WHH Trust Board Meeting Part 1 (Held in Public)

SUPPLEMENTARY PACK

Wednesday 26 January 2022
10.00am -12.00pm
Via MS Teams

TRUST BOARD MEETING PT 1
SUPPLEMENTARY PACK

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/12**			
SUBJECT:	**Scheme of Reservation & Delegation and Standing Financial Instructions Update**			
DATE OF MEETING:	26 January 2022			
AUTHOR(S):	Karen Spencer, Head of Financial Services			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ 		
EXECUTIVE SUMMARY *(KEY ISSUES):*	In November 2020, HM Treasury (HMT) issued a change to the delegated special payment limits, which requires all special payments above £95k within the Department of Health and Social Care (DHSC) group to be submitted to HM Treasury for approval. These changes have been reflected in the Scheme of Reservation & Delegation (SORD) on pages 6, 29 and 30. A review of losses and special payments has taken place and no such payments have been made since the delegated limit changed. As part of this work a general review of the SORD and Standing Financial Instructions (SFIs) has also been undertaken.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the changes.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee		
	Agenda Ref.	AC/21/11/84		
	Date of meeting	18/11/2021		
	Summary of Outcome	Reviewed and supported to be put forward for Board approval.		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Scheme of Reservation & Delegation and Standing Financial Instructions Update	AGENDA REF:	BM/22/01/13

1. BACKGROUND/CONTEXT

The purpose of the report is to provide the Trust Board with details of the proposed changes to the Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs).

2. KEY ELEMENTS

In November 2020, HM Treasury (HMT) issued a change to the delegated special payment limits, which requires all special payments above £95k within the Department of Health and Social Care (DHSC) group to be submitted to HM Treasury for approval. As a result, DHSC has asked that all commissioner and provider organisations provide detail of all such special payments above £95k.

These changes have been reflected in the Scheme of Reservation & Delegation (SORD) on pages 6, 29 and 30.

A review of losses and special payments has taken place and no such payments have been made since the delegated limit changed.

As part of the work performed an overall general review of the SORD and SFIs was undertaken to ensure that it was still current and valid.

The main changes that have occurred are where job titles have changed, the track change function has been used so that the Committee can see the changes.

There is one other change on page 26, which relates to Contract Awards. This has been split between up to £250k and over £250k, to bring it in line with invoice approval limits.

There is one change to the SFIs. This is to reflect the change to the split for technical and service capability from 60/40 to 70/30 which was agreed by Board previously.

3. RECOMMENDATION

The Trust Board is asked to approve the changes.

SCHEME OF RESERVATION AND DELEGATION (SORD)

CONTENTS AND PAGE NUMBER

INTRODUCTION

Reservation of Powers

The Standing Orders provides that "The Board of Directors may delegate any of its powers to a Committee of Directors or to an Executive Director". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust.

PURPOSE AND SCOPE

Reservation of Powers

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to Committees, Sub Committees, individual Directors or Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an Executive Eommittee or Sub-Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying which functions they shall perform personally and which functions have been delegated to other Directors and Officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

Caution over the Use of Delegated Powers

Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director or Officer'sLine Manager unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to themmay be exercised by the nominated Officer(s) acting in their absence after taking appropriate advice if required.

If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Deputy Chief Executive, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

Delegated Executive Lead

The Chief Finance Officer & Deputy CEO has been delegated by the Chief Executive to take the Executive ownership for this procedural document in accordance with standard practice.

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

Accountability

Those matters reserved to the Board of Directors are set out below: Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders (SOs), a schedule of decisions reserved to the Board and Standing Financial Instructions (SFIs) to reflect these;
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to Executives for the main programmes of action and for performance against programmes to be monitored and Senior Executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; and
- establish Audit and Nomination and Remuneration Committee on the basis of formally agreed Terms of Reference that set out the Membership of the Committees, the limit to their powers, and the arrangements for reporting back to the main Board.

General Enabling Provision

The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.

Regulations and Control

The Board of Directors remain accountable for all of its functions, even those delegated to individual Committees, Sub-Committees, Directors or Officers and would therefore expect to receive information about the exercise of delegated

functions to enable it is maintain a monitoring role. The following are decisions reserved to the Board.

- Approval, suspension and variation/amendment of the Trust's Standing Orders (SOs);
- Approval of the Trust's SFIs for the regulation of its proceedings and business;
- Approval of the SoRD of powers;
- Ratification of any urgent decisions taken by the Chair and Chief Executive in accordance with the Standing Orders.
- Requiring and receiving the declaration of Board members' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Approval of arrangements for dealing with complaints.
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree any significant modifications.
- To receive reports from Committees including those required by the Foundation Trust Constitution and NHS Act 2006 or other regulation.
- To receive reports from committees including those which the Foundation Trust is required by regulation to establish and to take appropriate action on other reports as requested..
- To confirm the recommendations of the Foundation Trust's Committees where the Committees do not have Executive powers.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a Corporate Trustee for funds held on Trust.
- To establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailee for patients' property.
- Authorise use of the seal.
- Ratify or otherwise, instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
- Approve a list of employees authorised to draw down loans on behalf of the Foundation Trust.
- Receive of such reports as the Board of Directors sees fit from committees in respect of their exercise of powers delegated.
- Continuous appraisal of the the affairs of the Foundation Trust through receipt of management reports and policy statements;
- Receive reports from the Chief Finance Officer & Deputy CEO on financial performance against the agreed annual financial plan.
- Disciplining Board members or employees who are in breach of Statutory Requirements or Standing Orders.

Appointments/Dismissal

- The appointment and dismissal of Committees that are directly accountable to the Board of Directors.
- The appointment, disciplining and dismissal of Executive Directors.

- Confirm the appointment of members of any Committee of the Foundation Trust as representatives on outside bodies.
- The appointment, appraisal, discipline and dismissal of the Board Secretary.
- Approve proposals received from the Nomination and Remuneration Committee regarding the Chief Executive, Directors and senior employees.

Strategy, Plans and Budgets

- Set the strategic aims and objectives of the Foundation Trust.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any guidance issued by the Secretary of State for Health and Social Care or the Independent Regulator.
- Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk.
- Approve Outline and Final Business Cases for Capital Investment greater than £0.5m (up to the thresholds delegated by NHS England and Improvement (NHSE/I) and the Department of Heatlh)
- Approve revenue and capital budgets.
- Approve annually Foundation Trust's Operational Financial Plan and Financial Strategy
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings
- Approve proposals for capital investment, for example Private Finance Initiaves (PFI) and Local Improvement Finance Trust (LIFT) proposals.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer & Deputy CEO .
- All special payments over £95,000 must be sent to HM Treasury for approval.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or is contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review use of NHS risk pooling schemes and risk management cover.
- Approve the opening of bank accounts.
- Approve individual compensation payments.

Audit Arrangements

- To receive recommendations from the Council of Governors regarding the appointment (and where necessary dismissal) of the external auditors.
- Receive the annual management letter received from the External Auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
- Receive an Annual Report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

Annual Reports and Accounts

- Receipt and approval of the Foundation Trust's Annual Report. Annual Accounts and Quality Account before being laid before Parliament, and presentation to the Governors' Council at a Members' Meeting.

- Receipt and approval of the Annual Report and Accounts for Charitable Funds

DELEGATION OF POWERS

Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and Terms of Reference of such Committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements. Committees may not delegate Executive powers to Sub-Committees unless expressly authorised by the Board.

Delegation to Officers

The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the Foundation Trust as a whole;
- financial systems and procedures promote efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and
- financial considerations are fully taken into account in decisions on Foundation Trust policy proposals.

The specific personal responsibilities of an NHS Foundation Trust Accounting Officer:

- the propriety and regularity of the public finances for which they are answerable;
- the keeping of proper accounts;
- prudent and economical administration;
- the avoidance of waste and extravagance; and
- the efficient and effective use of all the resources in their charge.

The Accounting Officer must:

- personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by NHS Improvement;
- comply with the financial requirements of the Terms of Authorisation;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts;
- ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and

safeguarded with similar care, and with checks as appropriate;
- ensure that any protected property (or interest in) is not disposed of without the consent of NHS Improvement;
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Governors' Council or in the actions or advice of the NHS Foundation Trust staff, including themselves; and
- ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

The Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems have been established.

An Accounting Officer should ensure that managers at all levels:
- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well defined responsibilities for making the best use of resources including a critical scrutiny of output and value for money; and
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

Schedule of Delegation - Appendices

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The 'Delegated to' authority is in accordance with the Standing Orders and Standing Financial Instructions. The 'Operational Responsibility' shown below is the lowest level to which authority is delegated.

Appendix 1 - Table A - Delegated Authority.
Appendix 2 - Table B - Delegated Financial Limits.

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate if the Chief Executive is absent powers delegated to them will automatically transfer to the Deputy Chief Executive.

Chair's Action of Committees of the Board

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

SCHEDULE OF DELEGATED MATTERS

DELEGATED MATTERS

Delegated Matter
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS

TABLE A (SEE APPENDIX 1)

Delegated Matter	Reference No.
AUDIT ARRANGEMENTS	1
AUTHORISATION OF CLINICAL TRIALS	2
AUTHORISATION OF NEW DRUGS	3
BANK/OPG ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
CAPITAL INVESTMENT	5
CLINICAL AUDIT	6
COMMERCIAL SPONSORSHIP	7
COMPLAINTS (PATIENTS & RELATIVES)	8
CONFIDENTIAL INFORMATION	9
DATA PROTECTION ACT	10
DECLARATION OF INTERESTS	11
DISPOSAL AND CONDEMNATIONS	12
ENVIRONMENTAL REGULATIONS	13
EXTERNAL BORROWING	14
FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY	15
FINANCIAL PROCEDURES	16
FIRE PRECAUTIONS	17
FIXED ASSETS	18
FRAUD	19
FUNDS HELD ON TRUST	20
HEALTH & SAFETY	21
HOSPITALITY/ GIFTS	22
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	23
IM&T	24
LEGAL PROCEEDINGS	25
LOSSES, WRITE-OFFS & COMPENSATION	26
MEETINGS	27
MEDICAL	28
NON PAY EXPENDITURE	29
NURSING	30
PATIENTS SERVICES AGREEMENTS	31
PATIENTS' PROPERTY	32
PERSONNEL & PAY	33
QUOTATIONS, TENDERING & CONTRACT PROCEDURES	34
RECORDS	35
REPORTING INCIDENTS TO THE POLICE	36
RISK MANAGEMENT	37
SEAL	38
SECURITY MANAGEMENT	39
SETTING OF FEES & CHARGES	40
STORES AND RECEIPT OF GOODS	41

TABLE B - DELEGATED FINANCIAL LIMITS (SEE APPENDIX 2)

Delegated Limit	Reference No.
Charitable Funds	**1**
Gifts & Hospitality	**2**
Litigation Claims	**3**
Losses and Special Payments	**4**
Petty Cash Disbursements	**5**
Requisitioning Goods And Services	**6**
Non Pay Expenditure	6.1
Agency Staff	6.2
Capital expenditure	6.3
Removal Expenses	6.4
Quotations and Tenders	**7**
Business Case Approval	**8**
Budget Redesignation	**9**

TRAINING

Training to underpin the implementation of the Policy can be found within the trust Training and Development Policy within the Training Needs Analysis.

AUDIT OF THE DOCUMENTED PROCESS OF THE POLICY

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation

DATE AUDIT REGISTERED IN THE AUDIT DEPARTMENT AND BY WHO

SOURCES/ REFERENCES

GLOSSARY OF TERMS

ASSOCIATED DOCUMENTS

APPENDICES

Appendix 1 - Table A - Delegated Authority

If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Standing Orders/Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chair	Chair
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two Non-Executive Directors
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the Chief Finance Officer & Deputy CEO (report to the Audit Committee)	All staff	All staff

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Audit Arrangements**		
a)	Recommendation to the Governors' Council for the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor.	Audit Committee (for recommendation to the Governors' Council for approval).	Chief Finance Officer & Deputy CEO
b)	Monitor and review the effectiveness of the internal audit function.	Audit Committee	Chief Finance Officer & Deputy CEO
c)	Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e)	Ensure provision of a cost-effective internal audit service	Audit Committee	Chief Finance Officer & Deputy CEO
f)	Implement internal audit recommendations	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects**	Chief Executive	Medical Director
3.	**Authorisation of New Drugs**	Chief Executive	Medical Director & Chief Pharmacist
4.	**Bank Accounts/Cash (**Excluding Charitable Fund (Funds Held on Trust) Accounts**)**		
a)	Operation:		
	• Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer & Deputy CEO	Head of Financial Services
	• Opening bank accounts	Chief Finance Officer & Deputy CEO	Head of Financial Services
	• Authorisation of transfers between Foundation Trust bank accounts	Chief Finance Officer & Deputy CEO	To be completed in accordance with bank mandate/internal procedures
	• Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer & Deputy CEO	To be completed in accordance with bank mandate/internal procedures
	• Authorisation of: - - BACS schedules - CHAPS schedules - RFT schedules - FASTER payments - Automated cheque schedules -	Chief Finance Officer & Deputy CEO	To be completed in accordance with bank mandate/internal procedures
b)	Investments:		
	• Investment of surplus funds in accordance with the Foundation Trusts Treasury Management Policy	Chief Finance Officer & Deputy CEO	Head of Financial Services
	• Development of a Treasury Management Policy	Chief Finance Officer & Deputy CEO	Head of Financial Services
c)	Petty Cash	Chief Finance Officer & Deputy CEO	Refer To Table B Delegated Limits
5.	**Capital Investment**		
	• Formulation of a capital investment programme necessary to meet legislative, regulatory, health and safety and service requirements	Chief Executive	Chief Finance Officer & Deputy CEO
	• Approval of emergency requests necessary to meet legislative, regulatory, health and	Chief Executive	Chief Finance Officer & Deputy CEO Deputy Chief Finance Officer

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	service requirements and Covid19 Capital Monitor and report on all capital expenditure including variance to plan	Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO
	• Responsiblility for the management of capital schemes to ensure they are delivered within the timescales and within the resources available.	Chief Executive	Chief Finance Officer & Deputy CEO
	• Ensure that capital investment is not undertaken without the approval of funding necessary to cover the cost	Chief Executive	Chief Finance Officer & Deputy CEO
	• Ensure that there is funding available to cover the revenue consequences of any capital investment	Chief Executive	Deputy Chief Finance Officer
	• Preparation and dissemination of policies and procedures to ensure compliance and adherence to capital accounting and reporting standards and requirements	Chief Finance Officer & Deputy CEO	Refer to Table B (Delegated Limits)
	• Authorisation of capital expenditure requests once the scheme has been approved and funding has been identified.	Chief Executive	Head of Financial Services Chief Finance Officer & Deputy CEO
	• Assess the requirements for the operation of the Construction Industry Taxation (CIS) scheme	Chief Finance Officer & Deputy CEO	
	• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the Standing Orders and Standing Financial Instructions	Chief Executive	
	•		
b)	Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.	Chief Executive	Chief Finance Officer & Deputy CEO
Leases (property and equipment)			
	• Granting and termination of leases with Annual rent < £250k	Chief Executive	Chief Finance Officer & Deputy CEO Chief Executive
	• Granting and termination of leases of > £250k should be reported to the Board of Directors	Board of Directors	
6.	**Clinical Audit**	Chief Executive	Medical Director
7.	**Commercial Sponsorship**		
	• Agreement to proposal	Chief Executive	Executive Directors / Assocate Directors of Operations / Clinical Business Unit Managers / Heads of Department. Approval and registration in line with the Policy on Business Conduct, Hospitality and Sponsorship.
	•		
8.	**Complaints (Patients & Relatives)**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse/Deputy Chief Executive
b)	Responsibility for ensuring complaints relating to a Clinical Business Unit/ department is investigated thoroughly.	Chief Executive	Clinical Business Unit Manager/Lead Nurse/Clinical Director
c)	Medico - Legal Complaints Coordination of their management.	Chief Executive	Chief Nurse/Deputy Chief Executive

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
9.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Medical Director.
	Freedom of Information Act compliance code	Chief Executive	Chief Information Officer
10.	**Data Protection Act**		
a)	Review of Foundation Trust's compliance	Chief Executive	Chief Information Officer
11.	**Declaration of Interest**		
	• Maintaining a register of interests	Chief Executive	Head of Corporate Affairs
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Senior Managers / Consultants
12.	**Disposal and Condemnations**		
	• • Develop and maintain a Disposal and Condemnations Policy • Disposal of Protected Property (as defined in the Terms of Authorisation •	Chief Finance Officer & Deputy CEO Chief Executive (with authorisation of the Independent Regulator)	Head of Financial Services
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Associate Director of Estates and Facilities
14.	**External Borrowing**		
a)	Advise Trust Board of the requirements to repay and draw down Public Dividend Capital.	Chief Finance Officer & Deputy CEO	Head of Financial Services
b)	Approve a list of employees authorised to request short term borrowings on behalf of the Foundation Trust.	Board	Chief Executive
c)	Application for draw down of Public Dividend Capital (PDC)m working capital and capital loans and other forms of external borrowing.	Chief Executive	Chief Finance Officer & Deputy CEO
d)	Preparation of procedural instructions concerning applications for PDC, working capital and capital loans and overdrafts.	Chief Finance Officer & Deputy CEO	Head of Financial Services
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting: • Submit annual capital and revenue budgets to the Trust Board • o Delegate budgets to budget holders	Chief Executive Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO Deputy Chief Finance Officer
b)	Monitor: o Developand maintain systems of budgetary	Chief Finance Officer &	Deputy Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
control.	Deputy CEO	
o Monitor performance against budget	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
o		
o		
o Submit returns in accordance with the Independent Regulator's requirements.	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
o Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Finance Officer & Deputy CEO	All budget holders
Preparation of: • Annual Accounts	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
• Annual Report	Chief Executive	Deputy Chief Executive
c) Budget Responsibilities Ensure that • no overspend or reduction of income that cannot be met from redesignation is incurred without prior consent of Board; • approved budget is not used for any other than specified purpose subject to rules of redesignation; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.	Chief Finance Officer & Deputy CEO	Budget Holders
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
d) Authorisation of Redesignation: Redesignation between different budget holders requires the agreement of both parties.	Chief Executive	Refer To Table B Delegated Limits
16. Financial Procedures and Systems		
a) Maintenance & update on NHS Foundation Trust Financial Procedures	Chief Finance Officer & Deputy CEO	Head of Financial Services
b) Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action. • Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors, Committees, Sub Committees and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
17. Fire precautions • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Associate Director of Estates and Facilities
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Finance Officer & Deputy CEO	Head of Financial Services

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Chief Finance Officer & Deputy CEO	Chief Operating Officer
c) Calculate, account and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Finance Officer & Deputy CEO	Head of Financial Services
d)Responsibility for security of Foundation Trust's assets.	Chief Executive	Associate Director of Estates and Facilities .
19. Fraud (See also 26, 36)		
a) Monitor compliance with Secretary of State directions on anti fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.	Audit Committee	Chief Finance Officer & Deputy CEO.
b) Notify NHS Counter Fraud Authority (NHSCFA). and External Audit of all suspected Frauds	Chief Finance Officer & Deputy CEO	Anti Fraud Specialist .
20. Funds Held on Trust (Charitable and Non Charitable Funds)		
a) Management of funds:: •	Charitable Funds Committee	Head of Financial Planning
b) Maintenance of authorised signatory list of nominated fund holders.	Chief Finance Officer & Deputy CEO	Head of Financial Planning
c) Compliance with expenditure Limits	Chief Finance Officer & Deputy CEO	Refer To Table B Delegated Limits
d) Development of procedures for receiving donations	Chief Finance Officer & Deputy CEO	Head of Financial Planning
e) Dealing with legacies	Director of Community Engagement + Fundraising	Charity Fundraising Manager
f) Fundraising Appeals	Director of Community Engagement +Fundraising	Charity Fundraising Manager
▪ Preparation of budget.	Director of Community Engagement & Fundraising	Fund raising manager for the appeal with advice from Finance. .
▪ Reporting progress and performance against budget.	Chief Finance Officer & Deputy CEO	Head of Financial Planning
g) Operation and management of Bank Accounts: • •	Chief Finance Officer & Deputy CEO	Head of Financial Planning
h) Operation and management of Investments in line with the policy • •	Charitable Funds Committee	Chief Finance Officer & Deputy CEO
i) Regulation of funds in accordance with Charities Commission	Chief Finance Officer & Deputy CEO	Head of Financial Planning
21. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse/Deputy Chief Executive
22. Hospitality/Gifts		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a)	Keeping of hospitality register	Chief Executive	Deputy Chief Executive
b)	Applies to both individual and collective hospitality receipt items. See Appendix B for limits.		All staff declaration required in Foundation Trust's Hospitality Register
23.	**Infectious Diseases & Notifiable Outbreaks**	Chief Executive	Chief Nurse/Deputy Chief Executive
24.	**Information Management & Technology**		
	Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T Strategy. • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested. • Seeking third party assurances regarding financial systems operated externally.	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
	• Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Chief Finance Officer & Deputy CEO	Chief Information Officer
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Chief Finance Officer & Deputy CEO	Chief Information Officer
25.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Executive Directors
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Director
26.	**Losses, Write-off & Compensation**		
a)	<u>Losses</u> Losses of cash due to (a) Theft, Fraud etc (b) Overpayment of salaries (c) Other causes	Chief Executive	Chief Finance Officer & Deputy CEO
	(2) Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer & Deputy CEO Chief Finance Officer & Deputy CEO
	(3) Bad debts and claims abandoned in relation to: (a)Private Patients (b) Overseas visitors (c) Other	Chief Executive	Chief Finance Officer & Deputy CEO
	(4) Damage to buildings, and property inxluding stores losses) due to: (a) Theft, fraud, arson etc (b) Store losses (c) Other	Chief Executive	

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Reviewing appropriate requirement for insurance claims	Chief Finance Officer & Deputy CEO	Head of Financial Services
d) A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer & Deputy CEO	Head of Financial Services
e) A report of all of the above payments should be presented to the Audit Committee	Chief Finance Officer & Deputy CEO	Head of Financial Services
(e)Special Payments Compensation payments by Court Order 5) Compensation payments by Court Order 6) Extra contractual to contractors	Chief Executive	Chief Finance Officer & Deputy CEO Chief Finance Officer & Deputy CEO
(7) Ex gratia Payments in respect of :-	Chief Executive	Chief Finance Officer & Deputy CEO
a) To patients/staff for loss of personal effects		
b) For clinical negligence with legal advice c) For personal injury with legal advice		
• Other clinical negligence and personal injury		
• Other employment payments (not including special severance payments which are disclosed below inheading No. 8 – Special Severance Payments.		
• Patient referrals outside the UK and EEA Guidelines		
• Other ex-gratia payments • (h) Maladministration, no financial loss loss		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
(8) Special Severance Payments		
• Redundancy <£50,000 – approval	Chief Executive	Chief People Officer / Chief Finance Officer & Deputy CEO
Assurance on Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
• Redundancy >£50,000 – approval and Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
• Mutually Agreed Severance Scheme <£50,000 – approval	Chief Executive	Chief People Officer / Chief Finance Officer & Deputy CEO
Assurance on Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
• Mutually Agreed Severance Scheme <£50,000 – approval and Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO Chief People Officer / Chief Finance Officer & Deputy CEO
• Legal Costs related to non contractual employment dispute / or negotiated agreement, with no payment to individual	Chief Executive	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
Assurance on Value for Money	Nomination and Remuneration Committee	Chief People Officer / Chief Finance Officer & Deputy CEO
• Non Contractual payment and Legal costs related to employment dispute / or negotiated agreement <£50,000 – approval	Chief Executive	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
Assurance on Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer & Deputy CEO
• Non Contractual payment and Legal costs related to employment dispute / or negotiated agreement >£50,000 – approval and value for money	Nomination and Remuneration Committee	
(9) Extra statutory and regulatory		
(10) Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Counter Fraud Management Ser4vices of frauds.		
27. Meetings		
a) Calling meetings of the Foundation Trust Board	Chair	Chair
b) Chair all Foundation Trust Board meetings and associated responsibilities	Chair	Chair
28. Medical		
• Clinical Governance arrangements	Medical Director / Chief	Medical Director / Chief Nurse/Deputy

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Nurse/Deputy Chief Executive	Chief Executive
	• Medical Leadership	Medical Director	Medical Director
	• Programmes of Medical Education	Medical Director	Medical Director/Director of Medical Education
	• Medical Staffing Plans	Medical Director	Medical Director
	• Medical Research	Medical Director	Medical Director /
29.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Chief Finance Officer & Deputy CEO
b)	Maximise value for money when requisitioning goods and or/ services	Chief Executive	Chief Finance Officer & Deputy CEO
c)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)	Chief Executive	Chief Finance Officer & Deputy CEO
d)	Develop systems for the payment of accounts	Chief Finance Officer & Deputy CEO	Head of Financial Services
e)	Prompt payment of accounts	Chief Finance Officer & Deputy CEO	Head of Financial Services
f)	Financial Limits for ordering / requisitioning goods and services	Chief Finance Officer & Deputy CEO	Refer To Table B Delegated Limits
g)	Approve prepayment arrangements	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
30.	**Nursing**		
	▪ Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Matters involving individual professional competence of nursing staff.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Compliance with professional training a development of nursing staff.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Quality assurance of nursing processes.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
31.	**Patient Services Agreements**		
a)	Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer & Deputy CEO
b)	Identifyingand monitoring non contract activity (NCA)	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
c)	Reporting actual and forecast income	Chief Executive	Deputy Chief Finance Officer
d)	Costing Foundation Trust Contract and Non Commercial Contracts	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
e)	Reference costing / Payment by Results	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
32.	**Patients' Property** (in conjunction with financial advice)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Nurse/Deputy Chief Executive	Deputy Director Nursing and Patietn ExperienceLead Nurse
b)	Prepare detailed written instructions for the administration of patients' property	Chief Nurse/Deputy Chief Executive	Deputy Director Nursing and Patient Experience

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Informing staff of their duties in respect of patients' property	Chief Nurse/Deputy Chief Executive	Assocate Director of Operations Clinical Business Unit Managers and / Heads of Department
d) Issuing property of deceased patients. ▪ <£4,999 in accordance with agreed Foundation Trust policies. ▪ >£5,000 only on production of a probate letter of administration	Chief Nurse/Deputy Chief Executive	General Office Halton / Cash Office Warrington
33. Workforce		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive / Executive Directors	Chief People Officer / Deputy Directors / Associate Directors of Operations / Clinical Business Unit Managers / Heads of Department
b) Develop Human Resource policies and strategies for approval by the board including training, industrial relations.	Chief People Officer	Deputy Chief People Officer
c) Authority to fill funded post on the establishment with permanent staff.	Chief People Officer	Executive Directors / DeputyDirector / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department in accordance with Trust policy
d) The granting of additional increments to staff within budget	Chief Executive	Chief People OfficerChief People Officer
e) All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Chief People Officer	Deputy Chief People Officer / Head of HR
f) Establishments		
• Additional staff to the agreed establishment with specifically allocated finance.	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer / Head of Management Accounts
• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Chief Finance Officer & Deputy CEO
• Self financing changes to an establishment	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer / Head of Management Accounts
g) Pay		
• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration and Terms of Employment Committee..	Chief Executive	Chief Executive
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Chief People Officer	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Service/Dept
• Authority to complete and authorise positive reporting forms (SVLs)	Chief Finance Officer & Deputy CEO	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Service/Dept
• Authority to authorise overtime	Chief People Officer / Chief Finance Officer & Deputy CEO	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department or Service / Lead Nurse / Matron / Lead AHP

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Authority to authorise travel & subsistence expenses	Chief People Officer / Chief Finance Officer & Deputy CEO Chief People Officer/Chief Finance Officer & Deputy CEO	Line Managers
• Authority to authorise travel & subsistence expenses over three months old	Chief People Officer	Deputy Directors / Associate Direcotrs of Operations / Clinical Busienss Unit Managers / Heads of Department or Service
• Authority to approve excess travel expenses as a result of organisational change		Deputy Directors / Associate Direcotrs of Operations / Clinical Busienss Unit Managers / Heads of Department or Service (with advice from HR)
h) Leave *(Note entitlement may be taken in hours)*		
	Chief People Officer	*Refer to Annual Leave Policy*
<u>Annual Leave</u>		
- Approval of annual leave		Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of 5 days	Chief Executive	Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers
- Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only)	Chief Executive	Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department Medical Staff – Medical Director
<u>Special Leave</u>	Chief People Officer	Refer to Special Leave Policy
• Special leave (as detailed in the Trust Policy)		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers
• Leave without pay		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Manager
• Authority to grant Special Leave over one week		Executive Directors / Deputy Directors / Associate Directors of Operations
• Medical Staff Leave of Absence – paid and unpaid	Medical Director	Medical Director / Divisional Medical Directors
• Time off in lieu		Departmental / Line Managers Line Managers
• Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance
<u>Sick Leave</u>		
i) Extension or re-instatement of sick leave on pay	Chief People Officer	Chief People Officer
		Chief People Officer

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	ii) Return to work part-time on full pay to assist recovery recovery over four weeks		Chief People Officer
	iii) Award Injury Allowance		
	Study Leave		
	• Study leave outside the UK	Chief Executive	Executive Director
	• Medical staff study leave (UK) - Consultant / Non Career Grade - Career Grade	Medical Director	Medical Director Post Graduate Graduate TutorTutor
	• All other study leave (UK)	Chief People Officer	Executive Directors / Deputy Directors / Associate Director of Operations / Heads of Department/Service (in accordance with agreed Foundation Trust policy)
i)	Removal Expenses, Excess Rent and House Purchases All staff (agreed at interview) Maximum £6,000 Senior Medical Staff Maximum £8,000 Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Chief People Officer	Executive Directors/Deputy Directors/Associate Director of Operations/Head of Department/Service Refer to Table B Delegated Delegated LimitsLimits
j)	Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Director of Organisational Development & Governance must be sought when the grievance reaches the level of Divisional Director of Operations / Heads of Department	Chief People Officer	As per procedure
k)	Authorised Car Grievance ProcedureUsers • Leased cars (Business and personal) • Regular user allowance	Chief Executive Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO Executive Director / Assocate Director of Operations / Clinical Business Unit Managers / Heads of Department
l)	Mobile Phone / Messaging Services	Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO / Associate Director of Estates and Facilities
m)	Renewal of Fixed Term Contract	Chief People Officer	Heads of Department /Service on advice from Human Resources and Divisional Accountants
n)	Staff Retirement Policy		
	▪ Authorisation of a retire and return application	Chief People Officer	Heads of Department/Service on advice from Human Resources and Divisional Accountants

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
o)	Redundancy		
	• Approval to proceed	Chief Executive	Executive Team Chief People Officer / Chief Finance Officer & Deputy CEO Commercial Development
	• Payments (including legal fees) fees payable to employees' solicitors as part of settlement agreement below £50,000	Chief Executive	Chief People Officer / Chief Finance Officer & Deputy CEO Commercial Development
	• Payments (including legal fees) (including legal fees payable to employee's solicitors as part of settlement agreement)) over £50,000	Nominations and Remuneration Committee	Chief People Officer Chief Finance Officer & Deputy CEO
	• Mutually Agreed Redundancy Scheme o Agreement to run scheme Approval of payments	Trust Board / Exec team	
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Executive	Chief People Officer
q)	Disciplinary Procedure (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
r)	Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Chief People Officer	Deputy Chief People Officer
s)	Engagement of staff not on the establishment		
	• Management Consultants		Refer to Table B
	▪ Booking of bank staff		
	• Nursing and AHPs	Chief Nurse/Deputy Chief Executive	Associate Directors of Operation / Divisional Heads of Nursing /Ward Managers
	• Medical		
	• other	Executive Directors	DeputyDirectors / Associate Directors of Operation / Heads of Department / Line Managers
	▪ Booking of agency staff		
	• Nursing	Chief Nurse/Deputy Chief Executive	Deputy Directors / Associate Directors of Operation / Divisional Heads of Nursing
	• Medical		
	• other	Executive Directors	Deputy Directors / Associate Directors of Operation / Heads of Department / Line Managers
34.	**Quotation, Tendering & Contract Procedures**		
a)	Services: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	
	• Nominate officers to oversee and manage the contract on behalf of the Foundation	Chief Executive	Clinical Business Unit Managers Head of Department Associate Director of Procurement

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Trust.		Deputy Head of Procurement Senior Procurement Manager
b)	Competitive Tenders:		
	• Authorisation Limits	Chief Executive	Refer To Table B Delegated Limits
	• Maintain a register to show each set of competitive tender invitations despatched.	Chief Executive	Associate Director of Procurement
	• Receipt and custody of tenders prior to opening	Chief Executive	Associate Director Procurement
	• Opening Tenders	Chief Executive	Release of electronic tenders on eTendering portal by a designated officer (procurement project lead and deputy procurement project lead)
	• Decide if late tenders should be considered	Chief Executive	Chief Finance Officer & Deputy CEO
	• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Associate Director Procurement
c)	Quotations	Chief Executive	Associate Director Procurement
d)	Waiving the requirement to request	Chief Executive	Refer To Table B Delegated Limits
	• tenders - subject to Standing Orders (reporting to the Board)		
	• quotes - subject to Standing Orders	Chief Executive or Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO
	• Waiving the requirement to obtain tenders or quotations subject t Standing Orders (reporting to Audit Committee)	Chief Executive	This should state in Table B £10,000 to £50,000 Deputy Chief Finance Officer £50,001 to EU Financial Limits Directcor of Finance and Commercial Development
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice	Chief Executive	Executive Directors / Associate Directors of Operation / Heads of Department
b)	Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Executive	/Local Secutity management Specialist (if relating to an employee this should be done with advice from HR)
b)	Where a fraud is involved (reporting to the Directorate of Counter Fraud Services) Fraud Services)	Chief Finance Officer & Deputy CEO	Head of Internal Audit / Local Counter Fraud Officer (if relating to an employee this should be done with advice from HR)
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Finance Officer & Deputy CEO	Chief Finance Officer & Deputy CEO (if relating to an employee this should be done with advice from HR)
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Nurse/Deputy Chief Executive
	• Developing systems for the management of risk.	Chief Nurse/Deputy Chief Executive	Deputy Director of Integrated Governance + Quality
	• Developing incident and accident reporting systems	Chief Nurse/Deputy Chief Executive	Deputy Director of Integrated Governance + Quality
	• Compliance with the reporting of incidents and accidents	Chief Nurse/Deputy Chief Executive	All staff
38.	**Seal**		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Head of Corporate Affairs
b)	Attestation of seal in accordance with Standing Orders	Chair / Chief Executive	Chair / Chief Executive (report to Board of Directors)
c)	Property transactions and any other legal requirement for the use of the seal.	Chair / Chief Executive	Chair or Non Executive Director and the Chief Executive or their nominated Director
39.	**Security Management**		
a)	Monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Executive	Chief Operating Officer / Local Security Management Specialist.
40.	**Setting and Recovery of Fees and Charges (Income)**		
a)	Setting and recovery of fees and charges for Private Patient, Overseas Visitors, Income Generation – patient related and non-patient related services.	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer -
c)	Recovery of fees and charges on private Patient Overseas Visitors, Income Generation, and other patient related and non-patient related services.	Chief Finance Officer & Deputy CEO	Head of Financial Services
e)	Security of cash and other negotiable instruments	Chief Finance Officer & Deputy CEO	Head of Financial Services
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over the receipt and distribution of goods, issues and returns	Chief Finance Officer & Deputy CEO	Associate Director of Procurement/Chief Pharmacist
b)	Stocktaking arrangements	Chief Finance Officer & Deputy CEO	Deputy Chief Finance Officer
stock.			

42.	**Contract Award Recommendation Reports**		
Completion of contract award recommendation reports		Chief Executive	Associate Director of Procurement Chief Finance Officer & Deputy CEO
Approval of contract awards recommendation reports – up to £250k		Chief Executive	
Approval of contract awards recommendation reports – over £250k		Chief Executive	Chief Executive

43.	**Business Cases**		
Completion of business cases		Chief Executive	Chief Finance Officer & Deputy CEO
Approval of business cases		Chief Executive	Chief Finance Officer & Deputy CEO

Appendix 2 - Table B – Delegated Financial Limits

All thresholds are inclusive of VAT irrespective of recovery arrangements.
Details of procurement thresholds will be provided by the Head of Procurement

If the Chief Executive is absent, powers delegated to them will automatically transfer to the Deputy Chief Executive.

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend (designated, restricted and unrestricted)	Up to £1,000	Financial Planning Accountant and Fundraising Manager
	£1,001 - £5,000	Chief Finance Officer & Deputy CEO and Chief Nurse/Deputy Chief Executive
	Over £,5000	Charitable Funds Committee
2. GIFTS AND HOSPITALITY		
2.1 Cash & Vouchers		
Cash and vouchers Should always be declined.	any value	All Staff
2.2 Gifts		
Gifts do not need to be declared	up to £50 (Single)	All Staff
Gifts Multiple Multiple gifts from the same source over a 12 month period should be treated the same as single gifts **over £50 (see below)**	up to £50 (Multiple)	
Gifts should be accepted on behalf of the Trust (not in a personal capacity) They should be recorded on the register and delivered to the WHH Charity as 'Gifts in Kind' to be used for the benefit of patients	Over £50	
2.3 Hospitality		
Meal and refreshments May be accepted and need not be declared	up to £25	All Staff
Meal and refreshments May be accepted and must be declared	£25 - £75	
Meal and refreshments should be refused unless (in exceptional circumstances) senior approval is given.	Over £75	

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
3. LITIGATION CLAIMS		
Clinical Negligence scheme for the Trust (CNST) and Clinical Risk Pooling Scheme (LTPS & PES - above excess only) for the Trust		NHS Resolution (NHSR) on behalf of the Trust
Employers Liability (EL) claims within excess	up to £3,000	Litigation & Risk Manager
Public Liability (PL) claims within excess	up to £10,000	
4. LOSSES AND SPECIAL PAYMENTS		
Losses:		
1. Losses of cash due to:		
a. theft, fraud etc. b. overpayment of salaries etc. c. other causes	up to £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
2. Fruitless payments and constructive losses	up to £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
3. Bad debts and claims abandoned in relation to:		
a. private patients b. overseas visitors c. other	up to £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
4. Damage to buildings, property etc. (including stores losses) due to:		
a. theft, fraud etc. b. stores losses c. other	up to £500	Ward Manager or Department Manager
	£500 - £1,500	Head of Service/CBU Manager
	£1,501 - £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive

	Over £250,000	Board of Directors

Appendix A (continued)

4. LOSSES AND SPECIAL PAYMENTS		
Special payments: From 2020/21 all Special Payment over £95k must be sent to HM Treasury for Approval		
5. Compensation under court order or legally binding arbitration award	up to £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
6. Extra contractual to contractors	up to £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
7. Ex gratia payments in respect of:		
a. loss of personal effects b. clinical negligence with advice c. personal injury with advice d. other negligence and injury e. other employment payments (not including special severance payments which are disclosed below) f. patient referrals outside the UK and EEA Guidelines g. other h. maladministration, no financial loss	up to £500	Ward Manager or Department Manager
	£500 - £1,500	Head of Service/CBU Manager
	£1,501 - £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
8. Special severance payments Special severance payments when staff leave a public sector employer should only rarely be considered. They will always require HM Treasury approval because they are usually novel, contentious and potentially repercussive: NHS bodies have no delegated authority to make such payments unless so approved. NHS	up to £10,000	HM Treasury
	£10,001 - £250,000	
	Over £250,000	

Bodies must complete a template for submission to HMT for approval.		

Appendix A (continued)

4. LOSSES AND SPECIAL PAYMENTS		
Special payments: From 2020/21 all Special Payment over £95k must be sent to HM Treasury for Approval		
9. Extra statutory and regulatory Extra statutory and regulatory are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms.	up to £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive and Chief Finance Officer & Deputy CEO
	Over £250,000	Board of Directors
5. PETTY CASH DISBURSEMENTS & PATIENT MONIES (authority to pay cash)		
Petty Cash	up to £50	Budget Holder
	Over £50	Chief Finance Officer & Deputy CEO OR Nominated Deputy (Head of Financial Services)
Patients Monies	up to £100	Cash & General Office Manager
	£101 - £5,000	Deputy Chief Finance Officer or Head of Financial Services
	Over £5,000	Chief Finance Officer & Deputy CEO
6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
6.1 Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses)	up to £5,000	Ward /Service/Theatre Managers/Divisional Administrator (or equivalent)
	up to £10,000	Matron/Lead Nurse/Head of Service/Department Managers

	up to £25,000	Associate Directors/Board Secretary/Deputy Chief Pharmacist/Deputy Clinical Business Manager/ Head of Service (or equivalent)
	up to £50,000	Director of Medical Education/Deputy Directors/ Associate Director of Estates and Facilities / Chief Pharmacist/Clinical Business Unit Manager
	up to £100,000	Deputy Chief Operating Officer
	up to £250,000	Executive Directors
	over £250,000	Chief Executive (delegated to Deputy Chief Executive in absence of CE)

6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
6.2 Consultancy Services	up to £50,000	Chief Executive / Executive Directors
	Over £50,000	NHS Improvement
6.3 Capital Expenditure	n/a	Board of Directors following recommendation by Capital Planning Group supported by Finance and Sustainability Committee
Annual capital programme and amendments to the capital programme		
Orders for schemes within the approved capital programme		see section 6.1 Delegated Authority
Emergency schemes approved by	up to £250,000	Chief Finance Officer & Deputy CEO or Deputy Chief Finance Officer
	£250,000 - £500,000	Chief Executive
	over £500,000	Board of Directors
6.4 Removal Expenses	up to £8,000	Chief People Officer
7. QUOTATIONS AND TENDERS		
Quotations: inviting minimum of 3 written quotations for goods/services	£10,000 - £60,000	Associate Director of Procurement (except drugs) Chief Pharmacist (drugs only)* *only these two people can

Competitive Tenders: inviting a minimum of 3 written competitive tenders for goods/services (incompliance with EC directives as appropriate) EU limits and subsequent changes to be provided under separate correspondence by Associate Director of Procurement	over £60,000	invite tenders or obtain quotes

Appendix A (continued)

8. BUSINESS CASE APPROVAL (TRUST FUNDED)		
Revenue only	All	Executive Team (once approved delegated authority limits apply)
Revenue including capital		
Revenue only	over £500,000	Board of Directors (once approved delegated authority limits apply)
Revenue including capital		
9. REDESIGNATION		
Trust must still meet Financial Targets. Total trust budget remains under spent. Total divisional /departmental budget remains under spent	up to £25,000	Deputy Chief Finance Officer
	up to £100,000	Chief Finance Officer & Deputy CEO
	up to £250,000	Chief Executive
	over £250,000	Trust Board
10. Contract Award		
Approval of Contract Award Recommendation Reports	up to £50,000	Deputy Chief Finance Officer
	Over £50,000	Chief Finance Officer & Deputy CEO

EQUALITY IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

What is being considered?	Policy ☐ Guideline ☐ Decision ☐ Other (please state) ☐
Is there potential for an adverse impact against the protected groups below? Age Disability Gender Reassignment Marriage and Civil Partnership Pregnancy and Maternity Race Religion and Belief Sex (Gender) Sexual Orientation Human Rights articles	Yes ☐ No ☐
If you are unsure, please contact the Equality and Diversity Specialist - 5229	
On what basis was this decision made? National Guidelines e.g NICE / NSPA / HSE / DH (other) ☐ Committee / Other meeting ☐ Previous Equality screening ☐	
With regard to the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance Equality relevance decision by Title / Committee Date	
The Equality Act 2010 has brought a new equality to all public authorities, which replaced the race, disability and gender equality duties. This Equality Relevance Assessment provides assurance of the steps Warrington and Halton Hospitals NHS foundation Trust is taking in meeting its statutory obligation to pay due regard to: Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act Advance equality of opportunity between people who share a protected characteristic and those who do not	

DOCUMENT INFORMATION BOX (COMPLETED BY AUTHORISED DIVISIONAL/CORPORATE SERVICE LIBRARIAN)

Item	Value
Type of Document	Policy
Title	Scheme of Reservation and Delegation

Published Version Number	7
What are the changes to previous version?	
Publication Date	December 2021
Review Date	December 2023
Author's Name + Job Title	Karen Spencer, Head of Financial Services
CQC Fundamental Standard (delete as necessary)	Person-centred care, Dignity and respect Consent, Safety,, Safeguarding from Abuse Food and Drink, Premises and Equipment, Complaints, Good Governance, Staffing, Duty of Candour, Fit and Proper Person
Consultation Body/ Person	
Consultation Date	
Approval Body	Trust Board
Approval Date	24 November 2021
Ratified by(Quality Committee and or Sub Committees)	Audit Committee
Ratification Date	18 November 2021
Author Contact	2186
Librarian	Karen Spencer, Head of Financial Services
Division	Finance
Specialty (if local procedural document)	Finance
Ward/Department (if local procedural document)	Finance
Patient documentation included Y/N	Not applicable
Date Approved at documentation group via Director of Communications and Engagement)	
Readership (Clinical Staff, all staff)	All Executive Directors, budget holders and managers
Information Governance Class (Restricted or unrestricted)	Unrestricted
Key Words for Search Engine	
Audit registered in the audit dept by: High risk = 1 Annually Medium = every 2 years Low risk= every 3 years	

STANDING FINANCIAL INSTRUCTIONS POLICY

CONTENTS AND PAGE NUMBER

EXECUTIVE SUMMARY/ INTRODUCTION

NHS England and Improvement (NHSE/I) sets the Terms of Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector with any relevant code of practice and guidance issued by NHSE/I.

The Code of Conduct and Accountability in the NHS issued by the Department of Health requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer & Deputy CEO or Deputy Chief Finance Officer & Trust Freedom to Speak Up Guardian **MUST BE SOUGHT BEFORE ACTING.** The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

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

PURPOSE AND SCOPE

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Foundation Trust.

These SFIs identify the financial responsibilities, which apply to everyone working for the Foundation Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. .

DUTIES AND RESPONSIBILITIES

Board of Directors

It is the responsibility of the Board of Directors to ensure systems and processes are in place to monitor and implement this policy.

Chief Executive

In line with the requirements of Governance, the Chief Executive carries ultimate responsibility for assuring the quality of the services provided by the Trust that is included within this policy .

Executive Directors

All Executive Directors are the authorised Leads to sign off corporate policies within their areas of responsibility.

Delegated Executive Lead

The Chief Finance Officer & Deputy CEO has been delegated by the Chief Executive to take the Executive ownership for this policy .

Senior Clinicians and Managers

Senior Clinicians and Managers are responsible for the provision of managerial and professional advice to their teams in accordance with this policy.

All Staff

All staff are required to comply with this policy. If for any reason a deviation occurs this should be alerted to their manager/supervisor.

TERMINOLOGY

Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the Constitution bear the same meaning as in the NHS Act 2006. References in the Constitution to legislation include all amendments, replacements, or re-enactments made.

In the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation the following definitions apply:

	Definition
the 2006 Act	Means the National Health Service Act 2006.
Accounting Officer	This Is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. They shall be the Officer responsible and accountable for

	Definition
	funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.
Appointing organisations	Means those organisations named in the Constitution who are entitled to appoint Governors.
Authorisation	This is the authorisation for the Trust to become an NHS Foundation Trust given by NHS Improvement, under Section 35 of the 2006 Act.
Board of Directors	Means the Board of Directors as constituted in accordance with the constitution.
Budget	Means a resource, expressed in financial or manpower terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust;
Budget Holder	The director or employee with delegated authority to manage finances for a specific area of the organisation.
The Chair	Means the Chairperson of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution..
Chief Executive	Means the Chief Officer (and Accounting Officer) of the Foundation Trust
Committee	Means a committee appointed by the Board of Directors or Council of Governors.
Constitution	Constitution of Warrington & Halton Hospitals NHS Foundation Trust. Describes the type of organisation, its primary purpose, governance arrangements and membership.
Contracting & Procuring	Means the systems for procuring goods and services.
Director	Means a person appointed to the Board of Directors in accordance with the Trust's constitution and includes the Chair.
Chief Finance Officer & Deputy CEO	Shall mean the Chief Finance Officer of the Foundation Trust.
Executive Director	Means an Executive Director of the Trust.
External Auditor	the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act;
Financial	a) The period beginning with the date on which the

	Definition
Year	Foundation Trust is authorised under the 2006 Act and ending with the next 31 March; and b) each successive period of twelve months beginning with 1 April.
The Foundation Trust (or Trust)	Means Warrington & Halton Hospitals NHS Foundation Trust.
Foundation Trust Contract	Agreement between the Foundation Trust and Commissioners for the provision and commissioning of health services.
Funds Held on Trust	those funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under 2003 Act. Such funds may or may not be charitable.
Member	Means a member of the Foundation Trust;
NHS England and Improvement	regulator of Foundation Trusts, NHS Trusts and Independent providers of NHS funder care.
Nominated Officer	Means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	Means an employee of the Foundation Trust.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters.
Scheme of Reservation and Delegation	(SoRD) details how the powers are reserved to the Board of Directors and delegated within the Foundation Trust.
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust.

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

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

RESPONSIBILITIES AND DELEGATION

The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of income and expenditure and capital budgets, approval of the Annual Plan and monitoring, returns to NHS Improvement;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and

d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Reservation and Delegation.

The Constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that, certain powers, and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Scheme of Reservation and Delegation adopted by the Foundation Trust.

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

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

It is a duty of the Chief Executive to ensure that Directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

The Chief Finance Officer & Deputy CEO is responsible for:

a) implementing the Foundation Trust's financial policies and procedures, and for co-ordinating any corrective action necessary to further these policies and procedures, (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are

prepared, documented and maintained, to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust, at any time;

and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer & Deputy CEO include:

d) the provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

All directors and employees are responsible for:

a) the security of the property of the Foundation Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

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

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

AUDIT

Audit Committee

In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and Foundation Trust Governance requirements, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

Internal Audit

- Monitor and review the effectiveness of the internal audit service

External Audit

- To assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable.
- To undertake a market testing exercise for the appointment of the external auditor at least once every five years.
- To make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor.
- To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

b) reviewing financial and information systems and monitor the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;

c) the monitoring of compliance with Standing Orders and Standing Financial Instructions;

d) reviewing schedules of losses and compensation and making recommendations to the Board of Directors as prescribed in the Scheme of Reservation and Delegation;

e) reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Statement on Internal Control and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors.

f) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems), that supports the achievement of the organisation's objectives.

The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, The Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer & Deputy CEO in the first instance).

It is the responsibility of the Chief Finance Officer & Deputy CEO to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the appointment

The appointment of the External Auditor is subject to the ratification by the Council of Governors.

Chief Finance Officer & Deputy CEO

The Chief Finance Officer & Deputy CEO is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function and the coordination of other assurance arrangements;

b) ensuring that the internal audit is adequate and meets the NHS Foundation Trust audit standards;

c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

The report must cover:

i) a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards,

ii) major internal financial control weaknesses discovered,

iii) progress on the implementation of internal audit recommendations,

iv) progress against plan over the previous year,

v) strategic audit plan,

vi) a detailed plan for the coming year.

The Chief Finance Officer & Deputy CEO or designated auditors is entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;

c) the production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and

d) explanations concerning any matter under investigation.

Internal Audit

The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

Role of Internal Audit

The role of internal audit have two key areas:

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

Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

   i) fraud and other offences,

   ii) waste, extravagance, inefficient administration,

   iii) poor value for money or other causes.

e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

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

The Senior Audit Manager will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

The Head of Internal Audit shall be accountable to the Chief Finance Officer & Deputy CEO. The reporting system for internal audit shall be agreed between the Chief Finance Officer & Deputy CEO, the Audit Committee and the Senior Audit Manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Senior Audit Manager shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

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

response to audit recommendations must be maintained in the future and not viewed as merely satisfying immediate audit point.

External Audit

Duties

The Foundation Trust is to have an External Auditor and is to provide the External Auditor with every facility and all information which they may reasonably require for the purposes of their functions under the 2006 Act.

The External Auditor is to carry out their duties in accordance with the 2006 Act and in accordance with any directions given by NHSE/I on standards, procedures and techniques to be adopted.

In auditing the accounts, the External Auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Foundation Trust is required to include a statement on internal control within the financial statements. The External Auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements and other work.

Appointment of External Auditor

The External Auditor is appointed by the Council of Governors following recommendation from the Audit Committee.

Appointment of the External Auditor must comply with Paragraph 23 of Schedule 7 to the 2006 Act.

The Council of Governors shall appoint or remove the External Auditor. Council of Governors

The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Any such auditors are to be appointed by the Council of Governors.

Undertaking Work

NHSE/I may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between NHS Improvement, the External Auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

The auditor may provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt

and implement a policy for considering and approving any additional services to be provided by the auditor.

Liaison with Internal Audit

It is expected that the External Auditor will liaise with the internal audit service in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The External Auditor may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the External Auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

Access to Documents

The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions.

Public Interest Report

In the event of the External Auditor issuing a Public Interest Report the Foundation Trust shall:

- Send the public interest report to the Council of Governors the Board of Directors and NHS Improvement:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- forward a report to NHSE/I within 30 days (or such shorter period as NHSE/I may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest Report.

Fraud and Corruption

The Foundation Trust shall take all necessary steps to counter fraud relating to its functions and having regard to any reasonable guidance or advice issued by the NHS Counter Fraud Authority (NHSCFA). The Foundation Trust shall act in accordance with:

- the NHS Fraud and Corruption Manual;
- the policy statement "Applying appropriate sanctions consistently" published by NHSCFA;

The Foundation Trust shall nominate a suitable person to carry out the duties of the Anti-Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

The Anti-Fraud Specialist shall report to the Chief Finance Officer & Deputy CEO and shall work with the staff in the NHSCFA in accordance with the Department of Health Fraud and Corruption Manual.

The Anti-Fraud Specialist will provide a written plan and report, at least annually on counter fraud work within the Foundation Trust.

Security Management

The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by the NHSCFA

The Foundation Trust shall nominate an Executive Director to be responsible to the Board of Directors for security management.

The Foundation Trust shall nominate and appoint a Anti-Fraud Specialist as per the Foundation Trust Contract.

The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Chief Operating Officer (COO) and the appointed Anti-Fraud Specialist.

BUSINESS PLANNING, FINANICAL PLANNING AND PERFORMANCE MONITORING

Preparation and approval of Strategic and Operational Plans

The Chief Executive will compile and submit to the Board of Directors strategic and operational plans. The annual operational plan incorporates financial targets and forecast limits of available resources. The annual operational plan will contain:

a) a statement of the significant assumptions on which the plan is based; and

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

Prior to the start of the financial year the Chief Finance Officer & Deputy CEO will, on behalf of the Chief Executive, prepare and submit revenue and capital budgets for approval by the Board of Directors. Such budgets will:

a) be in accordance with the strategic aims and objectives of the foundation trust.

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds;

e) identify potential risks;

f) be based on reasonable and realistic assumptions; and

g) enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

The Chief Finance Officer & Deputy CEO shall monitor the financial performance against budgets on a monthly basis and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer & Deputy CEO

to the Board of Directors in an appropriate timeframe and the Board of Directors shall be advised of action to be taken in respect of such variances.

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

All budget holders will sign up to their allocated budgets at the commencement of each financial year.

The Chief Finance Officer & Deputy CEO has a responsibility to ensure that adequate training is delivered on an on-going basis to all budget holders to help them manage successfully.

Budgetary delegation

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

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise budget re-designation;

e) achievement of planned levels of service; and

f) the provision of regular reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Board of Directors.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer & Deputy CEO.

Budgetary control and reporting

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

a) regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

   i) income and expenditure to date showing trends and forecast year-end position;

   ii) statement of financial position, including movements in working capital;

   iii) statement of cash flow

   iii) capital project spend and projected out-turn against plan;

   iv) explanations of any material variances from plan/budget; and

v) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer & Deputy CEO's view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, and workload budgets;

d) the monitoring of management action to correct variances;

e) arrangements for the authorisation of budget transfers;

f) advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and

g) review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer & Deputy CEO will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

Each budget holder is responsible for ensuring that:

a) any likely budget overspend or income under recovery which cannot be met by budget re-designation is not incurred without the prior consent of the Board of Directors;

b) officers shall not exceed the budget limit set;

c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of re-designation; and

d) no permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer & Deputy CEO other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and Service Development Strategy.

Capital expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in capital investment, private financing, fixed assets registers and security of assets section) A Project Sponsor will be identified who will assume responsibility for the budget relating to the scheme.

NHSE/I return

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

ANNUAL ACCOUNTS AND REPORTS

Annual Accounts

The Foundation Trust shall keep accounts in such form as the NHSE/I may, with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's External Auditor.

The following documents will be made available to the Comptroller and Auditor General for examination at their request:

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

The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer. The Accounting Officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts, in such form as NHSE/I may, with the approval of the Treasury direct. In preparing its annual accounts, the Accounting Officer shall cause the Foundation Trust to comply with any directions given by NHSE/I with the approval of the Treasury as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in the 2006 Act.

The annual accounts and statement of audit opinion are presented to the Audit Committee and Board of Directors.

The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the External Auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS Improvement.

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

Annual Reports

The Foundation Trust shall prepare an annual report and send to NHSE/I and lay before Parliament. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and
- any other information NHSE/I requires.

The Foundation Trust is to comply with any decision NHSE/I makes as to:

- the form of the reports;
- when the reports are to be sent to them; and
- the periods to which the reports are to relate.

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

BANK ACCOUNTS

General

The Chief Finance Officer & Deputy CEO is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by NHS Improvement.

The Board of Directors shall approve the banking arrangements.

Bank Accounts

The Chief Finance Officer & Deputy CEO is responsible for:

a) all bank accounts operated under the Government Banking Services initiative and other forms of working capital financing that may be available from the Department of Health;

b) establishing separate bank accounts for the Foundation Trust's charitable funds;

c) ensuring payments made from all bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken);

e) establishing an appropriate committed working capital facility which comply with DH/NHSI guidance on the level of cleared funds.

f) ensuring that committed working capital facility proposals are reviewed and agreed in line with the Scheme of Reservation and Delegation and the Trust's Treasury Management Policy.

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

Banking procedures

The Chief Finance Officer & Deputy CEO will prepare detailed instructions (including bank mandates) on the operation of all bank accounts, which must include:

a) the conditions under which each bank account is to be operated;

b) the limit to be applied to any overdraft; and

c) those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

The Chief Finance Officer & Deputy CEO must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

The Chief Finance Officer & Deputy CEO shall approve security procedures, including those arrangements with third party organisations, for any cheques issued without a hand-written signature e.g. electronic signature lithographed. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

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

Income systems

The Chief Finance Officer & Deputy CEO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

The Chief Finance Officer & Deputy CEO is also responsible for the prompt banking of all monies received.

Fees and charges other than Foundation Trust Contract.

The Chief Finance Officer & Deputy CEO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health (such as Payment by Results National Tariffs), HM Treasury or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's 'Commercial Sponsorship – Ethical Standards for the NHS' shall be followed. See Standing Orders for details.

All employees must ensure that procedures for the charging of income are adhered to.

Private Health Care

The Foundation Trust shall ensure that the proportion of total income of the Trust in any financial year derived from private charges shall not be greater than the percentage set out in Schedule 4 of the Terms of Authorisation.

If the percentage is exceeded, or is expected to be exceeded, NHSE/I will be notified and an appropriate action plan developed to correct the non-compliance.

Debt recovery

The Chief Finance Officer & Deputy CEO is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

Income not received should be dealt with in accordance with losses procedures.

Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

The Chief Finance Officer & Deputy CEO is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable. (No form of receipt which has not been specifically authorised by the Chief Finance Officer & Deputy CEO should be issued);

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

Official money shall not under any circumstances be used for the encashment of private cheques, nor for temporary loans.

Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

All cheques, postal orders and cash shall be banked promptly intact under arrangements approved by the Chief Finance Officer & Deputy CEO.

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

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

FOUNDATION TRUST CONTRACTS

Provision of Services

The Board of Directors of the Foundation Trust shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide the mandatory goods and services referred to in the Terms of Authorisation and related Schedules.

Foundation Trust Contracts (see overlap with Foundation Trust Contracts/Healthcare Services arrangements)

The Chief Executive, as the accounting officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTC) with commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the Performance Assessment Framework contained within the FTC; and
- that FTC builds where appropriate on existing partnership arrangements.

A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the FTC.

Non-Commercial Contract – Including SLAs with other NHS Bodies

Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible officer should ensure that an appropriate non-commercial contract is present and signed by both parties. This legally binding contract shall as a minimum incorporate:

- a description of the service and indicative activity levels;
- the terms, commencement date and length of the agreement;
- the value of service provided and price;
- the payment terms and payment mechanism;
- contract variation procedures;
- the lead officers;
- compliance with Trust policies, procedures and protocols (including employment) as deemed appropriate;
- compliance with applicable standards, regulations and legislation;
- monitoring arrangements and performance review process;
- dispute resolution procedures and processes;
- remedies;

- information sharing and confidentiality;
- risk management and clinical governance agreements;
- liabilities and indemnities;
- legal ownership for any delivered product or material; and
- contract cancellation and termination arrangements.

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

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

The Nomination and Remuneration Committee

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

The Committee will:

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

   i) all aspects of salary (including any performance-related elements/bonuses);

   ii) provisions for other benefits, including pensions and cars;

   iii) arrangements for termination of employment and other contractual terms;

b) make such recommendations to the Board of Directors on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust - having proper regard to the Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

c) monitor and evaluate the performance of individual Executive Directors (and other senior employees); and

d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

e) scrutiny and approval of all payments that fall outside normal salary remuneration when ceasing employment e.g. MARS schemes,

severance payments, redundancy payments, and any related compromise agreements.

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

The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

The Council of Governors, at the General Meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors.

Funded establishment

The manpower plans incorporated within the operational plan will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer & Deputy CEO is responsible for verifying that funding is available.

Staff appointments

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

a) authorised to do so by the Chief Executive; and

b) within the limit of their approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

The Board of Directors will approve procedures presented by the Chief Executive for the determination of salary and contractual terms and conditions of all employees.

Processing of the payroll

The Chief People Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances; including verification that the rates of pay and relevant conditions of service are in accordance with current agreements;

c) making payment on agreed dates; and

d) agreeing method of payment.

The Chief People Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee;

h) procedures for payment by cheque, bank credit, or cash to employees;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash; and

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

Appropriately nominated managers have delegated responsibility for:

a) processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;

b) submitting time records, and other notifications in accordance with the agreed timetables;

c) completing time records and other notifications in accordance with the Chief People Officer instructions and in the form prescribed by the Chief People Officer; and

d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer & Deputy CEO.

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

Contracts of employment

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

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health & Safety legislation; and

b) dealing with variations to, or termination of, contracts of employment.

NON-PAY EXPENDITURE

Delegation of authority

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

The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services should be updated and reviewed regularly by Procurement. An annual verification will be undertaken by the Procurement Department

b) where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

c) the maximum level of each requisition and the system for authorisation above that level.

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

The Scheme of Reservation and Delegation contains the delegated financial limits for each manager within the Trust. These financial limits are approved by the Board

Choice, requisitioning, ordering, receipt and payment for goods and services

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

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

The Chief Finance Officer & Deputy CEO will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be

obtained; and, once approved, the thresholds should be incorporated in Scheme of Reservation and Delegation and regularly reviewed;

b) prepare procedural instructions where not already provided in the Scheme of Reservation and Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Authorised signatures will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

ii) verification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

iii) a procedure and system for submission of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and

iv) instructions to employees regarding the handling and payment of accounts within the Finance Department; and

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except per section below in relation to prepayments).

It is expected that prepayments are sometimes required for fully comprehensive maintenance contracts, rental and insurance. However, prepayment arrangements for other goods and services are only permitted where exceptional circumstances apply. In such instances:

a) prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate;

b) the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c) the Chief Finance Officer & Deputy CEO will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

d) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Finance Officer & Deputy CEO;

c) state the Foundation Trust terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

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

a) all contracts other than for a simple purchase permitted within the Scheme of Reservation and Delegation or delegated budget, and other commitments which may result in a liability are notified to the Chief Finance Officer & Deputy CEO in the form of a written report in advance of any commitment being made that will be approved by the Chief Finance Officer & Deputy CEO

b) are advertised and awarded in accordance with EU rules on public procurement and subsequent tenders make reference to compliance with all relevant industry quality standards

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHSI, the Chief Executive and Chief Finance Officer & Deputy CEO; where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or

execution of work act independently of those who have placed orders and negotiated prices and terms.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; and

   ii) conventional hospitality, such as lunches in the course of working visits (see Gifts and Hospitality Policy); no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer & Deputy CEO on behalf of the Chief Executive;

e) all goods, services, or works are ordered on an official order with the exception of purchases from petty cash or on purchasing cards;

f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

h) goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future un-competitive purchase;

i) purchases from petty cash are restricted in value and by type of purchase in accordance with the Scheme of Reservation and Delegation; and

j) petty cash records are maintained in a form as determined by the Chief Finance Officer & Deputy CEO.

k) Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

Every contract entered into using Procure 21 (P21) tender for building or engineering works will abide by the rules and regulations regarding this procurement route. If the Trust deems appropriate and or in the best interests of the Trust these documents may be modified and/or amplified to accord with Department of Health Guidance and, in minor respects, to cover special features of individual projects.

Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under the powers of the 2006 Act shall comply with procedures laid down by the Chief Finance Officer & Deputy CEO which shall be in accordance with these Acts.

EXTERNAL BORROWING AND INVESTMENTS

External Borrowing

The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

The total amount of the Trust's borrowing must be affordable within the use of Resources Rating included within NHS Improvement's Single Oversight Framework.

Any application for a loan or overdraft facility must be approved by the Board and will only be made by the Chief Finance Officer & Deputy CEO or a person with specific delegated powers from the Chief Finance Officer & Deputy CEO.

All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer & Deputy CEO.

All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

Public Dividend Capital

On authorisation as a Foundation Trust the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team and is subject to approval by the Secretary of State.

The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

Investment

The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

The Foundation Trust may also give financial assistance (whether by way of loan, Guarantee or otherwise) to any person for the purposes of or in connection with its functions.

Investment of Temporary Cash Surpluses

Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors through the Foundation Trust's Treasury Management Policy.

The Audit Committee will review and approve the Treasury Management Policy on a regular basis and seek regular assurances that the policy is being adhered to and remains effective.

The Board of Directors is responsible for establishing and monitoring an appropriate investment strategy.

The Chief Finance Officer & Deputy CEO is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

The Chief Finance Officer & Deputy CEO will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will incorporate guidance from NHSE/I as appropriate.

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

Capital investment

Chief Finance Officer & Deputy CEO

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

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

For capital expenditure proposals the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Reservation and Delegation):

a) that a business case is produced setting out:

   i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

   ii) appropriate project management and control arrangements; and

   iii) the involvement of appropriate Foundation Trust personnel and external agencies; and

b) that the Chief Finance Officer & Deputy CEO has certified professionally to the capital costs and revenue consequences detailed in the business case.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "CONCODE" and any advice from NHS Improvement.

The Chief Finance Officer & Deputy CEO shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Chief Finance Officer & Deputy CEO shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender; and

c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with “CONCODE” and guidance in the Foundation Trust's Standing Orders.

The Chief Finance Officer & Deputy CEO shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

Private Finance (see overlap with Private Finance for Capital procurement)

The Foundation Trust should normally test for Private Finance Initiative when considering capital procurement. When the Board of Directors propose, or is required, to use finance provided by the private sector the following should apply.

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) A business case must be referred to the appropriate DOH for approval or treated as per current guidelines (refer to NHSE/I guidance ‘Roles and Responsibilities in the Approval of NHS Foundation Trust PFI Schemes’).

(c) The proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to ultra vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Asset registers

Director of Finance and Commercial Development is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer & Deputy CEO concerning the form of any register and the method of updating, and arranging for a physical check of assets against the Asset Register to be conducted once a year.

The Foundation Trust shall maintain a Fixed Asset Register recording fixed assets and containing all the details required to account correctly for its fixed assets.

Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

The Chief Finance Officer & Deputy CEO shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

The value of each asset shall be adjusted to current values in accordance with the relevant standards and guidance.

The value of each asset shall be depreciated using methods in accordance with the relevant standards and guidance.

The Chief Finance Officer & Deputy CEO shall calculate and account for capital charges in accordance with the Foundation Trust Financial Reporting Manual, and other applicable guidance issued by NHSE/I and HM Treasury.

Protected Property

A register of Protected Property is required to be maintained in accordance with requirements issued by NHS Improvement. The property referred to in Condition 9(1) of the Terms of Authorisation, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

No Protected Property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS Improvement.

This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

During the year when the proposed changes are made the Fixed Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

As required by Condition 9 (4) of the Terms of Authorisation the Foundation Trust must make the Fixed Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

Security of assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer & Deputy CEO.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer & Deputy CEO. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All significant discrepancies revealed by verification of physical assets to the Fixed Asset Register shall be notified to the Chief Finance Officer & Deputy CEO.

Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

Where practical, assets should be marked as Foundation Trust property.

STOCK, STORES AND RECEIPT OF GOODS

Stocks

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

a) controlled stores - specific areas designated for the holding and control of goods;

b) wards & departments - goods required for immediate usage to support operational services; and

c) manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

Such stocks should be kept to a minimum and for;

a) controlled stores and other significant stores (as determined by the Chief Finance Officer & Deputy CEO) should be subjected to an annual stocktake or perpetual inventory procedures; and

b) valued at the lower of cost or net realisable value.

Subject to the responsibility of the Chief Finance Officer & Deputy CEO for the systems of control, overall responsibility for the control of stores shall be delegated to an employee in accordance with the SORD by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer & Deputy CEO. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel, oil and coal stocks shall be the responsibility of a designated Associate Director of Estates and Facilities.

The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Associate Director of Procurement.

Wherever practicable, stocks should be marked as NHS Foundation Trust property.

The Chief Finance Officer & Deputy CEO shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses. Stocktaking arrangements shall be agreed with the Chief Finance Officer & Deputy CEO and there shall be a physical check covering all items in store at least once a year.

Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer & Deputy CEO.

The Head of Financial shall be responsible for a system approved by the Chief Finance Officer & Deputy CEO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Financial Services shall report to the Chief Finance Officer & Deputy CEO any evidence of significant overstocking and of any negligence or malpractice (see also Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Receipt of Goods

A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be

accepted on the authority of the designated officer and the supplier shall be notified immediately.

For goods supplied via third party distributors, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy them that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for low-value high volume items such as stationery.

Issue of Stocks

The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer & Deputy CEO. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variations.

All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer & Deputy CEO.

DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

The Chief Finance Officer & Deputy CEO must prepare detailed procedures and a Disposals Policy for the disposal of assets including condemnations and ensure that these are notified to managers.

When it is decided to dispose of a Foundation Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer & Deputy CEO of the estimated market value of the item, taking account of professional advice where appropriate. For protected assets see 'Protected Property' page 36 of these SFIs.

All other material items of unwanted equipment shall be dealt with in accordance with the Disposals and Condemnation of Assets Policy.

All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer & Deputy CEO; and

b) recorded by the condemning officer in a form approved by the Chief Finance Officer & Deputy CEO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer & Deputy CEO.

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

Losses and special payments

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

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

Where a criminal offence is suspected, the Chief Finance Officer & Deputy CEO must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer & Deputy CEO must inform their Local Counter Fraud Officer who will inform the relevant CFSMS regional team before any action is taken and reach agreement how the case is to be handled.

For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Chief Finance Officer & Deputy CEO must immediately notify:

a) the Board of Directors;

b) the External Auditor; and

c) Counter Fraud and Security Management Service (through the Anti-Fraud specialist).

The notifying and approval of losses and special payments is in accordance with the Scheme of Reservation and Delegation. The Chief Finance Officer & Deputy CEO shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

For any loss, the Chief Finance Officer & Deputy CEO should consider whether any insurance claim can be made.

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

Compensation Claims

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

The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by: -

a) adopting prudent risk management strategies including continuous review;

b) implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants;

c) adopting a systematic approach to claims handling in line with the best current and cost-effective practice;

d) following guidance issued by the NHSR relating to clinical negligence;

e) achieving the Standards for Better Health; and

f) implementing an effective system of Clinical Governance.

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

INFORMATION TECHNOLOGY

Responsibilities and duties of the Chief Finance Officer & Deputy CEO

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

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which they is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks.

e) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

The Chief Finance Officer & Deputy CEO shall satisfy them self those new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

The Director of Integrated Governance & Quality shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It

describes the classes or types of information about our Trust that we make publicly available.

Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the region wishes to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer & Deputy CEO:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer & Deputy CEO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer & Deputy CEO shall periodically seek assurances that adequate controls are in operation.

Requirement for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Finance Officer & Deputy CEO shall satisfy himself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Chief Finance Officer & Deputy CEO staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

Risk Assessment

The Chief Finance Officer & Deputy CEO shall ensure that risks to the Trust arising from the use of Information Technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

Disclosure

The Foundation Trust shall disclose to NHSE/I and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the

Terms of Authorisation, Schedule 6. Other information, as requested, shall be provided to NHS Improvement.

PATIENTS' PROPERTY

The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions.

The Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

The Director of Nursing must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money.

A patient's property record, in a form determined by the Chief Nurse shall be completed in respect of the following:

a) property handed in for safe custody by any patient (or guardian as appropriate);

b) property taken into safe custody having been found in the possessions of:

- mentally disordered patients;
- confused and/or disorientated patients;
- unconscious patients;
- patients dying in hospital; and
- patients found dead on arrival at hospital (property removed by police); and

c) A record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It

shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

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Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions instructions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions instructions. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Chief Nurse , in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Nursing or delegated finance officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, in which case the property shall be placed in the secure care of the most senior member of nursing staff on duty.

In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer & Deputy CEO.

Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing. (see Patient Property Policy)

FUNDS HELD ON TRUST

General

The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust, the trustee responsibilities must be discharged separately, and full recognition must be given to its dual accountabilities to the Charity Commission.

The reserved powers of the Board of Directors and the Scheme of Reservation and Delegation make clear where decisions for which discretion must be exercised are to be taken and by whom.

As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

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

Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board of Directors acting as Trustees.

The Chief Finance Officer & Deputy CEO shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

Existing Charitable Funds

The Chief Finance Officer & Deputy CEO shall arrange for the administration of all existing funds. A “Deed of Establishment” must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

The Chief Finance Officer & Deputy CEO shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

The Chief Finance Officer & Deputy CEO shall ensure that all funds are currently registered with the Charity Commission in accordance with the Charities Acts and the Charity Commission’s latest guidance and best practice.

New Charitable Funds

The Chief Finance Officer & Deputy CEO shall, recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund. All new funds must be formally approved by the Charitable Funds Committee.

The Deed of Establishment for any new fund shall clearly identify, among other things , the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

Sources of New Funds

All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer & Deputy CEO before accepting any gift. Advice to the Board of Directors on the financial implications of fund-raising activities by outside bodies or organisations shall be given by the Chief Finance Officer & Deputy CEO.

All gifts, donations and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Cash Office (Warrington) / General Office (Halton) to be banked directly to the Charitable Funds Bank Account.

In respect of Donations, the Chief Finance Officer & Deputy CEO shall: -

a) provide guidelines to officers of the Foundation Trust as to how to proceed when offered funds. These will include: -

   i) the identification of the donor's intentions;

   ii) where possible, the avoidance of creating excessive numbers of funds;

   iii) the avoidance of impossible, undesirable or administratively difficult objects;

   iv) sources of immediate further advice; and

   v) treatment of offers for personal gifts; and

b) provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

In respect of Legacies, the Director of Community Engagement & Fundraising shall be kept informed of and record all enquiries regarding legacies. Where required, the Chief Finance Officer & Deputy CEO shall: -

a) provide advice covering any approach regarding: -

   i) the wording of wills; and

   ii) the receipt of funds/other assets from executors;

b) after the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer & Deputy CEO who alone shall be empowered to give an executor a good discharge;

c) where necessary, obtain grant of probate, or make application for grant of letters of administration;

d) be empowered to negotiate arrangements regarding the administration of a Will with executors and to discharge them from their duty; and

e) be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies.

The Charitable Funds Committee approve all fund-raising appeals. The Chief Finance Officer & Deputy CEO shall: -

a) advise on the financial implications of any proposal for fund-raising activities;

b) deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations;

c) be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge;

d) be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and

e) be responsible for the appropriate treatment of all funds received from this source.

In respect of Trading Income the Chief Finance Officer & Deputy CEO shall: -

a) be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and

b) be primarily responsible for the appropriate treatment of all funds received from this source.

In respect of Investment Income, the Chief Finance Officer & Deputy CEO shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

Investment Management

The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer & Deputy CEO shall be required to provide advice to the Charitable Funds Committee shall include: -

a) the formulation of investment policy which meets statutory requirements with regard to income generation and the enhancement of capital value;

b) the appointment of advisers, brokers and, where appropriate, investment fund managers and: -

   i) the Chief Finance Officer & Deputy CEO shall recommend the terms of such appointments; and for which

   ii) written agreements shall be signed by the Chief Executive;

c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

d) the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;

e) that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;

f) the review of the performance of brokers and fund managers; and

g) the reporting of investment performance.

The Chief Finance Officer & Deputy CEO shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

Expenditure from Charitable Funds

Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee on behalf of the Board of Directors. In so doing the committee shall be aware of the following: -

a) the objects of various funds and the designated objectives;

b) the availability of liquid funds within each Trust;

c) the powers of delegation available to commit resources;

d) the avoidance of the use of trust funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the trust shall be discharged by trust funds at the earliest possible time;

e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and

f) the definitions of “charitable purposes” as agreed by the Department of Health with the Charity Commission.

Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Reservation and Delegation; exceptions are as follows: -

a) any staff salaries/wages costs require Charitable Funds Committee approval; and

b) no funds are to be “overdrawn” except in the exceptional circumstance that Charitable Funds Committee approval is granted.

Banking Services

The Chief Finance Officer & Deputy CEO shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each Trust where this is deemed necessary by the Charity Commission.

Asset Management

Assets in the ownership of or used by the Foundation Trust, shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer & Deputy CEO shall ensure: -

a) that appropriate records of all donated assets owned by the Foundation Trust are maintained, and that all assets, at agreed valuations are brought to account;

b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

c) that donated assets received on trust shall be accounted for appropriately; and

d) that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

Reporting

The Chief Finance Officer & Deputy CEO shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, among other things, the receipt of funds, investments and expenditure.

The Chief Finance Officer & Deputy CEO shall prepare annual accounts in the required manner, which shall be submitted, to the Charitable Funds Committee within agreed timescales.

The Chief Finance Officer & Deputy CEO shall prepare an annual trustees' report and the required returns to the Charity Commission for review by the Charitable Funds Committee and adoption by the Board of Directors.

Accounting and Audit of Funds held on Trust

The Chief Finance Officer & Deputy CEO shall maintain all financial records to enable the production of reports as above and to the satisfaction of the independent reviewer.

Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer & Deputy CEO.

The Chief Finance Officer & Deputy CEO shall ensure that the records, accounts and returns receive adequate scrutiny by the independent reviewer during the year.

The Charitable Funds Committee shall be advised by the Chief Finance Officer & Deputy CEO on the outcome of the annual independent review.

Taxation and Excise Duty

The Chief Finance Officer & Deputy CEO shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

TENDERING AND CONTRACT PROCEDURES

Duty to comply with Standing Orders and Standing Financial Instructions

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

EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust.

Formal Competitive Tendering

The foundation trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles and
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the department of health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

where the foundation trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

Formal tendering procedures are not required where:

a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation, (this figure to be reviewed annually); or

b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or

c) it relates to disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

d) where the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS).

e) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

Formal tendering procedures may be waived in the following circumstances:

f) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Foundation Trust record;

g) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

h) where specialist expertise is required and is available from only one source;

i) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

j) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

k) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law

Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Finance Officer & Deputy CEO will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Foundation Trust record and reported to the Audit Committee at each meeting.

Fair and Adequate Competition

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

Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Contracts and Commissions for the NHS Estate Concode) without prior approval in accordance with the Scheme of Reservation and Delegation.

Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Finance Officer & Deputy CEO and be recorded in an appropriate Foundation Trust record.

Contracting and Tendering Procedure

Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) it is received electronically by the due date and time specified in the Invitation to Tender (ITT) printed label supplied by the Foundation Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) All tenders will be issued electronically via the eTendering system. All tenders will be locked until the due date at which point, they will be unlocked by a designated officer.-

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Receipt and safe custody of tenders

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall recorded electronically on the eTenering system.

Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked via the eTendering system by a designated officer. The date will be recorded electronically recorded on the eTendering system.

(iii) The 'originating' Department will be taken to mean the department sponsoring or commissioning the tender.

(iv) The e contract management system will automatically record and store all the above information for competitive tender invitations despatched electronically.

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

Admissibility

i) If for any reason the option is that tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) the Procurement department will investigate as part of the procurement process and in compliance with EU Regulations. In the event that this cannot be resolved the Procurement Department would make a recommendation to either cancel the process or remove a particular supplier from the process.

(ii) Where only one tender is sought and/or received, the Chief Finance Officer & Deputy CEO shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) Contracts will be awarded based on the Most Economically Advantageous Tender (MEAT) that takes into account technical and service capability as well as cost, or the highest, if payment is to be received by the Foundation Trust unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. The % applied to price will vary based upon the goods or services being procured.

A standard tender evaluation criterion based on 70% technical and service capability and 30% related to cost (70/30). A requirement that any request to deviate from this 70/30 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

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

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; and

(b) that best value for money was achieved.

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

Quotations: Competitive and non-competitive

General Position on quotations

Quotations are required as per the values contained within the Scheme of Reservation and Delegation.

Competitive Quotations

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.

(ii) Quotations should be in writing.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Foundation Trust, or the highest if payment is to be received by the Foundation Trust, then the choice made and the reasons why should be recorded in a permanent record

Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals; and

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii) of this SFI) apply.

Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of the Chief Finance Officer & Deputy CEO.

Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, any commitments which may result in a liability are notified to the Chief Finance Officer & Deputy CEO in the form of a written report in advance of any commitment being made that will be approved by the Chief

Finance Officer & Deputy CEO. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives.

(a) The Foundation Trust shall use other external agencies for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

(b) If the Foundation Trust does not use other external agencies where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer & Deputy CEO.

Private Finance for capital procurement (see overlap with Capital Investment, Private Finance, Fixed Assets Register, Security of Assets – Private Finance)

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

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate body for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of Directors.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Compliance requirements for all contracts

The Board of Directors may only enter into contracts on behalf of the Foundation Trust within the statutory powers and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any available guidance on capital investment and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable;

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

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

Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

Foundation Trust Contracts / Healthcare Services Agreements (see overlap Foundation Trust contracts)

Service Agreement Contracts with NHS or Foundation Trust Providers for the supply of healthcare services shall be drawn up in accordance with legal advice.

All agreements entered into by the Trust for the receipt of services from, or the provision of services to, NHS and Foundation Trusts shall be reflected in a Contract Agreement. The Contract is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission Service Contracts with Providers of Healthcare.

Disposals (See overlap with Disposal and Condemnations, Insurance, Losses and Special Payments)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) obsolete or condemned articles and stores must be disposed of in accordance with the Disposal Policy

(b) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Reservation and Delegation, this figure to be reviewed on a periodic basis;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(d) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer & Deputy CEO representative.

All groups should work independently of each other and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board of Directors.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

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

These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

Business Case Approval

The Chief Finance Officer & Deputy CEO is responsible for defining the process for how business cases (revenue and capital) are generated, prioritised and approved)

All Officers are required to comply with the policies, procedures and processes established.

ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

The Chief Finance Officer & Deputy CEO shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is also deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

Refer also to Standing Orders, Standards of Business Conduct and Gifts and Hospitality Policy.

RETENTION OF DOCUMENTS

Context

All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

Accountability

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

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

Types of Record Covered by The Code of Practice

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

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

The documents held in archives shall be capable of retrieval by authorised persons.

Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

RISK MANAGEMENT

Programme of Risk Management

The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, which must be approved and monitored by the Board of Directors.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured; and

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

Insurance arrangements

The Board of Directors shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHSR or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decide not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

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

(1) Where the Board of Directors decide to use the risk pooling schemes administered by the NHSR the Chief Finance Officer & Deputy CEO shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer & Deputy CEO shall ensure that documented procedures cover these arrangements.

(2) Where the Board of Directors decide not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes, the Chief Finance Officer & Deputy CEO shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer & Deputy CEO will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer & Deputy CEO should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Standard Areas for Commercial Insurance Cover

(1) Foundation Trusts may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use.

(2) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into.

(3) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHSR. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer & Deputy CEO should consult the Department of Health.

Consideration for Other Areas of Insurance Cover

As a Foundation Trust the Board of Directors need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(1) Directors' and Officers' Liability – although recognising the cover available through the NHSR, due regard is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover;

(2) property damage – due regard for the provision for underwriting claims;

(3) business interruption resulting from property damage – due regard for the provision to cover for loss of income;

(4) personal accident and travel cover – for those individuals who travel in healthcare vehicles in the course of their business; and

(5) engineering cover – due regard for the provision for the continued use of the assets.

(Use of Standard Operating Procedures recommended giving clear and unambiguous guidance to staff).

TRAINING

Monitoring of the DOCUMENTED PROCESS OF THE Policy

(insert name of policy)

NHSLA /CQC Minimum requirements	Process for Monitoring e.g. audit	Responsible individual/ group/committee	Frequency of Monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for Monitoring action plan and implementation

SOURCES/REFERENCES

GLOSSARY OF TERMS

ASSOCIATED DOCUMENTS

ACKNOWLEDGEMENTS

(Insert section break after last Appendix)

APPENDICIES

(Insert section break after last Appendix)

EQUALITY IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Physical Disability	NO	
	• Learning Difficulties/Disability or Cognitive Impairment	NO	
	• Mental Health	NO	
	• Race	NO	
	• Carer	NO	
	• Nationality	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Culture	NO	
	• Religion or belief	NO	
	• Gender (Male, Female and Transsexual)	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
2	Is there any evidence that some groups are affected differently?	NO	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4	Is the impact of the policy/guidance likely to be negative?	NO	
5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this document, please refer it to Equality & Diversity Co-ordinator, together with any suggestions as to the action required to avoid/reduce this impact.

Document Information Box (Completed by AUTHORISED DIVISIONAL/CORPORATE SERVICE Librarian)

Item	Value
Type of Document	Policy
Title	Standing Financial Instructions
Published Version Number	V4
Publication Date	December 2021
Review Date	December 2023
Author's Name + Job Title	Karen Spencer, Head of Financial Services
CQC Standard Measure	
NHSLA General Standard	
NHSLA Maternity Standard	
Consultation Body/ Person	
Consultation Date	
Approval Body	Board of Directors
Approval Date	24 November 2021
Ratified by (insert the name of the sub-committees to Governance Committee) on behalf of Board of Directors or for Divisional Integrated Governance Boards for local procedural documents	Audit Committee
Ratification Date	18 November 2021
Author Contact	
Librarian	
Division	
Specialty (if local procedural document)	
Ward/Department (if local procedural document)	
Readership (Clinical Staff, all staff)	All Staff
Information Governance Class (Restricted or unrestricted)	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/13**			
SUBJECT:	**Quality Assurance Committee Cycle of Business 2022-2023**			
DATE OF MEETING:	26th January 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x 		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business and Terms of Reference (ToR) on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. Proposed changes to the Quality Assurance Committee Cycle of Business are highlighted on the attached Cycle of Business.			
PURPOSE: *(please select as appropriate)*	Information	**Approval √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2022-2023 Cycle of Business for QAC.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/01/09		
	Date of meeting	11th January 2022		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Quality Assurance Committee Cycle of Business 2022-23

Item		Lead	Jan 22	Feb 22	03/22	04/22	05/22	06/22	07/22	08/22	09/22	10/22	11/22	12/22
OPENING BUSINESS														
Welcome, apologies, declarations, cycle business	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Minutes and Action Log	**Decision**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review rolling attendance log	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story Bi-monthly wef June 21	**Note**	Dep Chief Nurse	✓	✓		✓		✓		✓		✓		✓
Deep Dive **AS RQD**	**Assurance**	Chief Nurse & Deputy CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Moving to Outstanding Action Plan Update Bi-monthly wef June	**Assurance**	Chief Nurse/Dep Dir Gov	✓	✓	✓	✓		✓		✓		✓		✓
Hot Topics **AS RQD**		Chief Nurse & Deputy CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ED Response high level update (wef 11/2021)	**Assurance**	**Chief Nurse**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sepsis high level monthly update (wef 11/2021	**Assurance**	**Dep CN PS&C Effectiveness**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
COMPLIANCE & OVERSIGHT														
Quality Dashboard Bi-monthly wef June TBC	**Assurance**	CN & DepC EO		✓		✓		✓		✓		✓		✓
Review and Refresh of Trust KPIs	**Assurance**	CFO & Deputy CEO			✓									
SAFETY														
Maternity Update & Maternity Safety Champion including: - Update on Ockenden Review - SI Maternity Monthly Report -	**Assurance**	CN & Deputy CEO and Director of Midwifery/ Mat Safety Champion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CNST Annual submission	**Approval**	CN+Dep CEO/Assoc CN (Midwifery)				✓	✓							
SI & Complaints Quarterly Report	**Assurance**	Dep Dir Gov		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**	
Safeguarding (Bi-Annual Report)	**Assurance**	Deputy CN											✓	
Safeguarding (Annual Report)	**Approval**	Deputy CN							✓					
Medicines Management/CD Annual Report	**Assurance**	Exec Med Director					✓							
Learning from Experience Report	**Assurance**	Dep Dir Gov			**✓Q3**		**✓Q4**				**✓Q1**			**✓Q2**

Item		Lead	Jan 22	Feb 22	03/22	04/22	05/22	06/22	07/22	08/22	09/22	10/22	11/22	12/22
6 monthly staffing report	Assurance	CN&Deputy CEO			✓						✓			
DIPC Infection Control (1/4 ly)	Assurance	CN&Deputy CEO			✓Q3		✓Q4			Q1			✓Q2	
DIPC Infection Control Annual Report	Assurance	CN&Deputy CEO							✓					
Infection Prevention and Control BAF Bi-monthly	Assurance	CN&Deputy CEO			✓		✓		✓		✓		✓	
Health and Safety Annual Report	Approval	Dep Dir Gov							✓					
DNACPR 6 month position report	Assurance	Exec MD / Dep CN P Safety				✓						✓		
Key discussion points from CROC (wef 04/21)	Assurance	COO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fit Testing Compliance Monthly Report (wef 01/21 (bi-mthly wef 05/2021) (1/4 ly wef	Assurance	Dep CN Patient Safety & Clin Educ	✓	✓	✓		✓			✓			✓	
CLINICAL EFFECTIVENESS														
Learning From Deaths Review Quarterly report	Assurance	Exec Med Director			✓Q3		✓Q4			✓Q1			✓Q2	
Clinical Forward Audit Plan	Assurance	Dep Dir Gov			✓									
Clinical Audit Quarterly report	Assurance	Dep Dir Gov			✓Q3		✓Q4				✓Q1			✓Q2
Clinical Audit Annual Report	Assurance	Dep Dir Gov							✓					
PATIENT EXPERIENCE														
Dementia Strategy Annual Review	Assurance	Deputy CN			✓									
Dementia Strategy Quarterly Report	Assurance	Deputy CN			✓Q3		Q4				✓Q1			✓Q2
Complaints Annual Report	Approval	Dep Dir Gov				~~✓ def 05~~	✓							
Patient Experience Strategy – Annual Review	Assurance	Deputy Chief Nurse							✓					
COMPLIANCE & OVERSIGHT														
Strategic Risk Register and Board Assurance Framework bi-monthly	Approval	Trust Secretary	✓		✓		✓		✓		✓		✓	
Quarterly Quality Priorities Report	Assurance	Dep Dir Gov			✓Q3		✓Q4			✓Q1				✓Q2
Quality Priorities 2020-21	Approval	Dep Dir Gov			✓									
Quality Strategy annual update	Assurance	Dep Dir Gov			✓									
Quality Strategy 2021-2024 **(due 2024)**	Approval	Dep Dir Gov												

Item		Lead	Jan 22	Feb 22	03/22	04/22	05/22	06/22	07/22	08/22	09/22	10/22	11/22	12/22
Risk Management Strategy Annual Review	Assurance	Dep Dir Gov					✓							
Nursing & Midwifery Strategy 2021-2024 (due 2024	Approval	Deputy Chief Nurse						✓						
Quality Impact Assessment Report for CIP plans	Assurance	CFO/Dep CEO			✓Q3		✓Q4			✓Q1			✓Q2	
Quality Improvement Progress Quarterly Report	Assurance	Chief Nurse& Deputy CEO		✓Q3			Q4			✓Q1			✓Q2	
Enabling Strategy alignment 6 mth Progress report	Assurance	Director of Strategy & Partnerships					✓						✓	
Terms of Reference	Approval	Chair/Trust Secretary										✓		
Cycle of Business	Approval	Chair/Trust Secretary	✓											
Committee Effectiveness Annual Review	Assurance	Chair/ Trust Secretary			✓rep toApr	✓								
Committee Effectiveness Bi-Annual Review	Assurance	Chair/Trust Secretary								✓repSpt	✓			
Committee Chair's Annual Report to the Board	Approval	Chair/ Trust Secretary							✓					
HIGH LEVEL BRIEFINGS														
Infection Control Sub Committee	Assurance	CN&Deputy CEO	✓		✓		✓		✓		✓		✓	
Patient Safety & Clinical Effectiveness Sub Cttee	Assurance	Exec Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safeguarding Committee	Assurance	Deputy Chief Nurse	✓	✓	✓	✓		✓		✓		✓		✓
Health and Safety Sub Committee	Assurance	Dep Dir Governance	✓	✓		✓		✓		✓		✓		✓
Complaints Quality Assurance Group	Assurance	Dep Dir Governance		✓		✓		✓		✓		✓		✓
Patient Experience Sub Committee	Assurance	Deputy Chief Nurse		✓		✓		✓		✓		✓		✓
Palliative and End of Life Care Steering Group	Assurance	Cons Palliat Med /Dir Med Educ	✓		✓		✓		✓		✓		✓	
Risk Review Group	Assurance	Dep Dir Governance	✓		✓		✓		✓		✓		✓	
HLB Quality Academy Committee	Assurance	Dep Dir Governance	✓			✓			✓			✓		

Item		Lead	Jan 22	Feb 22	03/22	04/22	05/22	06/22	07/22	08/22	09/22	10/22	11/22	12/22
IG + Corporate Records Group incl GDPR Readiness Plan	**Assurance**	CIO	✓		✓		✓		✓		✓		✓	
PATIENT Equality, Diversity & Inclusion Sub Committee (bi-monthly report wef 09/2021)	**Assurance**	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Level Briefing Strategy & Sustainability exception report when required	**Assurance**	Director of Strategy & Pships												
High Level Enquires (when notified)	**Assurance**	Dep Dir Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Summary (assurances/risks to escalate to Board)	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

2022 MEETINGS – DATES TBC	Jan	Feb	Mar	Ap	May	June	July	Aug	Sept	Oct	Nov	Dec
Infection Control Sub Committee												
Patient Safety & Clinical Effectiveness Sub Committee												
Safeguarding												
H&S Sub Committee												
Complaints Quality Assurance Group												
Patient Experience Sub Committee												
Palliative and End of Life Care Steering Group **DATES TBC**												
Risk Review Group												
HLB Quality Academy Committee March/15 June/Oct/December 2021												
ED&I Sub Committee Monthly												
IG & Corporate Records Group												
Patient ED&I Sub Committee (ef Sept 2021)												

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/16**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	26 January 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention & Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	√
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	

	#1331 Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	To provide the Trust Board with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control Board Assurance Framework Compliance Report	AGENDA REF:	BM/22/01/16

1. BACKGROUND/CONTEXT

Guidance on the required infection prevention and control measures for Covid-19 have been published, updated, and refined to reflect learning. Further guidance and mitigating actions have been advised as new variants of the virus have emerged.

This assessment tool (version 1.8) has been refined to reflect requirements specified in the Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021/22.

The framework is used to assure the Trust Board of Directors, by assessing the measures taken in line with current guidance and identifies areas where further action is required.

Legislative requirements relating to Covid-19 include: -

- *Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance* (2015), which is linked directly to Regulation 12 of the *Health and Social Care Act 2008*
- Personal Protective Equipment at Work Regulations 1992
- Workplace (health, safety, and welfare) Regulations 1992
- *Health and Safety at Work etc. Act* 1974

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users, and staff. Where it is not possible to eliminate risk, assessment and mitigation is in place to provide safe systems of work. Local risk assessments are based on the measures as prioritised in the hierarchy of controls.

This Assurance Framework and Action Plan will be reviewed bi-monthly by the Infection Prevention and Control Team and submitted to Infection Control Sub-Committee, Quality Assurance Committee and Trust Board bimonthly, with an action plan to address any areas of concern identified.

This assessment has been made against version 1.8 of the Infection Prevention and Control Board Assurance Framework published on 24th December 2021.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

It should be noted that a comprehensive action plan arising from the compliance assessment has been implemented with delivery closely monitored at the Infection Control Sub-Committee, Quality Assurance Committee and Senior Executive Oversight Group.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Include in cycle of business for Infection Control Sub-Committee and keep under continuous review to identify any emerging information that would require addition to the action plan

- Monitor the action plan to address gaps in assurance until completion

4. IMPACT ON QPS?

Q: Visiting restrictions due to risk of infection may have a negative impact on patient experience. Several communication mechanisms have been implemented

P: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. Several staff are absent from work due to shielding status

S: Financial impact of a global pandemic and major interruption to business as usual

5. MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF Action plan monitoring
- Environmental Action Plan monitoring
- Nosocomial case monitoring and outbreak detection and reporting

6. TRAJECTORIES/OBJECTIVES AGREED

- To ensure compliance with the Code of Practice on Prevention of Healthcare Associated Infections

7. MONITORING/REPORTING ROUTES

- Infection Control Sub-Committee
- Quality Assurance Committee
- Senior Executive Oversight Group
- Trust Board

8. TIMELINES

- For the duration of the Covid-19 pandemic at all stages which is yet to be determined

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

- The Board is asked to note the report.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A respiratory season/winter plan is in place: that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/ placement and safe management according to local needs, prevalence, and care services to enable appropriate segregation of cases depending on the pathogen plan for and manage increasing case numbers where they occur a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	Triage tool in ED: Molecular Point of Care Testing for Covid-19; Seasonal respiratory testing SOP (including Influenza A/B; RSV and Covid-19) for patients attending ED with respiratory symptoms ED triage and placement according to respiratory/ non-respiratory presentation. Liaison with Patient Flow on Covid status to ensure appropriate isolation or cohorting Covid capacity escalation plan discussed and agreed at Tactical Group meetings Additional side room capacity created with pods inserted in ED x1 ICU x5 B18 x4 Additional side rooms created on Wards A2 A3 A6 A9 C21	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Completed risk assessments			
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: - based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area - applied in order and include elimination; substitution, engineering, administration and PPE/RPE - communicated to staff	Risk assessments in place for all locations in the Trust Signage on room doors	Risk assessment formatting does not use hierarchies of control Communication of control measures	Revision to risk assessment in progress (draft 01/2022) to provide risk mitigation measures in the order of: elimination, substitution, engineering, administrative controls, and Personal Protective Equipment (including Respiratory Protective Equipment) Single page guidance given to all staff at CSTM building	
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	All risk assessments are approved via a robust Governance procedure at Tactical meetings			
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Nil derogation from national guidance			

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	- All completed risk assessments are reviewed by the Head of Safety and Risk	-	-	
- If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	- Risk assessments include RPE and other key items of PPE including eye protection	-	-	
- Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	- Patients are allocated to wards based on speciality requirements	- Learning from nosocomial Covid cases identified concerns about patient transfers	- Operational and Patient Flow teams work cohesively to minimise patient transfers as far as reasonably practicable	
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	- Chief Nurse/DIPC signs off data submissions - Sign off process in place for daily nosocomial SitRep - Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off			
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas	- Matron and IPC Walkarounds - Senior nursing team checks that action cards are being completed - Executive Team walkabouts - Ward Accreditation with IPC reviewer membership - Challenge occurs at the following meetings:			

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group Increased Microbiology support/ briefings delivered to medical cabinet			
- Resources are in place to implement and measure adherence to good IPC practice. - - This must include all care areas and all staff (permanent, agency and external contractors)	- PPE supply is monitored at tactical Group meetings - - Signage is displayed on donning and doffing as an aide memoire for staff.	-	-	
- The application of IPC practices within this guidance is monitored, e.g.: - hand hygiene - PPE donning and doffing training - cleaning and decontamination	- - - Weekly hand hygiene audits - Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas -	- - - Centralised information on PPE training	- - - UK HSA training videos are included in annual mandatory training programmes. Level 2 clinical training 84% at the end of November 2021.	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Board meeting agenda Board meeting minutes			
The Trust Board has oversight of ongoing outbreaks and action plans.	- Information on outbreaks included in daily executive summary and discussed at the			

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	daily Senior Executive Oversight Group Meeting - Learning from Outbreaks included in Nosocomial Board Paper 01 2021 - Nosocomial learning action plan in place reviewed at Silver IPC cell meetings - Covid-19 RCA findings fed back to CBUs with drill down to individual ward learning September 2021 - Outbreak email circulation			
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Fit Testing programme in place and working to ensure all staff are successfully Fit tested against 2 types of mask, using Qualitative and Quantitative methods			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Task and Finish Group established with Action Plan in place for implementation.			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	Progress will be included in IPC quarterly reports.			
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Communications team are involved in changes and ensure information is cascaded and signage displayed			
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards			
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	Additional cleaning of outbreak areas including frequently touched surfaces			
Where patients with respiratory infections are cared for, cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Chlorine based cleaning products are in use. Hydrogen peroxide Vapour is used following terminal cleaning.			
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Alternative disinfectant used in CT scanning room.	- Specialist cleaning plan in place in the CT scanning room	- CT Manufacturer provided alternative decontamination guidance - Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Information on contact time is included in the decontamination policy			
A minimum of twice daily cleaning of: - patient isolation rooms - cohort areas - donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails - where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea	- Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes - Increased cleaning frequency in all public areas including toilets, communal spaces, lifts - Cleaning of workstations is included in the Environmental Action Plan - Domestic staff time cleaning activity when areas are vacant - Increased cleaning included in ICU Bioquell pod SOP			
A terminal/deep clean of inpatient rooms is carried out: - following resolutions of symptoms and removal of precautions - when vacated following discharge or transfer (this includes removal and	- Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required to decontaminate the			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
disposal/or laundering of all curtains and bed screens) - following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	environment. Decontamination included in the Covid-19 policy - All policies are used in conjunction with any updates provided by COVID-19 national guidance - Terminal Cleaning Guidelines 2018 - Decontamination Policy 2019 - 4 additional HPV machines purchased - CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff - Associate Director of Estates is a member of Silver IPC cell - Terminal cleaning standards sign off checklist			
- Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment.	- Included in Decontamination Policy - Cleaning monitoring audits - Decontamination audits - Policy and certification process to confirm cleaning prior to service inspection or repair			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	- Robust audit programme with timely feedback for corrective action as per the national cleanliness standards	-		
- As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	- Maintenance records and theatre validations. - All mechanical ventilation is subject to monthly visual control checks, quarterly servicing. Theatres are validated annually	-		
- The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	- Trust supported by an Appointed Authorising Engineer/Ventilation. - Guidance sought on all capital projects with sign off of plans.	- Assessment of all in patient areas against HTM requirement to be carries out by Ventilation AP (Estates) and trust AE (external) and brought to Ventilation group		
- A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	- Sign off any changes to patient areas by trust AE (external). Head of capital Projects to provide to Ventilation group.	-		
- Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	- 'Give fresh air to show you care' campaign -	-		
- Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	- Trial of alternative technology completed - Products will be reviewed by the Ventilation Group to ensure fitness for purpose	-		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	- Discussion on air low takes place between IPC Team and Estates Team	-		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- Arrangements for antimicrobial stewardship are maintained - previous antimicrobial history is considered - the use of antimicrobials is managed and monitored - to reduce inappropriate prescribing - to ensure patients with infections are treated promptly with correct antibiotic.	- Consultant Medical Microbiology daily Ward Round in Critical Care - Ward based Pharmacist support - Prescribing advice available by telephone (in and out of hours 24/7) - Twice weekly antibiotic ward rounds continuing - Commenced Medical Admission Unit weekly board round - C difficile Cohort ward weekly MDT meeting - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated	- - Business case in progress to strengthen stewardship resources. Plan for recruiting 0.5 band 7 and a full-time pharmacy technician to improve the level of assurance through a better supported AMS team -	- - Change approach to auditing to provide more meaningful data	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Antibiotic prescribing guidelines for COVID suspected patients have been published - Antimicrobial Management Steering Group Meetings - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee – Process being reviewed to Biannual audits with focus on areas with higher concerns			
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	- Mandatory reporting of HCAIs has continued - Data on HCAIs is included on the Quality Assurance Committee and Trust Board and Infection Control Sub-Committee Dashboards - DIPC reports HCAI data at Trust Board - Information on Data Capture System - Distribution of HCAI surveillance data weekly - Annual PHE HCAI reports and monthly dashboards			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	- Infection control risk assessments completed on admission and updated in light of microbiology results - Electronic patient record alerting system			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	- Control measures in place in the form of risk assessment at ward level - Number of visitors in ward environment controlled as per national guidance - Exceptions to restricted visiting in place as per national guidance - Opportunities supported for virtual visiting			
National guidance on visiting patients in a care setting is implemented	National Guidance has been utilised to embed systems and processes around visiting for patients e.g.		Full updated standard operation procedure to be updated in line with new National Guidance published on 1st January 2022	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Lateral flow testing - Exceptions to visiting guidance in place - National guidance (Jan 2022) presented and discussed at trust Tactical Board meeting Visiting task and finish group in place fortnightly to review national guidance and local plans attended by key stakeholders within the Trust			
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	- Visiting Exception posters provided to ward areas - Email from Chief Nurse & Deputy Chief Executive to all nursing leaders		Good Morning Message planned for week commencing 31st January 2022 to include updated Standard Operating Procedure	
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Every Action Counts campaign in place to include - One way system - Information posters - PPE stands at every entrance which is replenished daily by the welcome team PPE champions in place			
If visitors are attending a care area with infectious patients, they should be made	Completed as part of risk assessment process which is			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM	completed prior to entering the hospital. FIT testing is carried out to support visiting as per exception criteria e.g. for patients at the end of their life			
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	- Visitor Risk assessment - Sign-in sheet symptom checker - FIT testing is carried out to support visiting as per exception criteria e.g. for patients at the end of their life - Full PPE provided as appropriate for areas including support for donning and doffing in ICU.			
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	Visiting risk assessment on wards if required / essential FIT testing and full PPE provided.			
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll out plan devised			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage displayed at all main entrances			
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	- SBAR transfer form in place - Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab - Covid-19 status included on SBAR form - Covid-19 has been added to e-discharge summary template - Pre-admission information provided to patients being admitted electively - Policy for patients being discharged to care homes			
Staff are aware of agreed template for screening questions to ask.	ED triage tool Covid screening sign in sheet			
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment	Visitor risk assessment			
Front door areas have appropriate triaging arrangements in place to cohort patients	Triage tool and molecular Point of Care testing is in use in ED. Positive			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	results are sent by text message to Infection Prevention and Control (IPC) Nurses, who review and put IPC advice in place. PCR testing is also undertaken on admission Respiratory SOP			
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Senior staff triage in ED			
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	Compliance reviewed during outbreaks and at nosocomial RCA review meetings	Audit of compliance required		
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients			
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	ED segregation of respiratory non-respiratory areas			
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	Prioritisation for side rooms is based on suspected/known diagnosis	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	Isolation Policy Isolation of immunocompromised patient s policy			
Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Virtual Ward			
Face masks/coverings are worn by staff and patients in all health and care facilities.	Universal masking policy in place SOP for face mask refusal			
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	- Inpatient bed spacing assessment - Perspex screens in place at reception areas	Some bed spaces are closer than 2 metres	- Use of clear curtains between bed spaces - Timing of visits to toilet facilities - Use of face masks where tolerated	
Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	Effective systems in place to support prevention of HCAI including: - training, policies, and audit plan: - - Hand hygiene audits weekly - PPE (readily available) audits of AGP and non-AGP weekly - Environmental audits according to risk category - High impact intervention audits			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Supplies monitoring of PPE levels daily - Social distancing check included on the daily Clinical Area Action Card - Spot checks on break rooms - Signage and refresh campaign aligned to national campaign - Infection Prevention and Control Team visibility on wards			
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Testing advice is included on the Antibiotic Formulary for patients with hospital onset Pneumonia	Contact tracing is challenging as there isn't an electronic Patient tracking system	Contact tracing is carried out as far as reasonably practicable. Letters are given to contacts advising them of the Covid contact and includes advice on isolation requirements	
Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.		Contact tracing is challenging as there isn't an electronic Patient tracking system Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	- Information provided prior to attending Outpatient Departments and further			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	symptom screening in place on arrival			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC Mandatory training programme Signage for visitors and support provided by staff on duty			
Training in IPC measures is provided to all staff, including: - the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and - the correct technique for putting on and removing (donning/doffing) PPE safely.	Fit Testing programme PPE Champions (58), roving training on donning and doffing of PPE			
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Mandatory IPC Training package			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	PPE audits in place			
Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Standard precautions and PPE guidelines			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	- Hand air dryers not in place in clinical areas - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Guidance on social distancing re-enforced			
Staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance included in Uniform Policy and Covid-19 PPE booklet.			
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of	SOP in place for testing staff and or household members			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
the symptoms (even if experiencing mild symptoms) in line with national guidance.				
To monitor compliance and reporting for asymptomatic staff testing	LAMP testing compliance data monitored at Tactical Group meetings	Uptake low approximately 450 staff	Uptake encouraged	
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Consultant Microbiologist presentations at Tactical Group meetings. BI reports with UpToDate position			
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team monitor incidence and report outbreaks in line with the HOCI SOP			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.				
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Virtual ward			
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Monitoring of Covid testing for patient placement	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Health and Safety review of clinical areas on rota system			
Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Sop for respiratory/non-respiratory pathways and PPE requirements			
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Care of deceased patients' guidelines			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Testing is undertaken by competent and trained individuals.	Training on swabbing technique provided verbally and by video Competency assessment tool launched Training provided on use of molecular testing equipment			
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening LAMP testing in place for staff	- RCAs identified some routine samples are being missed - Low uptake of staff LAMP testing	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
Staff testing protocols are in place	Staff testing SOPs			
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Monitoring at Silver IPC			
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	- LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 - Documentation of IPC advice on receipt of positive results			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- RCA requests for cases ≥ day 8 of admission, with monitoring system in progress - Daily data validation process for Sit Rep signoff and external reporting - IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission			
Screening for other potential infections takes place.	Other routine admission screening (CPE, MRSA, VRE) in place			
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All patients being admitted to the Trust have Covid admission tests taken in ED using point of care (Abbot ID Now) testing and PCR swab			
That those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	A small number of RCA investigation findings identified missed testing opportunities	Discussion took place at Medical Cabinet to advise timely testing for Covid in patients developing Hospital acquired pneumonia Guidance added to the Trust Antibiotic Formulary to test for Covid any patients who develop HAP	
That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs Weekly screening implemented	RCAs are identifying a very small number of routine samples are being missed	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol Additional control measures put in place to ensure compliance including reminders via	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
			daily safety brief, emails to senior staff, electronic monitoring system PowerPoint presentation on RCA learning fed back to CBUs with drill down of learning at individual ward level	
That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	- Community prevalence increasing >1400 per 100k/7-day rate January 2022 - Reduced nosocomial case numbers - Increased testing in outbreak areas as advised be the Infection Control Doctor - Daily testing has been implemented on wards during Covid-19 outbreaks			
That those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Discharge screening in place with results shared accordingly prior to patient discharge			
Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Named community facility for care of patients who require continued isolation for Covid-19			
There is an assessment of the need for a negative PCR and 3 days self-isolation before	Revision to pre-admission PCR testing in progress.			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.				

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The application of IPC practices is monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC Audit Programmes - Hand hygiene - PPE - High Impact Intervention Audits - Ward audit programme			
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	- PPE Champions in place - Clinical advice for management of patients with suspected infections continued - IPC on call service to provide advice 7 days per week - PPE donning and doffing included in Induction and Mandatory training sessions			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- IPC Team visit areas to discuss concerns raised in relation to national guidance			
Safe spaces for staff break areas/changing facilities are provided.	Break rooms are Covid secure risk assessed. Spot checks on social distancing are carried out			
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	- Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly - Occupational Health and Wellbeing Team monitor for clusters of staff cases - Outbreak meeting agendas, minuites and action plans - Outbreak reporting reference numbers from NHSE/I via web-based reporting system - Emails to PHE; CCG; CQC			
All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored, and managed in accordance with current national guidance.	- Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Guidance included in the Coronavirus Policy - Used linen is processed as infected via red alginate stitched bag stream			
PPE stock is appropriately stored and accessible to staff who require it.	- Stock control in place - In and out of hours access protocol in place - Specialist PPE equipment office with access available 7 days/week - National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.				
Bank, agency, and locum staff follow the same deployment advice as permanent staff.				
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	SOP in-place to allow return to work in line with NHSE/I guidance			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory IPC training. Level 2 compliance eat the end of November 2021 = 84%			
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing programme is in place.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence. Infection prevention and control board assurance framework - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	In place			
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Integrated self-risk assessment tool has been produced			
A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be	- An integrated self-risk assessment tool has been			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; that advice is available to all health and social care staff, including specific advice to those at risk from complications Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	produced for enable all staff to identify if they are 'at-risk'. Following identification (through the tool or the personal information held on individuals), and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group, compliance is currently (Sep-21) at 94% and is reported daily - Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback - Individual letters have been sent to BAME members of staff, outlining support available - Named midwife contact within Maternity Department provides advice for pregnant staff - All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- All staff working at home have been provided with a 'working from home pack', including access to mental health support - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical - An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy, and the British Psychological Society - Electronic system in place for Covid-19 Workforce risk assessment - Access to face to face counselling			
Vaccination and testing policies are in place as advised by occupational health/public health.	- In place			
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records	- Fit testing programme, including quantitative and qualitative testing, in place - Qualitative Fit testing SOP - Quantitative Fit testing SOP - Records are added to a central database - Powered Hoods are offered as an alternative where it has not been			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	possible to Fit close fitting face masks Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
Staff who carry out fit test training are trained and competent to do so.	Programme of Fit Testing in place which is only carried out by trained Fit testers An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	Programme of Fit Testing in place Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 08/10/2021 Total Number on Database: 3848 Total Number passed on at least 1 current supported mask: 2422 Total Number passed on at least 2 current supported masks: 554			
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	In place			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	- Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	- Spreadsheet with Fit testing details included	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	alternative equipment is provided			
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE	-	-	
A documented record of this discussion should be available for the staff member and	- Provision of specialist PPE equipment is recorded	- Documented evidence of discussion and	- Process under review to capture this data	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
held centrally within the organisation, as part of employment record including Occupational health.		central holding of this record		
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	- Spreadsheet with Fit testing details included - Compliance with Fit testing is monitored. Paper submitted to QAC - Email updates provided weekly by the Fit Testing Team Coordinator	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings - Report to QAC 02/2021	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	- Staffing reviews undertaken for all COVID areas - Staff movements managed by the senior nursing team at daily meetings - Senior Nurse presence 7 days per week 8am-8pm to support staffing management - Planned elective areas have designated teams, who are not moved to any other area in the Trust - Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. - This cross over has not occurred between Elective and Emergency Care pathways			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	- Risk assessment in place to reduce risk - Agile working policy includes home working			
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place - Data reported to Tactical meetings - Staff self-Isolation SOP in place from 08/2021 to enable staff to return to work, if they meet a risk assessed criteria from non-household Covid-19 contact			
Staff who test positive have adequate information and support to aid their recovery and return to work	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical - Occupational Health and Wellbeing advise staff of test results and provide further	- Test and Trace Service hours of operation	- National guidance for 16 hour per day service (cover in place for 11.5 hours per day) - Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	wellbeing support as and when required - Retesting is in place as appropriate and is set out in Staff Testing SOP			

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/15**	
SUBJECT:	**Learning From Experience Q2 Report**	
DATE OF MEETING:	26 January 2022	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING	

	in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1579** Failure to transfer patients with major trauma, PPCI and Vascular to specialist units, caused by unprecedented demands on the North West Ambulance Service, resulting in a delay for identified or accepted specialist high risk cases. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety and Clinical Audit related to Quarter 2, 2021/22.

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		

	Agenda Ref.	QAC/21/12/310
	Date of meeting	7 December 2021
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning From Experience Q2 Report	AGENDA REF:	BM/22/01/16

1. BACKGROUND/CONTEXT

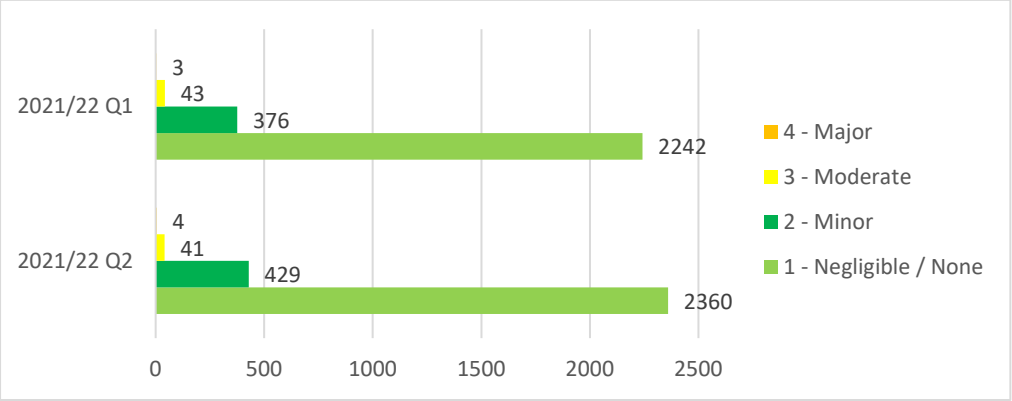
This report relates to the period 1st July – 30th September 2021 (2021/22 Q2). It contains a quantitative and qualitative data analysis (using information obtained from the Datix risk system) of Incidents, Complaints, Claims, Health & Safety and Clinical Audit. The report includes a summary of themes, trends and key findings identified in Quarter 2 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

a. Learning from Incidents

Reporting Position

There was a 6.38% positive increase in incident reporting across the Trust in 2021/22 Q2 (2664 in 2021/22 Q1 vs 2834 in 2021/22 Q2). There was a positive decrease in incidents causing Moderate to Catastrophic harm in 2021/22 Q2 (46 in 2021/22 Q1 vs 45 in 2021/22 Q2). The number of no harm incidents reported increased by 5.26% in Q2 following incident reporting returning to normal levels. The reduction in incident reporting was a likely consequence of less activity during the pandemic. The 'Report to Improve' campaign was relaunched following the first wave of the pandemic to support and provide assurance of active incident reporting.

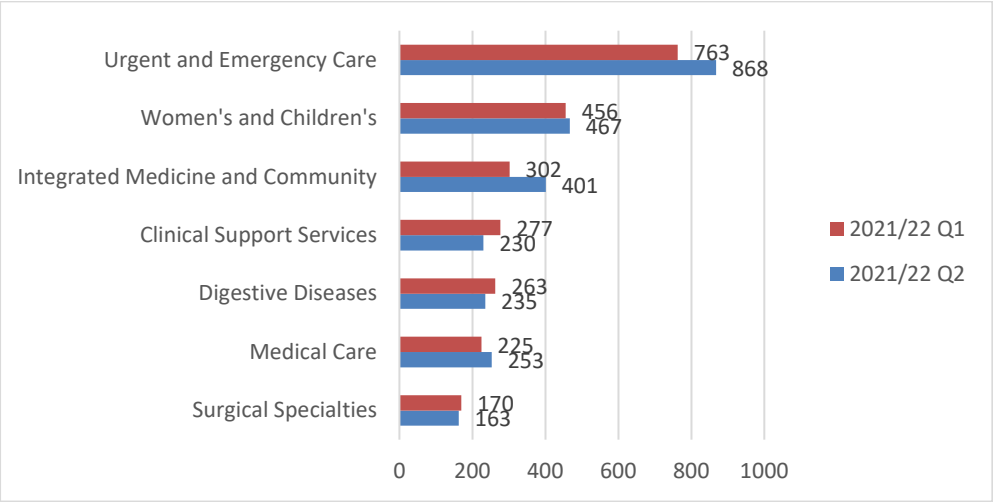


Incidents reported per CBU

There was an increase in the number of incidents reported from the previous Quarter. A total of 2615 incidents were reported across the 6 CBUs and Clinical Support Services in Quarter 2, this has increased from 2457 when compared to Quarter 1.

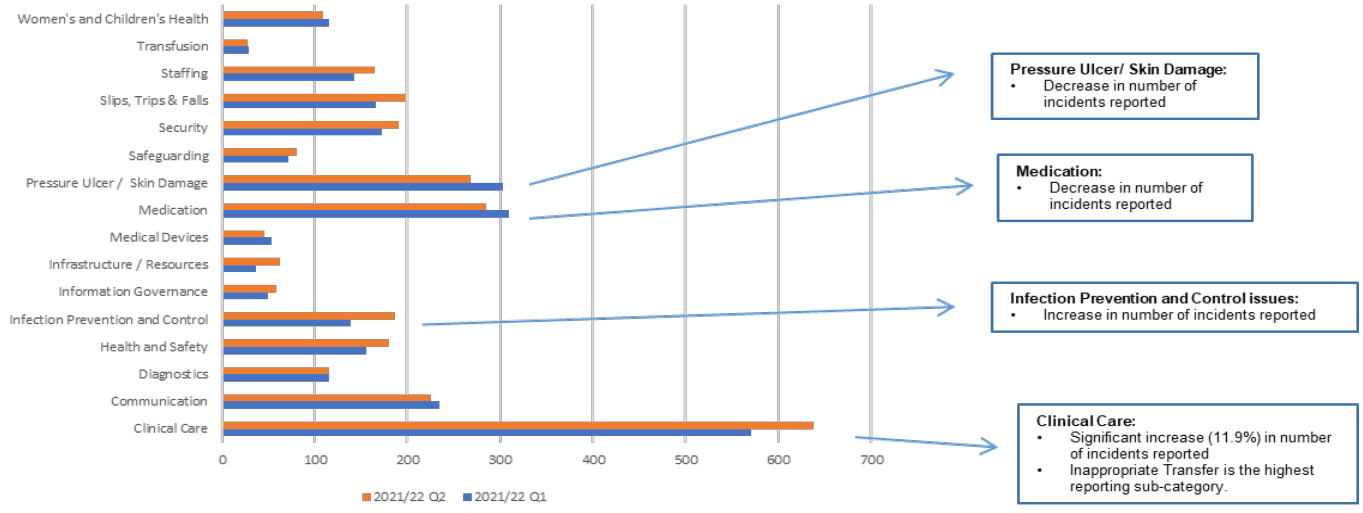
In Quarter 2, Urgent and Emergency care reported the highest number of incidents (868), this was also the case in Quarter 1. Of those reported in Quarter 2, 98.96% of these were minor or negligible harm. This demonstrates that the Urgent and Emergency Care CBU is promoting a culture of positive incident reporting. Digestive Diseases has reported 235 incidents in Quarter 2 when compared to 263 in Q1. This is a marginal decrease of 11%. In order to increase reporting cultures, the report to improve campaign will be reshared on a weekly basis with the CBU via the Governance Manager, this is in addition to the daily prompt the Governance Manager's do when reviewing incidents. In

addition, bespoke Datix training will be offered by the Senior Administrator for Datix over the next Quarter. An agenda item will be added to the CBU Governance agenda for December 2021 to highlight the slight reduction in reporting.



Types of Incidents being reported

The number of incidents reported relating to Clinical Care, Infection Prevention and Control and Slips, Trips & Falls increased in Q2. Incidents reported relating to Medication, Pressure Ulcer/ Skin Damage and Communication decreased in Q2. Incidents relating to Clinical Care continue to be the most commonly reported at 669 and 96.4% of these incidents were minor or negligible harm. When we look at these figures against Clinical Care incidents reported in Quarter 1 (594 reported, 94.9% minor or negligible harm) and also those reported in Quarter 2 20/21 (423 reported, 97.8%), we can see that the Trust is continuing to move towards a more transparent incident reporting culture, for incidents at all levels of harm.



Incident Themes

In Quarter 2 there has been a significant positive increase in the number of infection prevention and control incidents reported (34.5%). This is indicative of the on-going work of the Infection Prevention & Control Team in fostering a culture of increased vigilance around infection control across the Organisation. The Quality Improvement Team have developed a Gram-Negative Bloodstream

Infections (GNBSI) Collaborative. The aim of this collaborative is to reduce healthcare associated GNBSI by 5% by March 2022. Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. A change package outlining evidence-based interventions will be developed in Quarter 3, for all wards to implement. Work is also in progress to update and develop relevant trust wide policies and training.

Serious and Concise Incidents closed within the Quarter

There were 7 Serious Incidents closed within Quarter 2. This is a decrease from Quarter 1, where 18 Serious Incidents closed. This indicates a positive reduction, as the number of serious harms has reduced by more than 50% which has meant that less serious incident reports are open on the system to close.

There were 23 concise incidents closed within Quarter 2, this is a decrease from Quarter 1, where 30 concise incidents were closed. This indicates a positive reduction, as the number of moderate harms has reduced by more than 23% which has meant that less concise reports are open on the system to close.

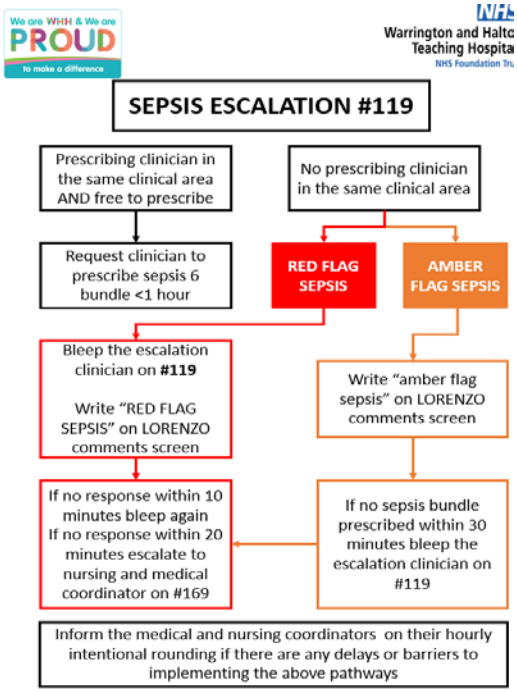
Learning from Incidents and Assurance

For the purposes of transparency, the Associate Director of Governance and the Patient Safety Manager have established attendance with the CCG in order to present SIs with the LIOs. This enables feedback and assurance in real time through broad discussion. The Serious Incident Review Group is chaired by the Chief Nurse of the CCG, who has commented that the meeting is proving successful in providing great assurance to the CCG. In addition, the Deputy Director of Governance presents at the Clinical Quality Focus Group any themes and trends and offers assurance to the CCG.

Following the Root Cause Analysis (RCA) investigations of these incidents, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend of the specific learning points noted below.

Delay in Sepsis Management

An Urgent and Emergency Care RCA identified that a patient had rapidly deteriorated and sadly died as a result of delays in the identification, escalation and management of her sepsis. As a result, a new process was introduced for a Sepsis Escalation Doctor to be identified for each shift. Patient Safety nurses now also attend the ED weekly to assist with education and complete sepsis audits, including reviewing the quality of documentation around sepsis escalation. A business case was escalated for fridges to be installed for pre-made antibiotics to be stored in the ED, to allow for quicker access in cases of a sepsis emergency. The business case has been approved, and the fridges are now in place. An SOP was also created for the escalation of prescribing for sepsis patients, which gives staff very clear guidance on the process to be followed. This is monitored via the Deputy Chief Nurse for Patient Safety and feeds into the wider action plan for Sepsis management, which reports in Quality Assurance.

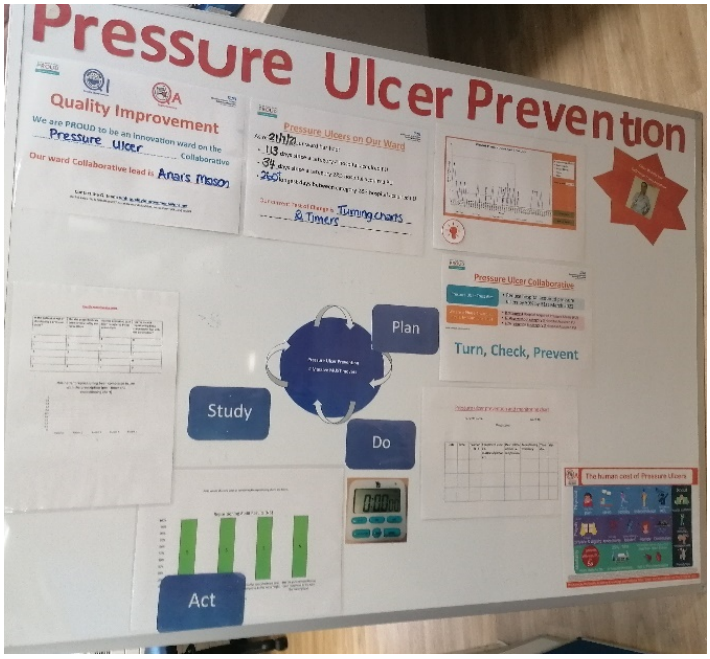


Inadequate Documentation

5 of the RCAs completed in Quarter 2 found that documentation errors or omissions were root causes or directly contributory factors in the incidents. In order to address the documentation omissions identified in the Integrated Medicine & Community RCA, whereby comfort rounds and body maps were incomplete, a pressure ulcer collaborative was commenced within the CBU, and a test of change implemented through link nurse involvement, whereby a Pressure Ulcer Board was established on ward A7. This supports the monitoring of the number of pressure ulcers on the ward ensuring it is in all staff areas with information displayed with information about the tools in place to prevent pressure ulcers occurring.

One of the Women's & Children's RCAs identified that a patient's pregnancy had been incorrectly identified as low risk due in part to green maternity records being created at a different time to the electronic records. In order to address this, a temporary process was set in place across the CBU for staff to update Lorenzo when a patient does not have handheld maternity notes at the time of the clinic appointment. This issue will be resolved with the introduction of the new BadgerNet records system, which is due to be implemented by April 2022. A new booking risk assessment tool (included as Appendix 1) was also implemented to support staff to carry out risk assessments correctly.

A different Women's & Children's RCA found that a baby had developed an infection on his heel following repeated heel pricks, the root causes included that there was a lack of documentation around the location of where the samples were obtained. As a result, the training regarding heel prick bloods was added to the current competency assessment, with documentation around location being included as a point for assessment. A communication was also sent to staff in the area to



Example of the Pressure Ulcer Collaborative board – Ward A7 Quarter 2

Inappropriate Transfer

A Women's & Children's RCA found that new-born twins were inappropriately transferred to transitional care. The root cause of this issue was due to a lack of staff knowledge of the transitional care guideline. In order to address this, a review of the transitional care guideline was carried out. This was completed on 30/09/21, with changes to the guideline included. The criteria for suitability for transitional care have changed to include babies from 34 weeks gestation (BAPM, 2017) and babies weighing ≥1.8kg. It has been clarified in the updated guideline that Nursery Nurses and Staff Nurses will oversee the care of this cohort of babies within the Maternity Ward with the support from the Neonatal shift leader and ANNP/Paediatric registrar. The standards are designed to ensure greater ownership of baby care split between two wards (NNU and C23).

Escalation of Mental Health concerns

2 of the RCAs completed in Quarter 2 concluded that the root cause of the incidents was a lack of escalation of patients with mental health concerns at risk of self-harming. As a result of the findings, a safety alert was issued on 29/10/2021 to all clinical areas regarding mental health referrals and will be audited. A review of the alert system on Lorenzo is also currently on-going and is due to be completed in Quarter 3. This is intended to make the alert system more prominent and easier to locate, and the request for this change has now been submitted to the supplier and is expected to be delivered in January 2022. Staff training compliance in relation to Mental Health was checked on the ED and A9 and confirmed that staff are up to date with their training.

Safety Alerts

The Trust uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 2:

Subject	Detail	Date issued
Patient Own Drugs	Patient's own medicines must be locked away on admission. There have been two incidents where a patient has taken a medicine not prescribed for them due to their medicines not being locked away on admission. **Action:** When a patient is admitted/transferred to a ward, please check with the patient if they have any medication with them and ensure all their medicines are locked away in their POD locker or if it is a controlled drug in the ward CD cupboard. **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	04/08/21
Administering Medicines – verbal order	An incident has occurred where a patient was administered a dose of intranasal fentanyl without a written prescription. This is contrary to the Medicines and Controlled Drugs Policy which states that Schedule 2 controlled drugs (CDs) must not be administered by non-medical staff without a prescription. When a verbal order is given there is a risk of miscommunication resulting in a medication error. For controlled drugs (CDs) there would be a failure to comply with legal requirements. **Action:** Verbal orders should only be given by an authorised medical prescriber to authorised staff to administer medicines without a prescription in exceptional cases of clinical emergency. **A verbal order cannot be used to administer a Schedule 2 Controlled Drug.** **Action:** All Divisional Clinical Governance Leads, Clinical Leads, Consultants, Divisional Head of Nursing, Matrons, Ward Manager and Heads of Departments print off the Alert and ensure this is communicated to your staff as part of all communication briefings. **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	10/09/21
Insulin prescribing	A theme was identified from incidents submitted in relation to prescribing errors, and it was identified that this was in relation to the complexity of the prescribing system. **Action:** Insulin prescribing on the EPMA Formulary on Lorenzo has been updated following feedback from users and DATIX reports. The layout has been simplified and dose sentences have been introduced for Insulin Infusions, Insulin Pumps and carb counting. **Assurance:** The changes have been approved via Medicines Governance Committee and aim to reduce the risk of mis-selection leading to prescribing and/or administration errors.	28 /07/21

	The Safety alert provided detailed instruction on the new processes to be followed by prescribers and nursing staff. The alert was printed and shared with ward staff. We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	

Never Events

Never Events are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The Never Event list (2018) is included as an Appendix (Appendix 2).

Never Events from this Quarter
There were no Never-Events opened or closed in Quarter 2. This is in line with Q1, where there were also no Never-Events opened or closed.

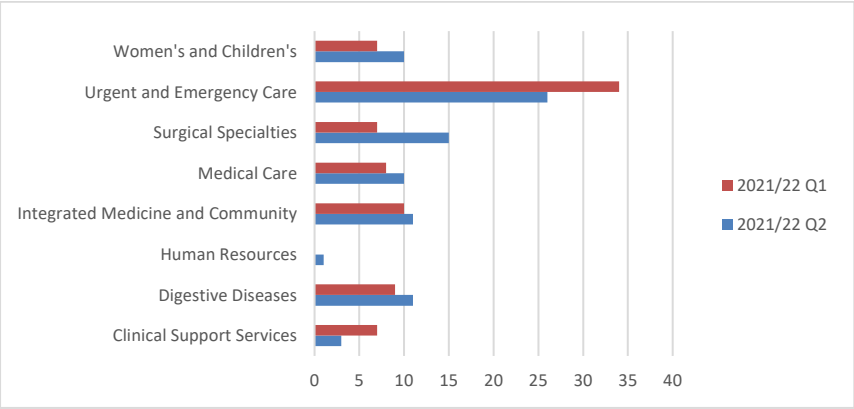
Duty of Candour

Whilst the Trust maintains its position of 100% compliance with Duty of Candour, we continue to look at methods for improving our Duty of Candour processes to support patient experience. In Quarter 2, a standalone Duty of Candour policy was implemented. This policy provides clear direction on the Duty of Candour process, including a script for staff to follow when discharging Duty of Candour, and information on which staff are appropriately placed to carry out Duty of Candour. Within the next Quarter, a Duty of Candour video will be developed, to assist in training.

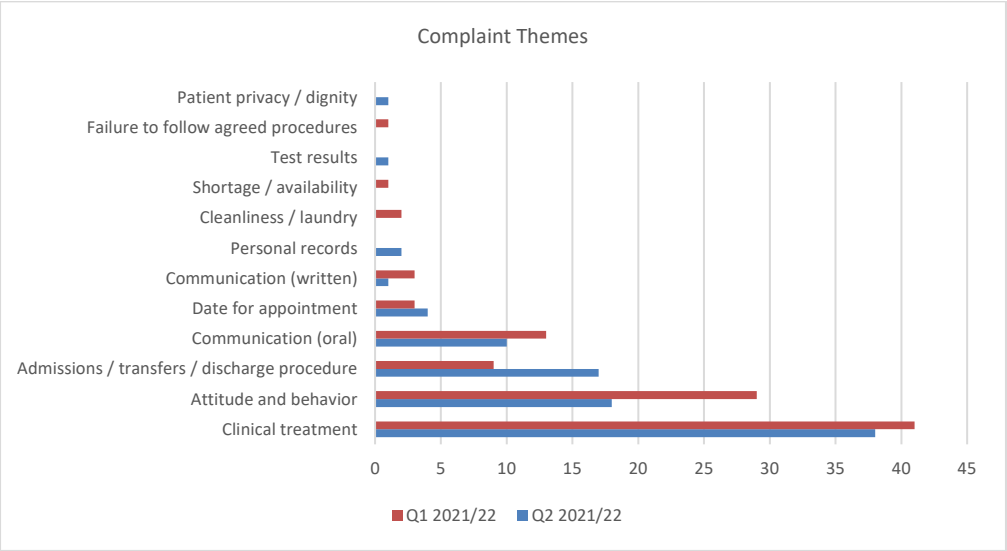
b. Learning from Complaints and PALS

Complaints

Complaints received
There was a 1% decrease in complaints opened Trust-wide in Q2 (88 in Q1 versus 87 in Q2). This is a significant decrease from the same Quarter in 20/21, where 115 new complaints were opened. Digestive Diseases, Human Resources, Medical Care and Surgical Specialties saw an increase in the complaints opened. Integrated Medicine and Community, Clinical Support Services and Urgent and Emergency Care reported a decrease in their complaints.

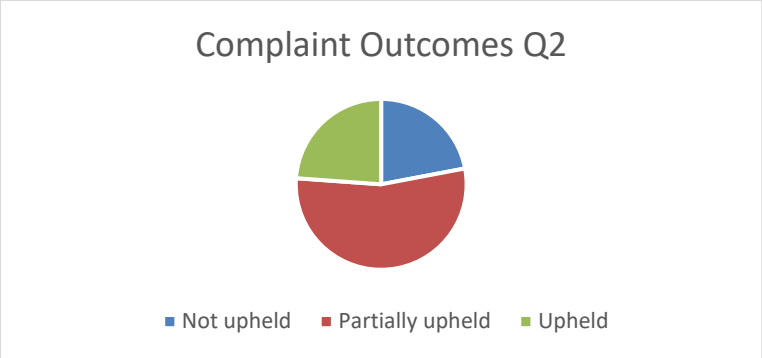


The Themes of complaints received in Q2 vs. Q1 are outlined within the below chart. Clinical Treatment remains the most common theme of complaints opened, however, the number of complaints relating to this theme have decreased slightly from 41 in Q1 to 38 in Q2.



Complaints closed

There was a decrease in the number of complaints closed in the Trust in Q2 (96 in Q1 versus 90 in Q2). Digestive Diseases, Human Resource. Integrated Medicine and Community, Medical Care and Urgent and Emergency Care have increased the number of complaints closed in Q2. All other specialities have decreased the number of complaints closed in Q2, this is a positive decrease as the number of complaints has reduced. Women's and Children's has seen the highest decrease. The outcomes for complaints closed in Q2 are detailed in the pie chart below:



*Partially upheld complaints are those where aspects of the case are upheld, but the main issues are not.

Responsiveness

All specialties have responded to complaints within timeframe in Q2. The Trust had a target to respond to 90% of complaint on time and in Q2 the Trust continued to achieve 100%. The Trust currently has 0 breached complaints and there are no complaints over 6 months old. In respect of responsiveness, the Trust is performing at its best in 3.5 years. It is worthwhile noting that for the next reporting period, the Trust has the least amount of complaints open in 3.5 years, at 44 open on the system (correct at time of reporting).

All Complainants are offered the opportunity to attend a meeting with the appropriate team to facilitate meaningful discussion – this approach facilitates wider learning and understanding.

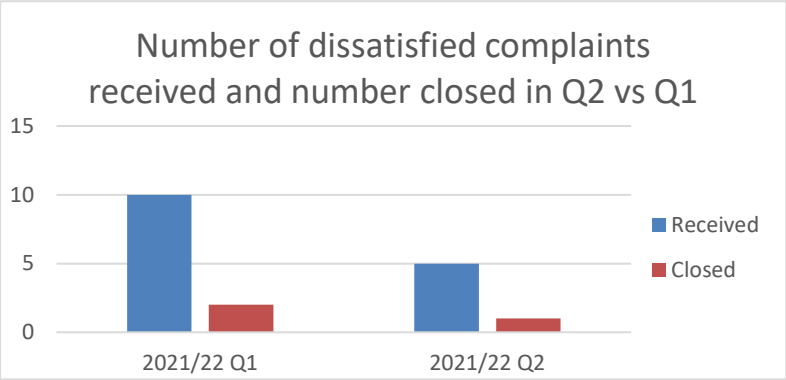
Actions resulting from Complaint investigations

The following table provides examples of complaints raised in Q2, and the actions we took in order to address the concerns raised and improve our processes. For further assurance a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaints meeting where a CBU or speciality will present a complaint, the lessons learnt, and actions implemented.

You Said….	We Did….
A patient raised concerns into the way her wound was stitched and dressed, leading to infection.	The ED training package has been updated by the ED Nurse Educator, to now include a specific section on wound closure and dressing, with a formal competency package for nursing staff in place. Nursing staff are signed off on this as a competency once completed.
A parent expressed concerns that staff on the unit that treated her son were dismissive of his needs, due to him being Autistic.	As a result, all staff on the unit were enrolled into Autism awareness training. A focus session around caring for patients with Autism also took place on the unit, where the staff discussed the concerns raised, and looked at the different needs that patients with Autism may have.
A family member complained that the ward team did not consider weekend working arrangements within the hospital when planning the patient's discharge.	The Medical Care Team revised the discharge process on the Ward to ensure that where a weekend discharge was planned for a patient, all assessments are completed by 16:30 on a Friday.

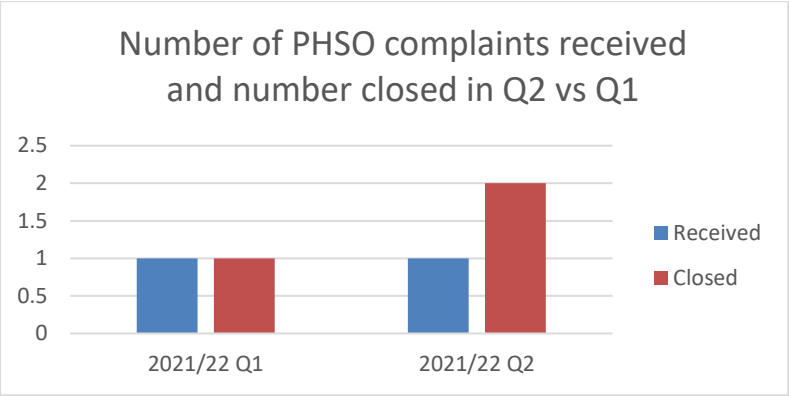
Dissatisfied Complaints

The below graph demonstrates the numbers of dissatisfied complaints received and closed in this Quarter vs. the previous Quarter. This demonstrates that the Trust received 50% fewer dissatisfied complaints in Q2 than Q1. The Complaints Team is continuing to work with the CBUs to improve the quality and detail of their complaint responses to reduce the number of dissatisfied complaints. The Complaints Team are also due to update their processes around how verbal complaints are logged, to ensure that all concerns are captured in the first instance.



PHSO Complaints

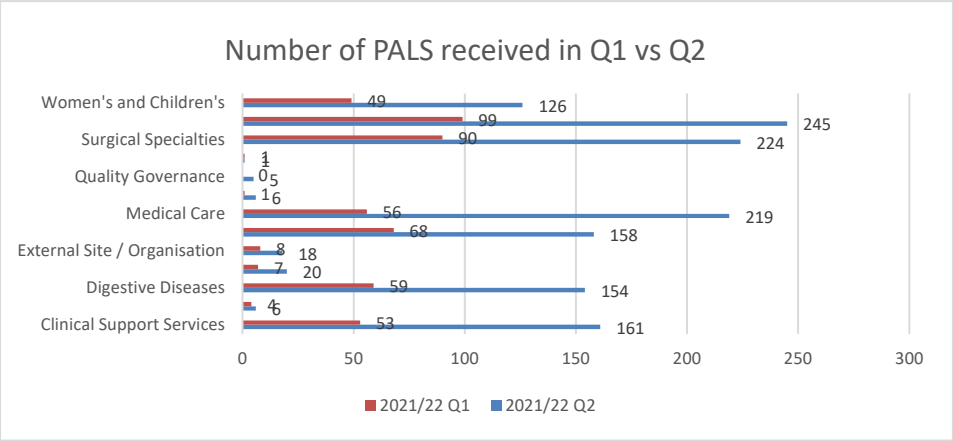
The number of PHSO complaints received and closed within Q2 remained low. PHSO complaints continued to be dealt with in a timely manner. The two PHSO complaints closed in Q2 were not upheld and no recommendations were made, indicating that the PHSO agreed with the findings and actions taken by the Trust in our initial response to those complaints.



PALS

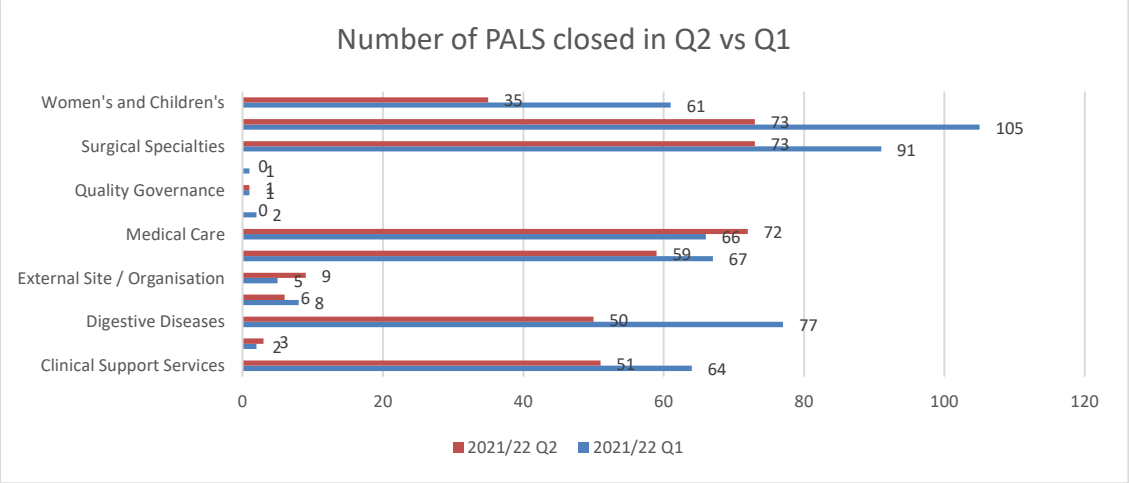
PALS received

There were 465 new PALS received in Q2, a decrease from the 561 received in Q1. The below chart demonstrates the breakdown of PALS received for each service.



PALS closed

In Q2 we closed 432 PALS cases, compared with 550 closed in Q1. The below chart demonstrates the breakdown for PALS closed for each service. This downward trend is not a cause for concern as the number of PALS being responded to is still significantly higher than the number of complaints received.



Actions resulting from PALS cases

You Said….	We Did….
Missing patient property.	The Trust is in the process of developing a new Patient Property policy as part of the Lost Property Campaign being led by Quality Matron. The Complaints, PALS and Claims Teams are providing input for this. The new policy will provide more in-depth detail on the processes for handling and returning patient property and will be supported by the Patient Property Improvement plan, which is also being led by Quality Matron. As part of the Improvement plan, a review of the storage facilities and property bags in place on all wards took place, and a storage box pilot has been initiated. The progress of the improvement plan and policy are being monitored by Patient Safety Sub Committee. This has since been completed in the reporting quarter.
A patient raised concerns after following signs to Ward A5 which took her to the wrong entrance of the Ward.	The Estates Team undertook a review of all the signage to Ward A5 to assess the clarity of the directions. In order to make the directions clearer, a further two signs showing the direction of the Ward A5 entrance have now been ordered, and these will be added to the index boards within the ground floor lift & stair lobby and on the main corridor. Delivery of the new signs is expected by the end of Quarter 3.

c. Learning from Claims

Clinical Claims

Clinical Claims Received

There were 34 clinical claims received in Q2. This is a slight increase from Q1, where 32 clinical claims were received.

Clinical Claims Closed

39 Claims were closed in Q2, 15 of which were with damages (totalling £1,239,980.59) (excluding costs)). This is not a concerning feature as the number of claims remain stable. Damages are higher than average for this Quarter due to 3 claims being settled at high value. The rest of the claims are

low in value, but high in volume. This is as expected due to the nature of the high value claim, which has increased the damages total completed for the Quarter.

Specialty	No of Claims	Damages Paid
Radiology	**2**	**£34,000.00**
Clinical assessment (investigations, images and lab tes	1	£10,000.00
Diagnosis, failed or delayed	1	£24,000.00
Gastroenterology	**1**	**£4,000.00**
Treatment, procedure	1	£4,000.00
Upper GI and Colorectal Surgery	**2**	**£65,000.00**
Diagnosis, failed or delayed	1	£15,000.00
Treatment, procedure	1	£50,000.00
Trauma & Orthopaedics	**5**	**£994,651.66**
Diagnosis, failed or delayed	1	£20,000.00
Other - please specify in description	1	£1,500.00
Treatment, procedure	3	£973,151.66
Acute Medicine	**1**	**£13,000.00**
Diagnosis, failed or delayed	1	£13,000.00
Emergency Medicine	**1**	**£34,146.13**
Treatment, procedure	1	£34,146.13
Gynaecology	**2**	**£40,000.00**
Treatment, procedure	2	£40,000.00
Obstetrics	**1**	**£45,000.00**
Labour or Delivery	1	£45,000.00
Grand Total	**15**	**£1,229,797.79**

Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received

There were 3 non-clinical claims received in Q2. This is the same as Quarter 1, where there were also 3 non-clinical claims received.

Non-Clinical Claims Closed

There were 3 employer Liability Claims closed in Quarter 2 with damages (totalling £10,182.80 (excluding costs))

CBU/Specialty	Damages Paid
Critical Care	**£6,000.00**
Abusive, violent, disruptive or self-harming behaviour	£6,000.00
Trust Escalation	**£282.80**
Abusive, violent, disruptive or self-harming behaviour	£282.80
Acute Medicine	**£3,900.00**
Abusive, violent, disruptive or self-harming behaviour	£3,900.00
Grand Total	**£10,182.80**

Improvements and changes arising from Claims

Following claims investigations for claims closed in Quarter 2, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend in relation to the themes of the specific learning points noted below.

Damage resulting from difficult catheterisation

Within Q2, a claim was closed where it was determined to be negligent to have taken 5 attempts to catheterise a patient, leading to patient harm. In response to this the Difficult Catheterisation Pathway was created, and this has now been ratified and widely published. This pathway is intended

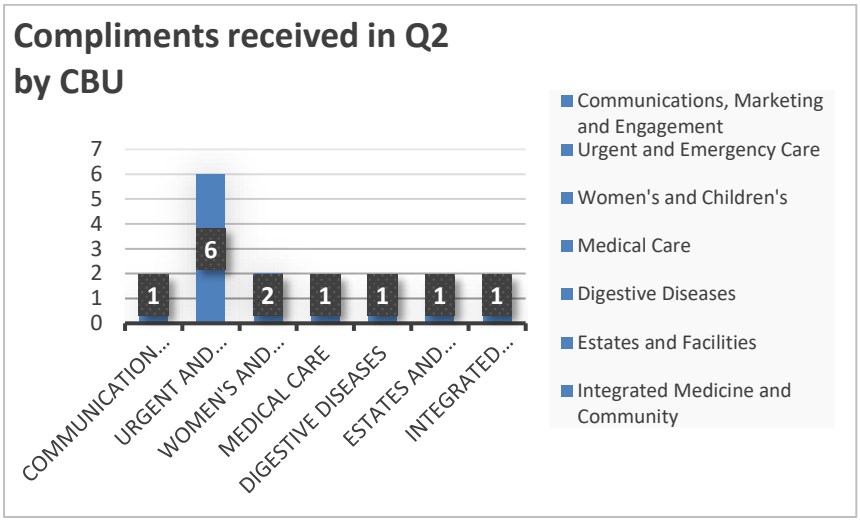
to provide staff with clear direction on processes to be followed which include escalation to a senior member of the team when attempts to catheterise a patient are difficult.

Failure to diagnose
A claim was settled where it was admitted that there had been a failure to diagnose a patient's fractured neck of femur. In response to this, the painful hip pathway was introduced to the ED, giving direction to staff on managing patients in relation to their pain presentation. A designated medical consultant was also introduced to Ward B1 to ensure continuity of consultants for patients.

Delay in treatment
The Trust settled a claim whereby a delay in treating ulcerative proctitis lead to complications for the patient. Following this, the service has since appointed a new gastroenterologist and an IBD nurse to meet the increased demand of new gastro/IBD referrals. A new pathway for referrals to the IBD Team upon findings of suspected IBD at the time of endoscopy has also been introduced.

d. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a really useful tool for the Trust to be able to identify what areas are working well. In Q2 the Trust received 13 compliments, this compares with 14 compliments which were received in Q1.



e. Learning from the CBUs

This section highlights points for learning identified in each CBU following the review of incidents, complaints and claims with actions identified for assurance of learning.

Medical Care

We found….

A Patient was risk assessed for Falls, but suffered an unwitnessed fall, resulting in a fractured neck of femur. The following omissions were identified:

- Noted to have blurred vision recorded (but there was no record of a bedside vision check
- No bedrail assessment was completed
- Not considered for enhanced care.

We Acted….

- All staff on the Ward receive updated risk assessment and falls training
- Staff were given instruction that, if the Lorenzo risk assessment is no longer in use this needs to be removed from the system or flag
- Ward staff received further training on completion of Care and Comfort Charting documentation
- Ward staff received training regarding the completion of neuro observations
- There has been an 18% reduction in falls this year, as a result of work on-going on the wards, and the QI Falls Prevention Collaborative.

Integrated Medicine & Community

We found….

A Patient agreed to be discharged and later to return for take home medication (TTOs), and the following issues occurred:

- Prescription taken to pharmacy hours later
- The discharge summary was not taken with the prescription so could not be dispensed
- Delayed dispensing
- Patient had to attend the ward for evening dose
- Patient had to return the next day for TTO's

We Acted….

- TTO dispensed ASAP the next day
- Apology offered to the patient for the delay
- Nursing staff reminded to send the prescription as soon as it is completed so any issues can be detected earlier
- Staff also reminded to send the discharge summary with the prescription

Clinical Support Services

We found….

There have been 13 incidents for extravasation of contrast media when using a pressure injector in Q2 2021-22.

- Measures are in place to reduce the risk of extravasation as far as possible, however extravasation is an inherent complication of the procedure and is sometimes unavoidable.
- The majority of extravasations cause negligible or minor harm but there is potential for more serious complications such as cutaneous ulceration or tissue necrosis.

We Acted….

Radiology has produced an SOP for the management of extravasation to include:

- The introduction of ice packs for immediate treatment of extravasation.

- Separate patient/ward information sheets for outpatients and inpatients advising on aftercare, complications to look out for/how to escalate any concerns.
- An extravasation record form which can be attached to the Datix and the patient record.
- A procedure for contacting the patient/ward the following day to check on the patient's condition along with guidance for the Radiographic staff on how to conduct the conversation with the patient.

Urgent & Emergency Care

We found….

A Patient attended the emergency department and disclosed concerns about domestic abuse:

- DASH Forms (for domestic abuse referral) were sent via the internal post meaning a 7-day delay in these being received by the safeguarding team
- The form was also missing pertinent information required

We Acted….

- ICE notification to be made with each DASH form to ensure electronic referral is received
- DASH form to be scanned onto Lorenzo for ability to be able to review electronically
- Victim and perpetrator details to be noted on all forms

Surgical Specialities

We found….

A Patient suffered an avulsion of the ureter following diagnostic ureterscopy:

- Although a known complication, there are rare complications that can occur
- Staff were unfamiliar with the size or ureteroscope used
- Potential risks of procedure were not adequately detailed on consent form

We Acted….

- The induction process for new Consultants has been updated to include details on the Trust's standard theatre equipment
- Training for consultants around the consent process (including quality of info to be provided) was updated
- Regular audits implemented to monitor the quality of consent documentation
- A new consent policy has recently been ratified at the Trust

Digestive Diseases

We found….

During surgery a plastic cover from the diathermy pen was noted to be missing:

- This lead to concerns that the cover may have fallen into the surgical wound
- Although a thorough search confirmed it wasn't in the wound, the cover could not be located elsewhere

We Acted….

- A change of practice has been put in place in theatres whereby the black bags used for theatre equipment remains in theatre until the procedure is finished, so that staff are easily able to check this in case of any future incidents of this nature.

Women's & Children's

We found….

A woman attended at 26 weeks of pregnancy with a history of diminished foetal movements. The woman was seen and 2 weeks later where no foetal heartbeat was heard; the baby had sadly died:

- There were missed opportunities to refer her to the smoking cessation team
- The care in triage did not follow guidelines for reduced foetal movements and a full antenatal assessment was not undertaken

We Acted….

- The incident was discussed for a month on a daily safety brief
- Review of the booking appointment and audit compliance and highlight training needs
- Review the documentation within triage to ensure CTG is highlighted for women who are 26 weeks or more into their pregnancy
- Individualised training packages were developed and delivered to the staff involved

f. Learning from our Staff

Health & Wellbeing

One of the Trust's People objectives is to create conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience. The Trust's intranet's section "Supporting you – General Health & Wellbeing" offers staff support the different campaigns and workstreams on-going to ensure staff are safe and healthy at work. These campaigns have been designed in response to feedback received from staff in regards to what matters to them. One of these campaigns which was active in Quarter 2 was the "Going Home Healthy" Campaign, which encourages staff go home on time and switch off from work.

Staff Networks

The Trust's staff network groups are staff led working towards improving equality, diversity and inclusion and the work experience of our colleagues across the organisation. The newly formed Armed Forces Staff Network is for anyone who may be a veteran or a supporter of our Armed Forces.

Morning Message

Each day, a morning message from the Chief Executive is emailed to all Trust staff. This is a useful platform for sharing details on current campaigns, cultural celebrations and Trust workstreams. In Quarter 2, morning messages provided staff with information on the Trust's Covid position and share learning around the importance of continuing to follow Infection Control policy.

Bright Spots

The Bright Spots section is within the daily Trust-wide Safety Brief and is an opportunity to recognise the efforts of our staff and thank them for their hard work. The table in Appendix 3 provides examples of some of the staff featured in the Bright Spots section.

g. Learning from Patient Experience

First Impressions

First impressions are the lasting impressions, which inspire confidence in the safe care and experience that our patients receive. First impressions are formed within 15 steps of entering the hospital and can influence the way patients, service users, their families and carers perceive their whole experience.

The Patient Experience Team has begun work on a First Impressions Programme to ensure that the Trust advances equality of opportunity between people who share a protected characteristic and those who do not. The objective of the first impressions programme is to enhance the overall image of the Trust, ensuring an optimal experience for staff, patients, families, carers and visitors when attending the hospital on both the Warrington and Halton site.

The programme aims to use the 15 Step-challenge approach (methodology devised by NHSE/I in conjunction with patients and relatives) to improve how our hospitals look, sound and smell, to have a positive impact on how this makes our patients and relatives feel.

The workstreams for this programme commenced in Quarter 2, and a High-level brief is expected to be presented to the Patient Experience Sub-Committee and Quality Assurance Committee on the progress of delivery in Quarter 3. The workstreams are outlined in the table below:

See **Led by Estates and Facilities**	Hear **Led by Patient Experience and Inclusion**

Key Stakeholders: ▪ Communications Team ▪ Patient Experience and Inclusion Team ▪ Infection Control ▪ Housekeepers ▪ Nursing/AHP representative ▪ Medical representation ▪ Patient representative	**Key Stakeholders:** ▪ Communications Team ▪ Organisational Development Team ▪ Patient Safety Nurse representative ▪ Housekeepers ▪ Nursing/AHP representative ▪ Medical representation ▪ Patient representative
Workstreams: ▪ Internal and External Entrances ▪ Site Smoking ▪ Increase staff pride in reporting estate concerns – 'Don't walk by' campaign ▪ Observational rounds	**Workstreams:** ▪ Warrington Hospital Welcome Team ▪ Enhanced WHH Volunteer support ▪ Noticeboards and patient/staff information ▪ Wall space and corridors ▪ Observational rounds

h. Learning from Clinical Audit

National Audits

Summary:
The Sentinel Stroke National Audit Programme (SSNAP) report is based on stroke patients admitted to and/or discharged from Hospital between April 2019 and March 2020. The report looks at changes in SSNAP score over time and looks at the improvement in hospital ratings over 7 years. Trusts are rated on an A-E scale (with A being the best) in regards to their performance against areas of care in the stroke pathway (including acute interventions, assessments, rehabilitation and longer-term domiciliary care). Nationally in 2013 43% of trusts scored an E rating for overall score (lowest rating), whereas in Jan – March 2020, 1% of Trusts scored an E rating and Trusts scoring an A rating nationally has increased from 0% to 26%.

WHH stroke unit is currently scoring a C rating (classed as moderate in performance but requiring improvement). In Quarter 4 19/20, the rating increased to a "B", following improvement work, particularly on audit compliance. But in the past year (20/21 and early 21/22) during the pandemic this has returned to a "C" grade. This has been affected by patients having to be on Covid wards and not spending 90% of their stay on a stroke unit. Also, staff redeployment and absence has affected the scoring. Senior oversight is being addressed so that by the next reporting period, improvements will have been implemented. This will enable the Trust to regain the B rating, which is classified as moderate and not requiring improvements.

Future Trajectory and Recommendations:
In order to reach the ambition of 20% of stroke patients receiving thrombolysis, there needs to be a whole system approach reducing delays to each aspect of the emergency pathway. This includes focusing on pre-hospital systems such as closer collaboration between ambulance and hospital services, efficient use of pre-alert systems, improved pre-hospital diagnostic accuracy, and improved patient awareness of stroke symptoms; and hospital emergency systems such as improving brain scanning times and facilitating rapid clinical assessments. This is being reviewed regionally in the Integrated Stroke Delivery Networks.

Improved outcomes to 6 months and beyond

The proportion of patients receiving a 6-month assessment nationally has increased from 20% to 40% since 2013. At WHH in the last year we have continued to complete 6-month assessments, and these have changed to virtual appointments due to the effects of Covid. Our average percentage compliance of completing 6-month assessments over the past year at WHH has been 66%, which is better than the national average.

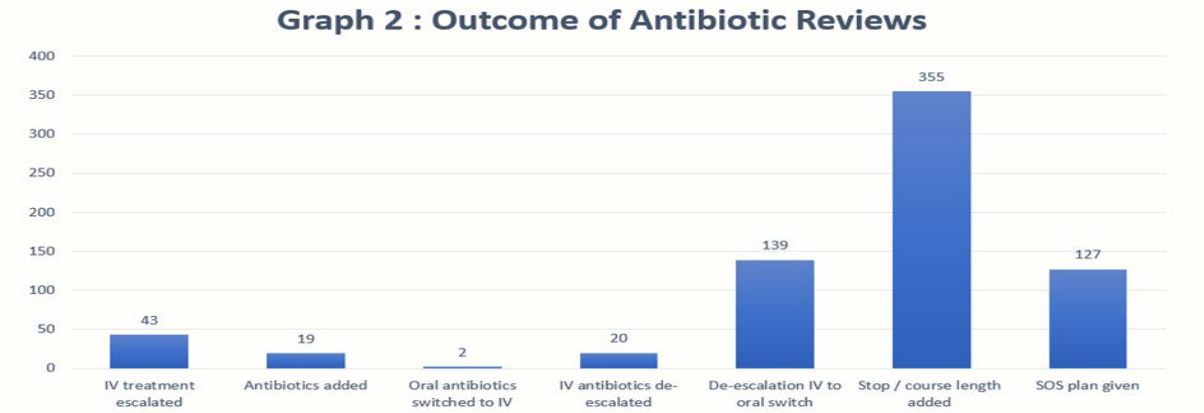
Future Trajectory and Recommendations
It is anticipated that in the next 5 years, the percentage of 6-month assessments carried out will be maintained above the national average at approximately 60% of applicable stroke patients if the rate of improvement continues from 2018-19 to 2019-20.

Local Audits

Summary: The Microbiology Team undertook an audit to assess the effectiveness of Antibiotic ward rounds. Twice weekly join Consultant Microbiologist and Pharmacist ward rounds were implemented, with the following aims:

- To look at prescribing practice across the Trust;
- To determine if the antibiotic prescribing was in line with the Trust's antimicrobial formulary and Department of Health's "start smart then focus treatment" algorithm.
- To determine if patients receive appropriate microbiological sampling to allow correct diagnosis and rationalisation of antibiotics.

69 joint Consultant Microbiologist and Antimicrobial Pharmacist ward rounds were carried out at Warrington hospital. 550 patients were reviewed, with a total of 676 antimicrobial reviews taking place. A variety of wards were visited, including the admissions ward, elderly care, Surgery and Orthopaedics. The graph below demonstrates the outcomes of the antimicrobial reviews that took place.



Key Findings:
The audit found that Carbapenems were predominantly prescribed on the advice of a Consultant Microbiologist or discussed with a Consultant Microbiologist within 48 hours of initiation. Piperacillin/Tazobactam (Tazocin) was overused across the Trust.

The key themes for inappropriate use of Tazocin were:
- Management of Community Acquired Pneumonia.
- Management of biliary sepsis.

This audit has shown missed opportunities for:

- Microbiological sampling.
- Antibiotic rationalisation i.e. switching patients from I.V. to oral antibiotics.

As a result:

- It is really important to continue antibiotic ward rounds to help address these issues.
- The data will be reassessed / re-audited in a years' time to help understand the impact of on-going antibiotic ward rounds.
- The data and findings of the Audit were presented on 07/07/21 in the General Pathology Audit Meeting and disseminated through a communication to the clinical teams via the Antimicrobial Management Steering Group and mentioned at the FY1 Doctor's teaching session on 02/09/21.

Assurance Rating*:

High – there is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied.

*The assurance rating is assessed by looking at the level of risk to the patient/service/department/Trust if action is not implemented; the measures put in place, and the likelihood of a consequence occurring given the measures that have been implemented.

i. Quarterly Learning Piece

Learning Disability Strategy

In this Quarter's LFE report, we want to feature the new Learning Disability Strategy which has been implemented at the Trust. This Strategy will be in place for 2021 – 2024. This three-year Strategy sets out the priorities and aims in delivering and supporting, high quality care for people who are living with a learning disability (LD), autism or both that access services at WHH.

Why this Strategy matters:

- We know that people with a learning disability are twice as likely to be admitted to hospital than the general population. The Equality Act (2010) requires that we make reasonable adjustments to accommodate the needs of people with a learning disability.
- There are 1.4 million people with learning disabilities in the UK, making up approximately 2% of the general population (Mencap, 2018).
- There are 347,000 children with a learning disability (aged between 0-17) in the UK (Mencap, 2018).
- It is currently estimated that there are approximately 2000 adults living with a learning disability (LD) in Warrington and Halton (Improving Health and Lives (IHaL): Learning Disability Observatory, 2018).

At WHH we will:

- Deliver inclusive person-centred care that supports the service user living with a learning disability, autism or both.
- Ensure that any communication difficulties along with access to carers during hospital stays are actioned appropriately, making reasonable adjustments on an individual basis with wrap around care to improve service user outcomes.
- Ensure that there is a greater understanding of diagnostic overshadowing, where symptoms or behaviours of a person with learning disability does not lead to the under diagnosis of a physical health condition.
- Develop a skilled and effective workforce able to champion inclusive person centre-care for service users living with a learning disability, autism or both.

- Develop effective partnerships with local agencies (health, social care, third sector) to improve care and outcomes.

How Success will be measured:

j. Workstreams for Quarter 3

Action Planning

On review of the actions arising from RCAs and complaints investigations in Quarter 2, the Head of Complaints, PALS and Legal Services and the Patient Safety Manager have identified that action planning across the CBUs is not consistently S.M.A.R.T (Specific Measurable Achievable Realistic Timed). In the next Quarter, the Complaints and Patient Safety Teams will work in collaboration with the Governance Managers to implement S.M.A.R.T action plan training and a toolkit, to help action planners and owners set and complete meaningful actions. This will be monitored via the Quality Assurance Committee.

Complaints Monitoring and Improvement

The new Head of Complaints, PALS and Legal Services recently started in post. Within the next Quarter, she will be arranging bespoke training packages around complaints. The aim of these will be give staff in the CBUs information around how to handle concerns at first contact to reduce the number of formal complaints, and to look at how formal complaints and PALS can responded to, to give the best outcome for our patients and their families. This also facilitates learning in real time.

Formal complaint responses continue to undergo close scrutiny through the complaints and senior Governance Team to review the quality of the responses. Where appropriate, the Complaints Team will continue to encourage staff to seek to resolve complaints via telephone conversations or local resolution meetings with complainants.

The Complaints Quality Assurance Committee (QAG) continues to meet each Quarter; focussing on a different CBU each time. These meetings are an opportunity for the Chairman to review the Trust's complaints position, and for CBUs to reflect and feedback upon the quality and detail included within their responses. The QAG held in Quarter 2 focussed on Urgent and Emergency Care, and the QAG due to be held in Quarter 3 is due to focus on Digestive Diseases.

Complaints Satisfaction Service Questionnaire

The Associate Director of Governance and Head of Complaints, PALS & Legal Services will be implementing a questionnaire to gather feedback from Complainants on how they feel there complaints have been handled. This information will enable the Trust to understand what works well, and what can be improved, to better support our patients and families through the Complaints process. A sample of the questionnaire findings will be available in the next reporting period with learning identified and included in reporting to the Quality Assurance Committee.

Welcome Booklet

The Patient Experience Team are in the process of redesigning the Trust's "Welcome to our Hospitals" booklet. This booklet provides information for patients, relatives and carers on what to expect from their hospital stay, from admission to discharge. It provides key details around topics including mealtimes, visiting and infection control. The booklet is being redesigned in collaboration

with the Digital Communications Team, Complaints & PALS Team and Clinical Teams from each of the CBUs and seeks to address questions commonly asked by patients and relatives.

Staff involved in incidents – Survey

The Associate Director of Governance and the Patient Safety Manager will be conducting staff surveys to understand the experiences of staff involved in incidents. The Survey will ask staff to respond to questions relating to the support they received, whether they were asked to provide a statement or be interviewed, whether findings of reports were shared with them and whether they were involved in developing any actions for improvement. The findings of this survey will assist the Governance Team in the delivery of training for RCA investigators, and will also help us to better support staff involved in incidents.

Hotline Phone

In Quarter 3, the Deputy Director of Governance, the Associate Director of Governance, the Head of Complaints, PALS & Legal Services will be setting up a Hotline phone service, that will give patients and their families access to a senior member of staff to resolve concerns in real-time. This is intended to provide fast resolutions to issues as they are occurring and reduce the number of PALS and formal complaints received and thus enhance the patient experience.

3. RECOMMENDATIONS

The Board of Directors is asked to note the paper's contents.

Headlines of Learning from Deaths

- Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- SHMI and HSMR, are within the expected range at present.
- There is a key focus on reviewing Covid-19 deaths.
- MRG 'Case of the Month' is actively disseminated to ensure learning is filtered across the Trust.
- A lesson learning bulletin has been developed and will be shared across all CBU governance meetings to highlight the learning.
- The Medical Examiners actively feed any themes and learning into MRG.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/16**	
SUBJECT:	Guardian of Safe Working for Junior Doctors Combined Report for Q2 2021-22	
DATE OF MEETING:		
AUTHOR(S):	Mrs Frances Oldfield, Guardian of Safe Working Hours	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain impact on patient care, reputation and financial position.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 3 (Oct – Dec) 2021-22, 61 Exception Reports were submitted of which 12 were highlighted as immediate patient safety concerns. Controls to mitigate patient safety risks are outlined The majority (77%) of Exception Reports relate to hours of working. 8 Exception Reports relate to missed educational opportunities (n=8) and 3 Exception Reports submitted related to service support available to the doctor. The total number of Exception Reports is in line with normal variation for the quarter.	

PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients. The Board are requested to note and receive assurance from the controls put in place to mitigate for risks identified through Exception Reports which highlighted immediate patient safety concerns			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/22/01/03		
	Date of meeting	19/01/22		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 3 2021-22 (1st October – 31st December 2021)	**AGENDA REF:**	**BM/22/01/18**

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most medical trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

Most Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

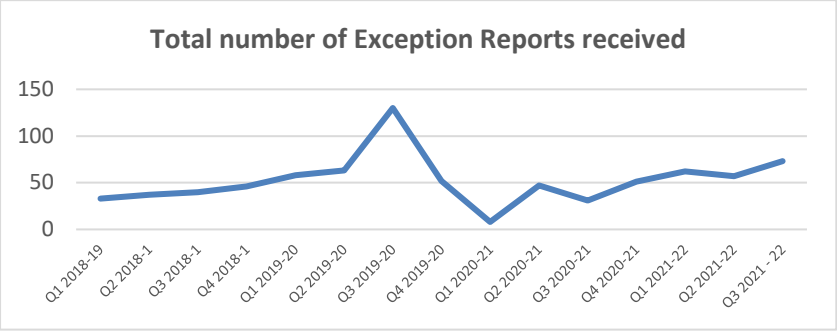
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relate to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

2.1 Exception Reporting (October – December 2021-22)

During Quarter 3 2021-22, 73 Exception Reports were submitted, which is higher than the last quarter and on an increasing trend. The increase in reporting could be as a result of engagement undertaken recently to try and encourage medical trainees to increase their levels of Exception Reporting, which are often underreported. The last two JDF meetings have been extremely well attended and there has been strong engagement between junior doctors' representatives, the Chief Registrars, DME and GSW.

Chart 1 below illustrates pre and post pandemic reporting trends:



The majority (77%) of Exception Reports relate to hours of working. There was almost a 50:50 split of ERs raised due to working hours in the medical and surgical specialties. Trainees comment that they stay late to complete ward duties or for review and management of sick inpatients, which they feel they cannot handover to the on-call teams. This is entirely understandable and predictable, although routine duties should not need to be done out of hours generally.

There is an increase in Exception Reports for the quarter relating to missed educational opportunities (n=8), 4 of which were in the ENT specialty. This was due to FY2s missing teaching due to carrying the on-call bleep; the issue has been resolved and no further ERs have been raised.

12 Exception Reports raised were categorised as having immediate patient safety concerns (ISC), all of which related to gaps in the medical rota and the management of medical outliers.

To address this ongoing issue a Medical Staffing Resilience Group has been established to agree tactical management of medical staffing through a central control function. It is proposed that outlier wards will be distributed amongst specialities for the month of January, with the expectation that the system will sanction other work being stepped down to allow AM rounds to all outliers. This area will require regular review and evaluation to ensure solutions are affective and will remain on the agenda for the Medical Staffing Resilience Group until further notice or fully resolved.

3 Exception Reports submitted related to service support available to the doctor.

Exception Reporting – Q3

Exception Reports (ER) over past quarter	
Reference period of report	01/10/21 - 31/12/21
Total number of exception reports received	61
Number relating to immediate patient safety issues	12
Number relating to hours of working	47
Number relating to pattern of work	3
Number relating to educational opportunities	8
Number relating to service support available to the doctor	3

Summary

- number of exception reports raised = 61
- number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 12
- fines that were levied by the Guardian = NIL
- The majority of ERs have been submitted by Foundation Trainees (90%) reflecting the busy workload of juniors on the wards. 6 ERs were submitted by trainees with central contracts from the Lead Employer.

2.2 Review of Exception Report Themes

Further work has been undertaken to review themes of Exception Reports which are raised.

2.2.1 Foundation Doctors Self Development Time

The issues cited in the last update relating to Foundation doctors not being able to take self-development time (SDT) at allocated times has now been resolved.

2.2.2 Out of Hours Orthopaedic On-Call rota

In the last report, it was reported that the Trauma & Orthopaedic F1 on-call rota had been non-compliance since 2019. This has now been resolved and no further exception reports have been submitted.

2.2.3 Junior Doctors Forum and Improving ES / Medical Trainee Engagement

Historically, there have been delays in the review meetings between the ES and Junior Doctor once an ER has been submitted.

The GSW and Medical Trainee Workforce Administrator are working on a new system to prompt junior doctors to complete the ERs, so it is hoped this will improve significantly in the next quarter. Junior Doctors are now receiving an email reminder to have their ER signed off within 2 weeks, if they want to receive compensatory payment or time off in lieu (TOIL). Any difficulties with the sign-off process are be escalated to the Medical Education Service and / or the Guardian of Safe Working.

At the end of Q3, there were 41 unresolved ERs. Evidence shows review meetings are taking place as required but some of the administrative functions have not been completed such as agreeing the outcomes on the system. With the new system there is an improvement to the volume of unresolved cases however this process will be required as an ongoing measure to encourage continued engagement and awareness and drive improvements.

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

Junior doctors have raised 12 Immediate Safety Concerns via Excption Reporting regarding Rota Gaps and Medical Outliers on Surgical Wards. The following describes these risks and controls which have been implemented to mitigate for them:

3.1 Rota Gaps

- Due to COVID and Deanery rotation Gaps acute rotas have a significant number of gaps which may come apparent at short notice.
- These are mitigated for by investment in locally employed doctors, additional locum and bank shifts and the work of the daily Medical Staffing Huddle which has delegated authority to move medical staffing resource to ensure safe staffing across the clinical areas.
- In the event of an individual rota gap having the potential to impinge directly on patient safety there is a clear escalation process through the CBUs with the default position that the if required the on call consultant for that speciality would remain on site to ensure patient safety during out of hours periods.

3.2 Medical Outliers on Surgical Wards

- A number of exception reports have been raised regarding the management of Medical Outliers on Surgical Wards The issues raised included unclear routes of escalation, CT/SPR support to surgical FY doctors and outlier consultant ward rounds occurring later in the day resulting in delayed patient review and late finishes for junior doctors in surgery
- These risks have been mitigated for with the following controls:
    - A dedicated contact point/number for senior clinical advice/escalation of acute issues with Medical Outliers
    - Additional CT/SPR resource is diverted to support medical outliers at times of high demand (managed through the daily Medical Staffing Huddle)
    - Changes to consultant work schedules to allow consultant outlier ward rounds to take place earlier in the day at 1100
- Following implementation of these controls in December, to date in January no further Immediate Safety Concern Exception Reports have been raised, with further assurance being provided at the Junior Doctor Forum were an improvement was reported by the surgical trainees to the GSW.

All Exception Reports highlighting Immediate Safety Concerns are reported and fed into the orgainsiations Clinical Governance Team via the Trust's DATIX system

4 IMPACT ON QPS?

As above

Quality – ensuring a fit for purpose Junior Medial working patterns able to deliver timely high quality care

People – to ensure the Trust remains compliant with the 2016 Junior Doctor Contract Terms and Conditions in order to

Sustainability – To ensure cost effective delivery of Junior Medical Staffing standards

5 MEASUREMENTS/EVALUATIONS

Exception Report Outcomes/Resolutions

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	14
Total number of overtime payments	20
Total number of work schedule reviews	1
Total number of reports resulting in no action	9
Total number of organisation changes	4
Compensation	0
Unresolved	41
Total number of resolutions	**48**
Total resolved exceptions	**49**

***Note**:*
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*
** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*
** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

6 TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every Exception Report submitted, ether for payment or TOIL, it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.
4. The Trainees need to indicate "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.
5. If an ER is not actioned within 7 days, the GSW will issue an email to expedite sign-off.

The GSW will be provided with timely data reports to support her role in the coming year, with reference to improvement in response times for ERs.

7 MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours' Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

The Trust's Executive Committee (Strategic People Committee) also has sight of the Quarterly and Annual Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8 TIMELINES

SPC – Strategic People Committee will receive the following reports prior to progression to Trust Board

Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q3 - (end of Dec 2021) – submitted January 2022
- Q4 – (end of March 2022) – submitted May 2022
- Q1 – (end of June 2022) - submitted July 2022
- Q2 – (end of Sept 2022) – submitted Nov 2022

9 ASSURANCE COMMITTEE

10 RECOMMENDATIONS

The Board are asked to consider the contents of the report and consider the assurances made accordingly.

- The GoSW will continue to monitor all exception reports to ensure the Trust remains compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed.
- To date, the trust continues to provide fully compliant and safe rotas in-line with safe working hours regulations for Junior Doctors
- Junior doctors are well engaged with the Exception Reporting process with Exception Reporting falling within the expected range
- The Board are asked to note and receive assurance through the controls that have been put in place in response to Patient Safety Concerns raised through exception reporting regarding Rota Gaps and Medical Outliers

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/17**			
SUBJECT:	**Charitable Funds Committee – Trustee Checklist**			
DATE OF MEETING:	26 January 2022			
AUTHOR(S):	Helen Higginson, Head of Fundraising			
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications and Engagement			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***				
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust Board is the Corporate Trustee of Warrington and Halton Teaching Hospitals' Charity. In June 2016 the Charities Commission (the regulator) issued new guidance for Charity Trustees. This checklist is designed to help the Corporate Trustee (delegated authority to the Charitable Funds Committee) evaluate the Charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the Charities Commission guidance: 1.Planning effectively 2.Supervising fundraisers 3.Protecting charity's reputation, money and other assets 4.Identifying and ensuring compliance with the laws or regulations that apply specifically to charity's fundraising 5.Identifying and following any recognised standards that apply to charity's fundraising 6.Being open and accountable The Corporate Trustee is requested to note that there are three updates: 1. Item 4.1 A draft fundraising strategy has been presented to the Charitable Funds Committee for final approval in March 2022 2. Item 5.3 Appraisals complete 3. Item 7.1 WHH Charity is now registered with the Fundraising Regulator			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note X	Decision
RECOMMENDATION:	That the Trust Board note the responsibilities of the Corporate Trustee (delegated to CFC) and the changes to the checklist as indicated above.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee		
	Agenda Ref.	CFC 21/12/92c		

	Date of meeting	9 December 2021
	Summary of Outcome	Submit to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Charitable Funds Committee CFC 21/12/92c

Charities Commission – Checklist for WHH Charity Trustees

December 2021

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively	RAG	
4.1 We have set out our fundraising plan		• 2017-20 Strategy in place and KPIs are monitored at each CFC. • Strategy refresh 2020-23 was deferred in 2020 due to the Covid-19 pandemic • 2022-25 Strategy presented in December 2021 • We continue to review our Strategy periodically in line with changing trends in charitable giving.
4.2 It reflects our charity's values		WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative and the Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Inclusive, Kind and Embracing Change.
4.3 The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at each CFC meeting as part of the Finance Report • The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit • Income and expenditure (actual and forecast) are scrutinised and challenged at each CFC • A revised reserves policy was adopted in June 2019.
4.4 The key financial and reputational risks we may face		This has been identified in the Risk Strategy developed in Feb 2016. All WHH Charity risks are now managed through the Trust's DATIX system and reported to each CFC
4.5 We monitor progress		A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks		The key risks are reviewed at each meeting
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate		Our Fundraising team is directly accountable to and line-managed by a member of the executive team
5.2 Our fundraising staff have job descriptions		Current and in place
5.3 Our fundraising staff are doing the job successfully		PDR complete October 21, Income objectives subject to approval of WHH Charity refresh forecast Monthly 1:1s with Director and informal catch ups in between meetings
5.4 Our volunteers know who they report to and who to approach with problems or concerns		WHH Volunteers assumed responsibility for all volunteers in September 2016, those on placement with WHH Charity report to and are supervised by the Fundraising Manager

5.5 Our volunteers understand the boundaries within which they must work when representing the charity		They receive Trust induction from WHH Volunteers and local induction from the Head of Fundraising and are supervised at all times
5.6 Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest	N/A	
5.7 Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the Corporate Trustee and ensure through contract that all legal requirements are met and maintained
5.8 Are in our charity's best interest because appropriate due diligence is undertaken		We procure using the Corporate Trustee's procurement team
5.9 Our fundraising values and expectations are communicated		These are agreed upon contract
5.10 The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
5.11 Proper control is kept of the money raised		• All monies are routed into the WHH Charity bank account, no other methodology is permitted. • Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook
5.12 Fundraising communications used are reviewed		All communications are approved by the Fundraising Manager and/or Director
5.13 Compliance with the agreement is monitored		Compliance is monitored following contract
5.14 Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity
Section 6: Protecting our charity's reputation, money and other assets		
6.1 The reputational risks our charity may face are identified, assessed and managed		Reputational risks have been identified in our Risk Strategy
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered		Our bid application process includes this to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Chartered Institute of Fundraising and the Association of NHS Charities Together guidance. We are registered with and regulated by the Charities Commission
6.4 Our values are communicated to the people who work on our fundraising		All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
6.5 The costs of our fundraising are managed and explained		We control our costs through a bid application process We review our costs at each CFC meeting
6.6 Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at each CFC meeting.
6.7 Effective financial controls are in place and followed		The Corporate Trustee's Finance Team monitor all expenditure
6.8 Risks of financial crime and fraud are reduced		WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.

6.9 Our charity is alerted to any suspicious donations		• Our Finance Team review all bank statements and incoming direct funds • Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
6.10 our charity can stop or authorise any unauthorised fundraising activity using its name		• We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. • We would alert the police to any suspicious activity undertaken in our name.
6.11 Serious incidents are reported to the Commission, police and other agencies		• NHS Protect may also be contacted where NHS Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected		• We do not issue our logo independently for 3rd party use • We use letters of authorisation for 3rd party fundraisers • We provide our own branded materials for support • Our intellectual property is protected to the best of our ability and knowledge
Sections 7 and 8 Following the Law and recognised standards		
7.1 the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising and the Association of NHS Charities guidance. We are registered with the Fundraising Regulator
7.2 These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
Section 9: Be Open and Accountable		
9.1 Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with		We are audited periodically and produce an annual report and accounts each autumn.
9.2 Our open and accessible complaints procedures are followed if concerns are raised		• In the first instance complaints should be raised to the Fundraising Manager or Director • The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure. • The Charity will make this process clear via its website
9.3 Our fundraising aims and achievements are clearly communicated to the public and donors/supporters		Our website is maintained and updated regularly, Our social media platforms are updated regularly.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/18**	
SUBJECT:	**Maternity and Neonatal Safety Champions Update Report**	
DATE OF MEETING:	26 January 20022	
AUTHOR(S):	Catherine Owens Director of Midwifery /Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following paper provides the Trust Board a progress report on the activities undertaken by the Materntiy and Neonatal Safety Champions in the month of December 2022 and highlights exceptions within the maternity transformation programme and national maternity safety agendas: • Ockenden Phase 2 feedback and compliance update • Safety Champions Walkaround update • Maternity Incentive Scheme Year 4 Incentive Scheme update including Quarter 2 Avoiding Term Admissions to Neonatal Unit (ATAIN) audit, Maternity Services Database System & Materntiy Voice Partnership • Moving to Outstanding update	

	The maternity safety standards are currently on track for completion.			
PURPOSE: ***(please select as appropriate)***	Information x	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to note the information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/01/11		
	Date of meeting	11 January 2022		
	Summary of Outcome	Noted for information		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***				

REPORT TO BOARD OF DIRECTORS

SUBJECT	Materntiy and Neonatal Safety Champions Update Report	AGENDA REF:	BM/22/01/18

1. BACKGROUND/CONTEXT

The following paper will update the Board of Directors on the Maternity and Neonatal Safety Champions activities undertaken during the month of December 2022.

The progress report will also highlight exceptions within the maternity safety agenda and trajectories of the maternity transformation programme; this includes Ockenden Phase 2 recommendations, Maternity Incentive Scheme Year 4 safety standards and Moving to Outstanding improvement plan.

2. KEY ELEMENTS

Ockenden Phase 2 update

- Provider report received October 2020. Position triangulated with submitted evidence and position paper shared with Executives in December 2021.
- Reported 67.7% compliance in 84/124 criterion.
- Phase 2 action plan has been added to Moving to Outstanding workplan and monitored monthly through governance and M2O meetings.
- On track to complete trajectory by April 2022
- Regional Team will be undertaking assurance visits in new year to all providers to monitor ongoing implementation of recommendations
- 2 criterion allocated to Cheshire and Mersey Local Maternity System:
  - Re Development of Maternal Medicine Pathway
  - Development of Perinatal Quality Surveillance Tool (PQST):. Recommended indexes are already captured and presented to QAC in a different format.

Ockenden: Safety Champions Walk Around

November Maternity Safety Champions visited Maternity Triage. Detailed discussion on how we monitor fetal well being.

Introduced Safety Champions News Letter (Appendix 1) to improve Ward to Board & Board to Ward communication

Informed NED and Chief nurse: on track to implement Birmingham System of Obstetric Triage (BSOTS) to improve safety , experience and outcomes from 11th January 2022

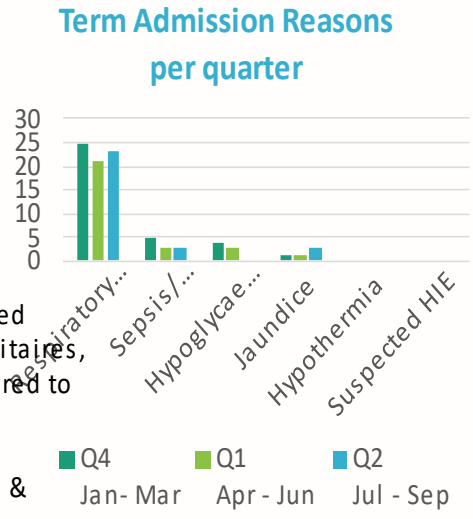
Maternity Incentive Scheme Exception Report

- Safety Action 2 continued data extract issue where BMI is being reported in Lorenzo however this is not reportable to MSDS as no Snomed coding facility . Escalated internally to Tom Poulter
- Safety Action 6 Saving Babies Live Version 2Carbon monoxide monitoring at booking and 36 weeks gestation. MSDS reporting to NHS Digital (NHSD) remains problematic noting WHH as*did not submit data.* Technical issues within NHSD and being reviewed.
- Safety Action 9: re Embedding Perinatal Quality Surveillance Tool and also Ockenden 2 criteria. Local Maternity System identified as a lead however no updates thus WHH developing own tool. Finalised PQST to be presented at January Women's Health Governance meeting.

Safety Action 3: Avoiding Term Admission in the Neonatal Unit (ATAIN) audit

WHTH 2021/22	Live Births	Term Admissions	
		Number	% live births
Q1 April- June 2021	617	40	6.5%
Q2 July – Sep 2021	706	44	6.2%
Q3 Oct – Dec 2021			
Q4 Jan – Mar 2022			

Average ATAIN rate of 5-6% across North West Region



Learning

- 50% of babies admitted with a low temperature. Developed warm care bundle inclusive of pre setting heater on resusitaires, pre warming thicker baby blankets, new resusitaires ordered to monitor neonatal temperatures
- ATAIN action tracker monitored weekly at ATAIN meetings
- Learning re CTG interpretation shared through governance & safety champions newsletter

Maternity Incentive Scheme update

Safety Action 7 Maternity Voice Partnership (MVP)

- Ockenden evidence and MVP sign off required to demonstrate co production and collaboration
- Lisa Welch New Chair appointed July 2021 commissioned for 1/7 week
- MVP Activity has included listening events across Warrington & Halton
- Co collaboration of Terms of Reference/ recruitment of Consultant Midwife/ marketing material/building social media platform
- Meets with Maternity and Neonatal Safety Champions monthly
- Building membership across Warrington & Halton
- Launch of 2022 calendar events 28th January at Peace Centre: aligned to public health agenda and Maternity Survey Findings

Moving to Outstanding Update

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Status of Action	Total number of Actions	Red	Amber	Green	Blue	Purple
Source of Action						
Aubury Report	23	0	5	10	8	0
Ockenden Assessment	54	0	18	8	27	1
Mock Inspection	20	1	11	8	0	0
Moving to Outstanding	15	0	12	3	0	0
Ockenden Phase 2	124	0	35	0	84	5

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

- WHH have been identified as top performing trust in October and November 2021:
- 72% of WHH babies received breast milk during their stay in hospital. To put this in to context Countess of Chester were ranked second and reported 48%. Network average was 48%
- 42% of WHH babies received only breastmilk during their hospital stay. First position was shared with Leighton hospital. Liverpool Women's Hospital reported 24%
- Network average reported as 24%
- National Average reported as 33%

3. RECOMMENDATIONS

The Trust Board is asked to discuss and note the paper.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/20**			
SUBJECT:	Breach of The Food Hygiene and Safety (England) Regulations, Warrington Catering Department.			
DATE OF MEETING:	26th January 2022			
AUTHOR(S):	Ian Wright Associate Director of Estates			
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	On Thursday 25.11.21, Warrington catering Department received a visit from an Environmental Health Officer (EHO). The EHO had received an anonymous call relating to there being no hot water supply to the kitchen area since 27th October 2021. Although several mitigations were already in place the Trust was considered in breach of The Food Hygiene and Safety (England) Regulations by failing to supply hot water to the kitchen area. However, as a result of the visit and the mitigations in place and those recommended, there was not deemed to be an imminent threat to health and no requirement to close the facility. On Monday 29.11.21 the Trust received two improvement notices relating to the supply of hot water to equipment washing sinks and the number of adequate hand washing sinks within the kitchen facility. A meeting with the BCM on 15.12.21 resulted in the Trust being informed that both improvement notices where spent and the Trust was now compliant with The Food Hygiene and Safety (England) Regulations 2013 Regulation 19.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board are asked to note the regulatory breaches and the outcome of the actions to date.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Breach of The Food Hygiene and Safety (England) Regulations, Warrington Catering Department.	**AGENDA REF:**	**BM/22/01/20**

1. BACKGROUND/CONTEXT

On Thursday 25.11.21, Warrington Catering Department received a visit from an Environmental Health Officer (EHO). The EHO had received an anonymous call relating to there being no hot water supply to the kitchen area since 27th October 2021.

On 25.10.21 the main hot water boiler that serves the kitchen was condemned by an external contractor during a maintenance visit after it experienced some electrical issues. The contractor visited at the Trust request. The electrical issues the boiler experienced prior to the visit were unable to be rectified by Trust engineers. A Trust estates maintenance engineer procured a replacement boiler on 29.10.21. The delivery date for the boiler was scheduled for 25.11.21. Consideration was given to the installation of temporary hand washing units but there was some difficulty in procuring them at the time. Several complex estates actions were required to divert piped hot water to the kitchen area from existing staff rest areas where hot water was available. The building work required would have exceeded the delivery time for the new boiler. These included an asbestos survey, asbestos removal/containment and fitting of new plumbing. The delivery date for the new boiler became delayed to 6.12.21. Several attempts were made to bring this date to forward by contacting the supplier directly.

The catering department manager applied several mitigations from 25.10.21 to continue to operate the kitchen safely. This included changes to staff hand washing, surface cleaning, food preparation and dishwashing.

- Temporary hand washing facilities were set up using cold water and standing hot water
- Staff were re-directed to staff change facilities with hot water
- Cold water chemicals were implemented for surface cleaning
- Cool water chemicals were implemented for dishwashing
- Heavy equipment items (pans) were being boil cleaned

Following the visit on 25.11.21 the EHO escalated concerns to Warrington Borough Council Business Compliance Officer (BCM). An immediate meeting was convened by the BCM and key estates and facilities staff where the risks and mitigation were discussed, resulting in a follow-on visit to the department by the BCM later that evening.

Although there was a breach of the Food Hygiene and Safety (England) Regulations by failing to provide a hot water supply to the kitchen, the BCM concluded on 25.11.21 that given the mitigations in place, there was not deemed to be an imminent risk to health and no requirement to close down the facility.

2. KEY ELEMENTS

Two Improvement notices were served to the Trust on 29.11.21. (**Appendix 1**).

Regulation 19

The Food Hygiene and Safety (England) Regulations 2013 Regulation 19

1) As specified in EU Regulation 852/2004 Annexe II Chapter 1 Paragraph 4: An adequate number of washbasins is to be available, suitably located and designated for cleaning hands. Washbasins for cleaning hands are to be provided with hot and cold running water, materials for cleaning hands and for hygienic drying. Where necessary, the facilities for washing food are to be separate from the hand-washing facility

2) As specified in EU Regulation 852/2004 Annexe II Chapter 2 Paragraph 2: "Adequate facilities are to be provided, where necessary, for the cleaning, disinfecting and storage of working utensils and equipment. These facilities are to be constructed of corrosion-resistant materials, be easy to clean and have an adequate supply of hot and cold water."

1. *'There were an inadequate number of hand wash basins with an appropriate supply of running hot and cold water in the premises considering the number of food handlers, size of premises and nature of food being handled.'*
2. *'There was an inadequate supply of hot running water provided to the equipment wash sinks in the catering unit kitchen as the hot water heater in the kitchen was not working adequately'*

Improvement notice 1 was complied with on 30.11.21 when additional hand wash facilities were installed.

Improvement notice 2 was met on delivery, installation and commission of the replacement boiler on 6.12.21.

In summary, although mitigations were in place to operate the catering department safely the improvement notices were still issued as there is a legal requirement for a hot water supply to the catering area.

3. SUMMARY OF ACTIONS & LESSONS LEARNED

A number of actions were initiated immediately post EHO visit, (**Appendeix 2**). This action plan is monitored via the Health and Safety Sub Committee.

Escalation to EHO should have occurred. This has been acknowledged by the senior team and incident reporting and management training for all catering department staff to maximise reporting efficiency across the department was arranged and carried out.

Chief Operating Officer, Deputy Director of Governance and Associate Director of Estates and Facilities convened a meeting with both the local EHO and BCM on 29.11.21 regarding relationships going forward. This proved positive.

The department secured delivery of cooked, chilled meals from Wigan and Wrightington Hospitals on 26th November 2021 and the delivery was received on Monday 29.11.21. This process was risk assessed and supported by Infection Prevention and Control (IPC). To support standards, patient feedback was gained and fed back as positive.

Associate Director of Estates and Facilities now provides visible leadership and direct support to the department and supports subsequent EHO visits directly.

The department has requested a substantial capital investment in 22-23. Head of Capital Projects is has costed some additional construction work to enhance the environment. Some of which is referenced in the 5 star rating of 16.10.21 as a requirement.

A meeting with the BCM on 15.12.21 resulted in the Trust being informed that both improvement notices were spent and the Trust was now compliant with The Food Hygiene and Safety (England) Regulations 2013 Regulation 19.

At this meeting an action plan (**Appendix 3**) that combined actions from a EHO food hygiene inspection visit in October 21 (that resulted in 5 stars being awared) , the subsequent inspection in November 21, A routine pest control audit in November 21 and and IPC Audit, also in November 21 were presented to the BCM who commended the trust on the prompt action taken and management plans in place. Unfortunately, the food hygiene rating for Warrington catering department was reduced to 3 stars (satisfactory).

3. NEXT STEPS

There are plans for a food hygiene rating resinspection in March 2022. The department has a long history of gaining 5 stars (the maximum available) over many years although the BCM did state it will be difficult to regain 5 stars if the catering environment is not improved. The steps set out in the agreed action plan and a proposal to upgrade the kitchen facilities in the 2022/23 Estates progamme of works will support regaining 5 stars as a priority.

Communication between Catering, Estates Maintenance and senior Estates and Facilities Management will continue to be closely monitored to ensure that the necessary escalation in operational matters are effected in a timely manner.

4. RECOMMENDATIONS

The Board are asked to note the regulatory breaches and the outcome of the actions to date.

Appendix 1

Improvments notices 30.11.21.pdf

Appendix 2

Warrington Catering Action Plan Nov 21.dc

Appendix 3

joint action plan EHO,Pest and IPC - De

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/20**
SUBJECT:	**Non-Executive Director Champion Roles**
DATE OF MEETING:	26 January 2022
AUTHOR(S):	John Culshaw, Trust Secretary
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All
EXECUTIVE SUMMARY *(KEY ISSUES):*	Following the release of ***'Enhancing Board Oversight – A New Approach to Non-Executive Director Champion Roles'*** by NHS England & NHS Improvement in December 2021, a new approach has been set out to ensure Board oversight of important issues by discharging the activities and responsibilities held by some NED Champion roles through Committee structures. The guidance further described which of the NED Champion roles should be retained. This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by Committees.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management ** Does not apply to Foundation Trusts**
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding

	Counter fraud Procurement Security management-violence and aggression The Trust already has the NED champion roles as identified within the guidance, as well as an identified committee to oversee those issues for committee discharge.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board is asked to note the current NED Champions in place and consider areas to adopt recommendations in the guidance.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Non-Executive Director Champion Roles**	**AGENDA REF:**	**BM/22/01/21**

1. BACKGROUND/CONTEXT

Over time and following on from high-profile failings in care and leadership, several national reviews and reports established a requirement for Trust Boards to designate Non-Executive Director (NED) Champions for specific issues to deliver change. This led to an increasing number of roles spanning quality, finance and workforce. As a result, the high number of NED Champion roles, some of which had been in place for over a decade, made it difficult for Trusts to discharge them all effectively and consequently measure their impact on delivering change.

Following the release of ***'Enhancing Board Oversight – A New Approach to Non-Executive Director Champion Roles'*** by NHS England & NHS Improvement in December 2021, a new approach has been set out to ensure Board oversight of important issues by discharging the activities and responsibilities held by some NED Champion roles through Committee structures. The guidance further described which of the NED Champion roles should be retained. This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by Committees.

The Care Quality Commission (CQC) was engaged throughout the development of this new approach and CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to the new guidance where appropriate.

2. KEY ELEMENTS

2.1 Retained NED Champion Roles

Retained NED Champion Roles				
NED Champion Role	**Type of Role**	**Legal Basis**	**Role Summary**	**Current NED in role**
Maternity Board Safety Champions	Assurance	Recommended	The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.	Margaret Bamforth
Wellbeing Guardian	Assurance	Recommended	The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of	Cliff Richards
FTSU Champion	Functional	Recommended	The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board	Steve McGuirk (Designate) Previously Ian Jones
Doctors Disciplinary Champion	Functional	Statutory	Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.	Margaret Bamforth

Security Management Champion	Assurance	Statutory	Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.	**Not required by a Foundation Trust

2.2 Issues that can be overseen through Committee Structures

The table below outlines those issues that reports or reviews previously suggested should be overseen by a NED Champion, but which are now considered best overseen through committee structure. Each Trust can determine whether each issue is relevant to their Trust and how best they should be allocated to their Committee structure.

Issues to be overseen through Committee structures			
Issue	**Oversight Committee**	**Recommended approach**	**Executive Lead**
Hip Fracture, Falls & Dementia	Quality Assurance Committee	Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The Board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.	Chief Nurse
Palliative and End of Life Care	Quality Assurance Committee	The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis. The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:	Exec Medical Director

		• attendance of a NED from the Quality Committee at the PEoLC Executive Committee • ensuring the board is aware of standards of care in PEoLC • reviving PEoLC complaints to see where improvements could be made.	
Resuscitation	Quality Assurance Committee	Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework. This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Assurance Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board	Exec Medical Director
Learning from Deaths	Quality Assurance Committee	Executive and Non-Executive Directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible. In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Assurance Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.	Exec Medical Director
Health & Safety	Quality Assurance Committee	Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.	Chief Nurse

		Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.	
Safeguarding	Quality Assurance Committee	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people. This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding. The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.	Chief Nurse
Safety & Risk	Quality Assurance Committee	The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit Committees as examples. CQC have endorsed the new approach recommended in this guidance. However, should Trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.	Chief Nurse
Lead for Children & Young People	Quality Assurance Committee	The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable	Chief Nurse

		oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.	
Counter Fraud	Audit Committee	The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud. NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.	Chief Finance Officer
Emergency preparedness	Finance & Sustainability Committee / Audit Committee	The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a Board level Director with Executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. The Framework suggests that a NED or other appropriate Board member should support the AEO and endorse assurance to the Board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR. The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on	Chief Operating Officer

Procurement	Finance & Sustainability Committee	Procurement should be seen by the board as a value-adding function. The Finance & Sustainability Committee should help raise awareness of commercial matters at Board and Director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The Committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement. Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.	Chief Finance Officer
Cyber Security	Finance & Sustainability Committee	Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the Board than a Committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced. Each trust should have a Senior Information Risk Owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber- security standards are followed throughout their organisation. The Board/Committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following: • Removal of unsupported systems from trust networks. • Timely patching of systems and prompt action on high severity Alerts when they are issued. • Ensuring robust and immutable backups are in place. It is also recommended that Boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual Board members are required to complete.	Exec Medical Director

Security Management – violence & aggression	Strategic People Committee	As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the Board may wish to ensure the following: • The Trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the Board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the Board. • Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders. • A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board. The Strategic People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence	

3. RECOMMENDATIONS

The Board is asked to note the current NED Champions in place and consider areas to adopt recommendations in the guidance.