NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

5 March 2025

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 29 Jan.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8 BAF Quarter 4 2024-25.pdf
- 9 IPR.pdf
- 9.1 WUTH IPR Dashboard - Feb 2025 - Intro.pdf
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- 9.5 CN Commentary - January 2025.pdf
- 9.6 WUTH IPR Dashboard - Feb 2025 - 4 CPO.pdf
- 9.7 CPO Commentary - for Feb BoD - Final.pdf
- 10 Estates and Capital Comm - MS edit.pdf
- 11 People Committee Chair's Report Feb25 Final.pdf
- 12 Audit Committee Chair's report for 20th February Meeting.pdf
- 13 Quarterley Maternity & Neonatal Report March 2025.pdf
- 14 Final Executive summary 6 Month Safe Staffing Report 24 25 (002).pdf
- 14.1 Final 6 Month Safe Staffing Report 24 25 (002).pdf

15 Guardian of Safe Working Report - Q3 October until December 2024.pdf

16 WUTH IPR Dashboard - Feb 2025 - 5 CFO.pdf

16.1 CFO Commentary M10 24-25 DRAFT.pdf

17 COO report for Jan 25 - March 25 meeting.pdf

18 Green and Sustainability Plan - Annual Progress Update.pdf

18.1 Appendix 1 Green and Sustainability Plan Annual Progress Update January 2025 v2.0.pdf

19 Trust Constitution Update.pdf

19.1 Trust Constitution 2025.pdf

20 Annual Review of Corporate Governance Manual.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 March 2025
Time	09:00 – 11:00
Location	Hybrid

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	2.	Declarations of Interest	Sir David Henshaw	
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	5.	Patient Story	Sam Westwell	
	Standing Items			
	6.	Chair's Update – **Verbal**	Sir David Henshaw	
19	7.	Chief Executive Officer Report	Janelle Holmes	Hayley Kendall
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69	10.	Estates and Capital Committee	Sir David Henshaw	
71	11.	People Committee	Lesley Davies	
73	12.	Audit and Risk Committee	Steve Igoe	
	Strategic Objective: Outstanding Care			
75	13.	Quarterly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
	Strategic Objective: Compassionate Workforce			
81	14.	6 Monthly Safe Staffing Report	Sam Westwell	
109	15.	Guardian of Safe Working Report Q2 2024/25	Dr Ranj Mehra	Dr Alice Arch
	Strategic Objective: Continuous Improvement			
113	16.	Chief Finance Officer Report	Mark Chidgey	

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	Strategic Objective: Infrastructure			
128	18.	Green and Sustainability Plan - Annual Progress Update	Matthew Swanborough	Clare Jefferson
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	Closing Business			
	21.	Questions from Governors and Public	Sir David Henshaw	
	22.	Meeting Review	Sir David Henshaw	
	23.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 2 April 2025, 09:00 – 11:00			

Meeting	Board of Directors in Public
Date	Wednesday 29 January 2025
Location	Hybrid

Members present:

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

In attendance:

DM	David McGovern	Director of Corporate Affairs
JC	Jo Chwalko	Director of Integration and Delivery
CM	Chris Mason	Chief Information Officer
JJE	James Jackson-Ellis	Corporate Governance Manager
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 13
MSa	Mustafa Sadiq	Consultant – item 13
TN	Tracey Nolan	Freedom to Speak Up Lead – item 15
AA	Dr Alice Arch	Guardian of Safe Working – item 16
SLa	Sharon Landrum	Head of People Experience – item 17
SH	Sheila Hillhouse	Lead Public Governor
DV	Devinder Roberts	LMNS representative – item 13
DG	Debby Gould	LMNS representative – item 13

Apologies:

LD	Lesley Davies	Non-Executive Director

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

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 4 December 2024 were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story from a care leaver who had undertaken work experience within the Estates and Facilities Team. The video story described their positive experience of undertaking this work experience and the subsequent opportunities. Members welcomed the video story and acknowledged the positive impact it had on this care leaver. Members queried if this was a programme of work specific to the Trust. DS stated the care leaver programme was originally part of the Wirral Place workforce programme, however the Trust was now leading the programme and working with Place partners. The Board **NOTED** the video story.	
6	**Chair's Business and Strategic Issues** DH provided an update on recent matters and highlighted the integration between WUTH and WCHC was progressing well, and a joint Board Seminar was taking place in the afternoon with both Board members. DH commented about the performance of the Trust, indicating WUTH had the second lowest deficit for an Acute Trust in Cheshire and Merseyside and had a strong record for performance and productivity. DH requested that as part of the 2025/26 annual planning process the Trust's productivity story be included as part of a narrative. The Board **NOTED** the update.	Mark Chidgey/ Hayley Kendall
7	**Chief Executive Officer Report** JH reported in November there were two Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework and one Reporting of Injuries, Diseases and	

	Dangerous Occurrences were reported to the Health and Safety Executive. JH stated following the cyber security major incident declared on 26 November the Information Commissioner and the Department for Health and Social Care were notified. The Trust confirmed that the security of patient records and other sensitive information was maintained throughout the incident**.** JH referenced the WCHC/WUTH 100 day plan which commenced in November 2024 and will conclude in April 2025. The plan focuses on eight key programme areas for integration between the two Trusts. JH gave an update on critical incident declarations in early January, indicating these had been declared because of unprecedented demand to urgent and emergency care. JD added this culminated in significant volumes of patients requiring admission and longer than desired waiting times. JH highlighted Professor Simon Rogers had received the lifetime achievement award for 2024 from the British Association of Oral and Maxillofacial Surgeons (BAOMS). Professor Rogers will receive the prize and medal at the BAOMS awards ceremony in June 2025. JH also highlighted the Trust's Research and Innovation Centre had been named as one of 10 'spoke' sites for a new NIHR Commercial Research Delivery Centre. This will bring cutting-edge clinical research to communities in Cheshire and Merseyside. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board on 6 December and the Wirral Place Based Partnership Board on 19 December. Members congratulated Professor Rogers on his award and for the Research and Innovation Team being selected as a NIHR Commercial Research Delivery Centre. SR queried about the operational impact arising from the critical incidents JH stated there had been a significantly reduced elective service, including out-patient appointments, however cancer diagnosis and elective work at Clatterbridge continued. The Board **NOTED** the report.	
8	**Board Assurance Framework (BAF)**	

	DM summarised the various key changes to the BAF from the previous quarter, noting of the four changes three risk scores had increased and one risk score had decreased. Members discussed the BAF and agreed the risks and controls appeared accurate and reflected the current position. The Board **NOTED** the BAF.	
9	**Integrated Performance Report** RM reported the number of patients recruited to NIHR studies remained below target and indicated this may warrant reviewing in future. RM added the Research and Innovation Team had a strong focus on high quality research and there were good integration opportunities with WCHC. SW explained C Diff remained above the target of 6 per month with 19 infections reported in the period, resulting in a cumulative total of 115 year to date. SW added there was 1 category 3 hospital acquired pressure ulcer in the period. SW updated on the current performance against friends and family test for ED, Maternity and Outpatients. SW explained in the period, 11 formal complaints and 219 informal concerns were raised. SW highlighted the RN and CSW fill rates, noting RN Days was below the threshold at 82% and CSW day fill rate was 83%. Nights exceed the threshold for CSWs but was below the threshold for RNs at 81%. DS indicated sickness absence remains above target at 6.68% and continues to be an area of concern. DS added absences continued to be related to short term and cold/flu and gastro problems. DS reported there was an ongoing focus on supporting health and wellbeing with strong management of absence in line with the Attendance Management Policy. DS highlighted the BAF risk increased from 3 to 4, moving the overall risk to 12. CM reported staff vacancies were currently at 13.9% of the workforce, which continues to impact the services provided and SARs completed requests were significantly below the trajectory, noting numbers received in December were exceptionally low and resulted in a slight decrease in the overall backlog. CM added as part of the 2025/26 cyber plan the cyber KPIs were being reviewed. Members discussed cyber KPIs in light of the recent cyber security incident and requested the mechanism for reporting these be	

	reviewed, noting these were publicly available to members of the public. The Board **NOTED** the report.	Mark Chidgey
10	**Committee Chair's Reports – Finance Business Performance Committee** SL alerted members that the Trust's cash position had been significantly lower than the level required for effective operation and the Trust had made an application for £23.1m cash support. SL added the Trust received £3.5m in January combined with an additional £4m from the ICB which will cover the Trust's cash requirements for January and February. SL also alerted members that the Trust's financial position to the end of December was a £17.2m deficit (an £11.3m adverse to plan). SL indicated this shows that the position has broadly held steady during December, but the position is off trajectory by £4.4m. SL alerted members that performance on CIP is forecast at £20.1m against a target of £28.9m. The amount transacted to month 8 was £17.9m with a full year effect at £26m. SL also alerted members that NHSE was prioritising capital funding for the Trust to cover a capital to revenue transfer of a building on one of the Trust sites. SL further summarised the various advice and assure matters from the Finance Business Performance Committee meetings on 12 December 2024 and 13 January 2025. The Board **NOTED** the report.	
11	**Committee Chairs Reports – People Committee** DS (in the absence of LD) alerted members that there has been a month on month decrease for fire safety level 2 mandatory training which is driven by a high did not attend rate and staffing pressures. DS explained because fire safety was a high risk on the significant risk register Committee requested the compliance rate be raised at the next Executive Assurance and Risk Committee. DS also alerted members to the position regarding sickness absence and referenced the work commissioned by Workforce Steering Board to identify specific Divisional interventions and also to review the newly implemented Attendance Management Policy. DS further summarised the various advice and assure matters from the People Committee meeting on 13 December 2024. The Board **NOTED** the report.	

12	**Committee Chairs Reports – Quality Committee** SR alerted members that the agreed improvement trajectories for Gram negative blood stream infections such as Escherichia coli had not been met alongside the trajectory for C Diff. SR added this indicated gaps in control of healthcare associated infections and acknowledged the opportunities for collaborative quality improvement with WCHC to help address this challenge and the Committee asked for an update at its next meeting. SR also alerted members to the position in relation to Trust policies, indicating a number remain overdue for updating. The Committee discussed the importance of having up to date policies and the mechanisms that could assist in this. SR alerted that a high number of complaints had been received about waiting times to access community paediatric services. The Committee discussed the collaborative improvement work underway and an OFSTED/CQC inspection of SEND service on the Wirral is currently underway. SR also alerted members that the Executive Director continued to be sighted on the high risk to the continued provision of a full range of medicinal products in the pharmacy Aseptic Unit. SR further summarised the various advice and assure matters from the Quality Committee meeting on 16 January 2025. The Board **NOTED** the report.	
13	**Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 6 Annual Declaration)** JL and MSa gave an overview of the ten Clinical Negligence Scheme for Trusts (CNST) Safety Actions as part of the Maternity Incentive Scheme Year 6. The presentation outlined how the ten safety actions, which have all been assessed as compliant, had been met and provided details of the evidence. JL informed members that for safety action 1 there had been a technical data issue in regard to the externally validated MBBRACE data for PMRT. JL added NHS Resolution had been made aware and that an adjustment would be made to any evidence in due course, however it was not expected to change the overall compliance level. SR commented as NED Maternity Safety Champion he agreed with the compliance level and acknowledged the rigor of the process and data collection. SR added he had discussed safety action 1 prior to this meeting with the Chief Nurse and understood the position would cause no impact on the final submission,	

	acknowledging there was robust processes in place at the Trust regarding perinatal deaths. DG commented the LMNS had reviewed the submission and agreed with the compliance level. DG indicated the LMNS had not reviewed safety action 1 due to the external data validation concern but acknowledged this was correctable before the final submission in March. Members thanked JL and MS for their presentation and continued hard work in Maternity Services. The Board: • **NOTED** the report and presentation; and • **APPROVED** the compliance document for the submission of the declaration form to NHSR	
14	**Learning from Deaths Report Q2 2024/25** RM summarised the report, highlighting the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) continued to be within the expected range of mortality data for the reporting period. RM explained 16 cases had been escalated by the Medical Examiners during quarter 2 and gave an overview of the specific learning and themes identified. RM added learning from mortality reviews is fed back to clinical areas by the Divisional Mortality Leads and via Divisional Quality Boards. RM recapped that from early 2025 HSMR will be changing to HSMR+ and it was anticipated this new methodology would increase the ratio but will remain within expected range. RM added the main driver of this was the removal of palliative care coding. The Board **NOTED** the report.	
15	**Freedom to Speak Up Bi-Annual Report** TN gave an overview of the report, highlighting 37 people had spoken up during Q1 and this was a significant increase compared to previously. TN added this number remained in line with regional and national averages. TN stated during Q2 13 people spoke up and this was a significant reduction compared to previously. TN added no regional or national data was currently available. TN summarised the most common themes of concerns raised, noting the highest was attitudes and behaviours followed by bullying or harassment.	

	TN explained the highest number of concerns raised were in the Surgery Division. TN noted Board had already been aware of the concerns ongoing in Theatres through previous reports. TN referenced the 2024/25 action plan and summarised the progress to date and areas of focus for the next quarter. DH queried about the bullying and harassment concerns. DS stated a deep dive on this would be presented to the next People Committee and explained she had also asked for equality monitoring to be included in future reports to determine if there were any barriers for those with protected characteristics speaking up. DS added given the number of concerns in the Surgery Division the Organisational Development Team had been asked to provide targeted support and this would be reviewed in 6 months. DS queried about the provisional quarter 3 period. TN stated there was likely to be an increase in the number of FTSU cases during quarter 3 compared to quarter 2. The Board **NOTED** the report.	
16	**Guardian of Safe Working Report Q2 2024/25** AA summarised the number of exception reports during the period, noting there had been a relatively higher number from non-foundation doctors. AA explained this was due to more senior Doctors in Training supporting their junior colleagues with their workload and facilitating them leaving on time. SR queried about the provisional quarter 3 period and if there had been an increase in exception reports due to the impact of the cyber incident. AA stated there was likely to be an increase but not a significant rise. DS commented at People Committee members took good assurance regarding the strong interventions in place to support junior doctors led by the Guardian of Safe Working with strong attention to detail and support from Educational Supervisors. The Board **NOTED** the report.	
17	**Equality Diversity and Inclusion Bi-Annual Report** SLa gave an overview of the bi-annual report, summarising the various activities that demonstrate the Trust continues to advance	

	the equality diversity and inclusion agenda in line with the Trust's People Strategy and EDI Strategic Commitment. SLa also gave an overview of the Equality Delivery System (EDS) 2024 self-assessment and the applicable ratings, noting these remain the same as 2023. DS commented the Trust was good at conducting equality analyses for policies but acknowledged improvement was required for business cases and service redesign/reviews. DH commented about metric relating to staff recommending the Trust as a place to work and receive treatment, noting this was a "developing activity" and queried how this compares to other Trusts. DS stated this was also a question within the NHS Staff Survey and proposed this comparison be provided as part of the results presentation to Board in April. Members agreed. The Board: • **NOTED** the report; and • **APPROVED** the EDS assessment rating	Debs Smith
18	**Chief Finance Officer Report** MC reported at the end of December, M9, the Trust was reporting a deficit of £17.2m, an adverse variance against plan of £11.3m. MC set out the key drivers of this forecasted variance, noting the reduced income and additional expenditure associated with the cyber incident, full delivery of the elective activity plan, the Cost Improvement Programme (CIP), maintaining expenditure on urgent care within planned levels and delivering planned integration benefits. MC explained the Trust's unmitigated forecast was a deficit of £25.6m, an adverse variance to plan of £19.0m. MC added the Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks. Full implementation of these agreed actions will reduce the unmitigated forecast deficit to £16.7m, an adverse variance to plan of £10.0m. This variance is consistent with the finance trajectory submitted by the Trust to NHSE, adjusted for the financial impact of the cyber incident. MC indicated the deficit position continued to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code. MC added NHSE confirmed £3.5m of cash support in January 2025 and the Trust will apply for the	

	remainder of the projected 24/25 cash requirement as part of the process for March 2025. MC provided an update on the statutory key financial risks, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency and cash were amber, agency spend, and capital was green. SI queried about the cash position moving forward. MC stated the cash position was currently being manged month by month and while the Trust remained in deficit it would impact on the cash position. Members discussed the cash position, acknowledging there was cash availability within System but there was no agreed mechanism for distributing cash between Trusts. The Board: • **NOTED** the report • **NOTED** that full implementation of agreed mitigations will significantly but not fully mitigate financial risk • **NOTED** the significant cash risk and that the Trust will be submitting an additional cash support request in M12 and that the NHSE approval criteria require full delivery of finance and workforce plans; and • **APPROVED** the revision of the capital budget to £19.707m	
19	**Chief Operating Officer Report** HK highlighted in December the Trust attained an overall performance of 73.98% against plan for outpatients and an overall performance of 81.93% against plan for elective admissions. HK indicated the underachievement had been driven by the cyber security incident the Trust experienced in November. HK summarised the referral to treatment standard and current performance against this, reporting the Trust had 151 65 week waiters at the end of December against a standard to have no patients waiting 65 weeks by September 2024. HK explained Gynaecology was a key contributor to this and there had been notable improvements between June – December 2024. HK summarised cancer performance against the trajectory and DM01 performance. HK highlighted in December type 1 unscheduled care performance was 45.56% and continues to remain below the planned improvement trajectory. HK added improvement projects including pilots remain in place and are progressing to address the non-admitted performance.	

	HK stated the number of patients not meeting the criteria to reside had decreased with an average of 105 patients. Demand for patients attending the ED with mental health conditions also reduced in December. Members discussed the various pilots being undertaken to improve performance and acknowledged the good progress so far and opportunities to embed these as part of business as usual. Members also discussed the acuity of patients, specifically the general deterioration of conditions compared to pre-pandemic. The Board **NOTED** the report.	
20	**Quality Committee Terms of Reference** DM highlighted the Terms of Reference had been presented to Quality Committee in November and included amends to the attendance, relating to the inclusion of all Executive Directors as part of a Deloitte well-led review carried out during 2024. DM explained following feedback at the Board meeting in December this has been amended to reflect other members of the Executive Team will attend on a rotational basis only. The Board **APPROVED** the Terms of Reference.	
21	**New Integrated Performance Report Template** DM referenced the revised Integrated Performance Report which had been included for information, noting this was based on the insightful provider Board guidance published in November. DM added the revised Integrated Performance Report would be used from April 2025. The Board **NOTED** the report.	
22	**Questions from Governors and Public** SH queried about the business case to recruit two locum consultants instead of three for the stroke service and if this was a fragile service. RM stated the service was sustainable with two agency consultants but there remained significant staffing shortages at consultant level within the stroke workforce.	
23	**Meeting Review** Members commented that the new structure of the agenda and template for Committee Chairs Report was welcome. Members requested to receive updates on the integration progress in the most relevant meeting.	Jo Chwalko

24	**Any other Business** No other business was raised.	

(The meeting closed at 11:15)

Action Log
Board of Directors in Public
5 March 2025

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	4 December 2024	9	To provide at a future Board Seminar the 4 pillar Wirral C Diff strategic plan, with WUTH and WCHC IPC teams presenting	Sam Westwell	In progress. Due April 2025.	April 2025
2.	29 January 2025	6	To provide a narrative as part of the 2025/26 annual planning process on the Trust's productivity story	Mark Chidgey/Hayley Kendall	Complete. Narrative included within the presentation to Private Board on 2025/26 annual planning.	March 2025
3.	29 January 2025	9	To determine the appropriate mechanism for reporting to Board the CIO KPIs of the Integrated Performance Report	Mark Chidgey	Complete. The CIO KPIs will be reported and monitored through Finance Business Performance Committee. This will allow escalation of any concerns but given sensitive nature of cyber assurance the report will no longer form part of the Integrated Performance Report.	March 2025
4.	29 January 2025	17	To provide an update on the comparators for how the Trust compares regarding recommending WUTH as a place to work and receive treatment	Debs Smith	In progress. Due April 2025.	April 2025
5.	29 January 2025	23	To consider the appropriate forum for the Director of Integration and Delivery to provide a report on	Jo Chwalko	Complete. Regular updates are provided at the Integrated Management Group meeting (both	March 2025

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
			progress regarding clinical integration		Trusts Executive Teams) as part of the 100 day plan. Future reporting will align to new governance arrangements as determined by a Partnership Agreement and the subsequent Integrated Management Board.	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
5 March 2025

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

Executive Summary and Report Recommendations
The purpose of this report is to provide Board with an update on activity undertaken since the last meeting and draws 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	**Health and Safety** There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in January. 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 no Patient Safety Incident Investigations (PSII) opened in January under the Patient Safety Incident Response Framework (PSIRF).
1.2	**News and Developments** **Quality Priorities Workshop** On 18 February the Trust held a Quality Priorities workshop which was well attended by staff and a wide range of internal and external stakeholders across Wirral Place. The purpose of the workshop was to gain views on what the Trust should be focussing on to improve patient safety and patient care in the year ahead. The workshop also reviewed the learning identified from the year at the Lessons Learned Forum to help identify key improvement priorities for the next 12 months where an organisation-wide approach is needed. **Valentine's movie night on Ward M1 for older patients** On 14 February staff hosted a special Valentine's movie night for older patients on Ward M1 at Clatterbridge Hospital. The ward team has transformed the dining room into a dedicated 'cinema-style' room where a themed movie night, with Valentine's decorations take place. Earlier in the day, patients enjoyed an afternoon tea complete with love heart biscuits and cakes. All patients on Ward M1 are aged 74 and above and cares for patients who are medically fit but awaiting support services such as a social worker assessment, a package of care or a bed in a rehabilitation facility. The Valentine's themed afternoon was one of many planned movie events designed to engage patients. **WUTH spotlights commitment to autistic patients for Autism Sunday** On Autism Sunday, held on 9 February the Trust spotlights its commitment to supporting the autistic community. Autism Sunday takes place on the second Sunday of February each year, raising awareness of autism. The Trust has put in place a number of important initiatives to support autistic patients whilst they are in hospital. We have appointed two new specialist nurses to the Safeguarding and Complex Care Team, who oversee the needs of autistic patients. All staff are now required to complete a training module, called the Oliver McGowan Mandatory Training on Learning Disability and Autism. In 2024 a sensory care bag initiative was launched at WUTH to support patients in the emergency department and admission units.
1.3	**System Working**

	Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update The CMAST Leadership Board met on Friday 7 February and discussed several system wide issues. The Leadership Board heard an update on, and discussed, the system's response to this year's NHS Planning Guidance. Several actions are already underway, and the necessity for a system wide, multi-year strategic response was also considered. An update was presented on the management arrangements, procedures and methodologies for specialised commissioning across Cheshire and Merseyside. There was also an update on the national nursing role profile review, and recommendations presented regarding a collective system wide approach. The Board heard a summary of ongoing discussion and progress on the move to a single Cheshire and Merseyside provider collaborative. Subject to further discussion, and agreement on governance arrangements, potential commencement dates are under consideration. **Wirral Place Based Partnership Board (PBPB)** The PBPB met on 20 February discussing a number of Place issues as follows. PBPB received the regular Quality and Performance Report which gave an overview of the Place aggregate position against key metrics. A key area of focus remains on Healthcare Associated Infections (HCAI). PBPB received an update on how All Age Continuing Care (AACC) and complex Care is commissioned and delivered within Wirral and how Wirral is performing against the national standards in Cheshire and Merseyside. PBPB discussed the developments that are in place and being undertaken in addition to opportunities to work together. PBPB also discussed the NHS operational planning guidance 2025/26 and the implications for Wirral Place. PBPB received the Place Finance Report and noted the Wirral system had an actual reported deficit of £39.4m compared with a planned year-to-date deficit of £19.1m, which represents an adverse variance of £20.3m.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 4 (To March) 2025

Item 8

Contents

1. Introduction

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

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

Baker Tilly 2021

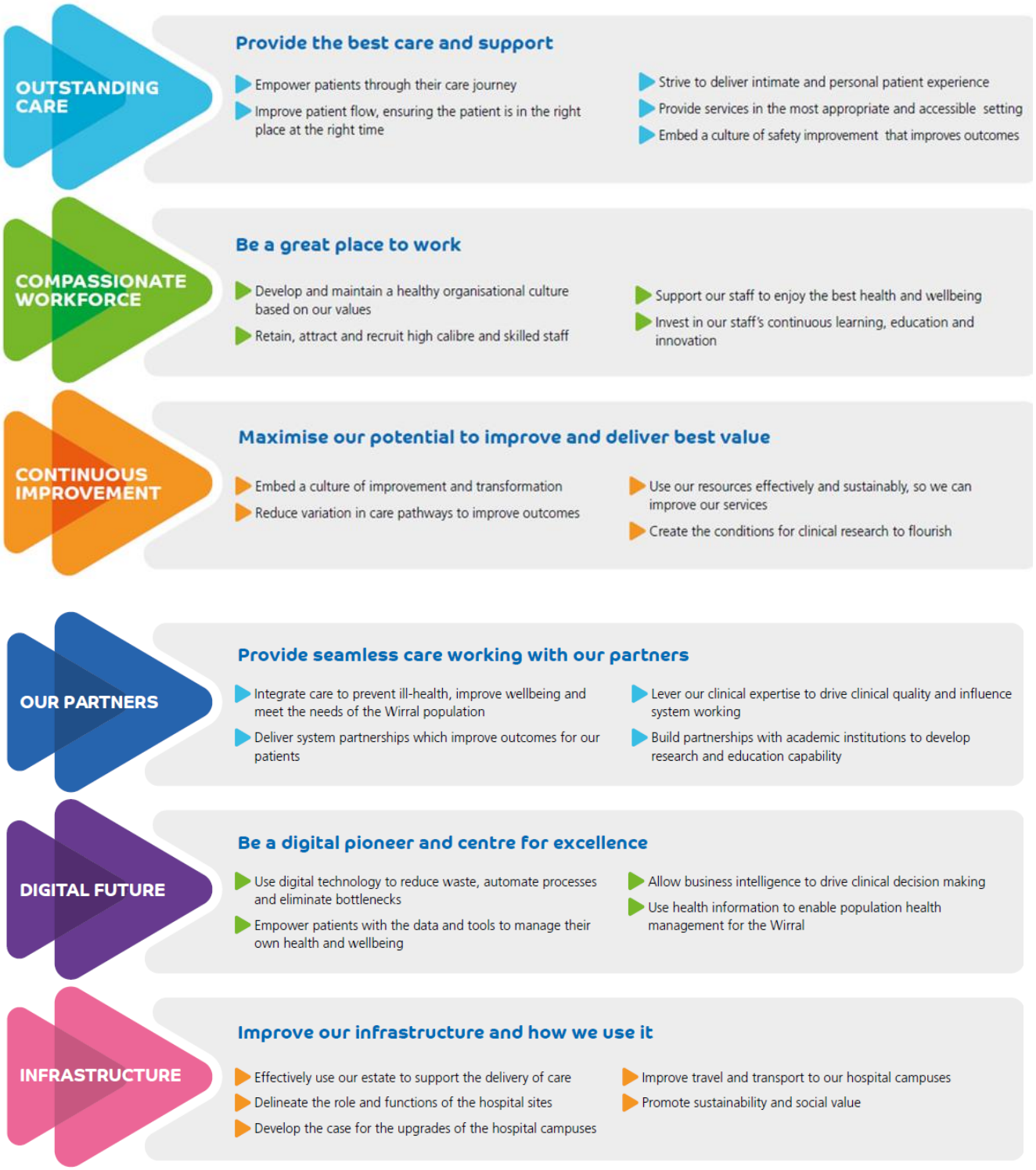
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

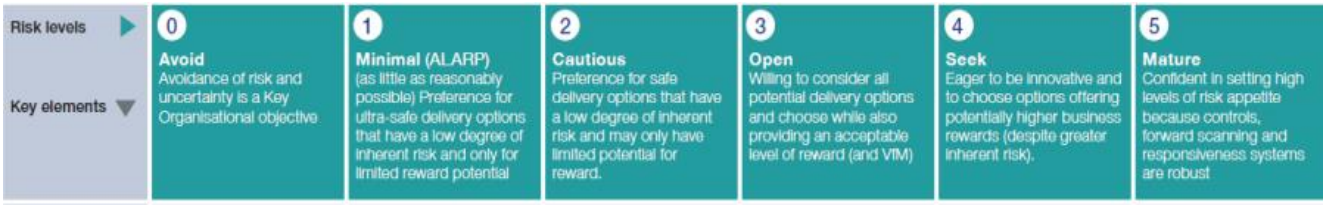
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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

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

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

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



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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

In order to support the Risk Management Process the Trust (via the Risk Management Committee) gives consideration to the latest set of significant risks at each meeting.

In order to further align this process the current list of significant risks is now included as an appendix to this BAF.

4.2 Risk Categorisation

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

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members. The BAF is updated on a Quarterly basis and subject to a full refresh on an annual basis.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be subject to regular monitoring, it was noted that the schedule had been designed to help highlight the BAF and its content and widen engagement across the Trust. Having achieved this aim it is now proposed that the schedule will revert to that originally in place and in line with sector norms as follows:

- Is Updated on a quarterly basis.
- Reports to the Board at every other meeting.
- Reports to every other meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every other meeting of relevant Board Committees.
- Reporting to every meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.

6. Update Report

6.1 Purpose

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

The controls, assurance, and actions for most of the current strategic risks have been, or are being, reviewed with Executive Team members and further iterations will be reflected in future reports to Board.

6.2 Changes to the previous version

Following the annual review of the BAF the Board has approved the strategic level risk that will be monitored for the year 2024/25. Work is continuous to update previous risks and populate newer risks.

Including in the key changes for this report are as follows:

- Risk 4 - Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy. This risk has increased its score from 9 to 12.

6.3 Risk Appetite and Risk Maturity

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

6.4 Recommendations

Board is asked to:

- Note and comment on the current version of the BAF.

Board Assurance Framework Dashboard								
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score (I and L)**	**Current (I and L)**	**Direction of Travel**	**Target (I and L)**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Finance and Board	20 (4 x 5)			12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Finance and Board	16 (4 x 4)			12 (4 x 3)
Outstanding Care **R, O, C, F**	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director and Chief Nurse	Quality and Board	16 (4 x 4)			12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	Chief People Officer	People	16 (4 x 4)	12 (3 x 4)	↑	6 (3 x 2)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)			6 (3 x 2)
Continuous Improvement **R, O, F**	6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	Chief Finance Officer	Finance	16 (4 x 4)			8 (4 x 2)
Digital Future **R, O, F**	7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Finance Officer	Finance	12 (4 x 3)			8 (4 x 2)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	Chief Strategy Officer	Board	16 (4 x 4)			6 (3 x 2)
Our Partners **R, S, F**	9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)			6 (3 x 2)
Infrastructure **R, O, C, F**	10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	Capital and Board	16 (4 x 4)			9 (3 x 3)
Infrastructure **R, O, C**	11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	Chief Operating Officer	Board	20 (5x4)			10 (5x2)
Our Partners **R, O, C, F**	12	Failure to work with local partners to address and reduce health inequalities across the Wirral population.	All Directors	Board	16 (4 x 4)			9 (3 x 3)

12 Month – Quarterly Trend

Risk No	Risk Description	Initial Score	Target	Feb 24	Mar 24	Apr 24	June 24	Sept 24	Dec 24	Direction	Mar 25 Current
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)		
2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		
3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)		
4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↑	12 (3 x 4)
5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		
6	Failure to embed the Trust's approach to financial planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	16 (4 x 4)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	16 (4 x 4)	20 (5 x 4)		
7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	N/A	N/A	N/A	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		
8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		
9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	12 (4 x 3)	6 (3 x 2)	8 (4 x 2)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		
10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		
11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	N/A	N/A	N/A	15 (5x3)	15 (5x3)	15 (5 x 3)		
12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.	16 (4 x 4)	9 (3 x 3)	N/A	N/A	N/A	N/A	12 (4 x 3)	9 (3 x 3)		

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	16 (4 x 4)		12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• **The Trust continues to be challenged delivering the national 4 hour standard for ED performance.** • **The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.**	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • **System 4 hour performance response to deliver 76% in March.** • **External support into ED from Aqua reviewing 4 hour and 12 hour performance – recommendation report received and local action plan in development with urgent actions.** • **Full engagement with the national Rapid Improvement Offer (RIO) from the national ECIST.**

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (3 x 4)		12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets • Impact of industrial action • 2 specialities are challenged in delivery of 65 and 75 weeks.	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients. • Utilisation of the LLP to deliver the gap in recurrent capacity.

Progress
Key Changes to Note • N/A.

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	16 (4 x 4)		12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from PSIRF. • Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • Trust safety huddle. • **Patient safety Learning Partners.** • **R and I Strategy.**	• Executive Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance. • GIRFT. • AXA accreditation. • National SNAPP Audits. • Nursing and Maternity Champions. • **Monthly Maternity report.** • **CEO Complaints sign-off.** • **Digital – Incident dashboard.** • **Programme Board.**

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies. • **Current operational impacts and organisational pressure.** • **Capital availability for medical equipment.** • **Medical workforce gaps.** • **Impact of unscheduled care demand.** • **Significant financial controls in place.** • **Update required to WISE accreditation programme.**	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements – SIT Review. • CQC preparedness programme and mock inspections. • **Delivery of Mental Health key priorities.** • **Unscheduled Care Board action plan.** • **Trust and C and M elective recovery programme.** • **Wirral system strategy for CDiff.**

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Compassionate Workforce				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	12 (3 x 4)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group. • Staff drop in sessions. • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring.

Gaps in Control or Assurance	Actions
14 Board Assurance Framework David McGovern Director of Corporate Affairs	

• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Increases in illness related to stress and anxiety.	• 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. • The staff winter vaccination programme and associated 'It starts with you' campaign. • Wellbeing Surgeries across sites • OH Capacity and Demand Review • Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing • Talent mapping exercise for senior leaders • Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months. • The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.

Progress
Key Changes to Note • Changes in red

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

Strategic Priority	Compassionate Workforce				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)		6 (3 x 2)

Controls	Assurance
• Just and Learning Culture work delivered and embedded as 'business as usual'. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum. • Just and Learning Plan implemented. • Provision for mediation and facilitated conversations as part of new Fairness in Work Policy • New approach to coaching and mentoring • New supervision and appraisal process • Talent Management approach launched • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool • Business as usual support continues to be in place such as FTSU. OH&WB, HR and line manager support • CPO working with local networks	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance	Actions
• Full understanding of the experience of Multi-Cultural staff across the Trust	• Debriefing tools (hot and cold) and guidance on the intranet for supporting staff affected by unplanned events. • Develop and implement the WUTH Perfect Start • Listening event with Black, Asian and Minority Ethnic staff • Work ongoing to resolve dispute in theatres • Working in progress to progress the settlement for CSWs – led by DCN • Q1 project planned for Q3 to address team working – led by CN

Progress
Key Changes to Note • Changes in red

BAF RISK 6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	20 (5 x 4)		8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • **Finance Gold Command implemented.** • **Weekly submission to and attendance at ICB FICC.** • **H2 control totals set for each division.** • **Fortnightly finance group implemented.**	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • **FBPAC meeting more frequently.** • **Finance Gold Command implemented.** • **Weekly submission to and attendance at ICB FICC.** • **Fortnightly finance group implemented.**

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • **Mitigated forecast of 7m variance to plan.** • **Unmitigated forecast of 29m variance to plan.**	• Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • **Expand current mitigation plan to measure risk.** • **Continue full engagement with the FICC.** • **Negotiate required support from PWC.**

Progress
Key Changes to Note • **Additions in red.**

BAF RISK 7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Digital Future				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	12 (4x3)	12 (4 x 3)		8 (4x2)

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • FBPAC Oversight. • Audit Committee oversight. • Integration of PMO and Digital Project Teams. • DIPSOC Oversight.	• Scale of projects versus resources. • FBPAC Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance. • MIAA Audit. • Digital Maturity Assessment.

Gaps in Control or Assurance	Actions
• Resources to remain up to date with emerging technology.	• Delivery of DHT annual plan.

Progress
Key Changes to Note • N/A.

BAF RISK 8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)		6 (3 x 2)

Controls	Assurance
• Programme Board oversight. • Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken. • Developed and embedded improvement methodology.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress and delivery of improvements. • Monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings • Improvement presentations at Board Seminar on a twice yearly basis • CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required. • Annual review and approval of improvement team supported projects, aligning to Trust priorities and risks • Project completion reviews

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Ability to deliver system wide change across Wirral NHS organisations and wider partners.	• Delivery of 24/25 improvement projects to plan • Strong Governance through PMO working of all schemes, risk and outputs. • Detail improvement staff training approach and programme • **Review of PMO and PDU in line with the Wirral Review**

Progress
Key Changes to Note • **Highlighted in red**

BAF RISK 9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)		6 (3 x 2)

Controls	Assurance
• WUTH senior leadership engagement in ICB and Wirral Place • WUTH Strategic intentions are aligned with the ICB. • ICB design framework. • NHS Oversight and Assessment Framework • Input of Trust CEO and Chief Strategy Officer into Outline of the Wirral Place governance. • Creation of IMB to oversee the outcomes of the Wirral Review. • Joint Chair and CEO now in place with WCHC.	• CEO and Chief Strategy Officer updates to Board and Executive Director meetings. • CEO attendance at Wirral Place Partnership Board • Executive participation in CMAST professional network groups • Chief Strategy Officer attendance at Wirral Health and wellbeing Board • Monthly reporting to Board of Wirral System Review progress • Recommendations of the Wirral Review

Gaps in Control or Assurance	Actions
• Formal mechanisms to ensure delivery of partnership working with Wirral Place partners	• Continue identification of partnership opportunities with Wirral Community Health and Care NHS Trust • Implement actions of the Wirral Review. • Refresh Governance processes at Place. • Stand up the WPP and IMB.

Progress
Key Changes to Note • N/A

BAF RISK 10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Infrastructure				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)		9 (3 x 3)

Controls	Assurance
• Implementation of 3 year capital programme • Delivery of 2021-2026 Estates Strategy. • Business Continuity Plans. • Procurement and contract management. • Assigned 3 year capital budgets, with Executive Director accountability • Assessment of current backlog maintenance risk and future potential risk	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks and completion of business continuity plans for critical infrastructure • Independent review of risks carried out. • Appointment of authorised engineers.

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance and funding of backlog maintenance • Timely reporting of maintenance requests.	• Develop Arrowe Park development control plan and Prioritisation of estates improvements • Heating and ventilation programme completion • Replacement of generators and ventilation systems • Delivery of 2024/25 Capital Programme to plan and budget allocation. • **Development of bids in preparation for potential NHSE Capital Grants.**

Progress
Key Changes to Note • **Highlighted in red**

BAF RISK 11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)		10 (5x2)

Controls	Assurance
• Implementation of the national Business Continuity Toolkit with a process underway to re-write all Business Continuity Plans (BCP) in the Trust. • Full risk assessment undertaken on critical infrastructure and mitigations for major failure in these areas. • Full engagement and adaptation of regional and national EPRR guidance and alerts. • Submission of Data Security and Protection Toolkit (DSPT) Annual assessment and associated audit. • Privileged Access Management (PAM) for external providers accessing systems.	• Trust command and control framework in place and tested thoroughly the Covid pandemic and industrial action over the last 12 months. • Regional core standards self-assessment process and central peer review. • Planned exercise programme in place to test BCPs. • Quarterly updates provided to the Risk Management Committee. • Annual report to the Board of Directors and updates in between as required. • Estates and Capital Committee sighted on the risk relating to the critical infrastructure • Trust received substantial assurance received from the MIAA DSPT audit. • Trust policy is to follow Privileged Access Management – preventing unauthorised access to 3rd parties.

Gaps in Control or Assurance	Actions
• System BCPs raised as a gap in the core standards self-assessment and a Wirral wide discussion on this is lacking. • Internal resource limited to cover the large spectrum of EPRR assurance - 1 WTE working to the Accountable Emergency Officer (AEO) • Issues identified as part of Dionach, Penetration testing conducted on Trust Network. • Some 3rd parties and national providers have not adopted PAM	• Continue with the actions highlighted in the core standards peer review assessment. • Engage with the regional Local Health Resilience Forum (LHRP) ensuring the Trust is up to date with the latest guidance and central notifications. • Operational Cyber programme addressing the risks raised within the Dionach, Penetration test. • Working with suppliers to irradicate legacy connections, expressing importance of the standards.

Progress
Key Changes to Note • N/A

BAF RISK 12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.

Strategic Priority	Our Partners				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	All Executive Directors	16 (4x4)	9 (3 x 3)		9 (3 x 3)

Controls	Assurance
• Wirral Place Based Partnership Board Governance Manual. • Wirral Place Target Operating Model. • ICB. • Wirral Review Terms of Reference. • Joint Chair and CEO in place across WCHC and WUTH.	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Unscheduled Care Board. • Wirral Place Partnership Committees and fora. • IMB for Integration.

Gaps in Control or Assurance	Actions
• Lack of strategic alignment between partner bodies.	• Board discussion on Phase 1 of Wirral Review. • Consider outcomes of full review. • Implement outcomes of the full review. • Board to Board sessions. • Council of Governors Joint session. • Standing up of the IMB. • Standing up of the WPP. • Refreshment of Wirral Place Governance.

Progress
Key Changes to Note • Changes in red.

Appendix – Risk Scoring Matrix

Table 1 – Consequence scores.

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

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

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

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

Table 2 – Likelihood

The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.

In considering the likelihood, the following supports the conversations and assessment from British Standards Institution (BSI) (2011) Risk management – Code of practice and guidance for the implementation of BS ISO 31000:

In risk management terminology, the word "likelihood" is used to refer to the chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively and described using general terms or mathematically [such as a probability or a frequency over a given time period].

Appendix – Risk Appetite

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	**Various**	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	**OPEN**	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	**OPEN**	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	**SEEK**	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	**SEEK**	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	**OPEN**	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

Appendix – Significant Operational Risks

Highest Scoring Risks

1547	Corp	Cash Management	(5 x 5) 25	↑
1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(4 x 5) 20	⇔
1251	Corp	3rd Parties	(4 x 5) 20	↑
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(5 x 4) 20	⇔

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

05 March 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 January 2025. It is recommended that the Board: • Note performance to the end of January 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.

	Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	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

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.

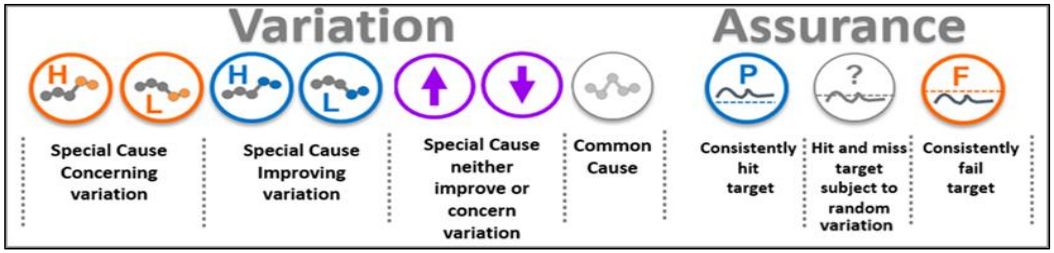
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - February 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:



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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.

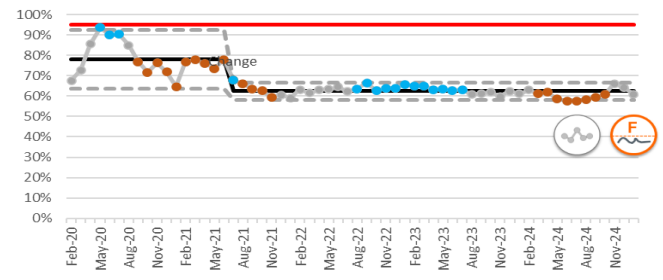
Changes to Existing Metrics:

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

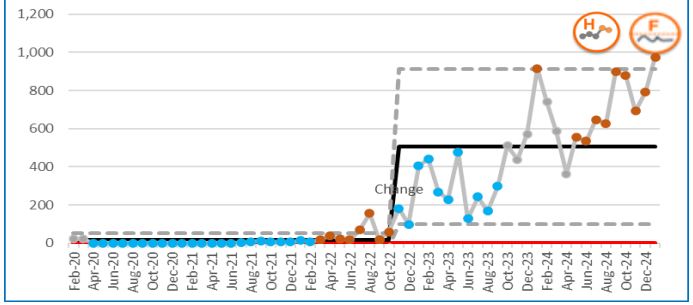
4-hour Accident and Emergency Target (including APH UTC)



Jan-25
60.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

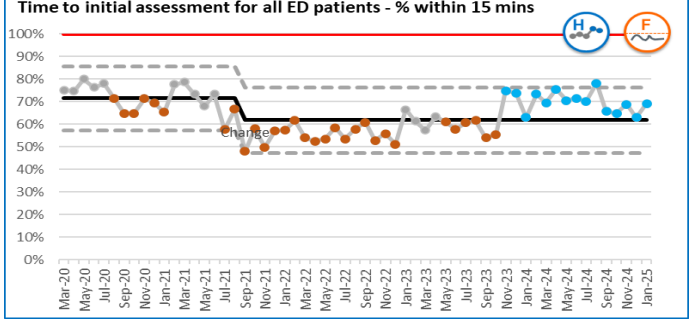
Patients waiting longer than 12 hours in ED from a decision to admit



Jan-25
976
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

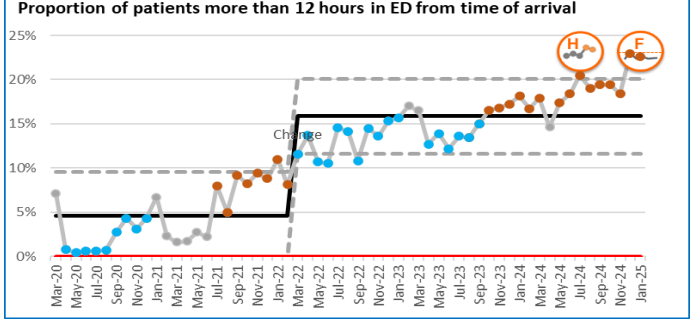
Time to initial assessment for all ED patients - % within 15 mins



Jan-25
69.2%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

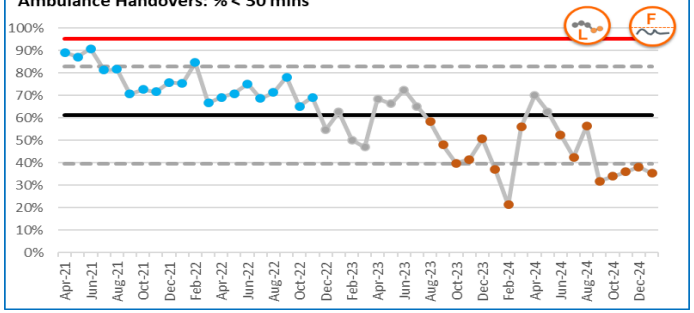
Proportion of patients more than 12 hours in ED from time of arrival



Jan-25
22.7%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

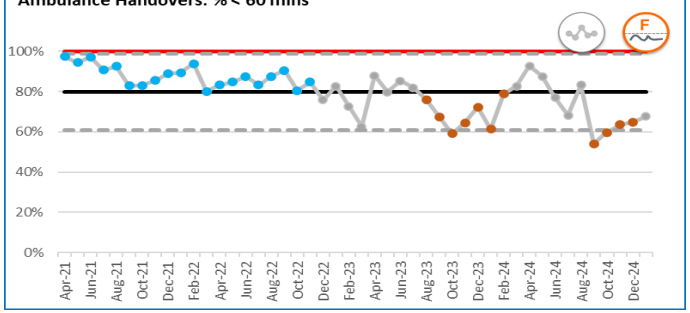
Ambulance Handovers: % < 30 mins



Jan-25
35.1%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

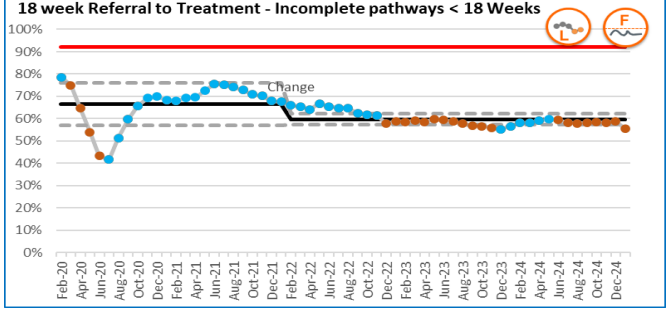


Jan-25
67.7%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

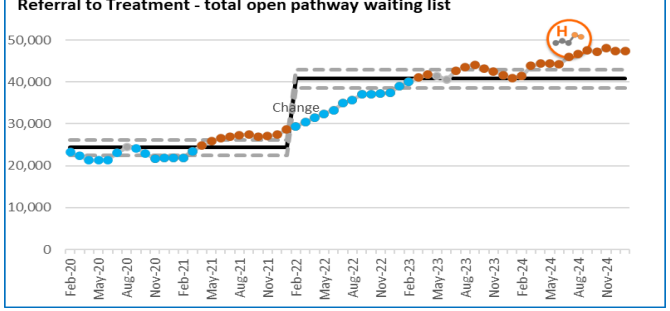
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Jan-25
55.55%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

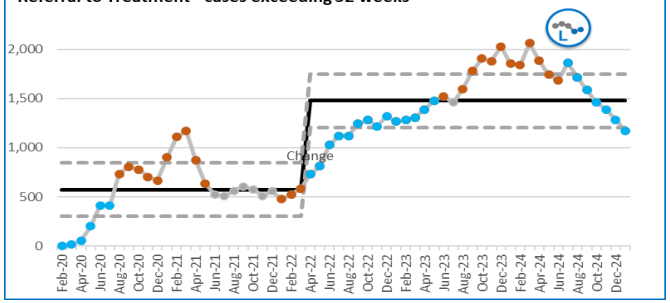
Referral to Treatment - total open pathway waiting list



Jan-25
47362
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

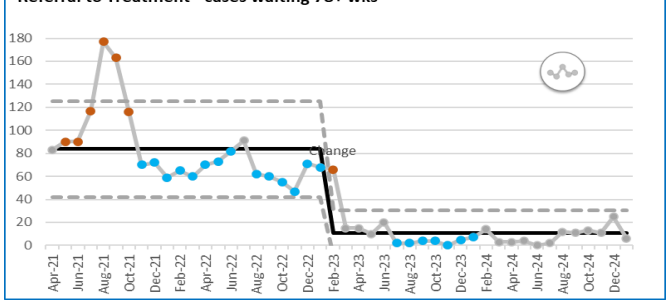
Referral to Treatment - cases exceeding 52 weeks



Jan-25
1172
Variance Type
Special cause variation - improving
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

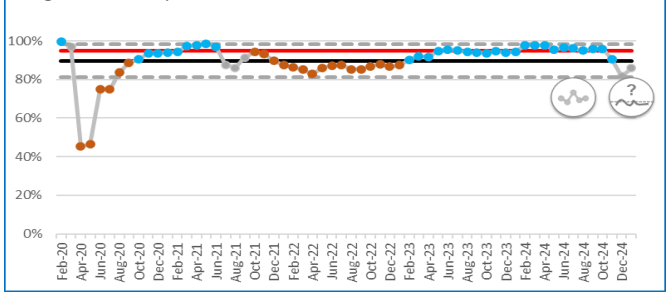
Referral to Treatment - cases waiting 78+ wks



Jan-25
6
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

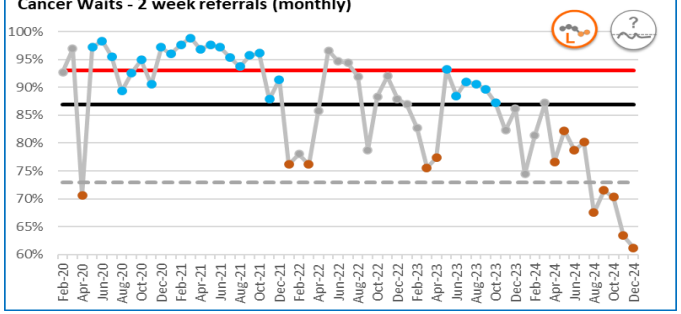


Jan-25
85.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

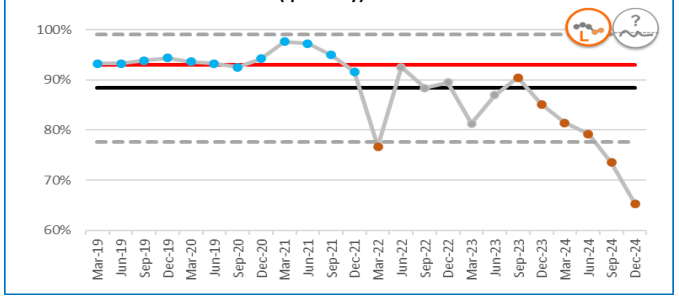
Cancer Waits - 2 week referrals (monthly)



Dec-24
61.2%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

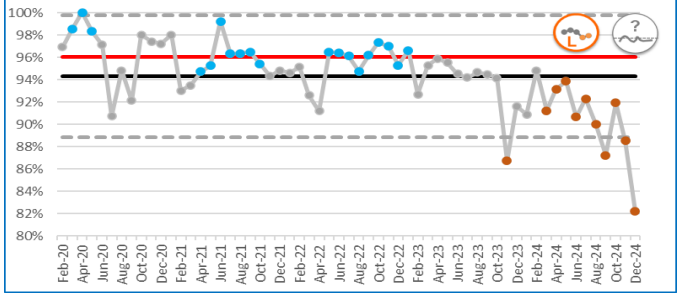
Cancer Waits - 2 week referrals (quarterly)



Dec-24
65.3%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

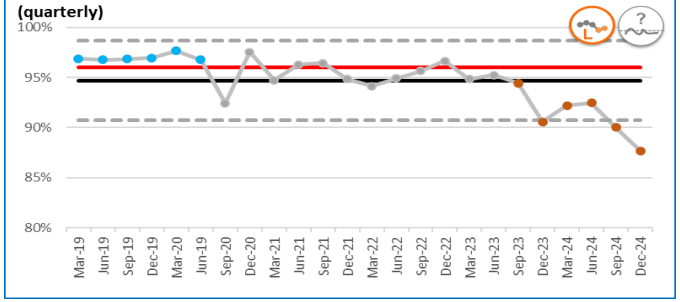
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Dec-24
82.2%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

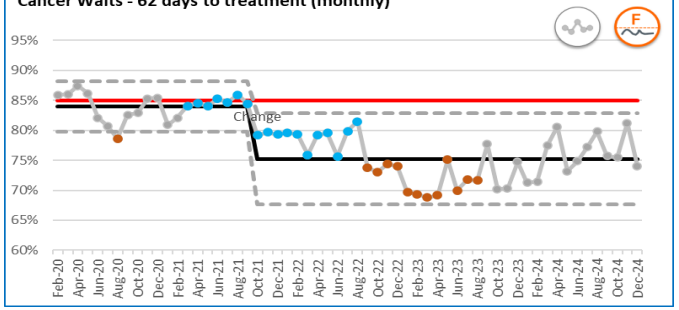
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Dec-24
87.7%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

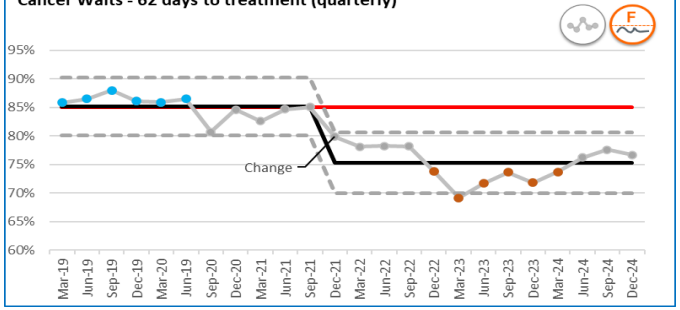
Cancer Waits - 62 days to treatment (monthly)



Dec-24
74.1%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

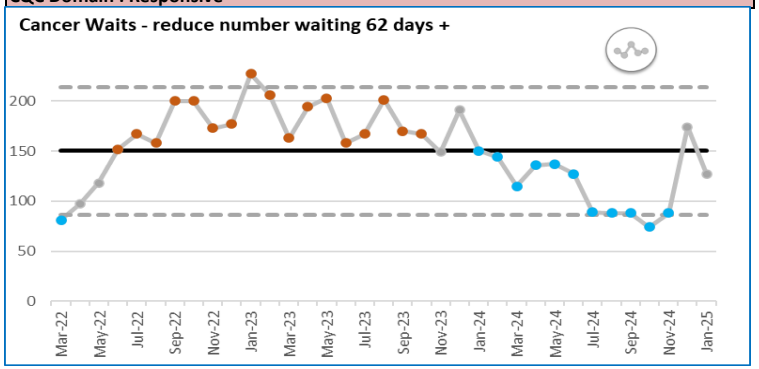
Cancer Waits - 62 days to treatment (quarterly)



Dec-24
76.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

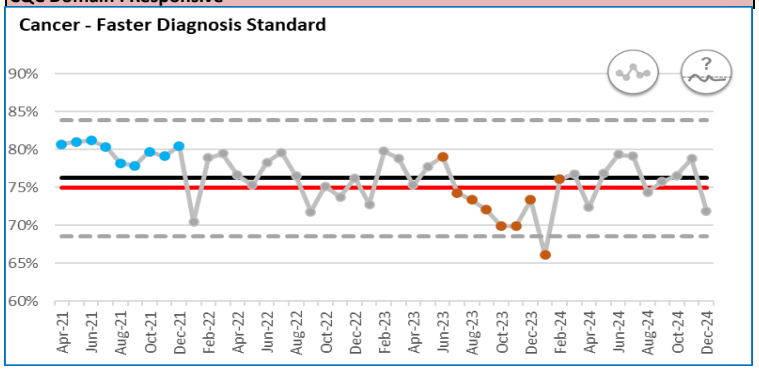
Chief Operating Officer (4)

CQC Domain : Responsive



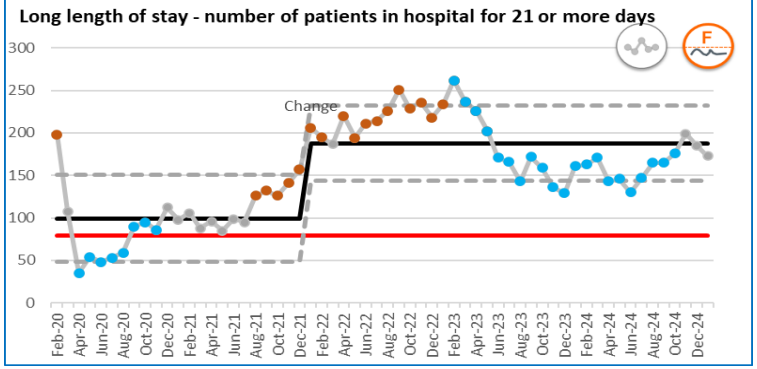
Jan-25
127
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Dec-24
71.9%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

CQC Domain : Effective

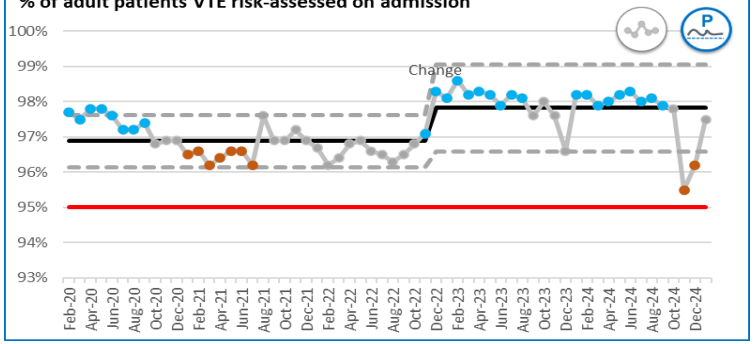


Jan-25
173
Variance Type
Common cause variation
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

Medical Director

CQC Domain : Safe

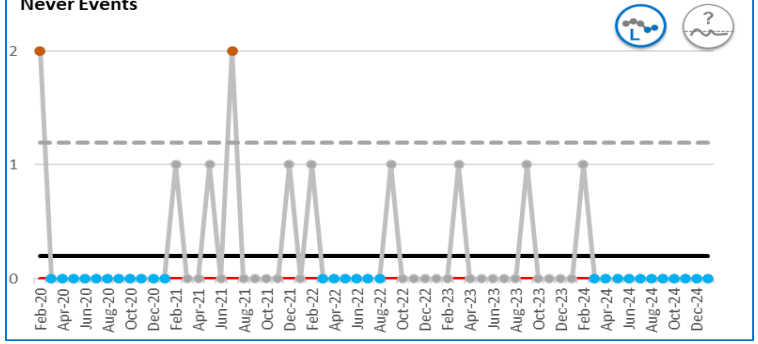
% of adult patients VTE risk-assessed on admission



Jan-25
97.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe

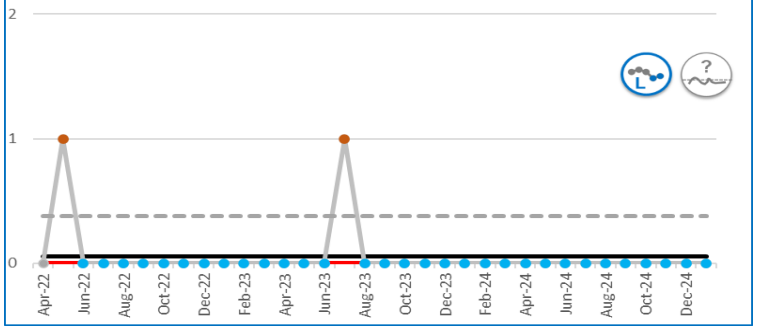
Never Events



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

CQC Domain : Well-led

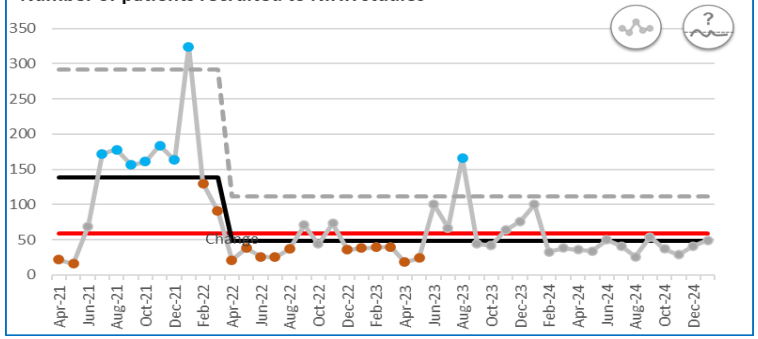
Duty of Candour compliance - breaches of DoC standard for Serious Incidents



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

CQC Domain : Well-led

Number of patients recruited to NIHR studies

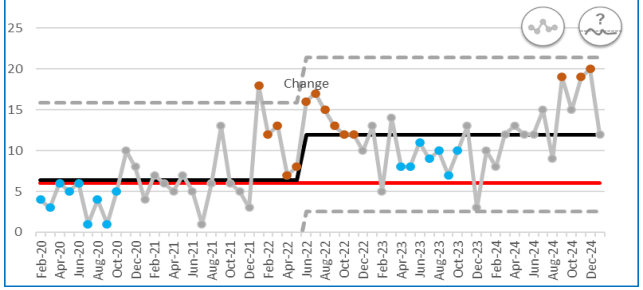


Jan-25
49
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

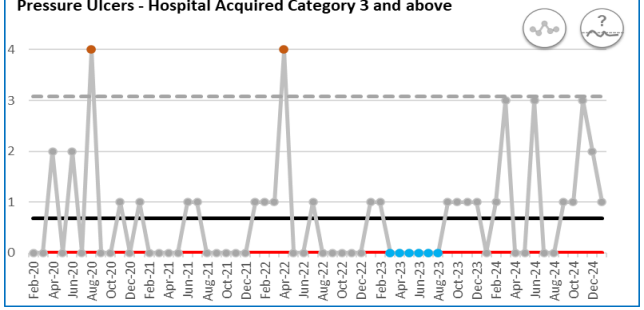
Clostridioides difficile (healthcare associated)



Jan-25
12
Variance Type
Special cause variation - concerning
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

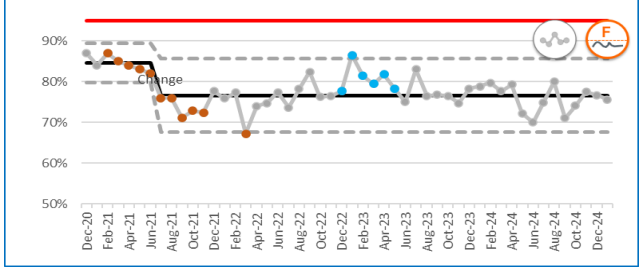
Pressure Ulcers - Hospital Acquired Category 3 and above



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

CQC Domain : Caring

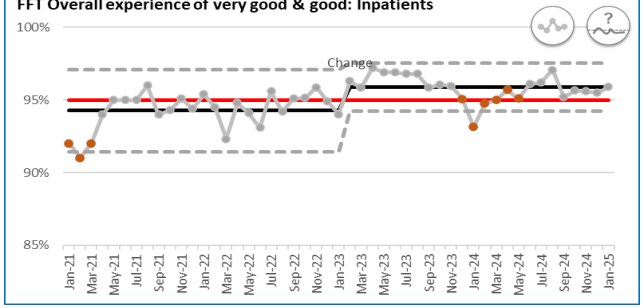
FFT Overall experience of very good & good: ED



Jan-25
75.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

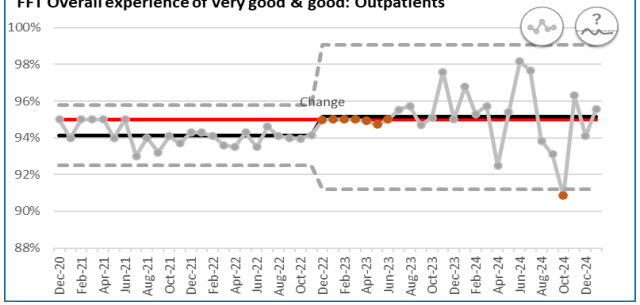
FFT Overall experience of very good & good: Inpatients



Jan-25
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

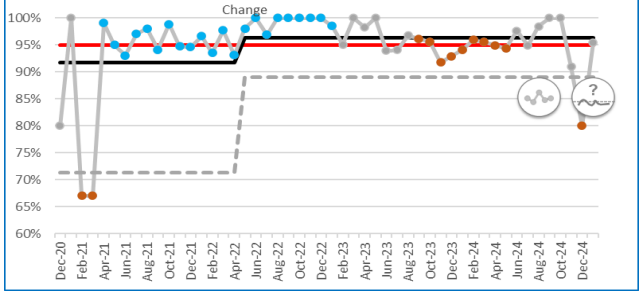
FFT Overall experience of very good & good: Outpatients



Jan-25
95.6%
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

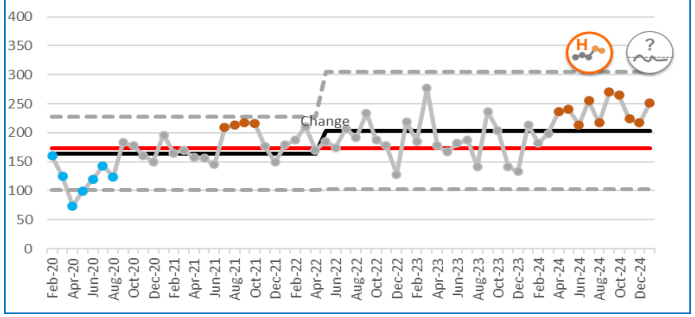


Jan-25
95.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

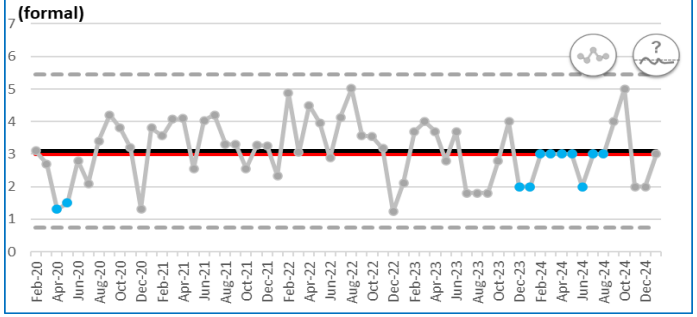
Patient Experience: concerns received in month - Level 1 (informal)



Jan-25
252
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

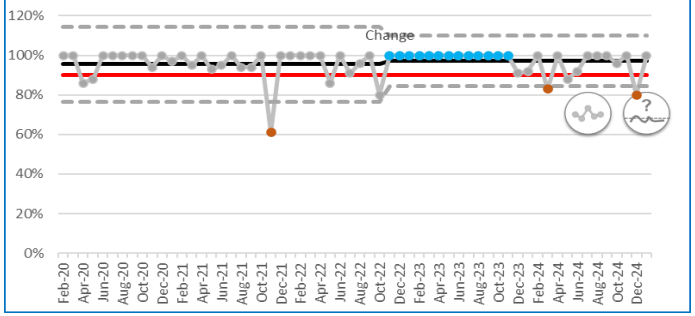
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



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

CQC Domain : Responsive

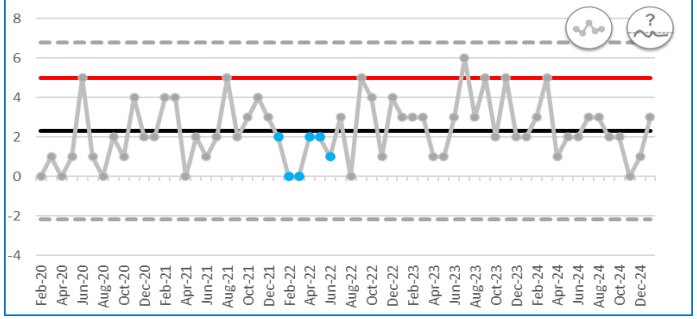
Formal Complaint acknowledged within 3 working days



Jan-25
100.0%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

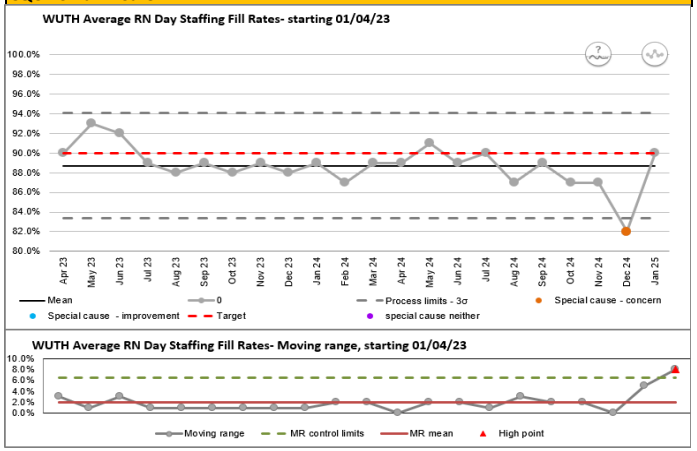
Number of re-opened complaints



Jan-25
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

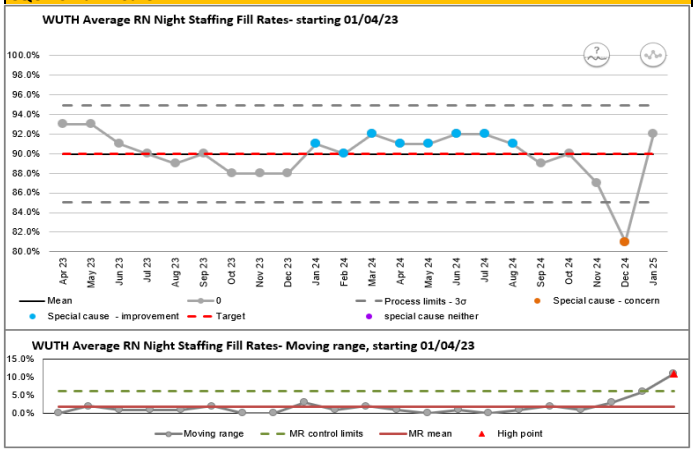
Chief Nurse (3)

CQC Domain : Safe



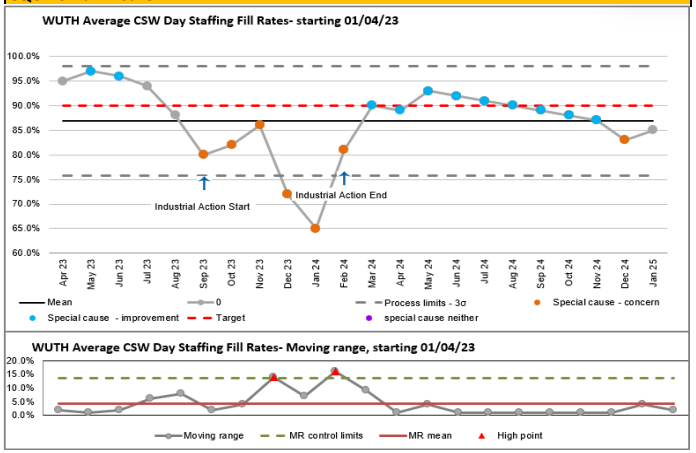
Jan-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



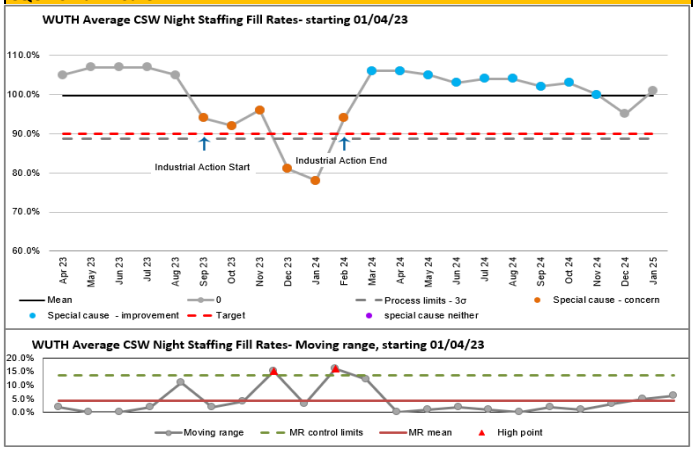
Jan-25
92.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



Jan-25
85.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



Jan-25
101.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse – January 2025 data

Overall position commentary

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

C Difficile remains above the target of 6 per month, there were 12 Incidents in January 2025

There was 1 category 3 hospital acquired pressure ulcer in January 2025 against a target of 0.

Friends and family test for ED 75.6%, Maternity, Outpatients 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.

RN and CSW staffing fill rates were above the threshold of 90% with the exception of CSW days which was 85%.

Infection Prevention and Control

Narrative:
To achieve the annual threshold of ≤ 103 patients diagnosed with CDT in 24/25.
Since 1st April 24 – 31st January 25 there has been 147 patients diagnosed with *Clostridioides difficile* Infection, of those reported there are 98 Hospital onset health care associated (HOHA) and 48 Community onset healthcare associated (COHA). In January there were 9 HOHA and 3 COHA. This is an overall reduction of 7 when compared to the previous month. In January all the back log of reactive cleaning utilising ward 44 to allow for the HPV program were completed.

At the end of Q3 24 patients accounted for 52 of the incidences, the IPC medical lead is currently reviewing the cases for themes. CDIF increase remains a regional and national issue, with 10 or the 25 trusts in the North West exceeding their thresholds at the end of Q3.

The CDI improvement project ended in January once the CDT change bundle had been shared with the wards during a Trust wide walk round. A 25% reduction in incidence was reported in the improvement wards at the end of the program.

The change bundle content consists of

- Identification of the *Clostridioides difficile*
- Patient management
- Reducing Risk
- Outbreaks
- Cleaning and Disinfection
- Patient/visitor advice

The *Clostridioides difficile* change bundle contains information on

1) Investigating the Problem
2) What is a Change Bundle?
3) Staff Education and Awareness
4) Oversight of Side Rooms
5) Improved Patient and Visitor Awareness
6) Cleaning and Disinfection
7) Cleaning and Disinfection (Continued)
8) C. diff Knowledge
9) Antimicrobial Stewardship

Actions:
Completed or in place.

- Ongoing use of ward 44 as a decant ward to facilitate bay movements to allow for HPV to take place following a patient identified with CDT.
- 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.
- A place wide 'working draft' improvement plan developed in partnership with WCT, the ICB and public health.
- 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 in the medical division to identify who can be moved out should a side room be needed for a patient with loose stools.
- Place based AMR champion funded by public health being progressed.
- Review of patients that relapse to identify common themes.

Risks to position
High site occupancy levels

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 75.1%. 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.
- Limited resource to process OPD FFT cards.

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 January there was 1 x Hospital Acquired Pressure Ulcer (HAPU) Category 3, to a patient's right heel which developed on ward 36.

Actions:

- Tissue Viability Team to provide ward-based training to Ward 36 due to increase in reportable pressure damage.
- Review reporting of incidents within Ulysses
- Review education around pressure ulcer prevention and management for all staff.
- Development of Tissue Viability Newsletter
- External review of service and operating model requested.

Risks to position and/or actions:

- Part time leadership within the tissue viability team.
- With increase in activity plus availability of beds and dynamic mattresses this can impact on the ability to review skin condition and undertake repositioning within the Emergency Department. Mattress contract currently under review.

Complaints

Narrative

During January 2025, WUTH received 18 formal complaints (level 2-4) and 252 informal concerns (level 1). The monthly averages year to date are 19 and 236 respectively.

Acute Care received in the highest number of formal complaints (9), then Surgery (6), then Medicine (4), then Women's and Children's (3), then Diagnostics and Clinical Support (2).

Medicine received the most informal concerns (87), then Surgery (65), then Women's and Children's (46), then Diagnostics and Clinical Support (37), and then Acute Care (33).

Corporate Departments received 1 complaint and 11 concerns, with four of these again reflecting the increased volume of concerns regarding delays in SAR / Access to Information requests – which is a recognised capacity pressure for the organisation.

Top three themes for the organisation (concerns and complaints) were:

- Access and Admission (34%, mostly reflecting delays and cancellations).
- Communication (19%, mostly communication failure rather than attitude).
- Treatment and Procedure (17%, again, mostly forms of delay)

The highest featuring departments were ED (9 formal and 31 informal), followed Community Child Health (18 informal, reflecting the known access problems with waiting times for assessment by that service), Radiology (16 informal), Urology (14 informal), and Cardiorespiratory (13 informal).

Average response time of 71 working days. At the end of January, there were 47 formal complaints in progress.

Of the 252 concerns opened, 144 (57%) were resolved within three working days and 79% within 10 working days.

Actions:

Average complaint response time during the fiscal year to date remains is at 68 working days (compared with 70 working days in 2022/23, 58 working days in 2021/22, and 45 working days 2020/21).

As noted previously, discussions have taken place with the divisional triumvirates to emphasise the role of a single divisional investigator to coordinate a unified response with all stakeholders, answering all complaint issues and with appropriate actions set out.
Performance oversight continues to be provided to the divisional triumvirates via daily reports and weekly meetings with the central Complaints Team, which also continues to provide monthly training sessions for staff.

Risks to position and/or actions:

· Operational pressures
· Lack of individual ownership
· Variable skillsets evident in investigations

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. January saw an improvement in fill rates for RN day and Night and CSW night shift.

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.

Acuity review completed with new safer nursing care tool, data currently being analysed. Report to board in March 2025, second round data collection to commence in March 25

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.

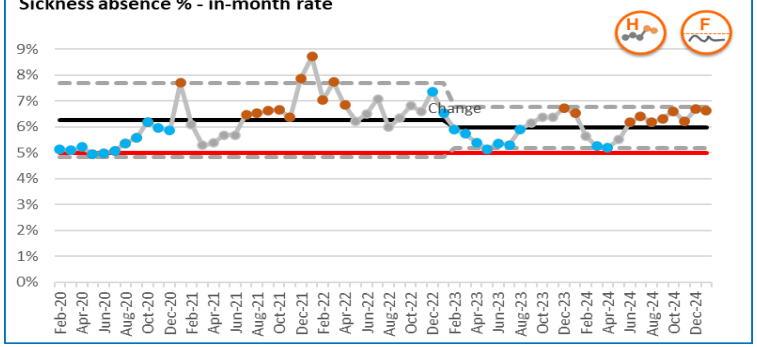
Risks to position and/or actions:

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

Chief People Officer

CQC Domain : Safe

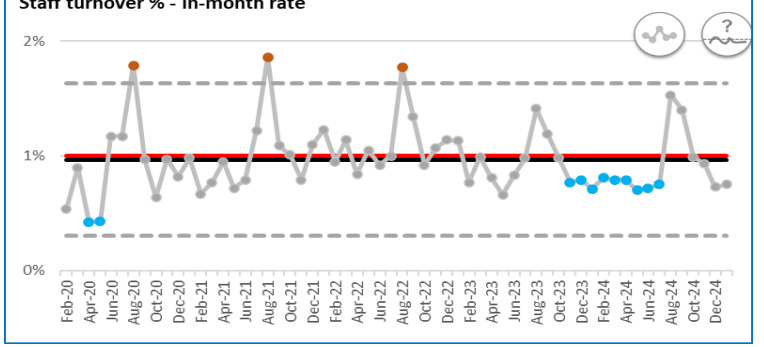
Sickness absence % - in-month rate



Jan-25
6.62%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

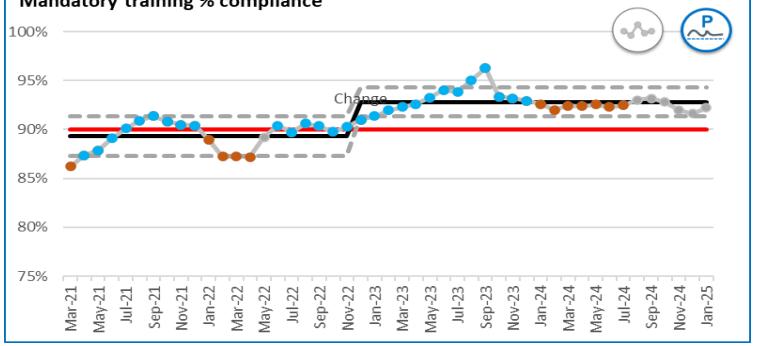
Staff turnover % - in-month rate



Jan-25
0.75%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

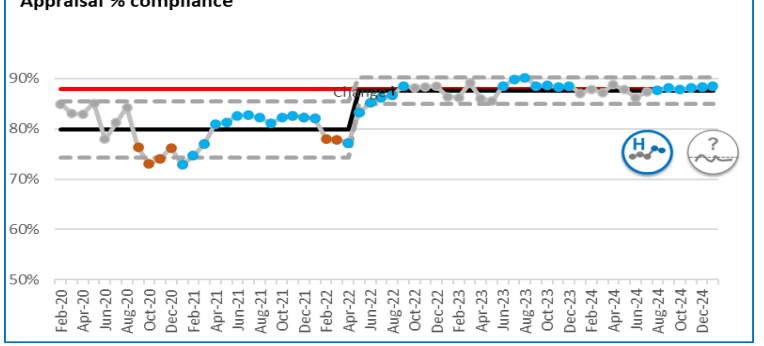
Mandatory training % compliance



Jan-25
92.20%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Jan-25
88.49%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – January 2025 data

Overall position commentary

The Trust's People KPIs for mandatory training, appraisal compliance and turnover are on target.

Sickness absence remains above target at 6.62% and an area of concern and focus.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For January 2025 the indicator was 6.62% and demonstrates special cause variation - concerning.

The majority of absences relate to short term sickness. Cold/flu, anxiety/depression and gastrointestinal illnesses account for over 50% of all absences in January 2025. Additional Clinical Services, Nursing and Midwifery, and Estates and Ancillary staff groups are experiencing higher levels of absence. All other staff groups are on or below target.

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 Wellbeing

- Onsite presence and ongoing promotion of the Trust's Employee Assistance Programme (EAP) continues with uptake increasing as a result.
- The EAP providers have been particularly focusing on promotion to NMW and ACS staff and have presented at Chief Nurse Check-In.
- Promotion of the EAP Wisdom App, which enables staff to access 24/7 support, continues. Uptake has increased has increased as a result.
- The Occupational Health (OH) Service are raising awareness of the impact of DNAs, as well as the process for expediting any required cases, with a particular focus on NMW and ACS staff.
- The OH Service have partnered with One Wirral CIC to offer health checks to staff aged between 40-74 to identify risk of Heart disease, Diabetes, Kidney disease or stroke.
- Proactive targeted psychological support is provided to areas with specific wellbeing concerns.
- February Wellbeing Surgery focused on reducing alcohol consumption.

Managing Absence

- 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.
- There is an increased number of cases managed through the Attendance Management Policy.
- A revised approach to formalise local Attendance Management Audits has been implemented.
- Revised reporting of local Attendance Management Audits has been implemented to include Divisional Triumvirates, DPRs and Workforce Steering Board.

Risks to position and/or actions:

The local risk (397) score is 15 and BAF risk is 12.

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR Team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels, financial controls and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The negative impact of both sickness absence and presenteeism on the workforce and patient care are well known and understood across the Trust. The Trust is committed to the health and wellbeing of its staff aligned to the NHS People Promise. This is set out in the Trust Strategy – Be a great place to work and in our People Strategy – Looking After Ourselves and Each Other.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
5 March 2025

Item No 10

Report Title	Committee Chairs Reports – Estates and Capital Committee
Date of Meeting	6 February 2025
Author	Sir David Henshaw, Chair of Estates and Capital Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ Committee discussed the quarterly Health and Safety update and acknowledged the number of violence and aggression incidents towards staff and patients continued to remain high and this was cause for concern. Committee also discussed Fire Safety Level 2 training compliance, noting this continued to be significantly below the 90% compliance target across most of the Divisions. The Committee recommended that this be referred to and discussed in more detail at the People Committee.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Committee received an update on the Neonatal Unit redevelopment and agreed proceeding with the recommended option. Committee also agreed to use a portion of capital funding from the 2025/26 capital programme. This is subject to Board approval on 5 March. ○ Committee also received an update on the plans and next steps to use NHSE capital funding to cover a capital to revenue transfer and purchase of a building on one of the Trust sites. ○ Committee received a presentation detailing the Trusts 2024 Estates Return Information Collection (ERIC) submission, which demonstrated the Trust's performance in relation to the costs for managing the hospital estate.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee received the quarterly performance report on the Estates functions across the Trust, with the Director of Estates providing assurance on delivery of statutory estates compliance, reactive maintenance and cleaning standards. Committee received good assurance that the Trust was continuing to meet these performance metrics.

	○ Committee received an annual progress update on the Trusts Green and Sustainability Plan. The presentation summarised recent key achievements and priority actions for the next year, including reducing emissions from nitrous oxide and reducing food waste. Committee commented on the positive progress and requested the presentation be provided to Board and Council of Governors. ○ Committee received an update on the Urgent and Emergency Care Upgrade Programme (UECUP). The presentation detailed phase 4 progress so far which was due for completion in June 2025. Committee also received an update the next phase relating to the entrance, Minors, Majors and UTC as well as the plans to ensure operational service delivery of the ED department were not impacted during phase 3. ○ Committee were provided with good assurance on the 2024/25 capital programme delivery and financial position, acknowledging the number of projects in construction/complete and that the capital budget would be fully spent.
Review of Risks	• Committee agreed the risks and controls for the relevant strategic risk, which appeared accurate and reflected the current position. Members agreed to receive a further update on the backlog maintenance risks later in the year.
Other comments from the Chair	• No other comments.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
5 March 2025

Item No 11

Report Title	Committee Chairs Reports – People Committee
Date of Meeting	7 February 2025
Author	Lesley Davies, Chair of People Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Committee continues to monitor sickness absence, retention, and appraisals. Improvements to appraisal completion was noted and is now above target. However sickness absence continues to be above the Trust's target at 6.62% in January 2025, which is mainly driven by short term sickness absence. Additional Clinical Services, Nursing and Midwifery, and Estates and Anciliary staff groups have the highest levels of sickness absence. ○ Estates and Facilities Division will provide a follow- up deep dive presentation, focused on the full range of workforce indicators, to the Committee in April.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee received an update from the Chief People Officer on system and national people related matters and noted the progression of the national work to implement a new Electronic Staff Record. The Committee noted the Trust's current state of readiness for an expected implementation period of 2027 to 2030. ○ The Committee had a detailed and positive discussion on the Trust's activities in relation to equality, diversity and inclusion. The Trust is compliant with all regulatory reporting requirements and the Committee noted the good progress against the NHS England EDI Improvement Plan. The Committee received good assurance in relation to the Equality Delivery System Assessment and approved the assessment rating of 'Achieving'. ○ The Committee has been consistently impressed by the range of activities carried out to improve staff satisfaction, especially for staff from ethnic minority groups and with disabilities, and that all staff have the confidence to speak up if issues are evident. Therefore, in addition to NHS England requirements, the Committee agreed that reporting on the following areas

	biannually, would provide the Committee with key information to demonstrate the impact of the work being undertaken across staffing teams: ▪ monitoring of applications through to successful appointment as all levels of the organisation ▪ staff satisfaction and expressed levels of trust through staff surveys ▪ promotion opportunities and successful progression through the organisation ▪ results of exit interviews monitoring reasons for leaving • The Committee agreed to review the impact of the People Strategy strategic priorities for 2023 at its April meeting and to agree the 2025 priorities.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Committee took good assurance on appraisal and mandatory compliance, although Fire Safety Training continues to be a focus of attention being behind target at 77.8%. ○ The Committee also took good assurance on turnover rates, which have return to below threshold rates following the planned annual spike in August and September 2024. ○ The Trust's annual Gender Pay Gap Report was received, which showed positive progress with no areas of concern. The Committee ratified the report.
Review of Risks	The Committee reviewed the people risks and noted the increased risk rating for sickness absence.
Other comments from the Chair	No other comments.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
5 March 2025

Item No 12

Report Title	Committee Chairs Reports – Audit and Risk Committee
Date of Meeting	20 February 2025
Author	Steve Igoe – Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Internal Audit Report on LoCSSIPs produced a limited Assurance outcome The Audit Committee asked that the report be considered by the Quality Committee alongside the rectification plan ○ Work is ongoing in relation to Multi Factor Authentication (MFA) and password security following the recent cyber incident.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ A deep dive was undertaken into the Trust's ongoing management of Sickness and absence. There is still work to do in certain areas to reduce levels of sickness however the Trust has a plan and is actively benchmarking against other similar trusts. ○ The Committee received reports and approved year end requirements in respect of : The external Audit plan and fee for 24/25 ,The 24/25 internal audit plan ,bad Debt policy, Going concern assessment and accounting policies to be used in constructing the year end accounts
Assure	• The Committee wish to assure members of the Board of Directors that: Positive Internal Audit reports were received for :Threat and vulnerability management ,and key financial controls , the latter being at the highest level of assurance. The risk maturity review yielded a positive outcome at level 4 of a 5 level scale .Designating the Trust as Risk managed. A detailed report on Information Governance was discussed including updates on the recent cyber incident and actions subsequently taken. A detailed report will come back to the Committee for further assurance however the report will be restricted given the commercial sensitivities. Positive work continues in resolving and clearing points made through Internal Audit reports . The Committee has agreed that the small number of outstanding items will be resolved by the time the Committee next meets in April

Review of Risks	• The BAF was reviewed in detail acknowledging that it was part way through its refresh process. The content was approved and the Trust's positive position in relation to risk management as set out in the Risk Maturity review was noted.
Other comments from the Chair	• This meeting noted and approved a number of matters in preparation for the Trust's year end and reporting requirements. A positive engagement with External Audit is in evidence which will no doubt assist given the pressures of year end accounting.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 13**

05 March 2025

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in December 2024.The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (January 2025) key quality and safety metrics and the position of patient safety incidents.

This paper provides a specific update regarding MIS Year 6, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Midwifery staffing update, Maternity Continuity of Carer (MCoC) together with an update on the UNICEF Accreditation and LMNS annual visit at WUTH.

It is recommended: -

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI).
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the 6 monthly workforce and staffing report for maternity along with Trust investment to increase the maternity establishment to permanent posts in line with associated funding.
- Note the results of the CQC maternity survey.
- Note the outcome of the UNICEF accreditation.
- Note the outcome of the LMNS annual review.
- Note the North West Neonatal Operational Delivery Network annual visit.
- Note the PMRT report for Q3 24/25.

Key Risks
This report relates to these key Risks: • BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
February 2025	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
February 2025	Divisional Quality Board	Quarterly Maternity and Neonatal Services Report	For information
February 2025	Safety Champion Monthly Meeting	Quarterly Maternity and Neonatal Services Report	For information
March 2025	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (January 2025) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution.

	However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months on review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers. A further set of clinical quality metrics has been provided by Cheshire and Mersey LMNS and the reporting pack has been challenged in terms of accuracy and relevance of the measures. There has been no further datasets shared or any feedback provided.

2	**Patient Safety Incident Investigations (PSIl's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in January 2025 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there are four ongoing cases. There were no Patient Safety Investigation Incidents (PSII's) declared in January 2025 for Neonatal services.

3	**Maternity Incentive Scheme (MIS) Year 6**
	The declaration for MIS Year 6 was submitted as approved by the Board of Directors in January 2025 to NHSR. As advised by MBBRACE and NHS Resolution Safety Action 1 was declared as non-compliant in the first instant, with a view to a review of the position when the external verification is undertaken. On submission the details of issues identified and the mitigations along with a full report were included in the action tab of the signed Board Notification Form. There have been no guidelines released on MIS Year 7 and publication is expected in Spring 2025.

4	**Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme**
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle

	(SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 30th September 2024 the Trust achieved 89% compliance against the 6 elements included at **Appendix 2**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper. Q3 evidence has been submitted and under review by the LMNS for compliance.

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

6	**Three Year Delivery Plan – Maternity and Neonatal**
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 4** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

7	**Midwifery Workforce and update on Maternity Continuity of Carer Model (MCoC)**
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has five maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. There are no further teams planned to be launched and a continued focused approach to deliver the model of care to enhanced women/birthing people.

	As previously presented to Board of Directors a full workforce review was last undertaken using the Birthrate+ tool in 2021, a repeat of this as recommended every 3 years in line with Ockenden is being undertake and publication is expected shortly. A comprehensive 6 monthly workforce paper is included at **Appendix 5**.

8	Maternity CQC Survey
	The Care Quality Commission (CQC) conduct and annual national survey of maternity services, which in 2023 produced some positive results for Wirral Women and Children's Hospital at **Appendix 6.** The 2024 survey is split into eight sections to identify the women's maternity experience. The overall results indicate that Wirral Women and Children's Hospital has been providing quality care to expectant and new mothers.

9	UNICEF Accreditation
	Included at **Appendix 7 and 8** is the outcome letter and report of the UNICEF baby friendly re-assessment providing an update on the on the Trust's position. A sustainability plan has been developed and monitored via the maternity and neonatal assurance meeting.

10	LMNS Annual Visit
	An annual visit was hosted by WUTH on 11th December 2024 by the LMNS. The feedback was very positive and is included at **Appendix 9**. On the day the Maternity and Neonatal quality improvement team received an award recognising the significant and outstanding contribution the team has made to exceptional contributions and participation in consistently improving practices and outcomes.

11	North West Neonatal ODN Annual Visit
	An annual visit was hosted by WUTH on 6th December 2024 by the Northwest Neonatal Operation Delivery Network (ODN). The feedback was very positive and is included at **Appendix 10**.

12	PMRT Reports
	The Perinatal Mortality Reviews Summary Report (PMRT) is included at **Appendix 11**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 3 24/25 period. .

13	Conclusion
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services.The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

14	Implications
14.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
14.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 10 safety standards in principle with a request to manual validate Safety Action 1 providing assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Progress with sustainability of Ockenden. • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
14.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity and neonatal workforce is required and funding options continue to be explored. A paper has been submitted to BDISC and EARC for approval to increase establishment with funding received was approved increasing the midwifery establishment. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels.
14.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 14**

04 March 2025

Title	Chief Nurse 6 Monthly Safe Staffing Report: Executive Summary
Area Lead	Sam Westwell, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
Author	Julie Roy, Deputy Chief Nurse Johanna Ashworth-Jones, Programme Developer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Trust Board with assurance that WUTH has met its regulatory requirements in accordance with national guidance 'Developing Workforce Safeguards' (NHSI 2018). National guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time National Quality Board (NQB 2016 & 2018).

In addition, the report demonstrates that the Trust has met effective governance requirements aligned to workforce decisions which promote patient safety and comply with the Care Quality Commission (CQC) fundamental standards.

This report comprises of an Executive summary report to support presentation at Trust Board and a comprehensive full report detailing process, assurance evidence, outcomes and next steps which will be published on the Trust website.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to the following key risks:

- 1091 – Emergency Department - staffing levels and temporary escalation areas
- 1807 – Surgical Division – Ward 10 – Insufficient nursing staffing levels
- 2058 – Women's & Childrens Division – Maternity services – Achievement of maternity incentive scheme
- 435 – Critical Care – potential risks related to fulfillment optimal staffing levels
- 809 – Medical Division – risk to staff wellbeing due to high numbers of sickness and vacancies

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

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

1 Executive Summary

1.1 **Process**

The Trust has a standardised approach to establishment setting within the adult inpatient wards. This consists of reviewing an 80 plus indicator establishment template that brings together nurse sensitive indicators, acuity and dependency results, workforce metrics, quality impact measures and finance. These templates are used to consult with each localised leadership model i.e., Ward Manager, Matron, and Associate Director of Nursing. Proposals are then presented by the Divisional Nurse Director at a 'confirm and challenge' meeting with the Chief Nurse and supporting specialist leads. This approach has been reviewed by the new Chief Nurse and Deputy Chief Nurse who are satisfied that it is in line with all required guidance.

Specialist areas such as Critical Care, Maternity Services, Children's services, Neonatal Unit and the Emergency Department have specialist specific establishment reviews aligned to the appropriate national guidance which are detailed later in this report.

1.2 Establishment review outcomes

Outcome details of the establishment reviews for each Adult inpatient ward are provided in Table1. This has been reviewed by the Chief Nurse and Chief Finance officer for overall approval.

As highlighted earlier in the report, utilising Adult SNCT results as a basis for recommendations to changes in establishments should only be used after a minimum of two audits. In addition national guidance is clear that the decision making for establishment change must be focussed on professional judgement using the triangulation of data intelligence.

For adult inpatients a recommendation of 3 changes have been proposed and approved, the changes to the funded establishment are detailed in Table 1. Appendix 1 shows the breakdown of the Surgical Divisions costing to facilitate the establishment changes within the current divisional budget allocation.

Division	Ward	Funded	Funded Housekeeper & Ward Clark	Overall SNCT no therapeutic supervision	Outcome
Surgery	10	28.71	30.71	31.89	**Up lift**
	11	40.57	42.57	35.85	**Reduction**
	12 EOU	39	41	10.34	No change
	WAFFU			17.56	No change

	14	56.86	60.47	44.4	**Reduction**
	SEU / 17	49.07	52.07	33.22	No change
	18	45.4	47.4	39.12	No change
Medicine	20	39.12	41.01	43.06	No change
	21	40.49	42.44	49.76	No change
	22	40.26	42.19	40.79	No change
	23	42.26	43.79	40.39	No change
	24	30.67	32.43	33.83	No change
	25	47.56	49.56	50.95	No change
	26	48.63	50.63	46.61	No change
	27	40.32	42.12	42.22	No change
	30	36.43	38.56	44.56	No change
	32	42.85	65.95	36.24	No change
	CCU	15.84		9.84	No change
	33	39.83	37.96	35.6	No change
	36	46.92	48.92	52.52	No change
	37	61.74	64.74	66.01	No change
	38				No change
	CRC	40.7	42.7	39.17	No change
	M1	39.4	41.07	48.79	No change
	OPAU	44.87	46.77	52.36	No change
Acute	AMU	54.81	58.45	45.21	No change
	MMSW	26.77	30.41	26.78	No change
	CDU	15.52	16.52	18.54	No change
W & C	31 / 54	Change of location and proposed bed base change			

Women's and Children's Division

At the time of the SNCT audit, ward 54 (Gynaecology ward) were decanted within the adult inpatient hospital site on ward 31. This ward move was to facilitate the upgrade of ward environments within the Women's and Children's building. Whilst ward 54 undertook the SNCT audit the results cannot be used as the audit incorporated the additional beds in use due to Trust wide operational demands. The Women's and Children's division are also in the process of implementing bed base changes as part of their overall activity review with the proposed removal of surgical division bed allocation within this area.

Surgical Division

As highlighted in table 1 there are 3 establishment ward amendments within the Surgical Division. These changes have been made in line with NQB guidance based on professional judgement using the triangulation of data and discussion with staff. Whilst the SNCT red rule advises that changes should not be made within the first cycle of the new SNCT, it does suggest that if professional judgment indicates that a change in establishment is required then this should be acted upon.

Ward 10 – Additional uplift of a CSW on the night shift to support with the number of patients who require enhanced therapeutic supervision, have increased dependency,

	and falls risk needs. This uplift will reduce the number of temporary staffing shifts currently provided by NHSP to maintain patient safety and as a result provide a proposed cost saving. Ward 11 – Reduction of a RN late shift at the weekend. This reduction is reflective of the general reduced activity during the weekend period. Ward 14 – Reduction of a RN early shift from 7 RN's to 6 RN's. These establishment amendments have been agreed with ward leadership teams and finance secured within the divisional budget as detailed in Appendix 1. Ward M2 Ortho & M2 Surgical are not detailed in Table 1 as these are elective surgical areas with protected beds., During the audit period overnight bed occupancy was lower than the available bed base which may be indicative of advancements in recovery, correct patient case mix allocation and surgical intervention techniques. The available bed base however influences SNCT outcomes. At a divisional level, staff are redeployed appropriately as identified through daily staffing meetings and staffing allocation is planned in line with patient theatre allocation lists. Medical Division Whilst there are no changes within the Medical Division's funded establishment, extensive consideration was given to the potential uplift of establishment within Ward 36 (previously located on ward 33). This ward has been identified as an area requiring additional support across a range of quality indicators, which have been reflected in its ward accreditation level one status. A series of improvement mechanisms are in place to support the ward. In addition, there have been several nurse leadership changes implemented from ward level through to Divisional Nurse Director. Any professional and clinical judgements around staffing requirements have been supported by using temporary staffing and redeployment of staff from within the division (including non-ward based nurses such as Practice Educators). Given all of these factors and the reinstatement of the 6 monthly acuity and dependency audit cycle due to commence 31/3/25 a pause on any significant establishment changes was deemed prudent. Emergency Department WUTH is currently upgrading its Emergency Department (ED) as part of a multimillion-pound capital investment. As the department transitions between the old environment and the new build the department is accommodated across several different areas which has resulted in some unforeseen staffing resource challenges due to temporary space allocation to facilitate the continuation of the new development. In addition, the Trust has experienced unprecedented operational activity pressures which have resulted in ED having to utilise several temporary escalation areas which require additional staff to maintain patient safety. In July 2024 the Emergency Department utilised the EDSNCT to complete its acuity and dependency review. As with previous audits the primary outcome of EDSNCT results recommended introducing a staffing model that is aligned to the department's increased periods of activity. This is a similar recommendation to the outcome reviews undertaken by NHS England's Emergency Care Improvement Support Team ECIST. The results have been used along with staffing considerations for the current environmental factors, temporary escalation requirements and overall professional judgment with a proposal to uplift ED staffing. A business case to support this proposal

has been approved by Trust Board and has increased the funded establishment by 44.4WTE. Recruitment to these additional RN and CSW posts is currently ongoing.

Maternity Services

Maternity services use a nationally recognised safe staffing tool Birthrate Plus which is completed daily and shared across the regional network. Monthly outcome results such as the number of red flags, compliance with the tool and any escalation implementations or diverts are reported in the bimonthly Workforce Assurance Committee report for monitoring and escalation. In addition, staffing for maternity services is also reported to the Executive team in relation to Ockendon report updates, progression against continuity of care model implementation and PSQB reports. The next annual Birthrate Plus staffing recommendation report is due March 2025, therefore, for this establishment review there is no change proposed to the funded establishment.

Children's Services

Children's services have specific RCN guidance in relation to staffing levels aligned to required patient to registered nurse ratios, these ratios also incorporate guidance on acuity levels and alignment to children's age. Whilst this guidance is incorporated as part of the professional judgement in determining staffing levels day to day for the Children's ward, there is currently no formal mechanism to digitally capture and monitor compliance against this guidance.

There is a specific Children's SNCT with similar implementation requirements to meet the licence agreement criteria. Nominated Trust staff have undergone the NHS England training and are implementing training to trust staff. The first children's SNCT audit will be commenced in March 2025.

Additional assurances that influence professional judgement include WUTH's attendance at the daily Cheshire and Merseyside network meeting where activity details are recorded and information on acuity shared. WUTH are also members of four children's services networks, Paediatric, Neonatal, Critical Care and Surgical, these networks provide regional support, scrutiny and gather staffing and patient data in relation to activity and workforce indictors.

Neonatal Unit

Due to the acute nature of neonatal medicine it can be difficult to accurately predict required staffing levels and therefore the application of professional judgement using average activity & acuity, aligned to staffing guidance recommendations (Appendix 2) form the basis of staffing deployment within WUTH's neonatal unit. This approach is in line with the British Association of Perinatal Medicine BAPM guidance.

WUTH's neonatal unit is part of a regional neonatal network and is represented at daily meetings to identify any required mutual aid, diverts or escalations. This detail is provided month on month as part of the bimonthly staffing paper. For this report period there is currently no proposed change to the establishment.

Critical Care

The current staffing establishment for critical care has been mapped according to the Guidelines for the Provision of Intensive Care Services (2022) (GPICS) developed by

	the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This provides a baseline of how the unit is staffed according to the standards. The staffing establishment is based on ensuring that the standards are achieved. For the period of this report there are no proposed changes to the establishment.

2	**Conclusion**
2.1	The Trust has met the standards and expectations within Developing Workforce safeguards requirements for adult inpatient wards. In addition, there are evolving processes in place to support professional judgement establishment setting within specialist areas. This report highlights a series of new and proposed workstreams that will ensure standardised approaches to safe staffing. These new initiatives and increased scrutiny and controls will provide a positive impact on patient safety and quality of care whilst also supporting efficiency reviews and increased transparency of staffing metrics. There is confidence that daily staffing monitoring processes are in place with a good system of internal control being applied to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 14**

04 March 2025

Title	Chief Nurse 6 Monthly Safe Staffing Report
Area Lead	Sam Westwell, Chief Nurse, Executive Director for Midwifery and Allied Health Professionals, Director of Infection Prevention & Control
Author	Julie Roy, Deputy Chief Nurse Johanna Ashworth-Jones, Programme Developer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Trust Board with assurance that WUTH has met its regulatory requirements in accordance with national guidance 'Developing Workforce Safeguards' (NHSI 2018). National guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time (National Quality Board (NQB) 2016 & 2018).

In addition, the report demonstrates that the Trust has met effective governance requirements aligned to workforce decisions which promote patient safety and comply with the Care Quality Commission (CQC) fundamental standards.

This report comprises of an Executive summary report to support presentation at Trust Board and a comprehensive full report detailing process, assurance evidence, outcomes and next steps which will be published on the Trust website.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to the following key risks:

- 1091 – Emergency Department - staffing levels and temporary escalation areas
- 1807 – Surgical Division – Ward 10 – Insufficient nursing staffing levels
- 2058 – Women's & Childrens Division – Maternity services – Achievement of maternity incentive scheme
- 435 – Critical Care – potential risks related to fulfillment optimal staffing levels
- 809 – Medical Division – risk to staff wellbeing due to high numbers of sickness and vacancies

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

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

1	Narrative
1.1	**Background** The fundamental purpose of a safe staffing nursing establishment review is to ensure that sufficient nursing capacity and capability is available to provide individualised, person-centered care in a safe and effective way. This is achieved through consideration of a range of decision-making factors which have been clearly articulated in a framework of expectations set out by the National Quality Board (NQB 2016 & 2018) enabling a triangulated approach to staffing decisions. These are;

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Hospital Trusts are required to comply with the NQB 2016 & 2018 guidance which states that providers:

- Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to always keep them safe.
- Must use an approach that reflects current legislation and guidance where it is available.

These expectations also form part of 'Developing Workforce Safeguards' (NHSI 2018), along with other recommendations for consideration to provide a triangulated approach for the review of staffing requirements. Trusts must demonstrate that they have used the following three components as part of their safe staffing reviews:

- Evidence-based tools (where they exist).
- Professional judgement.
- Outcomes

Whilst WUTH has a series of mechanisms to ensure safe nurse staffing is in place day to day there has not been a fully published nurse staffing establishment review since June 2023. There are three main influencing factors as to the cause of this delay.

- Extensive periods of CSW Industrial action – agreement achieved April 2024.

	• Launch of a new Adult Inpatient Safer Nursing Care Tool (SNCT) published October 2023 that required undertaking comprehensive training, competency assessment, deployment plan and quality assurance process to implement in accordance with license criteria – *Completed.* • Simultaneous changes in senior nurse leaders (Chief Nurse & Deputy Chief Nurse) – *Resolved.*
1.2	**Governance** Alongside the regulatory requirement to undertake a formal 6 monthly review of nurse staffing establishments, a bi-monthly safe staffing report is presented to People Committee. The bi-monthly report provides an oversight regarding the visibility of safe staffing assurances including any known consequence on patient care, safety, or experience. Included is a comprehensive dashboard providing a month-by-month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD) data, shifts that have experienced any 'red flags', and patient experience metrics. Any known risk is highlighted along with mitigations and plans to enhance staffing assurances moving forward. The bi-monthly report provides narrative and statistical process control (SPC) charts based on the data within a staffing assurance dashboard. In addition, WUTH complies with NHSE Digital requirements to submit monthly staffing data in relation to fill rates and calculation of CHPPD. These monthly returns are available for review on the Trust public website as per national guidance recommendations.

2	**Establishment Review**
2.1	**Process** The Trust has a standardised approach to establishment setting within the adult inpatient wards (SOP Appendix 1). This consists of reviewing an 80 plus indicator establishment template that brings together nurse sensitive indicators, acuity and dependency results, workforce metrics, quality impact measures and finance. These templates are used to consult with each localised leadership model i.e., Ward Manager, Matron, and Associate Director of Nursing. Proposals are then presented by the Divisional Nurse Director at a 'confirm and challenge' meeting with the Chief Nurse and supporting specialist leads. This approach has been reviewed by the new Chief Nurse and Deputy Chief Nurse who are satisfied that it is in line with all required guidance. Specialist areas such as Critical Care, Maternity Services, Children's services, Neonatal Unit and the Emergency Department have specialist specific establishment reviews aligned to the appropriate national guidance which are detailed later in this report.
2.2	**Expectation 1: Right Staff**

Adult Safer Nursing Care Tool

A new Adult SNCT was launched October 2023. Organisations must apply for a licence to utilise the tool and as part of the license agreement organisations must adhere to a series of criteria. These include:

- Nominated staff to undergo training directly from NHS England who must undertake and pass a competency assessment. The staff who pass the assessment are then eligible to train staff within their organisation.
- Staff trained in-house must also complete and pass an assessment in order to undertake the audit.
- Audits must be completed at the same time each day for 30 days for all areas taking part.
- Quality assurance of the data collected must be aligned to a non-budget holder for each area.
- A minimum of two audits should be completed before SNCT audit results are used to make any recommended establishment changes.

There are several new features within the new SNCT that have been built in to reflect specific additional staffing considerations. These modifications include:

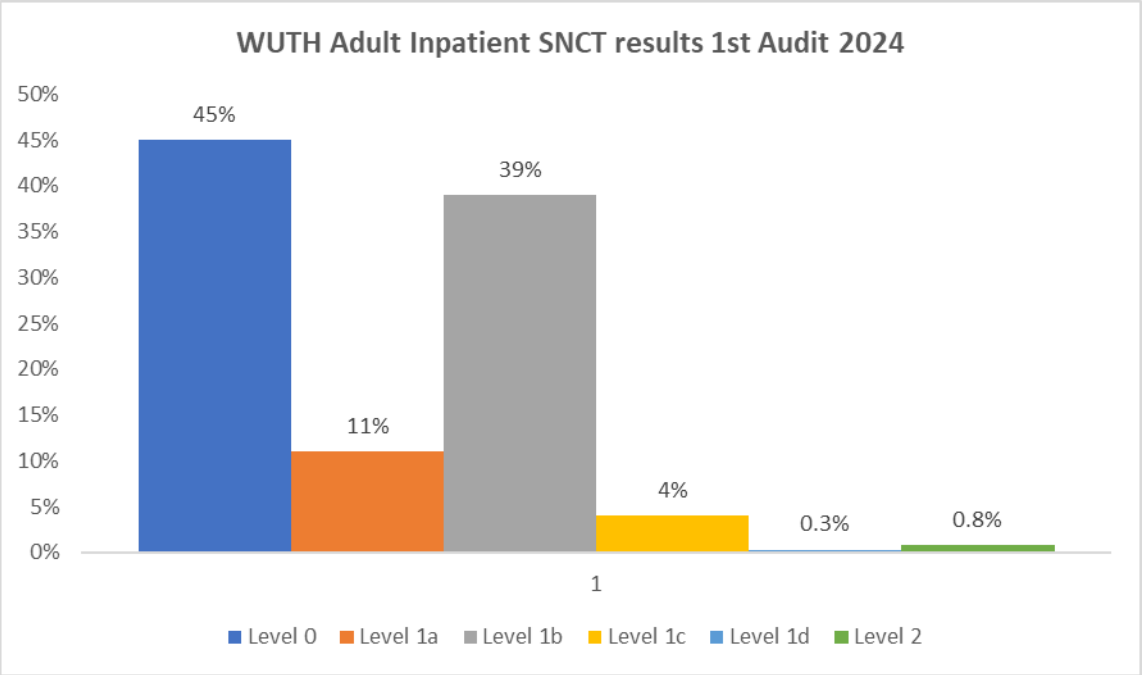
- Multiplier calculation for areas with significant number of side rooms
- Multiplier calculation for assessment areas
- The addition of therapeutic supervision levels
- Calculation of RN / CSW split based on preferred skill mix level.

Enhanced therapeutic supervision referred to as 1c & 1d levels within the SNCT is a significant area of potential efficiency and a quality improvement opportunity for WUTH. Initial discussions with senior nurse leadership and scoping potential support from PricewaterhouseCoopers LLP (PWC) have been initiated. Factors for consideration will include:

- Standardised approaches to supervision level application
- Completion and compliance reporting of vulnerable adult assessments within Wirral Millennium (WUTH's electronic patient record).
- Authorisation process and documentation compliance within Wirral Millennium
- Senior authorisation of NHSP shifts for 1:1's
- Potential for a dedicated enhanced therapeutic supervision deployment team
- Review of funded establishments utilising SNCT results *(Minimum of two audits)* to explore application of resource e.g. built into funded establishment model or if access to a potential centralised enhanced therapeutic supervision team would be the most efficient use of resource.

Several of the above factors are currently in progression, a proposal plan to pilot a dedicated enhanced therapeutic supervision care team with support from PWC will be formulated to coincide with the second set of SNCT results to ensure that any approved pilot is deployed to the areas that may provide the most significant efficiencies.

The chart below shows the 1st Adult inpatient SNCT results for the proportion of patients by levels of care:



There were some level 3 patients during the audit however not enough to create a percentage figure.

Patient care levels: Adult inpatient SNCT

- Level 0 – Needs met by provision of normal wards.
- Level 1a – Unstable with a greater potential to deteriorate.
- Level 1b – Stable condition but are dependent on nursing care to meet most of their needs.
- Level 1c – Stable condition but requiring additional intervention to mitigate risk.
- Level 1d – Stable condition but requiring intervention by 2 or more people to mitigate risk.
- Level 2 – Requires management in designated beds / required staffing expertise or transfer to designated level 2 facility.
- Level 3 – Advanced respiratory support / multiple organ failure

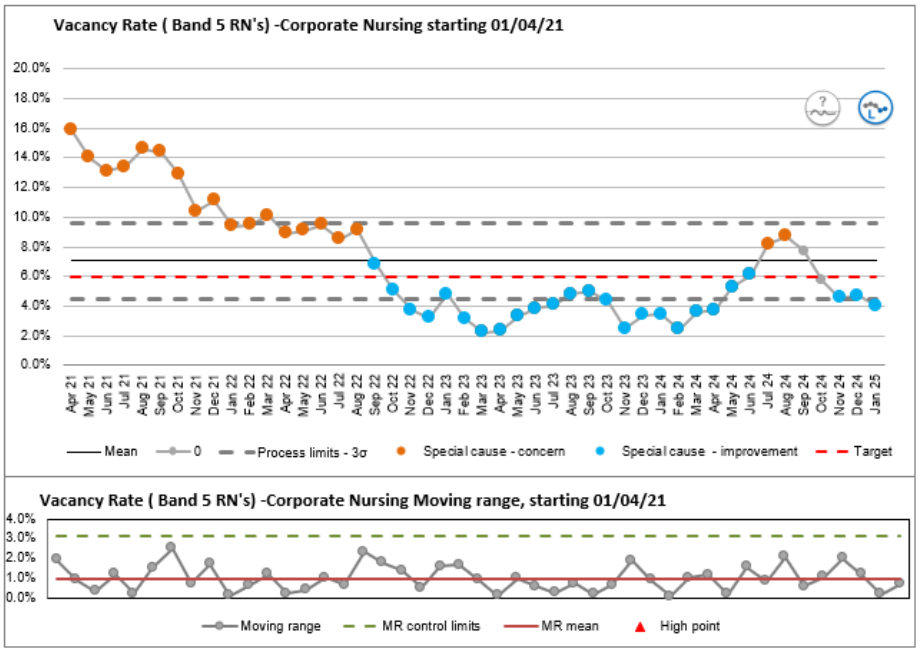
2.3

Expectation 2 – Right Skills

Mandatory training

Ensuring staff have the right skills to undertake their role safely and confidently is a national NHS requirement. WUTH has robust Ward to Board processes in place to monitor the compliance of staff against mandatory and role essential training including a specific Education Governance Group. Mandatory training consists of the following competency training requirements:

- Conflict resolution
- CPR
- Data Security
- Equality and diversity
- Fire safety.
- Health & Safety

	• Infection Control • Moving and Handling • Protecting Vulnerable People Due to the naming convention associated with nursing roles it is not possible at the time of this report to provide a compliance report for, ward-based nursing staff. Increased transparency in relation to this ward-based monitoring will be progressed through the new data presentations detailed within the next steps section of this report. As part of the wider NHS efficiency review Mandatory & Statutory training has been identified as one of the key areas where efficiencies can be made, NHS England will be providing a framework in 2025 which will look at the introduction of staff training passports and an alignment to training outcomes to determine training frequencies.
2.4	**Expectations 2 – Right Skills** **Recruitment & Retention** Data from NHS England reports the national registered nurse (RN) vacancy rate as 7.5% (Mar 24). WUTH reports nurses' vacancy data as part of the bi – monthly safe staffing report to People Committee, this month-on-month data is displayed below as Charts 1,2&3. With the exception of 3 months July – Sept, WUTH has maintained a vacancy rate below this national average. Recruitment of graduate registered nurses has been reduced to just one annual opportunity in August /September. The previous March cohorts have now ceased and WUTH's feeder Universities are using this March period to focus on apprenticeship opportunities which WUTH has identified as a potential recruitment opportunity for 2025 /26. A recruitment plan for 2025 is in draft and includes a targeted campaign for the Emergency Department alongside ad hoc divisional recruitment which is ongoing. The Nursing Recruitment and Retention group monitors the strategies and progress of improvements divisionally and Trust wide. **Chart 1** 

Both Trust wide and ward based CSW vacancy data is reported as special cause concern. Retention and recruitment campaigns are continuing and are supported by the following actions:

- Weekly CSW advert and targeted recruitment led by divisions.
- Quarterly system-wide recruitment events.
- Exit interviews; review of themes to address key areas.
- A nursing and AHP recruitment and retention working group has been established to enable divisional and organisational targets to be shared and monitored.
- Pastoral support for CSWs.
- Collaborative working with NHSP CSWs who undertake the care certificate program guaranteeing an interview for a substantive post.
- Specific placement of CSW apprentices and introductory visits to areas prior to placement.
- A focus on local support to improve retention of CSWs in their first year with the Trust.
- A successful recruitment event held January 2025

Chart 2

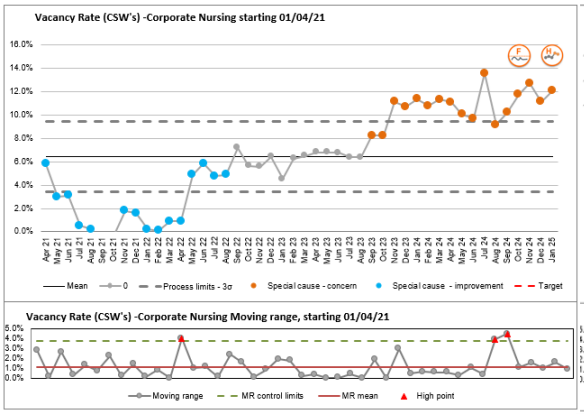
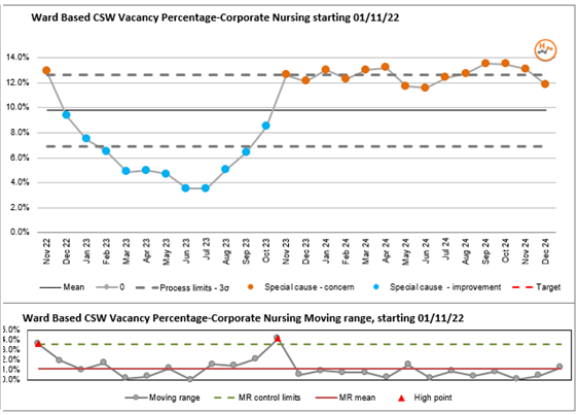


Chart 3



2.5 **CSW Band 2 & Band 3 Job description review**

Following extensive CSW industrial action in 2023/24 and a subsequent agreement being signed in April 2024 there has been significant work undertaken to clarify the roles and responsibilities of the Trust's care support workers moving forward.
A retrospective regrade process has been undertaken and is due to be completed in March 2024.
Two roles have been defined and matched to a new Agenda For Change (AFC) job description and person specification - a band 2 healthcare assistant (HCA) and a band 3 care support worker (CSW).
It has been identified that there is a need across the Trust to increase the number of band 3 CSW posts in order to ensure appropriately trained staff are available to deliver care within the remit of their role.
As such, a Trust-wide organisational change process will be launched in March 2025, led by each of the clinical divisions and following the Trust's organisational change policy with support from HR and working with staff side colleagues**.**

2.6

Expectation 3 – Right place and time

E – Roster

It is well recognised following Lord Carter's review of productivity and efficiency of NHS Acute hospitals 2016 that good roster control and management will provide efficiencies such as reducing the requirement on bank and agency staff and ensuring that there are the right staff, in the right place, at the right time by planning staffing against activity and demand aligned to experience and skills.

In August 2024, WUTH introduced an E-roster review group consisting of specialist service leads with attendance by invite to senior nurse leaders for each division. This weekly meeting, reviews key performance indicators aligned to good roster management to monitor improvement workstreams and identify areas requiring additional support including the cleansing of rosters within the system to match the funded financial establishments. Outputs from the implementation of these additional 'grip and control' measures are currently being drafted with support from PWC and will include a series of SPC charts and dashboards.

Safe Care E-roster Module

Safe Care within the Allocate E-roster system, provides visibility of staffing levels based on patient numbers and acuity and dependency, enabling day-to-day, operational changes to the roster, in real time which will support any required redeployment of substantive staff across wards and or allocation of any temporary staffing. This Safe Care module however is reliant on correct E-rosters being in place and staff inputting patient acuity and dependency 2 / 3 times a day. WUTH have the Safe Care Module as part of their E-roster package and following the outputs of the E-roster review meetings plan to launch the roll out of Safe Care starting with designated wards within the surgical division planned to commence Q1 25/26.

3.0

Establishment review outcomes

Outcome details of the establishment reviews for each Adult inpatient ward are provided in Table1. This has been reviewed by the Chief Nurse and Chief Finance officer for overall approval.

As highlighted earlier in the report, utilising Adult SNCT results as a basis for recommendations to changes in establishments should only be used after a minimum of two audits. In addition national guidance is clear that the decision making for establishment change must be focussed on professional judgement using the triangulation of data intelligence.

For adult inpatients a recommendation of 3 changes have been proposed and approved, the changes to the funded establishment are detailed in Table 1. Appendix 2 shows the breakdown of the Surgical Divisions costing to facilitate the establishment changes within the current divisional budget allocation.

Table 1

Division	Ward	Funded	Funded Housekeeper & Ward Clark	Overall SNCT no therapeutic supervision	Outcome

Surgery	10	28.71	30.71	31.89	**Up lift**
	11	40.57	42.57	35.85	**Reduction**
	12 EOU	39	41	10.34	No change
	WAFFU			17.56	No change
	14	56.86	60.47	44.4	**Reduction**
	SEU / 17	49.07	52.07	33.22	No change
	18	45.4	47.4	39.12	No change
Medicine	20	39.12	41.01	43.06	No change
	21	40.49	42.44	49.76	No change
	22	40.26	42.19	40.79	No change
	23	42.26	43.79	40.39	No change
	24	30.67	32.43	33.83	No change
	25	47.56	49.56	50.95	No change
	26	48.63	50.63	46.61	No change
	27	40.32	42.12	42.22	No change
	30	36.43	38.56	44.56	No change
	32	42.85	65.95	36.24	No change
	CCU	15.84		9.84	No change
	33	39.83	37.96	35.6	No change
	36	46.92	48.92	52.52	No change
	37	61.74	64.74	66.01	No change
	38				No change
	CRC	40.7	42.7	39.17	No change
	M1	39.4	41.07	48.79	No change
	OPAU	44.87	46.77	52.36	No change
Acute	AMU	54.81	58.45	45.21	No change
	MSSW	26.77	30.41	26.78	No change
	CDU	15.52	16.52	18.54	No change
W & C	31 / 54	Change of location and proposed bed base change			

Women's and Children's Division

At the time of the SNCT audit, ward 54 (Gynaecology ward) were decanted within the adult inpatient hospital site on ward 31. This ward move was to facilitate the upgrade of ward environments within the Women's and Children's building. Whilst ward 54 undertook the SNCT audit the results cannot be used as the audit incorporated the additional beds in use due to Trust wide operational demands. The Women's and Children's division are also in the process of implementing bed base changes as part of their overall activity review with the proposed removal of surgical division bed allocation within this area.

Surgical Division

As highlighted in table 1 there are 3 establishment ward amendments within the Surgical Division. These changes have been made in line with NQB guidance based on professional judgement using the triangulation of data and discussion with staff. Whilst

	the SNCT red rule advises that changes should not be made within the first cycle of the new SNCT, it does suggest that if professional judgment indicates that a change in establishment is required then this should be acted upon. Ward 10 – Additional uplift of a CSW on the night shift to support with the number of patients who require enhanced therapeutic supervision, have increased dependency, and falls risk needs. This uplift will reduce the number of temporary staffing shifts currently provided by NHSP to maintain patient safety and as a result provide a proposed cost saving. Ward 11 – Reduction of a RN late shift at the weekend. This reduction is reflective of the general reduced activity during the weekend period. Ward 14 – Reduction of a RN early shift from 7 RN's to 6 RN's. These establishment amendments have been agreed with ward leadership teams and finance secured within the divisional budget as detailed in Appendix 2. Ward M2 Ortho & M2 Surgical are not detailed in Table 1 as these are elective surgical areas with protected beds. During the audit period overnight bed occupancy was lower than the available bed base which may be indicative of advancements in recovery, correct patient case mix allocation and surgical intervention techniques. The available bed base however influences SNCT outcomes. At a divisional level, staff are redeployed appropriately as identified through daily staffing meetings and staffing allocation is planned in line with planned theatre lists. **Medical Division** Whilst there are no changes within the Medical Division's funded establishment, extensive consideration was given to the potential uplift of establishment within Ward 36 (previously located on ward 33). This ward has been identified as an area requiring additional support across a range of quality indicators, which have been reflected in its ward accreditation level one status. A series of improvement mechanisms are in place to support the ward. In addition, there have been several nurse leadership changes implemented from ward level through to Divisional Nurse Director. Any professional and clinical judgements around staffing requirements have been supported by using temporary staffing and redeployment of staff from within the division (including non-ward based nurses such as Practice Educators). Given all of these factors and the reinstatement of the 6 monthly acuity and dependency audit cycle due to commence 31/3/25 a pause on any significant establishment changes was deemed prudent. **Emergency Department** WUTH is currently upgrading its Emergency Department (ED) as part of a multimillion-pound capital investment. As the department transitions between the old environment and the new build the department is accommodated across several different areas which has resulted in some unforeseen staffing resource challenges due to temporary space allocation to facilitate the continuation of the new development. In addition, the Trust has experienced unprecedented operational activity pressures which have

resulted in ED having to utilise several temporary escalation areas which require additional staff to maintain patient safety.

In July 2024 the Emergency Department utilised the EDSNCT to complete its acuity and dependency review. As with previous audits the primary outcome of EDSNCT results recommended introducing a staffing model that is aligned to the department's increased periods of activity. This is a similar recommendation to the outcome reviews undertaken by NHS England's Emergency Care Improvement Support Team ECIST. The results have been used along with staffing considerations for the current environmental factors, temporary escalation requirements and overall professional judgment with a proposal to uplift ED staffing. A business case to support this proposal has been approved by Trust Board and has increased the funded establishment by 44.4WTE. Recruitment to these additional RN and CSW posts is currently ongoing.

Maternity Services

Maternity services use a nationally recognised safe staffing tool Birthrate Plus which is completed daily and shared across the regional network. Monthly outcome results such as the number of red flags, compliance with the tool and any escalation implementations or diverts are reported in the bimonthly Workforce Assurance Committee report for monitoring and escalation. In addition, staffing for maternity services is also reported to the Executive team in relation to Ockendon report updates, progression against continuity of care model implementation and PSQB reports. The next annual Birthrate Plus staffing recommendation report is due March 2025, therefore, for this establishment review there is no change proposed to the funded establishment.

Children's Services

Children's services have specific RCN guidance in relation to staffing levels aligned to required patient to registered nurse ratios, these ratios also incorporate guidance on acuity levels and alignment to children's age. Whilst this guidance is incorporated as part of the professional judgement in determining staffing levels day to day for the Children's ward, there is currently no formal mechanism to digitally capture and monitor compliance against this guidance.

There is a specific Children's SNCT with similar implementation requirements to meet the licence agreement criteria. Nominated Trust staff have undergone the NHS England training and are implementing training to trust staff. The first children's SNCT audit will be commenced in March 2025.

Additional assurances that influence professional judgement include WUTH's attendance at the daily Cheshire and Merseyside network meeting where activity details are recorded and information on acuity shared. WUTH are also members of four children's services networks, Paediatric, Neonatal, Critical Care and Surgical, these networks provide regional support, scrutiny and gather staffing and patient data in relation to activity and workforce indictors.

Neonatal Unit

Due to the acute nature of neonatal medicine it can be difficult to accurately predict required staffing levels and therefore the application of professional judgement using

	average activity & acuity, aligned to staffing guidance recommendations (Appendix 3) form the basis of staffing deployment within WUTH's neonatal unit. This approach is in line with the British Association of Perinatal Medicine BAPM guidance. WUTH's neonatal unit is part of a regional neonatal network and is represented at daily meetings to identify any required mutual aid, diverts or escalations. This detail is provided month on month as part of the bimonthly staffing paper. For this report period there is currently no proposed change to the establishment **Critical Care** The current staffing establishment for critical care has been mapped according to the Guidelines for the Provision of Intensive Care Services (2022) (GPICS) developed by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This provides a baseline of how the unit is staffed according to the standards. The staffing establishment is based on ensuring that the standards are achieved. For the period of this report there are no proposed changes to the establishment.

4	Conclusion
4.1	The Trust has met the standards and expectations within Developing Workforce safeguards requirements for adult inpatient wards. In addition, there are evolving processes in place to support professional judgement establishment setting within specialist areas. This report highlights a series of new and proposed workstreams that will ensure standardised approaches to safe staffing. These new initiatives and increased scrutiny and controls will provide a positive impact on patient safety and quality of care whilst also supporting efficiency reviews and increased transparency of staffing metrics. There is confidence that daily staffing monitoring processes are in place with a good system of internal control being applied to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy.

5	Recommendations / next steps
	• **Re-establishment of 6 monthly cycle** WUTH will commence the next Adult SNCT audit 31st March 2025 to adhere to the recommendation of a 6 monthly cycle of acuity and dependency reviews. Additional training has been planned to ensure that there is sufficient resilience within the senior nursing team to undertake the audits and provide development opportunities. • **Review of staffing establishments within Day case and outpatient areas** Work will commence in 2025/26 to review nurse staffing establishments within the multiple Day Case and outpatient areas across the Trust. There is currently no nationally recognised tool to support this work and therefore a standardised approach based on the NQB guidance focusing on the triangulation of data, clinical specialty guidance and professional judgement will be applied.

- **Safe Care Trust Wide Implementation**

As highlighted within the Expectation 3 section of this report the Trust will progress with the implementation of the Safe Care module during 2025/26 with the initial launch of this within the Surgical Division.

- **Development of formalised staffing model standards**

Variation in several staffing model considerations such as the application of ward manager supervisory time, and deputy ward manager model have been identified. Agreement of these basic standards will be formalised into a Trust wide standardised approach, led by the Chief Nurse.

- **Inclusion of digital efficiency workstreams**

Expanding the use of digital solutions and innovations has been identified as one of the main areas of focus within the NHS plan January 2025. It is recommended that progression with these workstreams that have a direct impact on nursing efficiencies are included as part of future reports.

- **Development of a nursing workforce plan**

Initial work has commenced on the development of a nursing work plan / strategy to support anticipated gaps in recruitment as detailed under Exception 2 section of this report and will include the consideration of Nursing Associate and further expansion of CSW apprenticeships.

- **Staffing Escalation policy**

A review of the current staffing escalation policy is planned for Q1 to ensure that it includes new additions implemented and incorporates support to Ed during periods of surge activity.

- **CSW Band 2/3 ratio implementation**

As detailed earlier in the report the band 2/3 CSW work is progressing; utilisation and deployment of staff with the correct skills is essential for safe and efficient staffing levels. Some of the implementation outputs of this review work will not be in place for the second phase of the SNCT audits and therefore this should be taken into consideration as part of the wider influencing factors on establishment settings.

- **Bimonthly Staffing report**

A proposal to change the current format of the bimonthly staffing report is underway to widen the report to have a greater holistic view of the triangulation of data bringing together staffing and quality metrics. Inclusion of Model hospital data will also form part of the new report.

- **E roster review group**

The E-roster review group will continue to progress with identifying areas for efficiencies and E-roster cleansing. The outcomes of this meeting will underpin and validate key performance indicators linked to several workstreams highlighted within this report.

- **NHSE Digital Safe staffing submission**

The introduction of an assurance data sign off report will commence from February 2025, this will strengthen the review process undertaken within the roster review meeting.

	• **DME ward changes** Since the first SNCT audit there has been reconfiguration of beds within the Department of Medicine for the Elderly (DME) wards changing areas from all male / all-female to mixed sex wards with same sex bays. This significant change will need to be considered as part of the second SNCT results as this may impact results and will therefore be classed as a first SNCT cycle. • **Therapeutic Supervision Pilot** Within the Expectation 1 section of this report it was highlighted that workstreams aligned to the allocation of therapeutic supervision are in development. It is recommended that an update in relation to this progression forms part of the next Trust Board Nurse staffing establishment report.

Appendix One: Establishment review SOP

Wirral University Teaching Hospital NHS Foundation Trust

STANDARD OPERATING PROCEDURE TEMPLATE

Document title:	*Wirral University Teaching Hospital (WUTH) SOP for Nurse Staffing Establishment Review Process V4.*
Document ref:	
Document author:	Johanna Ashworth-Jones Vic Peach Tracy Fennell
Job Title:	Programme Developer / Deputy Chief Nurse / Chief Nurse
Date:	Updated September 2023
Approved by:	Tracy Fennell Chief Nurse
Review by (date):	September 2024
Reviewed by	Sam Westwell Chief Nurse & Julie Roy July 2024
Review Date	July 2025

1. Purpose of SOP

The purpose of this Standard Operating Procedure (SOP) is to provide structured guidance for the completion of the 6 monthly Nursing establishment reviews.

2. Abbreviations and Definitions

RN: Registered Nurse
CSW: Care Support Worker
DTI's: Deep Tissue Injury
WTE: Whole Time Equivalent
HROD: Human Recourses & Organisational Development
CHPPD: Care Hours per patient Day
SSOT: Safe Staffing Oversight Tool
ADoN: Associate Directors of Nursing
WUTH: Wirral University Teaching Hospital

3. Who does this apply to?

This SOP applies to:
The Corporate Nursing Team,

Divisional Directors of Nursing,
Finance Department
Deputy Chief Nurse /Chief Nurse.
AHP Lead
Workforce Lead
Ward Managers
Matrons
Divisional Directorate Managers

4. When it should be used

This procedure should be followed every 6 months and or in line with any service development changes.

5. Procedure

As per the guidance from the National Quality Board, Developing Workforce Safeguards, multi factorial indicators should be considered as part of the nurse staffing establishment process to provide an informed presentation of data to support professional judgement when setting Establishments. WUTH undertakes this presentation in the completion of Establishment review templates which consists of 92 indicators for consideration. Appendix 2.

It is the responsibility of the Corporate Nursing Team to populate 64% of the establishment templates, Divisions are asked to populate the remaining 36% of indicators and are also asked to confirm the details provided prior to the Confirm and Challenge meeting with the Chief Nurse and provide any amendments in advance of the meeting.

Using the guidance set out in the National Quality Board, Safe, sustainable and productive staffing guidance resource 2018. Summary table below as table 1. The Establishment templates are split into the following sections:

- Current Ward Model
- Staffing Data
- Acuity & Dependency Results
- Operational
- Patient Harms
- Workforce sensitive indicators
- Finance
- Additional support
- Patient experience
- Narrative
- Audit
- Staff Experience

Table 1:

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Current Ward Model
The current ward model sections compromises of 19 indicators, and identifies current Leadership, Speciality information, Skill Mix and skill ratios indicators including CSW band 2 / 3 models current and proposed.

Staffing Data
This section compares staffing data with RCN guidance on nurse-to-patient ratios, CHPPD, Staffing incident data, SSOT intel data such as the number of professional judgement red shifts, Eroster completion and comparative benchmarking where available.

Acuity and Dependency Audit results:
WUTH uses the Shelford Acuity (SNCT) Tool to measure Acuity and Dependency every six months. This is one of the recommended tools set out in the Quality board guidance.

The audit consists of a minimum 21day day capture of each patient's acuity and dependency level at the same time per day and is completed by the Ward Manager or the Ward Deputy these are then signed off by the divisional matrons and Associate Directors of Nursing. Corporate Nursing team also review and advise on any validation queries or any significant variances. Training where required is provided by the corporate nursing team. All documentation is provided by the Corporate Nursing Team

and distributed in advance of the audit. Audit forms are collected at regular intervals by the Corporate Nursing Team.

Results are broken down into different levels of required care which provides additional intel to inform professional judgment on required workforce skill mix and CSW / RN ratios.

Operational

This section provides an opportunity for the division to highlight any environmental factors for consideration or additional services provided by the area of review.

Patient Harms (Nurse sensitive indicators)

Nurse sensitive indicators is a generic term for several quality indicators, for the purpose of the establishment reviews this consist of a selection of patient harms and serious incidents as other nurse sensitive indicators are captured under further quality headings such as patient experience as detailed further in this SOP.

Patient Harms – for the purpose of the establishment review the data presented is based on prevalence per PTBD within the last 3 months and reviews of moderate and above hospital acquired harms.

Workforce sensitive indicators

Workforce indicators are presented as a range of the last 6 months and the current / latest month data. Data is produced by HROD/ Workforce department and is collated by the Corporate Nursing Team.

Indicators for inclusions within the review template consist of:

- Mandatory Training Compliance – current month
- Appraisal Compliance – current month
- Sickness – 6 month range and current month
- Vacancy rate – 6 month range and current month for both RNs and CSWs
- Maternity – current
- Performance and Suspensions – current

Finance

Data is requested from Finance and cross referenced with the divisional senior teams for inclusion in the establishment review templates and then populated by the corporate

nursing team. This section considers and prompts discussion in relation to NHSP spend and budget performance positions.

Additional Support

This section allows an opportunity to look at the MDT approach to patient care allocated to the ward, this includes the provision and input from AHPs and reviews the support for student nurses as part of future workforce planning.

Patient Experience

Patient experience is recognised as a fundamental quality measure and output indicator therefore several patient experience feedback indicators are included within this section including localised and national measures.

Narrative

This section is for completion by the division and provides an initial opportunity to document current ward pressures and potential opportunity ward models for consideration as part of the establishment review.

Audit

Quality Audit results are included from the last 3 months or in line with the auditing schedule. The audits included as part of the establishment review are as follows:

- Ward accreditation
- IPC annual audit
- Perfect Ward: Ward Sister
- Perfect Ward Matrons
- Safeguarding audit
- Controlled Drugs audit

Staff Experience

This section is for completion by the division and collates key elements of staff experience these include exit interview themes and trends, national staff survey results including where available localised pulse data and freedom to speak up concerns.

Confirm and Challenge

The template provides a section for narrative capture within the Confirm and Challenge process meeting, this includes summary notes from localised review between the Ward Manager, Matron and ADN, as outlined in the flow chart Appendix 1 Each template

should be signed by the Divisional Director of Nursing, Matron or Associate Director of Nursing, Ward Manager, Finance lead and Divisional Director.

Divisional Directors from other divisions not presenting are also asked to attend the confirm and challenge meetings to provide a level of interdependent challenge and professional judgment.

Specialist areas

WUTH has a number of specialist areas where safer staffing is aligned to nationally agreed parameters or where a specialist acuity tool is in place to support establishment setting. These are:

Emergency Department:

The Shelford company introduced a specialist EDSNCT in 2022. The licence requirements for the use of the EDSNCT requires staff to undergo an evaluated training session by NHSE/I & Shelford group. Staff have to pass a test in order to be authorised to use the tool and provide cascade training within the organisation.

The EDSNCT is completed over a 12-day period at two points twelve hours a part until each of the 24hour periods is completed.

Critical Care

There is currently no validated acuity tool in place for the review of critical care staffing however patient acuity is defined into 4 levels, these levels have also been aligned to recommended nurse to patient ratios but are open to flexibility based on other factors such as presence of supervisory shift leaders, contribution of health care support workers, staff skill mix and environmental factors. These recommendations advise critical care units should have minimum nursing establishments that allow one registered nurse per patient staffing levels for level-3 (intensive care) patients; and one nurse for every two patients for level-2 (high dependency) patients. Skill mix and experience is a significant factor in deploying these recommended ratios as critical care nurses are expected to have specialist skills including, having knowledge of advanced assessments of patients' breathing and the advantages and disadvantages of non-invasive and invasive therapies to support breathing, such as mechanical ventilation.

Maternity Services

Maternity services use the Birth rate+ acuity and dependency tool, this tool is completed daily and is inputted into a centralised data capture system that supports regional collaborative support. In addition to the acuity tool NHS Maternity services are transitioning to a care delivery model "continuity of care". Outputs from the birth rate+ tool and progression to the continuity of care model is reviewed as part of the establishment review process.

Children's services

Childrens services adhere to the Royal College of nursing mandatory staffing levels guidance see table 2. This is primarily based on patients ages although additional acuity factors are considered for the high dependency unit using the critical care acuity level principle and staffing ratio recommendations.

Child age	Number of nursing staff	Number of children
Under 2 years	1	3
Above 2 Day shifts	1	4
Above 2 night shifts	1	5

Appendix Two: Surgical Division costings.

Ward 10 extra CSW on nights costing			
Cost of an extra CSW on nights - Ward 10			
	Hours	**Wte**	**Inc headroom**
worked hours/wte paid	80.50	2.15	2.64
Basic 1 wte band 2 salary based on mid point with on costs	£ 29,014		
Weekday/Saturday cost including 41% enhancements	£ 92,587		
Sunday cost including 83% enhancements	£ 20,028		
Total	**£ 112,615**		
Cost of removing RN on early shift - Ward 14			
	Hours	**Wte**	**Inc headroom**
worked hours/wte paid	43.75	1.17	1.44
Basic 1 wte band 5 salary based on mid point with on costs	£ 45,508		
Weekday/Saturday cost no enhancements	£ 46,646		
Saturday cost including 30% enhancements	£ 12,128		
Sunday cost including 60% enhancements	£ 14,927		
Total	**£ 73,700**		
Cost of removing RN on weekend late shift - Ward 11			
	Hours	**Wte**	**Inc headroom**
worked hours/wte paid	13.50	0.36	0.44
Basic 1 wte band 5 salary based on mid point with on costs	£ 45,508		
Saturday cost including 30% enhancements	£ 13,098		
Sunday cost including 60% enhancements	£ 16,121		
Total	**£ 29,219**		

The additional £9,969 will be offset by the recruitment of CSW apprentice posts throughout the division.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 15**

05 March 2025

Title	Guardian of Safe Working Report
Area Lead	Dr Ranj Mehra, Interim Medical Director
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

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

This report covers the period 1st October to 31st December 2024 (Q3 2024-25) and outlines the following:

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

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

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
February 2025	People Committee	As above	As above

1 Narrative

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

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 299 (282.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 299 (282.6 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the guardian (if any): Access to 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	5	14	19	0
General Practice	0	3	3	0
Geriatric Medicine	0	1	1	0
General Surgery	0	13	13	0
Total	5	31	36	0

Exception reports by Grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	23	23	0
F2	0	3	3	0
CT1-2 / ST1-2	5	5	10	0
ST3-8	0	0	0	0
Total	0	31	36	0

Exception reports by Rota

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Ger Med GPST 2024 LTFT 0.8 Flexi	0	1	1	0
GP F2 2023	0	3	3	0
Medicine F1 2024	0	6	6	0
Medicine F1 2024 LIFT WF	0	6	6	0
Medicine IMY2 2024	4	0	4	0

Medicine IMY2 LTFT 0.8 Flexi	1	1	2	0
Medicine SHO 2024	0	1	1	0
Surgical F1 2022	0	11	11	0
Surgical T1 1:10 2020	0	2	2	0
Total	0	31	36	0

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	6	9	0	8	0	0
F2	0	0	3	0	0	0
CT1-2 / ST1-2	4	0	0	1	5	0
ST3-8	0	0	0	0	0	0
Total	10	9	3	9	0	0

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
GP F2 2023	0	2	2	0
Medicine F1 2024 LIFT WF	0	1	1	0
Medicine IMY2 2024	0	6	6	0
Medicine IMY2 LTFT 0.8 Flexi	0	1	1	0
Surgical F1 2022	0	2	2	0
Total	0	12	12	0

Exception Reports

In the last quarter there has been a return to a majority of exception reports being completed by foundation doctors. There were a number of exception reports during the Major Incident but not resulting in an overall rise in the report numbers. There were a relatively large number of educational reports, half of which were from internal medicine year 2, which are being reviewed with the educational support team. The overall trend in exception reports is lower than the previous year.

Work schedule reviews

There have been no work schedule reviews in this quarter

Vacancies

There continue to be a number of vacancies which require cover to maintain safe staffing levels across departments.

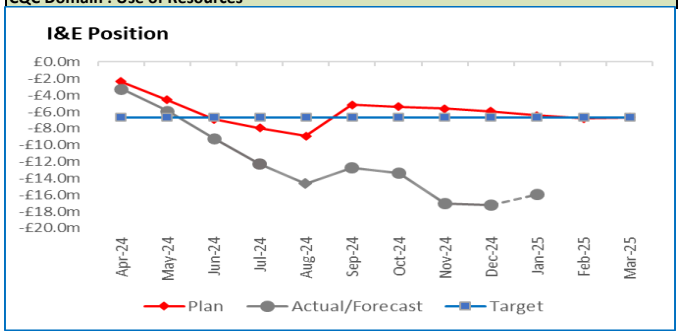
Fines

The process for collecting penalties has been addressed during this quarter and a fine was issued. The overall number and value of penalties remains low.

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

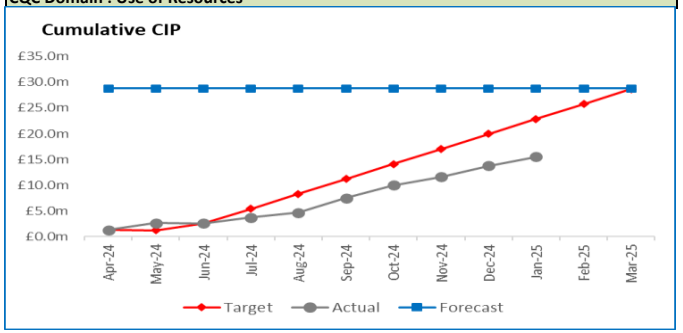
Chief Finance Officer

CQC Domain : Use of Resources



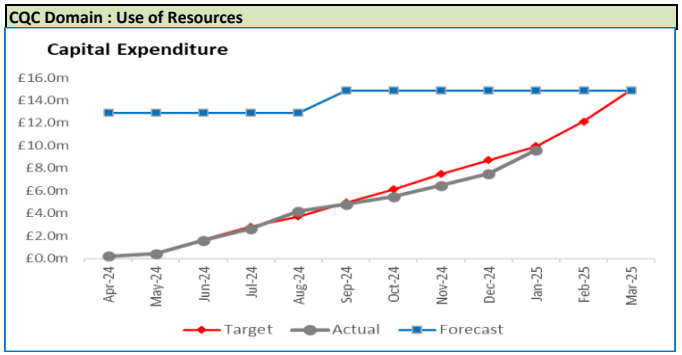
Jan-25
-£15.9m
Variance
Position worse than plan
Target
-£5.9m

CQC Domain : Use of Resources



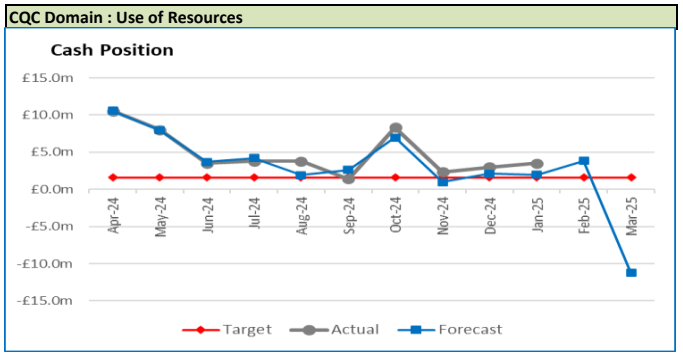
Jan-25
£15.5m
Variance
Position worse than plan
Target
£19.9m

CQC Domain : Use of Resources



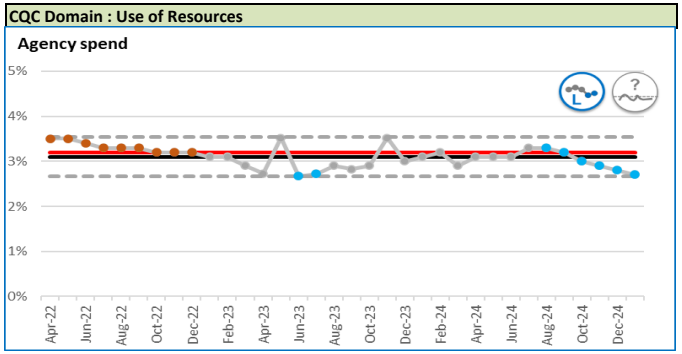
Jan-25
£9.6m
Variance
Position better than plan
Target
£8.7m

CQC Domain : Use of Resources



Dec-24
£3.5m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Jan-25
2.70%
Variance
Position better than threshold
Threshold
3.2%

Executive Summary

At the end of January, M10, the Trust is reporting a deficit of £16.0m, an adverse variance against plan of £9.7m.

The key drivers of this forecast variance and the internal risks to achievement of plan are:

- the cost and lost income associated with the Cyber Incident.
- the full delivery of the elective activity plan.
- the Cost Improvement Programme (CIP).
- maintaining expenditure on urgent care within planned levels.
- delivering planned integration benefits.

As a result, the Trust's unmitigated forecast would be a deficit of £22.6m, an adverse variance to plan of £15.9m. The Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks. Full implementation of these agreed actions will reduce the unmitigated forecast deficit to £13.6m, an adverse variance to plan of £7.0m.

The deficit is placing significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). Our January request of £3.5m of support was approved. This means the Trust will not need additional cash support before March.

Management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy. Quarterly updates are provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2024/25 are:

Statutory Financial Targets	RAG (M10)	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.
- Note that full implementation of agreed mitigations will significantly but not fully mitigate financial risk.
- Note that the Trust will be submitting an additional cash support request in M12.

I&E Position

Narrative:

The table below summarises this I&E position at M10:

	Year to Date			Unmitigated Forecast		
Cost Type	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£399.6m	£394.3m	-£5.3m	£478.8m	£468.1m	-£10.7m
Other Operating Income	£28.0m	£29.1m	£1.1m	£33.6m	£39.4m	£5.9m
Total Income	**£427.6m**	**£423.4m**	**-£4.3m**	**£512.4m**	**£507.6m**	**-£4.8m**
Employee Expenses	-£306.5m	-£308.7m	-£2.3m	-£367.8m	-£369.9m	-£2.1m
Operating Expenses	-£129.7m	-£126.6m	£3.1m	-£154.8m	-£156.6m	-£1.8m
Non Operating Expenses	-£5.0m	-£4.0m	£1.0m	-£6.0m	-£5.1m	£0.9m
CIP	£7.2m	£0.0m	-£7.2m	£9.6m	£1.4m	-£8.2m
Total Expenditure	**-£433.9m**	**-£439.3m**	**-£5.4m**	**-£519.0m**	**-£530.1m**	**-£11.1m**
Unmitigated Forecast	**-£6.3m**	**-£16.0m**	**-£9.7m**	**-£6.7m**	**-£22.6m**	**-£15.9m**

The unmitigated forecast position is before Board approved actions which are intended to reduce the forecast deficit to £13.6m.

Key variances within the YTD position are:

Clinical Income – £5.3m adverse variance relates to underperformance against the value of the elective plan in Surgery and the impact of the Cyber Incident. This has been offset by the release of historic deferred income balances.
Employee Expenses - £2.3m adverse variance relates to the approved increase in nursing staff and the continued pressure on medical bank in ED.
Operating expenses – £3.1m favourable variance relates to underspend on consumables driven by the under delivery of the elective plan in Surgery.
Cost Improvement Programme – £7.2m adverse variance for CIP across clinical divisions. This is offset by non-recurrent underspends.

The Trust's agency costs were 2.4% for the month and 2.8% for the YTD, the Trust is below the NHSE threshold of 3.2% of total staff costs.

Risks to position

The main risks to the I&E position are:

- The Trust fails to fully deliver the Elective Activity plan.
- The Trust fails to fully deliver the recurrent Cost Improvement Programme.
- The Trust fails to manage urgent care expenditure within planned levels.

Actions:

- Maximising elective capacity and recovery.
- Full delivery of recurrent CIP schemes and identification of non-recurrent underspends.
- Urgent care improvement plan.
- Full delivery of agreed mitigation plan.

Cumulative CIP

Narrative:

The Trust has transacted £18.6m of CIP at M10 which is £7.2m behind plan. The Trust has risk adjusted our CIP forecast to £20.6m, a shortfall against target of £8.2m.

The Trust does not classify non-recurrent underspends as CIP but the forecast under-delivery of CIP is fully mitigated by non-recurrent underspends.

Risks to position:

- That the gap between target and identified schemes is not reduced.
- That the momentum on delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:

- Continuation of the Productivity and Improvement Programme.
- Implementation of the Board approved mitigation plan which includes acceleration of enhanced controls over variable expenditure.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £8.9m in M10 and £84.5m YTD, an adverse variance of £18.5m for the year. This is primarily driven by underperformance in respect of the Cheshire and Merseyside Surgical Centre (CMSC), a shortfall of elective and day cases in Surgery, a lower case mix within the Division and the impact of the Cyber Incident.

Risks to position:

- That the Trust fails to utilise the elective capacity in place.

- That the current case mix of cases continues.

Actions:

- Implementation of the Board approved mitigation plan which includes increased productivity of core elective capacity and reduced reliance on non-core support.

Capital Expenditure

Narrative:

Description	Approved Budget at M1	Revision to Budget M2	Revision to Budget M6	Revision to Budget M7	Approved Revisions M10	Future Anticipated Revisions	Revised Budget
CDEL							
Internally Generated	£12.870m						**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	£1.953m		£1.074m	£6.060m	**£13.971m**
Charity	£1.000m			-£1.000m			**£0.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£1.074m**	**£6.060m**	**£26.841m**
Total Funding for Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£1.074m**	**£6.060m**	**£26.841m**
Capital Programme							
Estates, facilities and EBME	£5.000m						£5.000m
Heating and chilled water pipework replacement	£2.100m						£2.100m
Operational delivery	£2.750m						£2.750m
Medical Education	£0.080m						£0.080m
Transformation	£1.000m						£1.000m
Digital	£0.750m						£0.750m
UECUP	£6.010m						£6.010m
Charity	£1.000m			-£1.000m			£0.000m
Approved Capital Expenditure Budget	**£18.690m**			**-£1.000m**			**£17.690m**
Diagnostics Digital	£0.064m						£0.064m
LIMS - PDC	£1.400m	-£1.400m					£0.000m
RAAC	£0.000m		£1.953m				£1.953m
LED Lighting	£0.000m				£0.990m		£0.990m
DEXA scanner	£0.000m				£0.084m		£0.084m
IMS	£0.000m					£0.060m	£0.060m
Critical Infrastructure	£0.000m					£4.000m	£4.000m
Non-Central Programme	£0.000m					£2.000m	£2.000m
Confirmed PDC	**£1.464m**	**-£1.400m**	**£1.953m**	**£0.000m**	**£1.074m**	**£6.060m**	**£9.151m**
Total Anticipated Expenditure on Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£1.074m**	**£6.060m**	**£26.841m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

Since the last report the Trust has received the following confirmations of additional funding:

- £0.990m for LED lighting.
- £0.084m for the replacement of a DEXA scanner.

- £0.060m for the purchase of handheld devices to support the new Inventory Management System.
- £6.000m in respect of critical infrastructure and lease/management arrangements.

Spend at M10 totals £9.6m which is £0.4m behind plan. We do not anticipate any underspend at year end.

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

Risks to position:

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

Actions:

- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The cash balance at the end of M10 was £3.5m due to cash support received from NHSE in January.

The reduction in the cash balance is presenting difficulties on a daily basis with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value. The year-to-date position of bills paid within target stands at 74.6% which is 20.4% lower than the national target of 95%. In M10 the Trust was only able to pay 57.8% of invoices received within the timeframe required to achieve BPPC. This reduced performance is a direct consequence of the Trust managing its cash position.

The Trust continues to need deficit and working capital support and the Board has supported requesting cash support from NHSE for March. This will enable the Trust to service creditors until the new financial year when further cash support will still be required. The Trust continues to work on alternatives if our request for support in March is rejected but this is the principal risk in respect of our financial position.

Risks to position:

- Management of the cash trajectory is impacting significantly on BPPC performance.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Monitoring and escalation of any aged debt delays.
- Discussions with ICB around mitigations for cash position and process for applying for cash support.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 17**
5 March 2025

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Director of Operations Alistair Leinster, Divisional Director – Performance and Planning
Report for	Information

Report Purpose and Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times but the continued challenge in achieving reduced waiting times in gynaecology services.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Emergency Department (ED) and in particular 12 hour waiting times.

The Board should note improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED along with system partners.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. In addition cancer services and many surgical specialities have seen unexpected levels of increases in demand. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by AQuA on improving the 4 hour performance standards and is entering into discussions on tier one support from central teams.

2	Planned Care
2.1	**Elective Activity** In January 2025, the Trust attained an overall performance of 105.7% against plan for outpatients (100.5% for New outpatients) and an overall performance of 91.6% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for January	Actual for January	Performance
Out pt New	12501	12560	100.47%
Out pt Follow up	26112	27791	106.43%
Out pt procedures	3064	3715	121.25%
Total Out pts	41677	44066	105.73%
Day case	4633	4481	96.72%
Inpatients	773	472	61.06%
Total	5406	4953	91.62%

The Trust overachieved planned level of for outpatient new appointments with Medicine, Diagnostics and Clinical Support, and Women's and Children's Divisions all delivering activity levels above plan.

Medicine and Surgery Divisions underachieved daycase elective admitted activity plans, impacting the overall Trust position. Within the Surgical Divisions seeing the majority of under delivery in Ophthalmology and Trauma and Orthopaedics. Whilst within Medicine under delivery of daycase / elective activity is mainly attributed to Gastroenterology.

2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 65 week waits by September 2024. The Trust's performance at end of January against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 6 • 65+ Week Wait Performance - 88 • 52+ Week Wait Performance – 1,172 • Waiting List Size - there were 47,632 patients on an active RTT pathway which is at a similar level to the previous month of 47,379. Additional validation of the waiting list is being undertaken to ensure that backlogs following the cyber incident are addressed, with a view to reducing the caseload. The Trust continues to see a reduction in the number of 65 weeks achieving 88 patients waiting at the end of January. 13 of the patients are graft patients and 8 are Trauma and Orthopaedic mutual aid patients. Gynaecology is the largest contributor to the Trust's 65- and 52-week waiters but has continues to see notable improvements in both metrics. Gynaecology 65-week waiters reduced from 188 in June 2024 to 52 in January 2022. Whilst 52-week waiters in Gynaecology dropped from 779 in July to 288 in January. There remains an ongoing focus on reducing the number of over 65 week waiters with the use of additional lists and through mutual aid from the Liverpool Women's Hospital.
2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 3 to date: **Quarter** 3 **Period** 01/10/2024 - 31/12/2024 **National Standards:** 	Standard	Indicator	Threshold	October-24	November-24	December-24	Quarter 3
---	---	---	---	---	---	---
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	76.57%	78.76%	71.92%	75.82%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.92%	88.46%	82.17%	87.68%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.50%	81.18%	74.06%	76.65% | **Sub Standards:** | Standard	Indicator	Threshold	October-24	November-24	December-24
---	---	---	---	---	---
28 Day Wait	Individual Trust Provider Trajectory	Per Month	76.57%	78.76%	71.92%
28 Day Wait	Breast >=90%	90.00%	95.45%	91.80%	81.02%
28 Day Wait	Skin >=90%	90.00%	92.52%	92.36%	93.82%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.50%	81.18%	74.06% | **Removed Standards (Not National Standards):** | Standard	Indicator	Threshold	October-24	November-24	December-24
---	---	---	---	---	---
14 Day Wait	GP USC Referral to First Appointment	93.00%	70.31%	63.38%	61.18%	 • *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for December 2024, but did maintain performance for the quarter as a whole with performance of 75.82%, this was directly attributed to the cyber incident. • *62 day treatment* - For 2024/25, the 62 day treatment standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory

to achieve 77% performance by March 2025. The Trust did not achieve the local trajectory in December 2024 (see '62 Day Wait' in Sub Standards section of the table above).

- *62 day waiters* – the number of waiters decreased through January 2025, but remained above trajectory (127 patients against a trajectory of 33).

	01/04	06/05	03/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09	07/10	14/10	21/10	28/10	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12	06/01	13/01	20/01	27/01
Actual 24/25	135	141	127	106	91	92	103	89	82	90	92	93	88	76	74	79	88	88	81	80	74	83	88	88	88	116	137	146	146	174	167	174	148	127
Trajectory	120	112	103	93	93	93	93	93	83	83	83	83	72	72	72	72	72	60	60	60	60	50	50	50	50	40	40	40	40	40	33	33	33	33
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104 day long waiters* – performance is above of trajectory for January, at 30 against a plan of 10.

	01/04	06/05	03/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09	07/10	14/10	21/10	28/10	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12	06/01	13/01	20/01	27/01
Actual 24/25	45	38	34	42	37	36	40	37	26	23	22	19	24	22	21	17	19	15	16	12	12	18	20	20	20	25	21	24	24	29	31	33	37	30
Trajectory	50	47	42	39	39	39	39	39	33	33	33	33	30	30	30	30	30	23	23	23	23	20	20	20	20	14	14	14	14	14	10	10	10	10
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

Whilst performance for October and November was positive for both the 28 day and 62 day treatment standards, December and January saw a deterioration in performance. The impact of the cyber incident continues to be felt into January with delays earlier in patients' pathways still being seen to impact performance against cancer standards.

2.4 DM01 Performance – 95% Standard

At the end of January 85.93% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, below the revised national standard of 95%, and the requirement for Trusts to achieve 90% by March 2025.

Performance is noted to have increased from previous month performance of 81.6%, which was impacted by the cyber incident. Recovery plans are in place to restore performance to levels seen prior to the cyber incident when the Trust consistently achieved the DM01 standard.

2.5 Risks to recovery and mitigations

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

The cyber incident continues to be felt on RTT caseload, cancer and diagnostics standards. Operational teams continue to work through plans to recover lost activity.

The main areas of concern has been delivering 0 x 65 weeks and 0 x 78 weeks, with pressure seen across Trusts in the ICB, along with the deterioration seen in cancer performance. Mutual aid for Gynaecology continues with a number of patients transferring to a specialist provider.

3.0 Unscheduled Care

3.1 Performance

January Type 1 performance was reported at 46.28%, with the combined performance for all Wirral sites at 73.29%:

Type 1 ED attendances:	Type 3 ED attendances:
• 7,393 in December (avg. 239/day) • 7,419 in January (avg. 239/day)	• 2,879 in December (avg. 93/day) • 2,955 in January (avg. 97/day)

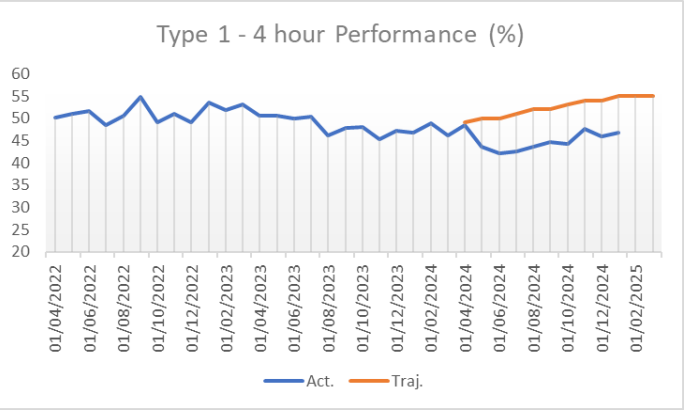
• 0% increase from previous month	• 2.64% increase from previous month

The performance of urgent emergency care (UEC) in January remains below the planned target.

Challenges such as staff shortages due to vacancies and sickness, and limited bed capacity continue to cause overcrowding, long waiting times, and treatment delays. The rising acuity of cases, along with seasonal pressures such as flu, COVID, and norovirus outbreaks, is further straining resources.

In January, the high number of patients requiring admission led to conversion rates reaching 46%. Corridor care also surged to unprecedented levels. Due to these pressures, the Trust declared a critical incident on two separate occasions. This situation was observed in several other Trusts across Cheshire & Merseyside as well. It should be noted that January and February were highlighted as two months where the deficit in required beds was 50-80 and this has certainly been felt through the month of January.

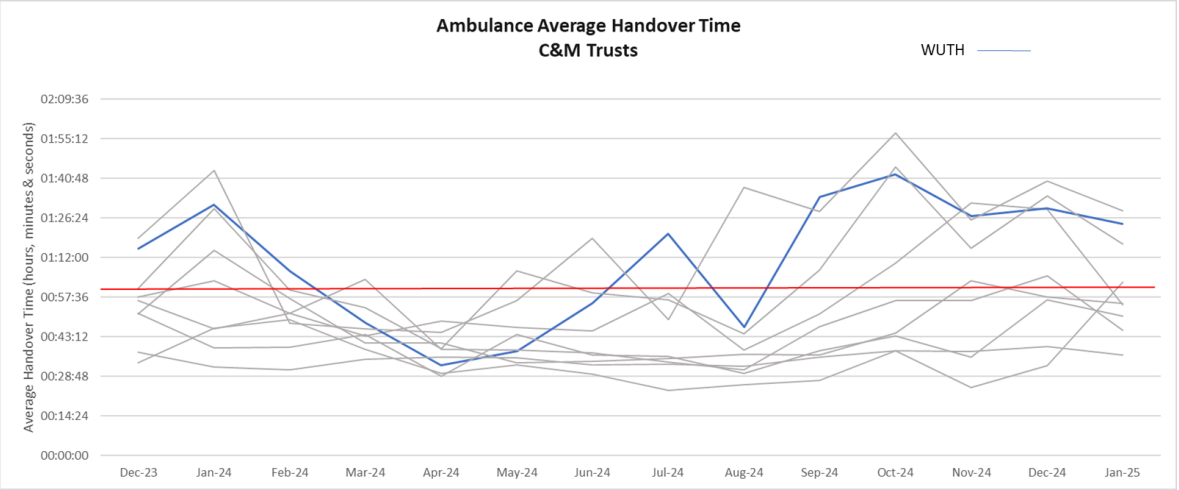
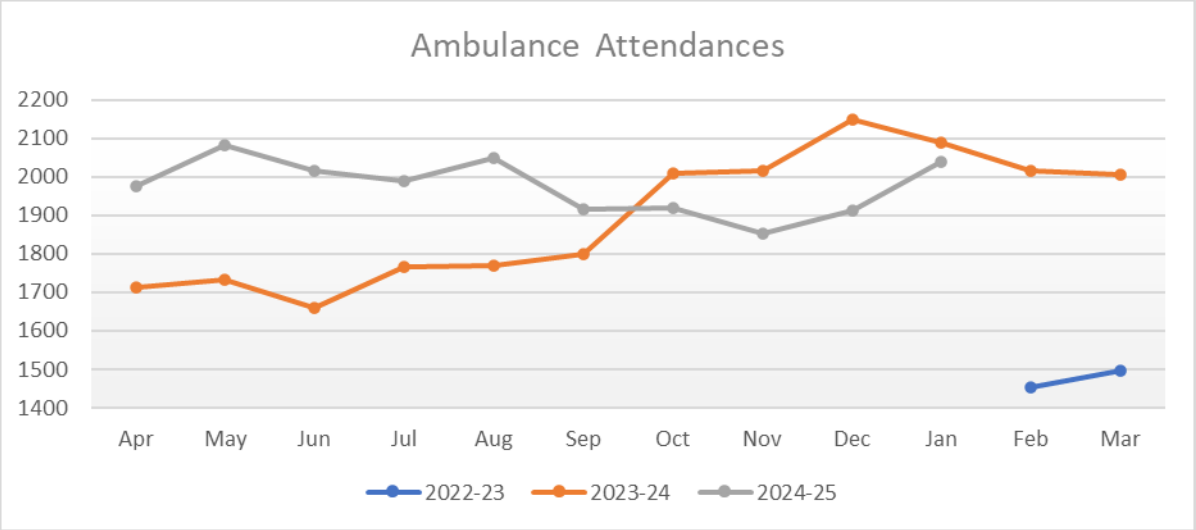
Despite ongoing efforts to enhance efficiency and patient flow, meeting the 4-hour standard remains difficult. However, improvement initiatives are still active and progressing to address non-admitted performance.



Urgent care improvement initiatives continued in January include expanding the increased offer of front door triage by the nursing team from the Urgent Treatment Centre. The operating hours for the front triage have increased up until the end of March 2025 to extend into the evening when ED often sees an increase walk-in patient.

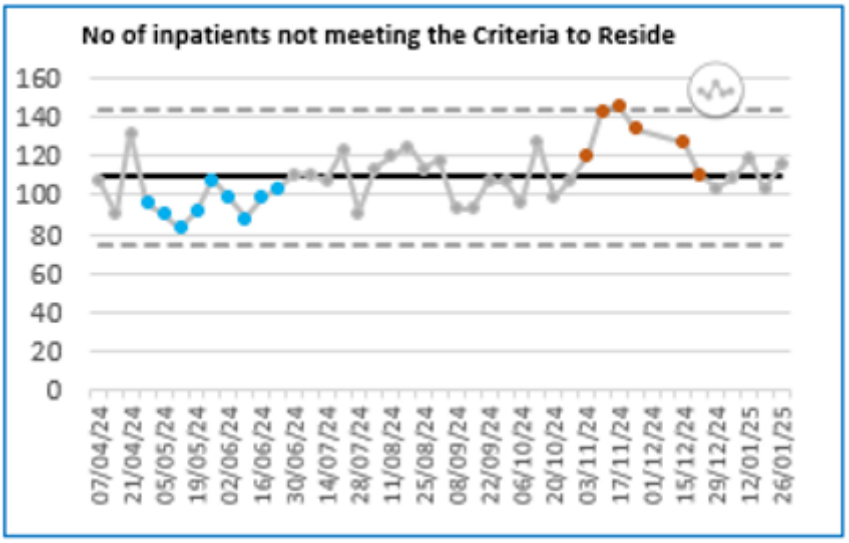
The call before convey offer to NWAS has been implemented as a core offer however uptake of the service remains low. A missed opportunities audit is planned for February to identify patients that could have accessed alternatives to ED following triage by the paramedic.
The integration of urgent care services across the community and the Trust are continuing the development with a focus on improving the referral pathways ensuring patients receive the right treatment at the right time, reducing waiting times and improving overall patient outcomes.

Plans are progressing with improving the offer of a Frailty Same Day Emergency Care (SDEC) service following the successful pilot earlier in December. To expand the estate and access to services, some changes may be required existing estate. Operational and workforce plans are due for completion by the end of February.

	The pilot of the Clinical Decision Unit (ED SDEC) is planned for the end of February. This will encourage the offer of 'fit to sit' for patients' conveyed by ambulance and also provide early treatment to those presenting to ED that could be treated and discharged potentially preventing admission and reduce the length of time patients are waiting in the department. Ambulance turnaround at Arrowe Park Hospital has remained a challenge. Contributing factors are similar to what is driving the challenges with 4-hour performance. Recruitment is ongoing substantively recruiting additional nursing staff and clinical support workers for A&E to staff several corridor spaces. The system is focusing on reducing the number of conveyances to A&E by utilising alternative services identified by the daily point prevalence in A&E. NHSE have recently set local improvement targets acknowledging those Trusts that are significantly pressured with handover performance. The Trust has been set a target of an average of 50 minutes by the end of March 2025. Performance at the end of January was reported at 1hr 9 minutes.  Ambulance attendances increased in January 2025 to similar volume seen in 2024. 
3.2	**Transfer of Care Hub development and no criteria to reside (NCTR).**

The number of NCTRs remained static in January which is positive compared to the increases we have seen in previous years over the winter months. The Trust ran a second MADE event in the beginning of January focusing on all our NCTR patients with a length of stay of more than 7 days which helped expediting discharges that required an MDT input.

Learning from both events will be captured and monitored through the weekly UEC improvement group at Place.



The performance against trajectory was below however the Trust remained in a strong position in comparison to other Trusts in C&M. The most recent position shows a performance of 15.2%.

Latest Date: 26 January 2025

	Trust	Trajectory	Current	PP Var
1	Wirral	9.9%	15.2%	5%
4	Countess of Chester	17.9%	19.2%	1%
2	Mersey and West Lancs	24.9%	20.8%	-4%
3	Mid Cheshire	26.1%	21.3%	-5%
5	East Cheshire	13.6%	21.8%	8%
6	LUHFT	24.2%	23.4%	-1%
7	Warrington & Halton	21.5%	27.0%	6%
	Total	21.1%	21.4%	0%

3.3 Mental Health

Mental Health provider continues to face challenges with the number of patients with NCTR on the wards, which is affecting ward flow and causing delays in the Emergency Department (ED). The Trust follows the escalation process for ED delays with CWP, ICB and NHSE however often options are limited and the Trust continues to see prolong waits.

	The Trust and partners are focused on working towards a solution including considering plans for addressing gaps in capacity and ensuring all alternative pathways are considered when appropriate to prevent an inpatient admission. The Trust is collaborating with the local mental health provider to develop a workforce model, which will include RMNs for the new mental health unit set to open in Q2 2025/26. The proposed model has progressed and a business case to address the new workforce model is expected by the end of the financial year.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to make progress with implementing actions from the improvement plans aimed at meeting urgent care quality standards. Performance and progress will be monitored through the UEC Improvement Group, with the sentinel metrics being overseen by Place leads and SCC. However, risks remain with acuity levels, pressure on demand for beds with high levels of conversion rates challenge these improvement plans. In addition, the need to increase nursing staff in the ED to ensure the timely release of ambulance crews (including staffing corridors when necessary) and the growing vacancies among junior medical staff are placing additional pressure on the department. Pilots such as triage by UTC nursing and "call before convey" are aimed at reducing the volume of patients in the department, with front door streaming already demonstrating positive results. While nursing recruitment is ongoing, corridor nursing support is managed by reallocating staff from other areas, minimising the risk of ambulance crews being delayed.

4	**Implications**
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

5	**Conclusion**

	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 18**

05 March 2025

Title	Green and Sustainability Plan Annual Progress Update
Area Lead	Matthew Swanborough, Chief Strategy Officer
Author	Clare Jefferson, Associate Director EFC Governance & Sustainability
Report for	Information

Executive Summary and Report Recommendations

To provide the Board with an update regarding Sustainability activities that have been undertaken within the Trust and future plans.

It is recommended that the Board:

- Note the report and presentation

Key Risks

This report relates to these key risks:

- NHS England Net Zero Target
  - For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
  - For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

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.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
06/02/2025	Estates and Capital Committee	As above	As above

1	Narrative
1.1	**Background** Attached slide pack was developed and presented to the Trust Estates and Capital Committee to provide an update on the Trust's Green Plan and Sustainability activities. The Committee recommended sharing the information with the Board.

2	Implications
2.1	**Patients** • The Green Plan actions have been developed to support the Trust to meet the NHS England Net Zero targets. By delivering on these actions, the Trust will be contributing to a reduction in the Trust's Carbon Footprint, directly impacting the local environment for residents of Wirral and the patients who attend our Sites. • Part of the Green Plan focuses on Social Value and how we support members of our local Community.
2.2	**People** • Considerable resource is required to deliver the Green Plan actions, from all areas of the Trust. • WUTH Green Champions network developed to encourage staff participation to support sustainability initiatives. • Part of the Green Plan focuses on Social Value and how we support members of our local Community.
2.3	**Finance** • The Trust has been successful in securing just under £1m to support LED lighting improvements at both Arrowe Park and Clatterbridge Hospital sites. The grant funding was awarded by NHS England in January 2025 as part of the National Energy Efficiency Funding (NEEF) Scheme Phase 3. The purpose of the scheme is to replace older style fluorescent lamps with high efficiency LED lamps, which significantly reduce energy consumption for a like-for-like lighting output. This will reduce energy costs for the Trust and improve carbon savings.

2.4	**Compliance**
	• Required to achieve the NHS England Net Zero Target
	  ○ For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
	  ○ For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Wirral University Teaching Hospital
NHS Foundation Trust

Green and Sustainability Plan Update

Board of Directors
5 March 2025

Version 2.0 January 2025

together we will

Delivering a Net Zero NHS
Context

Wirral University Teaching Hospital
NHS Foundation Trust

In October 2020, NHSE published the Delivering a Net Zero NHS guidance (image, right).

All NHS Trusts in England were subsequently required to develop and publish their own local Green Plans; a document that would outline how they intend to deliver a reduction in **Carbon Footprint to Net Zero** against a 1990 baseline, by 2040 (80% by 2028-32).

WUTH published its first Green Plan on 14th January 2022.

Green Plan | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The Trust were informed by Greener NHS on 29th November 2024 that NHS England is planning to publish updated Green Plan guidance to support organisations to refresh their plans. Greener NHS said *"The updated guidance is currently going through final clearances in NHS England. While we do not have a publication date yet, we will ensure timeframes for refreshing Green Plans are adjusted to reflect when the guidance is published. We currently do not anticipate requiring plans to be finalised 2025 and will keep this under review"*.

WUTH Green Plan 2022 - 2026
Progress

Wirral University Teaching Hospital
NHS Foundation Trust

The Trust Strategy "2021 – 2026 Our Strategy" along with the enabling Estates Strategy were incorporate throughout the WUTH Green Plan 2022- 2026 as part of the nine Areas of Focus:

1. Workforce and Systems Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation

Since the introduction of the WUTH Green Plan, the Trust has made significant improvements in Scope 1 (Direct) and Scope 2 (Indirect) emissions and has initiated workstreams to reduce Scope 3 emissions over the coming years.

Reduction in consumption of Fossil Fuels and schemes to reduce electricity use across both sites through infrastructure improvements in addition to procuring greener Electricity have contributed significantly to our Carbon Footprint and financial savings for the Trust.

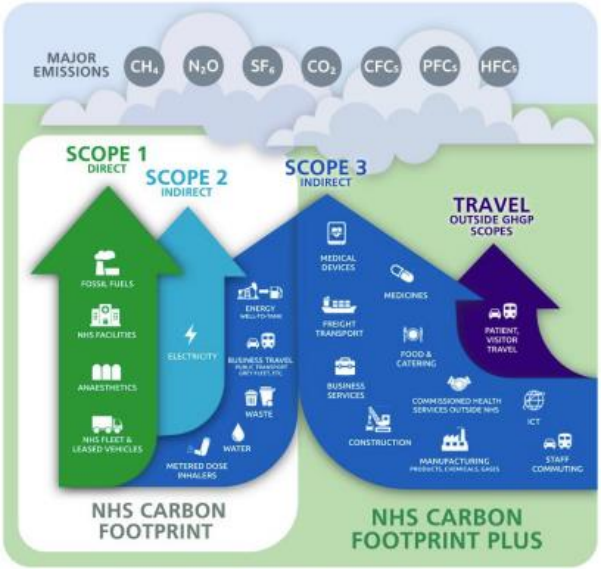


Figure 3 Greenhouse gas emission sources, and their 'scopes'

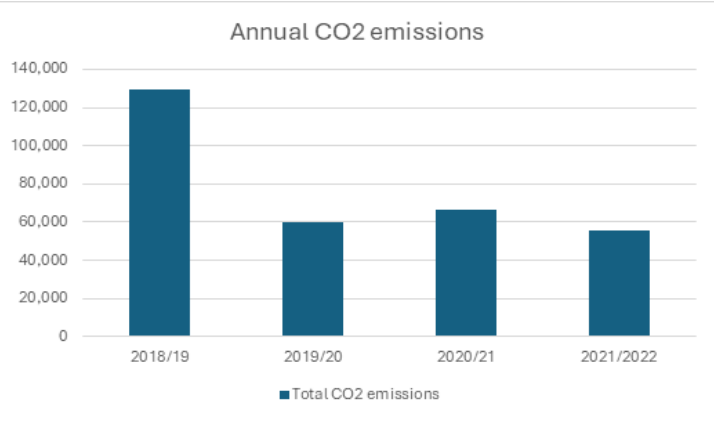
together we will

WUTH Green Plan 2022 - 2026
Carbon Targets

Wirral University Teaching Hospital
NHS Foundation Trust

In 2020, the 'For a Greener NHS' campaign set out the NHS's ambition to achieve net zero status by 2040, a decade ahead of the national 2050 target established by the Climate Change Act 2008. In line with this NHS target, WUTH aims to achieve a 100% reduction in our direct CO2e emissions by 2040 (80% by 2028-32) and reduce our indirect emissions to net-zero by 2045.

From 2018/19 up to the end of 2021/22 the Trust has reduced its carbon footprint by 72% from 129,771 tCO2e to 55,878 tCO2e. This accomplishment is largely due to improvements in our facilities to improve energy efficiency, combined with a substantial reduction in emissions from anaesthetic gases. This progress supports our target to become carbon 'net zero' by 2040.



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Sustainability Update
Key Updates – Staff engagement

Wirral University Teaching Hospital
NHS Foundation Trust

Estates & Facilities Day

As part of Estates & Facilities Day in June 2024, WUTH Sustainability Team were present in Firtrees Restaurant at CGH to talk to staff, patients and visitors about WUTH's initiatives such as the Green Champions Network (see below), and to promote active travel via the Merseyrail offer (see slide 6).

Health and Safety Week

As part of H&S week in September 2024, WUTH Sustainability Team were in the main reception at APH to talk to our staff, patients and visitors about the health impacts of climate change. WUTH Sustainability Team worked in partnership with Wirral Council for this event promoting their Cool Wirral Partnership and their Air Quality campaign.

Green Champions Network

The Green Champions Network was introduced to WUTH in May 2023 it is a low-cost initiative to drive down our carbon footprint and deliver efficiencies spread across the organisation through monitoring things like waste, energy and behaviours. The Network brings together like-minded individuals to discuss ways of changing behaviours and practices at a local level; the Endoscopy project outlined on slide 8 is an example of this.

Sustainability Update
Key Updates – Energy

Wirral University Teaching Hospital
NHS Foundation Trust

NHS Energy Basket (delivery from April 2025)

NHS England has worked with CCS to shape an energy product specifically for the NHS, which has allowed a provision of benefits such as:

- Greater price stability and resilience to external events
- Increased budget predictability
- Bulk discounts based on consumption volume commitment

This agreement has targets to support the aim to move to 100% renewable energy. There are also wider conversations on Power Purchase Agreements (PPAs) to reduce our energy bill.

Internal LED schemes reducing WUTH's carbon footprint

The Estates Team have undertaken several projects across the two main sites to deliver significant LED lighting installations. The two main projects were replacement of 431 fittings within the Education Centre and 1,252 fittings within Women and Children's buildings at Arrowe Park. Along with other smaller lighting replacement schemes, this has contributed to a reduction in electrical consumption across both sites.

NHS Energy Efficiency Funding (NEEF) LED Funding

The Trust has been successful in securing just under £1m to support LED lighting improvements at both Arrowe Park and Clatterbridge Hospital sites. The grant funding was awarded by NHS England as part of the National Energy Efficiency Funding (NEEF) Scheme Phase 3. The purpose of the scheme is to replace older style fluorescent lamps with high efficiency LED lamps, which significantly reduce energy consumption for a like-for-like lighting output. This will reduce energy costs for the Trust and improve carbon savings on the journey to a Net Zero NHS by 2040.

Sustainability Update
Key Updates

Wirral University Teaching Hospital
NHS Foundation Trust

Clean Air Day June 2024 – Free Merseyrail travel for staff

Merseyrail partnered with multiple NHS Trusts including WUTH to offer free rail travel on the network to staff on Thursday 20th June 2024 for Clean Air Day.

Anaesthetic Gases - Nitrous Oxide Reduction, APH

Working with our Estates and Clinical Teams, Consultant Anaesthetist Annette Cooper coordinated the Trust's successful application for the NHSE Nitrous Oxide Waste Mitigation Scheme which awarded the Trust with approximately £8k of funding. The funding is to supply APH with cylinder trollies which will be located within theatre areas so that the manifold can then be switched off. This will reduce the amount of Nitrous Oxide that is wasted, reducing our carbon footprint. Nitrous Oxide is a gas commonly used as an anaesthetic and analgesic agent that has an environmental impact 300 times that of Carbon Dioxide.

Reusable Theatre Hats

Consultant Anaesthetist Annette Cooper has collaborated with IPCG and Finance/Procurement colleagues to get approval for the introduction of reusable theatre hats. Switching from disposable to reusable theatre hats will reduce the Trust's waste and environmental impact.

Sustainability Update
Key Updates – External engagement

Wirral University Teaching Hospital
NHS Foundation Trust

APH Air Quality Monitoring opportunity with Liverpool John Moore's University (LJMU)

Wirral Council's Air Quality Manager has reached out to the WUTH Sustainability Team with an opportunity to be involved in a study that is being conducted by LJMU. The study will look at the impact that traffic movements around APH have on both the indoor and outdoor air quality of the Hospital and look for correlations between changes in outdoor air pollution levels and indoor pollution levels. Ideally it will be for a minimum of 12 months as this will help with looking at seasonal variations of air pollution. This is in very early stages and WUTH Sustainability Team are waiting on an initial meeting with LJMU to discuss in more detail.

Cool Wirral Partnership

Cool Wirral is a campaign aimed at encouraging local climate-related action in support of the climate change strategy for Wirral. WUTH is part of the Cool Wirral Partnership which co-ordinates local action on climate change and meets three times a year. The partnership is supported by Wirral Council and a variety of organisations participate, including CWP, Merseyside Police, Merseytravel, Merseyside Recycling and Waste Authority and Merseyside Fire and Rescue.

WUTH Sustainability Team have been supporting the development of the Cool Wirral Strategy 2025-2030 attending a number of in-person sessions working with multi-sector organisations as listed above.

Sustainability Update
Case study – Endoscopy Waste Segregation

Wirral University Teaching Hospital
NHS Foundation Trust

In July 2024, WUTH Sustainability Team and Facilities Support Services supported the Endoscopy Team with improving their waste segregation processes within the department.

It was highlighted that a lot of General and Recyclable waste was being disposed of in Offensive Waste bags. Offensive Waste is more harmful to the environment than General and Recyclable waste as it requires additional processing and is also more expensive to dispose of.

The aim of this project was to reduce the amount of waste that was being disposed of via the Offensive waste stream and re-directed as Recyclable waste that is produced via correct segregation.

Our General and Recyclable waste is sorted at the plant; however we want to separate the Recyclable waste at source so that it is not contaminated with any General waste such as food scraps, meaning that more of our Recyclable waste can be recovered and re-used.

WUTH Sustainability Team are hoping to introduce this Trust-wide in the long-term.

Sustainability Update
Case study – Catering Food Dryer Trial, APH

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

In December 2024, the Catering Team at APH took part in an Eco-Smart Food Dryer trial. The food dryer works by turning the food waste in hot air, extracting 80% of the water content (food waste is on average 80% water). The dryer turns wet food waste into a sterile, dry residue, 20% or less of its former weight. The remaining dried food waste would then be collected and can be taken to either; a Commercial Composting Facility, and Anaerobic Digestion Plant, or incinerated at a Waste to Energy plant which generates electricity for the grid.

This provides many benefits:

- Reducing food waste volume being collected from site by at least 80%
- Significant reduction in collection costs (Food waste from APH alone totals approximately 73,000kg per year with a collection and disposal cost of over £18,000, at CGH costs are approx. £9,000 per annum.)
- The dried waste food can be stored inside until collection, significantly reducing pest activity on the site, and preventing spills on the loading bay

WUTH Sustainability Team are currently working with the Catering Team to source funding to be able to purchase 2x food dryers for APH and 1x food dryer for CGH.

WUTH Sustainability – Plan on a Page 2025

VISION:

Work with colleagues to deliver improvements to reduce WUTH's Carbon footprint and improve sustainable health care.

THE 'HOW'

- Act as a critical friend.
- Provide best practice guidance.
- Support service development initiatives.
- Apply for national funding; LCSF, PSDS, NEEF

CHALLENGES/ ENABLERS

- Competing priorities/not core business.
- Timely data
- Short term planning.
- Linking financial, social and environmental outcomes effectively.

PRIORITIES	FOCUS AREAS	2025 OUTPUTS
Medicines	Reduce Emissions from nitrous oxide	• Use funding from the NHSE Nitrous Oxide Waste Mitigation Scheme to purchase cylinder trollies to allow us to switch off manifold at APH, reducing emissions from nitrous oxide
Travel and Transport	NHS low emissions Fleet vehicles	• From 2027, all new vehicles owned and leased by the NHS will be zero emission vehicles. Understand Electrical Infrastructure in readiness for EV Fleet. Seek funding opportunities.
	Travel and Transport Strategy Green Travel Plan	• Complete biennial staff travel survey to inform the policy. • Develop a Travel and Transport strategy for WUTH and associated Green Travel Plan.
Supply Chain	Net Zero supplier roadmap	• Support Procurement to implement the 2024 Net Zero Supplier Roadmap requirements. Focus on compliance with Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) for all contracts over procurement threshold.
Estates and facilities	Energy Plan	• Update Trust Energy Plan 2023-26 • Develop Energy campaign to reduce consumption across both sites – *Switch It Off campaign*
	Heat Decarbonisation Plans	• Develop Heat Decarbonisation Plans (HDP) up to stage 1 for both sites; to understand Trust plans to remove oil boilers and to work with Trusts subject to UK Emissions Trading Scheme penalties.
	Capital funding Opportunities	• Review National funding schemes available to NHS for infrastructure and capital projects • Link in with the NW Net Zero Hub and C&M Sustainability Fund • Complete funding applications with support from internal teams/divisions
	Food Waste	• Monitor, manage and actively reduce the Trusts food waste from production waste, plate waste and unserved meals.
Air Quality	Indoor and outdoor air pollution	• Develop a Clean Air Policy for the Trust • Engage with Liverpool John Moore's University to conduct studies to understand the impact that traffic movements around APH have on both the indoor and outdoor air quality of the Hospital
Adaptation	Climate Adaptation planning	• Initiate Climate Adaptation planning for WUTH • Identify direct and indirect climate risks for the Trust
Building Networks	Build Networks	• Continue to build networks, share best practice and embed Greener NHS priorities across Wirral Place and C&M ICB, including the reestablishment of the Wirral Place Sustainability Group
Green Plan Refresh	Refresh WUTH Green Plan	• Work with Area of Focus leads to define strategy for next 3-years • Include SMART actions to support accurate tracking and reporting of deliverables

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 19**

05 March 2025

Title	Trust Constitution Update
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Ellis, Corporate Governance Manager
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is set out the proposed amendments to the Trust Constitution.

As set out in the Trust Constitution both the Council of Governors and Board of Directors are required to approve any change to the Trust Constitution. The Council of Governors approved the amends at the meeting on 11 February 2025.

It is recommended that the Board of Directors:

- Approve the Trust Constitution

Key Risks

This report relates to these key risks:

- BAF Risk 12 - Failure to work with local partners to address and reduce health inequalities across the Wirral population.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
11 February 2025	Council of Governors	As above	As above

1	Narrative
1.1	Following the Wirral System Review, the 100 Day Integration Plan has been developed and key programme area relates to Governance. In order to establish and embed effective governance arrangements to facilitate the integration between WUTH (Wirral University Teaching Hospital) and WCHC (Wirral Community Health and Social Care) there is requirement to update the Trust Constitution. The work to determine the most effective governance arrangements reflects the legal position: • NHS Act permits NHSTs/FTs to agree arrangements for carrying out functions jointly 'with any other person'; and • From 2022, amendments to the NHS Act give greater freedom and more wide-ranging powers to NHST/FTs to collaborate with each other (and others e.g. Local Authorities) by inserting new delegation and joint committee powers (S65Z6 – joint committee / pooled fund) The Constitution has been updated to reflect that WUTH may exercise joint working and joint committee powers under s.65Z6 of the NHS Act, including provisions to confirm that persons who are not (voting) Directors of the Trust may be members of a joint committee. The Constitution is appended to this report and the relevant changes are visible in track changes throughout section 3. In line with NHSE Collaboration Guidance functions central to the corporate governance of individual organisations' cannot be delegated, this includes the Accountable Officer, Audit Committee and Annual Report preparation.

2	Implications
2.1	**Patients** • No implications
2.2	**People** • No implications
2.3	**Finance** • No implications
2.4	**Compliance** • No implications

Wirral University Teaching Hospital NHS
NHS Foundation Trust

CONSTITUTION OF

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

This version of the constitution took effect on TBD~~29.03.17~~

Version 2~~1.10~~

Constitution of Wirral University Teaching Hospital

NHS Foundation Trust

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Page

1. **Name**

The name of the foundation trust is Wirral University Teaching Hospital NHS Foundation Trust ("the Foundation Trust").

2. **Principal purpose**

2.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Foundation Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Foundation Trust may provide goods and services for any purpose related to:

2.3.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

2.3.2 The promotion and protection of public health.

2.4 The Foundation Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better to carry out its principal purpose.

3. **Powers**

3.1 The powers of the Foundation Trust are set out in the 2006 Act, updated in the Health and Social Care Act 2012 and Health and Care Act 2022.

3.2 The powers of the Foundation Trust shall be exercised by the Board of Directors on behalf of the Foundation Trust.

3.3 Any of these powers may be delegated to a committee of Directors or to an executive Director.

3.4 The Trust may enter into arrangements for the carrying out, on such terms as the Trust considers appropriate, of any of its functions jointly with any other person.

3.5 The Trust may arrange for any of the functions exercisable by the Trust to be exercised by or jointly with any one or more of the following:

3.5.1 A relevant body;

3.5.2 A local authority within the meaning of section 2B of the 2006 Act;

3.5.3 A combined authority with the meaning of section 65Z5 of the 2006 Act.

3.6 The Trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

3.7 Where a function is exercisable by the Trust jointly with one or more of the other organisations mentioned at paragraph 3.5, those organisations and the Trust may:

3.7.1 Arrange for the function to be exercised by a joint committee of theirs;

3.7.2 Arrange for the Trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund in accordance with section 65Z6 of the 2006 Act

3.8 The Trust must exercise its functions effectively, efficiency and economically.

3.9 In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to:

3.9.1 The health and well-being of (including inequalities between) the people of England;

3.9.2 The quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

3.9.3 Efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

3.10 In the exercise of its functions, the Trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate change in the most recent report under section 56 of the Climate Change Act 2008).

3.11 For the purposes of this section, “relevant body” means NHSE, an integrated care board, an NHS Trust, a NHS foundation Trust (including the Trust) or such other body as may be prescribed under section 65Z5(2). “Relevant bodies” means two or more of these organisations as the context requires.

3.12 The arrangements under this paragraph 3 shall be in accordance with:

3.12.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act;

3.12.2 any applicable statutory guidance that has been issued and;

3.12.3 otherwise on such terms as the Trust sees fit.

4. Membership and constituencies

The Foundation Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1 a public constituency (Elected Governors); or

4.2 a staff constituency (Elected Governors).

4.3 stakeholder constituency (Appointed Governors)

Further provisions as to members are set out in Annex 9.

5. **Application for membership**

An individual who is eligible to become a member of the Foundation Trust may do so on application to the Foundation Trust.

6. **Public Constituency**

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Foundation Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7. **Staff Constituency**

7.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a member of the Foundation Trust provided:

7.1.1 He is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 He has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

7.2 Those individuals who are eligible for membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.3 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.5 An individual who is:

7.5.1 eligible to become a member of the Staff Constituency; and

7.5.2 invited by the Foundation Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Foundation Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Foundation Trust that he does not wish to do so.

8. Restriction on membership

8.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 The Company Secretary shall make the final decision about the constituency or class of a constituency of which an individual is eligible to be a member.

8.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Foundation Trust are set out in Annex 9.

9. Council of Governors – composition

9.1 The Foundation Trust is to have a Council of Governors, which shall comprise both Elected and Appointed Governors.

9.2 The composition of the Council of Governors is specified in Annex 3.

9.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

10. Council of Governors – election of Governors

10.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time

10.2 The Model Rules for Elections, as may be varied from time to time by the Department of Health, form part of this constitution and are attached at Annex 4.

10.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the Foundation Trust cannot amend the Model Rules.

10.4 An election, if contested, shall be by secret ballot.

11. Council of Governors - tenure

11.1 Subject to the provisions of Annex 5, an Elected Governor shall normally hold office for a period of 3 years commencing immediately after the Annual Members' meeting at which his election is announced.

11.2 An Elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

11.3 An Elected Governor shall be eligible for re-election at the end of his term.

11.4 An Elected Governor may not hold office for more than nine consecutive years, and shall not be eligible for re-election if he has already held office for more than six consecutive years. An Elected Governor who has ceased to hold office in accordance with this paragraph shall, from then on, not be eligible for election.

11.5 Subject to the provisions of Annex 5, an appointed Governor shall normally hold office for a period of 3 years commencing immediately after the Annual Members' meeting at which his appointment is announced.

11.6 An Appointed Governor shall cease to hold office if the Appointing Organisation which appointed him terminates the appointment.

11.7 An Appointed Governor shall be eligible for re-appointment at the end of his term.

11.8 An Appointed Governor may not hold office for more than nine consecutive years, and shall not be eligible for re-appointment if he has already held office for more than six consecutive years. An Appointed Governor who has ceased to hold office in accordance with this paragraph shall, from then on, not be eligible for re-appointment.

11.9 For the purposes of these provisions concerning terms of office for Elected and Appointed Governors, –year‖ means a period commencing immediately after the conclusion of the Annual Members' meeting, and ending at the conclusion of the next Annual Members' meeting.

12. Council of Governors – disqualification and removal

12.1 The following may not become or continue as a member of the Council of Governors:

12.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

12.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been

discharged in respect of it;

12.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

12.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

12.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

13. Council of Governors – general duties

13.1 The general duties of the Council of Governors are –

13.1.1 To hold the non-executive Directors individually and collectively to account for the performance of the Board of Directors; and

13.1.2 To represent the interests of the members of the Foundation Trust as a whole and the interest of the public.

13.2 The Foundation Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as Governors.

14. Council of Governors – meetings of Governors

14.1 The Chair of the Foundation Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 22.1 below) or, in his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 23 below) or, in his or her absence, one of the non-executive Directors, shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor of the Council of Governors (appointed in accordance with the provisions of paragraph 4 of Annex 5) will chair that part of the meeting.

14.2 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

14.3 For the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance), the Council of Governors may require one or

more of the Directors to attend a meeting of the Council of Governors.

15. **Council of Governors – standing orders**

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

16. **Council of Governors – referral to the Panel**

16.1 In this paragraph, –"the Panel" means a panel of persons appointed by NHSI to which a Governor of the Foundation Trust may refer a question as to whether the Foundation Trust has failed or is failing –

16.1.1 To act in accordance with its constitution; or

16.1.2 To act in accordance with provision made by or under Chapter 5 of the 2006 Act.

16.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

17. **Council of Governors - conflicts of interest of Governors**

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

18. **Council of Governors – travel expenses**

The Foundation Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Foundation Trust.

19. **Council of Governors – further provision**

Further provisions with respect to the Council of Governors are set out in Annex 5.

20. **Board of Directors – composition**

20.1 The Foundation Trust is to have a Board of Directors, which shall comprise both executive and non-executive Directors.

20.2 Subject to paragraph 20.3, the Board of Directors is to comprise:
20.2.1 a non-executive Chair;
20.2.2 not more than seven other non-executive Directors; and
20.2.3 not more than seven executive Directors,

20.3 At least half of the Board of Directors, excluding the non-executive Chair, shall at all times comprise non-executive Directors.

20.4 One of the executive Directors shall be the Chief Executive.

20.5 The Chief Executive shall be the Accounting Officer.

20.6 One of the executive Directors shall be the Director of Finance.

20.7 One of the executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

20.8 One of the executive directors is to be a registered nurse or a registered midwife.

21. **Board of Directors – qualification for appointment as a non-executive Director**

A person may be appointed as a non-executive Director only if he is –

21.1 a member of the Public Constituency; and

21.2 not disqualified by virtue of paragraph 25 below or Annex 6.

22. **Board of Directors – appointment and removal of Chair and other non-executive directors**

22.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Foundation Trust and the other non-executive Directors.

22.2 Removal of the Chair or another non-executive Director shall require the approval of three-quarters of the members of the Council of Governors.

22.3 Further details as to the appointment and removal of the Chair and other non-executive Directors is set out in Annex 6.

23. **Board of Directors – appointment of Deputy Chair**

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive Directors as a Deputy Chair.

24. **Board of Directors - appointment and removal of the Chief Executive and other executive Directors**

24.1 The non-executive Directors shall appoint or remove the Chief Executive.

24.2 The appointment of the Chief Executive shall require the approval of

the Council of Governors.

24.3 A committee consisting of the Chair, the Chief Executive and other non-executive Directors shall appoint or remove the other executive Directors.

24.4 The Board of Directors may nominate one of the executive Directors to be the Deputy Chief Executive.

25. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

25.1 a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence or charged with an offence that has not yet been disposed of.

25.2 a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health or social care

25.3 a person who has been sentenced to imprisonment for three months or more within the last five years

25.4 a person who is an undischarged bankrupt or subject to a bankruptcy order or an interim bankruptcy order.

25.5 a person who has an undischarged arrangements with creditors

25.6 a person who have been included on any barring list preventing them from working with children or vulnerable adults.

25.7 a person who has any current NHS Counter Fraud and Security Management Service investigation following allegations made against them.

25.8 a person who has been investigated by the Police, or any other investigatory body resulting in their dismissal from employment.

25.9 a person who is currently the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the UK or any other country?

25.10 a person who does not have the qualifications, skills and experience necessary for the position they hold on the Board.

25.11 a person who is not capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010.

25.12 a person who has been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider

25.13 a person who is prohibited from holding the relevant position under any other law; eg under the Companies Act or the Charities Act.

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are set out at Annex 6.

26. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

27. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

28. Board of Directors - conflicts of interest of Directors

28.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include, in particular: -

28.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust; and

28.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

28.2 The duty referred to in paragraph 28.1.1 is not infringed if:

28.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

28.2.2 The matter has been authorised in accordance with the constitution.

28.3 The duty referred to in paragraph 28.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

28.4 In paragraph 28.1.2, "a third party" means a person other than:

28.4.1 The Foundation Trust; or

28.4.2 A person acting on the Foundation Trust's behalf.

28.5 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

29. **Board of Directors – remuneration and terms of office**

29.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive Directors.

29.2 The Foundation Trust shall establish a committee of up to 4 non-executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive Directors.

30. **Registers**

The Foundation Trust shall have:

30.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

30.2 a register of members of the Council of Governors;

30.3 a register of interests of Governors;

30.4 a register of Directors; and

30.5 a register of interests of the Directors.

31. **Admission to and removal from the registers**

The Company Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

32. **Registers – inspection and copies**

32.1 The Foundation Trust shall make the registers specified in paragraph 30 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

32.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Foundation Trust, if the member so requests.

32.3 So far as the registers are required to be made available:

32.3.1 they are to be available for inspection free of charge at all reasonable times; and

32.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

32.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable

charge for doing so.

33. Documents available for public inspection

33.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

33.1.1 a copy of the current constitution;

33.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them; and

33.1.3 a copy of the latest Annual Report;

33.1.4 a copy of the latest information as to its forward planning; and

33.1.5 a copy of the Foundation Trust's membership strategy.

33.2 The Foundation Trust shall also make the following documents relating to a special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times:

33.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

33.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

33.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

33.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

33.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act;

33.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

33.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

33.2.8 a copy of any final report published under section 65I

(administrator's final report);

33.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

33.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

33.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

33.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

34. Auditor

34.1 The Foundation Trust shall have an auditor.

34.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

35. Audit committee

The Foundation Trust shall establish a committee of non-executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

36. Accounts

36.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts.

36.2 NHSI may, with the approval of the Secretary of State, give directions to the Foundation Trust as to the content and form of its accounts.

36.3 The accounts are to be audited by the Foundation Trust's auditor.

36.4 The Foundation Trust shall prepare in respect of each Financial Year Annual Accounts in such form as NHSI may, with the approval of the Secretary of State, direct.

36.5 The functions of the Foundation Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

37. Annual report, forward plans and non-NHS work

37.1 The Foundation Trust shall prepare an Annual Report and send it to NHSI.

37.2 The Annual Report must include:

37.2.1 information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency (taking into account the need for those eligible for such membership to be representative of those to whom the Foundation Trust provides services) and of the classes of the Staff Constituency is representative of those eligible for such membership;

37.2.2 information on the Foundation Trust's policy on pay, the work of the committee established pursuant to paragraph 29.2 and such other procedures as the Foundation Trust has on pay.

37.2.3 information on the remuneration of Directors and expenses of Governors and Directors, to be disclosed in bands.

37.3 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to NHSI.

37.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

37.5 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

37.6 Each forward plan must include information about:

37.6.1 The activities other than the provision of goods and services for the purposes of the health service in England that the Foundation Trust proposes to carry on; and

37.6.2 The income it expects to receive from doing so.

37.7 Where a forward plan contains a proposal that the Foundation Trust carry on an activity of the kind mentioned in paragraph 37.6.1, the Council of Governors must:

37.7.1 Determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Foundation Trust of its principal purpose or the performance of its other functions; and

37.7.2 Notify the Directors of the Foundation Trust of its determination.

37.8 Where the Foundation Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

38. **Meeting of Council of Governors to consider annual accounts and reports**

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

38.1.1 the annual accounts;

38.1.2 any report of the auditor on them; and

38.1.3 the annual report.

38.2 The documents shall also be presented to the members of the Foundation Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

38.3 The Foundation Trust may combine a meeting of the Council of Governors with the Annual Members' Meeting for the purposes of paragraph 38.1.

39. **Instruments**

39.1 The Foundation Trust shall have a seal.

39.2 The seal shall not be affixed except under the authority of the Board of Directors.

40. **Amendment of the Constitution**

40.1 The Foundation Trust may make amendments of its constitution only if:

40.1.1 More than half of the members of the Council of Governors of the Foundation Trust voting approve the amendments; and

40.1.2 More than half of the members of the Board of Directors of the Foundation Trust voting approve the amendments.

40.2 Amendments made under paragraph 40.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

40.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Foundation Trust):

40.3.1 At least one member of the Council of Governors must attend the next Annual Members' meeting and present the amendment; and

40.3.2 The Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.

40.4 If, in accordance with paragraph 40.3, more than half of the members voting approve the amendment to the constitution in relation to the powers or duties of the Council of Governors, the amendment continues to have effect. Otherwise, the amendment ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

40.5 Amendments by the Foundation Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, NHSI's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

41. Mergers

The Foundation Trust may only apply for a merger, acquisition, separation or dissolution of the Foundation Trust with the approval of more than half of the members of the Council of Governors.

42. Significant transactions

42.1 The Foundation Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting approve the Foundation Trust entering into the transaction.

42.2 For the purposes of this paragraph:

42.2.1 "Transaction" may be either an investment or a disinvestment.

42.2.2 A transaction is "significant" if its value equates to 15% of either the Foundation trust's Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Foundation Trust's opening Balance Sheet for the Financial Year in which approval is being sought.

42.2.3 If more half of the members of the Council of Governors voting at a meeting of the Council decline to approve a significant transaction or any part of it, the meeting must approve a Statement of Reasons for its rejection for the Board of Directors.

43. Notice

43.1 Unless otherwise stated, any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications

43.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 72 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 72 hours after it was sent.

44. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

"the Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"Appointed Governors"	means those Governors appointed by the appointing organisations;
"Appointing Organisations"	means those organisations named in this constitution who are entitled to appoint Governors;
"Company Secretary"	means the Company Secretary of the Foundation Trust or any other person appointed to perform the duties of the Company Secretary, including a joint, assistant or deputy Company Secretary;
"Constitution"	means this constitution and all annexes to it;
"Director"	means a member of the Board of Directors;
"Elected Governors"	means those Governors elected by the Public constituency and the classes of the Staff Constituency;
"Financial Year"	means: (a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;

“Local Authority Governor”	means a Governor appointed by one or more local authorities whose area includes the whole or part of an area for a public constituency of the Foundation Trust;
“NHSI”	means the body corporate known as NHS Improvement, as provided by Section 61 of the 2012 Act;
“Partner”	means, in relation to another person, a member of the same household living together as a family unit;
“Public Governor”	means a Governor elected by the members of one of the areas of the Public Constituency;
“Staff Governor”	means a Governor elected by the members of one of the classes of the Staff Constituency;
“the 2006 Act”	means the National Health Service Act 2006;
“the 2012 Act”	means the Health and Social Care Act 2012;
“Voluntary Organisation”	means a body, other than a public or local authority, the activities of which are not carried on for profit.

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraphs 6.1 and 6.3)

Bebington and Clatterbridge
Bidston and Claughton
Birkenhead, Tranmere and Rock Ferry
Bromborough and Eastham
Greasby, Frankby, Irby, Upton and Woodchurch
Heswall, Pensby and Thingwall
Leasowe, Moreton and Saughall Massie
Liscard and Seacombe
Neston, Little Neston, Parkgate, Riverside, Burton, Ness, Willaston and Thornton
New Brighton and Wallasey
North West and North Wales[1]
Oxton and Prenton
West Wirral

The minimum number of members of each of the areas of the Public Constituency is to be four.

[1] This area of the Public Constituency comprises:

- the geographical area covered by the Betsi Cadwaladr University Local Health Board as set out in the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009; and
- any other geographical area covered by the North West Strategic Health Authority, as set out in the Strategic Health Authorities (Establishment and Abolition) (England) Order 2006, which is not already included within any other area of the Public Constituency.

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 7.3 and 7.4)

1. Registered medical practitioners and registered dentists
2. Registered nurses and registered midwives
3. Other healthcare professional staff
4. Other Trust staff

The minimum number of members of each class of the Staff Constituency is to be four.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 9.2 and 9.3)

The Council of Governors of the Foundation Trust is to comprise:

1 thirteen Public Governors from the following areas of the Public Constituency:

1.1 Bebington and Clatterbridge – one Public Governor;

1.2 Bidston and Claughton – one Public Governor;

1.3 Birkenhead, Tranmere and Rock Ferry – one Public Governor;

1.4 Bromborough and Eastham – one Public Governor;

1.5 Greasby, Frankby, Irby, Upton and Woodchurch – one Public Governor;

1.6 Heswall, Pensby and Thingwall – one Public Governor;

1.7 Leasowe, Moreton and Saughall Massie – one Public Governor;

1.8 Liscard and Seacombe – one Public Governor;

1.9 Neston, Little Neston, Parkgate, Riverside, Burton, Ness, Willaston and Thornton – one Public Governor;

1.10 New Brighton and Wallasey – one Public Governor;

1.11 North West and North Wales – one Public Governor;

1.12 Oxton and Prenton – one Public Governor; and

1.13 West Wirral – one Public Governor.

2 five Staff Governors from the following classes;

2.1 registered medical practitioners and registered dentists – one Staff Governor;

2.2 registered nurses and registered midwives – two Staff Governors;

2.3 other healthcare professional staff – one Staff Governor; and

2.4 other Trust staff – one Staff Governor.

3 two Local Authority Governors to be appointed by Wirral Metropolitan Borough Council.

4 Two Governors to be appointed by:

4.1 Liverpool University – one Partnership Governor;

4.2 Wirral Third Sector Assembly – one Partnership Governor.

ANNEX 4 –THE MODEL RULES FOR ELECTIONS

(Paragraph 10.2)

Model Election Rules

Part 1 - Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5 – Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting documents
25. Ballot paper envelope and covering envelope

The poll

Procedure for receipt of envelopes

Part 6 - Counting the votes

Part 7 – Final proceedings in contested and uncontested elections

Part 8 – Disposal of documents

Part 9 – Death of a candidate during a contested election

Part 1 - Interpretation

1. Interpretation – (1) In these rules, unless the context otherwise requires -

―corporation‖ means the public benefit corporation subject to this constitution;

―election‖ means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the board of governors;

―the regulator‖ means the Independent Regulator for NHS foundation trusts; and

―the 2003 Act‖ means the Health and Social Care (Community Health and Standards) Act 2003.

(2) Other expressions used in these rules and in Schedule 1 to the Health and Social Care (Community Health and Standards) Act 2003 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable - The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time - (1) In computing any period of time for the purposes of the timetable -

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, –bank holiday‖ means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer – (1) Subject to rule 64, the returning officer for an election is to be appointed by the corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff – Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure - The corporation is to pay the returning officer –

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation – The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election – The returning officer is to publish a notice of the election stating –

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the board of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer, and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates – (1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer-

(a) is to supply any member of the corporation with a nomination paper, and

(b) is to prepare a nomination paper for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars – (1) The nomination paper must state the candidate's -

(a) full name,

(b) contact address in full, and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests – The nomination paper must state –

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility – The nomination paper must include a declaration made by the candidate–

(a) that he or she is not prevented from being a member of the board of governors by paragraph 8 of Schedule 1 of the 2003 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate – The nomination paper must be signed and dated by the candidate, indicating that –

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination – (1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination paper is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

1. that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,

2. that the paper does not contain the candidate's particulars, as required by rule 10;

3. that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

4. that the paper does not include a declaration of eligibility as required by rule 12, or

5. that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates – (1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show –

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers – (1) The corporation is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the corporation is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates - A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election – (1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the board of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the board of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be board of governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot – (1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper – (1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify –

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the board of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies) – (1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter is the person to whom the ballot paper was addressed,

(b) that the voter has not marked or returned any other voting paper in the election, and

(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter, (b)

the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters – (1) The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll - The returning officer is to publish a notice of the poll stating–

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the board of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the address for return of the ballot papers, and the date and time of the close of the poll,

(g) the address and final dates for applications for replacement ballot papers, and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer – (1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters–

(a) a ballot paper and ballot paper envelope,

(b) a declaration of identity (if required),

(c) information about each candidate standing for election, pursuant to rule 59 of these rules, and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope – (1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have –

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote – An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance – (1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers (1) – If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a –spoilt ballot paper‖), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she –

(a) is satisfied as to the voter's identity, and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (–the list of spoilt ballot papers‖) –

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers – (1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she –

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original ballot paper, and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list (–the list of lost ballot papers‖) –

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper– (1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list (–the list of tendered ballot papers‖) –

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies) – (1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents – (1) Where the returning officer receives a –

(a) covering envelope, or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to –

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper – (1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) put the declaration of identity if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) mark the ballot paper -disqualified‖,

(b) if there is a declaration of identity accompanying the ballot paper, mark it as ―disqualified‖ and attach it the ballot paper,

(c) record the unique identifier on the ballot paper in a list (the ―list of disqualified documents‖); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency) – Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

(a) mark the declaration of identity ―disqualified‖,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets – As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing–

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the declarations of identity if required,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

stv36. Interpretation of Part 6 – In Part 6 of these rules –

―continuing candidate‖ means any candidate not deemed to be elected, and not excluded,

―count‖ means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

―deemed to be elected‖ means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

―mark‖ means a figure, an identifiable written word, or a mark such as ―X‖,

―non-transferable vote‖ means a ballot paper –

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule stv44(4) below,

—preference‖ as used in the following contexts has the meaning assigned below–

(a) –first preference‖ means the figure –1‖ or any mark or word which clearly indicates a first (or only) preference,

(b) –next available preference‖ means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a –second preference‖ is shown by the figure –2‖ or any mark or word which clearly indicates a second preference, and a third preference by the figure –3‖ or any mark or word which clearly indicates a third preference, and so on,

–quota‖ means the number calculated in accordance with rule stv41 below,

—surplus‖ means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

—stage of the count‖ means –

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

–transferable paper‖ means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

–transferred vote‖ means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

–transfer value‖ means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule stv42 below.

37. Arrangements for counting of the votes – The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count – (1) The returning officer is to –

(a) count and record the number of ballot papers that have been returned, and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

Stv39. Rejected ballot papers – (1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure –1‖ standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words –one‖, –two‖, –three‖ and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word –rejected‖ on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

fpp39. Rejected ballot papers – (1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to paragraphs (2) and (3) below, be rejected and not counted.

(2) Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

(3) A ballot paper on which a vote is marked –

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

(4) The returning officer is to –

(a) endorse the word –rejected‖ on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under paragraph (2) or (3) above, endorse the words –rejected in part‖ on the ballot paper and indicate which vote or votes have been counted.

(5) The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings –

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

stv40. First stage – (1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

stv41. The quota – (1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as –the quotall).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule stv44 has been complied with.

stv42. Transfer of votes – (1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped –

(a) according to next available preference given on those papers for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule stv43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1)(a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value (–the transfer valuell) which –

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped –

(a) according to the next available preference given on those papers for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule stv43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5)(a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at –

(a) a transfer value calculated as set out in paragraph (4)(b) above, or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are –

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

stv43. Supplementary provisions on transfer – (1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if –

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule stv42 above –

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare—

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule stv42 or stv44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule stv42 or stv44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non-transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

stv44. Exclusion of candidates – (1) If—

(a) all transferable papers which under the provisions of rule stv42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and

(b) subject to rule stv45 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as—

(a) ballot papers on which a next available preference is given, and

(b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule stv43 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule stv45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule—

(a) record –

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare—

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule stv42 and rule stv43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

stv45. Filling of last vacancies – (1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

stv46. Order of election of candidates – (1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule stv42(10) above.

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

fpp46. Equality of votes – Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

fpp47. Declaration of result for contested elections – (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to –

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the board of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected–

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

(2) The returning officer is to make –

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule fpp39(5),

available on request.

stv47. Declaration of result for contested elections – (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make –

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule stv39(1),

available on request.

48. Declaration of result for uncontested elections – In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll – (1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets –

(a) the counted ballot papers,

(b) the ballot papers endorsed with –rejected in partll,

(c) the rejected ballot papers, and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of –

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the declarations of identity,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents – Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chair of the corporation.

51. Forwarding of documents received after close of the poll – Where –

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

52. Retention and public inspection of documents – (1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election – (1) The corporation may not allow the inspection of, or the opening of any sealed packet containing –

(a) any rejected ballot papers, including ballot papers rejected in part,

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers,

(d) any declarations of identity, or

(e) the list of eligible voters,

by any person without the consent of the Regulator.

(2) A person may apply to the Regulator to inspect any of the documents listed in (1), and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

(a) in giving its consent, the regulator, and

(b) and making the documents available for inspection, the corporation,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

fpp54. Countermand or abandonment of poll on death of candidate – (1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to

(a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

(2) Where a new election is ordered under paragraph (1), no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

(3) Where a poll is abandoned under paragraph (1)(a), paragraphs (4) to (7) are to apply.

(4) The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 33 and 34, and is to make up separate sealed packets in accordance with rule 35.

(5) The returning officer is to –

(a) count and record the number of ballot papers that have been received, and

(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.

(6) The returning officer is to endorse on each packet a description of –

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

(7) Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (4) to (6), the returning officer is to deliver them to the chairman of the corporation, and rules 52 and 53 are to apply.

stv54. Countermand or abandonment of poll on death of candidate – (1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to –

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55. Election expenses – Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56 Expenses and payments by candidates - A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of [£100].

57. Election expenses incurred by other persons – (1) No person may -

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the corporation – (1) The corporation may –

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 59, must be –

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents - (1) The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of –

(a) a statement submitted by the candidate of no more than [250] words, [and]

[(b) a photograph of the candidate.]

60. Meaning of "for the purposes of an election" - (1) In this Part, the phrase ―for the purposes of an election‖ means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase ―for the purposes of a candidate's election‖ is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election – (1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the Regulator by -

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must –

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the Regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

(8) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

(9) The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy – (1) The following persons –

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

(i) the name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote – No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification – A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event – If industrial action, or some other unforeseen event, results in a delay in –

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraphs 11.1, 11.5, 12.3 and 19)

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Company Secretary that they are qualified to vote as a member of the relevant area of the Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2. The Company Secretary, having consulted Wirral Metropolitan Borough Council, is to adopt a process for agreeing the appointment of Local Authority Governors with that local authority.

3. The other Appointed Governors are to be appointed by their respective Appointing Organisations, in accordance with a process agreed by that organisation with the Company Secretary.

Appointment of Lead Governor of the Council of Governors

4. The Council of Governors shall appoint one of the Governors to be Lead Governor of the Council of Governors, who shall hold office for a period of two years from their date of appointment.

Further provisions as to eligibility to be a Governor

5. Paragraphs 6 – 7 apply in addition to the grounds set out at paragraph 11 and 12 of the constitution.

6. A person may not be appointed as an Appointed Governor and, if already holding office as an Appointed Governor, will immediately cease to do so if, he is an Elected Governor or a candidate for election as an Elected Governor.

7. A person may not become a Governor (whether Appointed or Elected) of the Foundation Trust, and, if already holding such office, will immediately cease to do so, if:

   7.1 he is a Director of the Foundation Trust or a Governor or Director of an NHS body (unless he is appointed by an Appointing Organisation which is an NHS body);

   7.2 he is the spouse, Partner, parent or child of a member of the Board of Directors of the Foundation Trust;

7.3 he is a member of a local authority's Scrutiny Committee covering health matters;

7.4 he is an employee or appointed official of Local Healthwatch;

7.5 he has been previously removed as a Governor pursuant to paragraph 8 of this Annex 5.

7.6 being a member of the Public Constituency, he refuses to sign a declaration in the form specified by the Company Secretary of particulars of his qualification to vote as a member of the Foundation Trust, and that he is not prevented from being a member of the Council of Governors;

7.7 he is subject to a sex offender order;

7.8 he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

7.9 he is a person whose tenure of office as the Chair or as a member or Director of an NHS body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

7.10 he is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs;

7.11 he has had his name removed from any list prepared under Parts 4, 5, 6 or 7 of the 2006 Act and has not subsequently had his name included in such a list;

7.12 he is a member of a class of the Staff Constituency and any professional registration relevant to his eligibility to continue to be a member of that class of the Staff Constituency has been suspended (by way of an imposition of a penalty) for a continuous period of more than six months; or

7.13 he is a Member of the UK Parliament.

8. Resignation, Removal and Disqualification of a Governor

Voluntary

8.1 A Governor may decide to resign from office by putting this in writing to the Chairman and/or the Company Secretary.

8.2 Resignation is effective upon receipt by the Chairman and/or the Company Secretary.

8.3 At the first Council of Governors' meeting following any such resignation, the Company Secretary shall ensure that an agenda item is proposed to formally communicate the departing Governor's resignation and to

discuss and agree how the vacancy created by the resignation may be filled, in accordance with paragraphs 9 – 11 of this Annex 5 of this Constitution.

Ineligibility

8.4 The eligibility requirements to become and to continue as a Governor are set out in paragraphs 6 and 7 of Annex 5 of this Constitution. Governors are personally responsible for ensuring that they continue to meet these requirements throughout their term in office.

8.5 The Governors' Code of Conduct has been updated to include the requirements of the Fit and Proper Persons Test as required by the Trust's Provider Licence.

8.6 A Governor must notify the Chairman or the Company Secretary within 5 days upon becoming aware of a circumstance which brings their eligibility to continue as a Governor into doubt.

8.7 The Chairman shall discuss any such notification with the Governor at the first available opportunity, following which:

8.8 the Governor may agree that he/she must step down from office, in which case he/she will provide written confirmation as such to the Chairman and, upon receipt of such notice, the process at paragraph 3 above applies; or if the Chairman considers the Governor ineligible to continue in post and if the Governor disagrees and considers that they are eligible to continue as a Governor, the process set out below at paragraphs 8.9 – 8.23 will apply.

Removal from office

8.9 The following individuals may present a proposal to the Council of Governors that a Governor should be removed from office:

8.10 The Chairman, Company Secretary or 5 Governors.

8.11 Any such proposal must be based on one or more of the following grounds:

8.11.1 consistent and unjustifiable failure to attend 3 consecutive meetings of the Council of Governors without reasonable excuse

8.11.2 an actual or potential conflict of interest which prevents or has prevented the Governor in the proper exercise of their duties,

8.11.3 breach of specific provisions of the Trust's Code of Conduct for Governors or otherwise actions which are incompatible with a values of the Trust

8.11.4 refusal without reasonable cause to undertake any mandatory training which the Council of Governors requires all Governors to undertake

8.11.5 failure to accept, sign and return the Code of Conduct for Governors'

8.12 Upon receipt of such a proposal, the Chairman together with the Company Secretary and the Lead Governor will be asked to investigate and identify whether the proposed grounds may be substantiated including undertaking interviews/discussions with the Governor in question, as appropriate.

8.13 Should the Chairman and/or the Company Secretary and the Lead Governor determine that there may be a case for removal, they must serve the Governor in question with written notice of:

8.13.1 The allegations against the Governor;

8.13.2 The evidence on which such allegations are based (including copies of any such evidence were possible); and

8.13.3 What action it is proposed that the Trust/Council of Governors shall take if the allegations are found to be proven.

8.14 The possible actions that may be taken pursuant to paragraph 8.13.3 are:

8.14.1 No further action necessary

8.14.2 A letter of censure (explaining the breach and required behaviour going forwards),

Or, if the Governor concerned has committed a serious breach of the code of conduct, or acted in a manner detrimental to the interests of the Foundation Trust and it is considered that it is not in the best interests of the Foundation Trust for them to continue as a Governor,

8.14.3 A letter outlining the recommendation to the Council of Governors for the removal from office

8.15 Upon receipt of such notice under 8.14.2 or 8.14.3, the Governor has 28 days to provide written representations as to:

8.15.1 which, if any, allegations he/she accepts or denies and, if the latter, his or her reasons together with supporting evidence;

8.15.2 whether he/she agrees or disagrees with the proposed action and, if the latter, his or her reasons together with any applicable supporting evidence.

8.16 Upon receipt of a Governor's representations in accordance with paragraph 8.15, the Chairman with the Company Secretary shall have 28 days within which to serve the Governor with a response which may confirm that all/some allegations are upheld or that the proposed action is/are no longer being pursued by the Trust.

8.17 Following service of representations in accordance with paragraphs 8.15 and 8.16, where there is a dispute as to the allegations against a Governor and the proposed action is for removal, an independent assessor agreeable to both the Trust and Governor should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.

8.18 The independent assessor will be sought from a panel of Chairpersons and Company Secretaries in the North West. The independent assessors decision will be final.

8.19 Following service of representations in accordance with paragraph 8.15 and any report from an independent assessor appointed in accordance with paragraph 8.18, the following documents will be presented to the Council of Governors:

8.19.1 Notice in accordance with paragraph 8.13;

8.19.2 Representations received in accordance with paragraph 8.15;

8.19.3 Response received in accordance with paragraph 8.16; and

8.19.4 Any report received in accordance with paragraph 8.18.

8.20 Whereupon the Council of Governors will decide whether the Governor should be removed by a resolution approved by not less than three-quarters of the remaining Governors present and voting.

8.21 The vote in these circumstances will be by secret ballot and for purposes of clarity the Chairman will be included and have a casting vote as required. The outcome of the vote will be applied with immediate effect.

8.23 A Governor whose tenure of office is terminated under paragraph above shall not be eligible to be re-appointed by the Trust.

Communication

8.24 Upon effective resignation by a Governor or a Council of Governors' final decision to remove a Governor, the Trust will arrange for members and the Board of Directors to be advised of the resignation/removal by the Chairman with the Company Secretary.

Vacancies amongst Governors

9. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

10. Where the vacancy arises amongst the Appointed Governors, the Company Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

11. Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

11.1 to call an election within three months to fill the seat for the remainder of that term of office; or

11.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office. Should that candidate decline, the Council of Governors shall be at liberty to approach each of the remaining next highest polling candidates in order until the seat is filled in accordance with this paragraph, failing which the options referred to in paragraphs 11.1 and 11.3 of this Annex shall be available to the Council of Governors; or

11.3 if the unexpired period of the term of office is less than six months, to leave the seat vacant until the next elections are held.

ANNEX 6 - ADDITIONAL PROVISIONS – BOARD OF DIRECTORS

(Paragraphs 21.2, 22.3 and 25)

Appointment and Removal of Chair and other Non-executive Directors

1. Non-executive Directors are to be appointed by the Council of Governors using the following procedure.

   1.1 The Council of Governors will maintain a policy for the composition of the non-executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

   1.2 The Board of Directors may work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive Directors.

   1.3 Appropriate candidates will be identified by a Nominations Committee through a process of open competition, which takes account of the policy maintained by the Council of Governors and the skills and experience required, referred to in paragraphs 1.1 and 1.2 above.

   1.4 The Nominations Committee will comprise the Chair of the Foundation Trust (or, when a Chair is being appointed, the Deputy Chair unless they are standing for appointment, in which case another non-executive Director), three elected Public Governors, one elected Staff Governor and one Appointed Governor. The Nominations Committee will be advised by an independent assessor, who may be a chair of another Foundation Trust. The Chief Executive will be entitled to attend meetings of the Nominations Committee unless the Committee decides otherwise and the Committee shall take into account the Chief Executive's views.

2. The removal of the Chair or another non-executive Director shall be in accordance with the following procedures.

   2.1 Any proposal for removal must be proposed by a Governor and seconded by not less than ten Governors including at least two Elected Governors and two Appointed Governors.

   2.2 Written reasons for the proposal shall be provided to the non-executive Director in question, who shall be given the opportunity to respond to such reasons.

   2.3 In making any decision to remove a non-executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chair.

   2.4 If any proposal to remove a non-executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put

forward to remove such non-executive Director based upon the same reasons within twelve (12) months of that meeting.

Further provisions as to disqualification of Directors

3. Paragraph 4 of this Annex applies in addition to the grounds set out at paragraph 25 of the constitution.

4. A person may not become or continue as a Director of the Foundation Trust if:

4.1 he is a member of the Council of Governors or a Governor or Director of an NHS body;

4.2 he is an employee or appointed official of Local Healthwatch;

4.3 he is the spouse, Partner, parent or child of a member of the Board of Directors of the Foundation Trust;

4.4 he is a member of a local authority's Scrutiny Committee covering health matters;

4.5 he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

4.6 he is a person whose tenure of office as a Chair or as a member or Director of an NHS body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

4.7 he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

4.8 in the case of a non-executive Director, he has refused without reasonable cause to fulfill any training requirement established by the Board of Directors; or

4.9 he has refused to sign and deliver to the Company Secretary a statement in the form required by the Board of Directors confirming acceptance of the Code of Conduct for Directors.

4.10 he fails to disclose any direct or indirect pecuniary or non-pecuniary interest required to be disclosed under this constitution and is required to permanently vacate his office by a majority of the remaining Directors and (in the case of a non-executive Director) by three quarters of the Council of Governors.

Expenses

5. The Foundation Trust may reimburse executive Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the remuneration committee of non-executive Directors decides. These are to be disclosed in the annual report.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 15)

Contents

Interpretation

1.1. Save as permitted by law, the Chair of the Foundation Trust shall be the final authority on the interpretation of Standing Orders (on which he shall be advised by the Chief Executive and Director of Finance).

1.2. Any expression to which a meaning is given in the National Health Service Act 2006 shall have the same meaning in this interpretation and in addition:

"Board" shall mean the Chair of the Foundation Trust and non-executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the Remuneration and Appointments Committee of the Board.

"Chair" is the person appointed by the Council of Governors in accordance with paragraph 22 of this constitution. The expression –the Chair‖ shall be deemed to include the non-executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent or is otherwise unavailable (the Deputy Chair) and any other non-executive Director appointed to take on the duties of Chair in the absence of the Deputy Chair. The expression –the Chair‖ shall also, for the purpose of these Standing Orders, be deemed to include the Lead Governor for so long as the Lead Governor chairs a meeting of the Council in accordance with standing order 3.3 of these Standing Orders.

"Chief Executive" shall mean the chief officer of the Foundation Trust.

"Committee" shall mean a committee appointed by the Council of Governors.

"Committee members" shall be persons formally appointed by the Council of Governors to sit on or to chair specific committees.

"Company Secretary" shall mean the person appointed by the Board to ensure the Foundation Trust complies with relevant legislation and to establish procedures for the sound governance of the Foundation Trust.

"Director" shall mean a person appointed to the Board of Directors in accordance with the Foundation Trust's constitution and includes the Chair of the Foundation Trust.

"Foundation Trust" means the Wirral University Teaching Hospital NHS Foundation Trust.

"Lead Governor" means the person appointed by the Council of Governors in accordance with Annex 5 paragraph 4 of the constitution to be Lead Governor of the Council of Governors.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Officer" means an employee of the Foundation Trust.

2. General Information

2.1. The purpose of the Council of Governors Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations. The Council shall at all times seek to comply with the Foundation Trust's Code of Conduct for Governors.

2.2. All business shall be conducted in the name of the Foundation Trust.

2.3. The Board of Directors shall appoint Foundation Trustees to administer separately charitable funds received by the Foundation Trust and for which they are accountable to the Charity Commission.

2.4. A Governor who has acted honestly and in good faith will not have to meet out of his own personal resources any personal civil liability which is incurred in the execution or purported execution of his functions as a Governor save where the Governor has acted recklessly. Any costs arising in this way will be met by the Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for the benefit of members of the Council of Governors.

3. Composition of the Council of Governors

3.1. The composition of the Council of Governors shall be in accordance with paragraph 9 and Annex 3 of the Foundation Trust's Constitution.

3.2. **Appointment and Removal of the Chair, Deputy Chair and Lead Governor of the Council of Governors -** These appointments shall be made by the Governors in accordance with paragraphs 22 and 23 and Annex 5 paragraph 4 of the Foundation Trust's constitution.

3.3. **Duties of Deputy Chair and Lead Governor** – For the purpose of these Standing Orders and meetings of the Council of Governors, where the Chair of the Foundation Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Deputy Chair of the Foundation Trust or, in the event that the Deputy Chair has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Deputy Chair owing to illness, absence from England and Wales or any other cause, to the non-executive Director appointed to take on the duties of Chair in the absence of the Deputy Chair. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, the Lead Governor appointed by the Council of Governors will chair that part of the meeting.

4. Meetings of the Council of Governors

4.1. Meetings held in Public

4.1.1 As stipulated by paragraph 14.2 of the constitution, meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds.

4.1.2 However, the Chair may exclude any member of the public from the meeting of the Council if he considers that he is interfering with or preventing proper conduct of the meeting or for other special reasons pursuant to paragraph 14.2 of the constitution.

4.1.3 Meetings of the Council of Governors shall be held at least three times in each financial year at such times and places that the Council of Governors may determine.

4.1.4 Without prejudice to the power of paragraph 14.3 of the constitution to require one or more Directors of the Foundation Trust to attend a meeting of the Council of Governors so that it may obtain information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and decide whether to propose a vote on the Foundation Trust's or Directors' performance), the Council may invite the Chief Executive, other appropriate Directors or other officers of the Foundation Trust to attend any meeting of the Council to enable Governors to raise questions about the Foundation Trust's affairs. The Council may also invite a representative of the auditor or any of the other Foundation Trust's advisors, to attend a meeting of the Council.

4.2 Calling Meetings

4.2.1 Notwithstanding standing order 4.1.3 above, the Company Secretary or the Chair may call a meeting of the Council of Governors at any time.

4.2.2 Ten Governors (including at least two Elected Governors and two Appointed Governors) may call a meeting of the Council of Governors at any time by giving written notice to the Company Secretary specifying the business to be carried out. On receipt of such a request by ten Governors, the Company Secretary shall send a written notice to all Governors and shall, save in the case of emergencies or the need to conduct urgent business, call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Company Secretary

fails to call such a meeting, then the ten Governors shall call such a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council of Governors, a written notice of the meeting, specifying the date and place of the meeting, shall be delivered by the Company Secretary to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him at least fourteen clear days before the meeting. Lack of service of the notice on any Governor shall not affect the validity of a meeting, subject to paragraph 4.3.4 below. Notice of the meeting shall also be published on the Foundation Trust's website.

4.3.2 Notwithstanding the above requirement for notice, the Company Secretary or the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business.

4.3.3 In the case of a meeting called by the Company Secretary at the request of ten Governors or in the case of a meeting called by ten Governors in default of the Company Secretary, no business shall be transacted at the meeting other than that specified in the notice.

4.3.4 Subject to paragraph 4.3.2, failure to serve notice on more than three quarters of Governors will invalidate any meeting. A notice will be presumed to have been served 72 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 72 hours after it was sent.

4.4 Setting the Agenda

4.4.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.4.2 Save for in the case of a meeting called by the Company Secretary at the request of ten Governors and in the case of a meeting called by ten Governors, a Governor desiring a matter to be included on an agenda shall make his request in writing to the Company Secretary at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Company Secretary or the Chair.

4.4.3 The Company Secretary shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2

above, are delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him/her at least five clear days before the meeting. For the avoidance of doubt, the final agenda and/or supporting papers may be delivered using electronic communications in accordance with paragraph 43.1 of the constitution.

4.5 **Chair of Meeting**

At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting or the Council of Governors is meeting to appoint or remove the Chair or decide his remuneration and allowances and other terms and conditions of office, the Deputy Chair shall preside. If the Deputy Chair is absent from the meeting, or the Council of Governors is meeting to appoint or remove the Deputy Chair or decide his remuneration and allowances and other terms and conditions of office, the Non-Executive Director appointed to take on the duties of Chair in the absence of the Deputy Chair shall preside. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, the Lead Governor appointed by the Council of Governors will chair that part of the meeting.

4.6 **Notices of Motions**

4.6.1 A Governor of the Foundation Trust desiring to move or amend a motion shall send a written notice thereof at least two clear days before the meeting to the Company Secretary, who shall insert this in the agenda for the meeting. All notices so received are subject to the notice given being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to section 4.3.3 of these Standing Orders.

4.6.2 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governors who gave it and also the signature of four other Governors. When any such motion has been disposed of by the Assembly it shall not be competent for any Governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

4.6.4 The mover of a motion shall have a right of reply at the close of

any discussion on the motion or any amendment thereto.

4.6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

(a) An amendment to the motion.

(b) The adjournment of the discussion or the meeting.

(c) The appointment of an ad hoc committee to deal with a specific item of business.

(d) That the meeting proceed to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

4.7 Attendance at Meetings

4.7.1 The Council of Governors may in exceptional circumstances agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.7.2 Governors who are unable to attend a meeting should advise the Company Secretary in advance of the meeting so that their apologies may be submitted.

4.8 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.9 Voting

4.9.1 Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting, save that the removal of the Chair or another Non-Executive Director from office shall require the approval of three-quarters of the members of the Council of Governors. In the case of any equality of votes, the person presiding shall have a second or casting vote. However,

no resolution shall be passed if it is opposed by all of the Public Governors present.

4.9.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

4.9.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.9.4 If a Governor so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.9.5 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.9.6 An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Company Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a member of the Foundation Trust. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors and every agenda for meetings of the Council of Governors shall draw this to the attention of the Governors.

4.9.7 The result of any vote shall be included in the minutes of the meeting and the minutes will be conclusive evidence of the result of the vote.

4.10 Suspension of Standing Orders

4.10.1 Except where this would contravene any statutory provision or a direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of members of the Council are present and that a majority of those present vote in favour of suspension.

4.10.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.10.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.10.4 No formal business may be transacted while Standing Orders are

suspended.

4.10.5 The Foundation Trust's Audit Committee shall review every decision to suspend Standing Orders.

4.11 Variation and Amendment of Standing Orders

These Standing Orders may be amended in accordance with the provisions of paragraph 38 of the Foundation Trust's constitution only if

4.11.1 notice of a motion to amend the Standing Orders has been given; and

4.11.2 the variation/amendment proposed does not contravene a statutory provision or a direction made by the Secretary of State

4.12 Record of Attendance

The names of the Governors present at the meeting shall be recorded in the minutes.

4.13 Minutes

4.13.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.13.3 Minutes shall be circulated in accordance with the Governors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded in accordance with stranding order 4.1.1 of these Standing Orders.

4.14 Quorum

4.14.1 No business shall be transacted at a meeting of the Council of Governors unless at least eight Governors, including not less than five Public Governors are present.

4.14.2 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and notice

of the adjourned meeting shall be circulated to members of the Council of Governors. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum.

4.14.3 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. Arrangements for the Exercise of Functions by Delegation

5.1 **Emergency Powers** - The powers which the Council of Governors has retained to itself within these Standing Orders may in an emergency be exercised by the Chair after having consulted at least five elected Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council for ratification.

5.2 **Delegation of duties** – The Council of Governors may delegate duties to an individual Governor, committee or sub-committee but only under a clear remit approved by the Council.

5.3 **Delegation of powers** - The Council may not delegate any of its powers to an individual Governor, committee or sub-committee.

5.4 **Committees** – The Council of Governors may appoint committees consisting of its members, Directors and other persons to assist it in carrying out its functions. The Council may, through the Company Secretary, request that advisors assist it or any committee it appoints in carrying out their duties. These Standing Orders shall, so far as they are applicable, apply, with appropriate alteration, to meetings of any committees established by the Council.

5.5 Each such committee shall have such terms of reference and be subject to such conditions, as the Council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders. The Council shall approve the membership of all committees that it formally constitutes and shall determine the Chair of each such committee.

6. Confidentiality

A member of the Council of Governors or any committee appointed by the Council shall not disclose a matter dealt with by, or brought before, the Council of Governors or the committee as the case may be, without its permission, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee resolves that it is confidential.

7. Declaration of Interests and Register of Interests

7.1 Declaration of Interests

Governors are required to comply with the Foundation Trust's Standards of Business Conduct and to declare interests that are relevant and material to the Council. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.1 Interests regarded as "relevant and material" include any of the following, held by a Governor, or the spouse or Partner of a Governor:

a. Directorships, including non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).

b. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

c. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS

d. A position of authority in a charity or Voluntary Organisation in the field of health and social care.

e. Any connection with a voluntary or other organization contracting for NHS service

f. private practice

g. other employment including agency/locum cover for another organization other than WUTH

h. care provided to patients where their care is funded by the NHS but the income is not received by the Trust

7.1.2 Interests which shall not be treated as -relevant and material‖ are:

a. Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

b. An employment contract with the Foundation Trust held by a Staff Governor.

c. An employment contract with a local authority held by a Local Authority Governor.

d. An employment contract with or other position of authority within an Appointing Organisation held by an Appointed Governor.

7.1.3 If a Governor has any doubt about the relevance of an interest, he should discuss it with the Chair who shall advise him whether or not to disclose the interest.

7.1.4 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes and entered on a Register of Interests of Governors to be maintained by the Company Secretary. Any changes in interests should be declared at the next Council meeting following the change occurring.

7.1.5 During the course of a Council meeting, if a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. He shall not be entitled to vote on the issue in respect of which the conflict of interest has been established (and if by inadvertence they do remain and vote, their vote shall not be counted).

7.1.6 Any Governor who fails to disclose any interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors in accordance with Annex 5 of the constitution.

7.2 **Register of Interests**

7.2.1 The Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

7.2.2 Details of the Register will be kept up to date and reviewed annually.

7.2.3 The Register will be available to the public.

8. Compliance - Other Matters

8.1 All Governors shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Foundation Trust.

8.2 All Governors shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Foundation Trust.

8.3 All Governors shall comply with the Foundation Trust's Code of Conduct for Governors as amended from time to time.

8.4 All Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life: -

Selflessness;

Integrity;

Objectivity;

Accountability;

Openness;

Honesty, and

Leadership.

9. Resolution of Disputes with Board of Directors

9.1. Should a dispute arise between the Council and the Board of Directors, then the disputes resolution procedure set out below shall be followed.

9.2. The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

9.3. Failing resolution under 9.2 above, then the Board or the Council, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

9.4. The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board or Council as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

9.5. The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 9.2 above shall be repeated.

9.6. If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 9.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as

the case may be, there is no prospect of a resolution (partial or otherwise) then he shall advise the Council and Board accordingly.

9.7. On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

9.8. On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

9.9. Nothing in this procedure shall prevent the Council, if it so desires, from informing NHSI that, in the Council's opinion, the Board has not responded constructively to concerns of the Council that the Foundation Trust is not meeting the terms of its constitution or failed to comply with the NHS Act 2006.

10. Validity of actions

No defect or deficiency in the appointment or composition of the Council of Governors shall affect the validity of any action taken by the Council of Governors.

11. Council Performance

The Chair shall, at least annually, lead a performance assessment process for the Council to enable the Council to review its roles, structure and composition, and procedures, taking into account emerging best practice.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 27)

Contents

9. Compliance - Other Matters

10. Resolution of Disputes with Council of Governors

11. Notification to the Council of Governors

12. Validity of actions

13. Board Performance

1. Interpretation

1.1. Save as permitted by law, the Chair of the Foundation Trust shall be the final authority on the interpretation of Standing Orders (on which s/he shall be advised by the Chief Executive and Director of Finance).

1.2. Any expression to which a meaning is given in the National Health Services Act 2006 shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Foundation Trust it shall be the Chief Executive.

"Board" shall mean the Chair of the Foundation Trust and non-executive Directors, appointed by the Council of Governors, and the executive Directors appointed by the Appointments Committee of the Board.

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust.

"Chair" is the person appointed by the Council of Governors in accordance with paragraph 22 of the Constitution. The expression –the Chair‖ shall be deemed to include the Deputy Chair or otherwise a non-executive Director appointed by the Board to preside for the time being over its meetings.

"Chief Executive" shall mean the chief officer of the Foundation Trust.

"Committee" shall mean a committee appointed by the Board.

"Committee members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Company Secretary" shall mean the person appointed by the Board of Directors to ensure the Foundation Trust complies with relevant legislation and to establish procedures for the sound governance of the Foundation Trust.

"Director" shall mean a person appointed to the Board of Directors in accordance with the Foundation Trust's Constitution and includes the Chair.

"Foundation Trust" means the Wirral University Teaching Hospital NHS Foundation Trust.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated Officer" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

"Officer" means an employee of the Foundation Trust.

2. General Information

2.1. The purpose of the Board Standing Orders is to ensure that the highest standards of corporate governance are achieved in the Board and throughout the organisation. The Board shall at all times seek to comply with the Foundation Trust's Code of Conduct for Directors.

2.2. All business shall be conducted in the name of the Foundation Trust.

2.3. The Directors shall appoint Foundation Trustees to administer separately charitable funds received by the Foundation Trust and for which they are accountable to the Charity Commission.

2.4. A Director who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director save where the Director has acted recklessly. Any costs arising in this way will be met by the Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for the benefit of members of the Board.

3. Composition of the Board

3.1. The composition of the Board shall be in accordance with paragraph 20 of the Foundation Trust's constitution.

3.2. **Appointment and Removal of the Chair and Non-Executive Directors** - The Chair and non-executive Directors are appointed/removed by the Council of Governors in accordance with the Foundation Trust's Constitution.

3.3. **Appointment and Removal of the Executive Directors** – The Appointments Committee of the Board (excluding the Chief Executive) shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors). The Remuneration and Appointments Committee of the Board (inclusive of the Chief Executive) shall appoint or remove the other executive Directors.

3.4. **Appointment and Removal of Deputy Chair** – For the purpose of enabling the proceedings of the Foundation Trust to be conducted in the absence of the Chair, the Council of Governors of the Foundation Trust will appoint one of the non-executive Directors to be the Deputy Chair.

3.5. **Powers of Deputy Chair** - Where the Chair of the Foundation Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair or, in the event that the Deputy Chair has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Deputy Chair owing to illness, absence from England and Wales or any other cause, to the non-executive Director appointed to take on duties of Chair in the absence of the Deputy Chair.

3.6. **Joint Directors** - Where more than one person is appointed jointly to a post in the Foundation Trust which qualifies the holder for executive Directorship or in relation to which an executive Director is to be appointed, those persons shall become appointed as an executive Director jointly, and shall count as one person.

3.7. Non-executive Directors may seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective one by the majority of non-executive Directors.

4. Meetings of the Board

4.1. Meetings held in Public

4.1.1. Meetings of the Board must be open to the public, unless the Board in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial confidentiality or on other proper grounds.

4.1.2. The Chair may exclude any member of the public from the meeting of the Board if he considers that he is interfering with or preventing proper conduct of the meeting.

4.1.3. Meetings of the Board shall be held at least three times in each financial year at such times and places that the Board may determine.

4.1.4. The Board shall arrange for an annual public meeting to be held within 9 months of the end of each financial year. The registers and documents set out in paragraphs 30 and 33 of this constitution shall be available for inspection at the meeting subject to the provisions of paragraph 32.2 of the constitution.

4.2. **Calling Meetings**

4.2.1. Notwithstanding paragraph 4.1.3 above, the Company Secretary or the Chair may call a meeting of the Board at any time.

4.2.2. Four Directors may call a meeting of the Board at any time by giving written notice to the Company Secretary specifying the business to be carried out. On receipt of such a request by four Directors, the Company Secretary shall send a written notice to all Directors and shall, save in the case of emergencies or the need to conduct urgent business, call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Company Secretary fails to call such a meeting, then the four Directors shall call such a meeting.

4.3. **Notice of Meetings**

4.3.1. Before each meeting of the Board, a written notice of the meeting, specifying the date and place of the meeting, shall be delivered by the Company Secretary to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least fourteen clear days before the meeting. Lack of service of the notice on any Director shall not affect the validity of a meeting, subject to paragraph 4.3.4 below. Notice of the meeting shall also be published on the Foundation Trust's website.

4.3.2. Notwithstanding the above requirement for notice, the Company Secretary or the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business or on written receipt of the agreement of at least two-thirds of Directors (executive and non-executive Directors taken together) but to include a minimum of two executive Directors and two non-executive Directors.

4.3.3. In the case of a meeting called by the Company Secretary at the request of four Directors or in the case of a meeting called by four Directors in default of the Company Secretary, no business shall be transacted at the meeting other than that specified in the notice.

4.3.4. Subject to paragraph 4.3.2, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 72 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 72 hours after it was sent.

4.4. **Setting the Agenda**

4.4.1. The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

4.4.2. Save for in the case of a meeting called by the Company Secretary at the request of four Directors and in the case of a meeting called by four Directors, a Director desiring a matter to be included on an agenda shall make her request in writing to the Company Secretary at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Company Secretary or the Chair.

4.4.3. The Company Secretary shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2 above, are delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least five clear days before the meeting. Copies of the final agenda must be delivered or sent to the Council of Governors at the same time. For the avoidance of doubt, the final agenda and/or supporting papers may be delivered using electronic communications in accordance with paragraph 43.1 of the constitution.

4.5. **Chair of Meeting**

At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair appointed by the Council of Governors to take on the Chair's duties shall preside. Otherwise, such non-executive Director as the Directors present shall choose shall preside.

4.6. **Notices of Motions**

4.6.1. A Director of the Foundation Trust desiring to move or amend a motion shall send a written notice thereof at least two clear days before the meeting to the Company Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to paragraph 4.3.3 above.

4.6.2. A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3. Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Directors who gave it and also the signature of four other Directors. When any such motion has been disposed of by the Board it shall not be competent for any Director, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if s/he considers it appropriate.

4.6.4. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5. When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(a) An amendment to the motion.

(b) The adjournment of the discussion or the meeting.

(c) The appointment of an ad hoc committee to deal with a specific item of business.

(d) That the meeting proceed to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate.

4.7. Attendance at Meetings

4.7.1. The Board of Directors may in exceptional circumstances agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.7.2. Directors who are unable to attend a meeting should advise the Company Secretary in advance of the meeting so that their apologies may be submitted.

4.8. Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the

Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.9. **Voting**

4.9.1. Decisions at meetings shall be determined by a majority of the votes of the Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote. However, no resolution shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

4.9.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.9.3. If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.9.4. If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.9.5. In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.9.6. An Officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An Officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.10. **Joint Directors**

Where an executive Director post is shared by more than one person:

(a) each person shall be entitled to attend meetings of the Board;

(b) in the case of agreement between them, they shall be eligible to have one vote between them;

(c) in the case of disagreement between them, no vote should be cast;

(d) the presence of those persons shall count as one person.

4.11. **Suspension of Standing Orders**

4.11.1. Except where this would contravene any statutory provision or direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including two executive Directors and two non-executive Directors, and that a majority of those present vote in favour of suspension.

4.11.2. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.11.3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.11.4. No formal business may be transacted while Standing Orders are suspended.

4.11.5. The Audit Committee shall review every decision to suspend Standing Orders.

4.12. **Variation and Amendment of Standing Orders**

4.12.1. These Standing Orders may be amended in accordance with the provisions of paragraph 40 of the Foundation Trust's constitution only if:

4.12.2. notice of a motion to amend the Standing Orders has been given; and

4.12.3. no fewer than two-thirds of the number of members of the Board approve the variation/amendment; and

4.12.4. the variation/amendment proposed does not contravene a statutory provision or a direction made by the Secretary of State.

4.13. **Record of Attendance**

The names of the Directors present at the meeting shall be recorded in the minutes.

4.14. **Minutes**

4.14.1. The minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.14.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.14.3. Unapproved minutes shall be circulated to the Council of Governors as soon as practicable after each meeting of the Board. Once agreed, minutes shall be circulated in accordance with Directors' wishes. The minutes shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of standing order 4.1 of these Standing Orders.

4.15. **Quorum**

4.15.1. No business shall be transacted at a meeting of the Board unless at least six Directors are present including at least three executive Directors (one of whom must be the Chief Executive or another executive Director nominated by the Chief Executive) and at least three non-executive Directors (one of whom must be the Chair or the Deputy Chair).

4.15.2. An Officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

4.15.3. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Board determine and notice of the adjourned meeting shall be circulated to members of the Board. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Directors present during the meeting is to be a quorum.

4.15.4. If a Director has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest s/he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. Arrangements for the Exercise of Functions by Delegation

5.1. Subject to the requirements of any statutory provision or any direction made by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Foundation Trust, of any of its functions by a committee or sub-committee, or by a Director or an Officer of the Foundation Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2. **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

5.3. **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

5.4. **Delegation to Officers** - Those functions of the Foundation Trust, which have not been retained as reserved by the Board or delegated to one of its Committees, shall be exercised on behalf of the Board by the Chief Executive. He shall determine which functions he will perform personally and shall nominate Officers to undertake remaining functions but still retain accountability for these to the Board.

5.5. The Chief Executive shall prepare a Scheme of Delegation identifying his proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board as indicated above.

5.6. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the executive Directors to provide information and advise the Board in accordance with any statutory requirements.

6. Committees

6.1. Appointment of Committees

6.1.1. The Board may appoint committees of the Board, consisting wholly or partly of Directors of the Foundation Trust or wholly of persons who are not Directors of the Foundation Trust.

6.1.2. A committee so appointed may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Foundation Trust) or wholly of persons who are not members of the committee (whether or not they include Directors of the Foundation Trust).

6.1.3. The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board.

6.1.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide from time to time following reviews of the terms of reference, powers and conditions. Such terms of reference shall have effect as if incorporated into these Standing Orders.

6.1.5. Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

6.1.6. The Board shall approve the appointments to each of the committees that it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

6.1.7. Where the Foundation Trust is required to appoint persons to a committee, which is to operate independently of the Foundation Trust, such appointment shall be approved by the Board.

6.2. Confidentiality

6.2.1. A member of the Board shall not disclose a matter dealt with by, or brought before, the Board without its permission.

6.2.2. A member of a committee of the Board shall not disclose any matter dealt with by, or brought before, the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

7. Declaration of Interests and Register of Interests

7.1. Declaration of Interests

7.1.1. Directors are required to comply with the Foundation Trust's Standards of Business Conduct and to declare the nature and extent of any actual or potential interest and/or any direct or indirect interest (including but not limited to those set out below) held by a Director, their Spouse or Partner, or a family member (or any member of the Partner's family). All Directors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.2. The following interests must be declared if held by a Director, or the spouse or Partner of a Director:

a) Directorships, including non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).

b. Ownership or part-ownership of private companies,

businesses or consultancies likely or possibly seeking to do business with the NHS

c. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS

d. A position of authority in a charity or Voluntary Organisation in the field of health and social care.

e. Any connection with a voluntary or other organization contracting for NHS service

f. private practice

g. other employment including agency/locum cover for another organization other than WUTH

h. care provided to patients where their care is funded by the NHS but the income is not received by the Trust

7.1.3. These Standing Orders do not require a declaration of interest of which a Director is not aware or where the Director is not aware of the transaction or arrangement in question.

7.1.4. A Director need not declare an interest:

a) If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
b) If, or to the extent that, the Directors are already aware of it;
c) If, or to the extent that, it concerns the terms of the Director's appointment that have been or are to be considered:
   i. By a meeting of the Board of Directors; or
   ii. By a committee of the Directors appointed for the purpose under the constitution.

7.1.5. If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

7.1.6. At the time Directors' interests are declared, they should be recorded in the Board minutes and entered on a Register of Interests of Directors to be maintained by the Company Secretary. Any changes in interests should be declared at the next Board meeting following the change occurring.

7.1.7. Board members' Directorships of companies likely or possibly seeking to do business with the Foundation Trust should be published in the Foundation Trust's annual report.

7.1.8. During the course of a Board meeting, if a conflict of interest is established in accordance with this Standing Order, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. He shall not be entitled to vote on the issue in respect of which the conflict of interest has been established (and if by inadvertence they do remain and vote, their vote shall not be counted).

7.1.9. Any Director who fails to disclose any interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Directors and (in the case of a Non-Executive Director) by three quarters of the Council of Governors) in accordance with Annex 6.

7.2. **Register of Interests**

7.2.1. The Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all Directorships and other interests that have been declared by both executive and non-executive Directors.

7.2.2. Details of the Register will be kept up to date and reviewed annually.

7.2.3. The Register will be available to the public.

8. Disability of Directors in Proceedings on Account of Pecuniary Interest

8.1. Subject to the following provisions of this Standing Order, if the Chair or a Director of the Foundation Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2. The Board shall exclude the Chair or a Director from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

8.3. The Board, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board that, in the interests of the National Health Service, the disability shall be removed. Such action shall have the support of at least two-thirds of the Directors present at the meeting (including two executive and two non-executive Directors).

8.4. Any remuneration, compensation or allowances payable to a Director of the Foundation Trust by virtue of paragraph 11 of Schedule 4 to the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.5. For the purpose of this Standing Order the Chair or a Director shall be treated, subject to paragraphs 8.3 and 8.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or his nominee is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; **or**

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and

in the case of persons living together the interest of one Partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.6. The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.7. Where the Chair or a Director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to her duty to disclose his/her interest.

8.8. This Standing Order applies to a committee or sub-committee of the Board as it applies to the Board and applies to any member of any such committee or sub-committee (whether or not he is also a Director of the Foundation Trust) as it applies to a Director of the Foundation Trust.

9. Compliance - Other Matters

9.1. All Directors of the Foundation Trust shall comply with the Standards of Business Conduct set by the Board for the guidance of all staff employed by the Foundation Trust.

9.2. All Directors of the Foundation Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board.

9.3. All Directors shall comply with the Foundation Trust's Code of Conduct for Directors as amended from time to time

9.4. All Directors must behave in accordance with the seven Nolan principles of behaviour in Public Life: -

Selflessness;

Integrity;

Objectivity;

Accountability;

Openness;

Honesty; and

Leadership.

10. Resolution of Disputes with Council of Governors

10.1. Should a dispute arise between the Board of Directors and the Council of Governors, then the disputes resolution procedure set out below shall be followed.

10.2. The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3. Failing resolution under 10.2 above, then the Board or the Council, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4. The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and

agenda paper at the next formal meeting of the Board or Council as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5. The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.2 above shall be repeated.

10.6. If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then he shall advise the Council and Board accordingly.

10.7. On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8. On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

10.9. Nothing in this procedure shall prevent the Council, if it so desires, from informing Monitor that, in the Council's opinion, the Board has not responded constructively to concerns of the Council that the Foundation Trust is not meeting the terms of its constitution or failed to comply with the NHS Act 2006.

11. Notification to the Council of Governors

The Board shall notify the Council of Governors of any major changes in the circumstances of the Foundation Trust, which have made or could lead to a substantial change to its financial well-being, healthcare delivery performance, or reputation and standing.

12. Validity of actions

No defect or deficiency in the appointment or composition of the Board of Directors shall affect the validity of any action taken by the Board of Directors.

13. Board Performance

The Chair shall, at least annually, lead a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programs for Directors.

ANNEX 9 – ADDITIONAL PROVISIONS – MEMBERS

(Paragraphs 4 and 8.4)

1. **ELIGIBILITY FOR AND DISQUALIFICATION FROM MEMBERSHIP**

An individual shall not be eligible for Membership of the Trust if:

1.1.1 he is under 11 years of age;

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the Foundation Trust's hospitals or facilities or against any of the Foundation Trust's employees or other persons who exercise functions for the purposes of the Foundation Trust, or against any registered volunteer;

1.1.3 he fails or ceases to fulfill the criteria for Membership of any of the constituencies;

1.1.4 he was formerly employed by the Trust and was dismissed for gross misconduct;

1.1.5 he was formerly employed by the Trust and in the preceding two years was lawfully dismissed other than by reason of redundancy;

1.1.6 he is included on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and their conviction is not spent under the Rehabilitation of Offenders Act 1974; or

1.1.7 he has been identified as a vexatious complainant in the reasonable opinion of the Trust or has been excluded from treatment at any of the Trust's Hospitals due to unacceptable behaviour. The eligibility for membership in such cases shall take into account the views of the Council of Governors.

2. **TERMINATION OF MEMBERSHIP**

2.1 A member shall cease to be a member if:

2.1.1 he resigns by notice to the Company Secretary or Membership Manager;

2.1.2 he dies;

2.1.3 he is expelled from membership under this Constitution;

2.1.4 he ceases to be entitled under this constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Company Secretary or Membership Manager that he no longer wishes to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Council of Governors, he fails to demonstrate that he wishes to continue to be a member of the Foundation Trust.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Company Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members' meetings and vote under this constitution;

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a meeting of the Council of Governors.

3. MEMBERS' MEETINGS

3.1 The Foundation Trust is to hold a members' meeting (called the Annual Members' meeting) within nine months of the end of each financial year.

3.2 All members' meetings other than annual meetings are called special members' meetings.

3.3 Members' meetings are open to the public. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a members' meeting.

3.4 All members' meetings are to be convened by the Company Secretary by order of the Council of Governors.

3.5 The Council of Governors may decide where a members' meeting is to be held and may also for the benefit of members:

3.5.1 arrange for the annual members' meeting to be held in different venues each year; and

3.5.2 make provisions for a members' meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

3.6 At the Annual Members' meeting:

3.6.1 the Board of Directors shall present to the members:

3.6.1.1 the annual accounts;

3.6.1.2 any report of the auditor on the annual accounts;

3.6.1.3 the annual report; and

3.6.1.4 forward planning information for the next Financial Year

3.6.2 the Council of Governors shall present to the members a report on:

3.6.2.1 steps taken 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;

3.6.2.2 the progress of the membership strategy; and

3.6.2.3 any proposed changes to the policy for the composition of the Council of Governors

3.6.3 the results of any election, appointment of any Appointed Governors and the appointment of any non-executive Directors will be announced.

3.7 Notice of a members' meeting is to be given:

3.7.1 by notice to all members;

3.7.2 by notice on the Foundation Trust's website

at least 14 clear days before the date of the meeting.

3.8 The notice must:

3.8.1 be given to the Council of Governors and the Board of Directors, and to the auditor;

3.8.2 state whether the meeting is an annual or special members' meeting;

3.8.3 give the time, date and place of the meeting; and

3.8.4 indicate the business to be dealt with at the meeting.

3.9 Before a members' meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is one member present from each of the Foundation Trust's constituencies as defined under section 4 membership and constituencies.

3.10 The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

3.11 It is the responsibility of the Council of Governors, the Chair of the meeting and the Company Secretary to ensure that at any members' meeting:

3.11.1 the issues to be decided are clearly explained; and

3.11.2 sufficient information is provided to members to enable rational discussion to take place.

3.12 The Chair of the Foundation Trust, or in their absence the Deputy Chair of the Board of Directors, or in their absence the Lead Governor of the Council of Governors, shall act as chair at all members' meetings of the Foundation Trust. If neither the Chair nor the Deputy Chair of the Board of Directors nor the Lead Governor of the Council of Governors is present, the members of the Council of Governors present shall elect one of their number to be Chair and if there is only one Governor present and willing to act they shall be chair.

3.13 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.14 A resolution put to the vote at a members' meeting shall be decided upon by a poll.

3.15 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second and casting vote.

3.16 The result of any vote will be declared by the Chair and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

7. OTHER DISPUTES

7.1 Where an individual is held by the Foundation Trust to be ineligible and/or disqualified from Membership of the Foundation Trust and disputes the Foundation Trust's decision in this respect, the matter shall be referred to the Company Secretary (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

7.1.1 The Company Secretary (or the nominated representative) shall:

7.1.1.1 review the original decision having regard to any representations made by the individual concerned and such other material, if any,

as the Company Secretary considers appropriate;

7.1.1.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which she has considered; and

7.1.1.3 communicate the decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

7.1.2 If the Member is aggrieved of the decision of the Company Secretary pursuant to paragraph 7.1.1 above, he may appeal in writing to the Council of Governors within 14 days of the Company Secretary's decision. The Council of Governors' decision is to be final

Constitution

Version Control

Document History

Date	Version	Changes
1/7/07	Vers 1.0	Final version on date of authorisation
1/12/08	Vers 1.1	Nominations Committee Membership, Insurance arrangements
5/5/09	Vers 1.2	Authority to approve Constitutional amendments passed from Members to Governors.
24/05/10	Vers 1.3	Constitution amendments approved by Assembly of Governors – removal of appendices to Governor and Board of Directors Standing Orders and other amendments.
16/04/12	Vers 1.4	Constitution amendments approved by Assembly of Governors – changes to tenure of Governor to 9 years maximum
27/09/12	Vers. 1.5	Constitution amendments approved by Council of Governors - Changes to title of Assembly and relevant changes re Private Patient Cap
28/11/12	Vers 1.6/1.7	Constitution amendments approved by Board of Directors – changes following review by joint working group (including changes to reflect the Health and Social Care Act 2012, the staff and members constituencies and the composition of the Council of Governors)
12/12/12	Vers 1.6/1.7	Constitution amendments approved by Council of Governors – changes following review by joint working group (including changes to reflect the Health and Social Care Act 2012, the staff and members constituencies and the composition of the Council of Governors)
08/01/13	Vers 1.6/1.7	Constitution amendments approved by the Members – changes following review by joint working group requiring members approval (changes to the staff and members constituencies and changes to the composition of the Council of Governors)
13/6/13	Vers 1.8	Constitution amendments approved by BoD (29.5.13) and CoG (12.6.13) following recommendation by Joint Working Group (inclusion of definition of significant transactions and deletion of two Governor seats appointed by FT Partnership Steering Group)
	Vers 1.9	Constitution amended to include the procedure for removal and disqualification of a Governor under Annex 5. Approved February 15
	Vers 1.10	Constitution amended to align with the Fit and Proper Persons Test, the Standards for Business Conduct Policy and the change from Monitor to NHSI
TBD	Vers 2	Section 3 amended to reflect greater powers for The Trust to enter into arrangements for the carrying out, on such terms as the Trust considers appropriate, of any of its functions jointly with any other person.

Effective Dates (with details of Monitor approval where applicable)

Date	Version	Name	Title
1/7/07	Vers 1.0	Monitor	Independent Regulator
1/12/08	Vers 1.1	Monitor	Independent Regulator
5/5/09	Vers 1.2	Monitor	Independent Regulator
29/10/10	Vers 1.3	Monitor	Independent Regulator
16/04/12	Vers 1.4	Monitor	Independent Regulator
09/10/12	Vers 1.5	Monitor	Independent Regulator
22/01/13	Vers 1.6	Monitor	Independent Regulator

01/04/13	Vers 1.7	N/A	N/A
13/06/13	Vers 1.8	N/A	N/A

Note: from 1 April 2013 Monitor's functions do not include a power or duty to approve amendments to the constitution.

Distribution

Date	Version	Distribution
1/7/07	Vers 1.0	Website / Intranet / Membership Office / Board / Governors / On demand
1/12/08	Vers 1.1	Website / Intranet / Membership Office / Board / Governors / On demand
5/5/09	Vers 1.2	Website / Intranet / Membership Office / Board / Governors / On demand
29/10/10	Vers 1.3	Website / Intranet / Membership Office / Board / Governors / On demand
16/04/12	Vers 1.4	Website / Intranet / Membership Office / Board / Governors / On demand
09/10/12	Vers 1.5	Website / Intranet / Membership Office / On Demand
22/01/13	Vers 1.6	Website / Intranet / Membership Office / On Demand
22/4/13	Vers 1.7	Monitor / Website / Intranet / Membership Office / On Demand
3/7/13	Vers 1.8	Monitor / Website / Intranet / Membership Office / On Demand
02/15	Vers 1.9	Monitor/website/intranet/Membership Office/On Demand
29.03.17	Vers 1.10	NHSI/Website/intranet/Membership Office/On Demand
TBD	Vers 2	Website

Document Owner	Company Secretary

Review Date

Review Date

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 20**

05 March 2025

Title	Annual Review of Corporate Governance Manual
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Ellis, Corporate Governance Manager
Report for	Approval

Executive Summary and Report Recommendations

This report provides the annual review of the Corporate Governance Manual and requests approval following updates being made. The Corporate Governance Manual is reviewed annually with any updates brought to this Committee and then the Board.

Following approval by the Board, the Corporate Governance Manual will be uploaded to the website for transparency purposes.

The Manual has been appended separately to the pack due to size.

It is recommended that the Board of Directors:

- Approve the Corporate Governance Manual, following recommendation from the Audit and Risk Committee.

Key Risks

This report relates to these key risks:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
20 February 2025	Audit and Risk Committee	As above	As above

1	Narrative
1.1	The Corporate Governance Manual is a term used in the NHS to describe a suite of key governing documents, which set out how the organisation is run. This suite of documents is usually updated as each individual element is updated i.e. the Standing Financial Instructions, Terms of Reference. WUTH's Corporate Governance Manual is consists of: • An Introductory Document • The Constitution • The Accountable Officer Memorandum • Standing Financial Instructions • Scheme of Reservation and Delegation • Board Code of Conduct • Governors Code of Conduct • Terms of Reference for the Board, Council of Governors and Committees. Throughout the year several of the documents in the Manual have been updated and the changes are summarised in the table below.

Document	**Comments**
Constitution	Updated section 3 to reflect that WUTH may exercise joint working and joint committee powers under s.65Z6 of the NHS Act. Approved by Council of Governors on 10 February and due for approval at March Board.
Standing Financial Instructions	Updated to incorporate the version approved by Board in December
Scheme of Reservation and Delegation	Updated to reflect the changes to delegated financial limits within the new version of the Standing Financial Instructions
Terms of References	Updated to incorporate the versions approved during 2024

2	Implications
2.1	**Patients** • No direct impact on patients.
2.2	**People** • No direct impact on people.
2.3	**Finance** • No direct impact on finance.

2.4	**Compliance** • This suite of documents is a key part of ensuring the Trust is governed appropriately and supports the requirements of well-led.