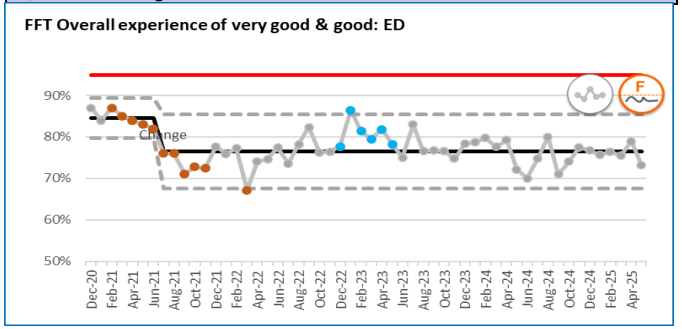
Pressure Ulcers - Hospital Acquired Category 3 and above



May-25
3
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

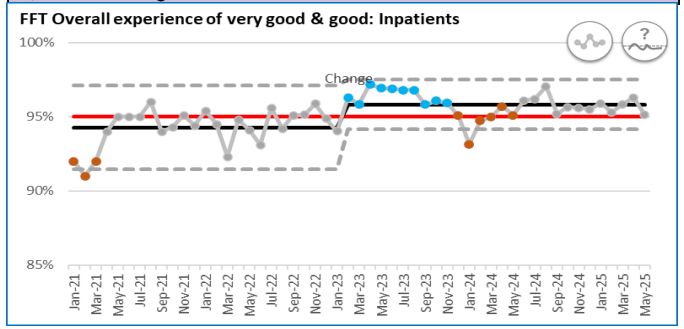
FFT Overall experience of very good & good: ED



May-25
73.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

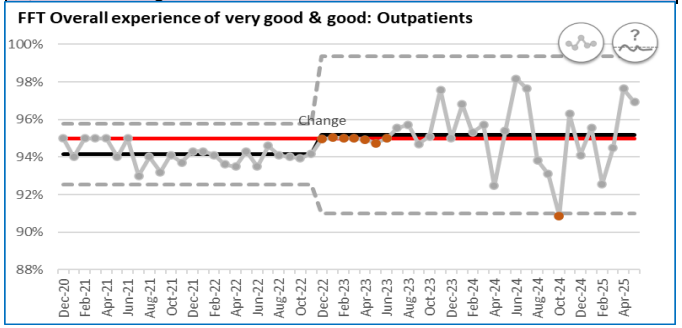
FFT Overall experience of very good & good: Inpatients



May-25
95.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

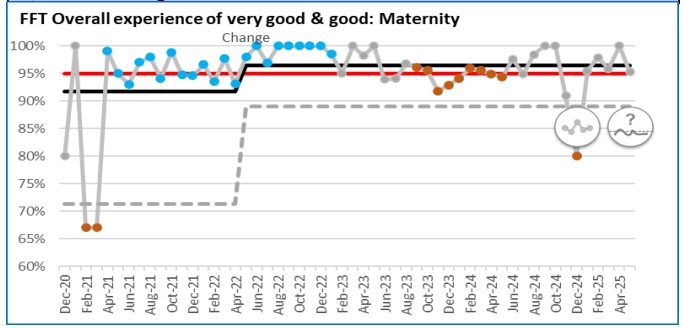
FFT Overall experience of very good & good: Outpatients



May-25
96.9%
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

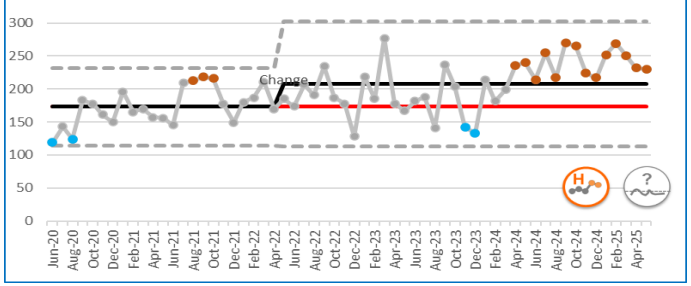


May-25
95.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

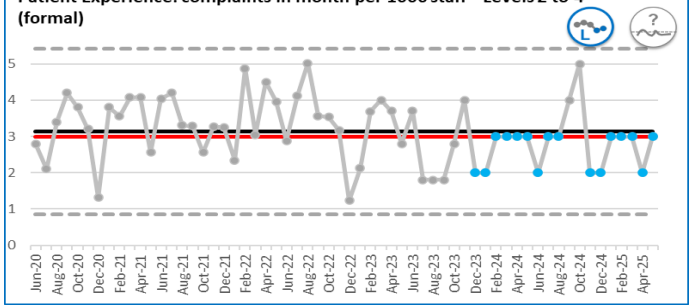
Patient Experience: concerns received in month - Level 1 (informal)



May-25
230
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

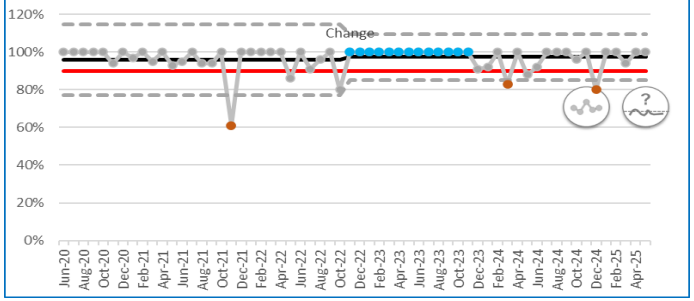
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



May-25
3
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

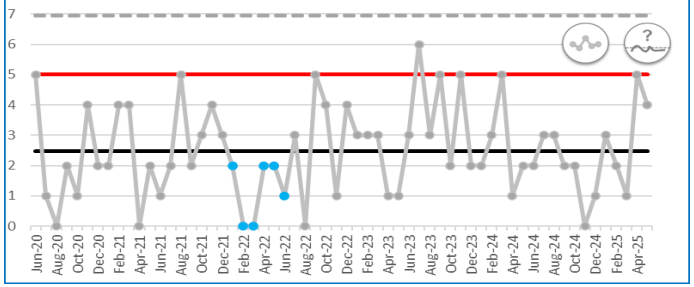
Formal Complaint acknowledged within 3 working days



May-25
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

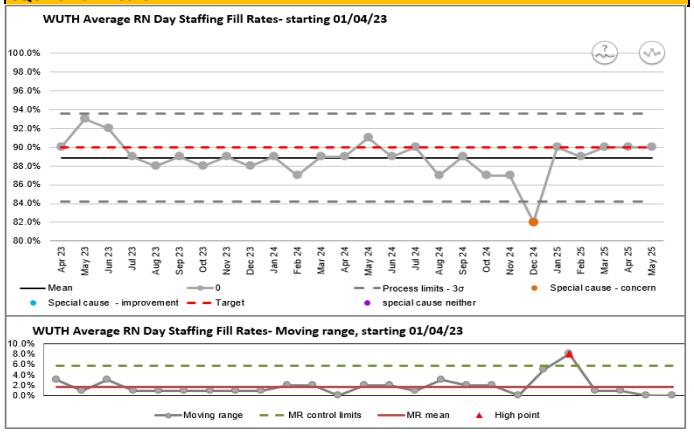
Number of re-opened complaints



May-25
4
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

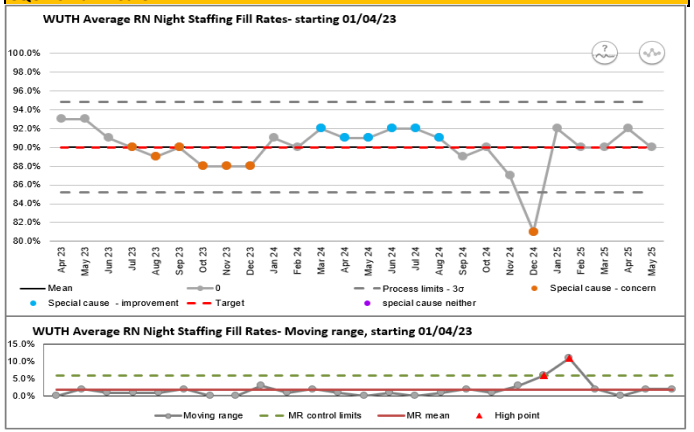
Chief Nurse (3)

CQC Domain : Safe



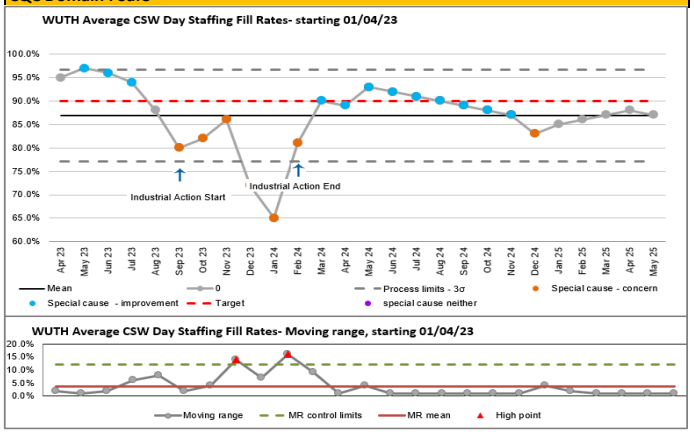
May-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



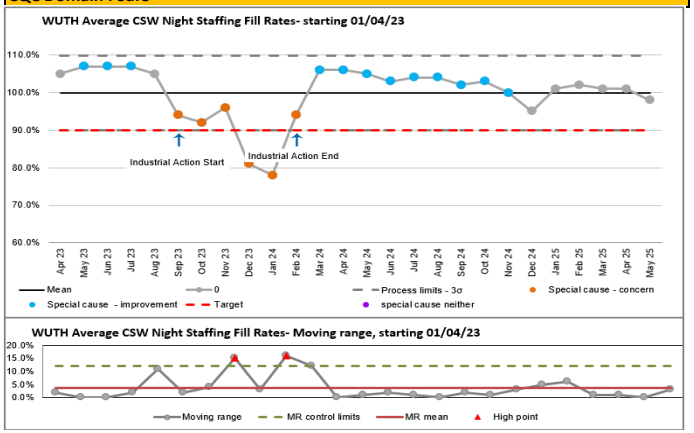
May-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



May-25
87.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



May-25
98.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation in month.

C Difficile there were 13 incidents in May 2025.

There was 3 category 3> hospital acquired pressure ulcer in May 2025 against a target of 0.

Friends and family test for ED 73.2%, Outpatients, Maternity and inpatients exceeded the 95% of those that responded were either satisfied or very satisfied with the service.

The number of level 1 concerns raised with the trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff was below the agreed threshold, 100% of complaints were acknowledged within 3 days of receipt.

With the exception of CSW day fill rates, RN and CSW staffing fill rates were above the threshold of 90%.

Infection Prevention and Control

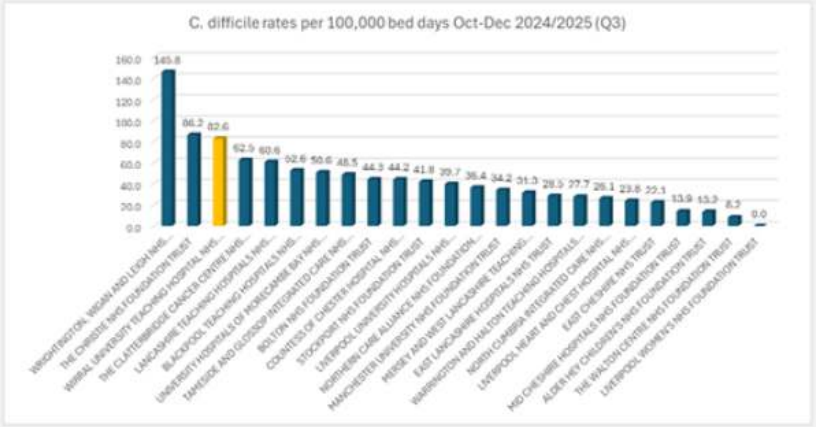
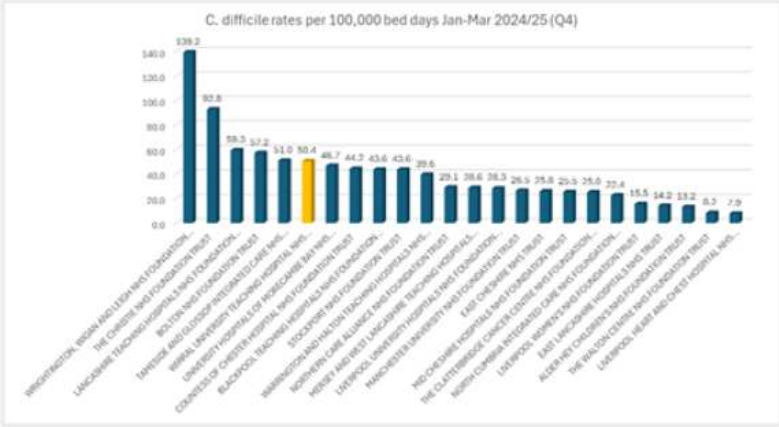
Narrative:

The trust diagnosed 13 patients with CDT in May, of those reported there were11 Hospital-onset health care associated (HOHA) and 2 Community onset healthcare associated (COHA). 5 patients had been nursed in areas where there were other patients identified with CDT/E previously, 1 of the patients had has 3 previous episodes of CDT diagnosed and 1 patient had previously been diagnosed with CDE. 6 of the patients were isolated at the time of sample collection.

Whilst this is an increase from the previous month it continues to show a downward trend since Dec 24

Infection Prevention & Control is one of the 3 quality priorities for the Trust in 2025/26 and the IPC plan going forward will further explore the key strategies to reduce patients diagnosed with *Clostridioidies difficile* and Gram negative bacteraemia.

Collaborative working with the Community Trust continues with further engagement with the ICB being explored.
Infection control remains a quality priority for the organization with the aim of improving on last year's outcomes
North west benchmark data demonstrates an improving position in Q4 24/25

Q3 (Oct-Dec 2024/25)	Q4 (Jan-Mar 2024/25)
Regional Average: 42.7 WUTH: 82.6 	Regional Average: 39.1 WUTH: 50.4 

Actions:

Completed or in place.

- Ongoing use of a decant ward to facilitate bay movements to allow for HPV to take place following a patient identified with CD Toxin/Equivocal results.
- Ongoing IPC visibility to wards and department offering expert advice and guidance.
- Robust process embedded to pick up weekend results.
- Senior nurse walk rounds focusing on IPC basics, including cleanliness, hand hygiene, bare below the elbows, decluttering and estates issues.
- Collaborative monthly meeting with WUTH IPC and the Community IPC team
- C&M IPC collaboration group focusing on CDT
- IPC daily review of all side rooms, including those with en-suite facilities in the medical division to identify who can be moved out should a side room with en-suite facilities be needed for a patient with loose stools.

- Place based AMR champion funded by public health being progressed.
- Review of patients that relapse to consider management plan

Risks to position

High site occupancy levels
Patients with competing needs for isolation
Patients with relapses of CDT Infection

FFT Overall experience of very good and good.

Narrative:

The NHS Friends and Family Test (FFT) was created to help service providers, and commissioners understand if patients are satisfied with the service provided, or where improvements are needed. It's a quick anonymous way for patients to provide their views. The trust monitors FFT across a range of care settings, with a target rating of a minimum 95% for good or very good.

ED score was 73.2%. Analysis of the patient comments for ED identifies waiting times and communication, as the main reasons for attributing negative ED response.

Actions:

- Proactively respond to feedback, making immediate rectifications when able to do so.
- Continued focus on providing people with access to provide feedback via FFT.
- Feedback to local teams' themes from FFT to identify areas of improvement.
- Regular announcements on waiting times within ED.
- Introduce new ways of working to enable a smoother patient journey.
- Rounding the department to check patients' needs are met.

Risks to position and/or actions:

- Bed occupancy is impacting on the length of time patients remain within ED. Processes are in place operationally to enable earlier egress from ED.
- Reduction in administrative support to deliver the patient experience strategy, due to current vacancy controls. Work being priorotised to mitigate risks to the strategy

Complaints

Narrative (May 2025)

In May 2025, the Trust recorded 18 formal complaints (Level 2) and 229 informal concerns (Level 1).

This aligns with the 18-month monthly average of 18. The volume of Level 1 concerns remained consistent with April and below the 2024/25 monthly average of 240.

Divisional Breakdown

- Medicine received the highest number of both formal complaints (8) and informal concerns (80).
- Surgery followed with 7 formal complaints, then Emergency Care (5), Women's & Children's (4), and Diagnostics & Clinical Support (2). No formal complaints were received for Corporate Departments or Estates, Facilities & Capital.
- In terms of informal concerns, after Medicine, the next highest volumes were: Surgery (68), Women's & Children's (44), Emergency Care (31), Diagnostics & Clinical Support (30), Corporate Departments (11), and Estates, Facilities & Capital (5). These figures were broadly in line with April.

Key Themes

The most reported themes across all complaints and concerns were:

1. **Access and Admission** (33% of cases): Primarily related to delays and cancellations.
2. **Communication** (22%): Mostly due to communication breakdowns, rather than staff attitude.
3. **Treatment and Procedure** (12%): Largely concerning delays in the delivery of care.

The most frequently referenced departments were the Emergency Department (ED) and Community Child Health, followed by ENT, Urology, and the Cardiorespiratory Department.

Timeliness and Case Progress

We have seen significant improves over the last 3 months with response rates within 40 working days.

The average response time improved slightly, from 60 to 59 working days.

At the end of May, 47 formal complaints were in progress (up from 41 in April), of which 13 had exceeded the 40-working-day target – unchanged from April. While this represents a minor deterioration, the position remains significantly improved from the 2024/25.

Actions

- Daily performance reporting and weekly divisional meetings with the Complaints Team continue to provide oversight, structured support, and escalation when required.
- PALs office now reliably open between the hours of 09:00 and 16:30.
- Complaints line refreshed and information on the call for concern (Marthas rule) line regarding how to raise a less urgent concern.
- Matrons daily visibility in areas to address concerns immediately.
- Monthly training sessions remain in place to support staff undertaking complaint investigations and to improve consistency and quality.

Risks to Position and/or Actions

- Ongoing operational pressures continue to impact the capacity for timely complaint handling.
- Variability in investigation quality persists, with some responses reflecting gaps in skill and experience.

Nurse Staffing Fill Rates

Narrative:

Registered nurse and care support working fill rates should be reported to the board on a monthly basis to ensure compliance with NHSE developing workforce safeguards 2018 and the national quality board safe sustainable and productive staffing 2017. A ward level dashboard should also be available to demonstrate safe effective care is being delivered. Fill rate threshold is currently set at 90% day and night CSW and RN. March saw adequate fill rates for RN day and Night and CSW night shift. Agency ceased in April in both ED and Theatres.

Actions:

Review of vacancies across the organisation, to fully understand the risk and impacts and determine the most effective recruitment process ie; speciality based recruitment events. Including ED.

Second acuity review completed with new safer nursing care tool, data currently being analysed.

Assurance re effectiveness of absence management.

Weekly roster oversight review meetings undertaken by DCN/CN to review use of bank and agency, and roster KPI's

Roster/establishment/ESR alignment project under way.

Proposal regarding the approach to maternity leave backfill in development.

ED recruitment to new establishment underway, staff being temporarily redeployed to ED from wards to maintain safety, impacting on the wards.

Retention group reinitiated.

Risks to position and/or actions:

- High sickness absence rates.
- Staffing temporary escalation areas ie; ED corridor.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired Pressure Ulcers (HAPU) category 3 and above.
During May we have had 3 x Category 3 pressure ulcers on 3 patients which have all been validated by the tissue viability team.

Breakdown:

Medicine

Category 3 to right buttock (Ward 21).

Acute

Category 3 to coccyx (Emergency Department)
Category 3 to left heel (Acute Frailty Unit)

Actions:

- Development of tissue viability guides on classification of wounds, management plans and wound assessments to support clinical staff in decision making.
- Monthly pressure ulcer training arranged for all staff by Tissue Viability Team on classification of pressure ulcer and aSSKINg model of care.
- Ad – hoc ward training.
- Continued divisional harms meetings arranged weekly and monthly.
- New fleet (350) high specification low air loss mattresses awaiting delivery.
- Service review concluded with a series of recommendations.
- Strengthening of service could be achieved through integration opportunities currently being reviewed.

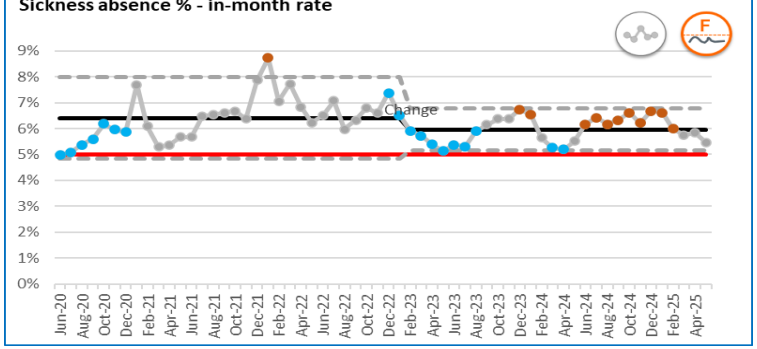
Risks to position and/or actions:

- Part time leadership within the tissue viability team.

Chief People Officer

CQC Domain : Safe

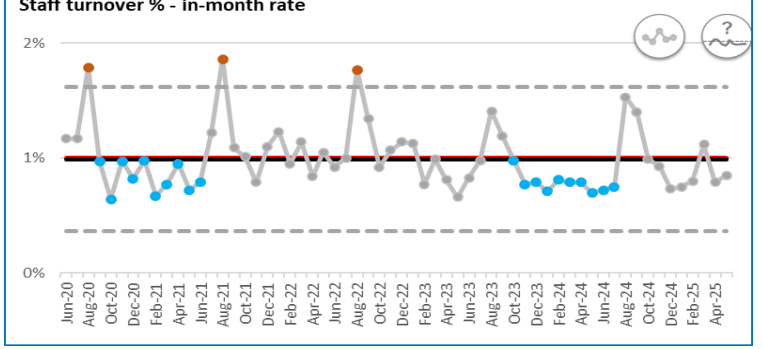
Sickness absence % - in-month rate



May-25
5.47%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

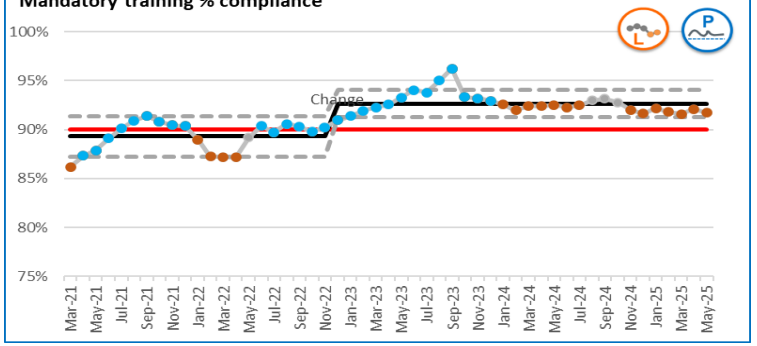
Staff turnover % - in-month rate



May-25
0.85%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

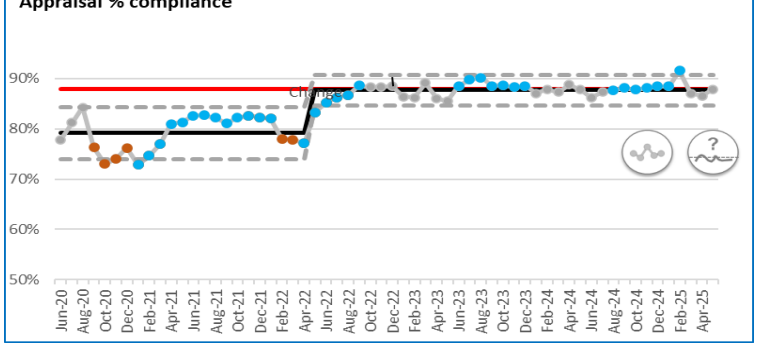
Mandatory training % compliance



May-25
91.74%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



May-25
87.85%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer

Overall position commentary

- The Trust's People KPIs for mandatory training is on target at 91.74%.
- Sickness absence has further improved but remains above target at 5.47%.
- Turnover is above target in May at 0.85% however is not a cause for concern. The Trust is in line with it's plan to reduce WTE.
- Appraisal compliance has increased to 87.75%.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For May 2025 the indicator was 5.47% and demonstrates common cause variation.

The majority of absences relate to short term sickness. Gastrointestinal illnesses remains the highest cause of sickness followed by anxiety/depression and Cold/Flu, these three reasons account for 52% of all absences in May 2025. Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy.

Actions:

Proactively supporting Physical Health & Wellbeing

- Wellbeing surgeries have taken place in May
- EAP uptake has increased following wide promotion and is higher than other Trusts in C&M
- Proactive promotion of the Active Care Support (EAP) for stress-related absences
- One Wirral Health CIC Health checks have begun in Estates, Facilities and Capital division.
- International nurses and midwives' day celebration events
- Burn out sessions lead by the Trusts psychotherapist begun in June with session planed for throughout the year including WCNT colleagues

Managing Absence

- HR Drop-In sessions running each weekday for managers to have direct access to 1:1 support from HR team
- HR team implemented a targeted approach to sickness absence management, enabling more effective resource allocation and focused support where it is most needed.
- Audits of application of policy remain ongoing; reports shared with divisional triumvirates as part of improvement measures and ensuring consistent application of policy.

- Monitoring of the sickness absence KPI and associated actions are ongoing via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.
- Additional training dates provided with good uptake from managers.

Risks to position and/or actions:

The local risk (397) score is 15 and BAF risk is 12, the increased risk position remains in month to reflect the impact that current sickness levels are having upon the organisation.

The management of sickness absence is primarily management led as they are responsible for monitoring and addressing sickness absence through consistent application of the policy with advice and support by the HR Team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels, financial controls and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. Impact on quality patient care from sickness absence and presenteeism in the workforce are well known and understood across the Trust. Work to ensure consistent and robust application of the policy continues to be led by HR Team together with targeted work to address areas of high prevalence.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of May 2025 compliance has risen to 87.75%.

Only Emergency and Corporate Support Divisions remain non-compliant, all areas except for Emergency and Medicine have seen an increase in compliance for May.

The OD team have been working with representatives from the divisions to review the appraisal and check-in paperwork, which had been identified as a barrier to completion. To inform improvements, a focus group was held on 29th May and recommendations on improvements to the appraisal and check in paperwork are tabled for presentation at Workforce Steering Board in June.

In addition to streamlining the appraisal documentation, appraisal audits will be developed and conduced monthly to drive improved quality of appraisals within divisions. This process will mirror attendance management audits which are positively received and are showing signs of having positive impact on sickness absence practices.

Actions:

- Review of appraisal and check-in paperwork conducted and new streamlined appraisal paperwork to be presented to Workforce Steering Board in June for approval
- Introduction of appraisal audit processes
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps
- Reporting now includes appraisals and check-ins which have been incorrectly recorded on ESR, together with guidance on how this should be resolved
- The Learning and Development Team continue to contact 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, note this is in addition to ESR automatic messages which are also issued.
- 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.
- The appraisal portlet makes recording appraisals easier for managers with a short step by step video to assist them in recording appraisals.

Risks to position and/or actions:

- Ongoing system pressures continue to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team work in collaboration with HR to provide targeted awareness, in a format and at a time which works around operational commitments, for teams / services that are particularly lower in compliance.

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. In May the indicator increased to 0.85% from 0.79% in April. This demonstrates a common cause variation.

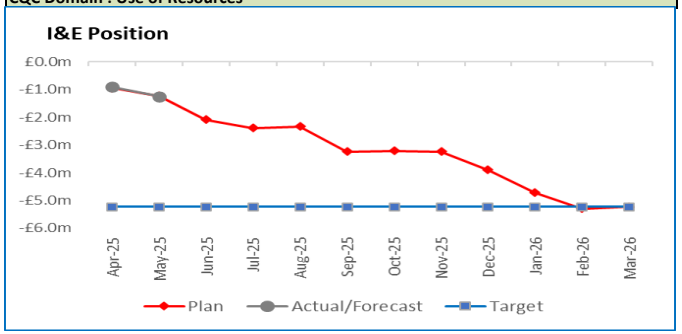
The current level of turnover in the Trust is not a cause for concern. The Trust is achieving it's planned WTE reduction.

Risks to position and/or actions:

It is anticipated that Turnover will increase further in coming months following delivery of the Mutually Agreed Resignation Scheme.

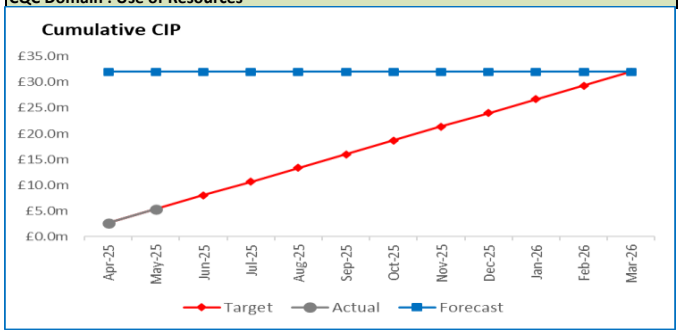
Chief Finance Officer

CQC Domain : Use of Resources



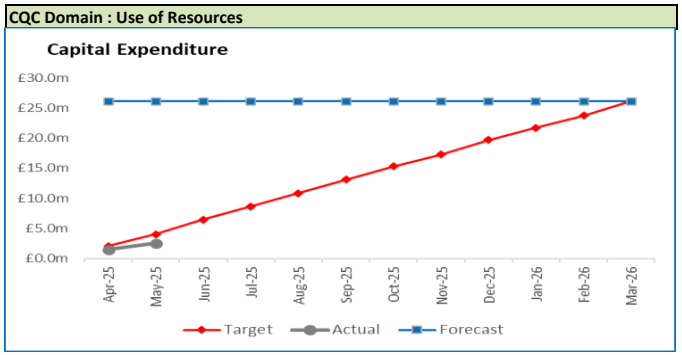
May-25
-£0.3m
Variance
Position meets the plan
Target
-£5.2m

CQC Domain : Use of Resources



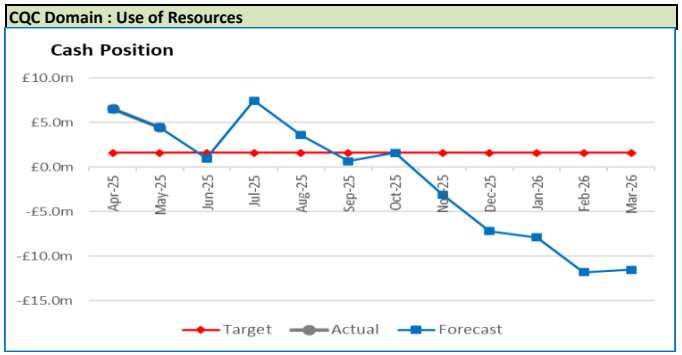
May-25
£5.3m
Variance
Position meets the plan
Target
£2.7m

CQC Domain : Use of Resources



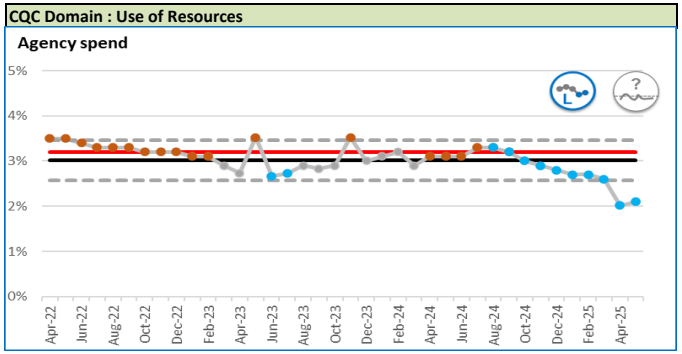
May-25
£2.5m
Variance
Position meets the plan
Target
£4.0m

CQC Domain : Use of Resources



May-25
£4.5m
Variance
Position meets the plan
Target
£1.6m

CQC Domain : Use of Resources



May-25
2.10%
Variance
Position better than threshold
Threshold
3.2%

Chief Finance Officer

Executive Summary

At the end of May 2025 (M2) the Trust is reporting a deficit of £1.24m which is in line with the M2 plan. At M2 £4.1m (out of £7.0m identified) non-recurrent mitigations have been utilised to support delivery of plan and offset the key risks outlined below.

The Trust identified 4 key risks to the plan which are:

- Full CIP delivery – This is the primary risk to achieving the 2025–26 financial position. The risk adjusted annual forecast is below the required target. This risk includes the delivery of the ICS schemes (£14.5m).
- Activity / Casemix – Elective income is below plan at M2.
- Aseptic Pharmacy – This risk is materialising with a significant reduction in income resulting from production compliance changes.
- Run-rate – 80% of targeted run-rate reductions have been identified.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). The cash balance at the end of M2 was £4.216m however, this level of cash balance will not be sustained. The Trust should be able to progress through to Q3 without the need to request additional cash support. NHSE has announced stricter controls in relation to the allocation of deficit support which could bring forward the requirement for cash support to as early as the end of Q2. Note that NHSE expectation is that cash positions are managed without national revenue support.

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 plan (MTFP). The MTFP for 2026/27 to 2028/29 is now being developed.

The risk ratings for delivery of statutory targets in 2025/26 are:

Statutory Financial Targets	RAG (M2)	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 report and agreed mitigations.
- Note that the Trust's most immediate finance risk remains the cash position.
- Note the risk of delivering the 25/26 plan, including the recurrent £32m CIP target and the ICS schemes of £14.5m.
- Endorse the revised capital budget of £26.071m.

I&E Position

Narrative:

The table below summarises the M2 position:

	Year to Date		
Cost Type	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£80.3m	£79.6m	-£0.7m
Other Operating Income	£5.7m	£5.1m	-£0.6m
Total Income	**£86.0m**	**£84.7m**	**-£1.3m**
Employee Expenses	-£63.5m	-£64.1m	-£0.6m
Operating Expenses	-£25.8m	-£25.2m	£0.6m
Non Operating Expenses	-£0.8m	-£0.7m	£0.1m
CIP	£2.9m	£0.0m	-£2.9m
Total Expenditure	**-£87.2m**	**-£90.0m**	**-£2.8m**
25-26 Position	**-£1.2m**	**-£5.3m**	**-£4.1m**
Non Recurrent Mitigations		£4.1m	
Mitigated Variance to Plan	**-£1.2m**	**-£1.2m**	**-£0.0m**

Key variances within the YTD position are:

Clinical Income – £0.7m adverse variance relates to underperformance across Surgery – (T&O) in respect of elective activity.
Employee Expenses - £0.6m adverse variance relates to use of bank, agency and undelivered vacancy factors.
Operating expenses – £0.6m positive variance relates to underspends on clinical supplies, drugs and other operating expenditure.
Cost Improvement Programme – £2.7m underdelivered at month 2 supported by non-recurrent mitigations.

The Trust's agency costs were 2% of total pay bill for the month, which is below the NHSE threshold of 3.2% of total staff costs.

Cumulative CIP

Narrative:

The Trust has transacted CIP with a part year effect of £16.6m at M2 however, as the £32m CIP target has been profiled in 12ths (£2.7m per month) this represents a £2.7 under delivery at M2. The Trust has identified recurrent CIP with a full year effect of £29.5m, a shortfall against target of £2.5m however, this identified figure reduces to £22.6m once risk adjusted, reflecting a risk adjusted shortfall of £9.4m recurrently and £11.4m in year.

Review of the CIP position is ongoing through weekly CIP Assurance, chaired by the COO and monthly Productivity Improvement Board, chaired by the CEO.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £17.2m at Month 2 (M2), reflecting an adverse variance of £0.5m. This underperformance is driven by the Surgical Division, primarily Trauma & Orthopedics (T&O).

Capital Expenditure

Narrative:

The table below confirms the Trust's final capital budget for 2025/26:

Description	Approved Budget at M1	Revision to budget M2	Revised Budget
CDEL			
Internally Generated	£9.765m		£9.765m
ICB/PDC/WCHC	£14.550m	£0.656m	£15.206m
Charity	£1.100m		£1.100m
Confirmed CDEL	£25.415m	£0.656m	£26.071m
Total Funding for Capital	£25.415m	£0.656m	£26.071m
Capital Programme			
Estates, facilities and EBME	£3.100m	£0.656m	£3.756m
Operational delivery	£8.440m		£8.440m
Medical Education	£0.080m		£0.080m
Transformation	£0.250m		£0.250m
Digital	£0.750m		£0.750m
UECUP	£7.800m		£7.800m
PDC commitments	£0.304m		£0.304m
ICB hosted	£3.591m		£3.591m
Charity	£1.100m		£1.100m
Approved Capital Expenditure Budget	£25.415m	£0.656m	£26.071m
Total Anticipated Expenditure on Capital	£25.415m	£0.656m	£26.071m
Under/(Over) Commitment	£0.000m	£0.000m	£0.000m

The Trust applied for and was successful in securing funding for solar projects in 2025-26. This funding is part of a £100 million NHS solar programme, delivered in partnership by the Department for Energy Security and Net Zero, DHSC, Great British Energy and NHSE. The Trust has been allocated £0.656m of PDC to support the planned projects which can be seen in the proposed revision to budget of the above table.

Spend at M2 totals £2.465m which is £1.548m below plan.

Cash Position

Narrative:

The cash balance at the end of M2 was £4.216m. Currently the Trust forecasts that, with working capital mitigations, revenue support can be deferred until Q3. NHSE has announced stricter controls in relation to the allocation of deficit support so this is a risk which could bring forward the requirement into Q2. In addition, where Trusts are in receipt of system capital support there is a separate approval process to complete. This may mean delays in receipt of PDC funding which would negatively impact on cash flow.

Mitigations include:

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

The reduction in the cash balance is presenting difficulties daily with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value.

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item 8**

02 July 2025

Title	Integrated Performance Report – Month 2
Area Leads	Executive Team
Author	Dave Murphy – Chief Digital Information Officer
Report for	Information

Executive Summary and Report Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of May 2025.

The Integrated Performance Report provides a summary of performance across operational, quality, workforce and financial metrics. The report provides an in-month and YTD position.

The Integrated Performance Board met on 25th June to review performance up to and including M02.

Performance is represented in SPC chart format to understand variation and a summary table indicating performance against standards. The metrics are grouped into Executive Director portfolios with individual metrics showing under each domain identified in this report. Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Grouping the metrics by report domains shows the following breakdown for the most recently reported performance:

This report should be considered alongside the briefings from the Chairs of the committees of the Board.

Strategic (Board Assurance Framework- BAF) and operational Risk and opportunities:

The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the performance of the Trust, to better service our communities and support the work of the Wirral Place, and the Cheshire and Merseyside Integrate Care Board (ICB). The IPR directly supports mitigation across all risks in the Board Assurance Framework as it provides performance against quality, people, finance and operational metrics.

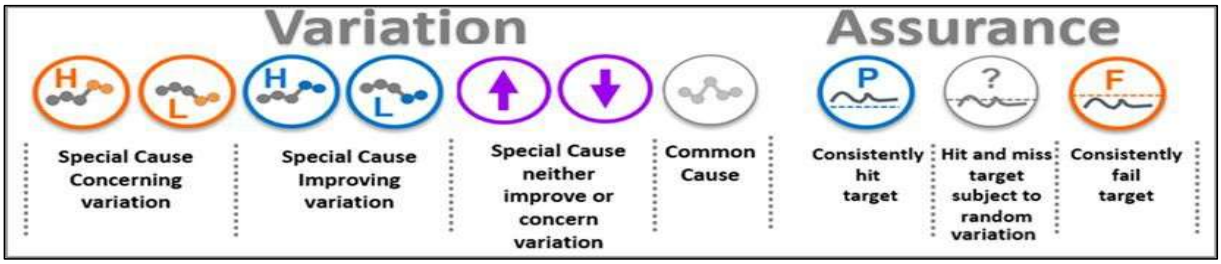
The Board is asked to note performance to the end of May 2025.

Key Risks
The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the performance of the Trust, to better service our communities and support the work of the Wirral Place, and the Cheshire and Merseyside Integrate Care Board (ICB). The IPR directly supports mitigation across all risks in the Board Assurance Framework as it provides performance against quality, people, finance and operational metrics.

The Trust Vision
Populations – We will support our populations to thrive by optimising wellbeing and independence
People – We will support our people to create a place they are proud and excited to work
Place – We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

1	Implications
1.1	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 report by each Executive Director.

2	General guidance and Statistical Process Charts (SPC)
2.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.

	• Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend. **Blue dots signify a statistical improvement. A data point will highlight blue if it:** • Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance. • Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend. **Grey dots signify a pattern of variation is to be expected.** Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

NHS
Wirral Community Health and Care
NHS Foundation Trust

Integrated Performance Report - May 2025

Together...

we will support you and your community to live well.

Our values:

Compassion

Supportive and caring, listening to others.

Open

Communicating openly, honestly and sharing ideas.

Trust

Trusted to deliver, feeling valued and safe.

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

Turnover remained steady and within target at 9.3%, following recent reductions over the last 12 months.
Mandatory training remained steady and within target at 95.2%. All localities are over the 90% target, demonstrating strong commitment to this important safety measure.
Sickness Absence improved by 0.5% in May however remains an area of concern at 6.2% against a threshold of 5%. Both short term sickness long term sickness improved in month. Mental health conditions continue to be the most commonly occurring reason, accounting for 43% of all sickness absences.

Agency expenditure has remained low in May at 0.2% (against Funded WTE).

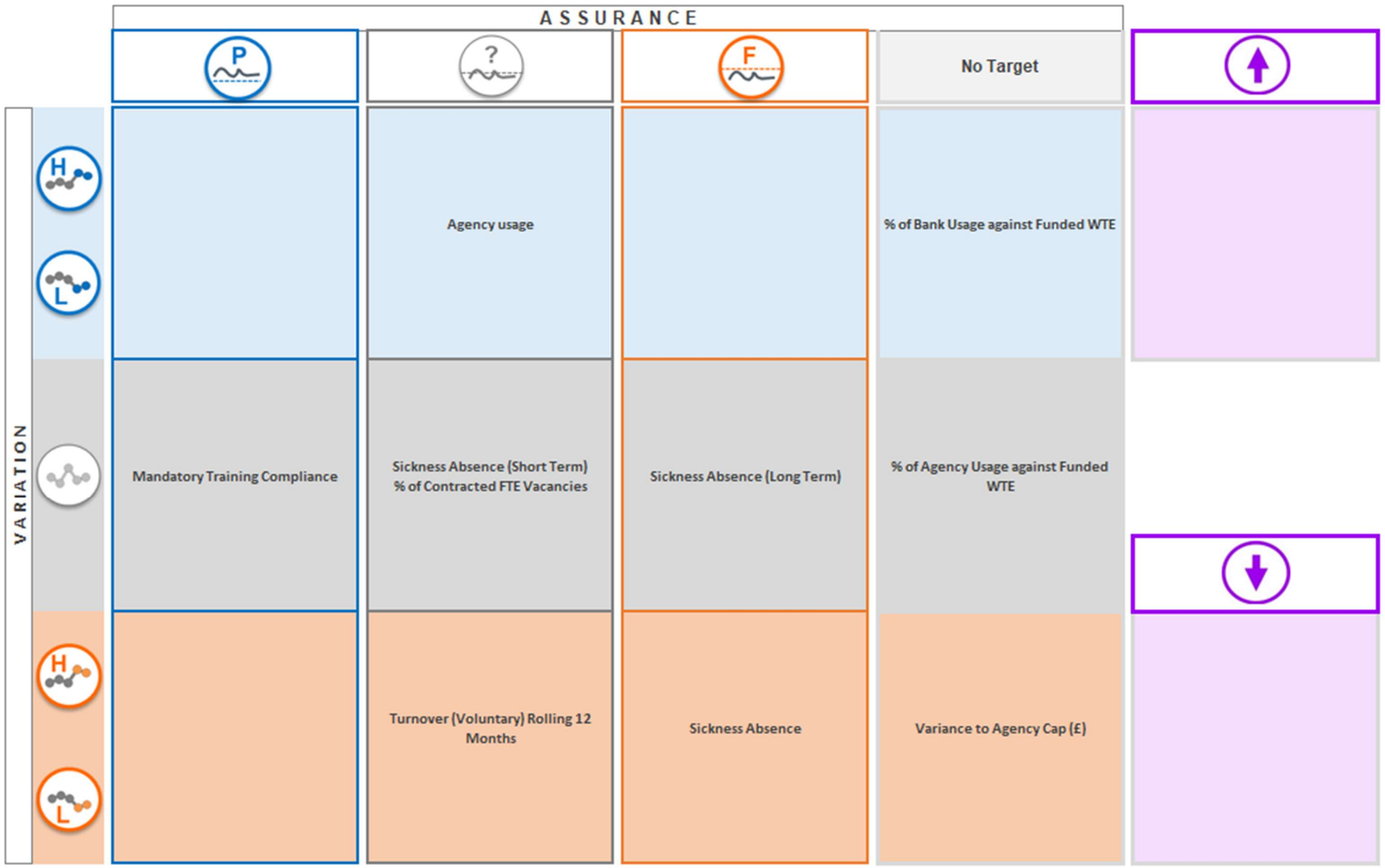
Highlights
Mandatory Training compliance is consistently above the target level and is a stable workforce metric.
Turnover has steadily reduced in line with national agenda to retain staff in line with the NHS People Promise and is below threshold.
Agency expenditure remains low.

Areas of Concern
Sickness absence is a cause for concern as it is above the target level at 6.2%. Significant focus is being placed on the appropriate management of sickness absence:

- "Return to Work" conversation compliance has improved by 40% from this period last year.
- Awareness sessions for EAP service have taken place and will continue throughout the year.
- Awareness sessions for Line Managers "Getting the best out of Occupational Health" have been delivered.
- Line manage training on Managing Attendance in line with Policy.
- Priority given to sickness absence in People and Culture Oversight Group, with a focus on local accountability.

Workforce Domain Matrix

Workforce

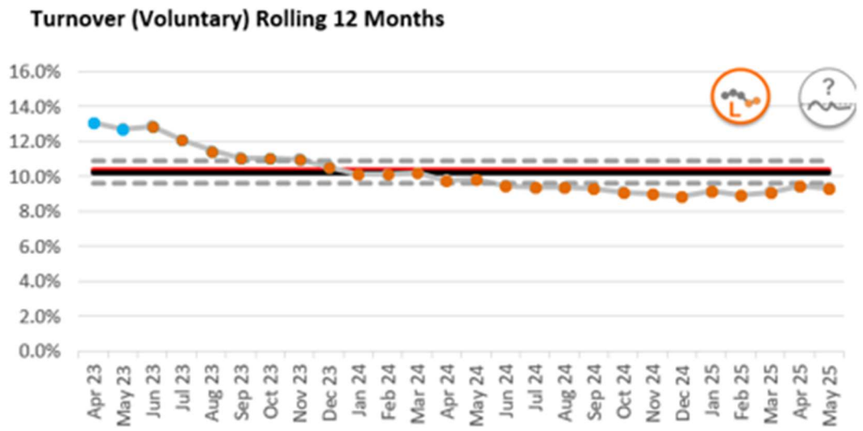


Workforce Summary

Highlights	Areas of Concern	Forward Look (Actions)
Mandatory Training compliance is consistently above the target level and is a stable workforce metric. Turnover has steadily reduced in line with national agenda to retain staff in line with the NHS People Promise and is below target rate.	Sickness absence is a cause for concern as it is above the target level at 6.2%	Significant focus on reducing sickness absence to target levels. Each locality has presented to People and Culture Oversight Group on the local action in place to address sickness absence. Priority has been placed on close management of absences in line with the Policy.

Turnover (Voluntary) – Rolling 12 Months

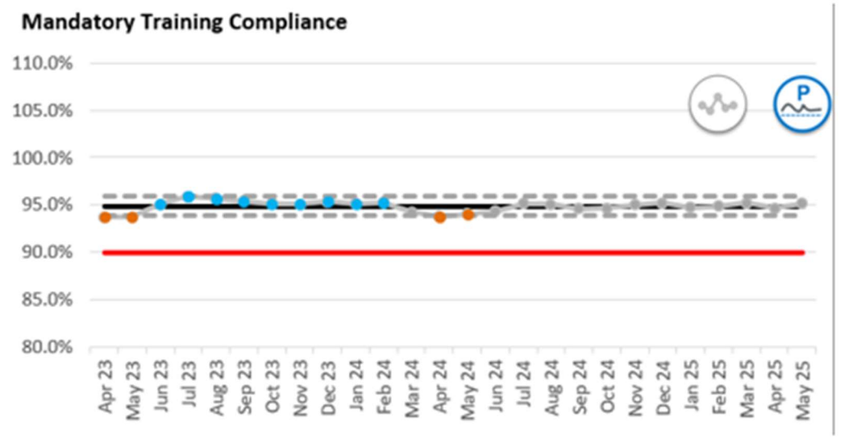
CQC Domain : Safe



May-25
9.3%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

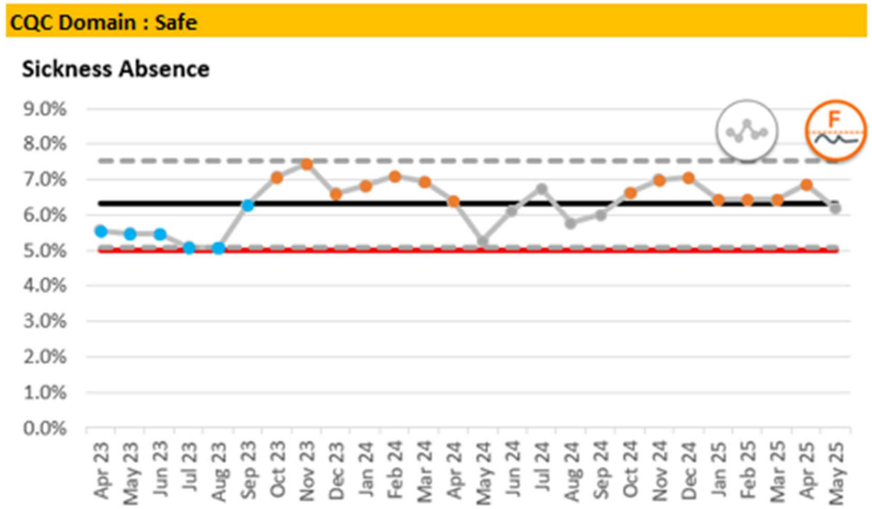
CQC Domain : Safe



May-25
95.2%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

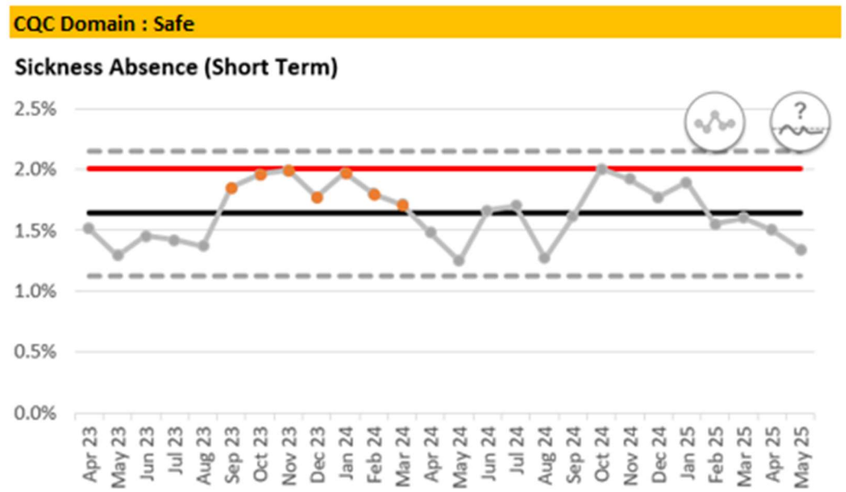
CQC Domain : Safe



May-25
6.2%
Variance Type
Special cause variation - Concerning
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

CQC Domain : Safe



May-25
1.3%
Variance Type
Common cause variation
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Commentary

Turnover has gradually been decreasing and is now below target. Training compliance is stable and well managed with consistent compliance with the KPI. Sickness absence is cause for concern and above acceptable levels.

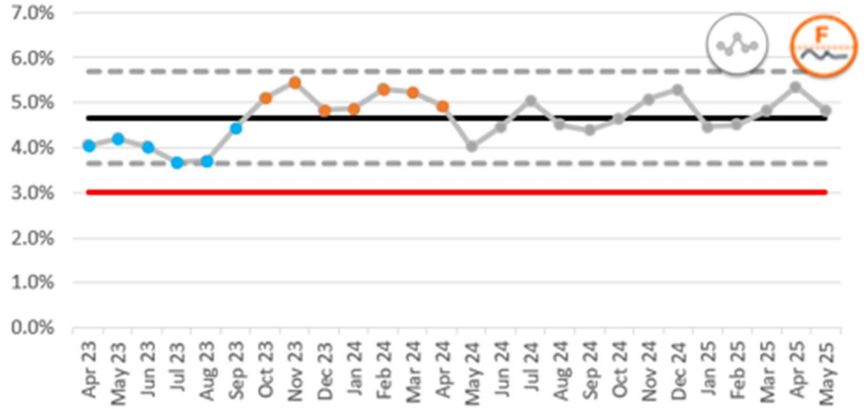
Reduced staffing levels due to sickness absence, leading to stress and burnout in staff and potential increased costs due to utilisation of Bank and Overtime staffing.

Focus on “Return to Work” conversation uptake and recording – monitored at PCOG and has improved to 70% up from 40% in July 2024. Training support including:

- Awareness sessions for EAP service taken place in March and more to be scheduled in Autumn
- Awareness sessions for Line Managers “Getting the best out of Occupational Health” 2 completed in Q1.
- Next training session for line managers on Managing Attendance taking place
- Focus on sickness absence in People and Culture Oversight Group

Sickness Absence (Long Term)

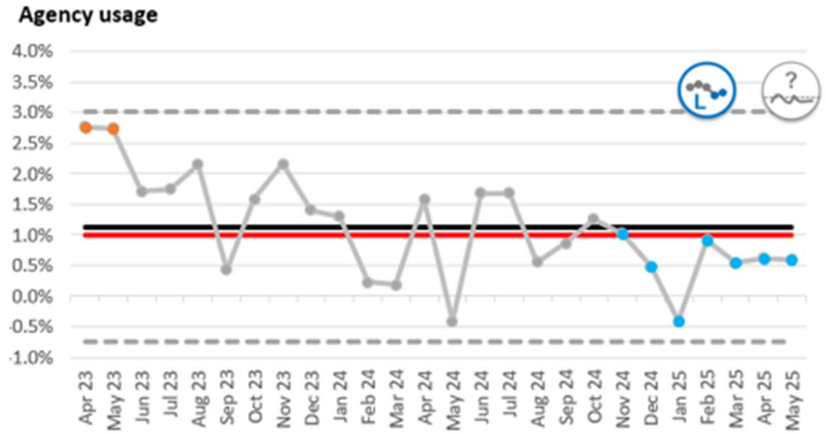
CQC Domain : Safe



May-25
4.8%
Variance Type
Common cause variation
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

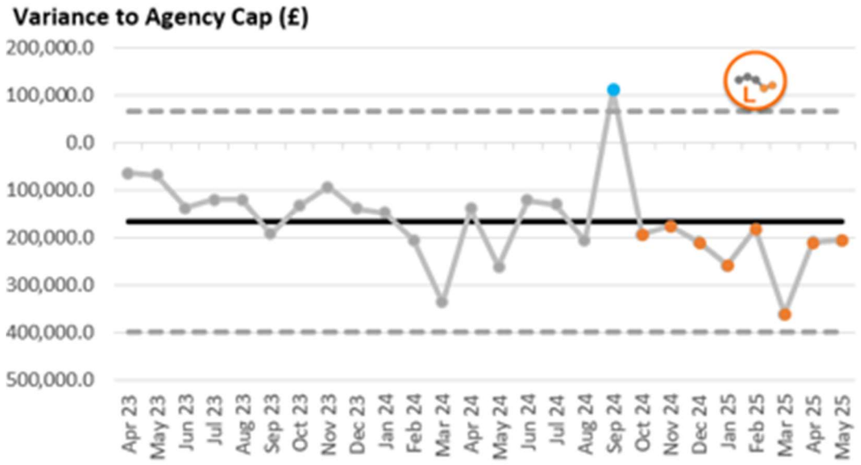
CQC Domain : Well-led



May-25
0.6%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

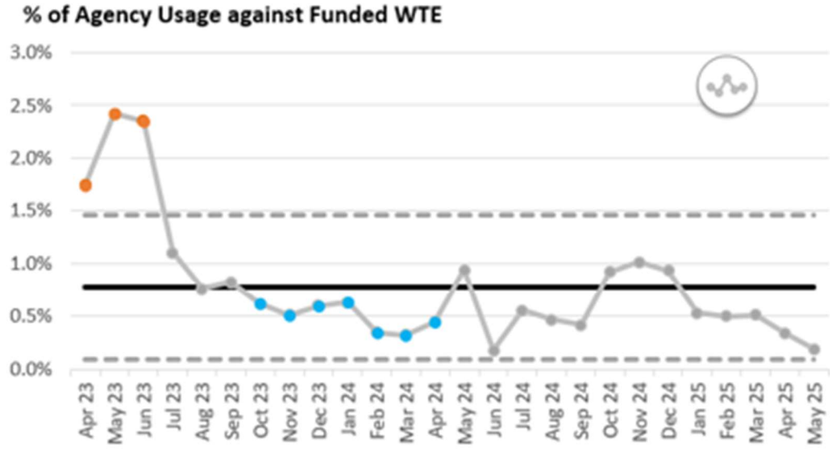
CQC Domain : Well-led



May-25
-£204,290.00
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

CQC Domain : Well-led



May-25
0.19%
Variance Type
Common cause variation
Threshold
Assurance

Commentary

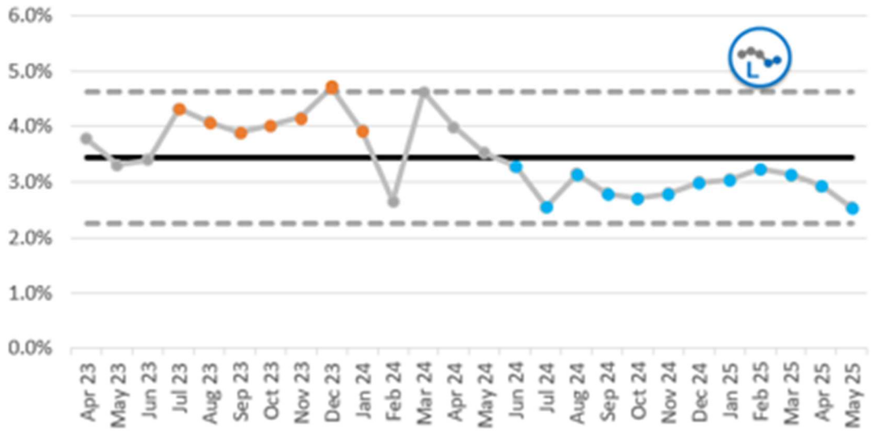
Minimal organisational use of agency staff, well below target and systems and processes in place to oversee utilisation.

Risk that the minimal use of agency will be driven by shortage occupations or difficult-to-fill posts.

Identification of opportunities to undertake substantive recruitment.

% of Bank Usage against Funded WTE

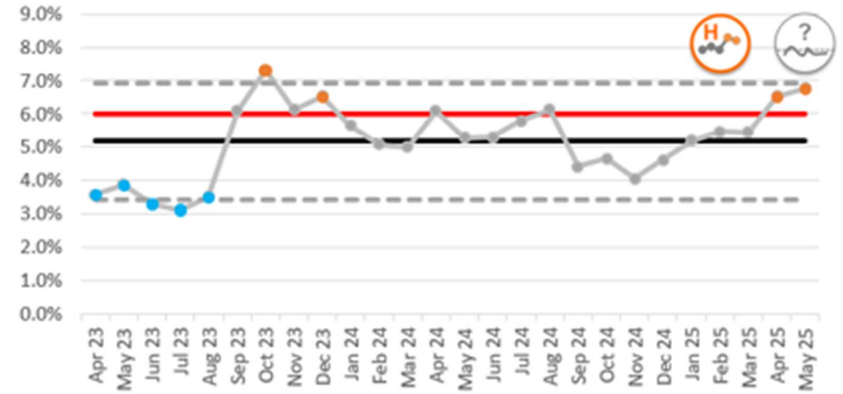
CQC Domain : Well-led



May-25
2.5%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led



May-25
6.80%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Commentary

Use of Bank staff has reduced over the past 2 years and has fluctuated between 2-3% and has been trending down since Jan 25.

Risks linked to staffing gaps on CICC, Community Nursing, GP Out of Hours and UTC and for covering sickness absence

Close monitoring of variable pay and inclusion in CIP workstream

Dashboard	Operations
Lead	Chief Operating Officer

Chief Operating Officer Update

Operational performance remains strong. There are 91 operational KPIs reportable to commissioners and the position for M2 25-26 is:

- 77 Green KPIs
- 7 Amber KPIs
- 8 Red KPIs

Highlights:

- Intermediate care - CICC occupancy (93.1%) and length of stay (16 days). Excellent performance in the bedded intermediate care unit, also supported by the community Home First service overperforming in-month achieving 179 discharges against a target of 170.
- UCR performance 88.2% against a 70% target.
- GPOOH UCAT 15 and 30 min responses above target.
- Waiting lists – RTT and DM01 100% and majority non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times
- 0-19/25 services – all key metrics across the four regional teams performing above target

Areas for improvement:

- 4 hour performance continues on its improvement trajectory (just shy of 95% target at 94.9%) and GPOOH CAS and 111 response times.

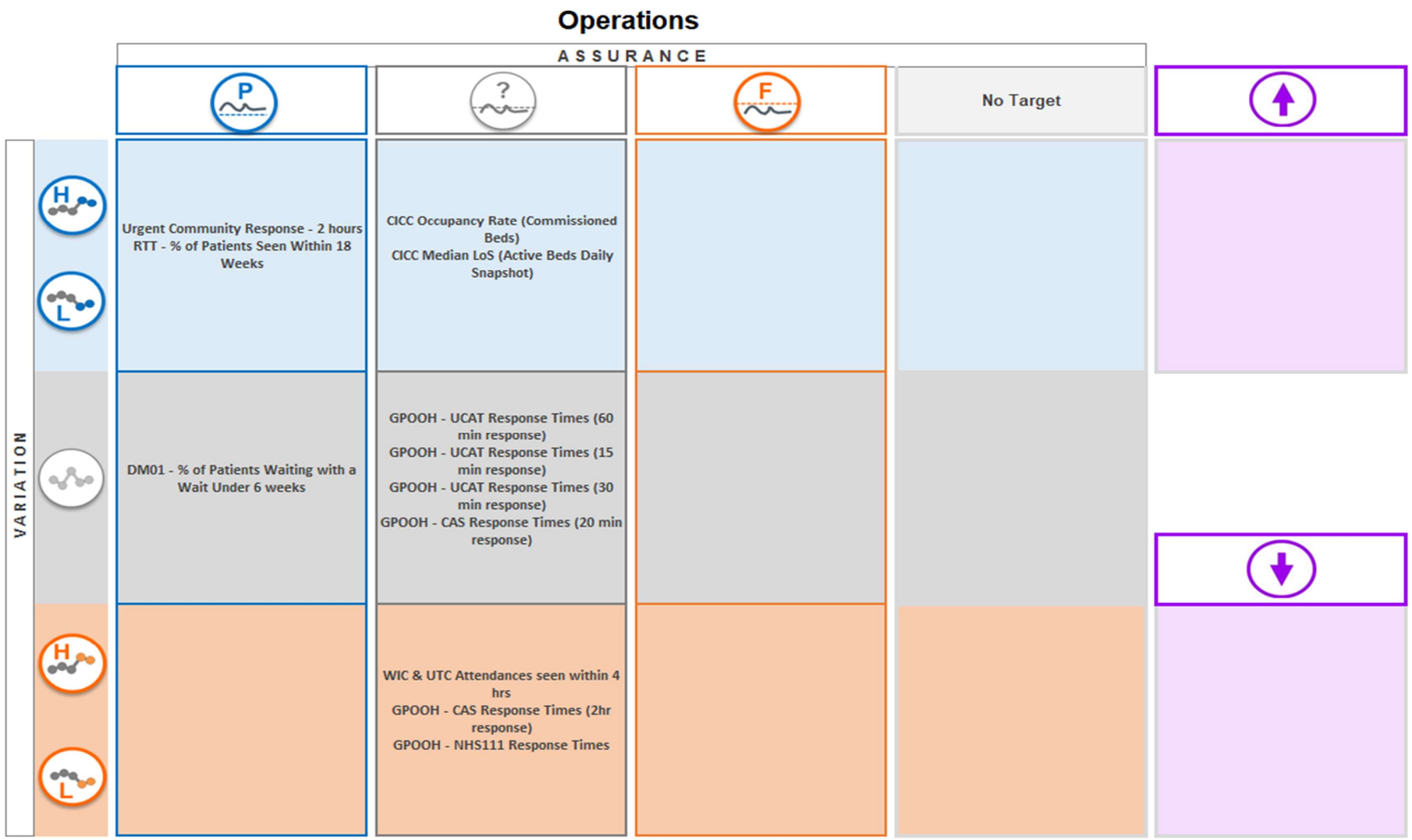
  Remedial action plans are in place to support performance improvements. Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies, reductions in sickness absence, daily huddles to review breach themes to drive learning, L&OD support

- Waiting lists: remedial action plans currently in place for Dental, Cardiology, Paediatric SALT services.

  All services are demonstrating improvements in wait times against agreed trajectories. Dental waits are related to volume of patients awaiting paediatric exodontia. Significant improvements in reducing the backlog and wait times since commencing the action plan in January 2025 with a 33% reduction in the waiting list. Cardiology performance challenges relate to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. This has been escalated formally with commissioners at the monthly Trust contract performance meeting and the service is working collaboratively with the ICB and Primary Care to agree a sustainable solution. Paediatric SALT continues to demonstrate month on month improvements on waiting times and reducing backlogs and is overperforming against the improvement trajectory agreed with local SEND Board.

Operational performance continues to be monitored via directorate SAFE/OPG meetings with key themes and escalations being highlighted and reviewed at the monthly Safe Operations Group (SOG) meeting. SOG reports to the monthly Integrated Performance Board where performance is triangulated with finance, HR and quality data.

Operations Domain Matrix

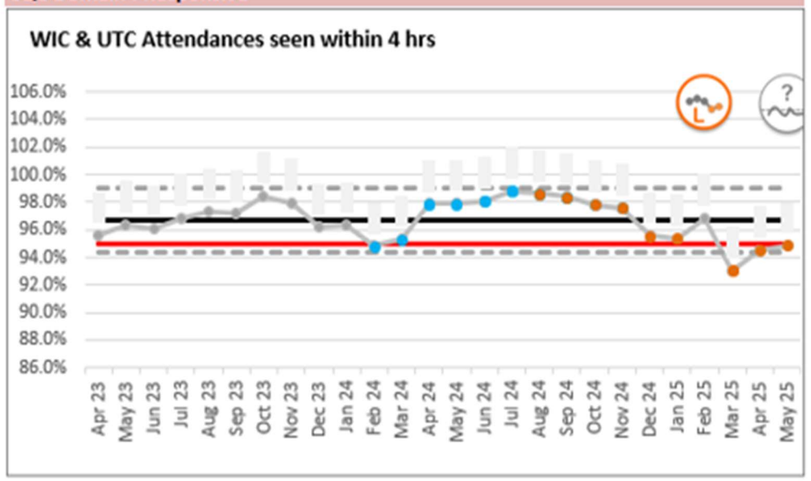


Operations Summary

Highlights	Areas of Concern	Forward Look (Actions)
• Intermediate care - CICC occupancy (93.1%) and length of stay (16 days). • UCR performance 88.2% against a 70% target. • GPOOH UCAT 15 and 30 min responses above target. • Waiting lists – RTT and DM01 100% and majority non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times • 0-19/25 services – all key metrics across the four regional teams performing above target	• 4 hour performance • GPOOH CAS and 111 response times. • Waiting lists: Dental, Cardiology, Paediatric SALT services.	• Continue with strong performance in over achieving areas • Remedial action plans are in place to support performance improvements for 4 hour performance and GPOOH. • Waiting lists: remedial action plans currently in place for Dental, Cardiology, Paediatric SALT services.

WIC & UTC Attendances seen within 4 hrs

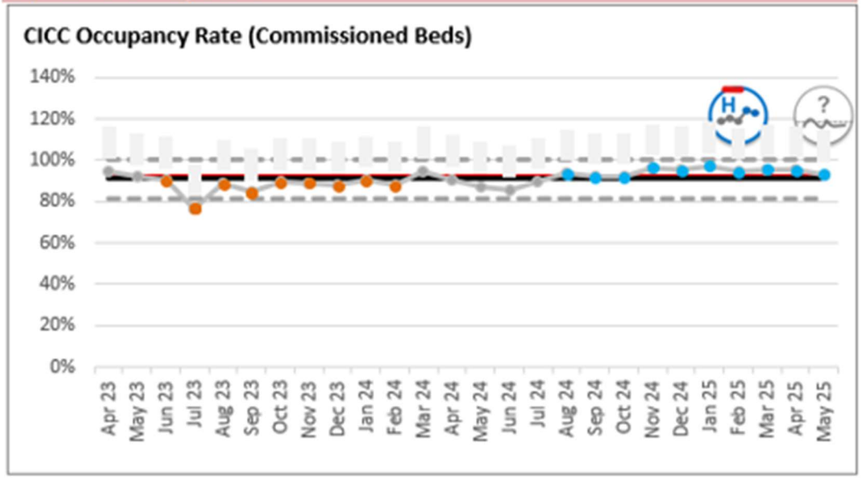
CQC Domain : Responsive



May-25
95%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CICC Occupancy Rate (Commissioned Beds)

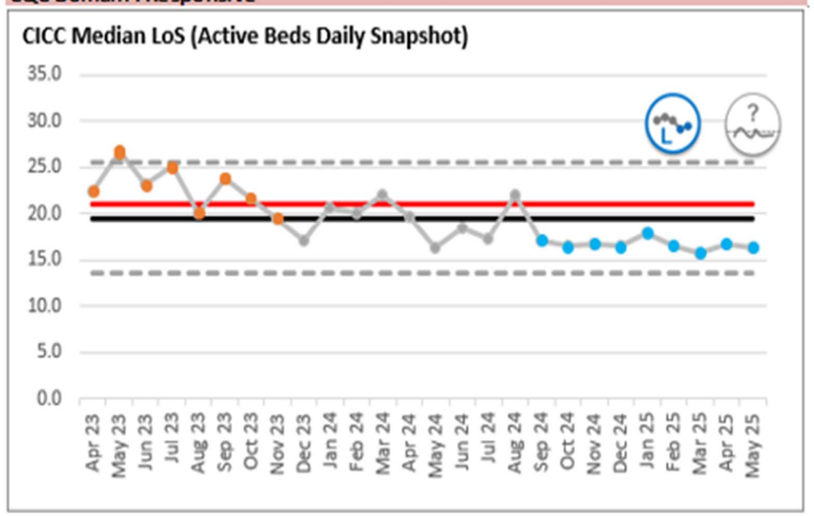
CQC Domain : Responsive



May-25
93.1%
Variance Type
Special cause variation - Improving
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

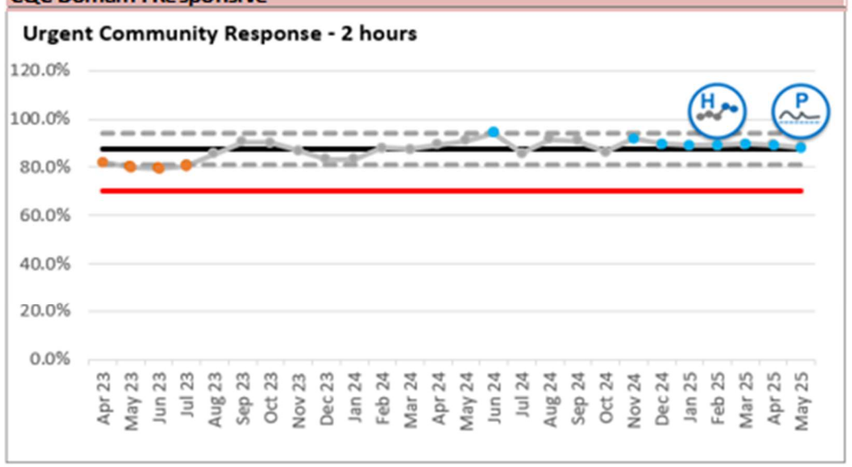
CQC Domain : Responsive



May-25
16
Variance Type
Special cause variation - Improving
Threshold
21
Assurance
Hit & miss target subject to random variation

Urgent Cmmunity Response - 2 hours

CQC Domain : Responsive



May-25
88.2%
Variance Type
Special cause variation - Improving
Threshold
≥70%
Assurance
Consistanly hit target

Commentary

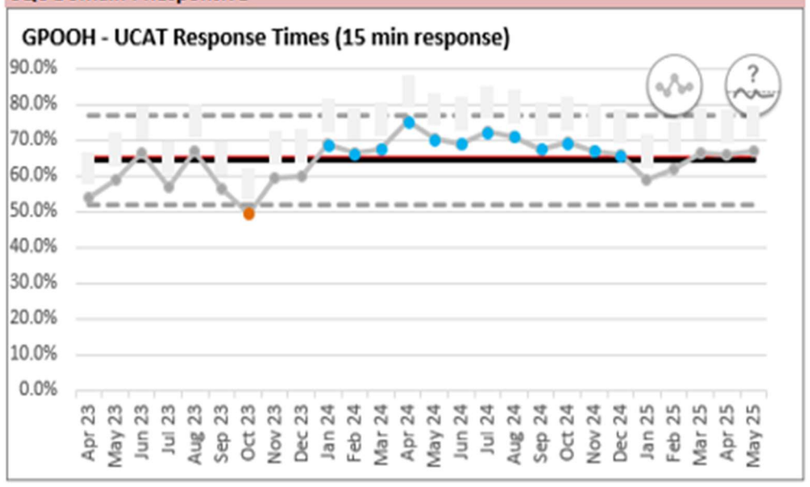
4 hour performance continues on its improvement trajectory (just shy of 95% target at 94.9%). Remedial action plans are in place to support performance improvements. Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies, reductions in sickness absence, daily huddles to review breach themes to drive learning, L&OD support

CICC occupancy (93.1%) and length of stay (16 days) excellent, sustained strong performance above averages for last 12 months.

UCR no concerns.

GPOOH - UCAT Response Times (15 min response)

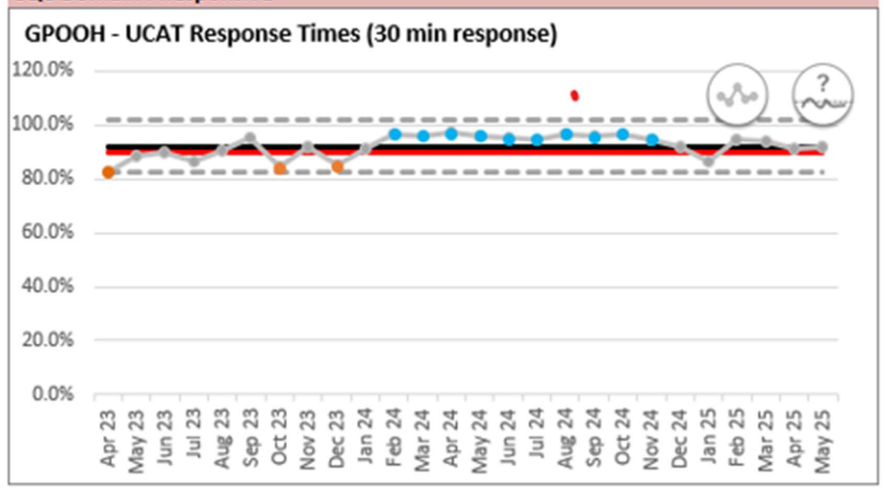
CQC Domain : Responsive



May-25
66.7%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

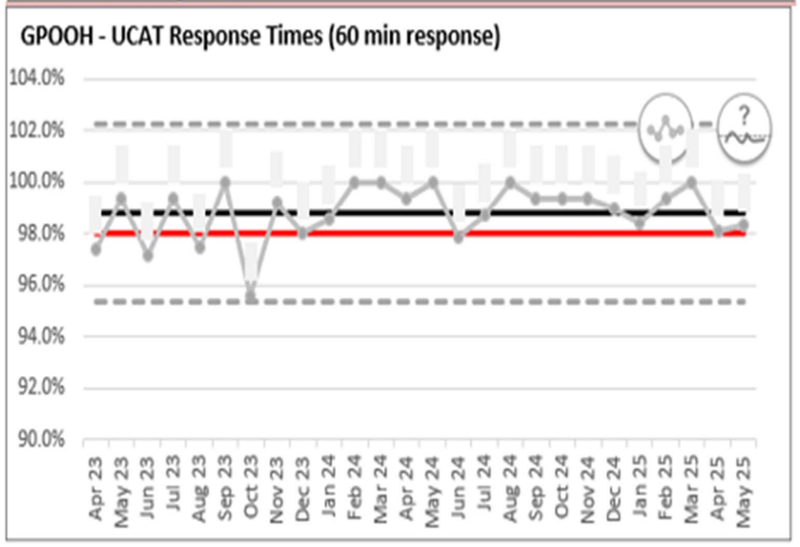
CQC Domain : Responsive



May-25
92.1%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

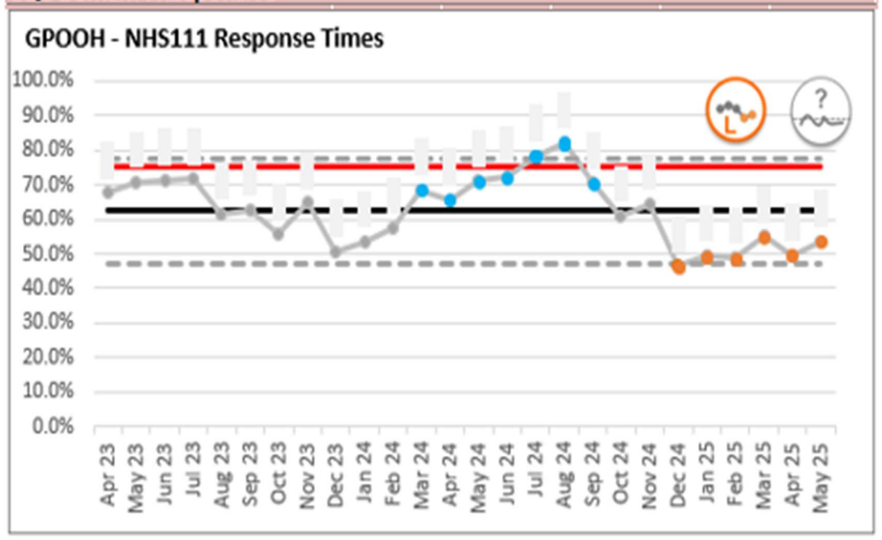
CQC Domain : Responsive



May-25
98.3%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive



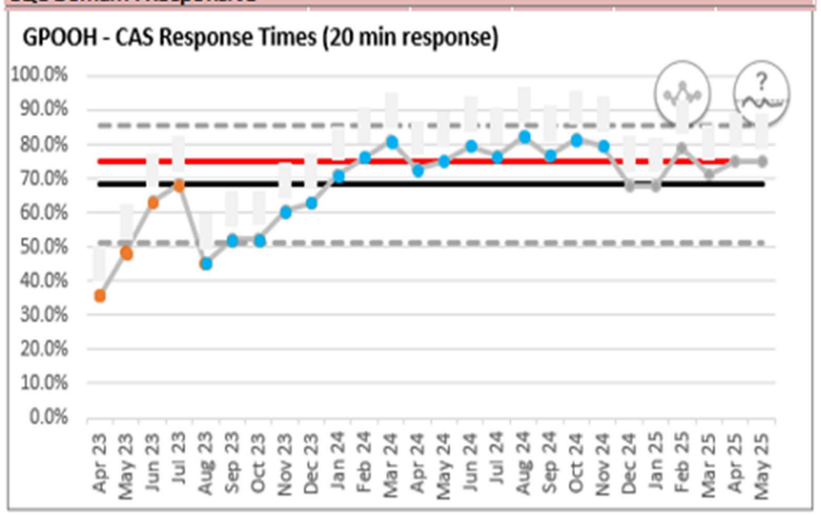
May-25
53.5%
Variance Type
Special cause variation - Concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

GPOOH CAS and 111 response times. Strong performance in UCAT (15, 30 and 60 mins) and CAS20 stable, however CAS 2 hour and 111 performance below target. Remedial action plans are in place to support performance improvements. Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies, reductions in sickness absence, daily huddles to review breach themes to drive learning, L&OD support

GPOOH - CAS Response Times (20 min response)

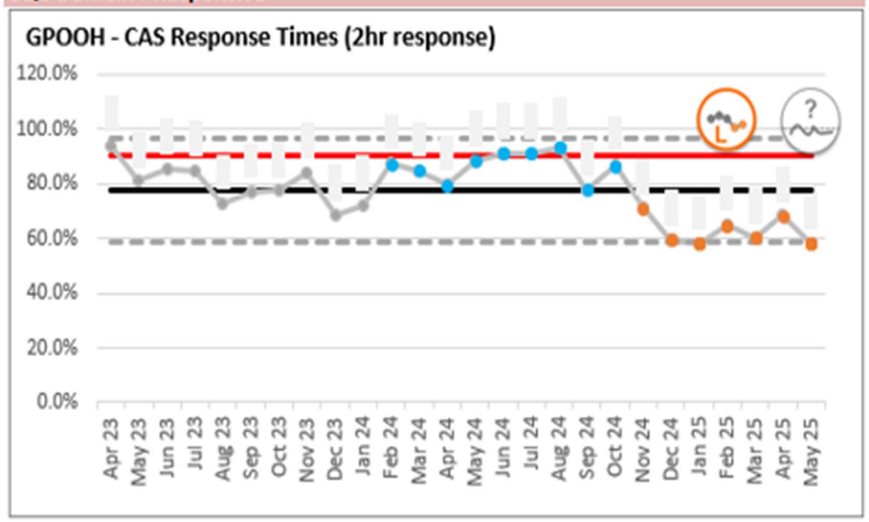
CQC Domain : Responsive



May-25
75%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

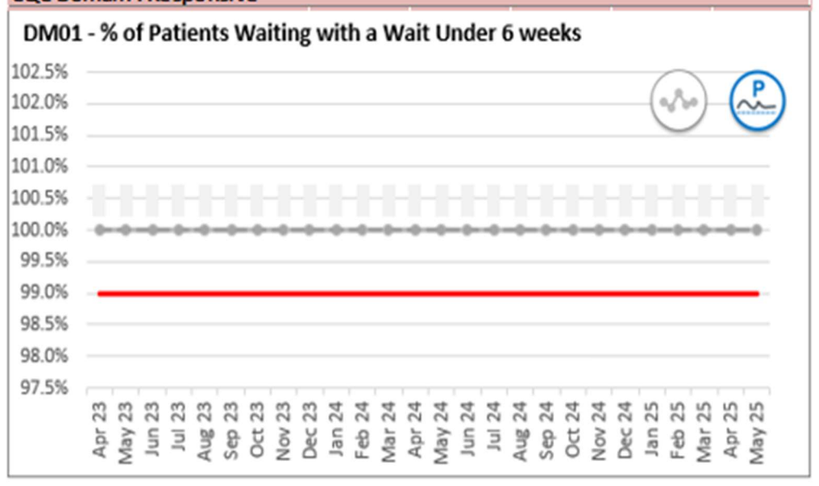
CQC Domain : Responsive



May-25
58.3%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

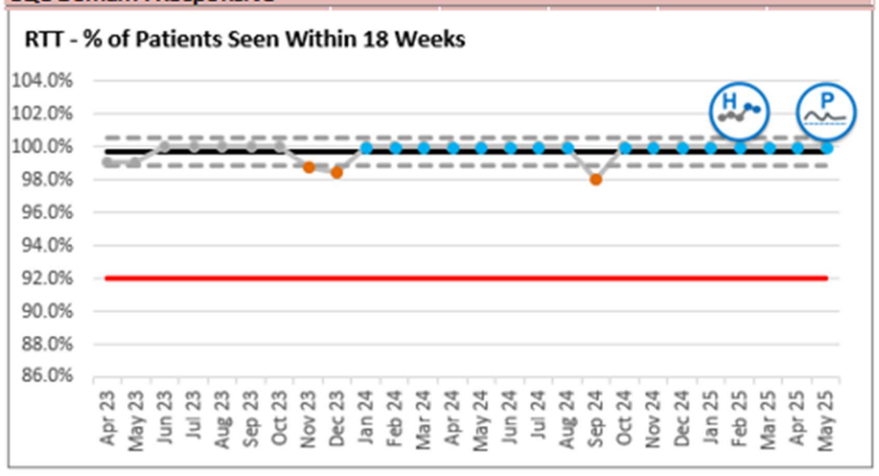
CQC Domain : Responsive



May-25
100%
Variance Type
Common cause variation
Threshold
≥99%
Assurance
Performance consistently achieves the target

RTT- % of Patients seen within 18 Weeks

CQC Domain : Responsive



May-25
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target

Commentary

DM01/RTT – 100% no concerns

Waiting List

Waiting list movement in Month - May 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	91% (5%)	99% (0%)	100% (0%)	360 (246)
Specialist Medical	80% (7%)	98% (1%)	100% (0%)	2804 (105)
Specialist Medical - Dental	32% (6%)	51% (12%)	61% (12%)	235 (39)
Therapies	51% (3%)	76% (-1%)	90% (2%)	5437 (63)

(percentage figure in brackets indicates movement since previous month)

0-19/25 Performance

0-19/25 Services - May 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	87.2%	88.6%	91.4%	90.0%	94.4%	94.7%	95.6%	95.3%
12 month reviews	93.4%	91.7%	89.1%	89.9%	94.7%	95.7%	91.8%	91.2%
2.5 year reviews	89.2%	88.2%	81.9%	86.4%	91.7%	92.1%	90.2%	91.0%
Breastfeeding 6-8 weeks	62.5%	58.2%	36.9%	36.1%	40.7%	41.6%	42.9%	42.8%

Commentary

Waiting Lists. The average waiting time for all services is below 18 weeks and each directorate demonstrating improvements in the volume of patients waiting. Remedial action plans currently in place for Dental, Cardiology, Paediatric SALT services.

Dental waits are related to volume of patients awaiting paediatric exodontia. Significant improvements in reducing the backlog and wait times since commencing the action plan in January 2025 with a 33% reduction in the waiting list. This improvement has been driven through collaborative working with WUTH colleagues for additional out of hours theatre sessions. A risk to sustainability of this improved position however is the requirement for an additional in-hours theatre session per week. Operational leads continue to work with WUTH colleagues on a resolution for this.

Cardiology performance challenges relate to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. This has been escalated formally with commissioners at the monthly Trust contract performance meeting and the service is working collaboratively with the ICB and Primary Care to agree a sustainable solution.

Paediatric SALT continues to demonstrate month-on-month improvements on waiting times and reducing backlogs and is overperforming against the improvement trajectory agreed with local SEND Board. However, there remains an ongoing risk with regards to additional substantive funding from the ICB for the required additional resource to sustain the current position.

0-19/25 services. No concerns, all key metrics across the four regional teams performing above target

Dashboard	Quality and Governance
Lead	Chief Nurse

Chief Nurse Update

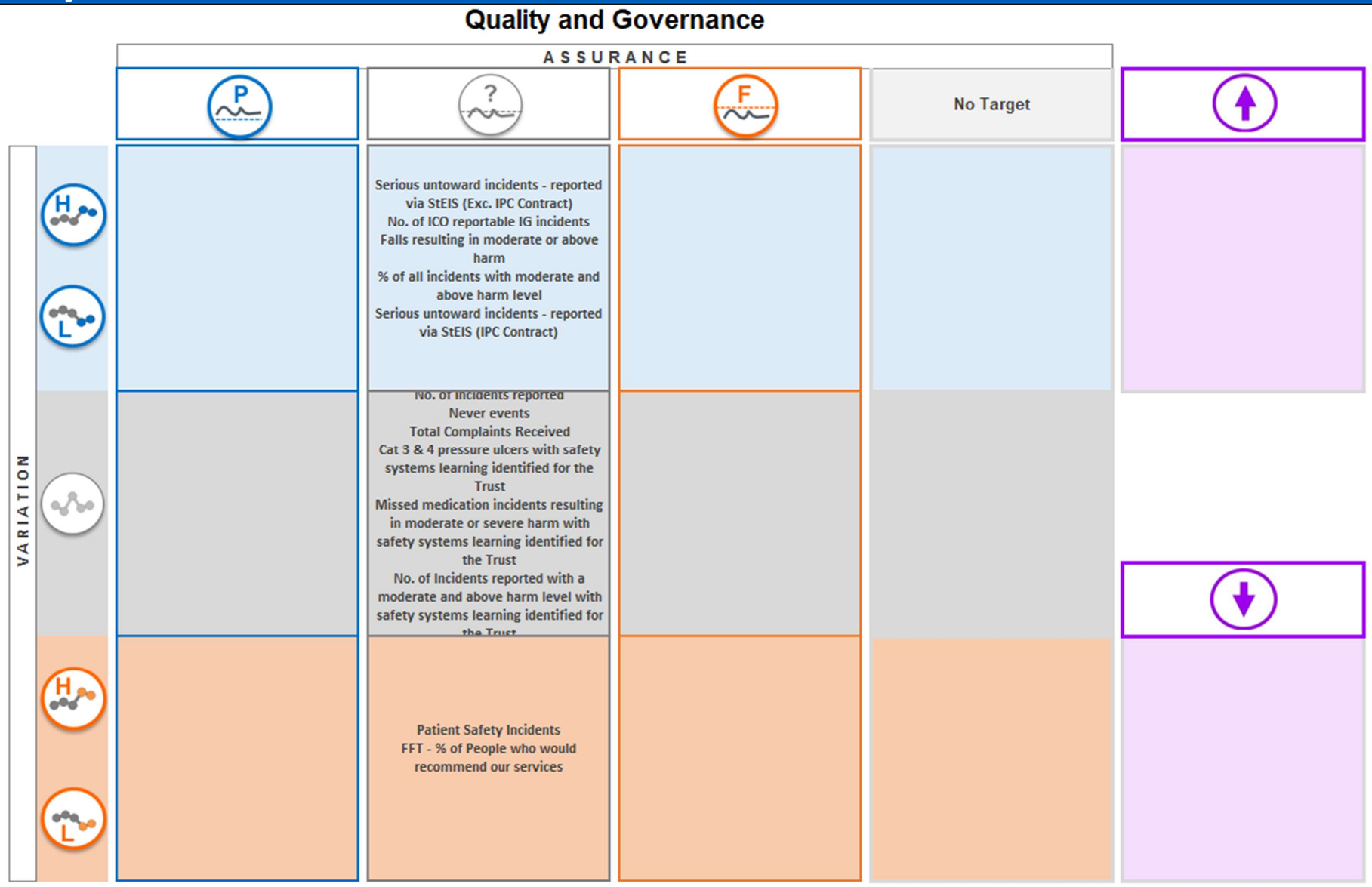
This report provides assurance that a positive patient safety system continues to exist across the Trust.

During the reporting period (M1-2), there have been no reported never events, IGO or StEIS reportable incidents.

During M2, there has been one fall at CICC resulting in severe harm. This is being investigated in accordance with Trust policy to further strengthen safety systems. Learning will be incorporated into the Trust's falls quality improvement plan reporting to the Clinical Risk Management Group.

Friends and family test continues to reflect a positive experience for the majority of our service users, with a M1 position of 92.6% based on 2,201 responses.
During M2, there was a reduction in the number of responses received. 405 responses were received compared to an average of circa 2500. This is due to errors in the commissioned text messaging service. As risk has been escalated in respect of this issue and mitigations are being considered.

Quality and Governance Domain Matrix

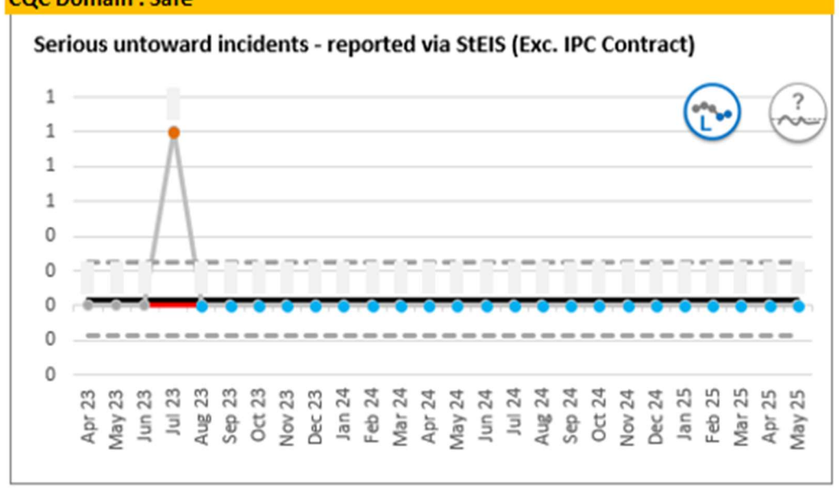


Quality and Governance Summary

The matrix provides assurance that a positive patient safety system exists across the Trust.	No specific areas of concern are identified.	Clinical Risk Management Group continue to track improvement plans relating to falls prevention on inpatient units, missed medication incidents, wound management and end of life improvements. All plans have demonstrated improvements in Trust wide safety systems and their consistent application.

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

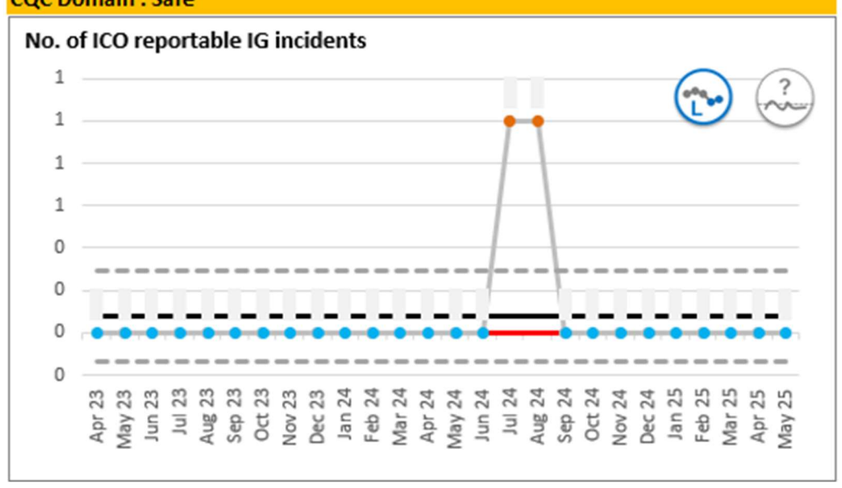
CQC Domain : Safe



May-25
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

No. of ICO reportable IG incidents

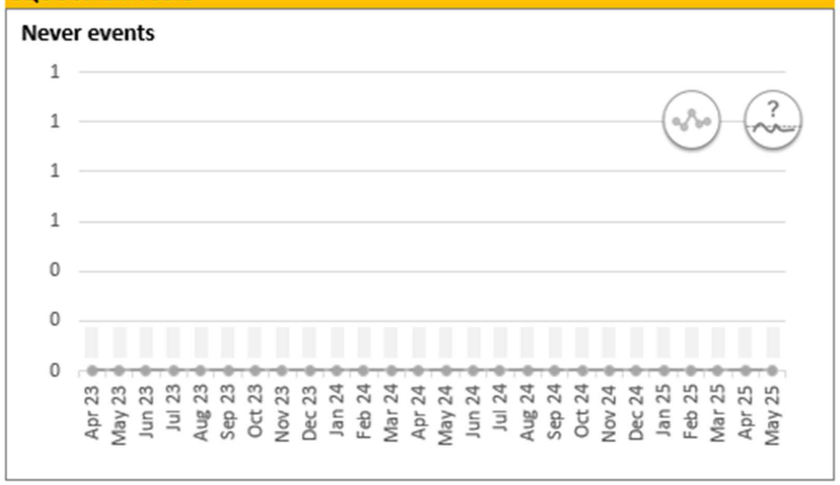
CQC Domain : Safe



May-25
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events

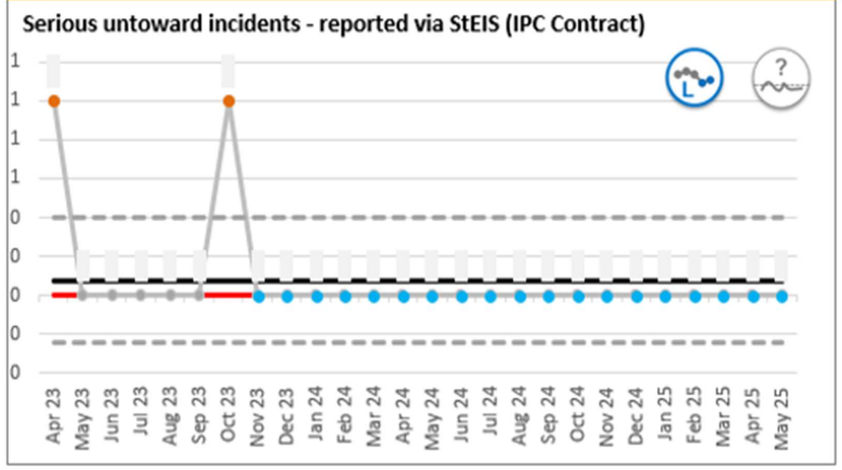
CQC Domain : Safe



May-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Serious untoward incidents – reported via StEIS (IPC Contract)

CQC Domain : Safe



May-25
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Commentary

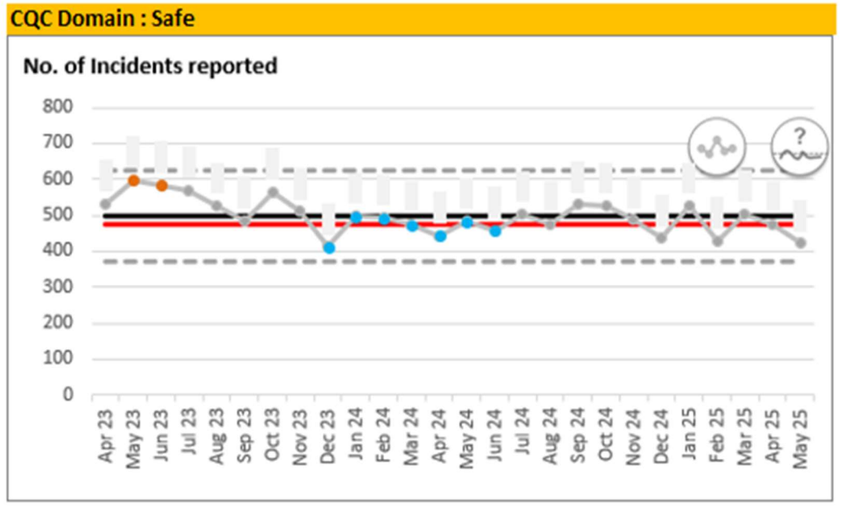
The above indicators all have tolerances of 0.

During the reporting period (M1-2), there have been no reported incidents relating to any of these indicators.
The 25/26 M2 position relating to ICO reportable incidents is 0.

During 2024/25, 2 ICO reportable incidents occurred during months 4 and 5, after which an improvement plan was implemented. There have been no further reportable incidents since August 2024.

Number of Incidents reported

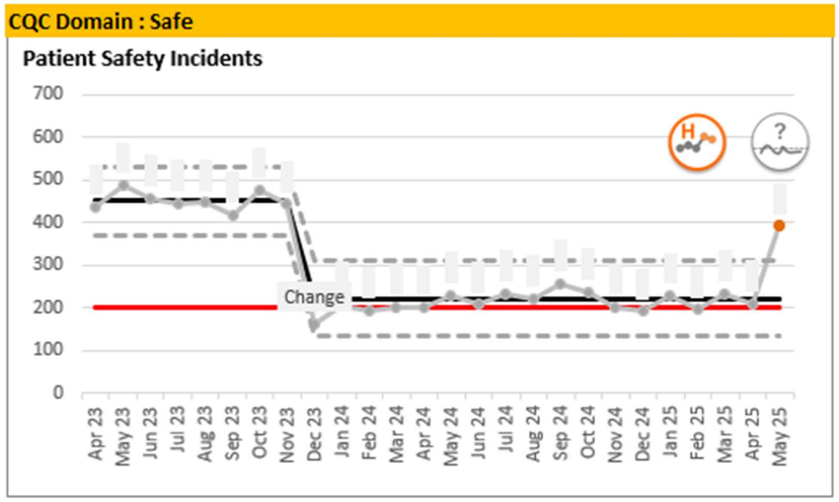
CQC Domain : Safe



May-25
421
Variance Type
Common cause variation
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

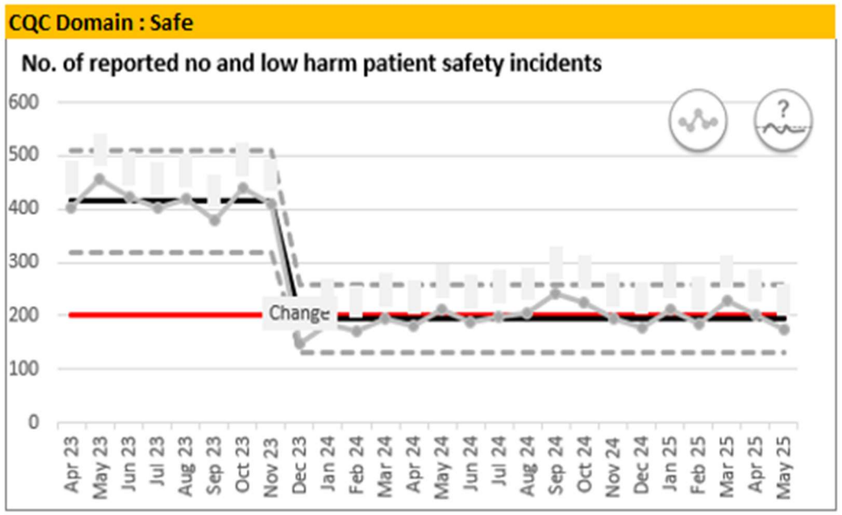
CQC Domain : Safe



May-25
391
Variance Type
Special cause variation - Concerning
Threshold
200
Assurance
Hit & miss target subject to random variation

No. of reported no and low harm patient safety incidents

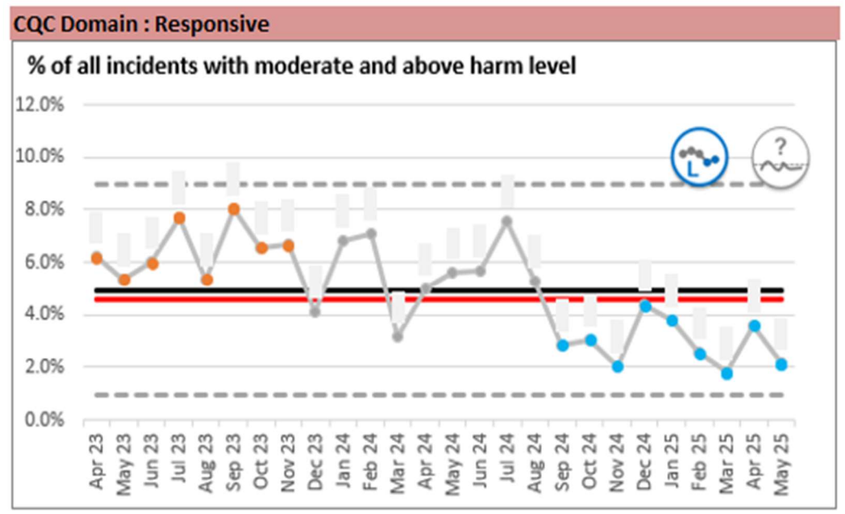
CQC Domain : Safe



May-25
174
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

% of all incidents with moderate and above harm level

CQC Domain : Responsive



May-25
2.1%
Variance Type
Special cause variation - Improving
Threshold
4.6%
Assurance
Hit & miss target subject to random variation

Commentary

Incident reporting is an effective measure of safety culture across an organisation. The data above indicates that incident reporting has remained within normal variation throughout the reporting period.

The number of low and no harm incidents remains within common cause variation and represents 96.2% of patient safety incidents reported during M2.

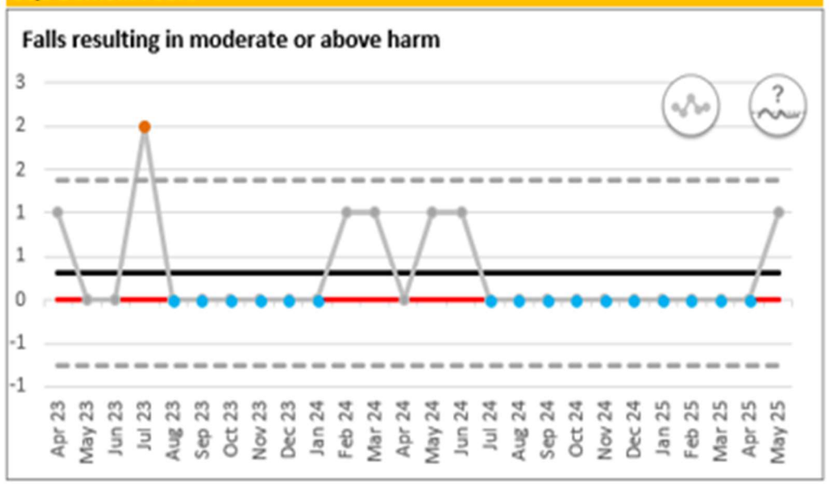
A M2 position of 2.1% of all incidents reported reach the threshold of moderate and above harm. These indicators reflect a positive reporting culture and high level of thematic learning resulting from low and no harm incidents which is aligned to PSIRF principles.

The change noted in December 2023 reflects the move from the National Reporting Learning System (NRLS) to the Learn from Patient Safety Events (LFPSE) system which focuses on NHS funded care for incident reporting.

In December 23, there was a reduction in incident reporting, which was lower than expected. A communication plan was implemented which reinforced NHS England guidance on what constitutes an LFPSE reportable patient safety event and guidance on completing the new Datix form. Since the initial month the number of patient safety incidents has settled into a pattern of normal variation.

Falls resulting in moderate or above harm

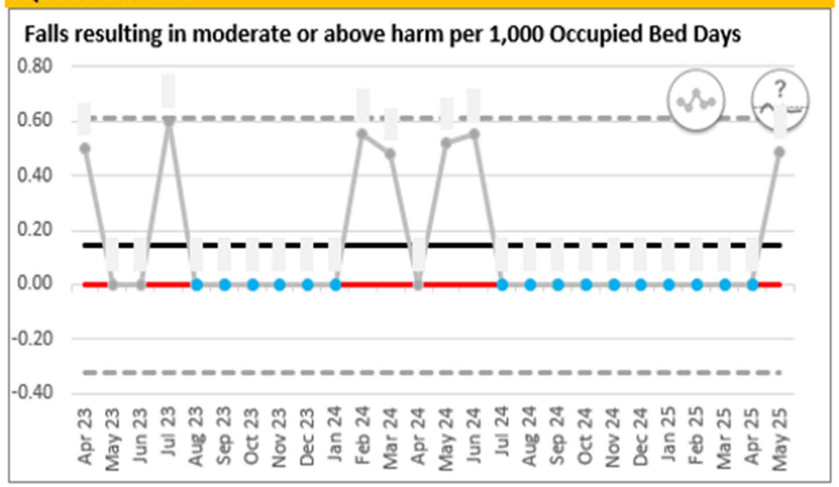
CQC Domain : Safe



May-25
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

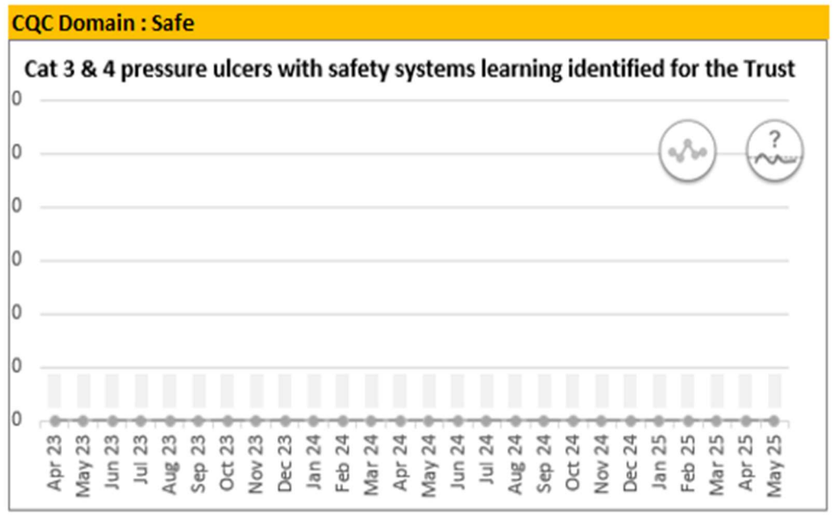
CQC Domain : Safe



May-25
0.49
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

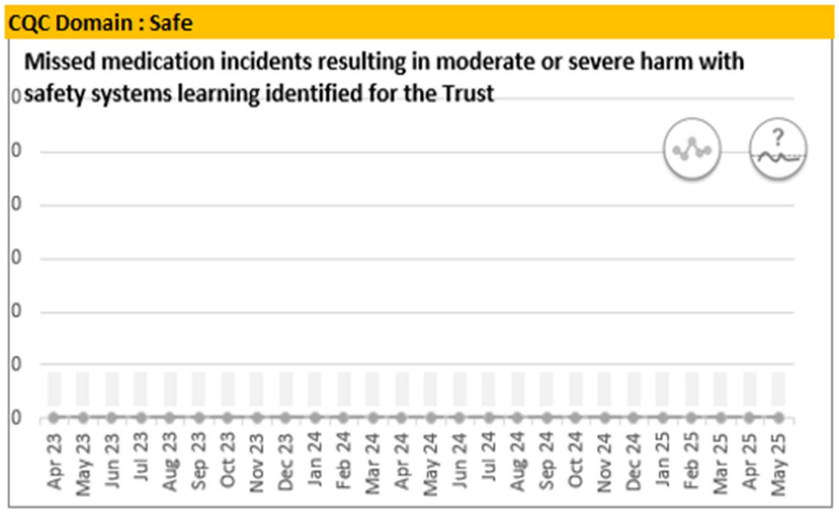
CQC Domain : Safe



May-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Safe



May-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Commentary

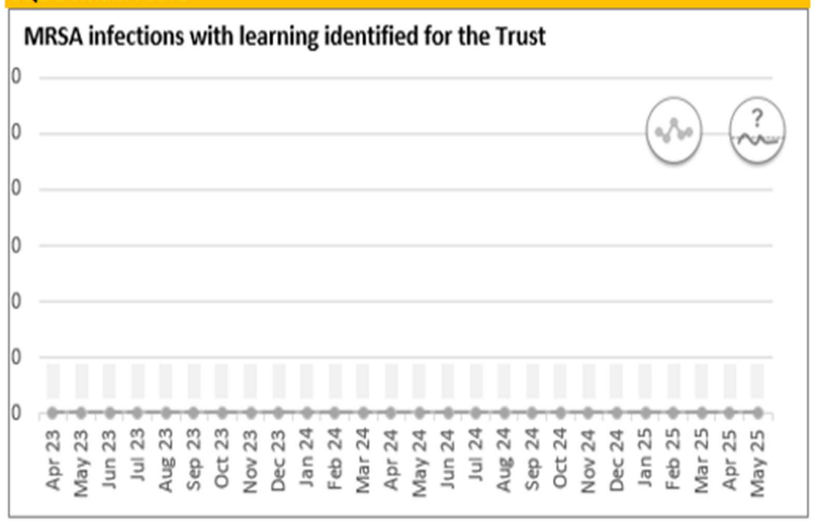
In accordance with the Patient Safety Incident Response Framework (PSIRF) the Trust have embedded a robust governance structure to identify safety systems learning for all moderate and above harm incidents.

During the reporting month, there has been one fall at CICC resulting in severe harm; this is being investigated in accordance with Trust policy to further strengthen safety systems. Learning will be incorporated into the Trust's falls quality improvement plan reporting to the Clinical Risk Management Group, which also tracks and monitors improvements in relation to medication incidents, indwelling urinary catheter devices, wound management and end of life care.

All plans have demonstrated improvements in Trust wide safety systems and their consistent application.

MRSA infections with learning identified for the Trust

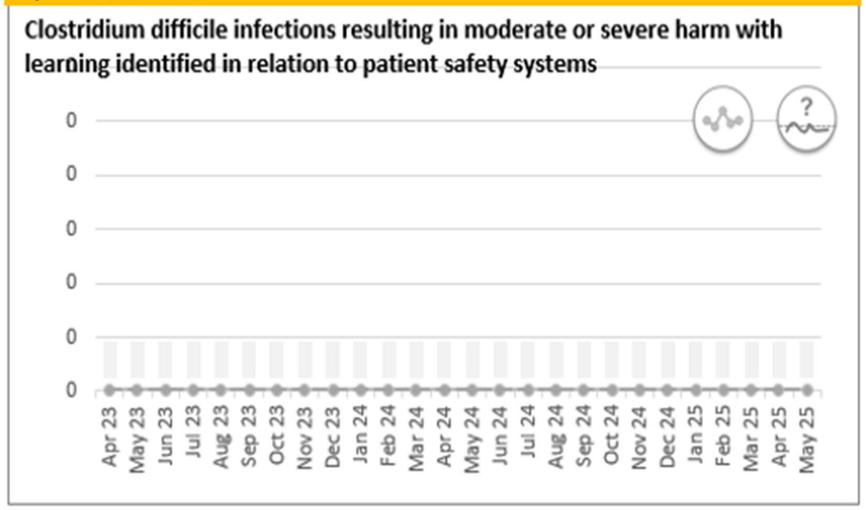
CQC Domain : Safe



May-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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

CQC Domain : Safe



May-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

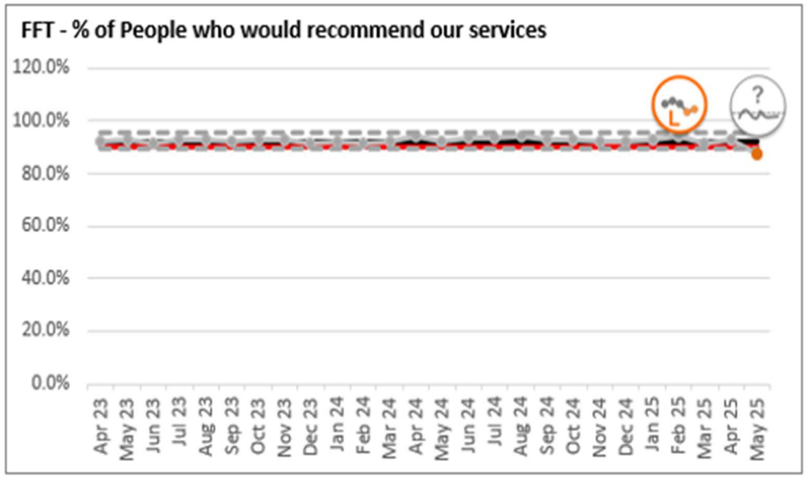
Commentary

There have been no incidents of MRSA or CDiff resulting in moderate or severe harm with learning identified in relation to patient safety systems.

Wirral is an outlier for C.diff cases nationally, a strategy has been developed with system partners to progress key workstreams across four pillars; Public Health/ICB, Primary and Domiciliary Care, Community(including complex care settings) settings and Hospital settings.

FFT - % of People who would recommend our services

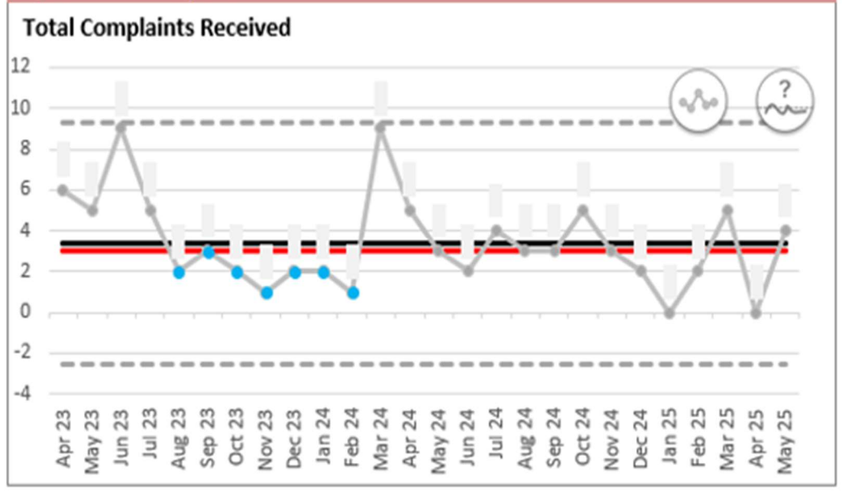
CQC Domain : Safe



May-25
87.3%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

Total Complaints Received

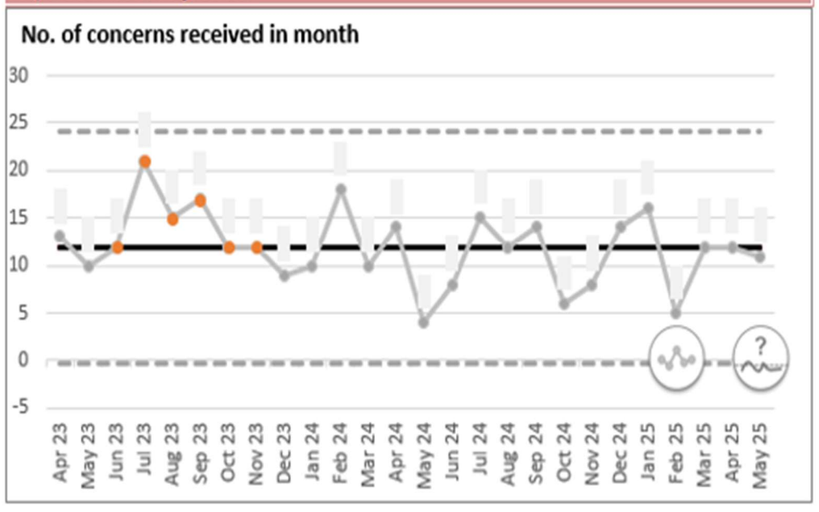
CQC Domain : Responsive



May-25
4
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month

CQC Domain : Responsive



May-25
11
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

Commentary

Friends and family test continues to reflect a positive experience for the majority of our service users, with a M1 position of 92.6% based on 2,201 responses.

During M2, there was a reduction in the number of responses received. 405 responses were received compared to an average of circa 2500. This is due to errors in the commissioned text messaging service. A risk has been escalated in respect of this issue and mitigations are being progressed.

All complaints are thoroughly investigated and opportunities for learning embedded in service improvements.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of May, M2, the Trust is reporting a deficit of £0.3m, broadly in line with plan.

The Trust is below plan in respect of income, due to delays in agreeing the 0-19 contracts, and in respect of non-pay, with pressures in respect of estates and supplies and services. However, this is fully mitigated by under spends on pay driven by vacancies across the Trust.

At M2 the Trust is slightly ahead of its CIP position and has transacted £4.4m against its revised target of £6.6m.

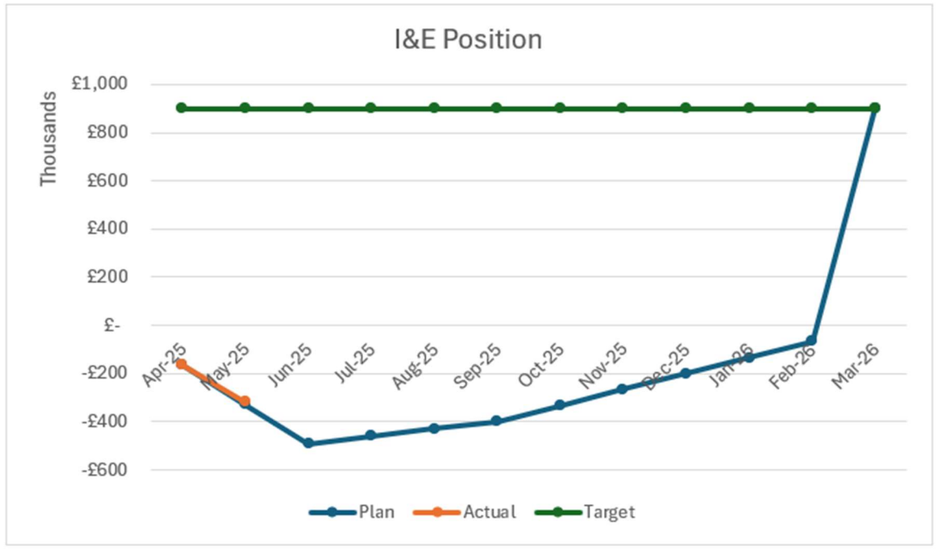
The key risks facing the Trust relate to the negotiations around the 0-19 service and over £1.2m of the CIP plans still categorised as high risk. An update on both of these issues will be provided at the next Board meeting.

Finance Domain Matrix

Finance Summary

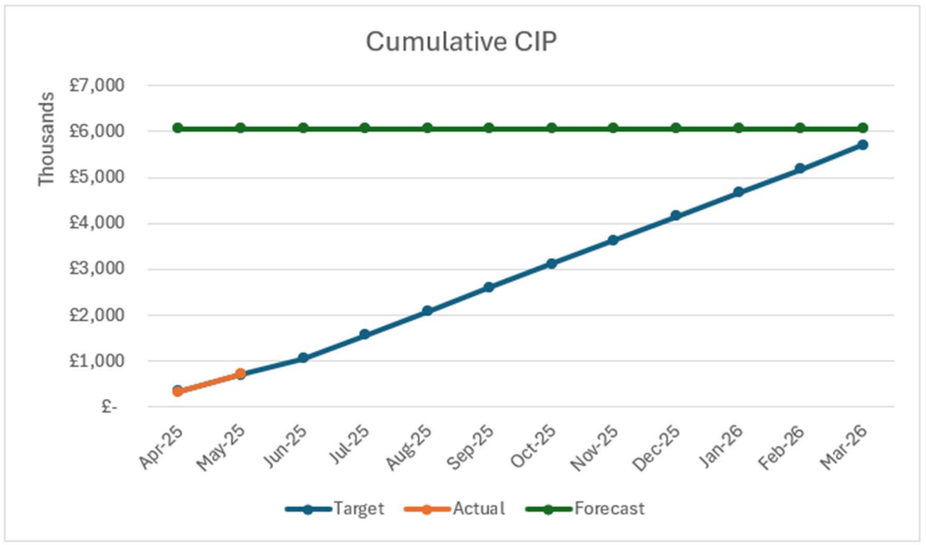
Highlights	Areas of Concern	Forward Look (Actions)
At Month 2 the Trust is reporting it is £10k ahead of plan of the Submitted £327k deficit. The Trust is £13k ahead of plan on CIP in month 2 however this is based on the submitted annual plan of £5.7m The Trust is not currently reporting any capital spend at month 2 as the schemes progress through POG but expecting to report delivery in month 3.	Whilst the Trust is broadly on plan in relation to CIP and I&E position at month 2 the Trust is still working to improve its expenditure run rate as CIP delivery is expected to increase from month 4 and there is currently a backend stretch target in month 12.	The Trust continues to look at identify additional CIP schemes, Looking to reduce expenditure where possible as well as Tracking capital and cash position over the next few months.

I&E Position



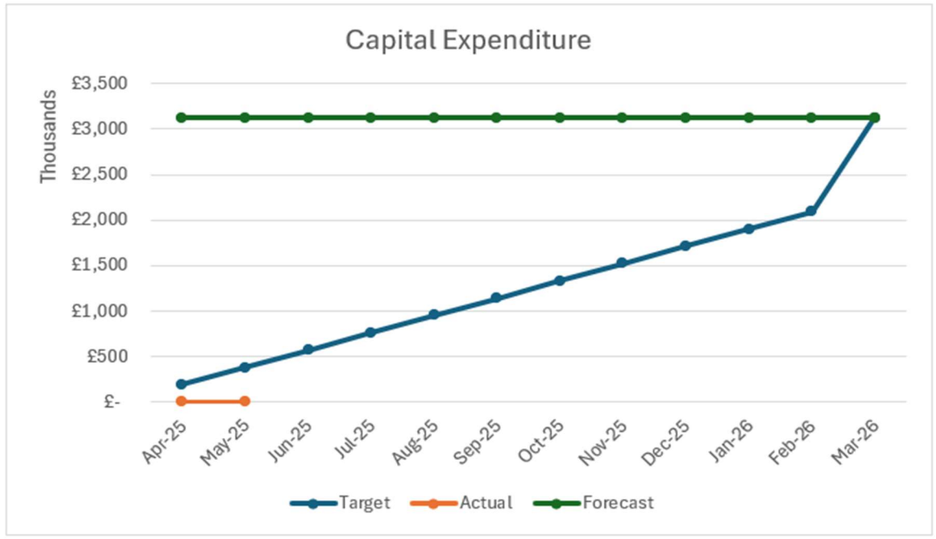
May-25
£-317k
Variance
Position better plan
Target
£-327k

Cumulative CIP



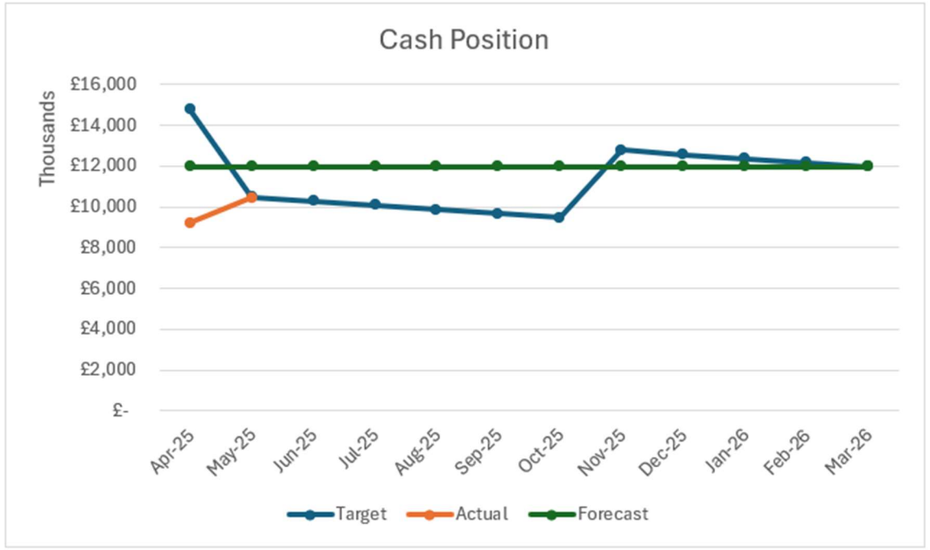
May-25
£713k
Variance
Position better than plan
Target
£700k

Capital Expenditure



May-25
£0k
Variance
Position worse than plan
Target
£381k

Cash Position



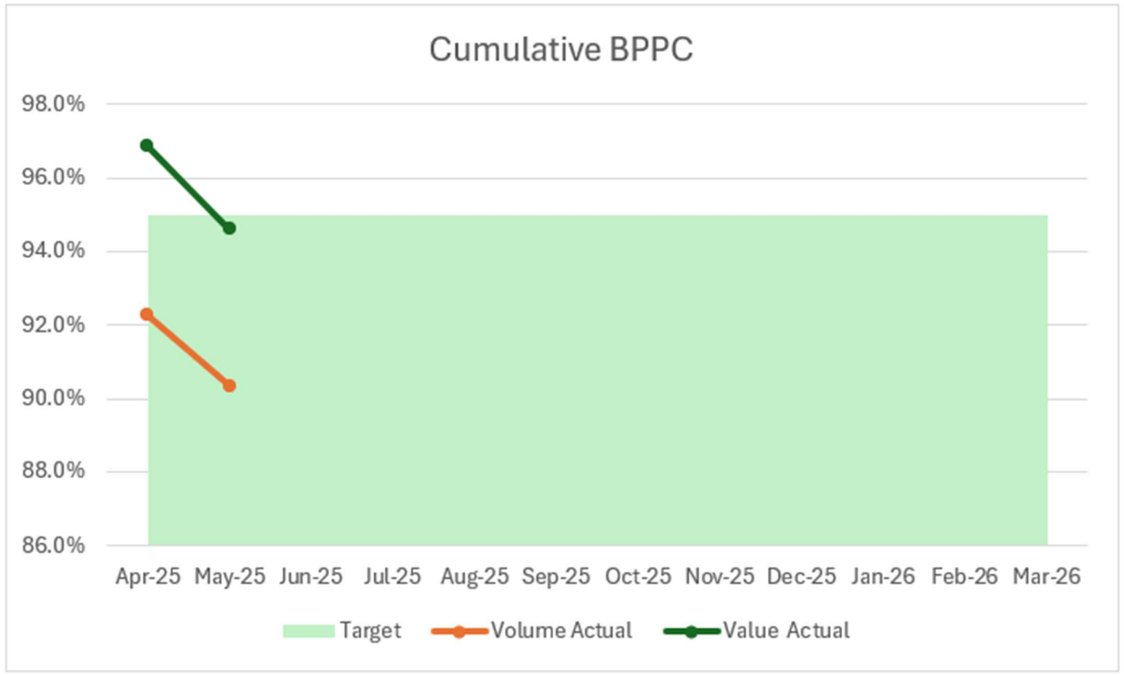
May-25
£10,451k
Variance
Position worse than plan
Target
£10,470k

Commentary

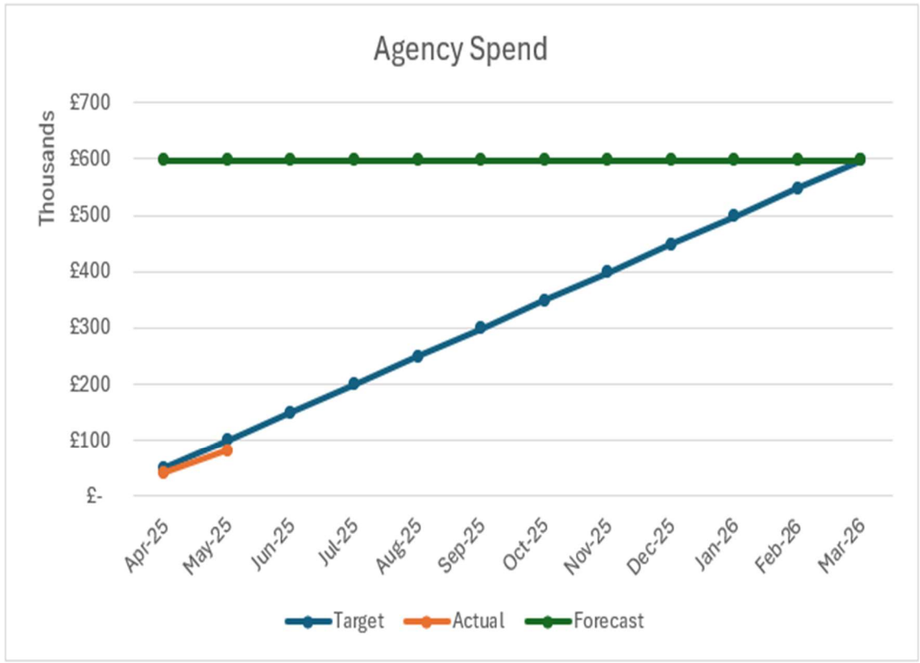
The Trust is delivering its I&E plan and is only slightly behind its CIP plan albeit all CIP identified for 25/26 is recurrent in nature. In Q1 we are expecting to be reporting delivery of capital schemes as they are approved through Programme Oversight Group and increasing CIP delivery through the oversight framework.

The Trust is working to make sure all outstanding invoices are paid within 30 days however we are conscious that there are a number of Trusts in the system that have cash pressures and as such are not paying their invoices within 30 days.

Cumulative BPPC



Agency Spend



May-25
£81k
Variance
Position better than plan
Target
£100k

Commentary

The Trust is achieving the better payment practice code in relation to value of the invoices as we are exceeding 95% however for volume we are at just over 92% which is rated as amber by NHS England. Finance continues to work with budget holders to make sure invoices are validated and approved in a timely manner.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
2 July 2025

Item No 9

Report Title	Chairs Reports – Quality Committee
Date of Meeting	2 June 2025
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It noted a risk around the workforce capacity of the ophthalmology clinic and the potential impact to lengthen waiting times and treatment intervals for patients receiving repeated injectable therapy regimens. A mitigating plan to reduce the risk to an acceptable level is in place, pending development of a new workforce model. ○ It noted it had been necessary to reduce manufacturing capability of the pharmacy aseptic unit, resulting in the cessation of production for other organisations. Preparation continues for "in-house" medicines but will need to be suspended when the unit is closed for upgrade works which will allow all provision to recommence. Mitigating plans are being developed for the provision of in-house medicines in that case. Partner organisations are being kept informed. ○ Two never events were reported in May in separate areas. Both have been subject to immediate and ongoing investigation. Neither patient has suffered significant harm. In one case all correct procedures at the Trust were followed and are consistent with procedures adopted regionally.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ There has been further progress with long-standing CQC action planning. On must-do action relating to the refurbishment of the neonatal unit is expected to be completed towards the end of 2025. Two remaining should-do actions are reliant on working with external providers. The Committee will continue to monitor these. ○ The draft Quality Account was noted and minor suggestions for amendments of clarification and amplification and context were recommended, and the draft will be amended prior to submission to the Trust Board. The Committee welcomed the quality of the report, the benefit of amplifying areas of success for communication to internal and external stakeholders and noted that the report was a fair, accurate and complete account of the Trust's approach to quality. It

	commended the team responsible for its preparation. Next (this) year's quality objectives were noted. ○ An external review of paediatric audiology service identified no immediate safety issues and gave good assurance on clinical care. Several actions were recommended and are in progress. ○ There has been further and consistent improvement in timeliness of complaint responses with the number of complaints in the system approximately halving and response times improving. The Committee asked for an update and outline trajectory for getting to our target response time.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ In a recent audit of WISE ward accreditation, all 6 audited wards reached level 3. (The highest level). Never-the-less the WISE accreditation system and approach is being reviewed to improve it. The Trust is working with an external Trust who the CQC identified as having a particularly outstanding accreditation system. ○ The Trust noted a report on continued assurance around the mortuary compliance with the Human Tissue Authority (HTA) standards for the maintenance of the HTA license for this activity. An external inspection by the National Accreditation Organisation of the United Kingdom (UKAS) assessment of the mortuary undertaken in March 2025. There were pleasingly no findings and recommendations focused on staff welfare and psychological support. Previous staffing risks noted at the last report have been dealt with following a business case and staffing is at expected levels. The Committee particularly thanked for the HTA Designated Individual for an excellent report and the leadership that led to it. ○ The Committee noted an Internal Audit report that reviewed 7 areas of practice from policy and procedures through to embedding and further development of the PSIRF system at the Trust. The review found a good system of internal control. Three medium and two low-risk recommendations will help augment the Trust's continued implementation and improvement of its approach. ○ The Committee were assured that the Trust had an appropriate Quality Impact Assessment policy in place which had been updated following collaboration with the Wirral Community Health and Care Trust who had a well-regarded policy.
Review of Risks	• No new or more significant risks were noted during the meeting and no changes were recommended for the Board Assurance

	Framework. The high risks of the pharmacy aseptics unit and the ophthalmology outpatient capacity and mitigations and action planning were noted.
Other comments from the Chair	• The Committee confirms that it is properly comprised with the appropriate skills and has met enough times to conduct its business. The Committee has reviewed its work it has discharged its duties in line with the authority delegated to it by the Board via its Terms of Reference and is therefore operating effectively.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
2 July 2025

Item No 10

Report Title	Chairs Reports – Audit and Risk Committee
Date of Meeting	5 June & 16 June 2025
Author	Steve Igoe, Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: Nothing to report on this heading
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The previously approved 2025/26Anti Fraud plan and 2025/26 Internal Audit plan and Audit Tracker were ratified. ○ The Committee discussed the External Audit ISA 260 report noting the findings and expectation of a positive set of outcomes to be discussed with the Board in due course. Work was still ongoing so the Committee noted the positive position and agreed to re- convene on 16th June to review a near final document.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The 2024/25 draft quality account was discussed in detail following its earlier discussion at Quality Committee. The Audit Committee welcomed the report noting some minor amendments from the Quality Committee discussion and approved the account for release to the Board for final approval. ○ The Committee re-convened on 16th June to consider the final version of the 24/25 accounts, Annual Report including Governance statements and finalized External Audit findings report. The Committee were encouraged by these positive reports, particularly the external audit outcome and agreed to recommend all of them along with the Auditors letter of Representation for approval by the Board. ○ The Committee discussed the current position of the Trust in relation to the Provider Self Certification. The Committee noted that self-certification against CoS7 was still a requirement and after discussion agreed to approve the statement of compliance against condition CoS7 and recommend its approval by the Board.
Review of Risks	• N/A given the specific accounts focus for these meetings
Other comments from the Chair	• An excellent Audit outcome and congratulations to the finance team for an excellent and high-quality year-end process.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
2 July 2025

Item No 11

Report Title	Chairs Reports – People Committee
Date of Meeting	12 June 2025
Author	Lesley Davies, Chair of People Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It was noted that a number of reports raised potential new risks, and these are identified at the end of this report
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Following the Committee's deep dive into work being undertaken to reduce bullying and harassment at the Trust, a report was provided which clearly identified the actions planned and those undertaken. It was agreed that a further progress report would be brought back to the Committee in six months ○ Workforce Integration Workstream - an update was provided on the progress being made with workforce integration. It was good to see the outcomes from both the WUTH and WCHC Staff Surveys presented side-by-side. Common themes were evident, and staff are now working on an action plan, coordinating this work across both Trusts. ○ The Committee noted feedback from the People Committee Effectiveness Review, which was positive with no considerations or issues raised
To address where both Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee discussed the Chief Nurse's Safe Staffing Report and took assurance that the Trust fulfils the regulatory requirements in line with Developing Workforce Safeguards (NHSI 2018), Fundamental Standards (CQC 2022) and the Safe Sustainable and Productive Staffing Guidance (National Quality Board's 2016). The positive fill rates for CSWs and RNs were also noted as was the reduction in Red Shifts for February-March 2025 ○ The Committee took good assurance and thanked the GOSW for her report and presentation which provided data, detailed information and trends on exceptional reporting across the Trust and the actions taken, where appropriate, to ensure doctors are supported.
Review of Risks	• Although the Trust continues to focus on the effective management of employee relation cases it was noted that there

	is an increased risk of the Trust falling outside of its timescales for managing cases. Pressure points include the resource requirement to implement CWS prospective organisational change and the national review of job matching profiles for Nursing and Midwifery. • The Committee discussed the proposed changes in rates of pay for bank staff, in the context of the Safe Staffing Report. There is concern that reduction in rates may negatively impact bank fill rates. The Chief Nurse has led the completion of a Quality Impact Assessment, to identify specific risks and mitigations. • It was highlighted that as part of the Doctors in Training contract negotiations there has been an agreed change to the Exception Reporting process which will come into force from September 2025. There are still some outstanding issues on how this process will work in practice and further guidance is expected. One of the main changes is a move away from Supervisor signing off Exception Reports with this process. In the future, all education exception reports will go to the Director of Medical Education and all other exception reports will go to the HR Team. This change will mean that there will be no direct involvement of the Trust's Educational Supervisors. Presently Education Supervisors provide valuable support where training issues are identified via the exceptional reporting process. There is an increased risk that this good practice will be more difficult to implement and that early intervention opportunities will be missed. It should be noted that the Guardian of Safe Working will maintain oversight of all exception reports. In addition, fines will be imposed across a greater number of situations, which could increase in the number of situations that will carry a fine will potentially impact on the Trust's finances. Work is being undertaken by the GOSW and HR to implement the changes and mitigate the risks associated. Mitigation will also include a communication strategy with relevant staff to ensure the potential of fines are minimised.
Other comments from the Chair	The Committee had wide-ranging discussions on a number of issues and reviewed the recent audit report on the Transitional Report for the New Payroll System. This was Chris Clarkson's last People Committee meeting, and the Chair thanked him for his valuable contribution

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 12**
2 July 2025

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	18 June 2025
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust ended month 2 with a deficit of £ 1.2m which is in line with plan. However, that is after the inclusion of £4.1m non-recurrent mitigations to compensate for variances relating to CIP, vacancy factor and the elective plan. ○ The full year value of CIP identified to date has increased to £29.5m against a target of £32m. After adjusting for risk the expected level of CIP reduces to £22.6m recurrently and £20.1m in year. Although the CIP identified and achieved continues to improve it is critical that the situation is recovered in full and the outstanding £11.9m is achieved. The executive team is fully engaged in this and continue to provide challenge and support across the organisation to provide new schemes. ○ The Committee received the quarterly financial forecast. Financial risk on approval of the plan was originally assessed as £25m. The primary risks relate to the CIP programme spanning the internal and ICS programme. After inclusion of non recurrent mitigations and an action plan proposed by the CFO, £7.6m of risk remains. This relates mainly to the stretch target agreed across the ICS. ○ The Committee received an update on Head and Neck Cancer and elective performance. This has deteriorated significantly during 2025 resulting in suspected cancer patients waiting 5-6 weeks for their first appointment and elective patients waiting over 65 weeks. The situation is causing detriment to patients and breaching national standards. After reviewing the evidence regarding increase in demand, staff absence, consultant job plan content and medium-term divisional plans to improve access, the Committee approved short term outsourcing of activity. In view of financial constraints, the Committee did not approve the addition of an agency consultant. The Board will note that the cost of the outsourcing is not currently in financial plans or forecast. The Committee agreed to seek Board review and support for this decision.

	○ The Trust ended M2 with a positive cash balance of £4.2m. Assuming that there is no material change to planning assumptions then the Trust does not anticipate to request revenue support before Q3.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Performance against CIP targets by division was received with a further CIP workshop arranged for 20th June. ○ Helen Walker, the Divisional Director of Women's and Children's Division presented to the Committee on how the divisional CIP programme is developed and managed. The division has achieved 76% of its CIP plan to date. In addition to CIP the division is improving financial literacy and encouraging wide engagement. The Committee noted that in the past the division had struggled with achievement of CIP and were pleased to note the new approach and how this aligned to the finance strategy. ○ The Committee received an update on the Procurement Strategy. This set out key objectives for procurement and how the team was working with internal and external stakeholders to deliver quality, efficiency, transparency and effective governance. The Committee sought assurance that there was clinical engagement and that the team was collaborating with external organisations wherever it was beneficial to do so. ○ The Committee approved a business case for an additional 2 consultant posts in the Emergency Department to be funded by vacant consultant PA's and a reduction in the Tier 2 establishment. This change will contribute to in-year and recurrent CIP delivery. ○ The Committee approved a business case for 2.7 General Internal Medicine consultants to be funded from agency and non-core medical staffing expenditure. This change will contribute to in-year and recurrent CIP delivery. ○ The Committee approved a case for the refurbishment of the Aseptic Unit for onward approval by the Board of Directors. The capital cost will be funded by external NHS funding and a contribution from the Trust's own capital budget. There is a revenue pressure during the scheme mobilisation driven by the loss of external sales, this is included in current financial forecasts. The Committee was keen to see the potential for enhanced income from drug sales once the unit is complete and the team undertook to revisit projections and provide for additional clarity on capital expenditure for the Board meeting paper.

	○ The Committee expressed a wish to see quality KPI's improving as a result of the business cases approved for permanent staff. The team agreed to provide this at a future meeting.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee received a report on progress in ED nurse recruitment resulting from the approved business case and noted that registered staff recruitment is progressing well with 4 vacancies remaining but there are still 15 vacancies for unregistered staff. The team is considering skill mix changes in addition to recruitment events. ○ A report on Trust productivity was received which demonstrated good performance on both productivity and real terms cost growth where the Trust has performed better than any other acute trust in the Cheshire and Mersey ICS. This triangulates with performance on CIP in recent years where the Trust has delivered significant recurrent savings.
Review of Risks	• There is a significant risk to the achievement of the financial plan driven by CIP and a shortfall in elective performance and pressure on service targets. The plan to manage this is significantly progressed and needs to be finalised.
Other comments from the Chair	• The Committee emphasised the importance to the Trust of delivering both improved service performance and the financial plan.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
2 July 2025

Item No 13

Report Title	Chairs Report – Charitable Funds Committee
Date of Meeting	23 May and 18 June
Author	Sue Lorimer, Chair of Charitable Funds Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Committee agreed to keep the Tiny Stars appeal open until 31/3/26 due to the continued fundraising in the community, the donations being received and the shortfall in funding to cover the cost of the Neonatal development. No further fundraising will be initiated by the Trust's Charity Team. ○ Fund balances increased by £0.361m during 24/25 and the Charity held funds of £1.443m at the year end. Of this sum the Tiny Stars appeal accounted for £0.647m. ○ Balances increased by a further £0.304m to May 2025 due principally to the receipt of a donation of £0.300m from the Incubabies Charity in respect of the Tiny Stars appeal. ○ The Committee received a proposal setting options for future activity and potential income. After a discussion on the options and risks the Committee agreed the addition of an additional admin and clerical post to support growth in fundraising with a view to increasing charity income in 2027/28.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ A presentation was received from Jo Garzoni, Divisional Director – Medicine, regarding items that patients would benefit from if the Charity was able to support with funding. These related to Heart, Stroke and Respiratory. Jo herself and her family engage in fundraising activities for the Charity and the Committee were impressed by her engagement and enthusiasm. ○ The Committee received a report on fundraising activity and noted that fundraising income for 24/25 had surpassed plan despite the team being in transition. The Committee noted that fundraising events yielded a good margin and costs were kept to a minimum.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee reviewed the Charity risk register and found no items for escalation.

	○ The Committee considered the Annual Effectiveness Review and were happy to support the statement of effectiveness.
Review of Risks	• The Committee accepted that there is a risk in agreeing to an additional member of staff but agreed that the current team is too small to be sustainable and that the risk of not covering the additional cost by fundraising income can be managed.
Other comments from the Chair	• The Charity Team are doing a good job in a difficult environment and the Committee will continue to support them as they develop.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors
2 July 2025

Item No 14

Report Title	Chair's Report – WCHC People & Culture Committee
Date of Meeting	11 June 2025
Author	Meredydd David, Chair

Alert	• The PPC wish to alert members of the Board to: ○ Sickness absence rates increased to 6.8% during this period with this mainly in long term sickness and absence linked to stress is increasing. ○ Pulse survey response rate in April was at 17.8% which was a decrease on previous rates achieved. This may be an indicator of staff engagement deceasing from a recent high, post CQC and impacted by integration announcement ○ Slight downturn in advocacy measure. The COO to develop an approach to engage directly with managers and staff through multiple means to triangulate data and understand the cause(s) . This will inform the action plan post survey. ○ It was reported that anecdotally, some staff state they are worried about loss of corporate memory and that there is some inconsistency of clarity of messaging around integration/merger through the organisation.
Advise	• The PPC wish to advise members of the Board that: ○ COO and Director of Corporate Affairs agreed to run a workshop for NEDs to test the triangulation and reporting of appropriate performance and information through the management and governance structure ○ Staff turnover rates are relatively stable at 9.4% in April which was anticipated due to the workforce plan and also training compliance remains good ○ There has been a decline in employee related cases being dealt with. ○ The 2025/26 People Strategy which has been aligned with WUTH's where possible was received and approved with 27 actions. Appropriate presentation of impact measures to be considered and revised. ○ Workforce sharing agreement had been shared with staff and no concerns raised. ○ A staff engagement and organisational development toolkit has been developed and is being delivered/implemented through the management structure. This should help managers lead their teams through this significant period of change. ○ An increase in reporting of return-to-work interviews to 70% for this period was noted as good progress. ○ Noted that staff survey results in 2025 may show a decline due to the impact of integration and financial pressures on Trusts.
Assure	• The PPC wish to assure members that:

	○ There is a 16-point action plan being implemented in response to the pulse survey with this being reviewed regularly ○ The Inclusion and Health Inequalities report included the closedown report for year 3 and the 2025/26 proposed plan. ○ Safe staffing quarterly reports were received and reflected a positive position. Higher levels of incidents on Bluebell Ward were to be reviewed. ○ The sexual safety update report was received and provided assurance. ○ The Gender Pay Gap report was received and provided assurance with a pay gap of 7.84, a slight improvement on the previous year. ○ The People Promise Manager end of programme report was received
Review of Risks	• No high-level risks to escalate to the Board • The risk health score at the middle of May had decreased to 97.8%. Due to the slight decrease, there would be a focus on targeting corporate and specialised medical teams during this period. • BAF, the committee will continue to monitor ID07, ID08 and ID10 as they align with the People Strategy. • Agreed the committee should review the risk appetite and tolerance levels with this being led by the Director of Corporate Affairs
Other comments from the Chair	• A three-month extension was given to three HR policy reviews and the committee was assured they are all still fit for purpose and adhere to current employment legislation.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 15**
2 July 2025

Report Title	Chairs Report - Finance and Performance Committee
Date of Meeting	11th June 2025
Author	Steve Igoe – Committee Chair

Alert	• The Committee wish to alert members of the Board of Directors that: ○ CIP continues to be a high risk to delivery of the financial plan for 2025/2026.The Committee discussed in detail the challenges being faced in the Estates area where substantial pressures still remain. The team are actively seeking resolution although delivery remains a risk . ○ The Committee discussed the BAF risks in detail .It was noted that there was no recognition of potential cyber security issues in the current risk register which appeared at odds to everywhere else. Not just in the NSH but in other sectors. Whilst recognising the Trust's previous positive position in relation to this area it was recommended by the Committee that the BAF includes a significant risk for cyber security in the next iteration.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee discussed the Trust's 2022/25 Green plan update report. It noted the lack of designated staff to manage this area but noted positive delivery against targets to date .The updated WCHC Green Plan for 2025/28 will come to Committee and the Board for Approval in July 2025. ○ The Committee discussed and approved a paper detailing the harmonisation of SFI's between WCHC and WUTH , specifically the harmonisation of authorisation levels.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee received a detailed presentation from the Estates department which provided an oversight not just of the year end position but also the plans for the future including Integration. The Committee were assured of the rigour with which the future plan had been prepared covering the period of Integration to 2027. ○ The Committee noted in the CICC place assessment that from 233 organisations reviewed nationally ,WCHC was 3rd from an organisational perspective and 10th from a site perspective . The Committee thanked colleagues across the Trust for this excellent performance.

	○ WCHC's CIP target for 2025/26 is£6.6m (including a £0.9m stretch from the ICB).On 2/6/25 , the Trust has achieved delivery of £4.4m of this target .A further £1.7m of schemes are in development of which £0.8mare fully developed. ○ The Committee received an update on the Trust's operational performance .At the time of the meeting the Trust had 80 green KPIs (76 mth 11),3 amber KPis (7 mth 11) and 8 red KPIs (8 mth 11).Waiting lists continue to be closely monitored and the average wait across all services is now below 18 weeks. ○ The Committee was assured that all relevant policies for which the Committee has oversight are up to date and valid.
Review of Risks	• See above re cyber security
Other comments from the Chair	• All covered in the above.

Public Board of Directors **Item 17**

02 July 2025

Title	WCHC Green Plan 2025-26
Lead Director	Tony Bennett, Chief Strategy Officer
Author	Philip Taylor, Health, Safety & Fire Manager
Report for	Approval

Executive Summary and Report Recommendations

In line with ICB guidance, the WCHC Green Plan for 2025-26 is leaner and more accessible to the general reader, with a greater emphasis placed on successes from the 2022-25 Green Plan while maintaining the focus on continuous improvement. The intention is for this Plan to run for one year, before being incorporated into a Joint Green Plan with WUTH from 2026 onwards.

It is recommended that the Board/Committee:

- Approve the refreshed Green Plan for 2025-26.

Key Risks

This report relates to the following key risks:

- Datix Risk ID 2951 relates to the Trust operating without a designated Sustainability resource in post. The Green Plan 2025-26 was written internally by the Health, Safety & Fire Manager with support from external consultants Inteb.

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 WCHC strategic objectives	
Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	Choose an item.
Groundbreaking innovation and research	Yes
People	Choose an item.
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Choose an item.
Grow, develop and realise employee potential	Choose an item.
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Choose an item.
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
17.06.25	Executive Group	Green Plan 2025-26	Approved with minor amendments to travel to Board

1	Implications
1.1	**Quality/Inclusion** No identified impacts
1.2	**Finance** The Green Plan 2025-26 has been produced by existing resources and external consultancy already budgeted for. Therefore, no additional costs have been incurred.
1.3	**Compliance** The Green Plan will be submitted to the ICB following Board approval.

2	The Trust Social Value Intentions
2.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: Community engagement and support ☒ Purchasing and investing locally for social benefit ☐ Representative workforce and access to quality work ☐ Increasing wellbeing and health equity ☒ Reducing environmental impact ☒

NHS

Wirral Community Health and Care

NHS Foundation Trust

OUR ROUTE TO NET ZERO

The Green Plan 2025/26

The Wirral Community Health and Care NHS Foundation Trust (WCHC) Green Plan for 2025-2026 sets out the Trust strategy for reducing environmental impact, and progressing toward Net Zero by 2040. In common with every NHS organisation, WCHC is required to create a Green Plan and review it every 3 years to support the implementation of NHS goals.

Our Green Plan will aim to create greener and more efficient healthcare facilities which support sustainable patient care.

What did we achieve with our previous Green Plan 2022-25?

We launched our first Green Plan in 2022 and our key achievements included:

Maintenance of the Trust's accreditation to the ISO 14001: 2015 standard for environmental management systems, which is externally audited annually. The Trust has now successfully retained this accreditation for seven consecutive years.

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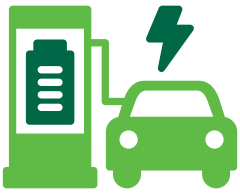
ISO14001
Certification No.212469

Increased EV charging capabilities at Trust sites, with cheap charging incentive offered to staff. There are five charging stations across two sites, allowing for up to 10 vehicles to charge at once. Fast charger is one of the most powerful on the Wirral.



Integration of environmental considerations into Procurement practices, particularly around responsible purchasing and incorporating sustainability into tender scoring processes.

Maintaining the Trust commitment to reducing greenhouse gas emissions associated with energy use; implementation of major projects such as BMS (building management system) upgrade for St Catherine's Health Centre. Carbon figures increased overall for the Trust due to the addition of a new site (Marine Lake) but were down by site.

The Trust also continued to engage with staff on green issues, acknowledging that the Green Plan cannot be implemented effectively without buy-in from all levels of the organization.

With over 1,800 employees providing a diverse range of community health services, the workforce is our most important and valued resource. This plan will set out how the Trust will engage with staff to tap into their potential and empower them to make a valuable contribution towards the NHS journey to Net Zero.

The goals of our new Green Plan

The Plan for 2025-26 focuses on 3 key areas:

1 Energy

Continue to strive to achieve Net Zero Carbon by 2040 by reducing carbon emissions year on year and apply for all available decarbonisation project funding as it becomes available. The Trust will continue to ensure we are using our estate in the most efficient way, ensuring that we are reducing our carbon footprint where possible by concentrating our staff in core locations and reducing travel.

2 Waste

Move closer to complying with the NHS England waste segregation target of 20% incineration, 20% infectious waste and 60% offensive. The offensive waste stream will be fully rolled out in all areas, with our clinical waste provider providing data on compliance and progress towards the target. The Trust's current breakdown is: 2% Incineration, 55% infectious waste and 43% offensive. The roll-out of offensive waste streams in clinical areas continues into 2025, and the target will be achieved by the end of this Green Plan period (2028).

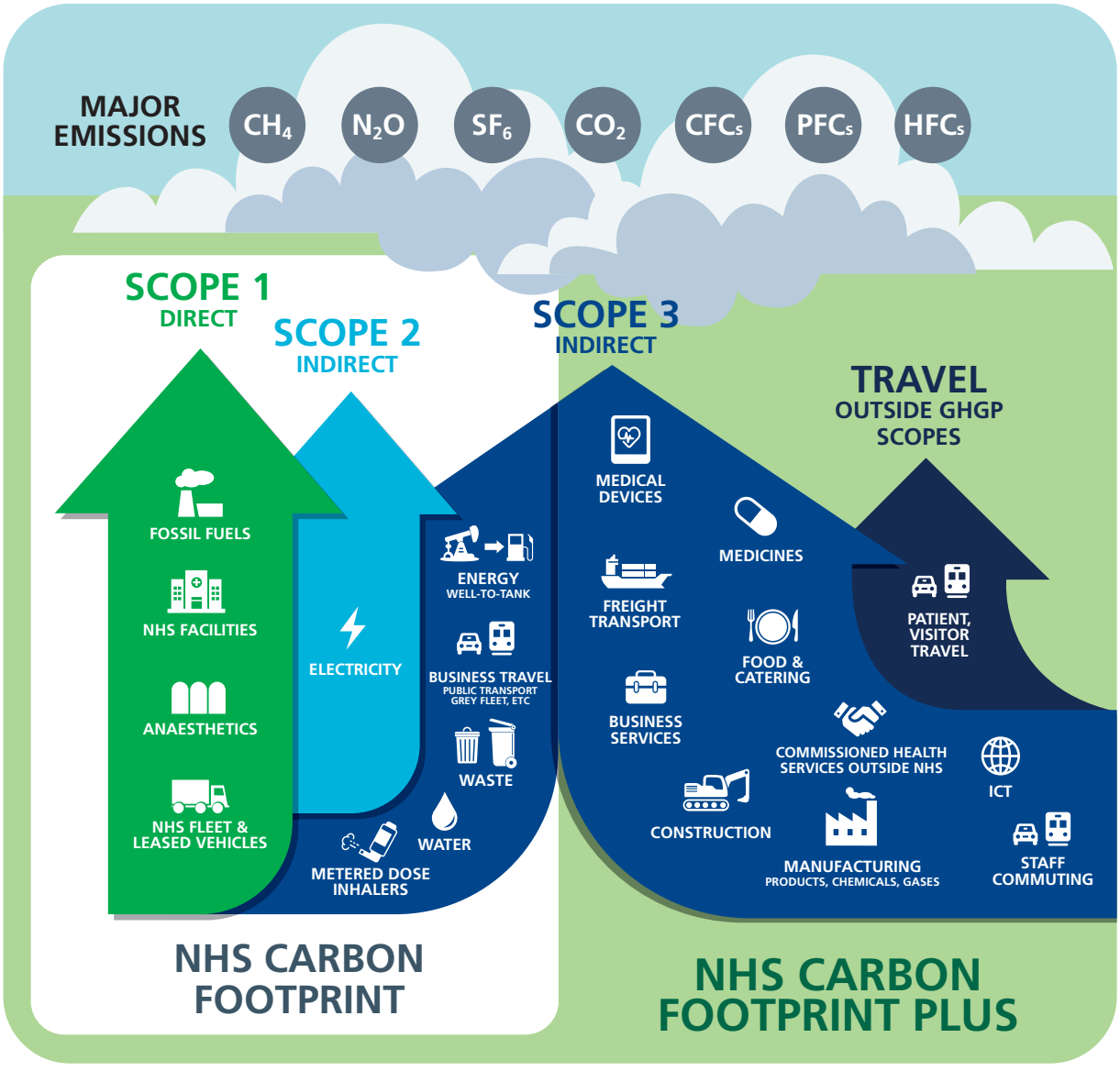
3 Adaptation

Produce climate adaptation plans to account for anticipated disruption to Trust services and operation caused by increasingly unpredictable and destructive weather events, and overall higher global temperatures. The Trust is represented on regional and national committees for climate adaptation, and receives consultant support from Inteb to ensure that climate adaptation is a top priority amongst our Green Goals.

Organisational Vision

The Trust has established an effective approach to managing its environmental impacts across operations. While the Trust is proud of its achievements to date, it recognises there is still more to be done, particularly in light of Greener NHS' commitments to be net zero in its own operations by 2040, and throughout the value chain by 2045 (NHS carbon footprint plus), and the renewed focus on reducing greenhouse gas emissions.

As such, the Trust is looking to build on past successes, and has taken into account the interventions which are most likely to benefit the local community while meeting the requirements of national commitments, in forming the following objectives and targets. These Objectives and targets are designed to guide the Trust on its sustainability journey over the next three years.



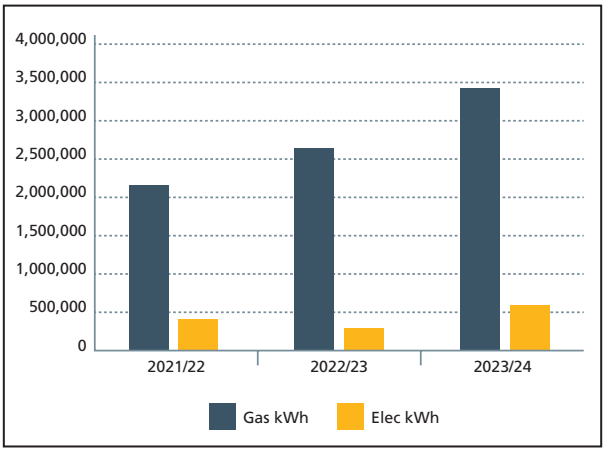
Oversight and Governance

Sustainability is overseen at Board level, with the Chief Strategy Officer being the lead responsible for net zero commitments and this Green Plan. Sustainability decisions are supported by the Estates Management Group and the Health, Safety, Security and Resilience Group. Both groups meet remotely, on a quarterly basis, to discuss sustainability ideas and to develop business cases for Board approval.

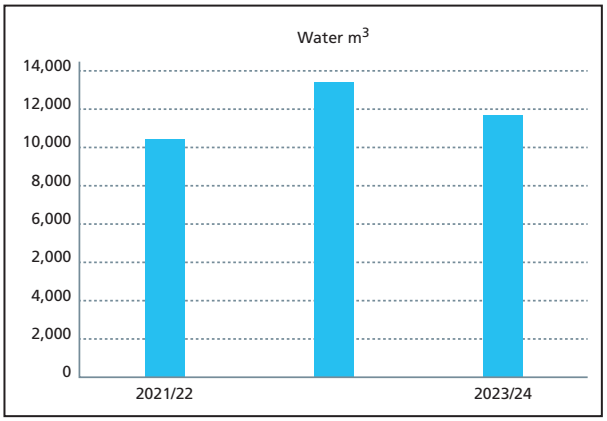
Our Green Group have operational and strategic oversight of the Green Plan and our ISO 14001 accreditation. Membership is drawn from all over the Trust, and for the period of this Green Plan (2025-26) our Green Group will also include membership from Wirral University Teaching Hospital NHS Foundation Trust colleagues and periodic attendance from ICB colleagues from Trusts such as Cheshire and Wirral Partnership and Clatterbridge Cancer Centre.

Energy and water usage

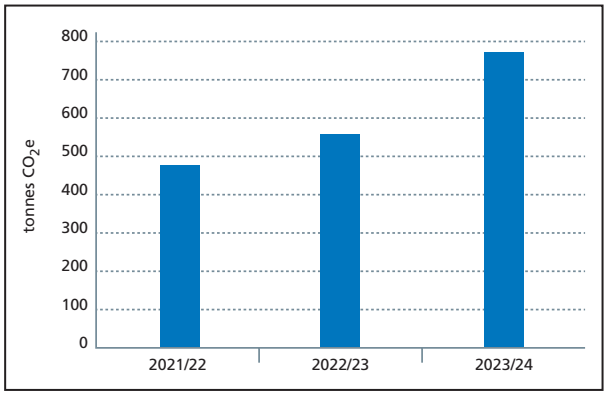
Gas and Electricity usage - last three years



Water usage - last three years



Trust's Scope 1 and 2 Emissions



Overall energy consumption and carbon emissions have gone up in the period of the 2022-25 Green Plan, but this can be attributed to our increased floor area as reported through ERIC.

Nevertheless, the Trust has implemented measures and initiatives which have ensured that the increase has been as small as possible, including Solar PV at St Catherine's Health Centre, intermittent use of the Bioboiler at SCHC, LED lighting and sub-metering, as well as continued accreditation and validation of the ISO 14001 standard.

Emission scopes as detailed in the above graph are broken down as follows:

- **Scope 1:** emissions from sources that the organisation owns or controls directly. For example, burning fuel in fleet vehicles
- **Scope 2:** emissions that the organisation causes indirectly and come from where the energy it purchases and uses is produced. The emissions caused by generating electricity used in our buildings would fall into this category

There is also a **Scope 3**, which encompasses emissions that are not produced by the organization itself and are not the result of activities from assets owned or controlled by them, but by those that it's indirectly responsible for up and down its value chain. An example of this is when the Trust buys, uses and disposes of products from suppliers. Scope 3 emissions include all sources not within the scope 1 and 2 boundaries.

BREEAM Case Study

Marine Lake Health and Wellbeing Centre

Marine Lake Health and Wellbeing Centre, located in West Kirby, is a modern healthcare facility designed to meet high sustainability standards. The building achieved a BREEAM UK New Construction 2018 Healthcare score of 60.6%, earning a **Very Good** rating.

The building incorporates a number of high energy-efficiency features, minimising energy consumption and reducing carbon emissions resulting from its operation.

Solar panels installed on the roof contribute to renewable energy generation, covering a significant portion of the building's electricity needs.

Low-flow fixtures and water-efficient landscaping help reduce water usage.

A key feature of the centre is the creation of a community wellbeing garden which features a range of plants and places for local people to grow their own vegetables, as well as a multiple use space for relaxing or use as an outdoor classroom for local primary school pupils.

The building scored particularly highly in the Pollution, Land Use and Ecology and Health and Wellbeing categories under the BREEAM assessment.

Marine Lake Health and Wellbeing Centre serves as a model for sustainable healthcare construction, demonstrating that it is possible to achieve high environmental standards without compromising on functionality or aesthetics. The BREEAM **Very Good** rating reflects the building and the Trust's commitment to sustainability and its positive impact on the environment and the local community.

Case Study

BMS upgrade project - St Catherine's Health Centre

St Catherine's Health Centre was opened in 2013. It was designed with sustainability at the forefront and was one of a new breed of 'smart' buildings. In practice, this meant that the building would be powered and heated in such a way that there would be a minimal amount of wasted energy, and systems such as heating and cooling would not compete against each other.

The 'brain' of a smart building is the building management system (BMS), which is a combination of hardware and software which enables the Estates team and our service providers to scrutinize, in real time, the current status of the building's heat, water and power.

The expected lifespan of the system is up to 15 years, so the decision was taken to apply for capital funding in order to overhaul it and bring the latest technology into the Trust's flagship building. The first part of the process was to secure funding via a capital business case, which was approved by the Executive team. The Estates department then worked with Procurement to build a specification and put the works out to tender, a process which included site visits, formal proposals and supplier interviews which were scored by a panel convened of colleagues from several departments.

The successful bidder was Inteb, a local company based just two miles from St Catherine's. Although the Trust had engaged Inteb previously for sustainability consulting services, the winning bid was managed by their technical and commercial division. As well as enabling the Trust to spend with a local supplier, the tender process allowed us to secure the best value both financially and in terms of ongoing support.

Inteb moved quickly to complete the works, from planning stage to sign-off, within five weeks, which was an imperative from a financial perspective, and to ensure the least amount of disruption possible. The hardware installed in the building is the most up-to-date on the market, and the new software interface built by Inteb is far more intuitive and therefore easier to read and manipulate. The Estates team can change temperatures, diagnose faults and provide information to contractors at the click of a button, meaning there are efficiencies gained in the use of resources and energy.

Les Edwards, Commercial Director at Inteb, says of the project:

At Inteb, we are proud to have partnered with the Trust on this forward thinking and sustainability driven project. St Catherine's Health Centre is a prime example of how smart building technology can be utilised to create energy-efficient, cost-effective, and future-proofed environments.

Our team worked closely with Phil, Carl and the wider Estates and Procurement teams to ensure a smooth transition to the new system, delivering state-of-the-art hardware and an intuitive software interface that enhances the Trust's ability to manage resources with precision and ease. Completing the project within a five-week timeframe was a challenge we fully embraced, recognising the importance of minimising disruption while maximising value.

As a local business, it is particularly rewarding to contribute to the ongoing success of such a flagship facility within our community. We look forward to continuing our support for the Trust, ensuring that St Catherine's remains at the forefront of smart building innovation for years to come.

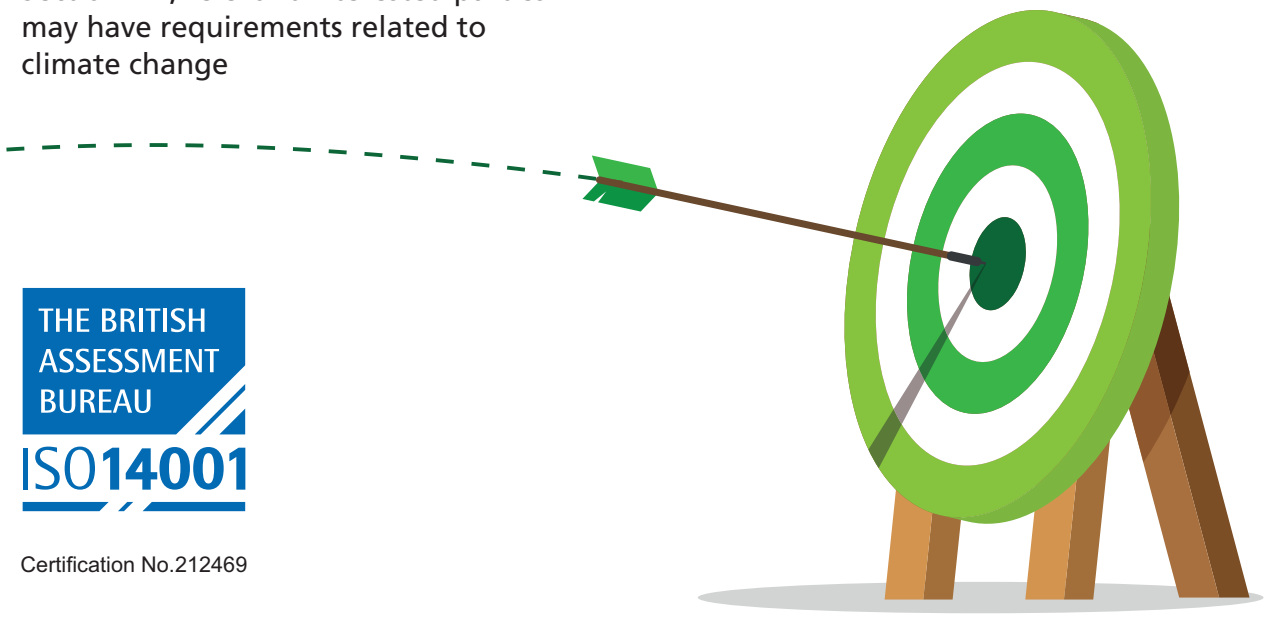
ISO 14001:2015

Environmental Management Systems - Amendments

In order to maintain the Trust's accreditation to the ISO 14001 standard, considerations will be made for the amendments made effective from 23rd February 2024, which are as follows:

- Section 4.1, requirement for organisations to determine whether climate change is a relevant issue impacting their management system
- Section 4.2, relevant interested parties may have requirements related to climate change

WCHC remains committed to holding this prestigious accreditation, which is held by very few NHS Trusts nationwide. To have been revalidated for seven consecutive years is a testament to the collaborative working approach adopted by the Trust in light of there being no dedicated sustainability resource in place.



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Veganism, Recycling and Staff Engagement

Key to the Trust's achievement of its environmental goals is the engagement from staff. In the period covered by the previous Green Plan (2022-25) we saw staff participate in the following ways:

- Attendance of the Green Group meetings
- Submission of Green ideas, initiatives and campaigns to our Communications team and to our Green Plan email address wchc.greenplan@nhs.net
- Membership of active travel schemes, such as using salary sacrifice and NHS discounts to purchase bicycles
- Making use of discounted public transport initiatives
- Opting to switch from combustion engines to electric when ordering a lease car via salary sacrifice. Some staff have also purchased EVs outright.
- Hosting and taking part in vegan events to raise awareness of the environmental impact of food production, as well as the nutritional considerations
- Donating surplus equipment to charity, or arranging for recycling of items which can still be used elsewhere
- Re-opened 'classified' section on the staff intranet to enable the above
- Bringing reusable bottles into work to reduce the amount of single-use plastic

In line with the Trust's commitment to inclusion, staff have been able to share their experience of veganism and submit ideas for promoting veganism in the workplace. Two staff members held the Trust's first Veganuary event in January 2025. The event took place in the atrium of St Catherine's Health Centre and was very well received by staff and members of the public.

Staff will continue to be encouraged to share their ideas for sustainability, environmental issues and dealing with climate change. This will ensure that the Trust isn't adopting a strategy which is solely top-down, management-level driven and that we can drive improvements which are relevant and deliverable.

Public Board of Directors **Item 18**

02 July 2025

Title	Standing Financial Instructions, including Delegated Financial Limits - June 2025
Lead Director	Robbie Chapman, Interim Chief Finance Officer
Author	Ben Banks, Head of Finance
Report for	Ratification

Executive Summary and Report Recommendations

The Standing Financial Instructions (SFIs) form a critical component of the Trust's governance and financial control framework. They set out the financial responsibilities, policies, and procedures to ensure compliance with statutory, regulatory, and operational requirements.

It is acknowledged that a key aspect of integration with Wirral University Teaching Hospital will be the trusts will need to harmonise financial policies, including expenditure limits and procurement rules.

This exercise will be completed in Q3 of 25/26 but until that time these SFIs have been updated to ensure consistent Delegated Financial Limits (DFLs) for both organisations. This update to the SFIs/DFLs was also a recommendation from the recent Gilburt Report following a review of financial governance related to 0-19 contracts.

It is recommended that the Board

- Receives and the revised Standing Financial Instructions for approval by the Board.

Key Risks

This report relates to the following key risks:

- There is a risk to financial control and governance if the SFIs and DFLs are not up to date.
- The updating of the SFIs responds to a recommendation from the recent Gilburt Review of financial governance of 0-19 contracts and the associated action plan (reported to the Board in June 2025).

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

Contribution to WCHC strategic objectives

Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	Choose an item.
Groundbreaking innovation and research	Choose an item.
People	Choose an item.
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Choose an item.
Grow, develop and realise employee potential	Choose an item.
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Choose an item.
Increase our social value offer as an Anchor Institution	Choose an item.
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
09.04.25	Finance & Performance Committee	Standing Financial Instructions, including Delegated Financial Limits	The SFIs were presented to the committee with updates related to the Procurement Act 2023. They were subsequently presented to the Board in April 2025 but not approved as other changes were identified to be addressed.
11.06.25	Finance & Performance Committee	Standing Financial Instructions, including Delegated Financial Limits	The updated SFIs were presented to the committee and were approved for formal ratification by the Board of Directors.

1	**Narrative**
1.1	The SFIs have been reviewed and updated to ensure alignment with the Procurement Act 2023 and current NHS England guidance. The changes reflect evolving best practices in financial management, procurement, counter-fraud measures, and governance. Key updates include: • **Procurement Compliance:** Updates to tendering and contracting procedures to reflect the new legal requirements under the Procurement Act 2023. • **Delegated Authorities:** Adjustments to financial limits and approval processes across areas such as capital investment, non-pay expenditure, and contract sign-off.

	• **Governance and Risk Management:** Clarification of responsibilities across key roles (e.g. Chief Executive, Chief Finance Officer, Audit Committee) in relation to financial oversight, internal controls, and assurance mechanisms. • **Audit and Counter Fraud:** Enhanced procedures for reporting, investigating, and responding to irregularities, including those related to fraud and loss. • **Updated Terminology and Format:** Minor editorial revisions to improve clarity and ensure consistency with current regulatory language and internal structures. **Changes are clearly marked in red** within the attached document for ease of reference.

2	Implications
2.1	**Quality/Inclusion** QIA and EIA on individual business cases.
2.2	**Finance** None identified in respect of this paper.
2.3	**Compliance** N/A

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Yes. If Yes, please select all of the social value themes that apply: Community engagement and support ☐ Purchasing and investing locally for social benefit ☒ Representative workforce and access to quality work ☐ Increasing wellbeing and health equity ☐ Reducing environmental impact ☐

NHS
Wirral Community
Health and Care
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

1 INTRODUCTION

1.1 General

These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and the Independent Regulator's relevant guidance. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including any trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer. These SFIs do not set out in full the requirements of the Independent Regulator's guidance and all relevant guidance of the Independent Regulator should be consulted. Such guidance will also change over time and these SFIs do not record or reference all such applicable guidance.

Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal.

Overriding Standing Financial Instructions - If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.

All policies and procedures of the Trust, to the extent that they are consistent with this SFI, must be followed by all governors, directors and officers of the Trust in addition to the provisions of the SFI (whether specifically referenced in this schedule or not).

1.2 Terminology

The definitions within the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are described on pages 5 & 6 of this manual.

Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting

on behalf of the Trust, including nursing and medical staff and consultants practising on the Trust premises and members of staff of the PFI contractor or Trust staff working the contractor under retention of employment model.

1.3 Responsibilities and Delegation

The Board exercises financial supervision and control by:

- formulating the financial strategy
- requiring the submission and approval of the Annual Plan and budgets within overall income
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
- defining specific responsibilities placed on the Board and employees as indicated in the Scheme of Reservation and Delegation.

The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Reservation & Delegation document. All other powers have been delegated to such other committees as the Trust has established.

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as the Accounting Officer, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chair and Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that members of the Board and employees and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

The Chief Finance Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies; (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes.)
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

- the provision of financial advice to other members of the Board of Directors and employees;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All members of the Board and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

2 AUDIT, ANTI-FRAUD, CORRPUTION, BRIBERY AND SECURITY

2.1 Audit Committee

The Audit Committee has been formally constituted by the Board of Directors in accordance with its Standing Orders and will report through to the Board of Directors. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

The committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the committee.

The committee is authorised to obtain outside legal and other independent professional advice and to secure the attendance of outsiders with relevant experience, expertise if it considers it necessary.

2.2 Scope and Duties

In order to fulfil its role effectively, the Committee will undertake the following:

2.2.1 Governance, risk management and internal control

The committee shall seek an independent review of the work of the relevant committees to enable it to review the establishment and maintenance of an

effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Committee shall have responsibility for final sign off of the Trust's Annual Quality Report.

The Committee will specifically review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The Corporate Governance Manual, Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

2.2.2 Internal audit

The committee shall ensure that there is an effective internal function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignations and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the Audit needs of the organisation as identified in the Assurance Framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources through the

use of the audit tracker (the detail of the internal audit reports will be scrutinised at the relevant committees of the board)
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- An annual review of the effectiveness of internal audit.

2.2.3 External audit

The committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work.

This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

2.2.4 Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff functions (for example, Royal Colleges, accreditation bodies, etc)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

In reviewing the work of the Quality & Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

2.2.5 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall approve the counter fraud plan and review the outcomes of counter fraud work.

2.2.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

2.2.7 Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

In performing its duties, the Committee will have due regard to the Trust's commitment to equality, diversity and human rights as well as compliance with the Equality Act 2010 and other legislation requirements.

2.2.8 Whistleblowing

In accordance with the UK Code, the Audit Committee shall remain aware of the arrangements and processes in place by which staff of the organisation may in confidence, raise concerns about possible improprieties in matters of financial reporting or others matters.

The Audit Committee shall acknowledge the work and oversight of the Board of Directors and the Quality & Governance Committee in the application of the Trust's Raising Concerns Policy (GP51).

This will be facilitated through the Audit Committee's review of the minutes from the Quality & Governance Committee where quarterly assurance reports are presented.

2.3 Chief Finance Officer

The Chief Finance Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
- ensuring that internal audit is adequate and meets the Public Sector Internal Audit Standards;
- deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;
- ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:
- a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards,
- major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- progress against plan over the previous year,
- strategic audit plan,
- a detailed plan for the coming year.

The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises, members of the Board of Directors or employee of the Trust;
- the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and
- explanations concerning any matter under investigation.

2.4 Role of Internal Audit

The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.
- The provision of an independent and objective view specifically to help line management improve the organisation's risk management, control and governance arrangements.

Internal Audit will review, appraise and report upon:

- The extent of compliance with, and the effect of, relevant established policies, plans and procedures;
- The adequacy and application of financial and other management controls;
- The suitability of financial and other management data;
- The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  - fraud and other offences,

- waste, extravagance, inefficient administration,
- poor value for money or other causes.

- Internal Audit shall also independently verify the Assurance Framework in accordance with guidance from the Department of Health.

Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

The Head of Internal Audit shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The Head of Internal Audit shall have access to report direct to the Chairman or a non-executive member of the Trust's Audit Committee.

Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Financial Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Financial Officer and Audit Committee.

2.5 External Audit

The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors (FT constitution para 38).

The Audit Code for NHS Foundation Trusts ('The Audit Code') contains directions of the Independent Regulator under Schedule 7 paragraph 24 of the National Health Service Act 2006, with respect to the standards, procedures and techniques to be adopted by the Auditor.

The Trust shall apply and comply with the Audit Code.

The Auditor shall be required by the Trust to comply with the Audit Code.

In the event of the Auditor issuing a public interest report the Trust shall forward a report to the Independent Regulator within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Trust's response to the issues raised within the public interest report.

2.6 Counter Fraud

The Trust shall take all necessary steps to counter fraud and deal effectively with security management issues affecting NHS funded services in accordance with;

- ~~The NHS Fraud and Corruption Manual published by the Counter Fraud and Security Management Service (CFSMS)~~
- The NHS Counter Fraud National Strategy 2023-26
- Government Functional Standard GovS 013: Counter Fraud
- NHS Resolution Anti-Fraud, Bribery and Corruption Policy and Procedures
- The main key areas of activity as outlined by NHS Protect and within an agreed work plan.
- The Trust shall nominate a suitable person to carry out duties of the Local Counter Fraud Specialist (LCFS) in accordance with the relevant Secretary of State Directions.
- The Local Counter Fraud Specialist will provide a written plan and report to the Audit Committee, at least annually, on counter fraud work within the Trust.
- The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work with NHS Protect

2.7 Security Management

In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Trust contractual requirements for security management
The Trust shall nominate a suitable person to carry out duties of the Local Security Management Specialist (LSMS) in accordance with the relevant Secretary of State Directions.

The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated via the ~~Chief Financial Officer~~ Chief Operating Officer to Local Security Management Specialist (LSMS).

3. FINANCIAL PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Financial Planning

The Chief Executive or nominated director will compile and submit to the Board annually a Financial Plan which takes into account financial targets as defined by the regulator. The plan will detail the significant assumptions on which it is based and contain, (but not be limited to):

- activity and income plans;
- expenditure;
- operational requirements and capacity;
- cost improvement plans;
- capital programme;
- cashflow and liquidity; and
- risk ratings.

3.2 Budgets

Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the financial plan;
- accord with workload and manpower plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;

- identify potential risks and mitigations;
- be based on reasonable and realistic assumptions;
- be prepared on a basis to maximise value for money; and
- enable the Trust to comply with the requirements of the Single Oversight Framework set by NHSE.

The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board. Any significant variance should be reported by the Chief Finance Officer to the Board as soon as they come to light and the Board shall be advised of action to be taken in respect of such variances.

All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

The Chief Finance Officer has a responsibility to ensure that adequate financial training is delivered on an on-going basis to budget holders to help them manage their budgets effectively.

3.3 Budgetary Delegation

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and
- the provision of regular reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

3.4 Budgetary Control and Reporting

The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

- Statement of Comprehensive Income to date showing trends and forecast year-end position;
- Statement of Financial Position including movement in working capital;
- Cash flow;
- Capital project spend and projected outturn against plan;
- Explanations of any material variances from plan/budget;
- Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;
- The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

- Investigation and reporting of variances from financial, workload and manpower budgets;
- Monitoring of management action to correct variances;
- Arrangements for the authorisation of budget transfers;
- Advising the Chief Executive and Board of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall provide advice on the economic and financial impact of future plans and projects;
- Review of the basis and assumptions used to prepare the budgets.
- In the performance of these duties the Chief Finance Officer will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

Each Budget Holder is responsible for ensuring that:

- any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the budget holder's line manager;
- officers shall not exceed the budget limit set;
- the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;
- no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

The Chief Operating Officer and is responsible for ensuring delivery of the Trust's cost improvement programme in line with agreed schemes and with appropriate quality and equality impact assessments.

3.5 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.6 Monitoring Returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSE within the specified timescales.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 Accounts

The Foundation Trust shall prepare accounts in respect of each financial year in such form as NHSE may, with the approval of HM Treasury, direct. The accounts are to be audited by the Foundation Trust's External Auditor. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

- the accounts;
- any records relating to them;
- any report of the External Auditor on them

The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer. The Accounting Officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts in such form as NHSE may, with the approval of the HM Treasury, direct. The Accounting Officer will comply in preparing accounts with HM Treasury guidance as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts; and
- shall be responsible for the functions of the Foundation Trust as set out in the 2006 NHS Act.

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

- the annual report including the annual accounts; and
- any report of the External Auditor on them;

The Accounting Officer shall cause the Foundation Trust to lay a copy of the annual accounts, and any report of the External Auditor on them, before Parliament and once it has done so, send copies of those documents to NHSE.

Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

4.2 Annual Reports

The Foundation Trust shall prepare an Annual Report and send it to NHSE. The reports are to give information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership; and any other information NHSE requires.

The Foundation Trust is to comply with any decision NHSE makes as to the form of the reports; when the reports are to be sent to them; and the periods to which the reports are to relate.

The Financial Auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the External Audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

5. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

5.1 General

The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. The Board of Directors shall approve the banking arrangements.

5.2 Bank and GBS Accounts

The Chief Finance Officer is responsible for:

- bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health or commercial entity;
- establishing separate bank accounts for the Foundation Trust's non-exchequer funds;
- ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken);

All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

5.3 Banking Procedures

The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts, which must include:

- the conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

The Chief Finance Officer must ensure the accounts are operated in accordance with the conditions agreed with the Foundation Trust's bankers. The Chief Finance Officer shall approve security procedures for any cheques issued without a hand-written signature. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

5.4 Trust Credit Cards

The Chief Finance Officer shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether credit cards are being used appropriately; and take action where inappropriate use is identified.

5.5 Tendering and Review

The Chief Finance Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking. This review is not applicable to GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income System

The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties. The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges other than Foundation Trust Contract

The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health, NHSE or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship - Ethical standards in the NHS (2000) shall be followed NHS England's Managing Conflicts of Interest in the NHS (2017) as well. See also Standing Orders.

All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts. Overpayments should be detected (or preferably prevented) and recovery initiated. Income not received should be dealt with in accordance with the Losses procedure.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

The Chief Finance Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; (No form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);
- ordering and securely controlling any such stationery;
- the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs. Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc. All cheques, postal orders, cash etc., shall be banked promptly intact under arrangements approved by the Chief Finance Officer. Disbursements

shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by the Counter Fraud and Security Management Service. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Foundation Trust's Losses Procedure.

7. FOUNDATION TRUST CONTRACTS

7.1 Contracts

7.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable contracts and sub-contracts with Commissioners for the provision of Health & Care services.

7.1.2 The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. This should take into account:

- the standards of service quality expected;
- the relevant national service framework and/or national performance metrics (if any);
- the provision of reliable information on cost and activity;
- ability to provide timely and accurate information / reports relating to agreed CQUIN targets;
- the provision of agreed information regarding outcome measures; and
- any other matters relating to contracts of a legal or non-financial nature.

7.1.3 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in the both the delivery and commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Foundation Trust can jointly manage risk with all interested parties.

7.1.4 The table in appendix 1 section 9 outlines the delegated levels for contract signatory for expenditure and income, including contract extensions or variations that have financial impact.

7.1.5 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast performance against the contract. This will include information on income and costing arrangements for the contract.

7.2 Non-Commercial Contract

Where the Foundation Trust enters into a relationship with another organisation for the supply or receipt of other services - clinical or non-clinical, the responsible officer should ensure that an appropriate non-commercial contract is present and signed by both parties.

This should incorporate:

- a description of the service and indicative activity levels;
- the term of the agreement;
- the value of the agreement;
- the lead officer;
- performance and dispute resolution procedures;
- risk management and clinical governance arrangements; and
- exit provisions

Non-commercial contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement to ensure value for money and to minimise the potential loss of income.

Non-clinical services

Where the Foundation Trust is placing sub-contracts for non-clinical goods and services, they should use the standard NHS terms and conditions for procuring goods and services, published by the Department of Health and Social Care.

Non-clinical services should be commissioned using the NHS Terms and Conditions for the Supply of Goods (Contract Version), the NHS Terms and Conditions for the Provision of Services (Contract Version) and the combined NHS Terms and Conditions for the Supply of Goods and the Provision of Services (Contract Version).

These contracts should be used where a signed contract is required and the commercial schedule, specification and tender response document and all other schedules will be bound together with the legal terms and conditions to form the contract.

The NHS Terms and Conditions for the Supply of Goods (Contract Version) should be used for purchasing all types of goods including medical devices and pharmaceutical products. Optional schedules can be used when installation and commissioning services and/or maintenance services are required in connection with the goods to be purchased.

The NHS Terms and Conditions for the Provision of Services (Contract Version) should be used for purchasing all types of services including facilities related services, back-office services and all types of outsourcing. This includes all instances where there will be a transfer of staff at the commencement of the services.

The combined NHS Terms and Conditions for the Supply of Goods and the Provision of Services (Contract Version) can be used for the supply of goods and services together.

The NHS Terms and Conditions for the Supply of Goods (Purchase Order Version), the NHS Terms and Conditions for the Provision of Services (Purchase Order Version) and the NHS Terms and Conditions for the Supply of Goods and the Provision of Services (Purchase Order Version) should be used where the intention is that a contract incorporating the terms and conditions is formed when you place a purchase order. There will not be a signed contract.

Some expenditure is exempt from the requirement of a purchase order (please see table 12 in the Delegated Financial Limits appendix.

Clinical services

The NHS Standard Subcontract (full-length and shorter form) should be used for clinical service sub-contracting, with the full-length NHS Standard Contract and with the shorter form Contract. These model sub-contracts, provide a systematic means of flowing down the relevant provisions from the Trust's "head contract" to the sub-contractor.

Where the NHS Standard Contract is not the "head contract", the terms of the sub-contract need to reflect the "head contract" appropriately. Use of the NHS Standard Subcontract is therefore not appropriate in such cases. There is no equivalent national template form of sub-contract for use with some standard contracts e.g. dental and Public Health therefore in line with NHS Standard Contract Guidance the Foundation Trust should produce local form contracts making sure that there satisfactorily "flows down" to the sub-contractor of the relevant obligations placed on them through the header contract.

7.3 Tendering (where WCHC is a competing body)

Where the Foundation Trust participates in a tendering exercise (whether in competition with others or not) for a health-related service, approval must be sought according to the delegated authority limits.

Delegated authority limits associated with tendering are outlined in appendix 1 section 9. No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Foundation Trust employee should sign a tender or contract unless they have authority, and the total contract value is within their delegated financial limits. All tender decisions will be reported to Foundation Trust Executive Leadership Team for noting.

Staff who participate in a tendering exercise must notify the Chief Strategy Officer and ensure appropriate authority is sought to tender for services.

8. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration Committee

In accordance with the Constitution, the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other senior employees), including:

- all aspects of salary (including any performance-related elements and bonuses);
- provisions for other benefits, including pensions and cars, arrangements for termination of employment and other contractual terms;
- review recommendations to the Board of Directors on the remuneration and terms of service of Executive Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust - having proper regard to the Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;
- determine the expenses policy of the Foundation Trust
- determine the relocation policy of the Foundation Trust
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board of Directors meetings should record such decisions.

The Council of Governors, at a general meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors (FT constitution para 34).

8.2 Funded Establishment

The workforce plans incorporated within the annual budget will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Director of People & Culture under delegation from the Chief Executive. The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the SoRD. The Divisional Accountant is responsible for verifying that funding is available.

8.3 Staff Appointments

No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

- unless authorised to do so by the Chief Executive; and
- within the limit of their approved budget and funded establishment as defined in the SoRD.

The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 Processing the Payroll

The processing of the Foundation Trust's payroll is a contracted-out service. The Chief People Officer remains responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;
- the financial determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
- making payment on agreed dates; and
- agreeing method of payment.

The Chief People Officer in conjunction with the Chief Finance Officer will issue instructions regarding:

- verification and documentation of data;
- the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- security and confidentiality of payroll information;
- checks to be applied to completed payroll before and after payment;
- authority to release payroll data under the provisions of the Data Protection Act;
- methods of payment available to various categories of employee;
- procedures for payment by cheque, bank credit, or cash to employees procedures for the recall of cheques and bank credits;
- pay advances and their recovery;
- maintenance of regular and independent reconciliation of pay control accounts;
- separation of duties of preparing records and handling cash; and
- a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

Appropriately nominated managers have delegated responsibility for:

- processing a signed copy of the contract / appointment form and such other documentation as may be required immediately upon an employee commencing duty;
- submitting time records, and other notifications in accordance with agreed timetables;

- completing time records and other notifications in accordance with the Chief Executives Instructions and in the form prescribed by the Chief Executive; and
- submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

Regardless of the arrangements for providing the payroll service, the Chief Executive in conjunction with the Director of People & Culture shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

The Board of Directors shall delegate responsibility to a manager for:

- ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health & Safety legislation; and
- dealing with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

The Board of Directors will approve the level of non-pay expenditure on regular basis and the Chief Executive will determine the level of delegation to budget holders.

The Chief Executive will set out;

- the list of managers who are authorised to place requisitions for the supply of goods and services which should be updated and reviewed on an on-going basis and annually by the Finance & Procurement Departments.
- where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and
- the maximum level of each requisition and the system for authorisation above that level.

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust. In so doing, the advice of the Foundation Trust's advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

The Chief Finance Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Chief Finance Officer will:

- Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed;
- Prepare procedural instructions where not already provided in the Scheme of Reservation and Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;
- Be responsible for the prompt payment of all properly authorised accounts and claims;
- Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

The system shall provide for:

- A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.
- Certification that;
  - goods have been duly received, examined and are in accordance with specification and the prices are correct;
  - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
  - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
  - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
  - the account is arithmetically correct;
  - the account is in order for payment.
- A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- Instructions to employees regarding the handling and payment of accounts within the Finance Department.

- Responsibility for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance, and training are only permitted where exceptional circumstances apply. In such instances:

- Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate;
- The appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and
- The Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must:

- be consecutively numbered;
- be in a form approved by the Chief Finance Officer;
- state the Foundation Trust terms and conditions of trade; and
- only be issued to, and used by, those duly authorised by the Chief Executive.

Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

- All contracts other than for a simple purchase permitted within the Scheme of Reservation and Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
- Contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulations (2015) on public procurement;
- Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
- Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.
- No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
  - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
  - conventional hospitality, such as lunches in the course of working visits;

- No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;
- All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;
- Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order".
- Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future un-competitive purchase;
- Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer ;
- Petty cash records are maintained in a form as determined by the Chief Finance Officer; and,
- Orders are not required to be raised for utility bills, NHS Recharges; and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non-pay.

The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant Public Contract Regulations (2015) and IFRS accounting guidance.

Under no circumstances should goods be ordered through the Foundation Trust for personal or private use with the exception of permitted schemes such as lease cars or the cycle to work scheme.

9.3 Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made shall comply with procedures laid down by the Chief Finance Officer.

10. FINANCIAL FRAMEWORK

The Chief Finance Officer should ensure that members of the Board are aware of the Financial Framework issued by NHSE and the requirements of the annual planning guidance.

11. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital investment

The Chief Executive:

- shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

- is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges; and
- that NHSE is notified if the Foundation Trust has plans for material transactions in accordance with the thresholds defined in NHSE's Single Oversight Framework. NHSE will determine whether they class the transaction as material or significant. Material investments can, under specific conditions set out in NHSE's Compliance Framework, be approved by the FT's Board of Directors. Significant investments must be assessed by NHSE before the Foundation Trust can proceed. In addition all transactions which potentially impact the Financial Sustainability Risk Rating must also be notified to NHSE. All PFI transactions require NHSE assessment. All decisions to borrow money, from any source, will be rigorously reviewed by the Board of Directors and the Foundation Trust will undertake its own financial due diligence using independent financial experts prior to making any decision.

For capital expenditure proposals the Chief Executive shall ensure *(in accordance with the limits outlined in the Scheme of Reservation and Delegation - Delegated Financial Limits);*

- that a business case is produced setting out:
  - an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
  - appropriate project management and control arrangements; and
  - the involvement of appropriate Foundation Trust personnel and external agencies
- that the Chief Finance Officer has sought professional advice and assurance regarding the capital costs and has assessed and verified the revenue consequences detailed in the business case.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management. The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

- specific authority to commit expenditure;
- authority to proceed to tender;
- approval to accept a successful tender.

The Chief Executive will issue a Scheme of Reservation and Delegation for capital investment management which will be detailed in the Foundation Trust's Governance Manual.

The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes.

11.2 Private Finance

The Foundation Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
- where the sum involved exceeds delegated limits, the business case must be referred to the appropriate external authoriser Department of Health / NHSE for approval or treated as per current guidelines.
- the proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires; and
- the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

11.3 Asset registers

The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating and arranging for a physical check of assets against the Asset Register to be conducted on a regular basis. The Foundation Trust shall maintain an Asset Register recording fixed assets and additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour including appropriate overheads;
- lease agreements in respect of assets held under a finance lease and capitalised; and
- independent valuation of assets

Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers. The value of each asset shall be adjusted to current values in accordance with the principles outlined in the Annual Reporting Manual issued by NHSE and the value of each asset shall be depreciated also adhering to the methodology set out in the Annual Reporting Manual.

Any disposal of fixed assets must be in compliance with the Terms of the Trust License specifically section 5 conditions COS2 - restriction on the disposal of assets.

11.4 Security of assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

- recording managerial responsibility for each asset;
- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All significant discrepancies revealed by verification of physical assets to the Fixed Asset Register shall be notified to the Chief Finance Officer. Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.
Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses. Where practical, assets should be marked as Trust property.

12. STOCKS, STORES AND RECEIPT OF GOODS

12.1 Stocks

Stocks are defined as those goods normally utilised in day to day activity, but which a given point in time have not been used or consumed. There are three broad types of store;

- Controlled stores - specific areas designated for the holding and control of goods;
- Clinical areas and departments - goods required for immediate usage to support operational services; and
- Manufactured items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.
- Such stocks should be kept to a minimum and for;

    - controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stocktake or perpetual inventory procedures; and
    - valued at the lower of cost and net realisable value.

Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers / keepers,

subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer. The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practical, stocks should be marked as NHS property. The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores and losses.

Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer. The designated manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 13 - Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.2 Receipt of Goods

A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and / or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available. All goods received shall be entered onto an appropriate goods received / stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately. For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high volume low value items such as stationery.

13. DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and condemnations

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate. All unserviceable articles shall be:

- condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
- recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

13.2 Losses and special payments

Losses

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Finance Officer who will liaise with the Chief Executive.

Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud, bribery or corruption, the Chief Finance Officer must inform their Local Counter Fraud Specialist who will inform NHS Protect regional team **before** any action is taken and reach agreement how the case is to be handled. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify;

- the Board of Directors, and
- the External Auditor
- NHS Protect (through the Local Counter Fraud Specialist)

The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations. For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

Write-Offs and Special Payments

The writing-off of debts, the abandonment of claims and the making of any kind of special or ex-gratia payments will be approved in accordance with the scheme of delegation. In approving the write-off of debts consideration will be made of the nature of the monies owed and the likelihood of the receipt of monies against any costs which may be incurred in attempting to recover the debt. In approving

special payments account will be taken of national guidance, any precedents and any potential for admitting liability for further claims.

The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

13.3 Compensation Claims

The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and NHS Resolution in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim. The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by;

- Adopting prudent risk management strategies including continuous review.
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants.
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice.
- Following guidance issued by NHS Resolution relating to clinical negligence.
- Complying with Care Quality Commission Regulations.
- Implementing an effective system of Clinical Governance

The Medical Director is responsible for managing the clinical negligence governance framework: for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

14. INFORMATION TECHNOLOGY

14.1 Responsibilities and Duties of the Chief Finance Officer

The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

- devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (update 2000) and the Computer Misuse Act 1990;
- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;
- ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

The Chief Finance Officer shall satisfy themself that new financial systems and amendments to current financial systems are developed in a controlled

manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.2 Freedom of Information

The Director of Corporate Affairs shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Foundation Trust that we make publicly available.

14.3 Responsibilities and Duties of other Directors and Officers in relation to IM&T and Information Governance

14.3.1 General

In order to ensure compatibility and compliance with the Trust's IM&T Strategy, no computer hardware, software or facility will be procured without authorisation of the Chief Finance Officer and Chief Information Officer.

14.3.2 Information Governance

The Head of Information Governance together with the Head of Procurement are to ensure that all Trust contracts and SLAs have appropriate clauses to protect the Trust and its staff, patients and other stakeholders from any risk of breach of confidentiality or breach of Information Governance standards.

14.3.3 Risk Assessment

The Chief Strategy Officer shall ensure that risks to the Foundation Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans. The Foundation Trust shall disclose to NHSE and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the Terms of Authorisation, Schedule 6. Other information, as requested, shall be provided to NHSE

15. FUNDS HELD ON TRUST

15.1 Corporate Trustee

Management and administration of the Foundation Trust's Charitable Funds is undertaken on behalf of the Foundation Trust by Cheshire and Wirral Partnerships NHS Foundation Trust.

The Foundation Trust is responsible, as a corporate Trustee, for the management of funds it holds on Trust and shall comply with Charities Commission latest guidance and best practice.

The discharge of the Foundation Trust's corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Finance Officer shall ensure that each fund which the Foundation Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

15.2 Accountability to Charity Commission and Secretary of State for Health

The Trustee responsibilities must be discharged separately and full recognition given to the Foundation Trust's dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Secretary of State for all funds held on Trust.

The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Officers must take account of that guidance before taking action.

15.3 Applicability of Standing Financial Instructions to funds held on Trust

In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on Trust.

The over-riding principle is that the integrity of each Trust must be maintained and statutory and Foundation Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16. TENDERING AND CONTRACT PROCEDURE

16.1 Duty to comply with Standing Orders and SFIs

The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Standing Orders and SFIs (except where Suspension of Standing Orders is applied).

16.2 Directives Governing Public Procurement

Directives by the Public Contract Regulations (2015) promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and SFIs. Procedure notes detailing Public Contract Regulations (2015) thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust.

16.3 Formal Competitive Tendering

The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the

Department of Health); and
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

Where the Foundation Trust elects to invite tenders for the supply of healthcare these SFIs shall apply as far as they are applicable to the tendering procedure.

Formal tendering procedures are not required where:

- the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the SoRD, (this figure to be reviewed annually); or
- the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or
- regarding disposals as set out in SFIs 'Disposals and Condemnations'.

16.4 Direct Award

Procurements may be awarded by Direct Award ~~may be waived~~ in the following circumstances:

- Prototypes and development
- Single suppliers
- Additional or repeat goods, services or works
- Commodities
- Advantageous terms on insolvency
- Urgency
- Defence and security

Further detail is available in Schedule 5 of Procurement Act 2023

16.4 Fair and Adequate Competition

Where applicable the Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of suppliers / individuals to provide fair and adequate competition as appropriate, and ~~in no case less than three suppliers / individuals,~~ having regard to their capacity to supply the goods or materials or to undertake the services or works required.

16.5 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Procurement Act 2023 ~~Public Contract Regulations (2015) without Department of Health approval.~~

16.6 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in ~~this~~ these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Audit Committee and be recorded in an appropriate Foundation Trust record.

16.7 Contracting / Tendering Procedure

All tenders for goods and services with a value greater than £50,000 (inc VAT) must be published on the Central Digital Platform ~~contracts finder website~~.

16.8 Invitation to tender

1. all invitations to tender shall state the date and time as being the latest time for the receipt of tenders;
2. all invitations to tender shall state the procedures to be followed in submitting the tender;
3. every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable;
4. every tender for building or engineering works should be subject to the appropriate form of contract.

16.9 Receipt and Safe custody of Tenders

Tenders will be carried out using an electronic tendering system. The Chief Executive or their nominated representative will be responsible for the system to track the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The data and time of receipt of each tender shall be recorded. Access to the electronic tendering system will be by username and password and a full audit trail will be maintained. The system will ensure that submitted tenders, apart from in-house bids, cannot be accessed by any member of the Trust until after the closing date.

16.10 Opening Tenders and Register of Tenders

As soon as possible after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the Procurement lead, designated by the Chief Executive and not from the originating department;

The ‘originating’ Department will be taken to mean the department sponsoring or commissioning the tender. The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved Senior Manager from the Finance Department from serving as one of the managers to open tenders;

The date and time of the designated person opening every tender will be recorded in the audit trail of the trusts electronic tendering system;

An electronic audit record shall be maintained by the trusts e-tendering portal and maintained by the Head of Procurement, designated by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the name of all suppliers individuals invited;
- the names of suppliers individuals from which tenders have been received;
- the date tenders were opened;
- the person opening the tenders;
- the price shown on each tender; and
- a note where alterations have been accepted;

Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (see below).

16.11 Admissibility

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive. Where only one tender is sought and / or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

16.12 Late Tenders

Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer ie system failure. Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders, where significant financial, technical or delivery advantages would accrue and are satisfied that there is no reason to doubt the legitimacy and only then if the tenders that have been opened have not left the custody of the e-tendering portal or if the process of evaluation and adjudication has not started. While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody in the trusts e-tendering portal.

16.13 Acceptance of formal tenders

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of contract will not disqualify the tender. The tender which is the most economically advantageous to the Trust will be accepted. The weighting of finance, quality and other measures in determining the most economically advantageous tender will be consistent with the invitation to tender.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

All tenders should be treated as confidential and should be retained for inspection.

16.14 Tender reports to the Board of Directors

Reports to the Board of Directors will be made on an exceptional circumstance basis only.

16.15 General Position on quotations

Quotations are required where tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to exceed the sum thresholds defined in the SoRD.

16.16 Competitive Quotations ~~(£10-50k)~~ £12,000 to £50,000 (inc VAT)

Quotations may be obtained from ~~at least three~~ suppliers / individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust. Quotations must be obtained via the Trusts e-tendering portal via the procurement Team. For the avoidance of doubt, writing includes electronic means which can be permanently recorded. All quotations should be treated as confidential and should be retained for inspection. The Chief Executive or their nominated officer should evaluate the quotation and select the quote which is the most economically advantageous to the Trust. The factors used to determine economic advantage should be recorded in a permanent record.

16.17 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation trust and which is not accordance with SFIs except with the authorisation of either the Chief Executive or Chief Finance Officer.

16.18 Authorisation of Tenders

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in Section 9 of the SoRD. These levels of authorisation may be varied or changed. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

16.19 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering is not required the Foundation Trust should adopt one of the following alternatives;

- the Foundation Trust shall use the NHS Supply Chain or other national contracts/frameworks for procurement of all goods and services unless the Chief Executive or nominated officer deems it inappropriate. The decision to use alternative sources must be documented; and
- If the Foundation Trust does not use the NHS Supply Chain or other national contracts/frameworks – where tenders are not required, because expenditure is below the levels defined in the SoRD, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

16.20 Private Finance for Capital Procurement

The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the

following should apply:

- The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers an appropriate proportion of risk to the private sector;
- Where the sum exceeds delegated limits, a business case must be referred to NHSE in accordance with guidelines in the Single Oversight Framework;
- The proposal must be specifically agreed by the Board of the Foundation Trust; and
- The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

16.21 Compliance requirement for all contracts

The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- The Foundation Trust's SOs and SFIs;
- Public Contract Regulations (2015) and other statutory provisions;
- Procurement Act 2023
- The Health Care Services (Provider Selection Regime) Regulations 2023
- Such of the NHS Standard Contract Conditions as are applicable;
- Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
- Where appropriate contracts shall be in or embody the same terms of conditions of contract as was the basis on which tenders or quotations were invited; and
- NHSE principles / regulations.

In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

16.22 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. All contracts should be compliant with DH / HMRC tax rules and mitigate the Trust's liability for individual non-compliance accordingly.

16.23 Foundation Trust Contracts / Healthcare Service Agreements

Service agreements with NHS providers for the supply of healthcare services are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to SoRD).

16.24 Disposals

Competitive Tendering procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only be negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
- obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;
- items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;
- items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and
- land or buildings concerning with DH guidance has been issued but subject to compliance with such guidance.

All contractors should be compliant with DH / HMRC tax rules and mitigate to Trust's liability for individual non-compliance accordingly;

For any of the conditions noted above, check with the financial accountant prior to progressing.

16.25 In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering. In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification Group, comprising the Chief Executive or nominated officer/s and Specialist;
- In-house tender group, compromising a nominee of the Chief Executive and technical support; and
- Evaluation team, comprising normally a specialist officer, a supplier's officer and a Chief Finance Officer representative.

All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders. The evaluation team shall make recommendations to the Board of Directors and the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

Where the Trust is considering providing a service in-house which is currently contracted-out the same groups should be set up to evaluate the service and make recommendations to the Board of Directors.

16.26 Applicability of SFIs on Tendering and Contracting to funds held in trust

These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's charity and private resources. There may be times when instructions may be

waived e.g. when there is an opportunity to purchase an asset of strategic importance / benefit to the Trust.

17. ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

The Chief Finance Officer shall ensure all staff and any other interested and applicable parties are made aware of the Foundation Trust Policy - GP7 Declaration of Interests, Gifts, Hospitality and Outside Employment and the Standards of Business and Personal Conduct. This policy makes due provision to the Bribery Act 2010 and reflects the conflicts of interest guidance issued by NHS England. The policy is deemed to be an integral part of the Foundation Trust's Governance Manual and SFIs.

18. PAYMENTS TO INDEPENDENT CONTRACTORS

The Foundation Trust will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractors' NHS terms and conditions of service.

The Chief Executive shall;

- ensure that lists of all contractors, for which the Foundation Trust is responsible, are maintained in an up-to-date condition; and
- ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service. The Chief Finance Officer shall:
- ensure that only contractors who are included on the Foundation Trust's approved lists receive payments;
- maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;
- ensure that regular independent verification of claims is undertaken, to confirm that rules have been correctly and consistently applied;
- overpayments are detected (or preferably prevented) and recovery initiated;
- suspicions of possible fraud are identified and subsequently dealt with; and
- ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation.

19. RETENTION OF DOCUMENTS

19.1 Context

All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) - (2). ~~The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.~~ The ISO standard ISO 15489-1:2016 defines a record as: 'Information created, received, and maintained as evidence and as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business.'

Section 205 of the Data Protection Act 2018 defines a health record as a record which:

- consists of data concerning health
- has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates

19.2 Accountability

The Trust has in place a **Records Management Policy – GP6** and an **Information Governance Policy – IG01** which apply to all staff. These policies are available on Staff Zone.

~~The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and/or obsolete services. Under the Public Records Act all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.~~

~~The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in Department of Health guidance, Records Management Code of Practice.~~

19.3 ~~Types of Record Covered by the Code of Practice~~

~~The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:~~

- ~~Patient health records (electronic or paper based);~~
- ~~Records of private patients seen on NHS premises;~~
- ~~Accident and emergency, birth and all other registers;~~
- ~~Theatre registers and minor operations (and other related) registers;~~
- ~~Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint-handling);~~
- ~~X-ray and imaging reports, output and other images;~~
- ~~Photographs, slides and other images;~~
- ~~Microform (i.e. fiche / film);~~
- ~~Audio and video tapes, cassettes, CD-ROM etc.;~~
- ~~Emails;~~
- ~~Computerised records;~~
- ~~Scanned records;~~
- ~~Text messages (both out-going from the NHS and in-coming responses from the patient).~~

~~The documents held in archives shall be capable of retrieval by authorised persons and documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.~~

20. RISK MANAGEMENT

20.1 Programme of Risk Management

The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board of Directors. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including; Internal Audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured;
- arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

20.2 Insurance Arrangements

The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Resolution, use commercial insurance or self-insure for some or all of the risks to which the Foundation Trust is exposed. A combination of all three may be used. If the Board decides not to use NHS Resolution risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

In addition, the Board of Directors will need to consider the implications of leaving the NHS Resolution scheme upon its quality profile as determined by NHSE and the CQC.

20.3 Insurance arrangements with commercial insurers

The following areas are not covered by NHS Resolution schemes and therefore need to be covered by commercial insurance or self-insurance:

- Motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;
- Where the Foundation Trust is involved with a consortium in a Private Finance Initiative (PFI) contract and the other consortium members require that commercial insurance arrangements are entered into; and
- Income generation schemes are not covered by NHS Resolution schemes. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health.

20.4 Arrangements to be followed by the Board of Directors in agreeing Insurance cover

The Chief Finance Officer shall examine the options with regards to insurance cover and make a recommendation to the Board on which arrangements, or combination of arrangements, represent the best value for money for the Foundation Trust. In coming to their decision the Board will take account of the impact of a major incident / loss on the operation and reputation of the Trust.
Where the Board decides to use commercial insurance the insurance contract will be let subject to the procurement rules set out in these SFIs. The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case and will maintain records of the policies and insurance certificates in line with the retention of records policy.

DELEGATED FINANCIAL LIMITS - ~~Updated May 2023~~ Updated June 2025

Financial Limits (subject to funding available in budget)		
	Value	**Delegation**
1. Gifts and Hospitality		
Any gifts or hospitality or offers of gifts or hospitality which exceed the £25 threshold must be declared. Low-cost branded aids offered by a supplier or contractor should only be accepted if their value does not exceed the industry standard of £6 (as per NHS England guidance)	£25	Chief Finance Officer
2. Legal / Litigation Claims		
Most claims will be covered by NHSLA, any other litigation claims should be reported to Board via the Quality & Safety Committee	Over £100,000	Board of Directors
	Up to £100,000	Chief Executive
	Up to £50,000	Chief Finance Officer
	Up to £10,000	Claims Manager
3. Litigation, losses, Compensation & Special Payments - All to be reported to the Audit Committee		
This includes losses relating to fruitless payments (including abandoned capital schemes), loss of cash due to theft, fraud, overpayments, damage to buildings, fittings, exgratia payments, write offs, bad debts and compensation payments	Over £10,000	Board of Directors
	Up to £10,000	Chief Executive / Chief Finance Officer
	Up to £1,000 (Write offs, bad debts and ex gratia payments only)	Deputy Chief Finance Officer
4. Petty Cash Disbursements		
Small incidental items of expenditure	Up to £100	Chief Finance Officer
	Up to £30	Deputy Chief Finance Officer
5. Authorisation of Sponsorship Deals		
A central register of sponsorships will be maintained by the Director of Corporate Affairs for reporting to Audit Committee	Above £20,000	Board of Directors
	Up to £20,000	Chief Executive / Chief Finance Officer

6. Management Consultants		
Adherence to SFIs is required for tendering of services	Over £50,000	Board of Directors (NHSE approval required)
	Up to £50,000	Chief Executive
	Up to £10,000	Chief Finance Officer
7. Capital Expenditure and Disposals (including IT Equipment)		

The annual capital programme will be submitted to the Board for overall approval prior to the new financial year following approval through Programme Oversight Group (POG) and the Integrated Performance Board (IPB). In year variations within the plan approved by the Board should be subject to approval by the Chief Executive and the Chief Finance Officer. In year variations in excess of the plan approved by the Board should be subject to approval by the Board. All Capital schemes require completion of a business case, templates and guidance for which are available from the Programme Management Office (All values exclusive of VAT). Disposal of capital assets approval are based on the carrying value at the time of disposal.		
8. Agreement of Contracts/ Service Level Agreements (including in-year variations to Contracts/Service Level Agreements)		
All pay and non-pay expenditure including software and IT equipment, maintenance contracts, service contracts, management consultants and call off orders. The limit is the total value over the life of the contract. All subject to funding available in budget. (inclusive of VAT) All contracts / service level agreements must be approved and signed off by Procurement and / or the Deputy Director of Contracts and Commissioning prior to sign off by the relevant budget holder. This applies to all values of contracts / service level agreements and includes those that are "zero-value".	Over £1,000,000	Board of Directors
	Up to £1,000,000	Chief Executive
	Up to £500,000	Chief Finance Officer
	Up to £100,000	Deputy Chief Finance Officer
	Up to £12,000	Budget Holder

Lifetime Income Contract Value (Non-NHS - Local Authority or other)

All limits include VAT where applicable

Lifetime contract value	**Approval**
Up to £500,000	Chief Financial Officer
Up to £1m	Chief Executive
Over £1m	Board of Directors

Local Authority contracts that are sealed require an Executive member witness signature

Lifetime Income Contract Value (NHS)	
Lifetime contract value	**Approval**
Up to £100,000,000	Chief Finance Officer
Over £100,000,000	Chief Executive

9. Budget Virement		
In accordance with the SFIs budgets may be vired, however all other budgetary controls will be required to be met	Over £100,000	Chief Executive
	Up to £100,000	Chief Finance Officer
	Up to £50,000	Other Directors
	Up to £25,000	Deputy Chief Finance Officer and Budget Holder

10. Quotations & Tenders		
Quotations - Obtain a minimum of 3 written quotations for goods/services	Over £12,000** up to £50,000	In accordance with Section 9
Tenders - Obtain a minimum of 3 written tenders for goods/services	Over £50,000 but below £139,688 (unless a direct award is approved by Chief Finance Officer)	In accordance with Section 9
Financial threshold set by regulation		
Good/services	Over £139,688*	In accordance with Section 9
Works	£5,372,609*	In accordance with Section 9
Light touch	£663,540*	In accordance with Section 9
*Regulatory thresholds are revised bi-annually ** All non-pay above £12,000 (inc VAT) must be published in the Central Digital Platform		
~~Supplies and Services (except R&D and certain telecom services)~~ ~~Social and other specific services, listed in Schedule 3 of Public Contract Regulations (2015) Reg 5 (1) (D) and (74)~~ ~~Light touch~~ ~~Works~~	~~£138,760~~ ~~£663,540~~ ~~£5,372,609~~ ~~£5,336,937~~	

12. Expenditure Exempt From Purchase Order		
Type of Expenditure	PO/Non PO	Rationale

Agency Staff: Admin & Clerical	Non-PO	Invoices paid via Booking System
Agency Staff: Medical	Non-PO	Invoices paid via Booking System
Agency Staff: Nursing & Non-Medical	Non-PO	Invoices paid via Booking System
Electricity	Non-PO	Managed by Tariff and bill validated, raising PO would add additional resource with no added value
External debt recovery charges	Non-PO	Debt payment plans are managed on a monthly basis
Fines and charges	Non-PO	Timescale to pay fines
FP10s	Non-PO	Prescribing activity
Fuel card	Non-PO	Based on fuel usage
Gas	Non-PO	Managed by Tariff and bill validated, raising PO would add additional resource with no added value
Medical gases	Non-PO	Infrequent low use and volume
Pharmacy Drugs	Non-PO	Paid via control account to WUTH
Staff benefits (e.g. salary sacrifice / car lease / childcare vouchers)	Non-PO	Finance and HR approvals in place
Telephone Calls and Rental	Non-PO	Timescale to pay and to manage late payment fees
Water and Sewerage	Non-PO	Managed by Tariff and bill validated, raising PO would add additional resource with no added value