We are
WHH

NHS
Warrington and
Halton Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting –

Thursday 24 May 2018

TIMES 13.30– 17.00

Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in Public (Part 1)

Thursday 24 MAY 2018 **TIMES 13.30pm-16.30pm**

Trust Conference Room, Warrington Hospital

AFTERNOON

	PUBLIC PART 1 (a)	PRESENTER	PURPOSE	TIME	
BM/18/05/32	Welcome, Apologies & Declarations of Interest	Terry Atherton, Deputy Chair	N/A		Verb
BM/18/05/33	**CNST incentive scheme**. *(evidence needs to be submitted to Trust Board for sign-off and then sent on to NHS Resolution by 29 May 2018)*	Tracey Cooper, Head of Midwifery	Assurance	13.30	PPT
BM/18/05/34	Guardian of Safe Working Quarterly Report (January-March 2018) + - briefing paper re: Jnr Doctor handover time (from March board)	Alex Crowe, Medical Director	Assurance	13.40	Enc
BM/18/05/35	Minutes of the previous meeting held 28 March 2018	Terry Atherton, Deputy Chair	Decision	13.50	Enc
BM/18/05/36	Actions & Matters Arising	Terry Atherton, Deputy Chair	Assurance		Enc
BM/18/05/37	Chief Executive's Report	Simon Constable, Deputy Chief Executive & Executive Medical Director	Assurance	13.55	Verbal
BM/18/05/38	Chairman's Report	Terry Atherton, Deputy Chair	Information	14.00	Verbal

Quality People Sustainability

BM/18/05/39	Integrated Performance Dashboard M1		Assurance	14.10	Encs
(a)	Quality Dashboard - Quality Assurance Committee Key Issues Report 1.05.2018	Alex Crowe Medical Director Kimberley Salmon-Jamieson Chief Nurse Chris Evans, Chief Operation Officer			
(b)	Sustainability Dashboard - Financial + Sustainability Committee Key Issues Report (i) 18.04.2018	Andrea McGee Director of Finance + Commercial Development			
(c)	- Audit Committee Key Issues Report 26.04.2018				
	People Dashboard - Workforce Committee Key Issues Report 17.04.2018	Michelle Cloney Director of HR&OD			
BM/18/05/40	Spinal Services Update	Simon Constable Deputy Chief Executive/ Executive Medical Director	Assurance	14.40	Verb

Quality

BM/18/05/41	Annual SIRO Report	Jason DaCosta Director of IM+T	Assurance	14.45	Enc
BM/18/05/42	CQC Action Plan Update Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	14.55	Enc
BM/18/05/43	Quality Strategy	Kimberley Salmon-Jamieson Chief Nurse	Decision	15.05	Enc

Sustainability

BM/18/05/44	Working Capital Loan Resolution & Working Capital Loan approval	Andrea McGee Director of Finance + Commercial Development	Assurance	15.10	Enc
BM/18/05/45	Quarterly Response to Lord Carter	Andrea McGee Director of Finance + Commercial Development	Assurance	15.25	Enc
BM/18/05/46	My Choice	Andrea McGee Director of Finance + Commercial Development	Assurance	13.35	PPT

People

BM/18/05/47	Engagement Dashboard – yearly report	Pat McLaren Director of Community Engagement	Assurance	15.45	Enc

GOVERNANCE					
BM/18/05/48	Strategic Risk Register Update	John Culshaw Head of Corporate Affairs	Assurance	15.55	Enc
BM/18/05/49	(a) Finance and Sustainability Committee (i) Committee Chairs Annual Report – To be tabled (ii) ToR and Cycle of Business (b) Audit Committee Chairs Annual Report – To be tabled	Committee Chair/ Head Corporate Affairs Committee Chair	Approval	16.00	Enc & To be tabled
BM/18/05/50	Trust Operational Board Cycle of Business	John Culshaw Head of Corporate Affairs	Approval	16.10	Enc
BM/18/05/51	Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	Andrea McGee Director of Finance + Commercial Development	Approval	16.15	Enc
BM/18/05/52	Any other Business			16.25	

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And together we

make a difference

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme Maternity Actions

- Trusts have to provide evidence of their progress against 10 safety actions by 28th June 2018
- Requires Board sign off prior to submission
- Up to 10% off annual CNST payment

10 Safety Actions & Progress

1) Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths? Demonstrate compliance between Jan-Apr 18. Completed.

2) Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Demonstrate progress of 8 out of 10 of the criteria of submitted data Jan-Mar 18. Completed (Compliant with 9 out of 10).

3) Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme? Completed.

4) Can you demonstrate an effective system of medical workforce planning? provide data on the proportion of middle-grade sessions on the labour ward filled by other staff from other sessions. Trusts need to demonstrate that fewer than 20% of sessions are filled by consultants acting down as a proxy for workforce planning. Completed .

5) Can you demonstrate an effective system of midwifery workforce planning? Use Birthrate+ acuity tool. BR+ assessment 2015, new assessment currently in progress. Completed.

6)Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle? All 4 elements of Saving Babies Lives care bundle (Smoking cessation, 'Fresh Eyes' CTG, Reduced fetal movements information, Using GROW package). Completed.

7) Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? Completed.

8) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? Completed for Midwives, Medical staff and HCAs. 72% compliance for anaethetists inc e-learning. ODPs 92% e-learning

9) Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? Completed

10) Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme? Evidence position to end March 2018. Completed

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/34 i**
SUBJECT:	**Guardian Quarterly/Annual Report on Safe Working Hours for Junior Doctors in Training**
DATE OF MEETING:	24 May 2018
ACTION REQUIRED	**The Board are requested to note the report 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.**
AUTHOR(S):	Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Head of HR Strategic Projects
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Deputy Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.2: Health & Safety
	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.3: Medical Staffing
STRATEGIC CONTEXT	The junior doctor contract was implemented in the trust on 7.12.16 but with national safeguards that the junior doctors should not be working excessive hours which could affect their health and wellbeing and the service they deliver to patients. Each trust was required to appoint a Guardian of Safe Working whose primary role is to ensure that junior doctors do work safely and are able to access appropriate training and development opportunities. A system of Exception Reports allows junior doctors to report areas of non-compliance and provides the opportunity for the Guardian to monitor trends and issues. It is a requirement of the national contract that the

	Guardian submits a quarterly and annual report to the Board so that the Board can gain this level of assurance. The Board has previously received three reports: one covering the period from December 2016 to May 2017, another covering June to September 2017 and the last one covering the period from October to December 2017. This is the fourth Report and primarily covers the period from January to March 2017 but also includes a section examining the period from April 2017 to March 2018.
EXECUTIVE SUMMARY (KEY ISSUES):	The new Junior Doctors Contract has been in place since August 2016, and now all our Foundation Doctors have converted over, as well as the newer appointments on the CT and ST grade. There is good engagement from the doctors, who have worked well with rota managers, HR, postgraduate department, and the Clinical and Educational Supervisors. As noted previously, the majority of Exception Reports (ERs) relate to juniors working late past their rotas. This 3 month report relates to the busiest period of the year, both locally and nationally, and this has been borne out in the high number of reports. Although a large number relate to high acuity and very sick patients, there are still large numbers of juniors staying late to perform routine tasks, including TTOs and rewriting prescription charts. During these 3 months, there was a rise in submission of ERs from surgical F1s, who were asked to cover medical outliers, not just on the surgical wards (which they expect), but also on non-surgical wards. As mentioned previously, this may cause an issue with the upcoming Deanery visit, as F1s in particular have missed out on educational opportunities, in order to complete these tasks. We have persistent problems with the sign-off meetings between the Educational Supervisors and the

	trainees, with large numbers of ERs having not been completed. This leads to a long delay in our trainees being able to put in claims for time-off in lieu (TOIL) and compensatory payment. Although there is still a preference for juniors to request compensatory payment rather than TOIL, this has levelled off a lot, and it is encouraging to see trainees opting for TOIL. Hopefully, this will prevent them exceeding their recommended maximum hours. I have had a number of useful discussions with ES and trainees in attempts to allow fair resolution of ERs. I have sent numerous emails to our Educational Supervisors and trainees, to remind them of the importance of getting all ERs signed off as quickly as possible.	
RECOMMENDATION:	The Board are requested to note the report 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. Any concerns that the Board have should be reported back to the Guardian for his attention.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS	Release Document in Full	

(FOIA):	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	**Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training covering 1 January 2018 – 31 March 2018 and incorporating the Annual Report covering April 2017 t0 March 2018**	**AGENDA REF:**	**BM/18/05/3 4 i**

1. Executive Summary

The New Junior Doctor Contract is now well established at WHH. All our rotas remain compliant, and in general the juniors are happy with their allocations. Our Junior Doctors' Forum is now very well attended and enjoys robust discussion. The collaboration of the Medical Director, HR and the Guardian into a single meeting for the JDF seems to work well, to identify and correct persistent ongoing concerns from the juniors. In addition, the juniors seem happy to engage with their consultants, Educational Supervisors and Guardian, if any new issues develop.

We have had the largest number of Exception Reports (ER) to date submitted in the first 3 months of 2018. This was to be expected, with the desperate bed shortages and sheer volume of acute patients in WHH, and seemingly every hospital in the country, during this period.

The vast majority of ERs still relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there have been a large number of ERs from 2-3 areas, which have prompted work schedule reviews.

I am pleased to report that within general medicine there has been good engagement with the FY1 trainees to resolve a long standing issue with evening medical handover. This has resulted in changes to the FY1 rota and the detailed changes are compliant, and have involved consultation with all of the trainees. This was highlighted as a priority at the last Board meeting, and it is good to see it has been finally resolved in an amicable fashion

Only 13 ERs relate to missed educational opportunities. When considering the high volume of teaching provided, and the high volume of sick inpatients during these months, this is very reassuring for our provision of training, and demonstrates engagement of senior colleagues in allowing them to attend.

Most ERs are submitted by juniors working on the medical wards, but this reflects the busier nature of their jobs. I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, and despite the high acuity, the F1s appear to be getting good support and teaching there.

I am concerned that there has been some slippage in the review meetings between ES and trainee, once an ER has been submitted. I have encouraged the F1s to contact me as Guardian, if they are unable to arrange a timely meeting with their ES. I have contacted a number of supervisors, both individually and collectively, to try and address this.

There has again been no escalation of an ER to a level 2 review or fine to the trust since the last Report.

In terms of the annual report, the number of exception reports has steadily increased throughout the year as the trainees have become more familiar with the process and have been encouraged to report instances of when their hours of work have been affected or their access to training opportunities. This is a positive situation, as it identifies where the main problem areas are within the trust and the rotas which need further examination. The number of exception reports resulting in an overtime payment is still high but the last quarter has suggested that time off in lieu is now becoming more popular and this is consistent with the national position.

2. Introduction

As a reminder, the role of the Guardian of Safe Working Hours under the Terms and Conditions of Service is to:

'provide boards with assurance that junior medical staff are safe and able to work, identifying risk and advising boards on the required response'

This Report primarily covers the period from 1 January 2018 to 31 March 2018 as well as including a section on the Annual Report for 2017/18 and follows the format as recommended by NHS Employers.

<u>High level data</u>

	Number of
doctors / dentists in training (total):	72
Number of doctors / dentists in training on 2016 TCS (total):	70
Amount of time available in job plan for guardian to do the role:	1.5 PAs / 6 hours per week
Admin support provided to the guardian (if any):	Nil WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

The 72 doctors in training at the trust are made up of 36 FY1 trainees and 36 FY2 trainees. The 36 FY1 trainees transferred to the new contract on 7 December 2016 and from the August 2017 changeover all of the FY1 and FY2 trainees went on to the new contract (2 appointments on the FY2 intake were initially vacant but one was filled on a locum basis). In addition, the Lead Employer (St Helens and Knowsley) employ trainees at ST1+ and CT1+ who rotate to different trusts as part of their training. At any one time, the trust usually has c80 trainees from the Lead Employer and the most recent rotations now include the vast majority of trainees on the new contract. The Lead Employer is responsible for their own monitoring and Quarterly Report for the trainees they employ.

3. Exception Reports (with regard to working hours)

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding including those

				from previous reports
General Medicine – FY1	**43 (65)**	**71 (80)**	**44 (47)**	**63 (91)**
General Surgery – FY1	**14 (20)**	**27 (38)**	**11 (19)**	**29 (36)**
Anaesthetics – SST/JST	**0**	**1**	**0**	**1**
Medicine - JST	**0**	**1 (3)**	**0**	**20**
Medicine – ST3	**0**	**5 (6)**	**0**	**5 (8)**
Trauma and Orthopaedics – FY1	**11 (11)**	**1**	**1**	**0**
Obstetrics & Gynaecology JST	**0**	**1**	**1**	**0**
Paediatrics – Alder Hey – FY1	**7 (7)**	**0**	**0**	**7**
ENT – ST3	**4 (4)**	**0**	**0**	**2**
Total	**79 (107)**	**107 (130)**	**57 (68)**	**127 (165)**

NB.

1. The figures in brackets denote the total number of reported incidents. In some instances one Exception Report has been used to report more than one incident/issue. Therefore, a total of 107 exception reports were completed but these cover 130 incidents. The previous quarter was 64 exception reports and 84 incidents.
2. The 130 incidents were submitted from a total of 24 trainees and 20 Educational Supervisors, 11 of which do not appear to have yet engaged in the process over this period. There was three exception reports completed (9 incidents) which were classified as an 'Immediate Safety Concerns' (ISCs). Upon further examination, not all of these were actual ISCs, but they all received the immediate attention they required. Four separate reports were from an F1 following 4 consecutive nights on call for Medicine without an SHO grade. Three were submitted from an F1 who was unable to attend teaching, felt unsupported on the wards, and had to leave a number of jobs incomplete, despite staying late. The final two ISCs were again from an F1, who did 2 weekend shifts over a bank holiday in surgery, without a second F1, who had called in sick. He felt very overstretched due to high volume of both acute admissions and routine ward work. In these circumstances, the trainee is contacted by the Guardian within 48 hours, and an early meeting with the ES is mandated
3. 127 (165) exception reports remain open and need resolving. I have communicated the need to close these ERs to both the trainee and educational supervisors on a number of occasions. This was a common theme at our recent Regional Guardian meeting, and has proved a difficult problem to correct among many trusts. I will make this a priority at the

induction of the new F1s in August. One possible solution is to allow the Guardian access to edit all reports on Allocate, to allow sign-off of delayed reports.

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	13 (16)	13	30 (38)	43 (52)
JST	0	1	0	2 (4)
ST3	0	0	0	5 (6)

Guidelines for exception reports state that reports should be completed by the doctor as soon as possible, but no later than 14 days of the exception. Ninety (109) Exception Reports were submitted within 14 days and 17 (21) were outside this limit. If the doctor is seeking payment as compensation, the report should be submitted within 7 days. Upon receipt of a report, the Educational Supervisor should respond within 7 days. We have allowed some flexibility in the time allowed after submission of an ER, to claim for payment or TOIL. However, we have put a provisional limit at 3 months, and whenever possible, to only allow TOIL within their current placement.

The above table shows that 27 (43) reports (25%) have been addressed by the Educational Supervisor within 7 days, but 30 (38) reports (28%) were addressed in more than 7 days and 50 (62) reports (47%) still remain open (53% remained open in the last Quarter Report so there has been some improvement). This latter figure is of some concern as the Educational Supervisors should have met to resolve the incidents. The exception reports which have been resolved were largely resolved at the 'Initial Stage' but 1 Exception Report was escalated to 'Level 1 Review Stage'.

Exception reports (type of issue)				
	Hours	**Education**	**Service Support**	**Working Pattern**
FY1	**87 (106)**	**13 (14)**	**4 (7)**	**2**
JST	**1**	**0**	**0**	**0**

Clearly the overwhelming number of issues relate to the number of 'hours' that the trainees are being asked to work in addition to their contracted hours.

Exception Reports (Outcome)				
	Overtime Payment	**Compensation and Work Schedule Review**	**Compensation: Time Off in lieu**	**No Further Action**

FY1	**16 (24)**	**3**	**35 (38)**	**2**
JST	**0**	**0**	**1**	**0**

There has been a marked change in the outcome of Exception reports to claim time off in lieu (TOIL) at 61%, compared with the previous quarter at only 16%. This is more in line with the national position taken from feedback at Guardian meetings, and is reassuring to us regarding safe working hours. Overtime payments are still quite high at 28% but have fallen from the previous quarter of 55%.

Another interesting observation is that no Exception Reports have been raised by the FY2 trainees, despite the fact that they were familiar with the system having raised a number of exceptions when they were FY1 trainees. In addition, only a very small number of Exception Reports have been raised by Lead Employer trainees ie, 8 (11). This trend is not dissimilar to previous reports.

Junior Doctors on the 2002 Contract

It is important to remember that some junior doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years and will require their rotas to be monitored in line with their terms and conditions so that assurance can be given for all doctors in training and not just those on the new contract. A monitoring exercise has been completed on these doctors and the results are being analysed.

4. Work Schedule Reviews

There have only been 3 Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report. Two of these relate to the medical rota and 1 to the trauma and orthopaedics rota. These issues have been brought to the attention of the appropriate Clinical Directors.

The Work Schedule Reviews all relate to the FY1 trainees. We have not had to escalate a Work Schedule Review to level 2, 3 or fine status yet.

Work schedule reviews by grade	
FY1	**3**

Work schedule reviews by department	
Acute medicine	**2**
Trauma and Orthopaedics	**1**

5. Locum Bookings

Bank and Agency

The normal arrangements for covering gaps on the rotas are for the trainees to be approached first to see what cover they can provide. Where gaps still remain, the shifts which need covering are submitted via the CBUs to the Medical bank which uses the TempRe system for filling shifts.

The tables below show the shifts which were escalated to the Medical bank for filling on the TempRe system The first table shows the total shifts by specialty and the second table shows the reason. All of the shifts relate to FY2 trainees.

Locum bookings (bank and agency) by department					
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
FY2					
Acute Medicine	164	48	55	1,554	395
Cardiology	44	0	0	352	0
Care of the Elderly	507	298	328	4,552	2,468
Trauma & Ortho	147	40	45	1,440	507
General Surgery	31	27	27	289	282

TOTAL FY2	**893**	**413**	**455**	**8,187**	**3,652**

Locum bookings (bank) by reason					
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
FY2					
Annual Leave	95	23	25	954	199
Extra	59	38	43	472	354
Maternity/Paternity Leave	4	0	0	12	0
Vacancy	709	321	381	6,448	2,829
Sickness	26	31	6	302	270
Total FY2	**893**	**413**	**455**	**8,187**	**3,652**

1. The above tables show that the main reason, by far, for requesting cover was due to vacancies.
2. Three specialties stand out in terms of requiring cover and these relate to Acute Medicine, Care of the Elderly and Trauma and Orthopaedics with the prime reason known to be other vacancies with the specialties. Not surprisingly, these three specialties also account for the highest use of agency staff.
3. The number of shifts requested to be covered this quarter has risen from 587 shifts to 893 shifts. This is reflective of the Winter Pressures.
4. The reason for the difference between requested shifts and the number of shifts given to agencies, is due to subsequent cancellations from the CBUs.

6. Locum Work Carried Out by Trainees

The table below shows trainees by specialty, who have undertaken internal locum work by performing 'extra duties' which in effect supplement the cover arrangements mentioned in the previous section for agency staff. A claim form is completed and authorized and then processed by Payroll.

Locum work by trainee						
Specialty	**Grade**	**Number of shifts**	**Number of hours**	**Number of hours**	**Actual hours**	**Opted out of**

		worked	worked	rostered per week	worked per week	WTR?
General Medicine	FY1	c53	426.75	757	757	N/K
General Surgery	FY1	c9	74.5	544	544	N/K
TOTAL	FY1	c62	501.25	1390	1390	N/K
Psychiatry – NW Boroughs	FY2	c39	311	1468	1468	N/k
Accident and Emergency	FY2	c73	580.25	352	352	N/K
General Medicine	FY2	c15	117	464.5	464.5	N/K
Paediatrics - Alder Hey	FY2	c11	90.5	376	376	N/K
General Surgery/ENT	FY2	C31	248.5	464.5	464.5	N/K
Public Health	FY2	c2	16.75	40	40	N/K
Total	FY2	c171	1364	3125	3125	N/K

NB.

1. The number of shifts worked has been estimated as records only show the number of hours worked and have been based on 8 hour shifts
2. The number of hours worked per week takes account of vacancies and trainees on maternity leave but excludes sickness or other absences such as annual leave.
3. It is not known whether any of the trainees exceeded an average of 48 hours per week under WTR and whether they completed an opt-out form.
4. In comparison with the previous quarter, there has been a dramatic increase in the number of shifts/hours worked from 90 shifts/704.25 hours to 171 shifts/1364 hours in the last quarter. This is undoubtedly due to winter pressures, where increased activity has increased the need for more shifts to be covered. Whilst working additional hours is voluntary, the trainees have felt some compulsion to work more hours. To what extent this has affected their own health and safety, and those of their patients, is difficult to quantify. However, trainees have their own personal responsibility to only undertake additional hours without exceeding their maximum hours allowed, and if they feel capable of undertaking these. At the Regional Guardians' Meeting, none of the represented trusts were able to quantify the exact

number of hours worked by their trainees, in situations where they have opted for extra shifts on top of their rota.

5. The three main areas where additional hours/shifts have been worked are general medicine, surgery and AED.
6. A small number of the extra hours worked relate to Exception Reports and these are mostly in general medicine (63.25 hours) at the FY1 level.
7. The volume of locum work does not correspond to the number of Exception Reports which reached an outcome of 'Overtime Payment'. This would suggest that there are still a significant number of payments yet to be made. All of the trainees have received information on how to make claims and this has been reiterated at the Junior Doctors Forum meetings.

7. Vacancies

The table below shows the vacancies at **FY1 level only** from **Jan – March 2018**:

Specialty	Grade	Jan 18	Feb 18	Mar 18	Total gaps (average)	Number of shifts uncovered
General Medicine	**FY1**	**0.4**	**0.4**	**0.4**	**0.4**	**26**
General Surgery	**FY1**	**0**	**0**	**0**	**0**	**0**
Trauma & Ortho	**FY1**	**0**	**0**	**0**	**0**	**0**
Paediatrics	**FY1**	**1.0**	**1.0**	**1.0**	**1.0**	**65**
General Psychiatry	**FY1**	**0**	**0**	**0**	**0**	**0**
Total	**FY1**	**1.4**	**1.4**	**1.4**	**1.4**	**91**

NB.

1. One of the trainees is LTFT and works 60% which leaves a gap of 40%
2. There were no trainees who were on maternity leave.
3. The 0.4 wte vacancy in General Medicine was offset by one FY2 trainee working 1.0 wte in an FY1 slot in Respiratory Medicine from 21.2.18 and another FY2 trainee working 1.0 wte in an FY1 slot in Gastroenterology, both for educational reasons.
4. It does need to be recognized that there were other medical vacancies at different grades which would have had some impact on the resources available on wards and departments which could have contributed to difficulties in some trainees leaving wards on time.
5. Another caveat relates to the national reduction in supply of CT1/2 and ST3+ doctors, which will undoubtedly lead to insufficient doctors to enable compliant rotas in the future. As well as rota management, this will have a deleterious effect on training and educational opportunities for those left on the rota.

The table below shows the vacancies at **FY2 level only** from **Jan – March 2018:**

Specialty	Grade	Jan 18	Feb 18	Mar 18	Total gaps (average)	Number of shifts uncovered
Gastroenterology	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65 OA**
General Psychiatry	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65 MA**
Obstetrics & Gynaecology	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65 CM**
GP	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65 CB**
Total FY2	**FY1**	**3.0**	**3.0**	**4.0**	**3.33**	**215**

NB.

1. The gap at FY2 in gastroenterology has been offset by an FY2 trainee working at FY1 level for educational reasons.
2. Although there is not a gap at FY2 level in general surgery there are gaps at other levels and this has been offset by an LAT working at FY2 level in general surgery.
3. There has been no cover for the 1.0 wte vacancy in GP or 1.0 wte in Obstetrics and Gynaecology.

8. Fines

During the period there have been no fines imposed by the Guardian and therefore the balance for disbursement is nil.

9. Qualitative Information

Junior Doctors Forum: The JDF continues to be very well attended, and there is excellent engagement and debate during the meeting. The joint meeting with Medical Director, Guardian and HR appears to be appreciated by the juniors. Hopefully, we can continue to develop this meeting in the future.

Education supervisors: whilst there continues to be good engagement from most supervisors, there continues to be significant delays in timing of the review meeting. It is of concern that 127 ERs remain outstanding at the current time, and at the Regional meeting, we are all looking at strategies to attempt to sort this problem.

Exception reports: There has been a large increase in the number of Exception Reports over the first 3 months of 2018, mainly due to the increased workload with winter pressures. The numbers mirrors other trusts of our size. The nine Immediate Safety Concerns (ISC) in this

period all relate to reduced staffing (either sickness or rota gaps) on top of the high acuity and workload.

Compensation for extra duties worked: Our juniors still favour compensatory payment rather than TOIL. However, this has levelled out significantly in this 3 month period, with far more trainees taking TOIL, which is more reassuring for us. There have been 3 work schedule reviews, which are useful to correct problems for future F1s in the post.

Allocate training: there has been drop-in sessions available for ES to develop their skills in completion of ER reviews. We will endeavour to repeat these sessions shortly

10. Issues Arising

Our volume of exception reports (ER) has risen over this 3 month period. However, it is vital the juniors engage with the process, to ensure they are working safely within their allocated rotas. The vast majority of Exception Reports at WHH still relate to working excess hours at the end of their shift. It is very difficult to monitor individual doctors' hours to ensure they do not breach safe working, as it would be calculated as an average over a full rota

The 9 immediate safety concerns in this 3 month period were addressed and closed rapidly.

We have seen a positive shift in this 3 month period for compensation towards time-off in lieu, rather than supplementary payment, following submission of an Exception Report. This will lead to some reassurance that trainees are not exceeding their maximum safe hours

We do rely heavily on in-house locum cover for outstanding shifts, exaggerated by recent changes to IR35 legislation and agency usage. Whilst coverage of shifts in the surgical specialties is usually manageable, this is more difficult in medicine where the juniors are less inclined to cover extra work. In-house cover again has repercussions on the maximum hours that the juniors are permitted to work.

We need ensure continued engagement of our Education supervisors with our junior doctors, and continue to address the problem of persistent delays in participation of review meetings.

11. Action Taken to Resolve Issues

1) Training sessions for all Educational Supervisors and Guardian of Safe Working in Allocate have taken place.
2) Liaison with HR to calculate average hours for juniors across a rota cycle. The planned in house locum bank should help to spread the extra hours across the juniors to ensure they remain compliant.
3) There has been success in increasing staffing and junior support in high intensity areas. This has definitely been assisted by the appointment of nurse specialists and physician associates on the wards.
4) There may need to be extra recognition of the workload of some of the Educational Supervisors, whose juniors are in the more challenging posts, with PA allocation adjusted accordingly.
5) Continue to try and encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.
6) Work schedule reviews should continue to be implemented, especially in the medical rota, and medicine/surgery to allow regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

12. Annual Report of Exception Reports Raised April 2017 – March 2018

This section is just a brief analysis of all of the exception reports raised in the period from 1 April 2017 to 31 March 2018.

The table below shows a summary of the exception reports split by specialty and grade.

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine – FY1	222 (264)	162 (175)	60 (89)
General Surgery – FY1	65 (99)	38 (64)	27 (35)
Trauma and Orthopaedics – FY1	15	15	0
Anaesthetics – SST/JST	1	0	1
Medicine – JST	20 (22)	0	20 (22)
Medicine – ST3	5 (6)	0	5 (6)
Obstetrics & Gynaecology JST	1	1	0
Paediatrics – Alder Hey – FY1	8	1	7
ENT – ST3	2	0	2
Total	339 (418)	217 (256)	122 (162)

The number of exception reports has steadily increased throughout the year as the trainees have become more familiar with the process and have been encouraged to report instances where hours of work have been affected or they have reduced access to training opportunities. This is a positive finding, as it identifies the main problem areas for juniors within the trust, and the rotas which need further examination. A total of 339 exception reports were completed which referred to 418 separate episodes.

Not surprisingly, the highest number of exception reports has been raised within general medicine (65%) followed by general surgery at 19%.

217 exception reports (256 episodes) remain open and whilst the vast majority of these require attention from Educational Supervisors, there is a proportion which just need accepting by the trainees where there has been intervention from the Educational Supervisors.

The table below shows a summary of exception reports by type of issue raised.

Exception reports (type of issue)				
	Hours	Education	Service Support	Working Pattern

All rotas	**303 (376)**	**20 (21)**	**13 (18)**	**3**

Again, not surprisingly, the vast majority of exception reports refer to hours (89%), usually where trainees have felt they had no alternative but to stay beyond their shift to maintain safe patient care. Only 6% refer to education issues which would suggest that on the whole the vast majority of trainees feel that they are able to access their training and education opportunities.

The table below shows a summary of exception reports by outcome.

Exception Reports (Outcome)				
Overtime Payment	**Compensation: Time Off in lieu**	**Compensation or Time off in lieu**	**Compensation and Work Schedule Review**	**No Further Action**
133 (159)	**53 (62)**	**2**	**21**	**8 (10)**

The most favoured outcome for exception reports has been 'overtime payment' at 61% and this was certainly the case for three quarters of the year but in the last quarter there has been more of a shift to 'time off in lieu' (TOIL) which accounted for 24% overall. The shift towards TOIL is more in keeping with the national position, and as stated earlier, this is definitely a pleasing change

13. Summary

Our trust has continued to maintain good engagement of the new Junior Doctors Contract across the specialties. All our rotas remain compliant, the juniors are generally satisfied and engaged, and our HR department, rota managers, and Educational Supervisors have usually been supportive and responsive to any concerns amongst the junior doctors.

This was a particularly challenging 3 month period for the trust, with high volumes of sick patients and major problems with bed availability. The number of exception reports mirror this and again generally relate to juniors staying late after a particularly onerous shift.

The 9 immediate safety concerns reported by junior doctors all relate to low staffing levels on busy shifts, wither due to rota gaps or medical sickness. Apart from sporadic occasions, our juniors have been able to attend educational and teaching sessions, without recall to ward duty.

There remain a large number of outstanding ERs (127), and this clearly needs addressing. However, all completed reports have been signed off without resort to level 2 or guardian reviews. This was one of the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our trust.

There are still areas where there are limited numbers of junior staff covering busy wards. This will undoubtedly lead to extra burden on the incumbent doctors, in terms of workload, compliance to working hours, and opportunity to access educational sessions.

We need to ensure we provide continued training for Educational Supervisors, both in the expectations of their responses to exception reports, and instruction for use of the Allocate system.

In order to ensure compliance with junior doctors hours, Educational Supervisors should be encouraged to offer TOIL rather than compensatory payment wherever feasible. Work schedule reviews are mandatory where there is persistent infringement of hours or educational opportunities for our doctors.

14. Questions for Consideration

As Guardian of Safe Working Hours for the Junior Doctors in WHH, I am satisfied with the delivery and implementation of the new contract in our trust to date. Please note and consider the assurances during this report.

However, we do need to be watchful that work schedules and working hours are maintained in future rotations, being mindful of the likely challenges facing the trust with service delivery, in the face of the likely reduction in training posts offered to the trust by HENW Deanery.

AS Guardian of Safe Working, I would be grateful for feedback from the Board regarding any concerns or recommendations regarding the implementation of the new Junior Doctors Contract in our trust.

Mark Tighe
Guardian of Safe Working Hours

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

High Level Briefing Paper

AGENDA REFERENCE:	**BM 18 05 34 ii**
SUBJECT:	**BRIEFING PAPER REGARDING JUNIOR DOCTOR ROTA**
DATE OF MEETING:	16/5/2018
ACTION REQUIRED	**For Information Only**
AUTHOR(S):	Dr Kate Clark, Deputy Medical Director, Alex Crowe, Medical Director
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Medical Director
EXECUTIVE SUMMARY	Exception reporting related to additional hours worked has been noted, particularly within medicine. Feedback regarding workload and ward cover was also received via the GMC survey, feedback from the Deanery and juniors raising concerns via the Clinical Business Units. This briefing paper provides an overview of the actions taken to date to address this. These actions are discussed at Junior Doctors' Forum with attendance of Medical Director, Deputy Medical Director, Head of HR, Representatives from Education Department and Guardian of Safe working.
RECOMMENDATIONS:	Clinical Business Units continue to work collaboratively to improve the working lives of junior doctors and support their educational experience by developing improved systems to monitor training and access to educational opportunities. This also includes monitoring of ward cover with a ward level dashboard.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication

SUBJECT	Junior Doctors	AGENDA REF:	BM 18 05 34 ii

1. BACKGROUND/CONTEXT

In 2015 the Deanery placed WHH in special measures and withdrew trainees due to their poor educational experience. This act placed further pressure on the Trust to deliver safe levels of medical staffing and a variety of initiatives have been implemented to address this demand.
The Trust has also undergone organisational re-structure to support clinical leadership and create clinical business units lead by a triumvirate of clinician, nurse/AHP and manager to deliver high quality, safe and effective care.

Medicine currently sits across 4 separate business units: Specialist Medicine; Urgent & Emergency Care; Airway, Breathing and Circulation, and Digestive Diseases. Oversight of medical trainees was previously reviewed at a divisional level, since dissolution of the Divisions, CBUs will need to work more collaboratively to ensure trainees needs are addressed.

2. KEY ELEMENTS

Issue raised	Action	Progress
Senior Support on C21	Review of medical staffing and changes to the cardiology consultant of the week. The resulted in a change to their working pattern to deliver 7 day working across CCU & the ward. Further recruitment in cardiology has supported this work	There is now only 1 ward round in the afternoon and work continues to re-align consultant job plans and clinic scheduling to deliver this ward round in the morning. There is a consultant of the week accessible for advice and support.
Afternoon ward rounds on C21		
Doctors mess in poor state of repair, roof leaking and furniture mouldy	Roof repaired. Furniture replaced Lunch time activities arranged	These activities seem to have reduced with less juniors visiting the mess. Chief registrar and deputy MD to agree a lunchtime schedule to encourage juniors to attend the mess.
Staffing levels on A8 and overall delivery of care on the ward	An improvement plan was developed and implemented. This included the following actions: Increased medical staffing with a second consultant and additional junior locum. Matron placed on the ward to support delivery of nursing care Recruitment of staff to reduce	The ward has received improved feedback via patient survey, observational surveys and senior staff walkarounds. Juniors have reported better educational experience with ward level teaching. Discontinuation of a locum

	overall vacancies	consultant contract following feedback from trainees and staff.
Staffing levels and delivery of care on A3	An improvement plan was implemented and developed. This included the following actions: A3 was moved to ward B19 with a subsequent reduction in the bed base from 34 to 24. Dr Khan, specialty doctor was placed on the ward as a regular senior presence. Nursing staff supported by increased senior nurse presence	Overall quality metrics have improved with reduction in incidents, improved patient experience feedback and staff satisfaction.
Gaps in rota contributing to reduced ward cover and on-call deficit	Appointment of medical utilisation manager (MUM) to support ward oversight supporting CBUs	Jenny Taylor now appointed in to role.
Concerns regarding ST trainees in care of older persons	Providing Educational opportunities to attend clinic. Improving calibre of locum consultant appointments with ethos of creating a positive environment to encourage development.	Recent visit from regional head of school, met with ST trainees and was pleased with feedback and quality of their portfolios and has reduced monitoring. Regular review of locum workforce to ensure they are supportive of juniors
Juniors being moved to support gaps in ward cover	Oversight of ward cover to identify gaps. Junior doctors should only be moved if absolutely needed for patient safety. Locums and trust grades should be as the first option.	Ward RAG rated dashboard to identify gaps. Locums and trust grades moved to fill gaps ahead of time. Trainees have only been asked when there has been short notice due to sickness.
Access to clinics for CMT trainees	A clinic room was created for CMT trainees and the trainees created a roster supported by the chief registrar.	The clinic room was subsequently utilised for another reason. Further work has been done to identify additional rooms and a clinic template has been created. CMTs will be scheduled to attend and will need to report when this does not happen.

Exception reporting highlighted FY1s staying after 9pm to attend handover	Discussion with acute care team to identify strategy to allow junior to leave at 9pm. Further discussion identified that trainees felt it was important they attended to support education and patient safety	Changes made to rota to enable trainees to attend handover with time identified in lieu prior to their long day weekend.
Poor method of handover for medical on-call	Survey conducted to obtain views on medical on-call handover and risk identified relating to information governance with hand-written lists. Creation of electronic medical list	List created and tested and launched February 2018. Survey post launch was positive. New formal handover template being introduced
Concerns raised regarding educational experience on AMU	Working group created to address concerns and improve the AMU working environment	Regular meeting with CBU and trainees to improve the environment
Application of Trello App.	Documentation of work streams from Trainee Forum and opportunity for comments and advice	Trello App is no 'live' for trainees
Flow Clinician at Full Capacity	Daily Flow Clinician (Clinical Director, Associate Medical Director, Deputy Medical Director or Medical Director) of all wards when hospital at Full Capacity to assess inpatient flow, safety of wards and support to trainees	Development of Standard Operating Procedure to support Flow Clinician. Maintaining safety and appropriate support for trainees when hospital at Full Capacity. Recommendations to Winter planning. Engagement with trainees in order to support service development.

3. FURTHER ACTIONS REQUIRED

See above
Further actions ongoing to address needs of juniors and to link in to CQC observations:
Improvement with medical handover
Allocation of CMT Clinics
Winder planning for trainees
Further changes to FY rota (requested by trainees)
Work stream app use to share actions and engage with trainees

4. MONITORING/REPORTING ROUTES

Feedback via Education Centre, HEE and GMC surveys
Feedback via CBU monitoring of ward cover and CMT clinic attendance
Exception reporting
Trainees to report incidents real time via CBU structure
Feedback via junior doctors forum
Feedback via meetings with Deputy Medical Director, Medical Director and college tutors.
Feedback via clinical and educational supervisors

5. RECOMMENDATIONS

All work streams to continue with over sight at executive level

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 31 January 2018
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Non-Executive Director
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Anita Wainwright (AW)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Director of HR + OD
Lucy Gardner (LC)	Director of Transformation
Alex Crowe (AC)	Medical Director and Chief Clinical Information Officer
Chris Evans (CE)	Chief Operating officer
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Trish Richardson (TR)	Head of Patient Experience
Mark Tighe (MT)	Consultant – General Surgery
Natalie Gregory (NG)	Executive Assistant – Minute Taker
Karen Fox (KF)	Member of the public (Karen_e.fox@novartis.com)
Norman Holding (NH)	Lead Governor
Alison Kinross (AK)	Public Governor
Apologies	
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Jason DaCosta (JDaC)	Director of IM&T
John Culshaw (JC)	Head of Corporate Affairs
Observing	
Jane Hurst (JH)	Deputy Director of Finance (Strategy)
Alison Kennah (AK)	Associate Chief Nurse Patient Safety

Agenda Ref BM/18/03/	
BM/18/03/	**Patient Story** Discussed after agenda items BM/18/03/17 & BM/18/03/18 as TR was delayed slightly. The Board noted TR's arrival to the meeting and she was introduced by KSJ. TR has now been here for a month and the patient story format may change in the future. This particular patient story discussed a patient's time on the maternity unit. The midwife involved in the story was commended for her calmness in the situation and SMcG questioned if the midwife had been thanked and what the route for doing this. PMcL noted that this particular story came via the website and the midwife in question had been recognised with an accountability badge in line with Trust Procedures.

	Correlation between staff expressing their happiness at work to other colleagues and patients doesn't appear to have been reflected in the outcomes from the staff survey. Evident that some outcomes on the survey, which will be discussed later, do need to improve and SMcG put forward plans to look into an engagement piece in relation to working together, as an entire Trust, to establish a culture change. The Board were informed that the change in culture should stem from the planned Quality Improvement work, this should incorporate quantitative and qualitative data. JNE commented that organisations can be very good at systemising complaints but usually not as good as sharing positive comments, a thank you was expressed to TR and noted Warrington and Halton Hospital are good at recognising and sharing good news – especially with the Thank You Awards.
BM/18/03/17	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: None were noted and no other declarations were expressed in respect of agenda items. As an aside to the tabled agenda SMcG wanted to discussed, briefly, the commendable response in reaction to the fire within Kendrick Wing at Warrington Hospital on the afternoon of Friday 23rd March 2018. The fire was kept reasonably compartmentalised and SMcG has seen much smaller fires cause much more damage so a thank you was expressed to all. Thanks also expressed for those involved in the Thank You Awards, which also took place on 23rd March 2018. The new venue went smoothly however timings are to be revised for the following years event, a big congratulations to all the winners and the runners up and we will learn from lessons.
BM/18/03/18	**Minutes of the meeting held 31 January 2018 and 28 February 2018** <u>31 January 2018</u> Page 4 – LG requires a change as it was only Halton Accountability Care that was changed. Under CIP LG notes on Page 8 that it was a £3.8 million year to date figures that was achieved. LG & NG to discuss and update minutes. AMcG noted within the finance section the forecast deficit of £16.8 million reads as though NHSi suggested we changed our forecast – but it was ourselves at Month 9 that decided to speak with NHSi about altering our forecast from Month 10. SMcG sought clarification in that it was Warrington and Halton Hospitals NHS Foundation Trust who agrees with NHSi to

	change the forecast out-turn from month 10. 28 February 2018 The Board considered the minutes from the 28th February and there were no comments to be discussed other than actions rising within the meeting today that are already on the agenda. With these amendments, of the January meeting, the minutes of January and February 2018 were agreed as an accurate record of proceedings.
BM/18/03/19	**Actions and Matters Arising** It was noted by the Chair that there are a few actions that have slipped passed their action dates. However it appears that this may be due to the fact that the action plan has not been updated and action plan to be updated accordingly. BM/17/11/24 Lord Cater. **Action closed**. Report received at today's meeting. BM/17/11/127 Halton Accountable Care System. Requested changes had been submitted to both Accountable Care Organisations. **Action Closed** Matters Arising. BM/17/11/111 Guardian of Safe Working Quarterly Report. BM/17/04/49 Proposal to change Trust name. PMcL provided an update on this action in the fact a local hospital has had their name change declined which included 'University Teaching' Hospital. We will look to move forward with our name change as previously discussed as 'Warrington and Halton Teaching Hospitals NHS Foundation Trust' and all in agreeance. BM/17/01/12 PMcL asked to defer Charitable Funds Commission Strategy to after the July Executive Time Out. The Chair notes that the KPI Dashboard has had dates updated and for colleagues to note progression. MB noted that the CQC report delivered and that there is a paper in the pack, there is a paper in the pack detailing the report and this action can therefore be removed.
BM 18/03/20	**Integrated Performance Dashboard M10** The report was taken as read and each Director highlighted key areas for the Board to note. Quality Dashboard The Chief Nurse highlighted areas to note **relating to the Quality KPIs:** Quality indicators at Red have decreased from 12 to 10 and FFT & Safer Surgery is now Green. The number of incidents requiring review has dropped and moving forward the plan is for the Deputy Medical Director and Lead Nurses to look at managing these on a weekly basis. The Safety Thermometer all indicates that it is ok, except the Maternity Data which appears

erratic. There is not a clear picture of data within Maternity and a deep dive will take place moving forward.

On the wards the safety thermometer indicates problem areas of: Tissue Viability; UTI's, Falls. We are utilising the safety thermometer now at ward level where we are not meeting 100% compliance and in line with the Ward Quality Metrics that are being rolled out we are seeing changes.

KSJ noted that there had been an improvement in Sickness Absence rates, however this indicator remains Red and key actions are in place to address. The Trust has an amber staffing rating but high end agency has been utilised to cope with the extra 65 beds that have been operating due to the ongoing Winter Pressures and Daresbury being utilised. There have been mixed sex challenges but managing the flow of patients has been a priority.

The Medical Director highlighted areas to note:-

- AC commented on the 4 hour A&E Target and Ambulance Handover indicators, which continue to be a challenge but we were well placed within the local area.
- Cancer 31 say first treatment and Cancer 62 day urgent targets have moved to red due to internal breaches following no HDU bed space. New Cancer Manager in post now, Karen Mason.
- Discharge summaries remain challenging but there is an impact plan in place.

<u>Key Issues Report – Quality Assurance Committee 6 March 2018</u>

The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted:

- Data Protection changes, mindful not many companies will be ready for the change in legislation. Discussion as to whether this should be put on to the risk register and it is felt that it should be added.

<u>Sustainability Dashboard</u>

The Director of Finance + Commercial Development highlighted areas to note:

- At the end of month 10, the Trust had a financial deficit of £11.2m, which is £6.8m off plan YTD. This has increased by £2.7m in December. This poses significant risk to the Trust's forecast outturn and cash position which had been debated at length at the Finance + Sustainability Committee (FSC) on 24 January when the CEO, Chairman and NED colleagues joined the meeting to be part of those discussions. The FSC continue to scrutinise all aspects of spend on a monthly basis, as delegated by the Board, escalating any matters of concern to the Board.

<u>Key Issues Report – Finance and Sustainability Committee 24 January 2018 + 21 February 2018</u>

The Key Issues Reports were taken as read and Terry Atherton, Chair of Committee highlighted:

- Several meetings have taken place in relation to the current financial situation and pay

across the Trust in relation to seeking reassurance. To monitor any outcomes as a result of the Government's announcement of NHS Pay Rise.
- Chairs Reports to be more concise in the future.
- Nursing Business Case approved.

Key Issues Report – Audit Committee 22 February 2018

The Key Issues Reports were taken as read and Ian Jones, Chair of Committee highlighted:
- Several areas to bring forward to discuss have already been mentioned, specifically GDPR & National NHS Pay Rise.

People Dashboard

The Director of HR + OD highlighted areas to note **relating to the Workforce KPIs:**
- As KSJ reported sicknesses has improved but still remains red.
- Through FSC report on vacancies shows cost on spend and the plan on recruitment drive have been overseen here.
- Plan to support Return to Work Interviews, there is a new HR Business Partner in place who will look at fixing sickness reporting especially in relation to the Allocate system, options around an Attendance Manager was discussed.

Key Issues Report – Workforce Sub Committee 20 March 2018

Report noted. MC noted that we are the best performing Trust in the North for accessing our electronic wage slips.

Chief Executive Report

Discussion around performance over Winter and the discrepancies between medically optimised patients, LGardner provided information on a Discharge Event as part of the IMPACT five and 30 patients were able to be discharged out of hospital, but then there has been a block felt since then. It was questioned how do we look to improve this block and further co-ordination with the Local Authority / CCG's and NHSi and regulators to take place. Concerns record but heartfelt thanks expressed to all WHH Staff for ongoing hard work.

Assessment of where is the best place for the patient to be is the critical point and some patient's are appropriate for hospital beds, but if beds aren't there quantification is needed. If all beds utilised and A&E 'Full' there is surely a review needed for a larger hospital.

The Kendrick Wing Fire occurred on 23rd March, parts of the building were deemed to be unsafe and contingency plans are in place but at present we are looking at a period od discontinuity of services for up to six months affecting:
- Ophthalmology
- Finance
- Clinical Coding
- Specialist Nurses

First and foremost is priority of clinical services in relation to around 1000 people through the

	doors, and we are able to provide fragmented services, but in essence only one day was lost due to the remarkable job of staff. There are meetings in place and plans to move forward with lots of work required to get us up and running again. IJ enquired as to how it affects the Trust's year end position and AMcGee advised that work is ongoing to finalise the end position but the fire will impact on year end as asset valuation is taken as an as at on 31st March 2018. Update on Halton Healthy New Town project provided, and a presentation was shown, the first public consultation has taken place and note that the proposal to link a new hospital, a new community arts and craft centre, a new leisure centre and pool, and other element all together is a really exciting proposition for the local area.
BM 18/03/21	**Quarterly Mortality Review Report** The report was taken as read and the Executive Medical Director asked the Board to note: - Figures for the mortality review are the lowest they have been for a period of time. - Note that coding co-morbidity must be completed accurately for evaluation and financial purposes. **The Board noted the report.**
BM 18/03/22	**Learning From Experience Summary Q3 Report** The Chief Nurse highlighted key areas for the Board to note: - Quality Committee discussed the report in high detail; a proposal for reporting in to the Board is for a presentation, KSJ will look into this as it is a fairly new report we can alter it to deliver what we want it to show in the best format. **The Board noted the report and looks forward to seeing the data presented in a different way at the next meeting.**
BM 18/03/23	**CQC Update** The Chief Nurse highlighted key points for the Board to note: - We are now at a year on from our inspection. - There have been over 230 actions to address, assurance to be submitted and reports that have needed to be compiled. - There are currently 92 actions due and 14 returned to individual CBU's for further information. It is very clear what needs to be done and key is not to lose ground. - Actions have been split out over the next three months with 'Must Do's' and this action plan was complimented by the Board with a view to pushing the agenda of CQC into the forefront. Potentially one key focus area to be picked, for the whole organisation to work on and for future decisions to be made within the CQC Getting to Good Meetings. - Some actions we should be able to move fast with in auctioning and it is to be noted that two points are to be raised to go on to the Risk Register. These are: o Medical Device Training; and o APLS - Look into partnering up with an outstanding partner as has been done elsewhere with KEO Trusts. Previous funding had been available but the Board expressed being mindful of capacity and capability. To be discussed further but option for each division within the organisation to look into releasing one individual to focus solely on CQC actions.

	- The Chair commented that appreciation for what we have to do at WHH is felt. Great summary given but it shows that we still have a long way to go. **The Board noted the report and ongoing developments which are monitored regularly within the additional CQC Getting to Good meetings.**
BM 18/03/24	**Working Capital Loan** The Director of Finance + Commercial Development highlighted key points for the Board to note which are WHH has applied for a loan of £1.4million, repayments were due to start in May but these will now be commenced in November. Chair and Board agreed in principle as long as risks are documented within the risk register. **The Board noted the report and the advice to note and record risks appropriately.**
BM 18/03/25	**NHS Staff Opinion Survey** The Director of HR + OD spoke with the Chair and it was noted that the NHS Staff Opinion Survey is received and further discussions to be had within the private Board. **The Board noted the report and the actions taken to discuss safe staffing within the Private Board.**
BM 18/03/26	**Nurse Staffing Report** The Chief Nurse highlighted key points for the Board to note where average fill rates fall below 90% of actual versus planned, of particular note: - There are more reds on the report and over winter we have been managing on a shift by shift basis. - The Board have observed the Nursing Staffing Business Case, which is a consequence of a large staffing review, and this will be discussed further at the Private Board. **The Board noted the report, the Business Case and the actions to look to discuss further within the Public Board.**
BM 18/03/27	**Freedom to Speak Up Guardian Report** The Chief Nurse advised that Jane Hurst, who wrote the report is here attending the Board for development, and highlighted the following for the Board to note: - Further communications around Freedom to Speak Up to be sought, possibility of a wage slip notice, posters and other materials. - Promote Freedom to Speak Up Champions and note that not all queries may go through the correct channels to record Freedom to Speak Up requests. - The Board questioned how do we know that the follow up has been done, and it was expressed that the Patient Safety Board looks into these areas and then also the Workforce Committee. - Jane Hurst to look into reviewing on Datix and reassurance provided at a high level that feedback is given. **The Board noted the report and thanked Jane Hurst for ongoing work whilst she was in the room, further communication efforts to be completed in relation to raising awareness.**
BM 18/03/28	**Guardian of Safeworking Q3 report** The Trust Guardian, Mark Tighe, highlighted the following for the Board to note: - Safeguards are in place to ensure that Junior Doctors are not working excessive hours. - Assurance provided to the Board every 3 months.

	- This Q3 report doesn't quite capture the impact of winter pressures, but from January onwards it was noted that there were some rota gaps which caused problems. - Acuity in medical posts and surgical juniors were looking at moving to medical wards to complete ward rounds and MT is reassured by the exception report which is in line with other trusts similar to our size. - The Junior Doctor forum is well attended but colleagues have felt that issues have not been dealt with timely. One ongoing issue is the handover period is not within the scheduled rota and colleagues can work 30 minutes extra every time they are in, in order to complete a safe handover for patients and staff. AC to meet with Kate Clark to discuss position and find solution. Briefing paper to be brought to the next Board meeting for ratification and resolution moving forward. • **The Board noted the report and Mark Tighe was thanked for his ongoing role and the update.**
BM 18/03/29	**Strategic Risk Register (SRR) +Board Assurance Framework (BAF)** The Director of Community Engagement + Corporate Affairs highlighted the changes and updates to the Strategic Risk Register and BAF since the last report in January: - There have been some risks raised within the meeting to be added on to the register. **The Board noted the report and approved the changes/amendments to the Strategic Risk Register.**
BM 18/03/30	**ToR and Annual Cycle of Business for ratification** (i) <u>Trust Board</u> - KSJ noted that risk is with the Head of Corporate Affairs portfolio. - The Director of Infection Prevention and Control with within KSJ portfolio Cycle to be updated accordingly. - AMcGee noted that for sustainability the budget approval needs to take place in the March meetings not the November meetings under the cycle of business. (ii) <u>Quality Assurance Committee</u> - No comments were made in relation to the Quality Assurance Committee cycle of business. **The Board noted the report and approved the ToR and Annual Cycle of Business for the Trust Board, Audit committee and Quality Assurance Committee subject to the above amendments.**
BM 18/03/31	**Council of Governors** (a) The Director of Communication discussed the reappointment of the Trust Chair. This was noted by the Board. (b) Amendments to the Trust Constitution were discussed in relation to the following: a. Merging area 15 with the Mersey area and having two Governors for this area. Approval was gained for this action. b. Amendment of partners. Addition of Warrington Colligate to be added to the Governor list of partners. Approval was gained from the Board and commented a good addition for the Trust. c. Note new partner of Widnes Vikings. d. Dr Mike Brownsall from the University of Chester will be unable to continue his role as Partner Governor from the University as he is leaving the post. The University will be in touch with Dr Brownsall's replacement in due course.

	(c) Trust advised to look to realign the tenue and the table on pg243 shows that all can be aligned and will allow a more consistent panel however it is possible that no savings will be made. Noted a third of council changes are undertaken once a year and Board happy with this suggestion to bring tenures in line.
	There was no additional business raised, the meeting was brought to a close at 12:45 and aim for the Private Board to start at 13:15 in the Trust Conference Room. Apologies were given for over running but there has been a lot of business to discuss. **Colleagues noted the next Meeting:** **Trust Board –Year End meeting Thursday 24 May 2018** **Full Trust Board Meeting, Trust Conference Room.**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/05/39	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	24 May 2018

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/03/28	28/03/2018	Guardian of Safeworking Q3 report	Alex Crowe to meet with Kate Clarke to discuss and find solution for Junior Doctor's handover time being scheduled on to the rota. Alex Crowe to bring briefing paper to the Board for an update.	Medical Director	24.05.2018			
BM/18/03/22	28/03/2018	Learning from Experience Summary Q3 Report	A presentation slide deck to be available to the Board as opposed to the report, as the report is discussed in depth at Quality Committee.	Chief Nurse	27.06.2018			

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/03/27	28.03.2018	Freedom to Speak Up Guardian Report	Communications to look into raising the awareness of the Freedom to Speak up Report systems.	Director of Communnications + Engagement		10.04.2018	10.4.2018. Comms Plan in place to raise awareness. Questions asked as part of NED visits	
BM/18/01/07	31.01.2018	IPR Dashboard	Progress report from MP on progress against the CQC Action Plan from the Monthly CQC Steering Group.	**CEO**	28 February 2018	28.03.2018	To be reported in the CEO update to each Board.	
BM/18/01/14	31.01.2018	Engagement Dashboard	Full Year Dashboard to May Trust Board and bi-monthly thereafter	**Director of Community Engagement**		28.03.2018	28.03.2018. Full year dashboard to May Board and monthly thereafter.	

BM/18/01/07	31.01.2018	IPR Dashboard	Safer Surgery/check list – exceptions at speciality level to be included in next months IPR.	**Medical Director**	28 February 2018	**28.03.2018**	Included in CBU and IPR Dashboard from March.	

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/04/49	26.04.2017	Proposal to change Trust Name	Process to commence to incorporate 'teaching' element into its Brand.	Director of Communications + CA	On-Going		24.5.17. This process has commenced. 20.9.17. Shared at Annual Members meeting in September. 31.1.2018. awaiting outcome of Chester University application to become a Medical School on 7 March 2018. Anticipated GMC approval September 2019 following GMC visit in September 2018,. 31.3.2018. work to progress to change to W&H Teaching Hospitals.	
BM/17/01/12	25.01.2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	Director of Community Engagement + CA	25 July 2018		7.7.2017. Deferred to Part 1 Board on 26 July 2017. 26.7.17. Deferred to Part 1 Board 25 October.	

							23.01.2018. Deferred to February Board 31.3.2018. Deferred to after July Executive Time Out on 6 July.	
BM/18/01/01	31.01.2018	Partnership with King Edward Memorial Hospital Mumbai	Update Report to November Trust Board	**Medical Director**	28 November 2018			
BM/18/01/05	31.01.2018	CEO Update, Warrington Together	Draft Strategy to be presented to March Trust Board	**Director of Transformation**	28 March 2018			

RAG Key

	Action overdue or no update provided		Update provided and action complete
	Update provided but action incomplete		

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/39**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	24th May 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Alex Crowe – Acting Medical Director & Chief Clinical Information Officer Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Lucy Gardner – Director of Transformation Chris Evans - Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	**Quality** The number of Red indicators has decreased from 11 to 9 in month. There was 1 MRSA case reported in April which is currently being investigated. **Access & Performance** The Trust has achieved all Cancer standards in month. The Trust did not meet the 6 week diagnostic waiting time due to Cardiac CT capacity. There has been improvement in A&E 4 hour standard with the Trust meeting its improvement trajectory, although the Trust has not met the 95% national standard.

	Workforce There has been an improvement in Recruitment timescales. Agency spending/non-contracted pay spend continues to be a target area of focus with the average cost of the Top 10 agency workers has reduced in month. **Finance** The plan submitted to NHSI on 30th April 2018 was £24.6m deficit and the plan for period ending 30th April is £2.8m deficit which has been met. The Trust did not accept the NHSI control total so the plan excludes annual Provider Sustainability Funding of £9.9m.	
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	BM/18/05/39

1. BACKGROUND/CONTEXT

The RAG rating for all 66 indicators from May 2017 to April 2018 is set out in Appendix 1. The Integrated Performance Dashboard (Appendix 2) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings as follows:

- Red - 26 in April decreased from 32 in March.
- Amber – 11 in April increased from 5 in March.
- Green – 27 in April increased from 25 in March.
- Not RAG rated – 2 in April the same number as March

Please note, due to the 2018/19 KPI refresh, the overall number of indicators has increased from 64 to 66. Due to validation timescales for Cancer, VTE and Sepsis data, the dashboard and RAG rating is based on March's validated position.

Quality

Quality KPIs

There are 8 Red indicators in April, a reduction of 2 in month. Please note, due to the 2018/19 KPI refresh the number of Quality indicators has increased from 24 to 26.

The 7 indicators which were Red in March and remain Red in April are as follows:

- Incidents – the Trust has 176 open incidents which are over 40 days old.
- Safety Thermometer – The Trust achieved 96.4% for Adults, 100% for Children and 80% for Maternity against a 95% target.
- Healthcare Acquired Infections – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance; therefore this indicator will be Red for the remainder of the year.
- Total Falls & Harm Levels – There was 1 incident resulting in severe harm in month.

- Friends & Family Test (Inpatient & Daycase) – The Trust achieved 94% in April, (target 95%) a decrease from March's performance of 96%.
- Friends & Family Test (A&E and UCC) – The Trust achieved 85% in April, (target 87%) an improvement on March's performance of 81%.
- Mixed Sex Accommodation Breaches (MSA) – there were 7 Mixed Sex Accommodation Breaches in April, a decrease from 16 in March.

There is 1 indicator which has moved from Green to Red in month as follows:

- Safer Surgery – the Trust achieved 99.75% in April (target 100%), a decrease from March's performance of 100%.

There is 1 indicator which has moved from Red to Green in month as follows:

- Medication Safety – there were no incidents of harm in April compared to 1 in March.

There are 2 indicators which have moved from Red to Amber in month as follows:

- NICE Compliance – The Trust achieved 72.9% (target 100% for Green), an improvement from March's performance of 70.6%.
- Complaints – there are no complaints cases over 6 months old and the Trust is meeting its complaint backlog improvement target.

Access and Performance

Access and Performance KPIs

There are 7 Access and Performance indicators rated Red in April, a decreases from 9 in March.

The 6 indicators which were Red in March and remain Red in April are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 86.7% including walk ins and 84.4% excluding walk ins in April (target 95%), an improvement on March's performance of 81.9% including walk ins and 78.5% excluding walk ins.
- Ambulance Handovers 30>60 minutes – the Trust has seen an improvement in the number of patients experiencing a delayed handover in month from 197 in March to 153 in April.
- Ambulance Handover at 60 minutes or more – the Trust seen an improvement in the number of patients experiencing a delayed handover in month from 113 in March to 57 in April.
- Discharge Summaries % sent within 24 hours – the Trust has achieved 77.4% in April (target 95%), which is a decrease from March's performance of 81.2%.
- Cancelled operations on the day (for non-clinical reasons) – there were 13 cancelled operations in April, an improvement from 20 in March.

- Cancelled operations on the day (for non-clinical reasons), not offered readmission within 28 days – there were 7 cancelled operations in April, an increase from 5 in March. 6 of these instances were ophthalmology patients who could not be rebooked due to equipment damaged in the fire.

There is 1 additional Red indicator in month as follows:

- Diagnostic waiting times – the Trust achieved 98.6% in April, a decrease from March's performance of 99.14% (target 99%).

There are 3 indicators which have moved from Red to Green in month as follows:

- A&E STP Trajectory – the Trust's improvement trajectory for April was 85%.
- Cancer 31 day first treatment – the Trust achieved 100% in March (target 96%) an improvement from February's performance of 95%.
- Cancer 62 days urgent – the Trust achieved 85.9% in March (target 85%) an improvement from February's performance of 80.3%.

PEOPLE

Workforce KPIs

There are 6 indicators rated Red in April, the same number as March. Please note that due to the 2018/19 KPI refresh, the number of Workforce indicators has reduced from 13 to 12.

The 3 indicators which were Red in March and remain Red in April are as follows:

- Sickness Absence – 4.88% in April (target below 4.2%) an improvement from March's performance of 5.05%.
- Non-Contracted Pay – 13.41% above budget in April compared to 12.83% in March.
- Agency AHP Spend – £0.18m in April above the April 2017/18 baseline of £0.09m.

There are 3 additional indicators rated Red in month as follows:

- Agency Nurse Spend - £0.29m in April, above the April 2017/18 baseline of £0.21m
- Agency Medical Spend – £0.30m in April, above the April 2017/18 baseline of £0.22m
- Average Length of Service for Top 10 Agency Workers – has increased from 22 months in March to 28 months in April.

There is 1 indicator which has moved from Red to Amber in month as follows:

- Return to Work – 83% in April (target 85% for Green) an improvement from March's performance of 80%.

There are 2 indicators which have moved from Red to Green in month as follows:

- Recruitment - the average number of days to recruit in the last 3 months has reduced from 79.0 days in March to 56.7 days in April.
- Average Cost of the Top 10 Agency Workers – has reduced from £23,284 in March to £15,262 in April.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 5 Finance and Sustainability indicators rated Red in April, a reduction of 2 in month. Please note due to the KPI refresh the number of Finance & Sustainability indicators has increased from 9 to 10.

The 4 indicators which were Red in March and remain Red in April are as follows:

- Capital Programme – the annual capital programme is £9.9m (including £2.4m in respect of the restructure associated with the Kendrick Wing fire). The actual spend to date is £0.3m which is £0.2m above the planned spend to date of £0.1m.
- Better Payment Practice Code (BPPC) – due to the challenging cash position BPPC continues to underperform with a monthly performance of 27% which is 68% below the national standard of 95%.
- Use of Resources Rating – the current Use of Resources Rating is a score of 4 against a planned rating of 3.
- Cost Improvement Programme – the monthly savings total £0.1m which is a shortfall of £0.1m against the planned savings of £0.2m.

There is 1 additional Red indicator in month as follows:

- Agency Spending - agency spend of £0.8m is £0.1m (13%) above the agency ceiling of £0.7m.

There are 2 indicators which have moved from Red to Amber as follows:

- Financial Position – the monthly deficit of £2.8m is in line with the planned deficit of £2.8m. Income and expenditure is in line with plan although there is a £0.2m overspend on pay offset by a £0.2m underspend on non-pay.
- Cash Balance – the historical operating performance means that cash continues to be a challenge and is under daily monitoring and management. The cash balance at month end was £1.2m. A working capital loan of £24.4m has been requested to maintain liquidity and meet financial obligations.

The CIP In-year and recurrent has been split into 2 indicators.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in Appendix 3. The Trust is currently forecasting achievement of the planned deficit.

The Trust is working with Commissioners on a shared 3 year plan to improve sustainability using CEP lite (Capped Expenditure Process) as a framework.

A Use of Resource stamp has been developed to highlight indicators which relate to the Use of Resources Assessment. 

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

KPI's that are underperforming will be managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- KPI Sub-Committee

5. RECOMMENDATIONS

1. Note the contents of this report.

Appendix 1 – KPI RAG Rating May 2017 – April 2018

	KPI	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
	QUALITY												
1	Incidents												
2	CAS Alerts												
3	Duty of Candour												
4	Safety Thermometer												
5	Healthcare Acquired Infections												
6	VTE Assessment												
7	Safer Surgery												
8	CQUIN Sepsis AED Screening												
9	CQUIN Sepsis Inpatient Screening												
10	CQUIN Sepsis AED Antibiotics												
11	CQUIN Sepsis Inpatient Antibiotics												
12	CQUIN Sepsis Antibiotic Review												
13	Total Falls & Harm Levels												
14	Pressure Ulcers												
15	Medication Safety												
16	Staffing – Average Fill Rate												
17	Staffing – Care Hours Per Patient Day												
18	Mortality ratio - HSMR												
19	Mortality ratio - SHMI												
20	Total Deaths												
21	NICE Compliance												
22	Complaints												
23	Friends & Family – Inpatients & Day cases												
24	Friends & Family – A&E and UCC												
25	Mixed Sex Accommodation Breaches												
26	CQC Insight Indicator Composite Score												

Appendix 1 – KPI RAG Rating May 2017 – April 2018

	ACCESS & PERFORMANCE												
27	Diagnostic Waiting Times 6 Weeks												
28	RTT - Open Pathways												
29	RTT – Number Of Patients Waiting 52+ Weeks												
30	A&E Waiting Times – National Target												
31	A&E Waiting Times – STP Trajectory												
32	Cancer 14 Days												
33	Breast Symptoms 14 Days												
34	Cancer 31 Days First Treatment												
35	Cancer 31 Days Subsequent Surgery												
36	Cancer 31 Days Subsequent Drug												
37	Cancer 62 Days Urgent												
38	Cancer 62 Days Screening												
39	Ambulance Handovers 30 to <60 minutes												
40	Ambulance Handovers at 60 minutes or more												
41	Discharge Summaries - % sent within 24hrs												
42	Discharge Summaries – Number NOT sent within 7 days												
43	Cancelled Operations on the day for a non-clinical reason												
44	Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation												

Appendix 1 – KPI RAG Rating May 2017 – April 2018

	WORKFORCE												
45	Sickness Absence												
46	Return to Work												
47	Recruitment												
48	Turnover												
49	Non Contracted Pay												
50	Agency Nurse Spend												
51	Agency Medical Spend												
52	Agency AHP Spend												
53	Core/Mandatory Training												
54	PDR												
55	Average cost of the top 10 highest cost Agency Workers												
56	Average length of service of the top 10 longest serving agency workers												
	FINANCE												
57	Financial Position												
58	Cash Balance												
59	Capital Programme												
60	Better Payment Practice Code												
61	Use of Resources Rating												
62	Fines and Penalties												
63	Agency Spending												
64	Cost Improvement Programme – Performance to date												
65	Cost Improvement Programme – Plans in Progress (In Year)												
66	Cost Improvement Programme – Plans in Progress (Recurrent)												

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - April 2018

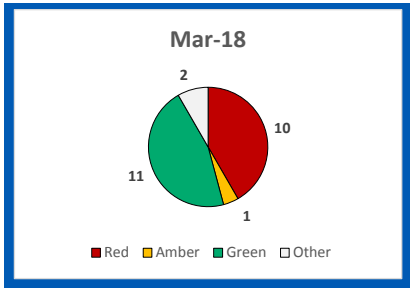
Appendix 2

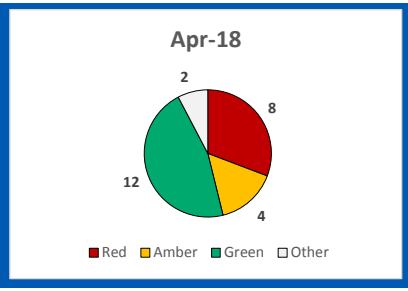
Key

Use of Resource Indicator UoR

Key Points/Actions

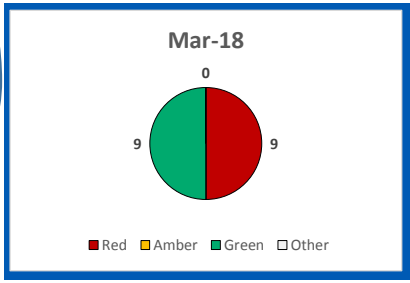
Quality Improvement

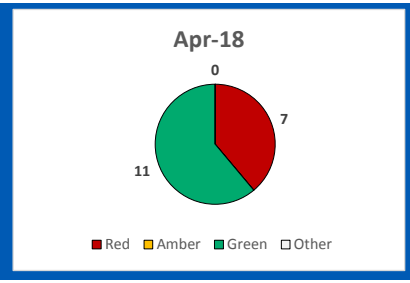




At the time of writing this report there are 646 open incidents that require review and sign off. Clinical Services have 608 incidents. The remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents remains at 100% compliance across the CBU's. Reported HCAI's have increased across all areas in April, most notably with an occurrence of MRSA being reported which is currently under investigation. Although we have seen a decrease in the number of falls during the month of April compared to the previous month, we have unfortunately seen an increase in the level of harm caused by the fall. We have not achieved the targets for FFT in relation to Inpatients or for A&E which could be attributed to the decrease in the number of responders in month. At the time of writing this report Inpatient Sepsis data is awaiting internal validation.

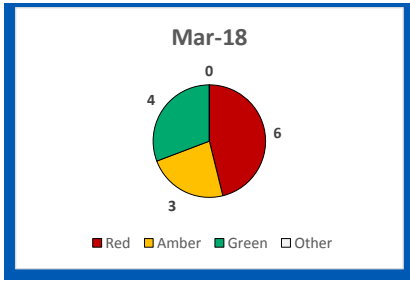
Access & Performance

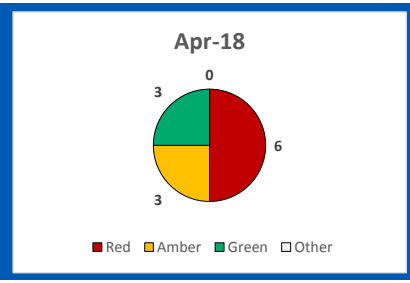




In April 2018, 11 out of the 18 indicators are RAG rated as Green. RTT and Cancer performance continues to be positive with standards being achieved. Diagnostic waiting times has fallen below target due to Cardiac CT capacity with plans in place to address. The Trust has achieved its A&E improvement trajectory in April. As a result of the fire at the hospital in April, a number of operations were cancelled and we were not able to be rebook due to equipment damage, however all patients have now been offered dates for re-admission.

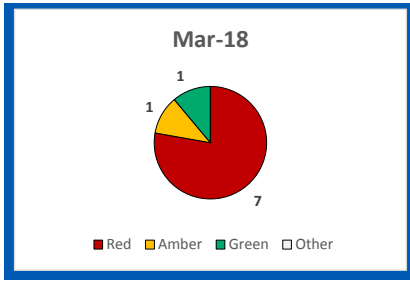
Workforce

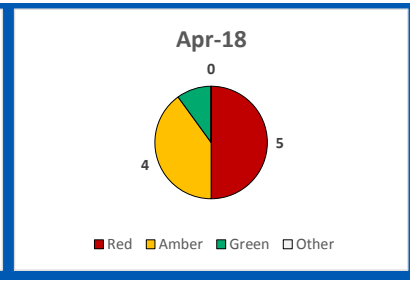




Sickness absence has continued to reduce in month but is still above target. Key actions continue to address sickness, which are a combination of managing attendance and supportive measures. Return to work interview compliance and PDR compliance has increased significantly with oversight by the workforce committee with CBUs being asked to produce exception reports to address areas of concern. Time to Recruit over the last 3 months has improved with the use of technology, streaming and forward planning. Turnover remains below target. Non-contracted pay including agency spending remains above budget with pressures from the winter ward remaining a factor. Agency spending has decreased with agency staff converting to the Trust bank, work continues to encourage more staff to move to the bank. Core Skills training compliance has improved in month.

Finance





In the month the Trust recorded a deficit of £2.8m which is in line with plan. Year to date income, expenses and non operating expenses are in line with plan. Capital spend is £0.3m which is £0.2m above the planned capital spend of £0.1m. Due to the historic and current operating position the cash balance remains low and at month end the cash balance is £1.2m which is in line with the planned cash balance and the minimum cash requirement under the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 27% which is 68% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 4 which is below the planned rating of 3.

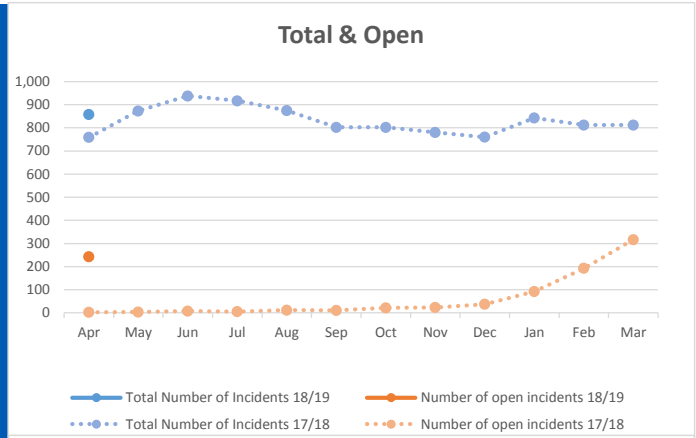
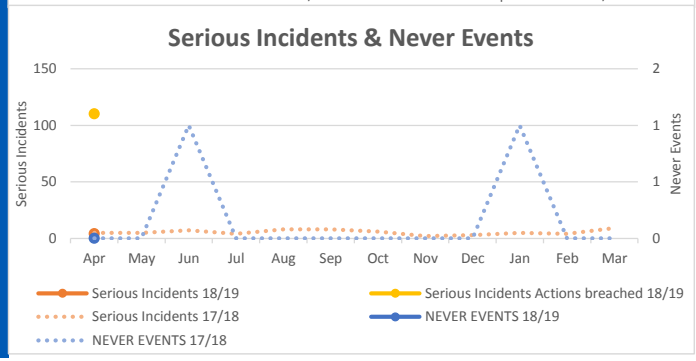
Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

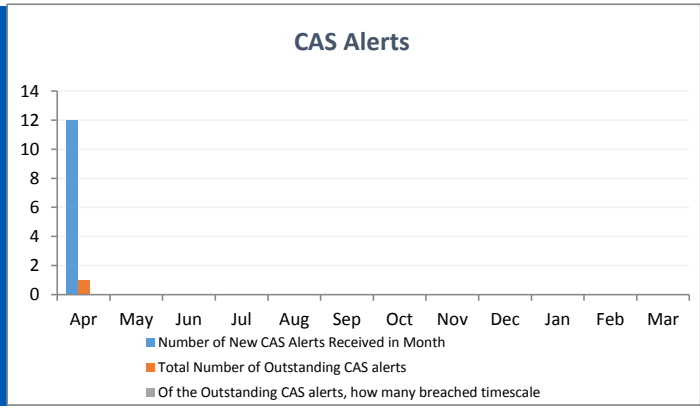
Patient Safety

Incidents

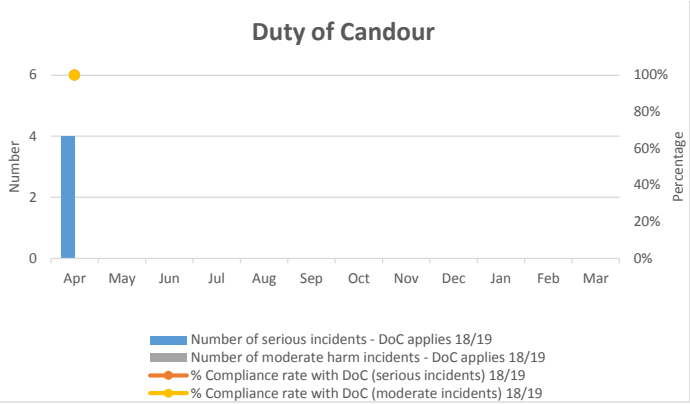
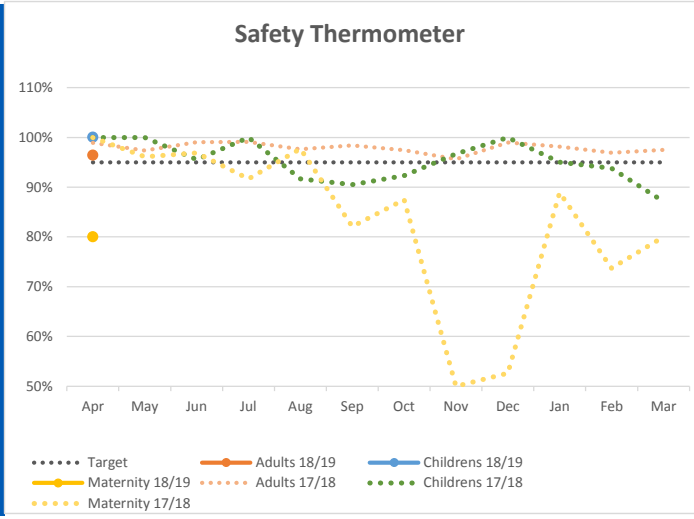
Red: 1 or more Never Events or open incidents outside 40 day timeframe .
Amber: Zero Never Events and open incidents between 20 - 40 days old.
Green: Zero Never Events and open incident within timeframe of 20 days.

Number of Never Events (Never Events are serious patient safety incidents that should not occur). Number of Serious Incidents and actions breached. Number of open incidents is the total number of incidents that we have awaiting review.	The target for Never Events is a zero tolerance. Green: open incidents within timeframe (within 20 working days) Amber: open incidents outside of timeframe (within 40 working days) Red: open incidents outside of timeframe (over 40 working days old).	 	At the time of writing this report, there are 646 open incidents that require review and sign off. 608 relate to CBUs with the remaining incidents for Corporate or External Organisations. The Chief Nurse has requested a review of open incidents at the weekly meeting of harm which has been in place for three weeks. This has resulted in a steady reduction of open incidents across this time period. A 2018/19 Quality Priority has been agreed to increase the profile of incident reporting in the Trust, to further implement the Trust Lessons Learned Framework. A workshop has been scheduled for May led by Director of Governance to review evidence against breached serious incident actions. This work is being overseen by Patient Safety and Effectiveness Sub Committee.

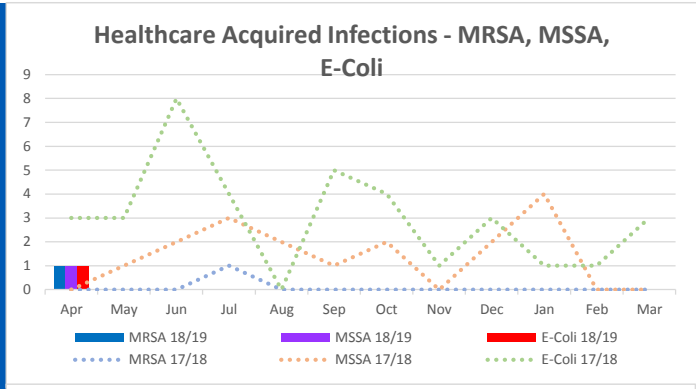
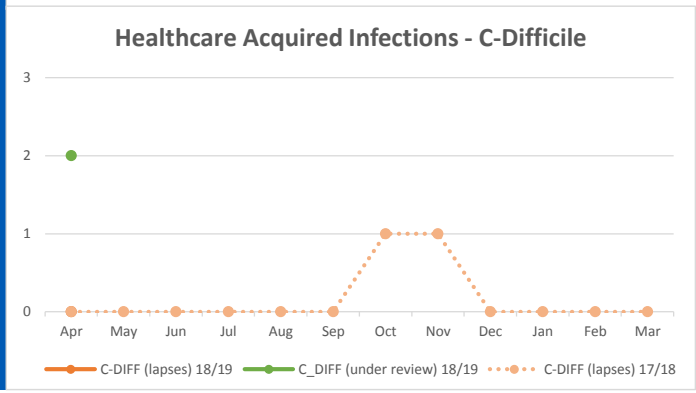
CAS Alerts -
Green - All relevant CAS Alerts actioned within timescales
Red - Applicable CAS Alert not actioned within the timescale.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependant upon the specific CAS alerts.	All CAS alerts should be reviewed and actioned within their individual timeframes.		We received 12 alerts in April (all closed). There is one alert outstanding with a close date of 30/05/2018. We have no alerts past the deadline date.

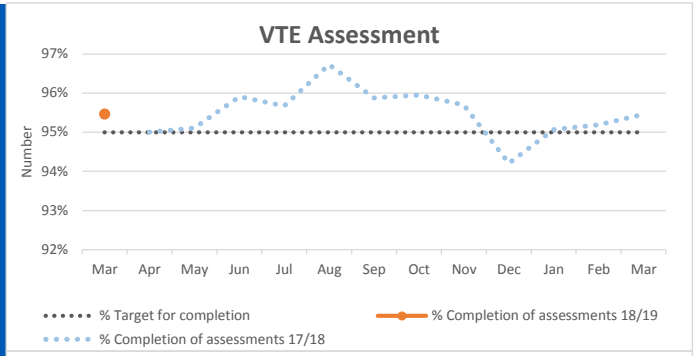
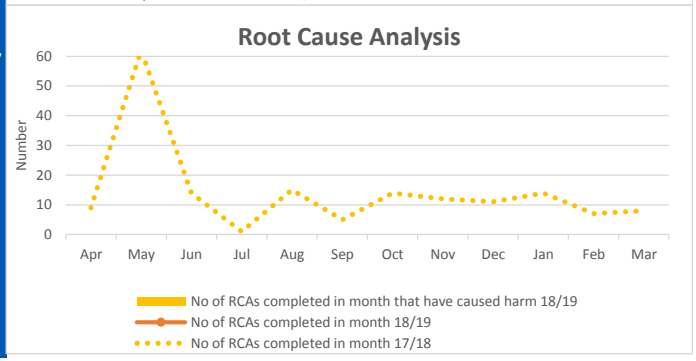
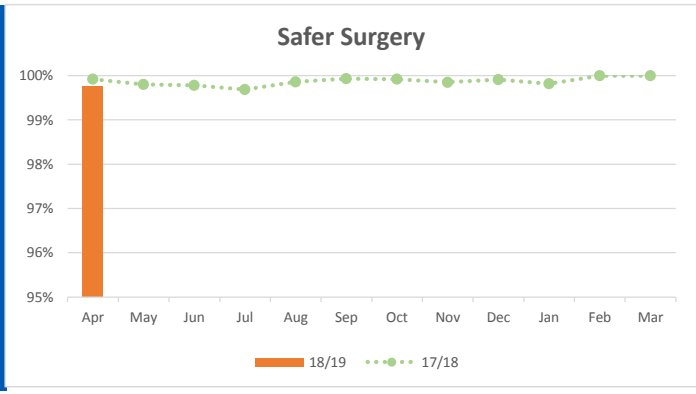
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Duty of Candour Red: <100% Green: 100%	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.	Duty of Candour has to be completed within 10 working days.		The Trust can report 100% compliance for completion of Duty of Candour for those incidents determined to be moderate/serious. There has been a review of training for Duty of Candour in February and a new training programme is being rolled out from April 2018. This will ensure all staff are aware of their legal/professional and contractual duties regarding Duty of Candour and also ensure that meaningful conversations are being had with patients and/or families.
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.	The target for all areas is to achieve over 95%.		The CQC Insight Report has given us some comparison data and identified our ward areas with highest level of harm. This is being addressed at Patient Safety & Effectiveness Sub Committee to monitor improvements required.

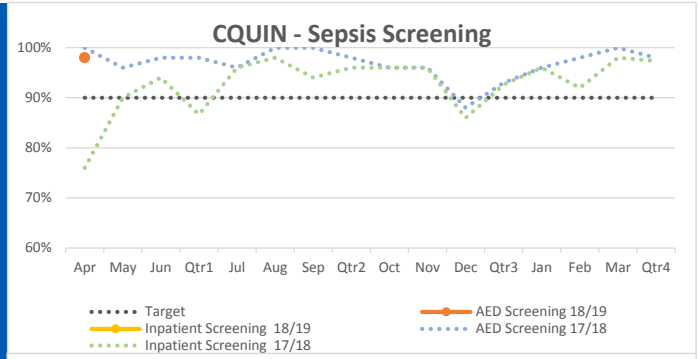
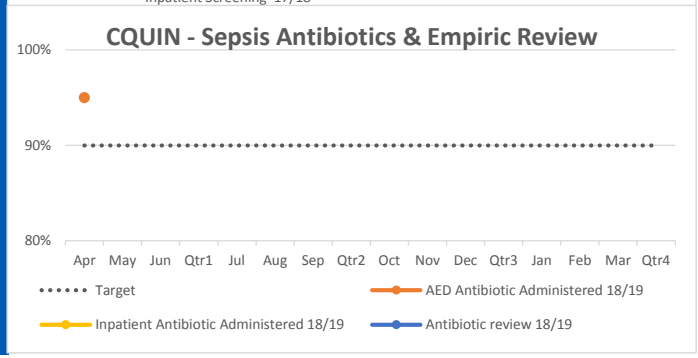
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Green: 0** **C-Difficile** **Red: More than 2** **Amber: 1 to 2** **Green: 0**	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.	 	MRSA bacteraemia - 1 hospital onset case reported by ward A7 in April 2018. Investigation is in progress. Clostridium difficile - 2 hospital onset cases reported in April 2018. Root cause analysis investigations are in progress. MSSA - 1 hospital onset case reported in April 2018. Investigation is in progress. E. coli bacteraemia - 1 hospital onset case reported in April 2018. The reduction action plan is being revised following attendance at the NHSI & NHSE improvement collaborative.

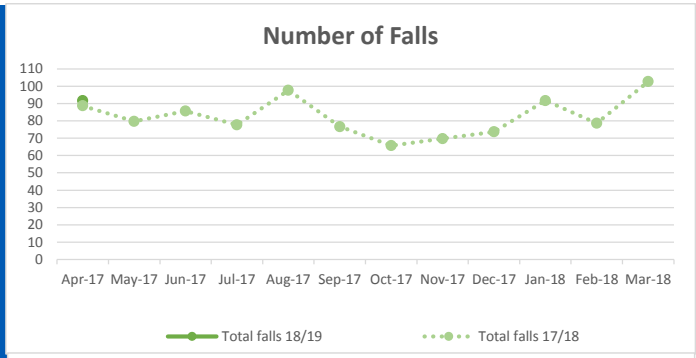
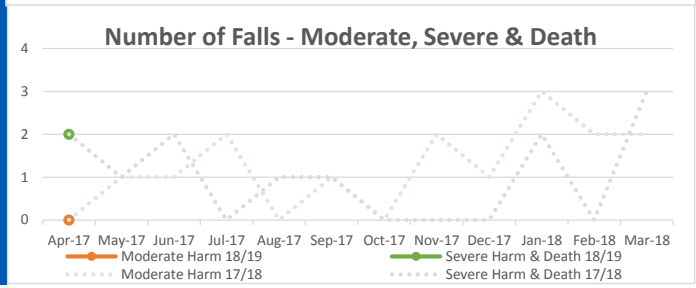
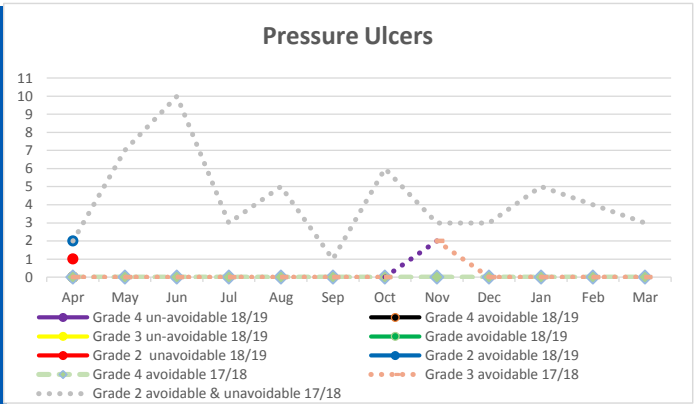
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17, 17/18 (risk assessed by harm and occurrence of PE).	 	VTE RCA There are 20 VTE RCAs outstanding from April 17-Mar 18. 6 specialist surgery 2 MSK 6 specialist medicine 4 ABC 2 U&E care
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.		In April 100% of check lists were reviewed and the overall score was 99.75%. There were 3 cases reviewed by the Head of Theatres and it was found that non-compliance was due to one cancellation data error, one staffing error and one critical emergency haemorrhaging.

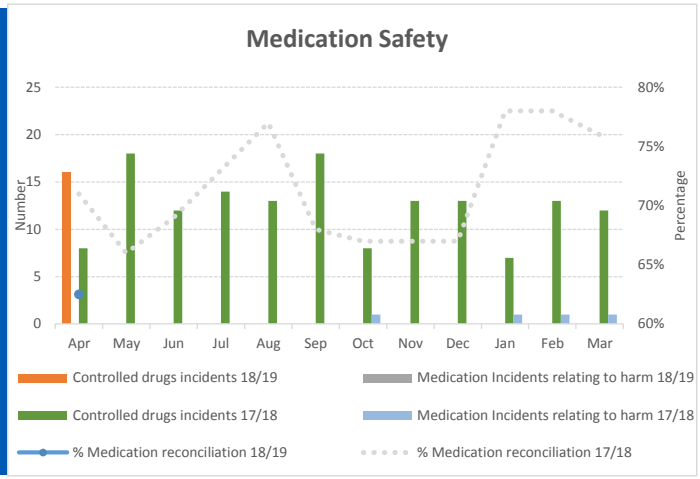
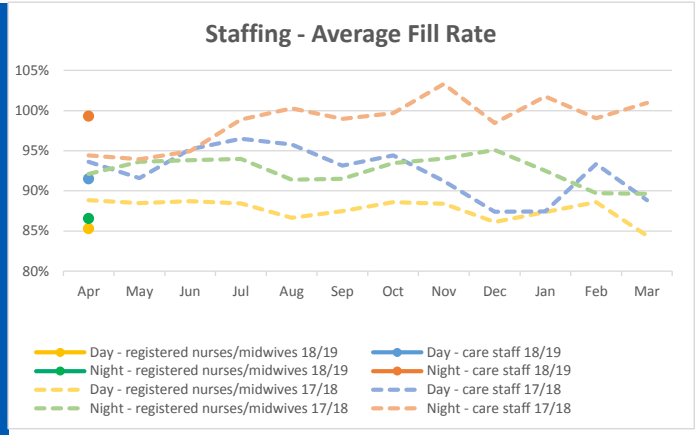
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%	 	At the time of writing this report ED data has been validated and shows compliance with screening and antibiotic administration. With regard to inpatients. Sepsis data is currently awaiting internal validation for April, however March's validated position shows that the standards were met.

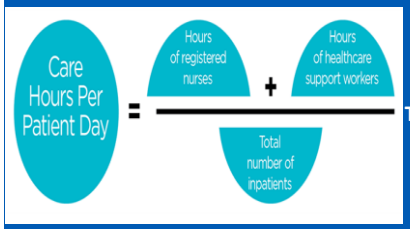
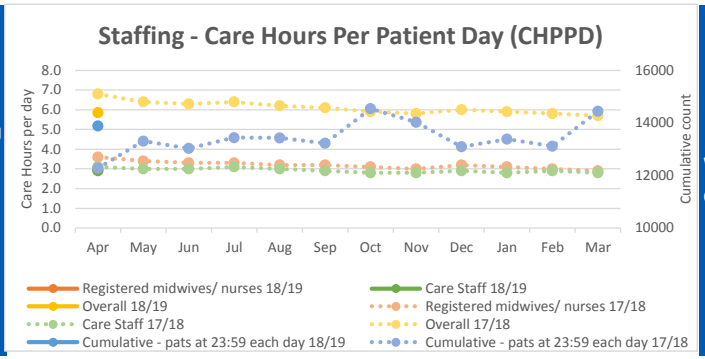
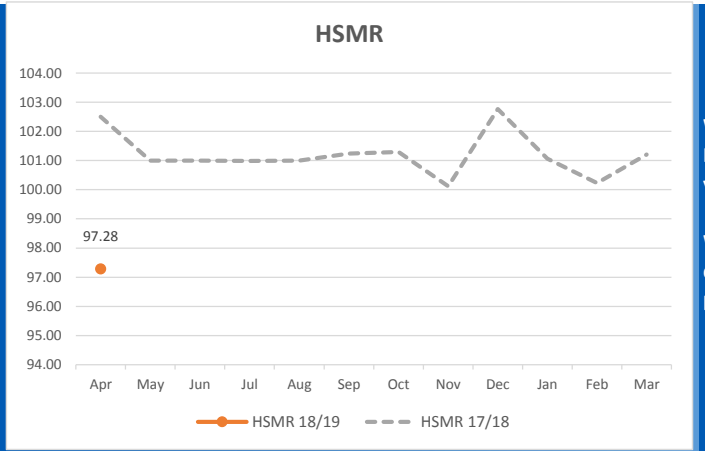
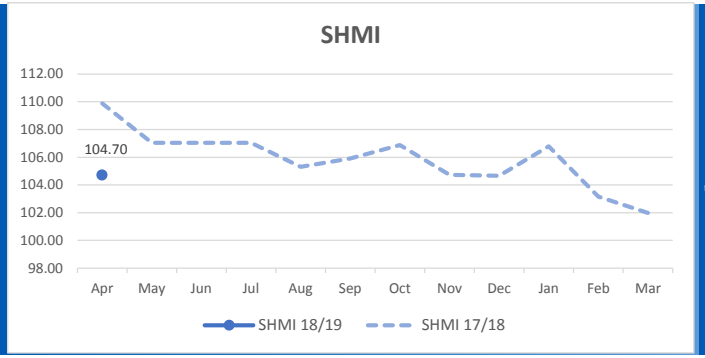
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2016/17 data as a baseline.	 	There has been 1 severe harm fall and 1 fall resulting in death reported during April. The overall number of reported falls has decreased from 103 to 92 since March. The indicator is rated red due to the harm and as we are not achieving 10% reduction in month. The Quality Account which is due to be approved by Audit Committee and Trust Board sets out priority for falls reduction in the Trust, set at 20% reduction for the year 2018/19. The indicator therefore will be updated in the Integrated Performance Report following approval.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 7 Green: 7	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable and unavoidable) Grade 3 hospital acquired(avoidable and unavoidable) Grade 2 hospital acquired (avoidable and unavoidable)		Monthly panel meetings are in place to ratify RCAs identifying whether the pressure ulcer was deemed to be avoidable or unavoidable and hospital or community acquired. Learning from these panels is disseminated via lessons learned flyers. During the month of April there were a total of 9 grade 2 pressure ulcers. However, at the time of writing this report there have only been 3 RCAs completed which found that 2 were unavoidable and 1 was avoidable. The remaiining 6 RCAs are underway and a further update on the ongoing investigations will be provided in the next dashboard.

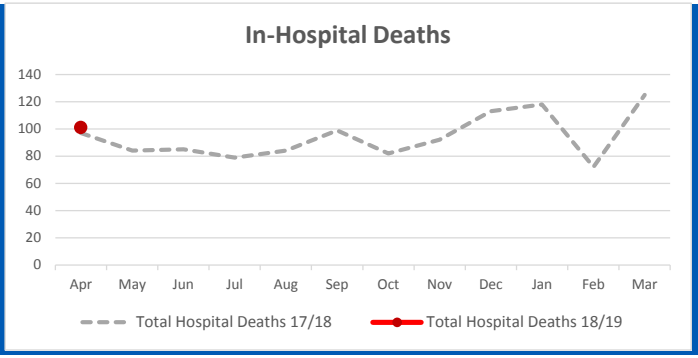
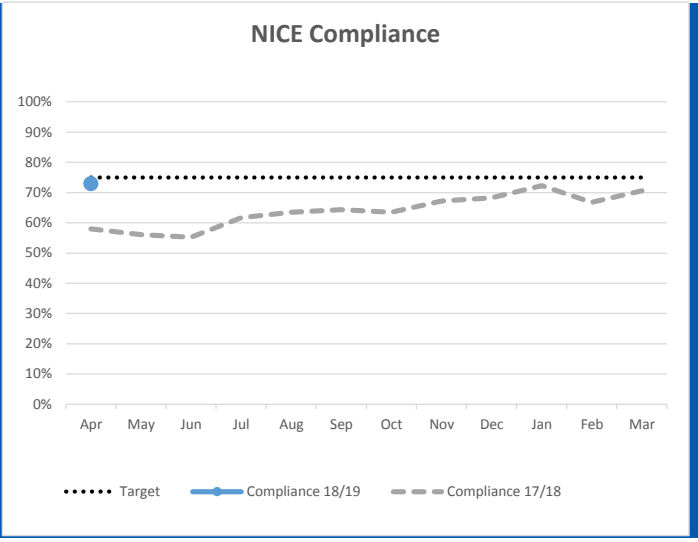
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.		The April medicines reconciliation position now includes maternity and children and is a key factor in the apparent reduction in the overall % of medicines reconciliation completed as without these figures the overall % returns to over 70%. Maternity and paediatrics have a rapid turnover of patients/clients and many of these are not on prescribed medication. The Pharmacy team are looking at ways of improving the recording to improve the figures (data quality). The high turnover of patients within Digestive Diseases is believed to affect % medicines reconciliation data. Additional staffing resources are to be allocated to A4 from June in order to see if this improves the figures. A 7 day ward service is needed for emergency admission areas. A business case is therefore being prepared.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%. The data produced excludes CCU, ITU and Paediatrics.		The majority of areas are above the 90% target YTD and it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have decreased, due to seasonal trend. Bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

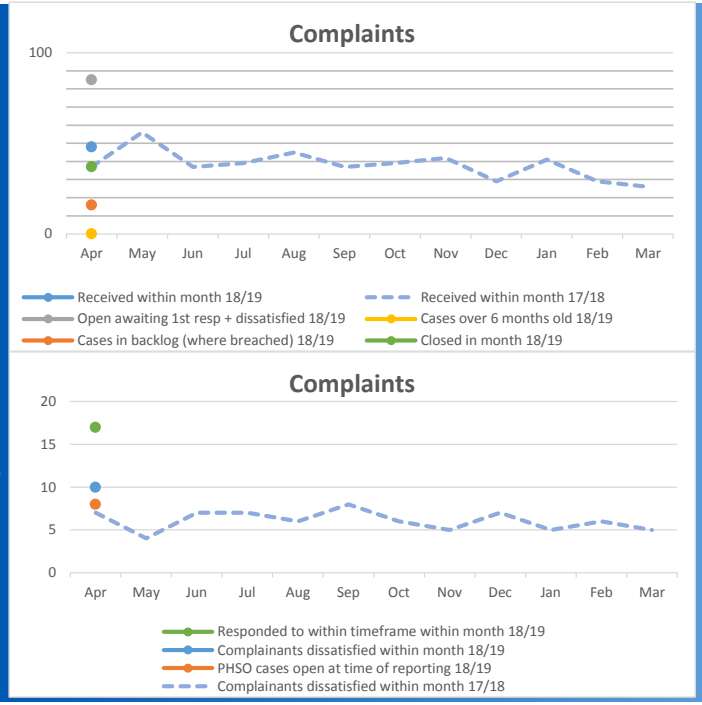
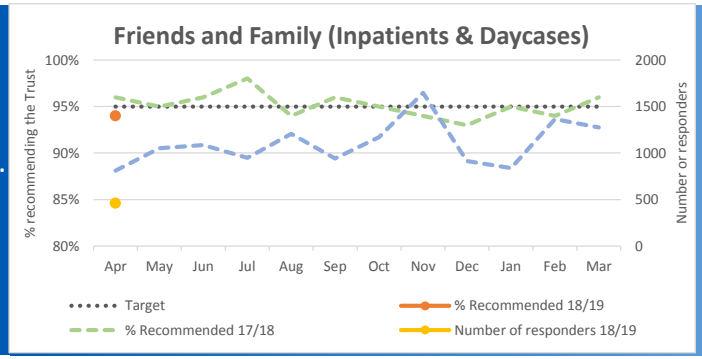
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.		We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Target for Green would be to be within expected ranges.		We are as expected for both HSMR and SHMI. Our HSMR is below 100 for the first time in a number of years. We are currently reviewing deaths within the diagnostic group: Pleurisy; pneumothorax; pulmonary collapse where we are an outlier.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Target for Green would be to be within expected ranges.		SHMI has been rated as "Green" and falls into the "As expected" range.

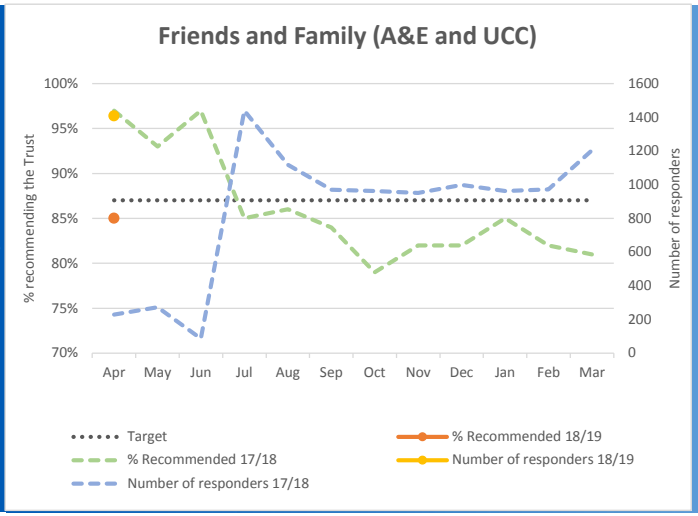
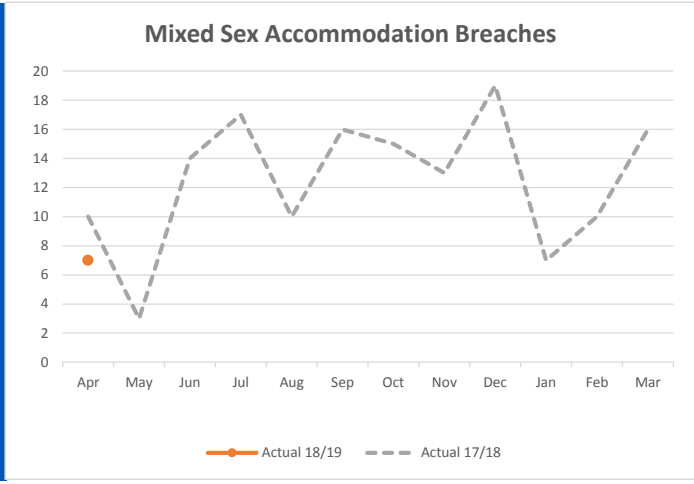
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	There is no target against this indicator.		All the Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. The Trust will be reporting avoidable mortality in the Quality Accounts, which are currently being prepared. Any review conducted where they may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed.
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	The target is to achieve 100% compliance against all NICE guidance.		There are currently 10 pieces of NICE Guidance which are outside the 90 day assessment period. 9 of the pieces of guidance are historical and pre-date 2018. The CBU with the most outstanding is ABC with 4, which is a slightly improved position on previous months. The 2 pieces of guidance outstanding in Specialist Medicine are related to Dementia and these are being assessed for compliance on 8th May 2018. There are 2 pieces of guidance outstanding for Urgent and Emergency Care and 2 pieces of guidance outstanding that are Trustwide. The Quality Standard for Patient Experience is being assessed and actions formulated and completed by a series of task and finish groups under the Patient Experience Sub-Committee. The 4 pieces that sit within ABC, 2 are Cardiology and are being taken up with the AMD Effectiveness, 1 is Anaesthetics and is being reviewed week beginning 8th May 2018 and last is with Respiratory and is being reviewed week beginning 14th May 2018.

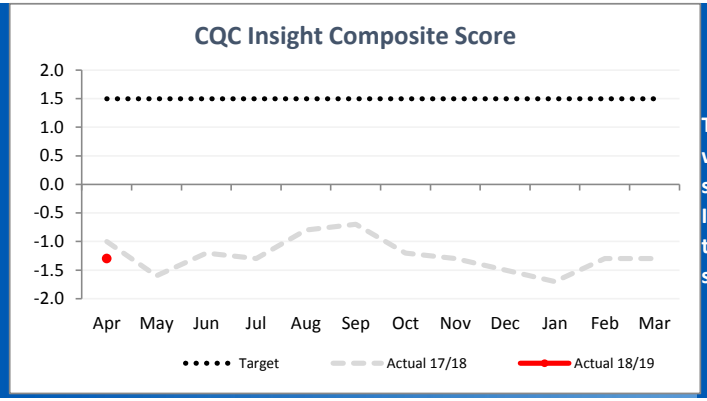
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Patient Experience				
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.	Red - Trust not meeting improvement trajectories or complaints open over 6 months old. Amber - No complaints over 6 months old, Trust meeting backlog improvement targets Green - No backlog, complaints responded to within agreed timescales. Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.		The overall complaints position has significantly improved from that of April 2017. There are now no cases over 6 months old and less in the backlog that are breached. The Trust registered an increased number of complaints in April 2018. Preliminary analysis shows the main trend is complaints occurring in A&E and issues around communication and a perception of inadequate treatment. The Trust also received 10 high risk complaints in this period. All these cases are currently having 72 hour reviews undertaken with Duty of Candour applied appropriately with patients and or their families.
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	The target set is to achieve over 95%.		We have achieved 94% target for inpatients and day cases for our patients recommending the Trust this month against a target of 95%. The response rate has increased to 21.6% in April from 14.7% in March 2018. Positive themes that were reported, highlighted staff attitude and implementation of care. The Head of Patient Experience is working with lead nurses, matrons & ward managers to ensure that patients are actively encouraged to provide feedback and recommending WHH as a place for care.

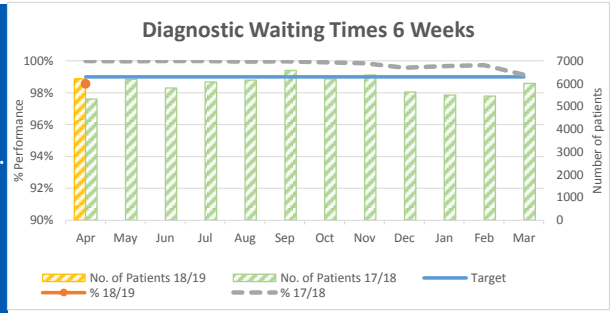
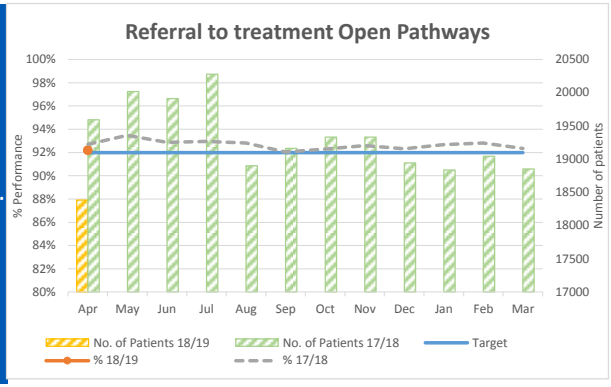
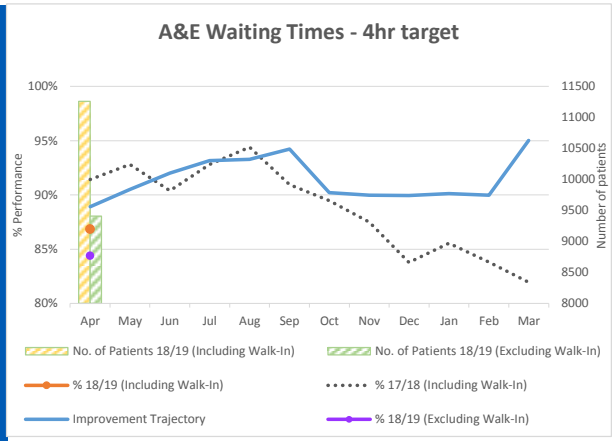
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The Trust has achieved the target with over 87% patients recommending the Trust and this month has seen a significant 4% increase since March 2018 with 85% of our patients recommending our A&E departments. The response rate has also increased significantly to 22.3% from 17.8%. The action plan to address issues related FFT is monitored monthly, by the Patient Experience Sub-committee and the solutions appear to be having a positive impact on the data and there is confidence that the recommendation rate will continue to increase. The Head of Patient Experience, Head of Complaints and Matron for A&E are triangulating information from complaints and FFT feedback, to progress improvement work in A&E.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		MSA breaches totalled 7 for April 2018, which is a reduction of 9 breaches compared to March 2018. The escalation process is being reviewed , to ensure there are robust measures in place, that potential breaches in ICU & CCU are escalated and patients are prioritised and moved to the most appropriate ward. All MSA breaches continue to be discussed at bed meetings and any breaches that do occur, a mini RCA is undertaken and a summary sent to the CCG as per national requirements.

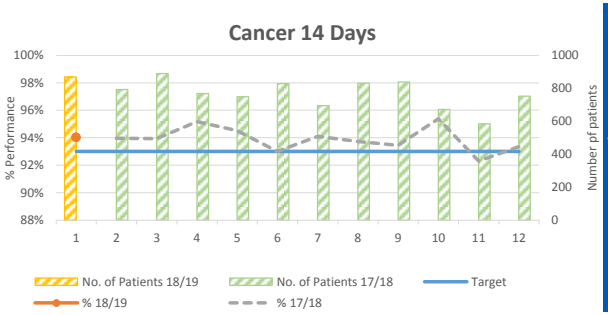
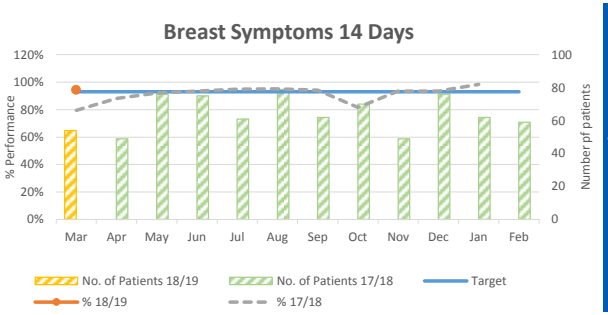
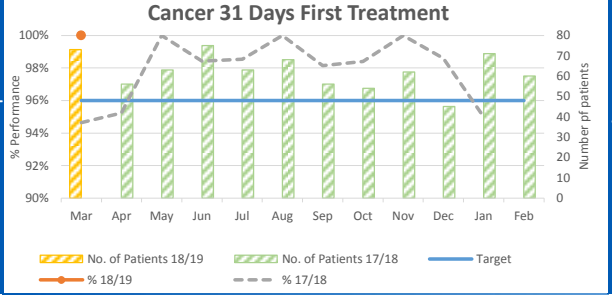
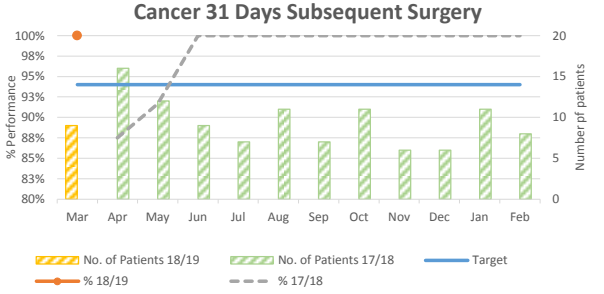
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	**CQC** The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.	The RAG rating is based on the thresholds within the CQC Insight Report. Scores Below -3 are rated as "Inadequate", between -2.9 and 1.5 scores are rated as "Requires Improvement", scores between 1.5 - 4.9 are rated "Good" , scores of above 5 are rated "Outstanding"		The Trust is currently rated as -1.3 by the CQC which means that we currently score in the spectrum of those Trusts that "Requires Improvement". Updates to the insight report in the month of April included addition of staff survey data.

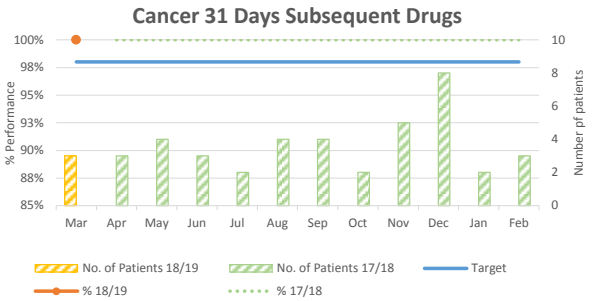
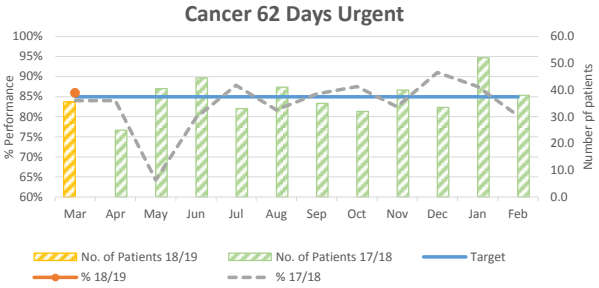
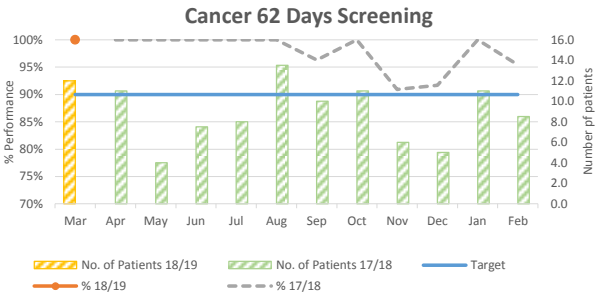
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks **Red: Less than 99%** **Green: 99% or above**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 98.57% in April 2018.		The diagnostic target has not been achieved this month which is the first time for over a year. The failure is associated with the lack of capacity for CT scans which represents 32 breaches and stress echo's which represents 41 breaches. The new Diagnostic CBU Manager is seeking additional capacity whilst a business case for additional support / equipment is developed.
Referral to treatment Open Pathways **Red: Less than 92%** **Green: 92% or** **RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red**	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 92.18% in April 2018.		The Trust achieved the 18 week referral to treatment target, achieving 92.18% against a target of 92%; this is a difficult target which remains challenging given the continued pressure experienced by the Trust. Additional validation support has been provided to assist the central team and all specialities not achieving this standard now have individual recovery plans in place for the remainder of the year to achieve compliance at speciality level.
Four Hour Standard - National Target **Red: Less than 95%** **Green: 95% or above** **Four Hour Standard Waiting Times - STP Trajectory** **Red: Less than trajectory**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 86.73% (including walk in) and 84.39% (excluding walk in) in April 2018.		An improvement trajectory has been agreed with NHSI to deliver improvement against the four hour standard with April set at 85%. The Trust has achieved this expectation in April by delivering a performance of 86.73% against the trajectory. The escalation areas are being closed as capacity allows, however this remained a challenge in May. A silver command rota has now been implemented which provides senior management presence in the patient flow office to ensure that the challenges are actioned in a timely manner. It is understood that there will be a national focus on non-admitted breaches during 2018/19, which continue to be reviewed on a daily basis.

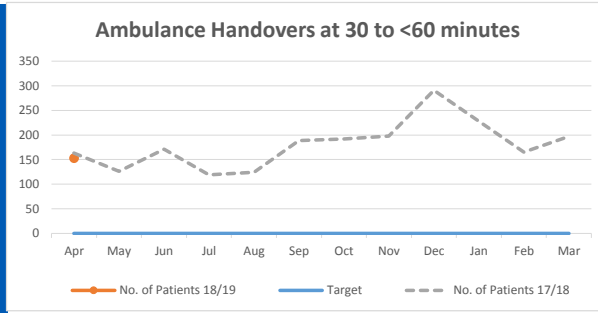
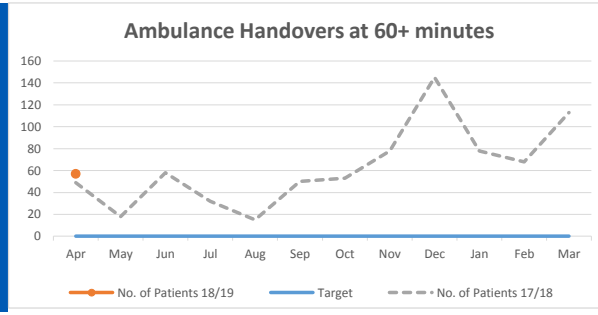
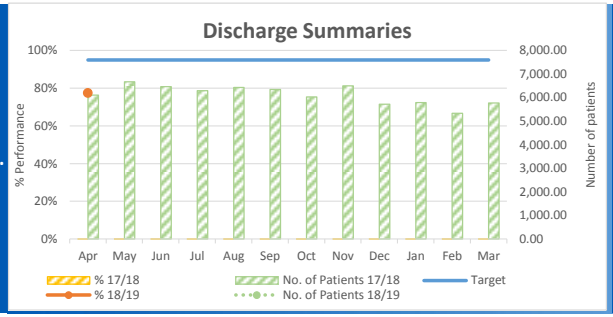
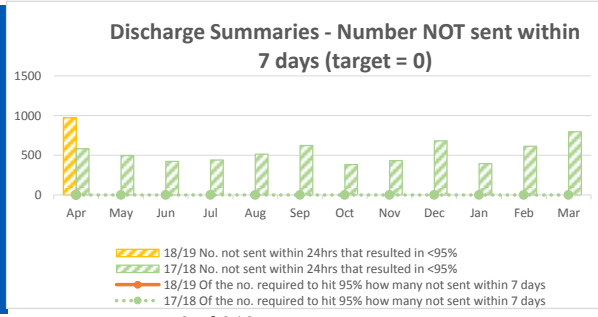
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 94.02% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target for March 2018.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 94.44% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.

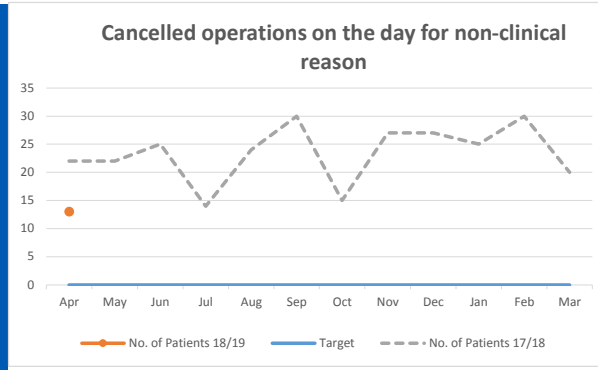
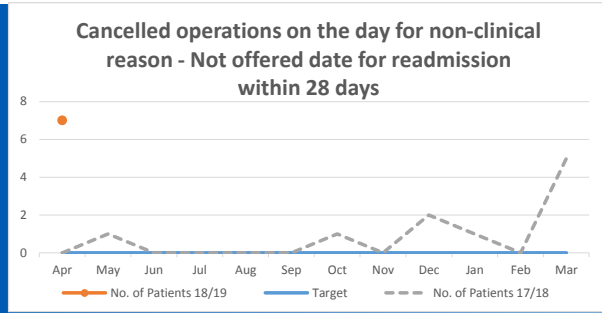
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 85.93% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in March 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in March 2018.

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).	There were 153 patients where the ambulance handover was between 30 and 60 minutes in April 2018.		Ambulance handovers remain a challenge, particularly when we have peaks in attendances within an hour. The department is working hard to ensure timely, safe handovers. We continue to encourage 'Fit to Sit' and the HAS handover screen has now been fitted at the streaming cubical to reduce handover time and avoid unnecessary waiting within the main department. We continue to be one of the best performers in the region for ambulance handovers, averaging 30 minutes.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).	There were 57 patients where the ambulance handover was more 60 minutes in April 2018.		We continue to work closely with NWAS and we remain one of the better performing Trusts across the North West. We continue to strive for the required improvements to make the difference to our performance and overall patient experience.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge.	The Trust achieved 77.38% in April 2018.		The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.	All discharge summaries were sent within 7 days in April 2018.		The Trust achieved this target in April 2018.

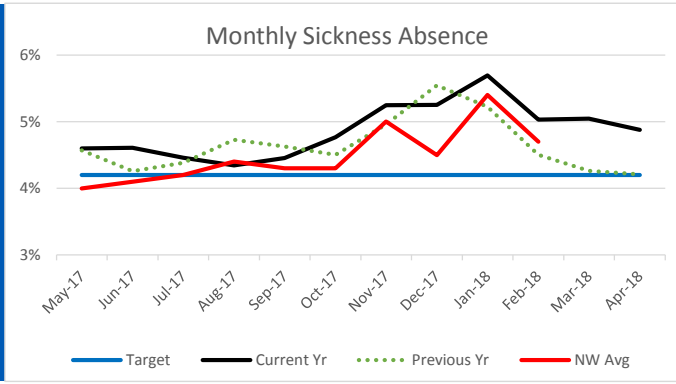
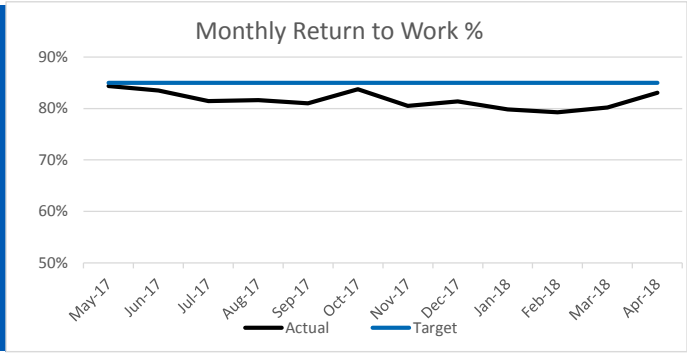
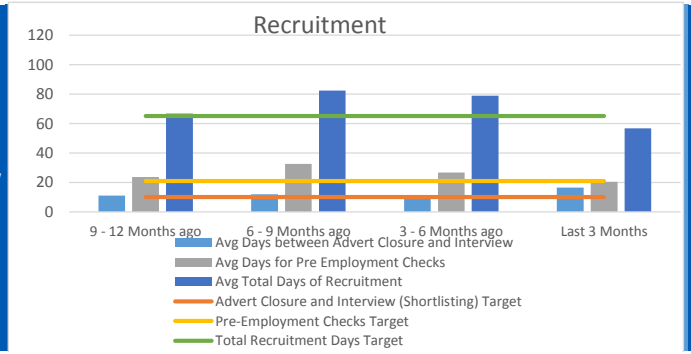
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason.	There were 13 operations cancelled on the day due to non-clinical reasons in April 2018.		There has been a decrease in cancelled operations on the day in April, however bed pressures at peak times have continued.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.	There were 7 patients whose operation were cancelled on the day for non-clinical reasons and were not offered readmission within 28 days in April 2018.		The 7 cases above were reported in the previous FSC report as these cancellations took place in March due to the fire and lack of HDU capacity. Unfortunately, we were unable to rebook any in the 28 day timeframe due to equipment unavailability (damaged in the fire) and 1 case where the consultant was not available. 6 of the ophthalmology patients have now got dates for surgery in May 2018 and 1 gynaecology patient was treated in April 2018.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - April 2018

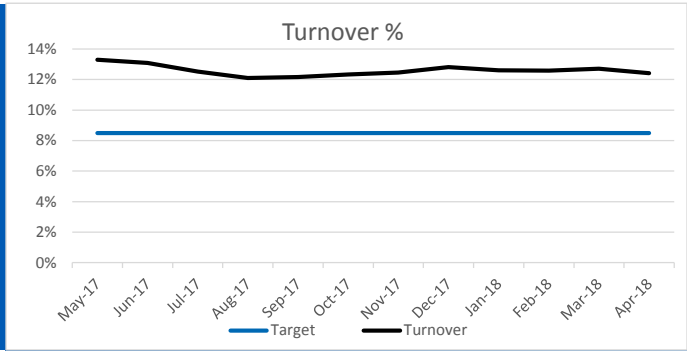
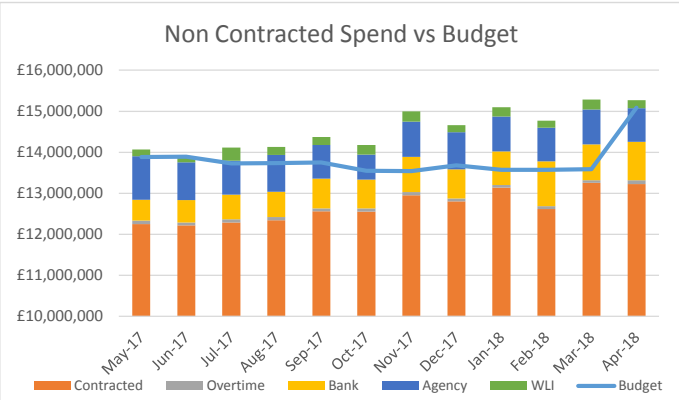
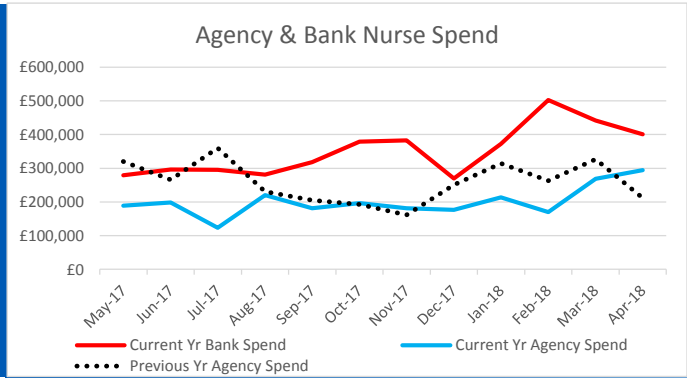
Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	UoR Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has decreased to 4.88%, which is below target and lower than the same period last year.		Sickness absence has reduced significantly in month but remains above target. Key actions to address this include: > Strengthened reporting arrangements for nursing staff > Mental health first aid training to take place > Bespoke actions on areas with high levels of absence
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	Return to work interviews have increased significantly to 83.03%.		Return to work interviews have increased significantly in month following a particular focus on this KPI in Workforce Committee and Trust Operational Board. All CBUs have been asked to produce exception reports to Workforce Committee explaining any areas of non-compliance.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	Average days to recruit has reduced to 56.7 in the last 3 months, which is below target.		Improved use of technology, streamlining and recruiting managers forward planning will continue to improve the efficiency of our 'Time to Hire.'

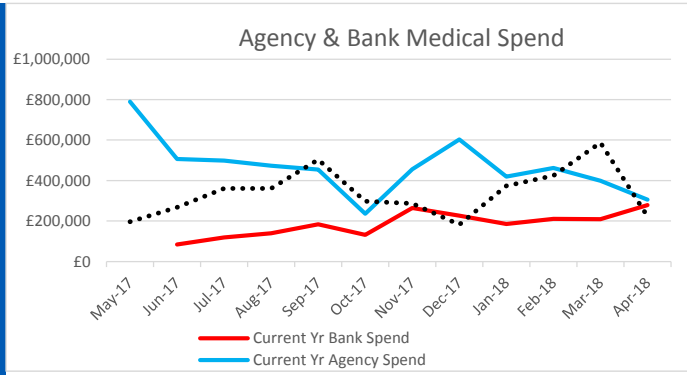
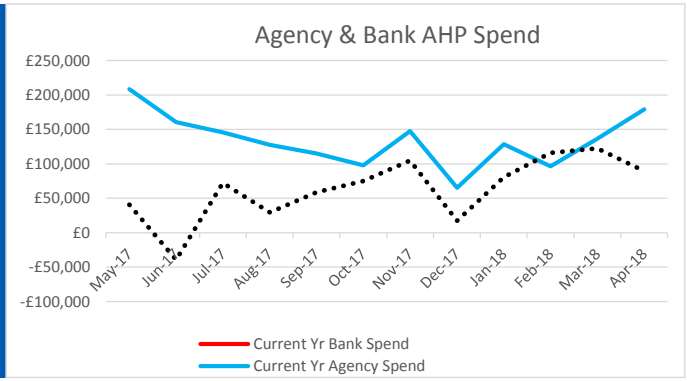
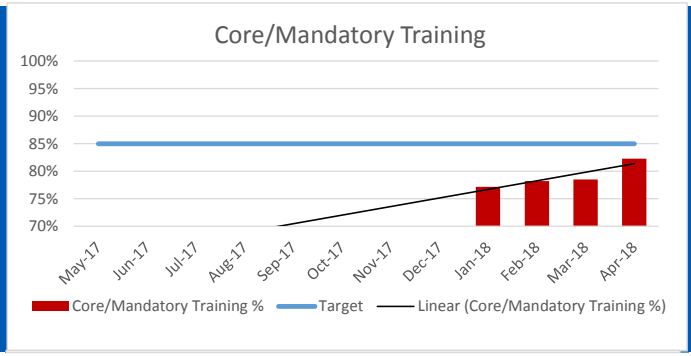
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - April 2018

Workforce

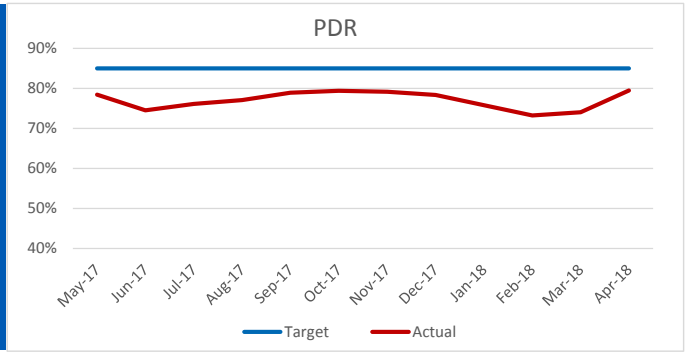
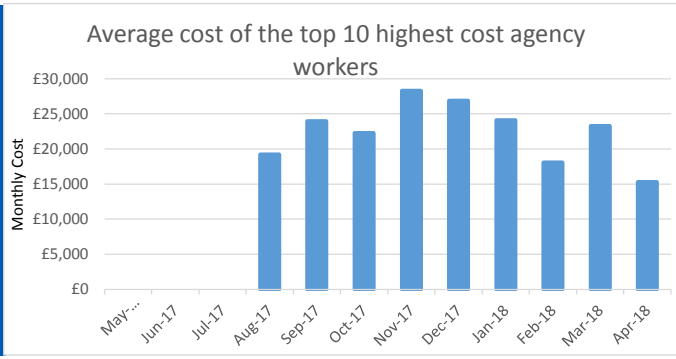
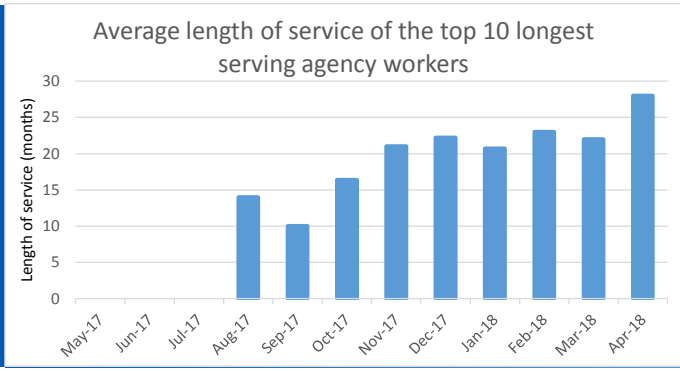
	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	UoR A review of the turnover percentage over the last 12 months	Turnover remains below target at 12.41%		Turnover has reduced again in month and remains below target.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	UoR A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Expenditure remains slightly above budget, mainly due to temporary staffing costs.		Total pay spend across the Trust in April 2018 was £15.27m, against a budget of £15.08m. The winter ward remained open in April at a pay cost of £0.22m which accounted for the pay overspend in Month 1.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Nurses	Agency nurse spend increased in month to £0.3m. Bank nurse spend decreased in month to £400k but remained above the same period last year.		There were circa 7,400 hours worked via nursing agencies which cost the organisation £0.3m in April 2018. During early April 2018 there has been a requirement to fill shifts via off framework agency which incurs a higher cost to the organisation. All off framework agency shifts were signed off by the Chief Nurse. The use of off framework agencies has now stopped from mid-April. There were circa 12,600 hours worked via the nursing bank which cost the organisation £0.4m in April 2018. This represents a reduction in month.

Workforce

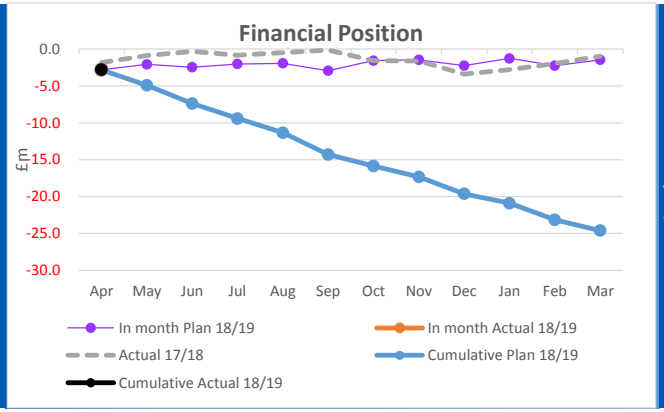
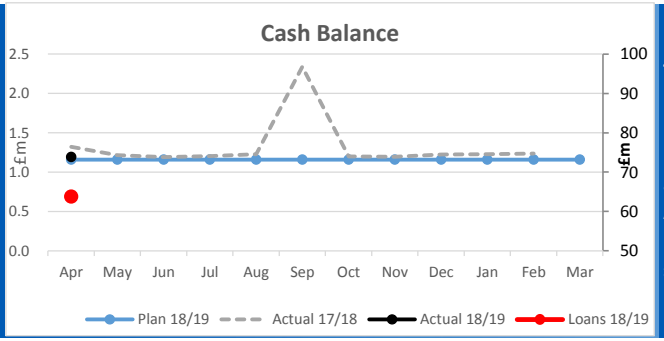
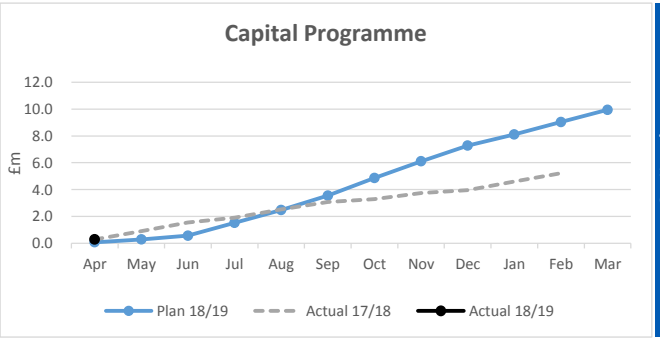
	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Locums	Medical agency spend has decreased in month to £0.3m. Medical bank spend increased in month to £0.28m but remained lower than the same period last year.		There was a further reduction in medical agency spend mainly due to conversion from agency to bank. Work is on-going to continuously review high cost agency workers and encourage them to convert to the Trust bank. There have been a number of recent successes, particularly within Specialist Medicine. There was an increase in medical bank spend to £0.28m in month which was matched by a decrease in agency spend.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	UoR A review of the monthly spend on AHP Locums	AHP agency spend increased to £0.18m		AHP spend has increased in month and work is on-going to review the reasons behind the increase.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safegarding.	Core Skills Training was 82.3% in month.		Core Skills training compliance increased to 82.3% in month. There has been a particular focus on training compliance and all CBUs have been asked to produce exception reports to Workforce Committee explaining any areas of non-compliance. In addition, all CBUs have been asked to provide improvement trajectories to Workforce Committee.

Integrated Dashboard - April 2018

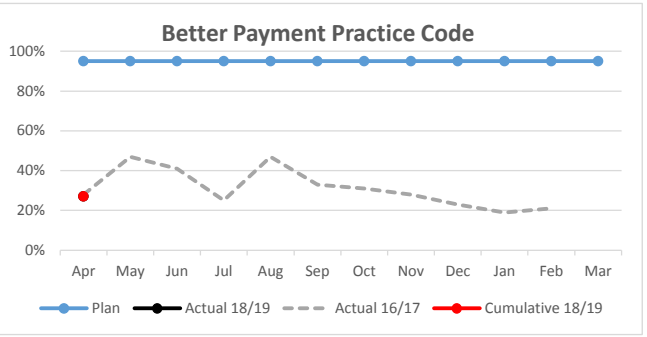
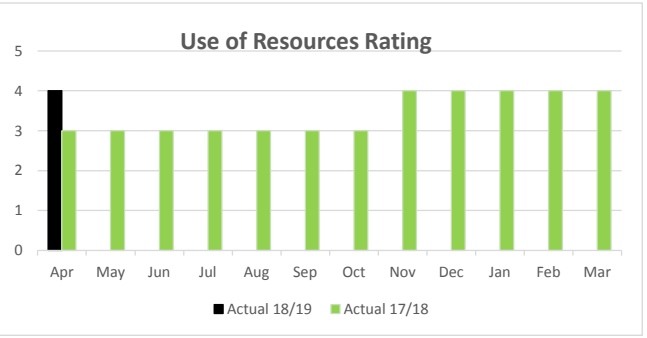
Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	PDR compliance remains below target at 79.5%		PDR compliance rates have increased following a particular focus on this KPI in Workforce Committee and Trust Operational Board. All CBUs have been asked to produce exception reports to Workforce Committee explaining any areas of non-compliance. In addition, all CBUs have been asked to provide improvement trajectories to Workforce Committee.
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	UoR Monthly costs for the top 10 highest cost Agency Workers	The monthly cost for the top earning agency workers ranged from £26k to £9.5k. The average cost was £15k.		The high cost agency workers data is scrutinised monthly and work is on-going to produce exit plans for each worker, as well as short term mitigation plans such as renegotiating rates. This work is reported through to the Premium Pay Spend Review Group.
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	The length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks.	The length of service for the longest serving agency workers ranged from 48 months to 17 months. The average length of service was 28 months.		The length of service for agency workers is reported on a weekly basis to NHSI. The current length of service poses low risk to the organisation.

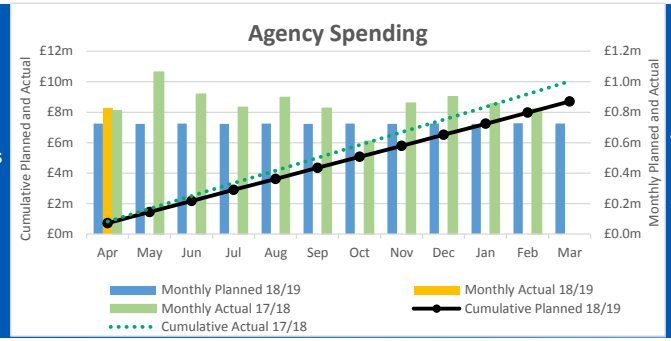
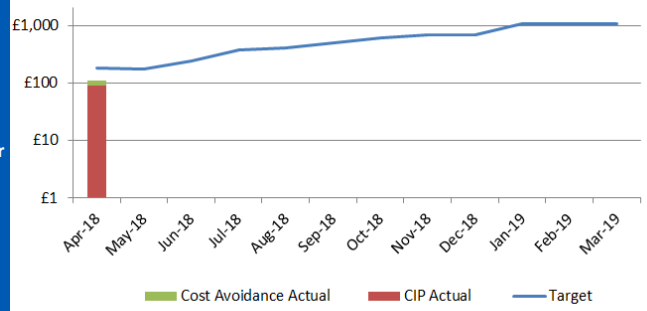
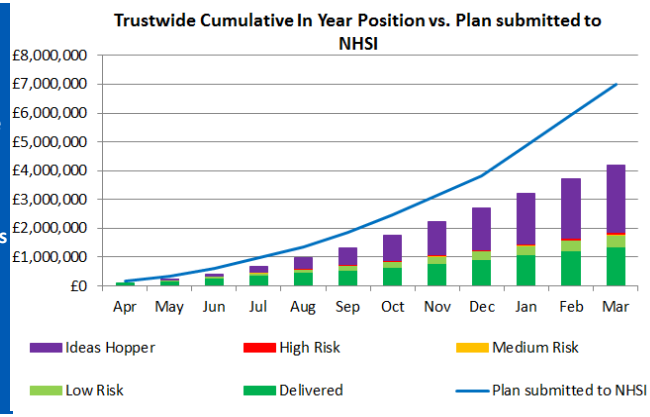
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	UoR Surplus or deficit compared to plan	The actual deficit in the month is £2.8m.		The cumulative deficit of £2.8m is in line with plan.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	UoR Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).	The current cash balance of £1.2m equates to circa 2 days operational cash.		The current cash balance of £1.2m is in line with the plan. Due to the operating position additional working capital loans are required to maintain liquidity and meet its financial obligations. Actual and planned working capital loans to year ending 2018/19 total £63.8m.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR Capital expenditure compared to plan (The capital plan has been increased to £7.3m as a result of additional funding from the Department of Health for A&E Primary Care Streaming and WiFi infrastructure upgrade and capital donations from Can treat, Health Education England and Charitable Funds.	The actual capital spend in the month is £0.3m.		The cumulative capital spend of £0.3m is £0.2m above the planned capital spend of £0.1m.

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or	UoR Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 27% of suppliers within 30 days.		The cumulative performance of 27% is 68% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	UoR Use of Resources Rating compared to plan.	The current Use of Resources Rating is 4. Capital Servicing Capacity, Liquidity, I&E margin and I&E margin (distance from financial plan) are scored at 4 whilst Agency Ceiling is scored at 2.		The current Use of Resources Rating of 4 is below the planned rating of 3.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties	Fines and Penalties are levied by commissioners as outlined in the contracts.		The Trust is awaiting notification of any fines or penalties levied by commissioners during April. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract.

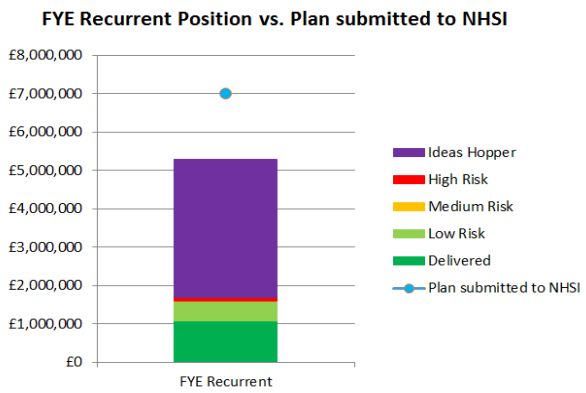
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.8m.		The cumulative agency spend of £0.8m is £0.1m (13%) above the cumulative agency ceiling of £0.7m.
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	Cost savings delivered compared to plan.	CIP savings delivered in M1 are £0.088m against the M1 target of £0.178m a further £0.021m was delivered in cost avoidance.		Financial improvement was £0.109m in M1 (£0.088m CIP & £0.021m cost avoidance) this is £0.069m below the Trust M1 CIP target of £0.178m.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Planned improvements in productivity and efficiency - In Year forecast vs £7m target.	In-year The best case In-year forecast for Trust CIP schemes is around £4.2m. Best case assumes full delivery of schemes on the tracker including all hopper ideas The worst case In-year forecast for CIP is around £1.83m. Worst case assumes the risk adjusted value of schemes on the tracker and excludes all hopper ideas		The worst case current In-year forecast for Trust CIP schemes is £1.83m which is £5.17m below the CIP target of £7m. The best case for CIP in year is £4.2m which is still £2.795m below the CIP target. Best case cost avoidance of £0.058m will help mitigate the position but would still leave a bottom line shortfall of £2.74m. * NOTE: £2m of schemes already incorporated into 2018/19 baseline activity plans.

Integrated Dashboard - April 2018

Sustainability & Mandatory Standards - Finance

Cost Improvement Programme - Plans in Progress - Recurrent
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

Description	Aggregate Position	Trend	Variation
Planned improvements in productivity and efficiency - Full Year Forecast vs. £7m target.	Recurrent The best case recurrent forecast for recurrent CIP is £5.28m. The worst case recurrent forecast for recurrent CIP is £1.6m.		The worst case recurrent forecast for Trust CIP schemes is £1.6m which is £5.4m below the CIP target of £7m. The best case recurrent forecast for Trust CIP is £5.28m which is £1.72m below the CIP target. * NOTE: £2m of schemes already incorporated into 2018/19 baseline activity plans.

Appendix 3

Income Statement, Activity Summary and Use of Resources Ratings as at 30th April 2018

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Clinical Income									
Elective Spells	2,679	2,554	-126	2,679	2,554	-126	33,894	33,894	0
Elective Excess Bed Days	8	12	4	8	12	4	101	101	0
Non Elective Spells	4,793	4,916	123	4,793	4,916	123	59,030	59,030	0
Non Elective Excess Bed Days	163	164	0	163	164	0	2,013	2,013	0
Outpatient Attendances	2,650	2,564	-86	2,650	2,564	-86	33,522	33,522	0
Accident & Emergency Attendances	1,080	1,141	61	1,080	1,141	61	13,451	13,451	0
Other Activity	5,551	5,311	-240	5,551	5,311	-240	68,320	68,320	0
Sub total	**16,925**	**16,662**	**-264**	**16,925**	**16,662**	**-264**	**210,331**	**210,331**	**0**
Non NHS Clinical Income									
Private Patients	5	46	41	5	46	41	152	152	0
Non NHS Overseas Patients	4	3	-1	4	3	-1	44	44	
Other non protected	95	76	-19	95	76	-19	1,135	1,135	0
Sub total	**104**	**125**	**21**	**104**	**125**	**21**	**1,331**	**1,331**	**0**
Other Operating Income									
Training & Education	641	641	0	641	641	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Sustainability & Transformation Fund	0	0	0	0	0	0	0	0	0
Miscellaneous Income	1,575	1,796	221	1,575	1,796	221	18,896	18,896	0
Sub total	**2,216**	**2,437**	**221**	**2,216**	**2,437**	**221**	**26,589**	**26,589**	**0**
Total Operating Income	**19,245**	**19,224**	**-21**	**19,245**	**19,224**	**-21**	**238,251**	**238,251**	**0**
Operating Expenses									
Employee Benefit Expenses	-15,084	-15,273	-189	-15,084	-15,273	-189	-179,196	-179,196	0
Drugs	-1,429	-1,186	244	-1,429	-1,186	244	-17,026	-17,026	0
Clinical Supplies and Services	-1,750	-1,792	-42	-1,750	-1,792	-42	-20,582	-20,582	0
Non Clinical Supplies	-3,101	-3,069	33	-3,101	-3,069	33	-36,874	-36,874	0
Depreciation and Amortisation	-501	-488	13	-501	-488	13	-6,007	-6,007	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-21,866**	**-21,807**	**58**	**-21,866**	**-21,807**	**58**	**-259,686**	**-259,686**	**0**
Operating Surplus / (Deficit)	**-2,621**	**-2,583**	**37**	**-2,621**	**-2,583**	**37**	**-21,435**	**-21,435**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	3	4	1	3	4	1	36	36	0
Interest Expenses	-53	-45	8	-53	-45	8	-1,159	-1,159	0
PDC Dividends	-170	-170	0	-170	-170	0	-2,042	-2,042	0
Net Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-220**	**-210**	**10**	**-220**	**-210**	**10**	**-3,165**	**-3,165**	**0**
Surplus / (Deficit)	**-2,841**	**-2,794**	**47**	**-2,841**	**-2,794**	**47**	**-24,600**	**-24,600**	**0**
Less Donations & Grants Income	0	0	0	0	0	0	0	0	0
Less Depreciation on Donated & Granted Assets	13	13	0	13	13	0	156	156	0
Control Total	**-2,828**	**-2,781**	**47**	**-2,828**	**-2,781**	**47**	**-24,444**	**-24,444**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	-33,512	-30,167	3,345	2,856	2,655	-201	36,135	36,135	0
Elective Excess Bed Days	-635	-435	200	33	49	16	415	415	0
Non Elective Spells	-33,050	-30,112	2,938	3,013	2,688	-325	37,091	37,091	0
Non Elective Excess Bed Days	-8,948	-5,885	3,063	673	674	1	8,283	8,283	0
Outpatient Attendances	-275,751	-266,321	9,430	24,703	24,015	-687	312,490	312,490	0
Accident & Emergency Attendances	-87,148	-93,803	-6,655	9,227	9,408	181	114,866	114,866	0

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics									
Capital Servicing Capacity (Times)				-9.5	-7.1	2.3	-4.8	-4.8	0.0
Liquidity Ratio (Days)				-15.8	-36.4	-20.7	-10.9	-10.9	0.0
I&E Margin (%)				-14.7%	-14.5%	0.2%	-10.3%	-10.3%	0.0%
Performance against control total (%)				-9.5%	-8.5%	1.0%	-7.6%	-7.6%	0.0%
Agency Ceiling (%)				0.0%	13.2%	13.2%	0.0%	0.0%	0.0%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	4	4	0
Liquidity Ratio (Days)				4	4	0	3	3	0
I&E Margin (%)				4	4	0	4	4	0
Performance against control total (%)				4	4	0	4	4	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**4**	**0**	**3**	**3**	**0**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 05 39 a	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	24th May 2018

Date of Meeting	1 May 2018
Name of Meeting + Chair	Quality Assurance Committee Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/18/04/44	**Maternity Deep Dive**	Key points were highlighted from the deep dive review including: • Induction Labour rate – Trust is above the national average; • Elective C-Sections – Trust is above the national average.	• Dr Hasan, Governance Lead Obstetrics/Obstetrics Safety Champion Lead to attend future QAC meetings. • Maternity Update/Maternity Safety Champion progress report to be presented to future QACs including Safety Improvement Action Plan. • Themes and recommendations on response rate for induced labour choices and what is currently being actioned to be reported to PSCE with oversight at QAC through high level briefing reports. • Audit on Induction of Labour rate to	• **QAC July 2018** • **QAC July 2018** • **QAC July 2018** • **QAC July**

			be completed and presented to QAC • Elective C-Section rates to be audited and presented to PSCE	**2018** • **PSCE Oct 2018**
QAC/18/04/44	**Maternity CNST Incentive Scheme**	The Trust is required to show compliance against the 10 safety actions to achieve 10% reduction in the CNST Incentive Scheme costs.	• Midwifery training compliance to be reported to QAC bi-monthly • The Committee supported the Maternity CNST Incentive scheme with recommendation for approval to the Trust Board in May.	**QAC July 2018**
QAC/18/05/48	**Getting to Good (G2G) Steering Group**	The Committee received an update on progress against the CQC action plan highlighting those actions overdue. The key points were: • 54 actions due to be closed at the end of April, still waiting to be closed. • 74 out of total action plan completed. • DoLS and MCA training is available via E-Learning, face to face and that compliance remains a significant challenge. Reported that 17 Drs had attended a Hill Dickinson facilitated training session for MCA/DoLS. And that three further sessions were planned throughout the month	• To provide further assurance to the Board/NEDs and Audit Committee, it was agreed to circulate this high level briefing and CQC Action plan to Audit Committee/Board.	**Trust Board May 2018**

QAC/18/05/53	**High Level Briefing Report – Health and Safety Sub Committee 8 March 2018**	The Committee received a briefing report form the H&S Sub Committee with the key point noted as: • There has been an increase in the number of reported falls for March 2018, one resulting in moderate harm and one resulting in a patient death which are currently being investigated using the Trust's RCA process. A falls task and finish group has been developed in order to drive quality improvement within the area of falls.	• Performace to be measured through PSCE Sub Committee and reported through to QAC.	**PSCE July 2018**
QAC/18/05/54	**Clinical Audit Quarterly Report**	The Committee received the report which provided information on developments and progress on audit plans. Included in the Trust's priority audits was the identification of a Trust lead for consent.	• A report is currently being drafted.	**QAC Sept 2018**
QAC/18/05/57	**Complaints Quality Assurance Group High Level Briefing**	The Committee noted the significant progress made during the last year.	The Chair of the Committee will report the progress to the Trust Board acknowledging continued improvement and focus is required	**Trust Board May 2018**

QAC/18/05/63	**Strategic Risk Register & BAF**	The Committee received the report which highlighted the following: • 4 new risks proposed relating to Information Governance, General Data protection Regulations (GDPR), Medical Devices, Compliance with Getting to Good (CQC) action plan. • The Committee supported the removal of 2 risks relating to Blood Administration and Paediatric Urgent and Emergency care	• The Committee supported the addition of the 4 new identified risks. • The Committee supported the removal of the 2 identified risks.	**QAC July 2018**
QAC/18/05/67	**High Level Briefing IG and Corporate Records**	The Report highlighted the following key points relating to Information Governance and GDPR readiness	• The Committee agreed that bi-monthly progress reports should be brought to QAC relating to GDPR readiness.	**QAC July 2018**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 05 39 b i	**COMMITTEE OR GROUP:**	Trust Board	**DATE OF MEETING**	24 May 2018

Date of Meeting	21st March 2018
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC 18/03/30	**Pay Assurance Dashboard Monthly Report**	• Received revised report highlighting the whole of pay not just bank and agency. February pay was £14.7m • The bank expenditure has increased linked to the work to convert from agency. Agency hasn't increased even though it has been winter. Activity and bed occupancy discussed as to how this links with bank and agency spend and most of this spend is in the escalation area. Further discussion of the increase in off framework and other hospitals are experiencing the same with a drop in NHSP fill rates.	**An audit of agency has been agreed for quarter 1 of 2018/19**	
FSC 18/03/31	**Risk Register**	• Reviewed and discussed – noted new risks as per last months discussion	**The Committee noted the risks.**	
FSC 18/03/32	**ToR and Cycle of Business**	• Reviewed and approved	**The Committee reviewed and approved.**	

FSC 18/03/33	**Chargeable patient policy**	Chargeable patient policy was replaced by overseas policy updated in line with national guidance and a chargeable patient guide.	**The policy and guide will be circulated through TOB, SMTs and intranet.**	
FSC 18/03/34	**Month 11 Finance Report at 28 February 2018**	For the period ending 28 February 2018 the key financial headlines are: • Monthly deficit of £2.0m • Year to date deficit of £15.9m mitigations of £1.4m mostly fall in month 12, FOT £16.8m on track). • Cash balance of £1.2m • Use of Resources Rating of 4. • The Trust will need to apply for loans on a monthly basis as the DoH can only provide loans on need on the current financial position rather than based on a forecast outturn. Current revenue loans total £41m and the committee noted the interest rates. • Aged creditors value of £13.3m remains a concern.	**The Committee reviewed, discussed and noted the report and the financial challenges faced.**	**April 2018 FSC Committee**
FSC 18/03/35	**Draft operational plan**	• 2018-19 draft plan submitted on the 8 March to NHSI was reviewed. • The control total has been set at £3.3m surplus • The plan submitted is for a £27.1m deficit relating to the funding of £24.7m cost pressure which are being reviewed further. • The Trust has yet to sign contracts with lead Commissioners but is working closely with them under the CEP framework and looking to secure a block contract.	**The Committee reviewed, discussed and noted the report and the financial challenges faced.**	**March Board and April 2018 Board and FSC Committee**
FSC 18/03/36	**Transformation Programme**	• In February 2018 the Trust delivered CIP schemes to the value of £0.4m against a M11 plan of £1.2m. YTD	**The Committee reviewed and discussed and noted the report and the**	**April 2018 FSC Committee**

		CIP actuals are £4.6m against the YTD target of £9.3m. • Challenging CIP target for 2018-19 of £7m of which £5m is mostly pay cost out. • The total best case financial improvement has increased by £0.15m between M10 and M11 with worst case financial improvement increasing by £0.4m over the same period as values associated with schemes are firmed up towards the year end. • The forecast recurrent CIP for 2017/18 is £4.143m.	**mitigations in place against further financial risk.**	
FSC 18/03/37	**Ward Nursing Establishment Business Case cover report needed**	• Current funded establishment is 886.66 wte. Evidence modelling recommends the ward establishment to be increased to 980.32 wte. • The wards included within this review have an annual budget of £32.1m. It is forecast that by the end of 2017/18 these wards will have overspent that budget by approximately £2.4m with a total spend of £34.5m. • Issues relating to CQC and recruitment were discussed. • The business case has been reviewed by the Quality committee	**The Committee only considered the financial implications of the case, and highlighted the need for the implementation and allocation of resources to be closely monitored and reported. The Committee caveated the need to understand the implications of the pay increases currently being agreed nationally.** **The Committee agreed if approved by the board the impact would need to be monitored and reported back to the Committee.**	**March 2018 Board**
FSC 18/03/39	**Corporate Performance Report**	• Based on the performance in month 11 the Trust has a draft Service Performance Score of 3. The 3 relates to the reportable targets not met in month, which are the 4 hour performance target and the 31 and 62 day performance in month. • In February the Trust had 183 medically fit patients	**The Committee reviewed, discussed and noted the report.**	**April 2018 FSC Committee**

		this impacts on performance. • 4 hour performance standard – 83.51% delivered against 90.0% trajectory. • RTT achieved in February 92.82% against a target of 92% • Cancer some validation to be done but 2 breaches on 62 days relating to clinical priority and ITU bed not available. • Executive to executive meetings with CCGs and other organisations with the system to work to discharge an extra 45 patients have taken place, with support available to expedite to care homes and out of hospital services. Some delays are due to patient choice but home of choice process and policy is being used collectively as a commitment to discharge this cohort of patients. • Ambulance Handover – Significant challenges to achieve at peak times but the Trust remains one of the best performing in Cheshire and Mersey.		

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/18/05/39 b ii	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	24 May 2018

Date of Meeting	18th April 2018
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/18/04/45	**Pay Assurance Dashboard Monthly Report**	• Received revised report including amended graphs highlighting increase in activity and bed impact on pay pressures. • Noted medical bank has been set up • Trust has signed up to join the STP collaborative and sustainability bank work group	Continue to monitor agency and bank reduction as vacancies reduce	**May 2018 FSC Committee**
FSC/18/04/46	**NHSI Checklist Quarterly Report**	• Agreed pay assurance checklist was a more meaningful report		
FSC/18/04/48	**Key Performance Indicator Updates 2018-19**	• Reviewed changes to KPIs relating to FSC	Recommended agreement to Board	**April 2018 Board**
FSC/18/04/49	**Monthly Finance report**	• Month 12 position reviewed £16.8m deficit financial position	The Committee reviewed, discussed and noted the report and the financial challenges faced.	**April 2018 Board**

		• Loans discussed in detail		
FSC/18/04/50	**Transformation Plan**	• CIP and cost avoidance discussed • 2018/19 CIP plan discussed • Challenge is CIP plan owned by the rest of the Executive Team. • NHSI asked if CIP stretching enough and supported the need to balance Quality, Sustainability and Performance	Agreed CIP should not be examined in isolation to the financial position and current arrangements therefore need to be reviewed. Executives meeting with Director of Transformation to sign up to CIP	**May 2018 FSC Committee**
FSC/18/04/51	**Operational plan**	• 2018/19 final plan to be submitted on 30 April to NHSI was reviewed. • The control total has been set at £3.3m surplus • The plan submitted is £24.6m deficit relating to the funding of cost pressures including £3m investment in nursing. • The Trust has signed contracts with lead Commissioners securing a sustainability (block) contract and is working more collaboratively under the CEP framework.	The Committee reviewed, discussed and noted the report and the financial challenges faced.	**April 2018 Board**
FSC 18/04/52	**Financial Implications of Fire**	• Confirmed insurance cover is appropriate • Appointed Project Director • Timeframe expected at 6 months for like for like	Future financial updates to be included within finance report.	**May 2018 FSC Committee**
FSC 18/04/53	**Corporate Performance Report**	• 4 hour performance standard – 81.95% delivered. • RTT and cancer achieved in March	The Committee reviewed, discussed and noted the report.	**May 2018 FSC Committee**

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 18 05 39 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	24 May 2018

Date of Meeting	**Thursday 26 April 2018**
Name of Meeting + Chair	**Audit Committee**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
AC/18/ 04/ 26	Ward Managers Delegated Authority	Request to reinstate the £5,000 authorisation limit for Ward Managers to enable enhanced budgetary control for Ward Managers	The Audit Committee supported the proposed changes to the SoRD with a recommendation to the May Board for formal approval of these changes.	**May 2018 Trust Board**
AC/18/ 04/ 27 & AC/18/ 04/ 32	Review Minutes 22 February 2018 and Action Log & Changes or updates to the BAF and Strategic Risk Register	• Inclusion of a specific GDPR risk on the Board Assurance Framework • Audit Committee to receive update on the CQC Action Plan	• The Audit Committee requested that the GDPR risk be reviewed for inclusion on the BAF • The CQC Action Plan to be shared with members of the Audit Committee	• **Quality Assurance Committee (May 2018)** • **Audit Committee July 2018**

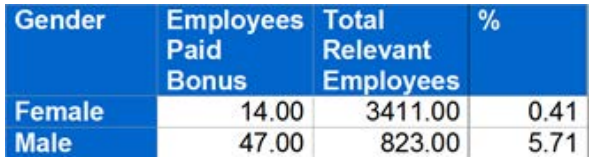
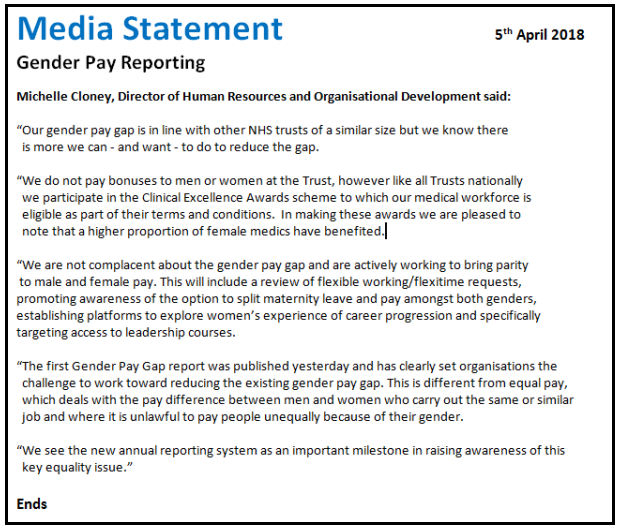
AC/18/04/36	Draft Unaudited Accounts and Financial Statements	The Draft Unaudited Accounts were presented to the Audit Committee with key points highlighted.	The Audit Committee supported the Draft Unaudited accounts with a recommendation to the Trust Board for approval in May.	**May 2018 Trust Board**
AC/18/04/38	Going Concern Report	The Going Concern report was presented to the Audit Committee with key points highlighted.	The Audit Committee supported the accounts being prepared on the going concern basis. The Audit Committee recommendation to the Trust Board in May for approval.	**May 2018 Trust Board**
AC/18/04/40	Review of Quotation and Tender Waivers Q4 Period 1.01.2018-31.03.2018	The Audit Committee were asked to consider a proposal to amend the current process and waiver request form to reduce/eliminate the number of waivers submitted retrospectively.	The Audit Committee supported the amendment to the Waiver process.	**Audit Committee July 2018**
AC/18/04/43	Head of Internal Audit Opinion	An overall opinion of Moderate Assurance has been assigned to the Trust which will be included in the Trust Annual Governance Statement.	The Audit Committee supported the Audit Opinion for inclusion in the Annual Governance Statement.	**May 2018 Trust Board**

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 18/05/39 c	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	24.05.2018	CHAIR:	

Date of Meeting	17th April 2018
Name of Meeting	Workforce Committee
Was the Meeting Quorate	Yes

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
WC/18/ 04/59	**Gender Pay Gap Report**	**Deputy Director HR & OD**	Gender Pay Gap Information was submitted via the Government Gateway as required. The information is published on our website. There has been some media interest from the Warrington Guardian. Workforce Committee were asked to note that in addition to the Gender Pay Gap presented at the last meeting, the government also required information on 'Bonus Schemes'. For WHH this relates to Clinical Excellence Awards for medical staff. **Gender Pay Gap - Bonus Pay Information** Gender / Avg. Pay / Median Pay Male: 19,531.70 / 10,486.23 Female: 21,001.09 / 15,729.25 Difference: -1,469.38 / -5,243.02 Pay Gap %: -7.52 / -50.00		

			  		
WC/18/ 04/60	**Mental Health First Aid**	**Anita Kirkham, Senior Staff Counsellor**	**Aim:** Set up a network of Mental Health First Aiders and Mental Health Champions. **Plan:** **Mental Health First Aiders:** Information presentation to be given to managers – focusing on areas with high levels of stress/anxiety/depression related absence. Managers will then nominate Mental Health First	Assurance	

			Aiders to attend the course. First course 28th June 2018 Dates planned for September, October and November 2018. **Mental Health Champions:** One day courses to be held later in the year Also planned activity around mental health awareness. Research shows that this can take up to 2 years to embed in an organisation. Need to remember that staff need support in meantime. Wendy Johnson confirmed that Clinical Supervision will be implemented in June 2018 and will be another element of support for clinical staff.		
WC/18/04/63	**Director HR & OD Annual Report (2017/18)**	**Michelle Cloney, Director of HR and OD**	Workforce Committee reviewed and evaluated the topics covered from October 2018. The Committee agreed that an appropriate balanced between 'Quality', 'Sustainability' and 'People' is achieved and that the topics support the Terms of Reference for the Workforce Committee.	Assurance	
WC/18/04/64	**Director HR & OD Report**	**Michelle Cloney, Director of HR and OD**	Core Skills and Role Mandated Training – changes to reporting arrangements noted by Committee. Detailed project plan for compliance in the areas highlighted by CQC noted by the Committee. Role Mandated Resuscitation Training and recommended actions. Capacity and demand exercise undertaken and Committee assured that	Assurance **<u>Escalation – please escalate importance of attendance to all CBUs via TOB</u>**	**May 2018**

			sufficient training is available for the workforce. The challenge is releasing staff to attend the training. Booking is not required – staff can 'turn up' on the day. Education Team are promoting attendance and also ringing round wards on the day of each training session to fill places. Sessions to be also promoted via safety briefs. Investment in nursing establishment approved by Trust Board. Committee were updated on recruitment plans in place – recruitment day scheduled for early May 2018. Presentation on targeted approach and strategy to be given at Workforce Committee in May 2018.	Assurance	
WC/18/04/72	**Trust Board Monthly Staffing Report**	**Rachael Browning, Associate Chief Nurse**	February 2018 data A number of 'reds' i.e. below 80% Mitigate risks by: • NHSP • Utilising non ward based nurses • Cancellation of training • Increasing numbers of HCAs • Use of Thornbury nurses • Mitigation also reported via ward	Assurance	
WC/18/04/65	**BAF and Risk Register**	**Mick Curwen, Head of Strategic HR Projects**	No new risks Existing risks: • Staffing Levels – updated to reflect business case • Spinal Service – update to reflect receipt of College report • Engagement – updated to reflect new approach to Staff Survey results	Assurance	

WC/18/ 04/66	**People Strategy Dashboard**	**Heads of Service, HR and OD**	Absence 4.93% Majority is long term sick therefore focus. Scrutiny put in place for each case, including new performance measures and tracker Mental Health First Aiders Action to revisit the self-help tools available Return to work interviews 79% 2 issues: • Not all RTW Interviews are taking place (this is not a recording issue) • Allocate systems is closed down at the end of each month and therefore it becomes complex to retrospectively record the interviews (only for areas using e-rostering) Time to Hire 79 days Due to recruiting student nurses in advance of registration rather than true delays in recruitment PDR Compliance 74.1% Performance trajectories are being put in place. Review of PDR process on-going – recommendations to Committee in May 2018	Assurance <u>**Escalation – please escalate to CBUs via TOB:**</u> • **Importance of completion** • **Importance of recording 'live' i.e. as soon as interview takes place.** • **Action** **Each CBU to provide an update report to WFC in May 2018 giving reasons for non-compliance and the action they will take. Upon receipt of the report, the WFC may request attendance from any CBU.** • **Please note that the data is pulled from both ESR and E-Rostering. The data input into E-Rostering is pulled directly from Allocate and is not transferred to ESR therefore this is not an issue of data being 'lost' between the 2 systems.** Assurance Assurance	**May 2018**

			Medical Job Planning 70% Deadline of 31.03.2018 has now passed however support to achieve sign off is still in place and dedicated work is on-going. Action - Medical Staffing Team to support Medical Director to produce options appraisal on next steps Pay Spend Full analysis is submitted to FSC monthly Projects to address pay spend are managed via Premium Pay Spend Review Group (PPSRG) Action agreed – PPSRG to submit a quarterly report to Workforce Committee, updating on progress of projects.	**<u>Escalation:</u>** **<u>Please escalate to CBUs via TOB:</u>** • **<u>The deadline has passed and it is now vital that the outstanding job plans are completed urgently. Please continue to engage with Job Planning Project Manager.</u>** Assurance	
WC/18/ 04/67	**Employee Relations Report**	**Head of HR Business Partners**	3 Suspensions 4 Actions short of suspensions 4 High risk cases escalated to the Committee	Assurance **Action:** **Letter to be drafted from Director HR & OD to Director Finance to raise specific concerns around a High Risk case – specifically about the potential employment consequence and cost to the organisation.**	
WC/18/ 04/68	**Policies and Procedures**	**Head of Strategic HR Projects**	The following policies were approved by the Committee: • Alcohol, Drug and Substance Misuse • Providing Employment References • Travel Policy • Retirement and Long Service (nb. staff side have not agreed the section on	Assurance	

			retirement but do agree with the principles of the policy)		
WC/18/ 04/69	**WHH Staff Opinion Survey**	**Head of HR Business Partners**	New, more OD focused approach. • Staff engagement event 9.05.2017 WHH A Great Place To Work CEO and Chairman to attend Invitations send out to attendees • Presentations on local results to CBUs via HRBPs in May 2018 • Presentations on local results to G2G, M2O work streams in May 2018	Assurance	
WC/18/ 04/70	**Employment Legislation Changes**	**Head of Strategic HR Projects**	Update to the Committee on key changes to employment legislation upcoming in 2018/2019	Assurance	
WC/18/ 04/71	**Engagement and Recognition Report**	**Head of Communications and Engagement**	Committee updated on: • Occupational Health led campaigns on 'Heart and Stress' and 'Heart and Activity' • Easter 'Choc Swap' • Health Kiosk – very well received and utilised • WHH Weigh Ins in partnership with Live Wire • WHH Choir – first meeting April 2018 • New discounts and benefits to staff • Head of HRBPs to work with Comms to promote Employee and Team of the Month • Comms to undertake review of badge process • Thank You Awards	Assurance	
WC/18/	**Education**	**Head of**	Approval requested for:	Assurance	

04/73	**Update**	**Education and Wellbeing**	• Clinical Simulation Strategy 2018-22 • Knowledge Evidence Services Strategy 2018-2021 • Multi-Professional Clinical Supervision Policy Committee to feedback any comments/amendments by 20.04.2018. If no amendments, Committee happy to approve.		
WC/18/ 04/78	**AOB**	**Director of HR and OD**	Liaison (the company who provide the Trust Medical Temporary Staffing booking system) have withdrawn from the regional tender exercise for a Direct Engagement system. This is a very new development and work is on-going in the HR and OD Directorate to understand the implications for the Trust.	Assurance	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/05/41**
SUBJECT:	**Senior Information Risk Owner Report**
DATE OF MEETING:	24/05/2018
ACTION REQUIRED	**The Board is asked to note the contents of the report**
AUTHOR(S):	Jason DaCosta, Director of IM&T
EXECUTIVE DIRECTOR SPONSOR:	Jason DaCosta, Director of Information Technology
LINK TO STRATEGIC OBJECTIVES:	SO3: To deliver well managed, value for money, sustainable services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.3: Clinical & Business Information Systems
	BAF3.3: Clinical & Business Information Systems
	BAF3.3: Clinical & Business Information Systems
STRATEGIC CONTEXT	This assurance report is provided on behalf of the Senior Information Risk Owner who has executive responsibility for information risk and information assets. In order to demonstrate compliance with the NHS Digital Data Security and Protection Toolkit standards and to ensure the Board is adequately briefed on information risks it is necessary to provide a report detailing identified information risks and progress against the Data Security and Protection Toolkit standards more generally. The Senior Information Risk Owner is required to act as an advocate for information risk on the Trust Board and is responsible for providing appropriate Information Governance content for inclusion in the Quality Account Statement and the Annual Report.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides summarises the salient developments within the Information Governance agenda including: • Results of the 2017/18 MIAA IG Assurance audit • General Data Protection Regulation

	accountability principle and extant risks. GDPR is enforceable from May 25TH 2018. • The newly released Data Security and Protection Toolkit which requires a baseline submission in October 2018 • The implementation of the Network and Information Systems Directive (NIS) which was adopted by the UK in May 2018 Cyber security updates and actions taken in response to security updates released by NHS Digital	
RECOMMENDATION:	The Board is asked to note the contents of the Senior Information Risk Owner Report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Senior Information Risk Owner Report	AGENDA REF:	WHHFT/IG&CRSC/18/025

1. BACKGROUND/CONTEXT

In order to demonstrate compliance with and to ensure the Board is adequately briefed on information risks it is necessary to provide a report detailing identified information risks and progress against the Data Security and Protection Toolkit standards.

The NHS Digital Data Security and Protection Toolkit replaced the Information Governance Toolkit in April 2018. The DSP Toolkit is a self-assessment tool which enables organisations to measure performance against the National Data Guardian's ten data security standards. It will also provide the means to measure progress against key areas of the General Data Protection Regulation (GDPR) and the EU directive on the security on Networks and Information Systems (NIS Directive).

2. KEY ELEMENTS

Item	Key Points
MIAA IG Assurance Audit 2017/18 (Phase 2) & Final Report	• The MIAA Information Governance Assurance report was finalised on 12th March. The assurance level provided was significant assurance. • MIAA agreed with the evidence provided for 13 of the 15 standards audited. Two standards relating to Clinical Coding and an assessment against NICE guidance relating to information sharing could not be substantiated due to audit results which were not available at the time of IG assurance audit.
General Data Protection Regulation (GDPR)	• The Data Security and Protection Requirements self-assurance web form was submitted to NHSI to confirm that by May 2018 a documented plan will be available to detail how compliance with GDPR and the UK Data Protection Act will be achieved. • A key provision of GDPR is the

	principle of 'accountability'. WHH must be able to demonstrate compliance with the GDPR principles and in particular that we have appropriate technical and organisational measures in place. For the Trust, the principle demonstrations of compliance are: ➢ Submission and attainment of requisite standards within the Data Security and Protection Toolkit. ➢ Extensive existing policies and procedures associated with the IG agenda which are currently being updated to reflect specific requirements of GDPR. ➢ Review of the Information Asset Register and the procurement of a bespoke system to manage assets and information flows. ➢ Development of a new subject access system to manage requests for access to health records in line with new timescales defined within GDPR. ➢ Development of new privacy notices defining what data we process for both patients and staff. ➢ Defining the legal basis for the processing of data for both patient care and the management of data for employment purposes. ➢ Contacting all the individuals/data subjects on the WHH charity database to offer opt-out/unsubscribe

	options as required by GDPR. ➢ Issuing information to staff in relation to 72 hour information breach notification in order to build upon existing processes for data breach reporting in line with GDPR requirements. ➢ Demonstrating Privacy by Design principles by embedding processes whereby a Data Protection Impact Assessment is completed in cases where new IT systems are implemented. ➢ Nominating a Data Protection Officer (DPO) as required by GDPR. • The Trust's IT Team have secured a newly developed IT system to record assets that contain person identifiable data and records of information flows. The system has been designed to assist with GDPR compliance and has recently been purchased by three local NHS Trusts. • Risks relating to ongoing GDPR compliance are available on the Datix system. Key compliance risks relating to GDPR are currently comprised of: ➢ Incomplete information flow mapping ➢ Difficulty in maintaining IT asset registers ➢ Identification of data processors and resource issues for ongoing compliance with the wider Information Governance (Data Security and Protection) agenda.
NHS Digital Data Security and Protection Toolkit	• The successor to the Information Governance Toolkit, the Data

	Security and Protection (DSP) Toolkit went live in April 2018. This is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy. • The Toolkit has been developed in response to The NDG Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017. • The Toolkit will be used to measure ongoing compliance with the General Data Protection Regulation and the resulting UK Data Protection Act • The first baseline submission of the Trust's position via the DSP Toolkit will be made in October 2018
NIS Directive	• The NIS Directive will significantly expand the scope of cyber security regulation in the UK • EU Member States will implement financial penalties similar to that of the GDPR (General Data Protection Regulation) for incidents that impact on service continuity
Cyber Security Preparedness	• An IT Technician has been deployed to the Server Team in order to apply critical security patches. In addition the use of each server and the data it holds will be documented. • Desktop PCs and laptops are now automatically updated with security updated • WHH Firewall renewal and enhancements are 90% complete. • The new Firewall product will provide more functions and greater security. In particular it will provide the ability

	to scan incoming files against a Global Threat Database to categorise the file as safe or malicious

Current Board Assurance Framework Information Governance/Cyber Security Risks

Strategic Objective 1	**Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Director of IM&T**
	Operational Lead **Information Governance Manager**
	Assurance Committee: **Quality Assurance Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**4**

Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Data Security and Protection Toolkit Returns (NHS Digital) • MIAA Cyber Security baseline • Firewall Health Check	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Ongoing effectiveness of GDPR related processes and policies in response to MIAA GDPR readiness assessment • Effectiveness of Trust server estate patching in response to security alerts • Effectiveness of controls in relation to the resilience of the Trust's IT infrastructure, particularly in light of the demands of the 2018 EU NIS Directive • Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements
Assurances *(How do we know if the things we are doing are having an impact and can we* *validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Cyber Essentials Plus Certification Audits • Reporting to Information Governance and Corporate Records Sub-Committee and Quality Committee. • MIAA Annual Data Security and Protection Toolkit Assurance Audit (significant assurance in 2018)	**Mitigating Actions** *(What more should we do?)* Restructure of IT Team to allow for an information security role. **IT Manager – 30.06.2018** Report on status of Cyber Essentials Plus certification **IT Manager – 30.06.2018**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	**Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by the lack of resources resulting in the areas of data protection non-compliance**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Director of IM&T**
	Operational Lead **Information Governance Manager**
	Assurance Committee: **Quality Assurance Committee**
	Date to be reviewed **Monthly:**
Initial Risk Rating (1-25)	**9**
Impact (1-5)	**3**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* ▪ Controls and assurances identified in readiness assessments and action plan. ▪ Progress reporting to the Quality Assurance Committee	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Incomplete information flow mapping. • Difficulties in maintaining asset registers and lack of resources (1 staff member) to maintain compliance with requirements of general data protection regulations on a long terms basis. • Identifying data processors and varying contracts

Assurances *(How do we know if the things we are doing are having an impact and can we* *validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* ▪ Progress reporting to the Quality Assurance Committee	**Mitigating Actions** *(What more should we do?)* • Restructure of IT Team to allow for an information security role. **IT Manager – 30.06.2018** • Report on status of Cyber Essentials Plus certification **IT Manager – 30.06.2018**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**3**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation**
Risk Source: Escalated from risk	**Exec Lead: Director of IT**

assessments	**Operational Lead** **CCIO** **Head of Information**
	Assurance Committee: ePR Programme Board
	Date to be reviewed: 15/03/2017
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Anti-virus/anti-spam measures deployed on servers and desktops. The McAfee product used is due for review/renewal in September 2017. Capital funds allocated for this purpose. • Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network. The Stonegate Firewall product is due for renewal in March 2018. Capital funds being sought as part of improvements to the overall security suite. • Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis. • Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets. • Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN).	**Gaps in Assurance** *(What additional assurances should we seek?)* • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment. • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls. • Routine, quarterly reporting of attacks to the Information Governance and Corporate Records Sub-Committee

Data loss in the event of a Cyber-attack would be minimised due to the replication of data. • Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance protection against circa 80% of Cyber-attacks. • Removal of obsolete operating systems (eg Windows XP) and automatic patching of critical updates offered by Microsoft. Removal of XP operating system across WHH continues and three tier patching regime is proposed	
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Cyber Essentials network penetration testing to be completed as soon as possible. This will provide evidence that robust protection is in place. • Evidence that the WHH network wasn't infected during the recent Cryptolocker cyber-attack can be provided MIAA have been provided with evidence that patching of operating systems is carried out. Significant assurance awarded. • MIAA Information Governance assurance audit 2017-significant assurance awarded.	**Mitigating Actions** *(What more should we do?)* • Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware **Director of IT/Director of Finance – end April 2018** • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan **Director of IT – end July 2017 moved to end March 2018** • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. **Director of IT – end July 2017 moved to end November 2017** • Ensure upgrade of security systems such as web filtering, anti-virus and

	firewalls – development of a plan **Director of IT – end July 2017 moved to end March 2018** • Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training **Director of IT – ongoing** • Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee **Director of IT – ongoing**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Information Asset Register IT System developed by the Walton Centre will be procured in order to address gaps in long term GDPR compliance. The system can be used to maintain an up-to-date IT Asset register, link assets to information flows and define the legal basis for data processing which are key areas that need to be improved. This will be completed by the IT and Information Governance Managers respectively.

4. IMPACT ON QPS?

The quality of patient data may be impacted if best practice Information Governance procedures are not maintained. The sustainability of WHH services relies upon the availability of its IT infrastructure and the confidentiality, integrity and availability of personal data processed at WHH.

5. MEASUREMENTS/EVALUATIONS

Monitoring of compliance with NHS Digital Information Governance policy takes place as part of audits conducted on an annual basis as part of the Trust's internal audit programme.

Monitoring of compliance with national Information Governance policy, the National Data Guardian's 10 data security standards and the General Data Protection Regulation will be carried out through the completion of Information Governance Toolkit returns of NHS Digital's newly developed Data Security and Protection Toolkit which replaced the Information Governance Toolkit in April 2018.

The Trusts compliance with Cyber Security standards will be assessed against the Cyber Essentials Plus standard in July 2018.

6. TRAJECTORIES/OBJECTIVES AGREED

The Data Security and Protection Toolkit baseline assessment for 2018/19 to be submitted to NHS Digital in October 2018.

7. MONITORING/REPORTING ROUTES

Information Governance and Corporate Records Sub-Committee reporting to Quality Assurance Committee

8. TIMELINES

GDPR-enforceable from May 25th 2018
Data Security and Protection Toolkit inaugural submission-October 2018
EU Network and Information Systems (NIS) Directive-Operators of essential services (OES) required to comply-November 2018

9. ASSURANCE COMMITTEE

Quality Assurance Committee

10. RECOMMENDATIONS

The Board is asked to note the contents of the report.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/05/42**	
SUBJECT:	**CQC Update report**	
DATE OF MEETING:	May 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • CQC performance is shown in this report • An update of assurances – use of internal audit and also a Mock CQC is included within the report • An analysis of current compliance with the fundamental breaches is included within the report	
RECOMMENDATION:	Discuss and note the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM 18/05/42

1. BACKGROUND/CONTEXT

The Trust received its CQC report in November 2017, following the inspection in March 2017.

An action plan has been developed, which is being overseen by the Trust's Getting to Good Steering Group.

The following report gives an update of the action plan progress to date, and an analysis of work that has been undertaken against the fundamental breaches that were highlighted within the report.

2. KEY ELEMENTS

2.1 CQC action plan performance

The following are key points relating to the CQC action plan.

- There were initially 230 actions on the CQC action plan when this was reported to the Board of Directors in March – this has increased to 260, as due to work commencing, additional actions have been determined. For example some actions are 'to review' or 'to audit' and therefore further actions have been identified.
- At the time of writing this report (16th May 2018) 198 actions are due to be completed by end May. To date the Governance Department and Executive Leads have received and reviewed 129 reports. The overall performance is shown below:

Status Description	However	Must	Should	Grand Total
Amended date agreed	4	2	2	8
No report provided	11	4	5	20
On Track	27	8	6	41
Report completed - Compliant	54	14	20	88
Report completed - further evidence requested	23	10	8	41
Grand Total	**119**	**38**	**41**	**198**

- The Governance team/Executive Leads have seen robust evidence for 88 reports due by end May 2018, and can sign these off as compliant. 41 have been reviewed requesting further evidence.

The following table shows performance against action type.

Action Type	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	No report provided	Grand Total
However	54	24	55	8	11	152
Must	14	10	18	5	4	51
Should	21	8	18	5	5	57
Grand Total	**89**	**42**	**91**	**18**	**20**	**260**

The following table shows action by core service.

Row Labels	Amended date agreed	No report provided	On Track	Report completed - Compliant	Report completed - further evidence requested	Grand Total
Children and Young People		1	4	7	1	13
Critical Care	2	2	14	11	5	34
End of Life		2	2		1	5
Maternity and Gynae	3	5	18	19	13	58
Medical Care (inc Older People's care)	3	4	22	6	11	46
Outpatients and Diagnostic imaging	3	2	12	23	4	44
Surgery	2	2	9	13	3	29
Trustwide	4	1	5	3	1	14
Urgent and Emergency Care	1	1	5	7	3	17
Grand Total	**18**	**20**	**91**	**89**	**42**	**260**

2.2 CQC action plan assurance

89 actions have been achieved and rated as compliant to date. These include:

- Putting in place critical care multi-disciplinary governance structures
- Ensuring backlog of open incidents in critical care is reviewed
- Undertaking a review of nurse staffing and ensuring that action is undertaken
- Provision of dedicated pharmacy support for paediatric services
- Undertaking a review of play therapy within the Trust
- A review of medical handover has been undertaken, with clear processes and a review of the environment to ensure this is done effectively
- Audit of consent process been undertaken in endoscopy
- Dedicated obstetric staff for the elective caesarean list

- Information governance storage audit undertaken Trustwide with an options appraisal developed to improve storage of records within the Trust
- A full competency review for community midwives and evidence provided that competencies are in place
- Local Standards for Invasive Procedures (LocSSIPs) in place within Interventional radiology and being audited showing high compliance
- Audit of patient not attending outpatients undertaken, with agreed actions identified
- A review of outpatient clinics – environment and furnishings at Halton – with all actions taken
- Child friendly work in theatres completed
- Emergency Department room for patients who are awaiting mental health assessment fully refurbished, with full compliance to Royal College of Psychiatrist standards

Mersey Internal Audit Agency will be auditing compliant cations, along with the Clinical Governance Department, to ensure actions are embedded.

In addition the Chief Nurse and Clinical Governance Department is currently planning a Mock CQC inspection, where we will invite clinical experts from other Trust and partners to come in and peer review our practice, using information from our regulators and our own governance information to develop Key Lines of Enquiry. This Mock CQC assessment is planned to take place in July 2018.

2.3 Fundamental breach Analysis

Within the Trusts CQC report, there were a number of fundamental breaches listed within the CQC report. Appendix 1 of this report outlines the breaches and position, with actions taken to date.

As evident, there is still further work to do regarding fundamental breach actions.

2.4 CQC Risk Assessment

A risk has been elevated to Strategy Risk Register following discussion at Risk Review Group and Quality Assurance Committee.

Risk	**Failure to ensure timely delivery of Getting to Good action plan, caused by potential lack of capacity and resource resulting in an organisational risk of not attaining a rating of 'Good'**
Controls and assurances	▪ Development of a getting to Good Action plan ▪ Getting to Good Steering Group chaired by CEO, reporting to Quality Assurance Committee and Audit Committee ▪ All core services rated Requires Improvement being overseen by an allocated Executive Director ▪ Improvement workstreams in place, engaging clinical staff ▪ Enabling strategies in place e.g. Organisational Development ▪ Ring fencing capital monies to ensure support for CQC actions (c£0.5 million) ▪ Getting to Good Steering Group meetings scheduled monthly ▪ Reporting function in place- led by Clinical Governance, supported by Transformation team ▪ Triangulated data being scrutinised – NHSI/CQC Insight report ▪ Trust Board have approved a business case to increase establishment of nurse staffing in the Trust following an acuity review, which will ensure must do actions regarding staffing are delivered
Gaps	▪ Capacity in the system to deliver a high number of actions – linked to significant

	operational pressures and competing priorities ▪ Financial pressures ▪ Staffing pressures ▪ Cultural change required in some areas ▪ Gaps in compliance in Must Do/Should Do actions ▪ Use of Resource assessment may be difficult with current financial pressures
Actions	Identify where there are priorities for additional capacity and ensure that this is flagged **Executive Director Leads- end June 2018** Where there are significant financial impacts from delivery of CQC action plan, (either capital or revenue) ensure that these are flagged to Director of Finance **Executive Director Leads- ongoing** Ensure there is an implementation plan for recruitment and retention, following on from investment in nurse staffing **Chief Nurse- end May 2018** Ensure that there is a plan developed for the Cultural and Organisational Development workstream, focusing in on areas for improvement (aligned to staff survey) **Director of Workforce and OD – end May 2018** Ensure a compliance report of Must Do/Should Do actions is given at every Getting to Good Steering Group meeting **Director of Governance – April 2018 onwards** Ensure that a workstream and plan is developed for Use of Resource assessment reporting into the Trust Getting to Good Steering Group **Director of Finance – end May 2018**
Residual Risk score	**12** Impact 4 Likelihood 3

3 RECOMMENDATIONS

Trust Board are asked to discuss and note the

- CQC action plan progress and update
- The update on fundamental breaches

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 – Fundamental Breach Action Updates

To note – RAG rating will move to green when evidence/assurance is given that we have sustained actions in place.

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
Regulation 11- Consent and Mental Capacity	Action was put in place at the time of the CQC assessment and after, regarding training and increased surveillance. An audit of MCA and consent is being presented to G2G Steering Group April 2018 to assess current compliance Update May 2018 – audit undertaken December 2017, which showed poor compliance in some areas. Training is being rolled out - Trust still has training gaps, which are being addressed. Spot check audits to be undertaken as part of nursing walkrounds – a further Trustwide audit being undertaken – which is reporting to Getting to Good meeting July 2018	Chief Nurse	
Regulation 12 – medical devices training	A medical devices training database has been purchased, inventories and training needs analysis are underway. Trust Medical Devices Policy has been approved. Update on paediatrics medical devices to be given to April G2G Steering Group Update May 2018 - this is a Trust wide issue and a workstream is in place. A risk has been escalated to Board re this via Strategic Risk Register. Action plan in place- starting to be implemented.	Chief Nurse	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
Regulation 12- checks in theatre Halton to prevent Never Events	We have implemented training, observational audits and are now auditing 100% of WHO checklist completion every month. We are also completing an assurance framework against the new Never Events list published to look at our policies and controls in place. This is being presented to PSESC March 18. Update May 2018– NatSSIPs/LocSSIPS being presented to May Patient Safety and Effectiveness Sub Committee. This is amber/green	Medical Director	
Regulation 12 – checks of equipment trollies and anaesthetics machines	Additional controls were put in place at the time of the inspection and audits are being undertaken – presented at April Getting to Good meeting Update May 2018. Green in theatres (6 months' worth of evidence given, showing 100% compliance) Maternity not showing 100% compliance – increased scrutiny and oversight at Getting to Good meeting	Chief Nurse	
Regulation 12 – equipment and checks in radiology	1. CR reader in Halton – resolved 2. IRR99 compliance – audit presented at G2G Steering Group March 2018 showing 97% compliance (significant improvement) – not closed as not 100% compliant – further audits being undertaken 3. Ultrasound machines in radiology – resolved	Chief Operating Officer Medical Director	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	Update May 2018 – 2 radiation safety breaches still not 100% compliant (warning lights and handover of equipment) – significant improvement but still breaching. Other 4 breaches- audits show 100% for last 3 months. increased scrutiny and oversight at Getting to Good meeting	(radiation safety lead)	
Regulation 13- Safeguarding training	A review of safeguarding training has been undertaken, with each CBU to report to April G2G meeting a trajectory for compliance Additional training capacity being commissioned Update May 2018 – training compliance showing improvement – need to assess where requires further improvement work. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly.	Chief Nurse	
Regulation 15 – premises (radiology, gynae, maternity)	A review and options appraisal is underway regarding maternity and gynae. Radiology review is also underway. Halton – actions taken at the time and audit reports being presented to Getting to Good Steering Group in April to ensure sustainable actions in place • Treatment couches were not wiped down in between patients in outpatient treatment rooms. • Portable x-ray equipment was found to be covered in a thick layer of dust.	Chief Operating Officer	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	• Both phlebotomy chairs in outpatients were broken: one had cracked covering on the armrests and the other had a large tear in the seat covering. • Clinic areas were congested and there was inadequate seating for some areas, with patients needing to stand in corridors whilst waiting. Update May 2018 – need to review environmental work and determine preferred options and mitigations for Induction of Labour and Radiology. Reviews have been undertaken and papers being written for presentation at Getting to Good Steering Group.		
Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely	a) The risk processes have been reviewed and Datix web for risk is being rolled out, with training in place. All risk registers are due to be on the system by end April 2018. b) There is a records audit being undertaken reporting to Getting to Good Steering Group. There is an IG audit underway and results, with an options appraisal regarding records storage which will be presented to Getting to Good Steering Group Update May 2018 – risk registers on Datix – will be reviewed in next 4 weeks to ensure quality checked	Chief Nurse/Medical Director /Director of Informatics	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	Information governance – storage audit undertaken. Need to implement preferred option following discussion with nursing team. Need to have training/awareness campaign re information governance, which has been requested by Getting to Good Steering Group. Need to undertake a clinical audit regarding records - storage audit component undertaken. Information governance is amber/red.		
Regulation 18 – a) staffing b) APLS training for staff	a) Staffing - Acuity and dependency review been undertaken and business case being presented to the Board of Directors for nurse staffing Medical staffing meeting and actions implemented Audit of staffing escalation underway The neonatal unit did not have sufficient numbers of suitably qualified staff. There was no dedicated paediatric pharmacist. A review of neonatal staffing underway. Paediatric pharmacy provision addressed. b) APLS training – additional capacity for APLS training in paediatrics and critical care and recovery in theatres. An update being presented to April G2G Steering Group Update May 2018 – nurse staffing business case approved – need evidence	Chief Nurse/Medical Director	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	of implementation plan. Staffing escalation processes have been audited and a survey undertaken- awaiting report, which is being presented to Getting to Good Steering Group in June 2018. Need report of actions taken to improve medical staffing. Re APLS – recovery, paediatrics, critical care still not compliant – clarification of standards raised to CQC as there is some confusion as to the standards assessed. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly.		

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/05/43**	
SUBJECT:	**Quality Strategy and Quality Academy Update**	
DATE OF MEETING:	May 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • The Trust Quality Strategy is presented to the Trust Board of Directors for approval • The Trust Quality Academy update is given in this paper	
RECOMMENDATION:	Discuss and approve the Trust Quality Strategy and note the Quality Academy Update.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	May 2018
	Summary of Outcome	Approved Quality Strategy
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Quality Strategy and Quality Academy Update	AGENDA REF:	BM 18/05/43

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

2.1 Quality Strategy

The Trust Board of Directors are asked to approve and ratify the Trust's Quality Strategy. This Quality Strategy has been developed with stakeholders, as part of the Trust's Quality Strategy Day, held at the end of 2017.

It also incorporates priority areas flagged by CQC, as part of their assessment process in 2017, and in addition integrates the work that the Trust has been doing with NHS Improvement, as part of their 'Getting to Good' Programme setting out the Board's vision and pledges to support delivery of this strategy.

As part of Getting to Good and the Well Led assessments, Boards are expected to set out their commitments to Quality and Quality Improvement. This is what is included as the Board's pledge.

The Board are committed to delivering this Quality Strategy and the aim is to ensure that, like all the best organisations that focus on constant improvement, innovation and adaptation, the Board pledge to:

- Set out the Vision for staff and patients regarding Quality within the Trust;
- Ensure that the Leadership and Culture of the Trust focuses on Quality of care for patients;
- Invest in developing capability for staff in Systems and Quality Improvement;
- Help support a system where staff know what the direction of the Trust is, so that leaders can develop their business planning and delivery;
- Put in place a system within the Trust where Service and Quality Improvement will be facilitated and enabled by support services.

The Board Setting Direction for Quality Improvement

Below sets out the Board's Vision for Quality Improvement,

- We want to ensure that we know how good we are and where we stand relative to the best and that we outline for staff our vision.
- We ensure then we engage staff so that in order to deliver our vision, we engage them to develop our Clinical Strategy for the Trust.

- Our enabling strategies are in place to support delivery of that Clinical Strategy e.g. workforce, finance and this Quality Strategy.
- We ensure that due to our governance systems, we know where our risks are and that we have plans to ensure we manage and reduce our risks.
- We ensure that we have Quality Improvement skills in the Trust so that when we need to make improvements, we have the people who know how to do this and who are empowered
- We have robust data and information that can show tests of change and the effectiveness of improvement.

As part of implementing this strategy, the Clinical Governance & Quality Team will be working with clinical leads and the Communications Team over the forthcoming months to ensure this is communicated widely in the Trust.

2.2 Quality Academy Update

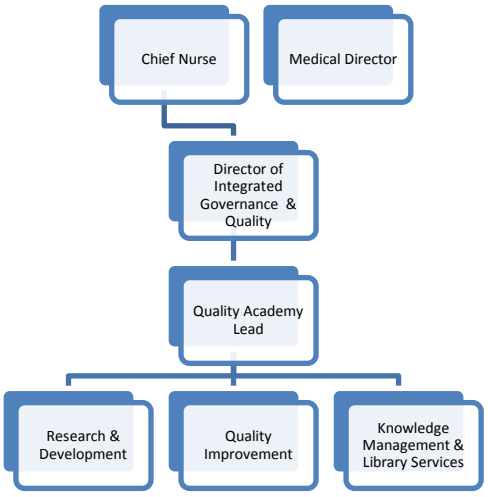
A key enabling tool of the Quality Strategy within the Trust was the development of a Quality Academy. The Board have previously received information regarding how this was being developed in the Trust. Since then the following has been undertaken:

1. A full consultation exercise has been completed across staff in the Clinical Governance Department, Research & Development and Library Services. This consultation concluded end April 2018 and the staff moved over into the Quality Academy in May 2018. Roles have been created in the Quality Academy as follows:

    - Quality Academy Manager
    - Quality Improvement Facilitators (x2)

    There has been no resource allocated to this – therefore roles were created from redesign and is cost neutral.

The Quality Academy structure is shown below:



2. The Trust met with AQUA to support the development of a training needs analysis and training provision for Quality Improvement (QI) within the Trust and secured Advanced Practitioner Quality Improvement Training places for this year. In addition AQUA are going to support the development of further in house training and provide some free Quality Improvement coaching from the Directors.

3. Quality Academy Board terms of reference have been developed, with the inaugural meeting currently being planned.

4. A brochure for the Quality Academy and social media platforms are currently in development.

5. A Quality Improvement Toolkit is being developed to support staff understand and apply Quality Improvement methodology. Drivers diagrams are being established for all the identified Quality Account Quality priorities and leads will be focused to have advanced QI training.

6. An innovation forum is in the process of being developed.

The Quality Academy will launch the same time as the Quality Strategy across the Trust in June.

3 RECOMMENDATIONS

Trust Board are asked to approve The Trust Quality Strategy and note the update of the Trust Quality Academy.

Warrington and Halton Hospitals
NHS Foundation Trust

WHH Quality Strategy 2018-2021

Everyone in Healthcare has two jobs when they come to work; to do their work and to improve it. This is the essence of Quality Improvement Paul B. Batalden

Welcome

Welcome to Our Quality Strategy

We would like to welcome our staff, patients, carers and stakeholders to our Quality Strategy. This Strategy sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality, in terms of equipping our staff with the right policies, processes skills and environment to deliver quality patient care, every day.

It is important to recognise we have made many improvements to the safety and quality of patient care. However, there is recognition that we have further to go on our journey of continuous improvement.

In the words of Paul B. Batalden:

"Everyone in Healthcare has two jobs when they come to work; to do their work and to improve it. This is the essence of Quality Improvement."

Our aim is to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The objectives and commitments set out in this strategy will be reviewed on an annual basis to ensure our plans and key projects support the delivery of this strategy in practice.

We look forward to working with staff to support the implementation of this strategy. Together we will report measurable success in our Trust Annual Quality Account and commit to celebrating your achievements year on year.

Thank you for all your hard work.

Prof Simon Constable and Kimberley Salmon-Jamieson
Executive Medical Director and Chief Nurse

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Foreword

Quality

We will… **Always put our patients first** through high quality, safe care and an excellent patient experience

We are proud to present our Quality Strategy which is built on the foundations of our Quality, People and Sustainability Framework (QPS).

Recognising that our patients and staff deserve nothing less than the very best, we have embarked on an organisation-wide change journey called '*Getting to Good, Moving to Outstanding'*. We have updated our strategy to reflect our 'Outstanding' ambitions and our mission has changed to '*We will be OUTSTANDING for our patients, our communities and each other'.*

We are remedying our shortcomings, we are investing (where appropriate) in our aging estate to ensure it is an acceptable environment to treat patients; we will launch our Quality Academy, we are embedding the highest quality and safety of care at every level and throughout every staff group - so that everyone knows how and is empowered to make a difference for our patients – every time.

We believe this is the single most important thing we can do for our patients and I have every confidence in our amazing Team WHH to embrace this task so that together we can take the Trust to where it deserves to be – *Moving to Outstanding*.

Mel Pickup
Chief Executive

You must be the change you wish to see in the world.
Mahatma Gandhi

Our Quality Pledges

Perfection is not attainable. But if we chase perfection, we can catch excellence.

Vince Lombardi

Our Quality Pledges

This strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be.

With this care model in mind we use the following three priority domains:

- Patient safety
- Clinical effectiveness
- Patient experience

Our Quality Pledges

Patient Safety

We are committed to developing and enhancing our patients' safety and learning culture where quality and safety is everyone's top priority

Our Patient Safety Pledge

We will have **safe systems** of work in place – all staff will work with robust clinical policies, procedures, safe equipment, have training to enable them to competently their job and work within appropriate Health & Safety processes;

We will ensure that we **minimise harm for patients**, specifically pledging to deliver:

- A 20% reduction in falls for our patients who stay in hospital.
- 100% medicines reconciliation when patients come into hospital and promotion of safe prescribing and administration of medicines.
- A 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway.
- 100% of patients having sepsis screening and being treated appropriately.
- 100% patients to have a Venous Thromboembolism (VTE) assessment and to have appropriate treatment.

*We will have systems in place to ensure that we are a **learning organisation** and we will foster a culture of continuous learning and Quality Improvement.*

Clinical Effectiveness

Clinical effectiveness is about ensuring practice is based on evidence so that we do ‘the right things the right way to achieve the right outcomes’ for our patients

- Reduce DTOCs to no greater than 3%
- Reduce readmissions within 30 days for patients >65 to no greater than 12.5%
- Understand variance in clinical outcome measures across all specialities, measure and agree improvements
- Number of Quality Improvement projects successfully completed
- Increase number of staff with quality improvement training via Quality Academy

Our Clinical Effectiveness Pledge

We will ensure that we providing care that is **evidence based** and that we adopt a culture of innovative and research and development within the Trust, to always look to provide the best for our patients.

We will ensure that we are focused on **outcome**s for patients and that are benchmarking/peer reviewing ourselves against the ‘best in class’.

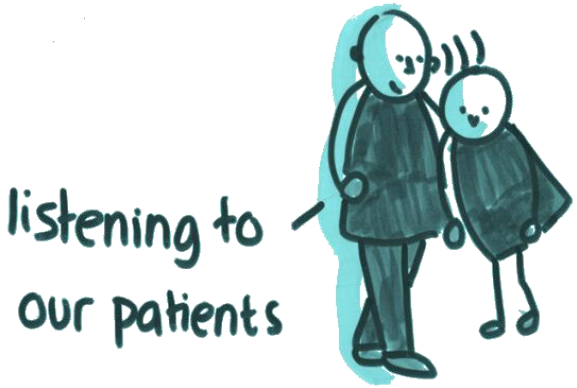
We will ensure that we foster a culture of **Quality Improvement** and we provide our staff with the information, training, systems and empowerment to make changes to our services to benefit our patients and public that we serve.

Our Quality Pledges

By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is the norm.

Our Patient Experience Pledge

- Increase in Friends and Family Test scores to ensure all specialities meet or exceed national benchmarks
- Improve across all indicators in the inpatients survey
- 10% reduction in formal complaints



Listening, learning and leading change
We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services

Communicating in line with our values
We believe our patients should be first in everything we do and we promise to communicate based on what matters most to you

Partnership Working and needs based care
We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay

Simplifying patient focused processes
We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.

How we will deliver our Ambitions and Pledges

Our WHH values

In line with our Trust values, we will **Work Together** in **Excellence**, commit to being **Accountable and Responsible** as **Role Models** and **Embrace Change** for each of the quality priorities.

Achieving our ambitions

We agree that to achieve this Quality Strategy, we need to focus on areas for priority every year.

Working Together | Excellence | Accountable | Role Model | Embracing Change

Our Quality Pledges

Board Commitment

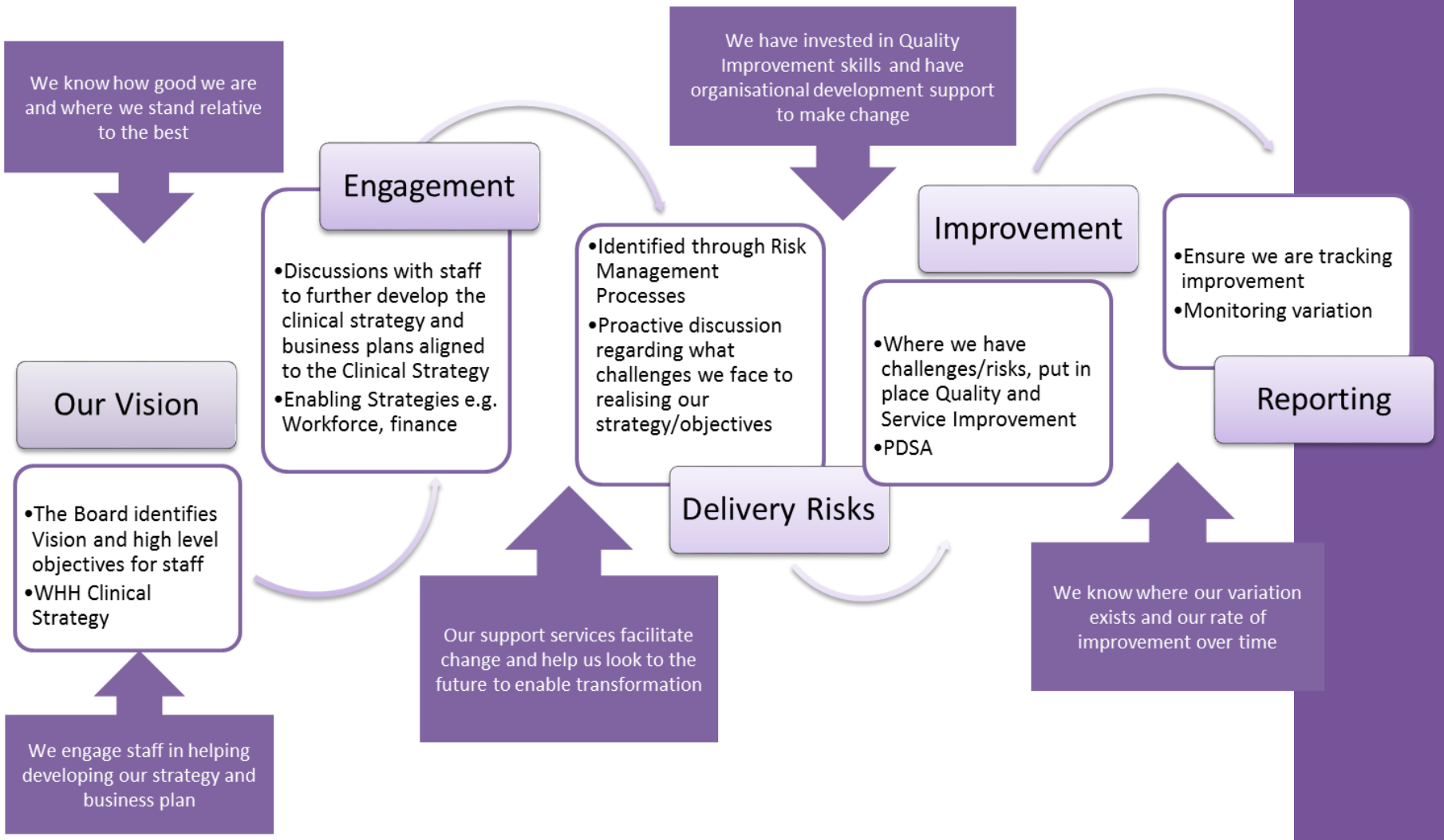
The Trust's Board of Directors

Pledges

- The Board are committed to delivering this Quality Strategy and the aim is to ensure that, like all the best organisations that focus on constant improvement, innovation and adaptation, the Board pledge to:
- Set out the Vision for staff and patients regarding Quality within the Trust;
- Ensure that the Leadership and Culture of the Trust focuses on Quality of care for patients;
- Invest in developing capability for staff in Systems and Quality Improvement;
- Help support a system where staff know what the direction of the Trust is, so that leaders can develop their business planning and delivery;
- Put in place a system within the Trust where Service and Quality Improvement will be facilitated and enabled by support services.

Direction Setting

- We want to ensure that we know how good we are and where we stand relative to the best and that we outline for staff our vision.
- We ensure then we engage staff so that in order to deliver our vision, we engage them to develop our Clinical Strategy for the Trust.
- Our enabling strategies are in place to support delivery of that Clinical Strategy e.g. workforce, finance and this Quality Strategy.
- We ensure that due to our governance systems, we know where our risks are and that we have plans to ensure we manage and reduce our risks.
- We ensure that we have Quality Improvement skills in the Trust so that when we need to make improvements, we have the people who know how to do this and who are empowered
- We have robust data and information that can show tests of change and the effectiveness of improvement.



'Transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses and other staff in improvement programmes'. (Ham, 2014)

Quality Improvement

Quality Improvement Training

In order to enable delivery of this Quality Strategy the Trust is launching a **Quality Academy**.

The key objectives for the Quality Academy are to help foster a culture of learning and continuous improvement by:

- Ensuring staff are trained in Quality Improvement methodology, for example 'Plan, Do, Study, Act' (PDSA) methodology;
- Encourage innovation and increase Research & Development profile within and outside the Trust;
- Support us to use knowledge management to move toward best practice in all of our services

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

Quality is not an act, it is a habit." Aristotle

Practice the philosophy of continuous improvement. Get a little bit better every single day. ***Brian Tracy***

Quality Improvement Methodology

The Trust will use a variety of methodologies dependent on the need. For example:

Example	Suggested QI method
A capacity and demand study reviewing elective sections within the Trust and ensuring productivity	LEAN/Failure Modes and Effects Analysis
Outlier for outcomes in a national audit	Cause and Effect Plan Do Study Act to influence change
Understanding whether we are an outlier for anything	Information shown on a control chart to understand variance and monitor improvement.

There will also be a training programme developed within the Trust based on the model shown, whereby there will be differing levels of Quality Improvement training given to individuals within the Trust. All staff will receive Foundation Level training, as part of induction.

Engagement

Key to ensuring that we are addressing the right issues with regard to the service we provide is to actively seek, listen and act on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy therefore will link to work being undertake with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

Also the Quality Academy will work with Workforce & Organisational Development, to ensure that staff can engage in the agenda and are given the empowerment and support to make improvements in their work.

Our Quality Priorities 2018-19

These quality priorities have been developed from information from our patients, public, our clinical governance systems and from our partners and regulators.

Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures

E-Prescribing – Improving patient safety by decreasing prescribing errors and saving time and resource

Increase Incident Reporting – Ensure that we don't miss opportunities to learn from mistakes and make changes to protect patients from harm

Diagnostics – Review policies and roll out training

Ward Accreditation – To engage staff and empower leadership

Discharge – Improve the quality and timeliness of discharge summaries

Child friendly - Making adult areas within the hospital more children friendly to increase the overall experience for patients/relatives/public

Rapid Discharge Process - Improve the Rapid Discharge Process for End of Life Care patients

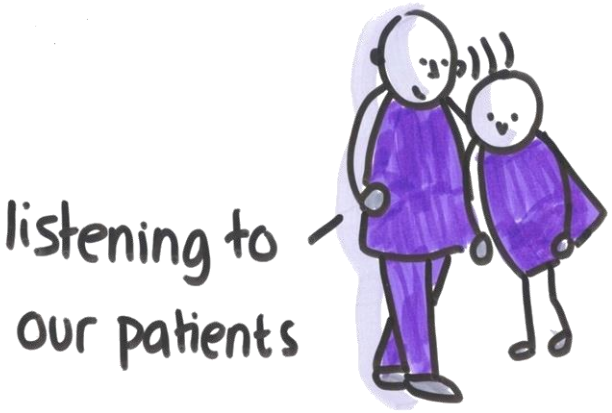
Bereavement Service - Ensure that Bereavement Services are equipped to provide a caring and compassionate service, offering *support* and reassurance, information and guidance

What will delivery of this strategy look like?

This strategy will be monitored by our Board and Quality Assurance Committee and by our public and partners by publication of our Quality Accounts, but here are examples of what success will look like

Positive Friends and Family ratings

☺ ☺ ☺ ☺ ☺



An increase in the number of no/low harm incidents as we foster an open culture of learning

Safe Policies and Processes that are being audited to provide assurance

A decrease in the number of patients falls by 20%

What will delivery of this strategy look like?

NO Never Events

All wards accredited in the new Ward Accreditation Scheme

End of Life patients being able to be rapidly discharged to ensure they pass away in a place of their choosing

Safe prescribing and administration of medicines whilst in hospital with a reduction in avoidable harm

We are WHH & We are

PROUD

to make a difference

Great things are done by a series of small things brought together.

Vincent Van Gough

With thanks

To our Patients and their Families, our Council of Governors, our Health and Social Care Partners and our amazing WHH Staff for coming together to help us develop and test this Quality Strategy.

With special thanks to artist Caroline Chappel for helping us bring it to life with her illustrations.

We are guests in our patients' lives

Don Berwick

For more information about our Quality Strategy and programmes please contact:

Clinical Governance & Quality Department Tel: 01925 662789
Warrington and Halton Hospitals NHS Foundation Trust
Lovely Lane, Warrington WA5 1QG
www.whh.nhs.uk

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/05/44**	
SUBJECT:	Approval and Utilisation of 2018/19 Deficit Support from the Department of Health.	
DATE OF MEETING:	**24 May 2018**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Karen Spencer, Head of Financial Services	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	The purpose of the report is to obtain approval from the Board of Directors, by means of a Board Resolution, for the drawdown of funds from the Department of Health to support the deficit plan for the year ending 31st March 2019 in the form of a working capital loan.	
EXECUTIVE SUMMARY (KEY ISSUES):	This document outlines the process for the Trust to secure the drawdown of deficit support from the Department of Health for the year ending 31st March 2019.	
RECOMMENDATION:	The Board of Directors is requested to delegate authority to obtain revenue support via loans to the value of £24,444k. This relates to the deficit plan for the year.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

1. BACKGROUND/CONTEXT

The purpose of the report is to obtain approval from the Board of Directors, by means of a Board Resolution, for the drawdown of funds from the Department of Health (DH) in support of the control total for the year ending 31st March 2019 in the form of a working capital loan.

2. KEY ELEMENTS

On 30 April 2018 the Trust submitted a 2018/19 deficit plan to NHS Improvement of £24,444k. During 2018/19 the Trust will apply for working capital loans to this value. This is to enable the Trust to meet its day to day working capital commitments for 2018/19.

Working capital requirements for 2018/19 will be supported by a series of Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) agreements. A new agreement will be created each time the Trust applies for a proportion of the £24,444k control total.

The interest rate therefore for each ISUCL will be 3.5% per annum. The interest rate is higher for 2018/19 as the Trust was unable to sign up to the NHS Improvement control total. Interest rates are charged as follows:

- signed up to the control total – 1.5%
- not signed up the control total – 3.5%
- if a trust is in financial special measures – 6%

The anticipated draw down schedule for 2018/19 per the plan and estimated interest is outlined below:

Month	Planned Drawdown (£'000)	Interest charge (£'000)
July 2018	9,367	246
August 2018	1,922	45
September 2018	2,924	60
October 2018	1,564	27
November 2018	1,462	21
December 2018	2,253	26
January 2019	1,262	11
February 2019	2,244	13
March 2019	1,446	4
Total	**24,444**	**454**

Due to the national timetable for submission of the final 2018/19 plan, July is the earliest drawdown date.

In line with the Trust's Scheme of Reservation and Delegation and Schedule 1 of the ISUCL agreement DH requires the Trust Board to approve the utilisation of the ISUCLs, to authorise the Director of Finance and Commercial Development to sign the loan agreements to the value of £24,444k on its behalf and to confirm the Trust's undertaking to comply with the additional terms and conditions as contained in the agreement.

3. RECOMMENDATIONS

The Board of Directors is requested to:-

(A) approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorise the Chief Executive Officer to execute the Finance Documents relating to uncommitted interim revenue support loans to the value of £24,444k to which it is a party on its behalf; and

(C) authorise the Director of Finance and Commercial Development, on its behalf, to despatch all documents and notices (including, if relevant, any Utilisation Request) to be signed and/or despatched by it under or in connection with the Finance Documents up to which it is a party.

(D) confirm the Borrower's undertaking to comply with the Additional Terms and Conditions.

The above is in accordance with the Trust's Scheme of Reservation and Delegation and Schedule 1 of an Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) agreement.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/45**	
SUBJECT:	**Progress on Carter Report Recommendations**	
DATE OF MEETING:	24th May 2018	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea Mcgee, Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.3: Clinical & Business Information Systems	
STRATEGIC CONTEXT	The purpose of this report is to update the Board of Directors on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has embraced the recommendations of the Carter Report and is already compliant with some of the key targets and performance indicators and is on track with the remaining recommendations. Future reports will include detail around progress made towards the Use of Resource work stream as part of Getting to Good, Moving to Outstanding programme.	
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report and to note future Lord Cater updates will also include updates around the Use of Resource Assessment.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS

1. PURPOSE

The purpose of this report is to update the Board of Directors on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016.

2. BACKGROUND,

In June 2014 Lord Carter was asked by the Secretary of State for Health to assess what efficiency improvements could be generated in hospitals across England.

In June 2015 an interim report was published which outlined that potentially £5 billion of operational efficiency savings could be delivered in the acute sector by 2020 by improving workforce costs, hospital pharmacy medicines optimisation and estates and procurement management.

In February 2016 the final report was published and based on the work of 32 acute Trusts, it was estimated that if "unwarranted variation" was removed from Trust spend then that £5 billion could be saved by 2020 as summarised in the table below.

Table: The breakdown of the £5 billion savings:

Narrative	**£ billion**
Improved workflow and containing workforce costs	2.0
Improved hospital pharmacy and medicines optimisation	1.0
Better estates management and optimisation	1.0
Better procurement management	1.0
Total	**5.0**

3. Progress

This paper presents the quarterly update report for quarter 4 (Appendix 1). The majority of the recommendations are either complete or are on track.

4. Use of Resource Assessment

The Use of Resource Assessment (UoRA) is carried out by the CQC and NHSI and is designed to improve understanding of how effectively and efficiently trusts are using their resources. During the next 12 months the Trust will take part in an assessment day in which executive and operational leads will evidence the Trust's progress in improving its Use of Resources. Prior to the assessment day, the Trust will submit evidence and narrative. The Use of Resource Assessment is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance each of which has a number

of key performance indicators based on model hospital data. Use of Resource is a work stream on the Trust's Getting to Good, Moving to Outstanding programme.

The Director of Finance and Commercial Development has been identified as the Executive Lead of the Use of Resource work stream. In preparation for the assessment the work stream has established a meeting structure, identified leads against each KLOE , established a terms of reference and has developed a draft dashboard which will be used to measure and report progress against the Use of Resource key metrics.

As many of the key themes between Lord Carter and the Use of Resource Assessment align, the Contracts and Performance team will produce one dashboard that incorporates all metrics. The Trust Board will receive the new 2018/19 dashboard at the end of quarter 1.

5. Conclusion

It is important to recognise that NHS Improvement considers progress and implementation of the Lord Carter recommendations as mandatory and compliance is a key feature of future governance standards as indicated in the *Single Oversight Framework*.

6. Recommendation

The Board of Directors is requested to note the contents of the report and to note future Lord Cater updates will also include information around the Use of Resource Assessment.

Andrea McGee
Director of Finance and Commercial Development
17th May 2018

Appendix 1 - PROGRESS AGAINST LORD CARTER RECOMMENDATIONS

Key

	Complete
	On track for completion
	Progress off track - plans in place to get back on track
	Progress significantly off track
	Not started/Awaiting further information/New actions parameters to be established

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 1 - NHS Improvement should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all trusts. **Lead Director:** Director of Human Resources & Organisational Development					
Development and approval of a people strategy and dashboard.	• The people strategy and dashboard has been developed and data is refreshed monthly. • The dashboard is reviewed by the Workforce committee and any areas of concern are addressed.		• Ongoing monitoring and management of the dashboard.	Trust Board, TOB, Workforce Committee	Complete
HR polices are reviewed to ensure they are clear, simple and transparent.	• The HR & OD Directorate has a policies and procedures group with management and staff side members. All HR policies are taken through this group and then progressed to JNCC followed by the Workforce committee.		• The majority of policies have been reviewed and in addition there are plans in place to look at policies which can be simplified or made clearer and to put in place guidelines and toolkits for managers.	Workforce Committee	Ongoing Monitoring
"Fit to Care" Heath & Wellbeing Strategy	• As part of national CQUIN, support for a wide range of wellbeing approaches aimed at supporting staff back into work. • A programme of exercise classes has been established. • The Trust is currently trialling a weight management clinic which is proving popular. • February, March and April's health topics focused on		• Wellbeing initiatives will continue to be offered and monitored for effectiveness. • Planning for 2018/19 flu vaccination campaign to commence.	Workforce Committee	Rolling Programme

	the different effects of stress both physically and mental. • Drop in sessions have been held for staff on healthy hearts and stress management. • The Trust has had a Wellbeing clinic on site since the beginning of a March for staff to access. Over 1000 people accessed its information on BMI, blood pressure and body fat within the first week. • Planned activity includes heath topics on exercise and movement at work and hydration.				
Development of a Workforce Streaming Programme across the North West	• The Trust continues to work with colleagues across the North West to agree unified ways or working and to reduce bureaucracy. • Key actions to date include: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • The HR Director/Deputy Director networks have agreed milestones for year 3.		• Continue time to hire reporting regionally. • Regionally agree TUPE guidelines. • Regionally agree guidelines around starting salaries on appointment. • Regionally agree processes around Occupational Health referrals.	Workforce Committee	Ongoing
Staff Opinion Survey	• The Staff Opinion Survey (SOS) closed in December 2017. The Trust response rate was 46% compared to 38% for the 2016 survey. • Results from the SOS have been received by the Trust and a proposed change in approach was presented to and approved by the Trust board in March 2018.		• An staff engagement event will take place in early May 2018.	Trust Board, TOB, Workforce Committee	Rolling Programme
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• Bullying and harassment is a key element of the Staff Opinion Survey and is measured by a number of metrics. • In the 2016 staff survey, the Trust scored either average or better than average for all metrics related to Bullying and Harassment, compared with other Trusts nationally. • The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. Links		• The Trust has performed in the upper quartile in the 2017 staff survey in relation to bullying and harassment in comparison with other Acute Trusts. The survey did highlight a need to look into the number of staff experiencing physical violence from other staff; work is ongoing to look at how this correlates with other employee relations metrics.	Workforce Committee	Ongoing Monitoring

	have been made with Junior Doctors and the People Champions as this agenda continues to embed.				
Ensure staff have regular performance reviews	• The number of staff with a valid PDR is 73.31% (February 2018) against a target of 85%. • HR Business Partners have worked with CBUs to develop a recovery plan, although this people measure continues to create challenges across clinical and non-clinical staff groups with the exception of medical workforce.		• The PDR process is being reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. Focus groups will take place with staff and management in April with recommendations taken to the Workforce committee in May 2018.	Trust Board, TOB, Workforce Committee	Ongoing Monitoring – March / April
Improving Sickness Absence	• Sickness absence was 4.82% in February 2018. • An audit has been completed on compliance with the Trust Attendance Management Policy and a number of recommendations are being implemented. • Promotion and improvement of flu vaccination uptake took place in Q3/4. • Mental Health "Train the Trainer" training is complete.		• Key actions to address this increase include: > proposals to strengthen reporting arrangements for nursing staff. > mental health first aid training to be rolled out across the Trust. > bespoke actions on areas with high levels of absence.	Trust Board, TOB, Workforce Committee	Ongoing Monitoring
Restructure of HR Directorate	• HR restructure is complete and key posts in the Senior Management Team have been recruited to.			Trust Board, Workforce Committee	Complete

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care. **Lead Directors:** Medical Director & Chief Nurse					
Care hours per patient	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board.		• Care Hours are reviewed each month as part of the IPR at Trust and CBU Level. • Data is submitted monthly to NHS(I) via the Trust Information team.	Trust Board, TOB	Ongoing Monitoring
Electronic roster and safe care module – All trusts using an e-rostering system, with the following practices being implemented: • Publishing rosters six weeks in advance, submitted to NHS Improvement • Formal process to tackle areas that require improvement and developing associated cultural change and communication plans • Implementing NHS Improvement guide on enhanced care by October 2016, to be monitored by NHS Improvement.	• Implementation of Electronic Roster & Safe Care – all core wards are now live on the system with over 50 wards or departments. • The corporate nursing team has taken over management of the e-roster team. • The e-roster team is now co-located within the patient flow team in a centralised location. • Operational capacity and demand meetings are attended by the e-roster team to ensure staffing is matched to operational demand, along with ensuring staff are deployed to areas of high acuity in conjunction with the Matron and Lead Nurse. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 2 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.		• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Theatres, Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions.	Trust Board	Ongoing development and daily monitoring with senior nurse oversight.

Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	• 2017/18 Job planning continues to progress. • 2nd Job Planning round with Allocate inc. Specialty and Associate Specialists. • 70.05% of job plans completed for 2017/18 although if we discount those who are unavailable for review due to long term absence the figure increases to 71.43%. • The project around a corporate budget for programmed activities, medical leadership, education and research, quality governance and appraisal and revalidation is nearing conclusion with all non-core SPA and non-direct clinical care PAs being transferred from the CBUs to one of four medical budgets. A meeting has been arranged meeting to discuss further. An updated draft job planning policy is progressing and has been shared with Medical Cabinet and JLNC for consideration. • The Job Planning Project Manager has established 'drop-in sessions' throughout March 2018 to support CBU Managers.		• Job planning progress will continue to be monitored on a weekly basis. • Job planning compliance is scrutinised at a weekly HR meeting when data is presented to the Deputy Director of HR & OD. • HR Business Partners are in the process of collating information from the CBUs to establish any 'hold ups' in relation to the outstanding job plans. • The draft job planning policy has been considered at a task & finish group (at the request of the JLNC) and this is now in the final stages of moving to ratification for the next job planning round. Proposed 2 sign offs for 2018/19 and 2019/20: by CBU managers/Clinical Directors (1st sign off) and again by consistency panel (2nd sign off). The timeline for future job planning rounds have been improved.	Workforce Committee	2017/18 Job Planning – final sign off March 2018.

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities. **Lead Directors:** Medical Director & Chief Operating Officer					
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level, with each trust board nominating a Director to work with their Chief Pharmacist to implement changes.	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement.		• Completed in May 2017.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA).	• Electronic prescribing and medicines administration (EPMA) business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • A project board has been established with terms of reference and schedule of meetings. • A draft project plan has been developed. • Preparatory work and testing has identified several issues for which solutions have been identified by the system supplier. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users has been received.		• A second ePMA pilot began on 26th March and is due to run throughout April, learning from this pilot will be used to inform further implementations. • ePMA will be upgraded to version 2.14 which due in April and includes several fixes and developments. • The Trust is working with the supplier on further developments to ensure flow between A&E and non-elective wards is robust. • Once the pilot phase is complete, it is expected that roll out of system to elective wards will commence during Q2/3 of 2018/19.	Trust Board/IM&T Committee	Project expected completion – March 2020

Ensuing that coding of medicines are accurately recorded.	• The JAC pharmacy system was upgraded to enable use of DM+D codes in July 2017. • Pharmacy drug files were updated where possible with DM+D codes in August 2017. • Review of and improvement of quality of data sets submitted to NHS England, CCGs & PHE completed in September 2017. • The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this the Trust is achieving current data quality targets. • A Blueteq drop in presentation day to be held in January 2018 to demonstrate the system and inform clinicians about the contractual requirements to get prior approval for the patient pathway before commencing treatment and the review process – commencing 1st April 2018.		• A meeting with NHSE's medicine management lead is to be set up to look at current issues regarding DM+D codes which the Trust believes will further improve data quality when addressed, the meeting will also help us to understand the areas that we can target to further improve data quality. • The Trust has met with CCG commissioners to agree an implementation plan for Blueteq from 1st April 2018. There are some technical issues being addressed as well as issues with the structure of the forms which are being progressed by the CSU.	IM&T Committee	Ongoing Work Programme
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits.	• The Trust is achieving the recommendation for pharmacists. • The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post.		• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • Three wards now have a pharmacy technician administering medicines to patients. A plan in place to increase this to six during Q2 2018/19. • A business case is in development to support the medicines optimisation agenda.	Quality & Assurance Committee	Ongoing Monitoring

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017. **Lead Directors:** Chief Operating Officer & Director of Transformation					
Establishment of a shared pathology across the local economy.	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. The first meeting was held on 21st November 2017. • Three main working groups have been established (Blood Sciences, Microbiology & Cellular Pathology). The Pathology Manager for WHH is leading on the Cellular Pathology workgroup.		• There is a Cheshire & Mersey STP workshop schedule for 26th April 2018, it is anticipated that guidance will be developed to give a clear remit of the programme of work required for each of the working groups.	Strategic Development and Delivery Committee	Project – expected completion 2020.
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.		N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July 2016, with NHS Improvement hosting the dashboard.	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented in "shadow" form from November 2016.		• Monthly data indicators continue to be submitted. • The Trust is currently reviewing quarterly and bi-annual indicators for inclusion in the submission.	Strategic Development and Delivery Committee	Ongoing Monitoring

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018. **Lead Directors:** Director of Finance & Commercial Development					
Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB). Trust to send all spend data to NHSI's appointed supplier - AdvisInc - for cleansing and incorporating into the PPIB tool.	• The procurement team continues to provide the data to NHSI for the NHS Purchasing Price Index benchmarking tool on a monthly basis.			Finance & Sustainability Committee	Rolling Programme
Procurement and Transformation Plan Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes	• The Procurement Transformation Plan has been drafted and submitted to NHSI. To support this, a procurement dashboard has been established to measure Trust performance against the Carter metrics. • The Director of Finance & Commercial development is the responsible board member and will work with the Associate Director of Procurement to implemented changes around the PTP plan.		• The PTP which was developed in 2016 will be refreshed due to changes in the procurement landscape since it was originally re-written. This will be submitted to NHSI prior to the deadline of 11th May 2018. A briefing paper will be presented to the Trust board to highlight any changes to the plan. • The Trust will continue to measure progress against the PTP.	Finance & Sustainability Committee	Project Implementation – expected completion May 2018
Adoption plan for Scan4Safety	• The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards is currently being updated and will require approval by the Trust Board.		• The Trust is currently out to advert for a Supply Chain Manager who will be key to the adoption of Scan4Safety. • Briefing setting out principles for Scan4Safety to be prepared for the Trust board for approval.	Trust Board/ Scan4Safety Project Board	Project Implementation

NHS Standards of Procurement – Trusts adopting NHS Standards of Procurement, with those that have already achieved Level 1 achieving Level 2 of the standards by October 2018; and those trusts that are yet to attain Level 1 achieving that level by October 2017. All trusts to produce a self-improvement plan to meet their target standard by March 2017.	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation.		• The Trust is working towards level 2 accreditation for review in 2018.	Finance & Sustainability Committee	Project Implementation – Expected Completion June 2018
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 50/136 Trusts – placing the Trust in the middle of upper quartile. • Data has been submitted for the Model Hospital.		• The Trust will work with NHSI to understand how we can work differently to improve our ranking within the model hospital. • The criteria that contributes to the ranked position is to be reviewed to establish plans to improve the Trusts ranking and how this links in with the PTP plan. This is reported to the Finance & Sustainability Committee.	Finance & Sustainability Committee	Ongoing
Trust focusing on the measurement of Key procurement metrics and being responsible for driving compliance to the following targets by September 2017: • 80% addressable spend transaction volume on catalogue • 90% addressable spend transaction volume with a purchase order • 90% addressable spend by value under contract.	• 92% of addressable spend transaction volume on catalogue. • 96% of addressable spend transaction volume is covered by a purchase order. • 82% of addressable spend by value under contract.		• **<u>Addressable Spend Transaction Volume</u>** Even though the target has been achieved this continues to be monitored on a monthly basis. For spend that is not transacted via a PO suppliers are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected. • **<u>Addressable Spend under Contact</u>** Enhancements have been made to the Contract Register held by the Procurement Team; this now incorporates an automatic trigger that highlights dates for the commencement of the procurement process in order to	Finance & Sustainability Committee	Ongoing Monitoring

			implement contracts in a timely manner. This is inclusive of waivers that have been processed so that these can also be actioned in accordance with Trust SFIs and reduce the number of waivers.		

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer					
Every trust has a strategic estates and facilities plan in place, including a cost reduction plan for 2016-17 based on the benchmarks, and in the longer term (by April 2017), a plan for investment and reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and STP estates strategy.		• Explore internal and H&C Partnership collaboration opportunities for relocation of back and clinical support services. • Relocate any back office and clinical support services off Warrington and/or Halton site.	Estates and Facilities sub-Committee/TOB/ Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems,	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. Trust has invested in Combined Heat.		• CHP contract to be monitored for performance and savings.	Estates and Facilities Sub-Committee	Complete
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into PLICS system. Quarterly service lines reports are provided to CBUs by the income team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.			Estates and Facilities Sub-Committee	Complete

Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. Model Hospital data for 2016/17 has been published and benchmarks appear to be inaccurate due to discrepancies in data from other NHS trusts which has been confirmed by NHSI.		• Whilst the Trust benchmarks well against most metrics, (cost efficiency), there are some areas where meeting national benchmarks can prove challenging due to fixed costs, the condition of the estates and unavailability of capital expenditure. However, where the Trust is not benchmarking well (productivity, quality and safety) and change is within our control, measures are in place to improve performance and it's hoped these are reflected in 2018 PLACE scores.	Estates and Facilities Sub-Committee/ TOB	Ongoing Monitoring
All trusts (where appropriate) have a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.	• Model hospital data for 2016/17 reports the Trust utilises 41% of its estate for non-clinical use and has 2.2% of empty space. Whilst efforts to minimise the use of trust accommodation for non-clinical purposes have been made it difficult given the complexities of the numerous corporate functions.		• The current estate strategy aims to address the under-utilised space by rationalising the estate. Better use of under-utilised estate will result a reduction in the size of the estate and the amount of estate used by non-clinical functions.	Strategic Development and Delivery Committee	Ongoing Monitoring

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner. **Lead Directors:** Chief Operating Officer and Director of Transformation					
NHSI Data Collection	• The Trust's corporate and administration functions current costs are 7.7% of income based on planned income. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • LDS Corporate Services Collaboration programme of work launched in spring 2017 chaired by WHH Director of Finance. This is designed to create a formal structure for corporate function leads from all LDS partner organisations to discuss, develop and implement ideas to generate financial efficiency savings either individually or in collaboration with other partners. • A series of workshops were held during 2017 to discuss and explore ideas for collaboration and financial efficiency with corporate functions from each LDS organisation participating. • Subsequent changes to the STP/LDS configuration have meant that momentum around this particular piece of work has been lost (largely from an external perspective). Therefore, the focus of this work has now shifted internally.		• Reports for each corporate function have been compiled using the latest NHSI Model Hospital data and distributed to corporate service leads for them to use as a start point for internal service reviews (see Corporate Services A&C Review section for more detail).	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2017/18. The targets and the progress to date in identifying schemes to meet the targets are summarised, along with CIP delivery at M9. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage		• Corporate CIP targets for 2017/18 totalled £1.47m. At the end of Q4, the corporate functions had delivered £1.57m against this target (see table below for details). However, only £0.80m of this was delivered on a	ICIC	Rolling Programme

	cost figures. • CIP targets for 2018/19 are to be set against specific programmes of work linked to the organisation's agreed portfolio of strategic projects. The main project impacting on corporate functions is the Corporate Services review.		recurrent basis. • 2018/19 CIP targets are being set linked to individual strategic projects.		
Corporate Services A&C Review	• Following ICIC in December, a named Trust Lead (Acting Deputy Chief Operating Officer) appointed to lead on the Admin & Clerical review together with Director of IM&T as Executive Lead. • In 2018/19, the Trust's financial efficiency across its corporate functions will be monitored as part of the revamped CQC "Use of Resources" assessment. The Trust Director of Finance is the named Executive Lead overseeing this work and the organisation's position as per the NHSI Model Hospital metrics will be the basis for much of the measurement of progress.		• Meeting arranged with Executive and Trust Lead and Senior Transformation Manager to agree principles of review and discuss timeframes of IM&T improvements to support changes. • Use of Resources group established meeting monthly and reporting to the Trust's "Getting to Good" steering group.	Strategic Development and Delivery Committee/ GTGM2O programme	Ongoing

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Directors:** Chief Operating Officer and Director of Transformation					
Variation in Theatres and Outpatients	• Unwarranted variation within theatres and outpatients is being addressed through the theatres and outpatient work streams of the transformation programme. • A new theatre scheduling process launched in November is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Shortfalls in anaesthetic capacity have proved to be a bottleneck in terms of ensuring efficient use of theatre capacity. A business case has recently been approved for additional capacity and work ongoing to ensure available capacity is utilised as effectively as possible. • Theatre Listing' meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week. • Theatre '6-4-2' scheduling meetings introduced in October 2017 and are now fully established entering the financial year 2018/19. Theatre sessions are now 'locked down' at two weeks. • Capacity and Demand work for Outpatients commenced in December 2017 with the aim of understanding the exact clinic requirements for each specialty to deliver their activity plans and then ensuring we have robust monitoring systems in place to track delivery. • Analysis of Outpatient Capacity and Demand for the following specialties is now complete: o Haematology o Colorectal o Breast o Orthotics		• The new list planning process is set to be launched imminently with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • The Demand and Capacity work is ongoing but the model itself is now fully functional. Clinic templates for all specialties are being validated to ensure the accuracy of all outcomes.	Strategic Development and Delivery Committee.	Ongoing

	o General Surgery o Gastroenterology o Upper GI o Anaesthetics o Cardiology o Respiratory o Pain Management o Vascular o Hepatology				
Emergency Care Improvement Programme	• An Improvement Programme around improvements in patient flow has agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is now collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is now in place with partner organisations expected to respond with actions in place to reduce the delays.		• Frailty workstream – strategy document ratified by the Trust Board sub-committees in November 2017 and Frailty Assessment Unit capital works are scheduled to be completed by the end of March. The unit is planning to open in April 2018 following a contractual agreement with commissioners. • Significant work has been progressed via the Trust's Impact 5 event. Progress against the identified objectives will be monitored through the Trust's internal patient flow board. • Refreshed Patient Flow Steering Group will now move to govern a more strategic programme of work.	A&E Delivery Board Flow Board	Ongoing
Specialty level reviews across local delivery system.	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Agree and implement plans to reduce variation within pathways across the LDS. • Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign.		• The LDS Director of Service Redesign is pulling together data packs for the 3 specialties within the initial scope of this work (T&O, Urology & Ophthalmology). This data will blend the findings of the recent GIRFT reports with some other clinical and performance metrics to identify where the major opportunities lie for each of the LDS organisations.	Strategic Development and Delivery Committee.	Ongoing

	• A new clinical strategy is being developed and will be launched early in 2018/19. This will support delivery of the Trusts objectives by the clinical teams.		• The Transformation Team will be supporting the development of PIDs following individual workshops to enable delivery of improvements identified. • Work is ongoing at STP level to explore options around provision of elective care across the STP footprint. • Launch of the new clinical strategy in early 2018/19.		

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives. **Lead Director:** Director of Information Management & Technology					
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs this project is monitored by the IM&T Project Board. • During Q4 the Trust has tested and implemented 2 upgrades of Lorenzo. • The Trust has introduced paperless referrals in Q4 and will optimise and review benefits during Q1. • Updates to Outpatient Letters took place during Q4.		• Work has commenced of the GP viewer which will give Trust clinicians access to GP records via Lorenzo. It is anticipated this functionality will be available during Q1 2018/19. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record and will review next steps during Q1 2018/19.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A business case for an Electronic Document Management System has been developed. There has been some minor delays to the development of the full business case however, it is anticipated that the full business case will be approved during Q1 2018/19.		• The full business case to be signed off by the Trust Board during Q1 2018/19. • The Trust will tender for EDMS system; once this has been completed a full implementation plan will be developed with the successful bidder.	IM&T Sub-Committee	Project Implementation – Initiation
e-Prescribing	• Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • ePMA pilot commenced on CDU in March with a further pilot in Halton Urgent Care centre commencing at the end of March.		• A third pilot within T&O is planned for Q1 2018/19. Learning from all pilots will be used in the development of new functionality and develop fixes to any issues identified. • Further testing and build phases will be required throughout 2018/19 with further rollouts commencing in March 2019.	IM&T Sub-Committee	Project Implementation

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 10 - DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers. **Lead Director:** Not Applicable					
Further information from national bodies is awaited.					
Recommendation 11 - Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community. **Lead Director:** Not Applicable					
Collaborative working across the healthcare economy	• The Trust is working in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities. • Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records.				

Recommendation 12 - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice. **Lead Director:** Not Applicable					
Development of "Model Hospital"	• NHS Improvement has now published the model hospital data and the Trust is focussing on the use of the information to drive forward clinical and corporate practices so that outputs and financial performances can be improved.		• A report that extracts all key metrics from the Model Hospital portal that enables our individual services to review, analyse and respond will be prepared. • The key metrics include Clinical Service Lines (Emergency, General Surgery, Urology and Paediatrics) Operational (Theatres, Procurement, Pathology, Estates) and People (Nursing, AHP, Medical, Workforce Analysis). https://model.nhs.uk		Ongoing Monitoring
Recommendation 13 - NHS Improvement should, in partnership with NHS England by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow trusts to focus on quality and efficiency. **Lead Director:** Not Applicable					
Implementation of Single Oversight Framework	• NHS Improvement published the document Single Oversight Framework (SOF) effective from 1st October 2016, updated in October 2017. • New SOF reviewed and indicators have been incorporated into IPR and other performance monitoring tools.			Trust Board	Ongoing Monitoring
Segmentation	• The Trust received written confirmation on 7th December 2017 that it has been moved from Segment 3 to Segment 2.			Trust Board	Ongoing Monitoring

Recommendation 14 - All acute trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved. **Lead Director:** All Executive Directors					
See individual recommendations.					
Recommendation 15 - National bodies should engage with trusts to develop their timetable of efficiency and productivity improvements up until 2020/21, and overlay a benefits realisation system to track the delivery of savings, so that there is a shared understanding of what needs to be achieved. **Lead Director:** Not Applicable					
Further information from national bodies is awaited.					

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

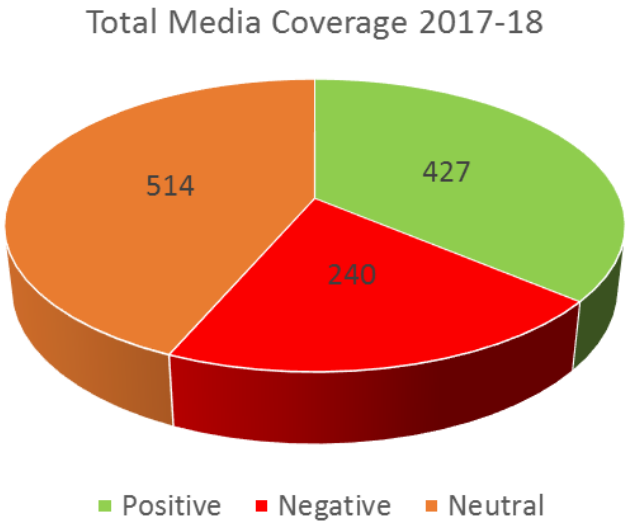
AGENDA REFERENCE:	**BM/18/05/47**
SUBJECT:	**Engagement Dashboard Full Year 2017-18**
DATE OF MEETING:	18 May 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren Director of Community Engagement
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce
	All
STRATEGIC CONTEXT	The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high-level overview of how well and to what effect the Trust is engaging and involving key stakeholder groups. **Media dashboard:** The Trust achieved 1181 media reports in year, 941 of which were positive or neutral. Most challenging months media-wise were October with the suspension of spinal services and January with winter pressures and DH-mandated cancellation of elective procedures. **Social Media:** • Twitter followers grew steadily throughout the year to 9.3K up from 8.2K at start of year • Twitter reach was highest over winter corresponding with both winter pressures and seasonal celebrations • Facebook engagement continues to attract our biggest audiences, peaking in March corresponding with Kendrick Wing Fire and the Thank You Awards. **Website whh.nhs.uk** • The Trust's website continued to receive circa 25K visitors per month and again saw the impact of social media referrals. There was a spike in February related to winter pressures and members of the public checking A&E and UCC waiting times. • 70% of all visitors to the website used mobile devices (mobile, tablet) • We completed a procurement exercise via competitive

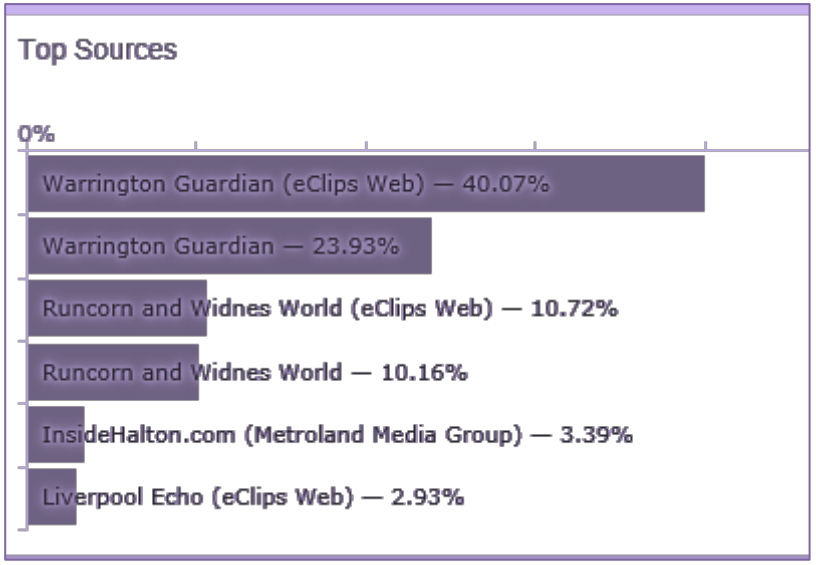
	commercial tender for the new Trust Website which will go live over the summer 2018. **Staff Engagement** • Attendances at Team Brief continue variable across all CBUs as are overall attendances. Alternatives are being found for Halton site which is seeing reduced engagement. • The NHS Staff Survey 2017 achieved an overall engagement score of 3.74 against national average of 3.79 • The Extranet is well used by all staff and is available via mobile platform for out of office use. • We distributed 629 values badges to staff in year, most commonly 'working together' and 'excellence'. **Patient Engagement** • We were pleased to launch our new Friends and Family test via text message and automated voice call in addition to paper methodology in the year. Response rates have increased 10-fold as a result • Patient feedback via external sites gave a 3.5-4* rating to Warrington Hospital, a 4.5-5* rating to Halton and a 4-4.5* rating to CMTC. • The Trust's own FFT via the combined paper and automated methods in year delivered an average 95% recommendation for inpatient and day case care. For A&E and Urgent Care patients feedback rose significantly corresponding to the introduction of the automated service.	
RECOMMENDATION:	The Board is asked to note 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)*		

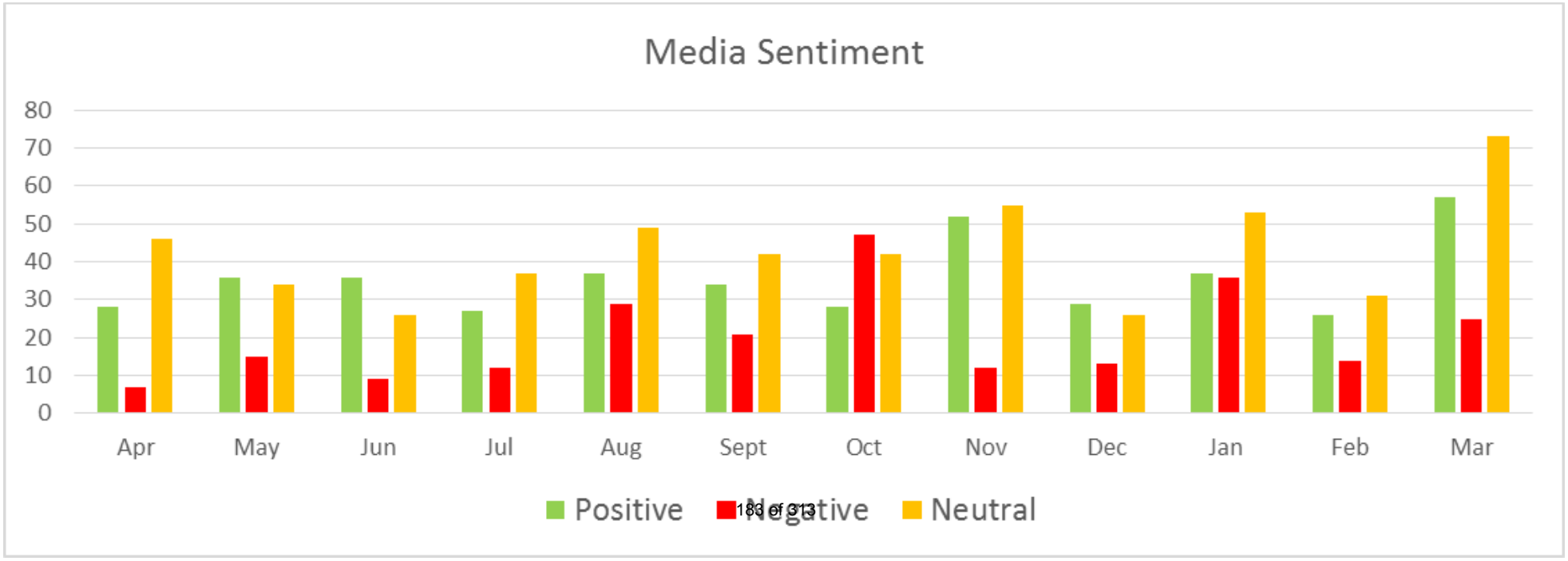
Media Sentiment April 2017 – March 2018

Most challenging months:

October - Suspension of Spinal Services
January – Winter pressures, mandated



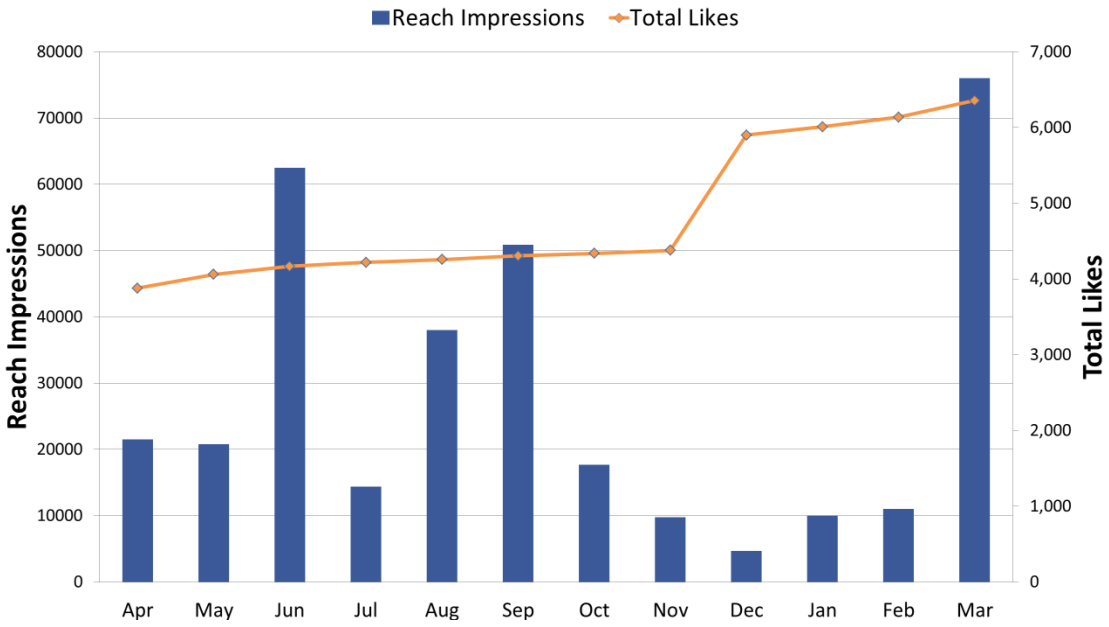




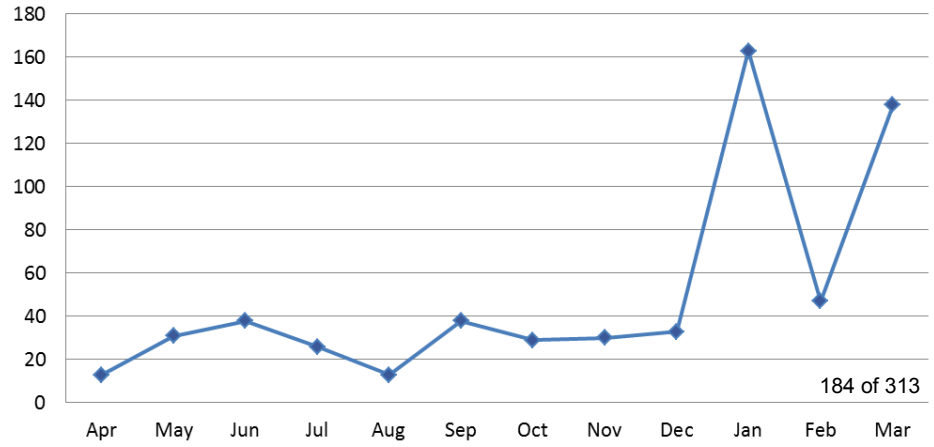
facebook

WHH SOCIAL NETWORKING: April 2017- March 2018

FACEBOOK ENGAGEMENT APRIL 2017- MARCH 2018



WHH Posts



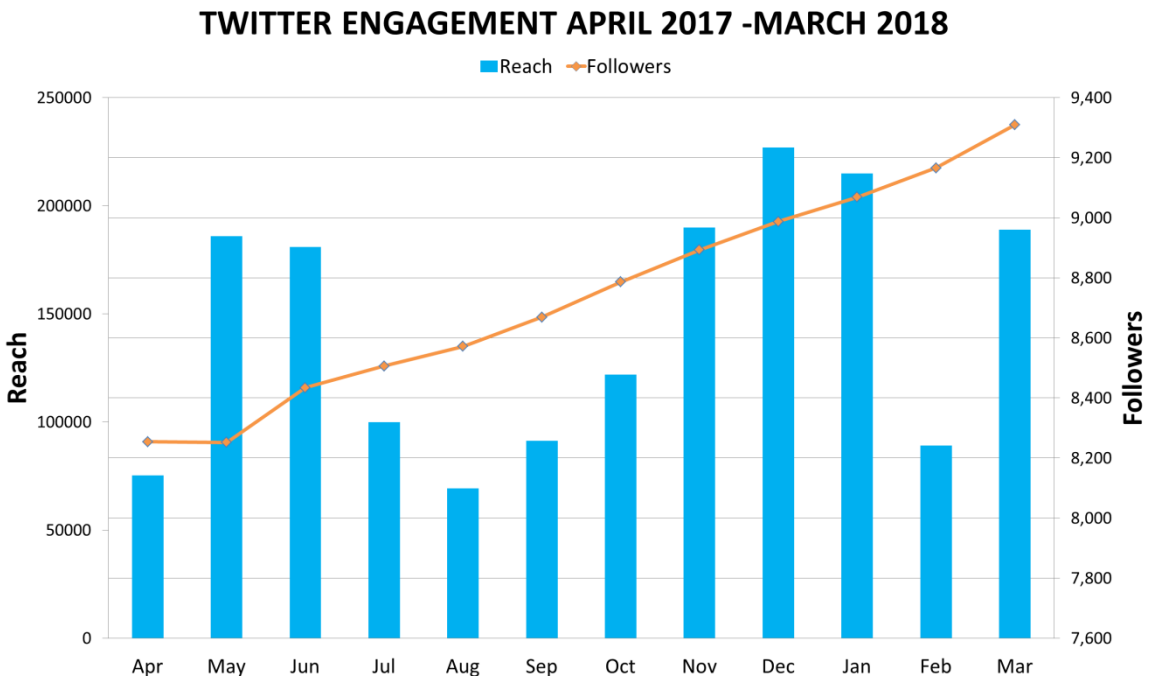
Other WHH Facebook Pages

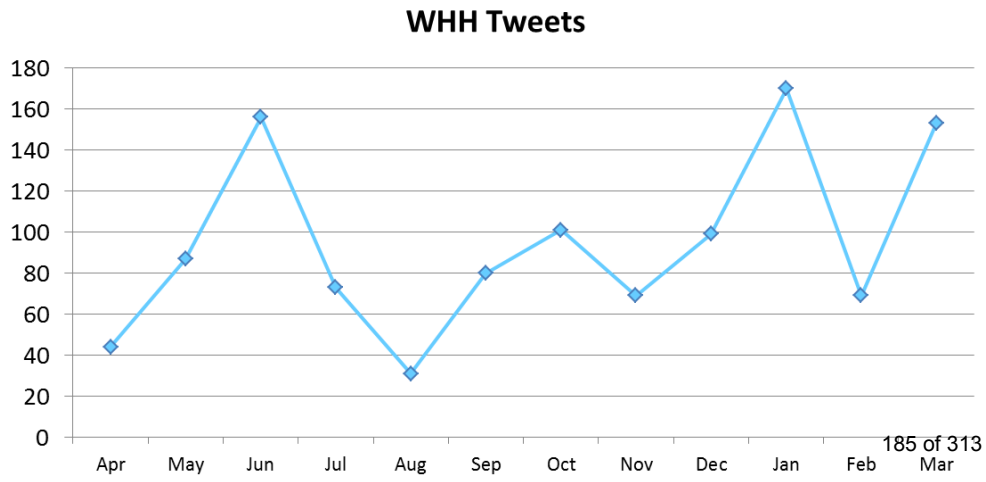
WHH Maternity
Followers: 5938

Fit to Care
Members: 364

People's Champions
Members: 18

WHH SOCIAL NETWORKING: April 2017- March 2018





Other WHH Twitter Pages

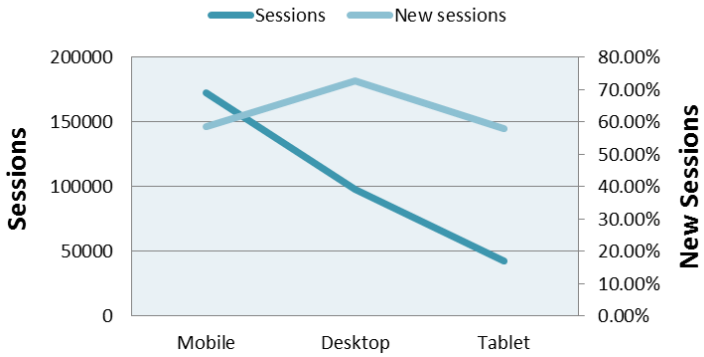
WHH Careers
Followers: 569

WHH Charity
Followers: 826

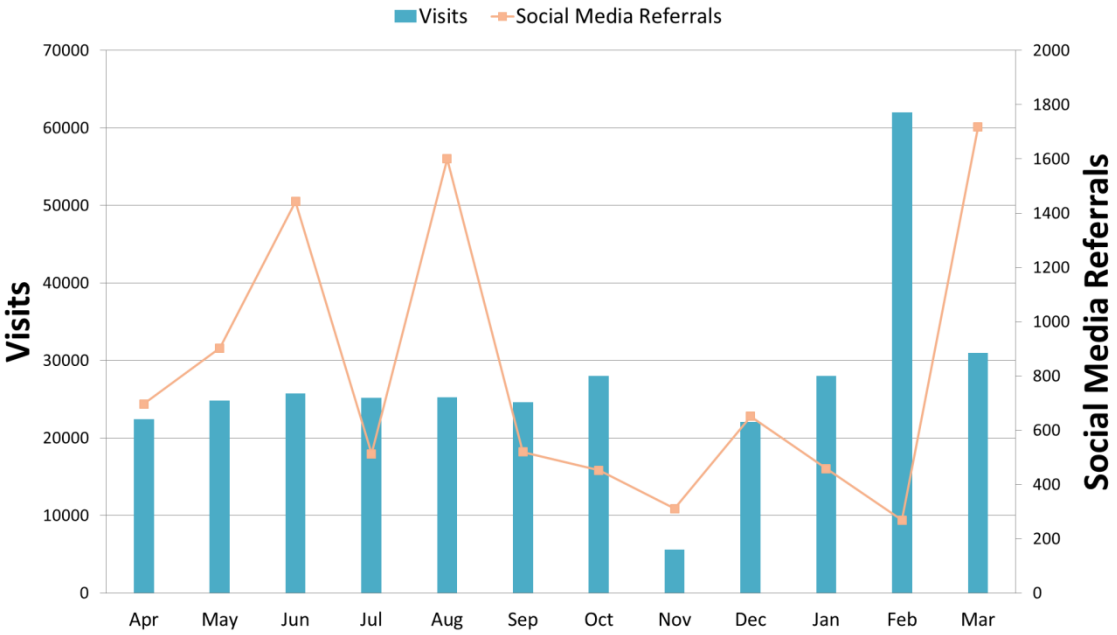
WHH Volunteers
Followers: 173

Website Dashboard: April 2017 – March 2018

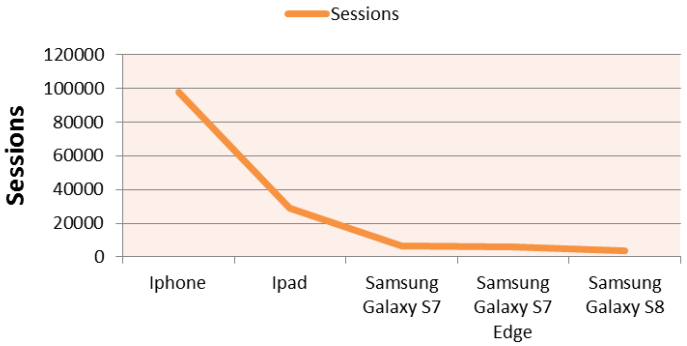
DEVICE USAGE

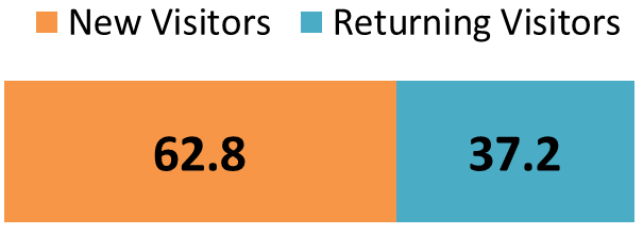


WEBSITE ENGAGEMENT APRIL 2017-March 2018



MOBILE USAGE INFORMATION

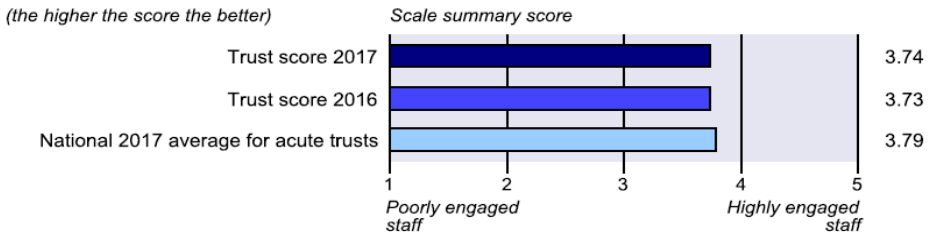




Staff Engagement: April 2017 – March 2018

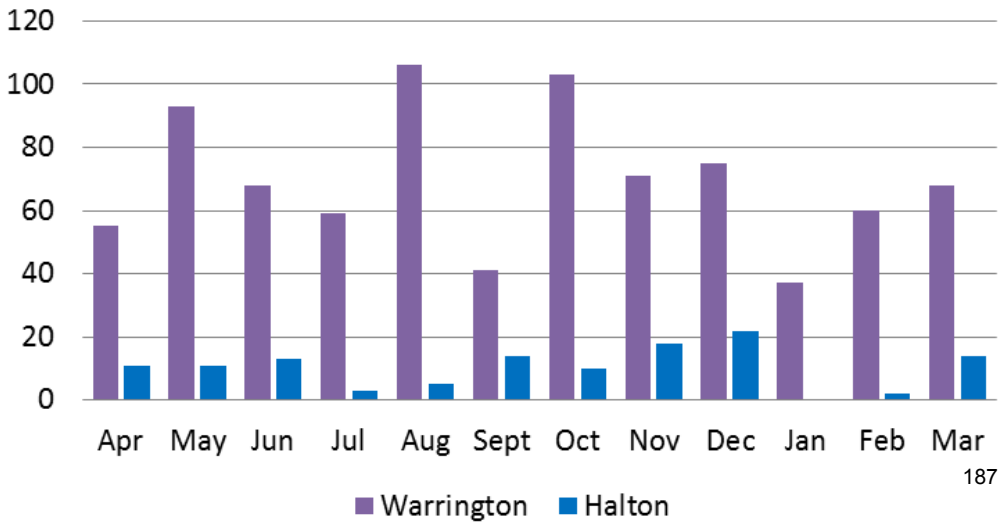
NHS National Staff Survey

Overall engagement score is virtually static year on year at 3.74 against national average of 3.79



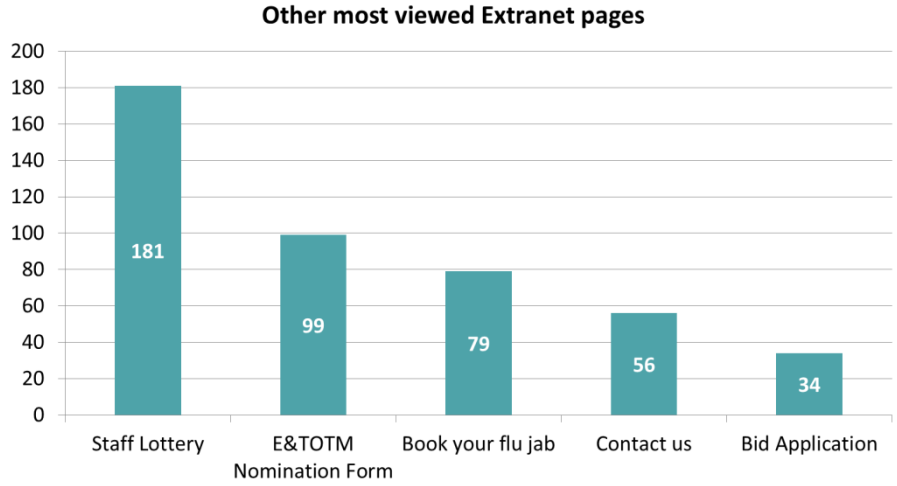
Team Brief Attendances

Staff engagement with Team Brief, delivered at two sites on two separate days following Board each month. Additional programmes are being implemented to drive this engagement, including changing venue/time at Halton and the development of the 'Brief in Brief'. Team Brief is a proven large, multi-site organisation engagement tool.



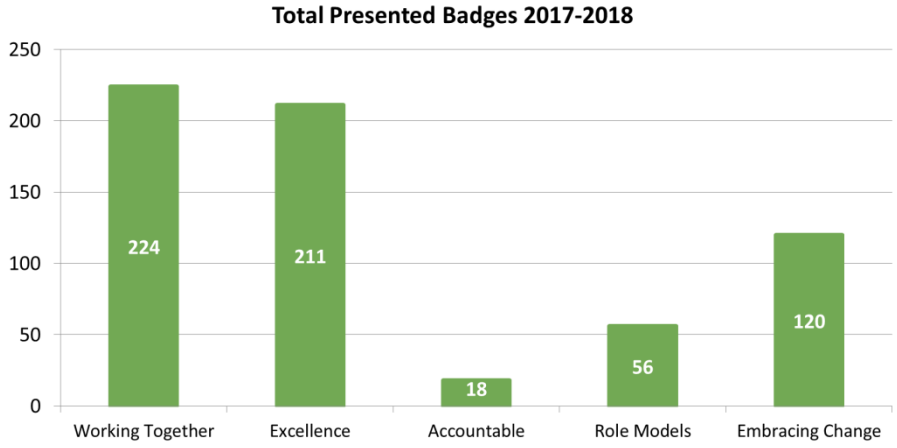
WHH Extranet

The most viewed workspace is **Staff Wi-Fi** with 2348 staff members visiting.



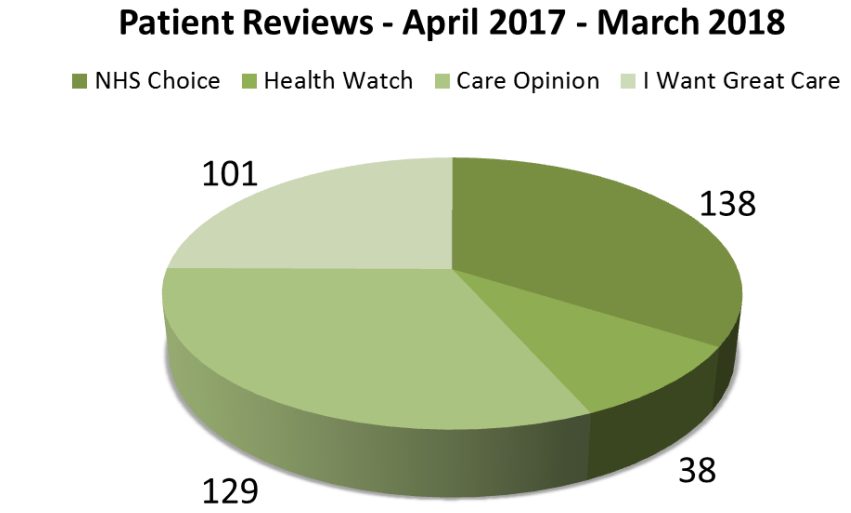
Staff Value Badges

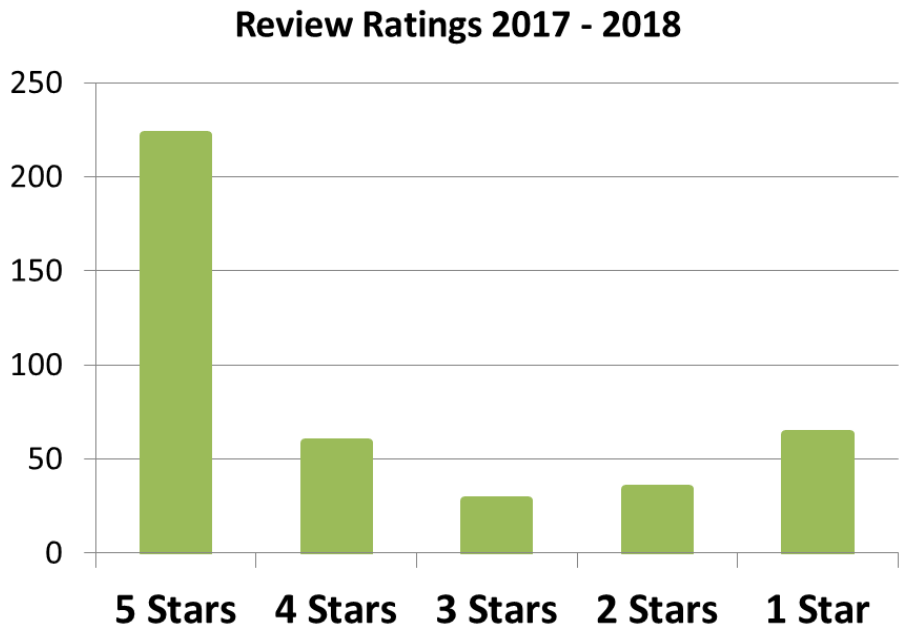
Our values shape the way that we deliver high quality, safe and effective healthcare for patients.



Patient Experience April 2017 – March 2018

Feedback Rating by NHS Choices	Feedback Rating by Health Watch	Feedback Rating by Care Opinion	Feedback Rating by iWantGreatCare
			
3.5 Average rating at Warrington	4 Average rating at Warrington	3.5 Average rating at Warrington	5 Average rating at Warrington
			
5 Average rating at Halton	4.5 Average rating at Halton	4 Average rating at Halton	5 Average rating at Halton
			
4.5 Average rating at CMTC	4 Average rating at CMTC	4 Average rating at CMTC	5 Average rating at CMTC



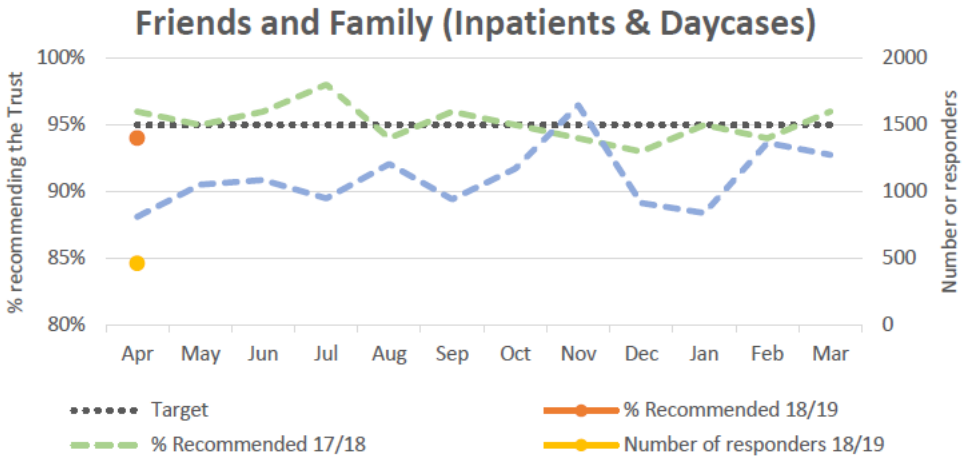


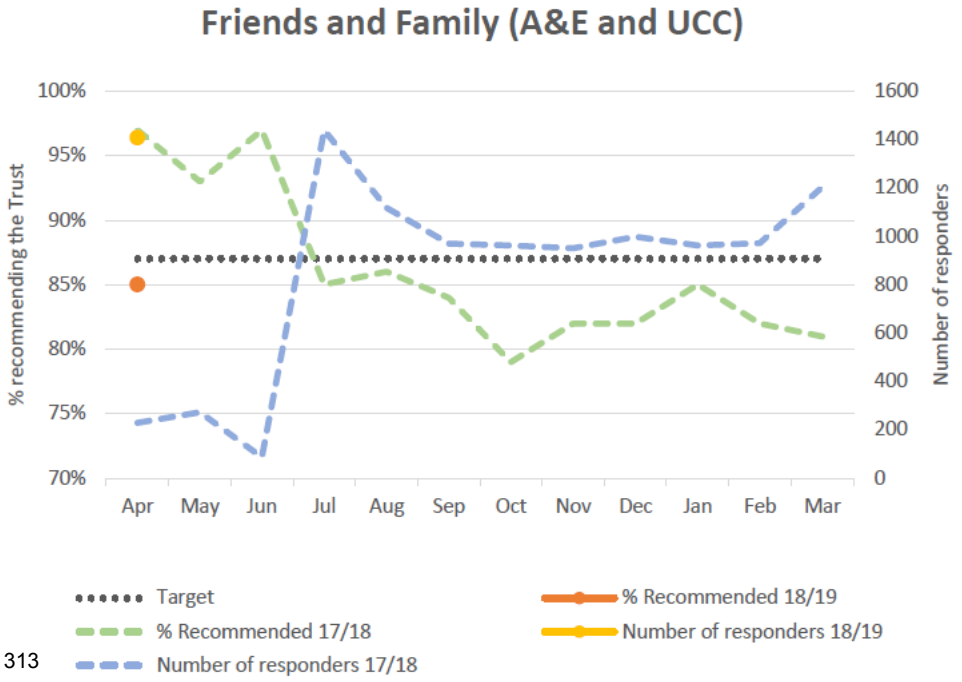
Patient and Staff Feedback
April 2017 – March 2018

NHS National Staff Survey 2017

Key Finding	WHH 2017	Ave Score	WHH 2016
Staff recommendation of the Trust as a place to work or receive treatment (/5)	3.61	3.75	3.57

Patients are asked - *How likely are you to recommend our ward to friends and family if they needed similar care or treatment?*





We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/48**
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**
DATE OF MEETING:	24 March 2018
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	All
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures, as well as regulatory implications.
EXECUTIVE SUMMARY (KEY ISSUES):	There have been four additional risks added to the BAF in the last quarter. Notable existing risk updates are given, with any impact of risk scores. In addition, two risks have been closed following completion of actions
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/18/03/05/48

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Board Assurance Framework. It has been agreed that the Board receives a monthly update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis.

The strategic risk register is outlined in Appendix 1 and the Board Assurance Framework. The following gives notable updates since the strategic risks were last presented to the Board of Directors.

2. KEY ELEMENTS

2.1 New Risks –Since the last meeting there have been four new risks added to the register.

Risk	**Risk: Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff**
Controls and Assurances	▪ Data Security and Protection Toolkit Returns (NHS Digital) ▪ MIAA Annual Data Security and Protection Toolkit Assurance Audit (significant assurance in 2018) ▪ Cyber Essentials Plus Certification Audits ▪ MIAA Cyber Security baseline ▪ Firewall Health Check ▪ Reporting to Information Governance and Corporate Records Sub-Committee and Quality Committee ▪ MIAA GDPR Readiness assessment
Gaps	▪ Ongoing effectiveness of GDPR related processes and policies in response to MIAA GDPR readiness assessment ▪ Effectiveness of Trust server estate patching in response to security alerts ▪ Effectiveness of controls in relation to the resilience of the Trust's IT infrastructure, particularly in light of the demands of the 2018 EU NIS Directive ▪ Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements
Initial Risk Rating	12 (4x3)
Residual Risk Rating	12 (4x3)

Actions	Restructure of IT Team to allow for an information security role. IT Manager – 30.06.2018 Report on status of Cyber Essentials Plus certification IT Manager – 30.06.2018

Risk	**Risk: Failure to ensure timely delivery of Getting to Good action plan, caused by potential lack of capacity and resource resulting in an organisational risk of not attaining a rating of 'Good'**
Controls and Assurances	▪ Development of a getting to Good Action plan ▪ Getting to Good Steering Group chaired by CEO, reporting to Quality Assurance Committee and Audit Committee ▪ All core services rated Requires Improvement being overseen by an allocated Executive Director ▪ Improvement workstreams in place, engaging clinical staff ▪ Enabling strategies in place e.g. Organisational Development ▪ Ring fencing capital monies to ensure support for CQC actions (c£0.5 million) ▪ Getting to Good Steering Group meetings scheduled monthly ▪ Reporting function in place- led by Clinical Governance, supported by Transformation team ▪ Triangulated data being scrutinised – NHSI/CQC Insight report ▪ Trust Board have approved a business case to increase establishment of nurse staffing in the Trust following an acuity review, which will ensure must do actions regarding staffing are delivered
Gaps	▪ Capacity in the system to deliver a high number of actions – linked to significant operational pressures and competing priorities ▪ Financial pressures ▪ Staffing pressures ▪ Cultural change required in some areas ▪ Gaps in compliance in Must Do/Should Do actions ▪ Use of Resource assessment may be difficult with current finance ▪ ial pressures
Initial Risk Rating	16 (4x4)
Residual Risk Score	12 (4x3)
Actions	Identify where there are priorities for additional capacity and ensure that this is flagged **Executive Director Leads- end June 2018** Where there are significant financial impacts from delivery of CQC action plan, (either capital or revenue) ensure that these are flagged to Director of Finance **Executive Director Leads- ongoing** Ensure there is an implementation plan for recruitment and retention, following on from investment in nurse staffing **Chief Nurse- end May 2018** Ensure that there is a plan developed for the Cultural and Organisational Development workstream, focusing in on areas for improvement (aligned to staff survey) **Director of Workforce and OD – end May 2018**

	Ensure a compliance report of Must Do/Should Do actions is given at every Getting to Good Steering Group meeting **Director of Governance – April 2018 onwards** Ensure that a workstream and plan is developed for Use of Resource assessment reporting into the Trust Getting to Good Steering Group **Director of Finance – end May 2018**

Risk	**Risk: Failure to have robust processes in place across the Trust relating to Medical devices, caused by inconsistency in applying policies and procedures and inability to provide assurance, resulting in potential for patient safety incidents, service disruption and non-compliance of regulatory standards.**
Controls and Assurances	▪ A review of the Trust Medical Devices policy has been undertaken with new processes across the Trust ▪ Clear processes have been agreed for the loaning of equipment internally across Wards. ▪ A training database to report competencies has been developed and is currently being trialled within outpatients and Labour Ward. ▪ Medical Device Safety Group has been set up and will be chaired by the Medical Director. ▪ Medical Devices Co-ordinator in place, who has moved to the Clinical Governance Department ▪ An issues log and action plan has been developed ▪ Assurance reports have been received for maternity and critical care regarding the CQC actions ▪ An issues log has been developed ▪ Terms of reference and dates have been diarised for Medical Devices Group and task and finish groups, to ensure the work is completed.
Gaps	▪ CQC has flagged 'Must do' actions regarding medical devices in maternity, critical care and paediatrics ▪ An in-house review has raised issues with regard to o Implementing new policy and procedures o Ensuring there is a clear inventory of devices in place within the Trust – as currently there are different systems on which to log devices o Ensuring that there is visibility of all risks with regard to medical devices within the Trust and we have assurance that there is appropriate replacement programmes in place Trustwide o Ensuring that we have assurance that staff have been trained on medical devices within the Trust.
Initial Risk Rating	16 (4x4)
Residual Risk Score	12 (4x3)
Actions	Ensure CQC report for paediatrics is completed and presented to CQC Getting to Good, Moving to Outstanding Meeting **Lead Nurse Paediatrics – end May 2018** Ensure that a communications and awareness plan is in [place within the Trust regarding the revised medical Devices Policy – incorporating

	drop in sessions **Medical Devices Co-ordinator – end May 2018** Ensure that all medical devices are risk assessed, with a competency assessment sheet for each device **Medical Devices Co-ordinator – end May 2018** Ensure work is undertaken to have a robust inventory of medical devices within the Trust **Medical Devices Co-ordinator – end June 2018** Ensure training for medical devices is recorded on the Trust system E-Quip for all clinical services **Medical Devices Co-ordinator – end September 2018**

Risk	**Risk: Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by the lack of resources resulting in the areas of data protection non-compliance**
Controls and Assurances	▪ Controls and assurances identified in readiness assessments and action plan. ▪ Progress reporting to the Quality Assurance Committee
Gaps	▪ Incomplete information flow mapping. ▪ Difficulties in maintaining asset registers and lack of resources (1 staff member) to maintain compliance with requirements of general data protection regulations on a long terms basis. ▪ Identifying data processors and varying contracts
Initial Risk Rating	9 (3x3)
Residual Risk Rating	12 (4x3)
Actions	Restructure of IT Team to allow for an information security role. IT Manager – 30.06.2018 Report on status of Cyber Essentials Plus certification IT Manager – 30.06.2018

2.2 Existing Risks – updates

Strategic Risk	**Update since last Risk review**	**Impact of update on risk rating**
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	• The 4 firewalls (2 at Warrington and 2 at Halton) have been upgraded with several proactive modules. Anti-virus has been upgraded for the next 3 years; however, with the new agreement with Microsoft we are looking to see if the Windows 10 Advance security protection is better or not. We have secured capital funding for web filtering and is scheduled to start the implemented in	No impact on risk rating

Strategic Risk	Update since last Risk review	Impact of update on risk rating
	July 18 • The Information Governance and Corporate Sub-Committee are provided with the following information: • A firewall report including any successful and unsuccessful attacks, suspicious network traffic that could indicate a potential attack • Current status of security patches for the Desktop PC's and laptops • Current status of security patches for all Trust in-house servers • Current position on anti-virus installed on PC's and laptops and how up-to-date they are.	
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	Four Serious Incident (SI) falls were reported in April • A weekly Falls Review Meeting commenced week beginning 23rd April 2018 to support the learning from no harm and low harm falls, this will help to identify the early common themes to avoid more serious harm falls. • A Falls Prevention Task and Finish Group will be developed • Relaunch of Trust wide documentation • Review of falls prevention equipment across the Trust and ensure details for replacing equipment are available The financial impact associated with falls is great, the average cost of a no harm fall is approximately £2,600 for people over the age of 65 and for a severe harm fall £14,100.	No impact on risk rating

2.3 Removal of risks

Following a review at the Patient Safety & Clinical Effectiveness Sub-Committee, and subsequent approval at Quality Assurance Committee the, following two risks were closed as all the actions have been completed:

- *Failure to meet the standards relating to administration of blood, caused by non-completion of this role specific training, resulting in potential harm to patients, and non-compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation.*

- *Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care.*

2.4 Risk Management Strategy Updates

The Risk review Group continues to meet monthly with the next meeting due to be held on 11th June 2018.
The Kendrick Fire Response Group continues to meet bi-weekly in which potential financial risks are discussed.

3 RECOMMENDATIONS

The Board of Directors are asked to note the updates to the strategic risks and the Board Assurance Framework.

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)	20 (4x5)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience,	N/A	N/A	N/A	N/A	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
potential safety concerns for those patients with delayed procedures or follow ups, reputational damage and potential regulatory and contractual issues.										
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4	16 (4x4	16 (4x4
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4	16 (4x4	16 (4x4

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.										
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
external review may impact on patient safety and cause the Trust to breach regulations.										
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
lessons from complaints										
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
receiving the appropriate, preventative treatment for VTE in hospital.										
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to achieve the highest level of corporate governance, caused by the requirement to	12 (4x3)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
review and embed new structures, which may impact on statutory and regulatory requirements										
Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)
Failure to ensure timely delivery of Getting to Good action plan, caused by potential lack of capacity and resource resulting in an organisational risk of not attaining a rating of 'Good'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)
Failure to have robust processes in place across the Trust relating to Medical devices, caused by inconsistency in applying policies and procedures and inability to	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)

Risk	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18
provide assurance, resulting in potential for patient safety incidents, service disruption and non-compliance of regulatory standards.										
Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by the lack of resources resulting in the areas of data protection non-compliance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (3x4)

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/49 ii**	
SUBJECT:	**Finance & Sustainability Terms of Reference & Cycle of Business**	
DATE OF MEETING:	24 May 2018	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	John Culshaw Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable Executive Medical Director/Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Cycles of Business on an annual basis.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Finance & Sustainability Committee has been adjusted for 2018/19	
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and Cycle of Business for 2018-19	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC 18/03/32
	Date of meeting	21 March 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. AUTHORITY

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

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider Licence (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).
- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is

provided.

- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Key Issues Report.
- To monitor compliance with NHSI requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.

5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

6. CORE ATTENDEES

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development
- Chief Operating Officer
- Director of Transformation
- Chief Nurse
- Executive Medical Director and Deputy Chief Executive
- Medical Director
- Director of HR and Organisational Development
- Deputy Director of Finance Strategy

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Innovation and Cost Improvement Committee ICIC
- Capital Planning Group
- Out-Patient Turnaround Board
- Pay Spend and Review Committee, including reports on premium pay spend

10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee.

Date: March 2018

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	V4
Implementation Date:	November 2017
Review Date:	12 months from approval date
Approved by:	Finance + Sustainability Committee
Approval Date:	XXXXXXX

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	
18th October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and	

		Records	
22nd November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21st March 2018	**Core Attendees**	Addition of Medical Director	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

			2018								2019		
	Exec Lead	**18.4.18**	**23.5.18**	**20.6.18**	**18.7.18**	**22.8.18**	**19.9.18**	**24.10.18**	**21.11.18**	**19.12.18**	**Jan**	**Feb**	**Mar**
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of the Last Meeting	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising+ Action Log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Rolling attendance log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference	**EMD/HCA**												X
Committee Cycle of Business	**EMD/HCA**												X
Annual Report of the FSC to the Board	**Chair**	~~X def to May~~	X										
Pay Assurance Dashboard + Pay Spend and Review Group Notes/Mins	**Dir HR+OD**	X	X	X	X	X	X	X	X	X	X	X	X
NHSI Checklist quarterly report	**Dir HR+OD**	X			X			X			X		
Risk Register	**HCA**	X	X	X	X	X	X	X	X	X	X	X	X
FINANCIAL ASSURANCE													
Monthly Finance report, + Capital Planning Group Minutes	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
Transformation Report + ICIC mins	**DoT**	X	X	X	X	X	X	X	X	X	X	X	X
INVESTMENT													
Annual Capital Programme	**DoF&CD**											X	
PLANNING													
Operational Plan & Budgets	**DoF&CD**									X			
Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs) + Outpatient Board Mins	**COO**	X	X	X	X	X	X	X	X	X	X	X	X
Service Line Reporting/Ref Costs – 6 month report	**DoF&CD**				X						X		
CLOSING													
Key issues to the Board	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**EBM/18/05/50**	
SUBJECT:	**Trust Operational Board Cycle of Business**	
DATE OF MEETING:	24 May 2018	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	John Culshaw Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable Executive Medical Director/Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Cycles of Business on an annual basis.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust Operational Board Cycle of Business has been adjusted for 2018/19 to update the frequency of the Corporate Service Reports. Corporate Service reports will now be required on a nine month cycle as opposed to quarterly, to allow sufficient emphasis and scrutiny for each department.	
RECOMMENDATION:	The Trust Board is required to ratify the Cycle of Business for 2018-19	
PREVIOUSLY CONSIDERED BY:	**Committee**	Trust Operational Board
	Agenda Ref.	TOB/18/04/70
	Date of meeting	23 April 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

TRUST OPERATIONAL BOARD CYCLE OF BUSINESS 2018-19

	Lead	23.4.18	29.5.18	25.6.18	23.7.18	28.8.18	24.9.18	29.10.18	26.11.18	17.12.18		28.1.19	25.2.19	25.3.19
STANDING ITEMS														
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Minutes of the Last Meeting	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Matters Arising+ Action Log	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Previous Meeting - Effectiveness Review	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Chief Executive's Briefing	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
CBU QPS Forum Update	**Chair**	X			X			X				X		
CBU Integrated Perf Dashboard incl Exception reports	**All**	X	X	X	X		X	X	X	X		X	X	X
F&S Committee Chair's Key Issues Report	**AMcG**	X	X	X	X		X	X	X	X		X	X	X
TOB SUB-COMMITTEE REPORTS														
ICIC Chair report	**LG**	X	X	X	X	X	X	X	X	X		X	X	X
KPI Performance Chair Report	**CE**	X	X	X	X	X	X	X	X	X		X	X	X
Workforce Chair Report	**MC**	X	X	X	X	X	X	X	X	X		X	X	X
Patient Flow Chair Report	**CE**	X	X	X	X	X	X	X	X	X		X	X	X
OPD Transformation Chair Report	**CE**		X		X		X		X				X	X
Emergency Planning and Resilience Chair Report	**CE**	X	X	X	X	X	X	X	X	X		X	X	X
Estates and Facilities Chair Report	**CE**	X	X	X	X	X	X	X	X			X	X	X
IM&T Report	**JDC**				X				X					X
Strategic Development and Delivery Chair report	**LG**	X	X	X	X		X	X	X	X			X	X
CORPORATE SERVICES REPORTS														
Pharmacy Department Report	**DM**		**X**					**X**						**X**
Communication and Engagement Dept Report	**CR**					**X**							**X**	
Quality Governance Dept Report	**UM**		X						X					
Corporate Nursing Dept Report	**JG**	X					**X**							**X**
IM&T Dept Report	**KF**				**X**							**X**		
Finance, Procurement and Commercial Dvt report	**SB**			X						**X**				
Estates and Facilities Dept Report	**IW**				**X**					**X**				
HR, Education and OD Dept report	**DS**			X					**X**					
Transformation Dept Report	**SB**					**X**							**X**	
STRATEGY and COMMERCIAL DEVELOPMENT														
Commercial Opportunities Update	**JH**	X	X	X	X		X	X	X					
Quarterly Report Business Case Position Statement	**JH**		X			X			X				X	
GOVERNANCE														
Review of Cycle of Business	**PMc**													X
Review of Terms of Reference	**PMc**								X					
National reports or legislation of interest	**PMc**	X	X	X	X	X	X	X	X	X		X	X	X
Break Glass report	**DS**	X	X	X	X	X	X	X	X	X		X	X	X
CLOSING														
Any other business	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Items to escalate to Audit/Quality Assurance/Finance and Sustainability Committees OR to Board	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X		X	X	X

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/05/51**	
SUBJECT:	**Standing Financials Instructions and Scheme of Reservation and Delegation**	
DATE OF MEETING:	**30 May 2018**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	The Trust's Standings Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) are reviewed and revised at least bi-annually. The purpose of this report is to seek approval from the Board of Directors for proposed amendments following the latest review.	
EXECUTIVE SUMMARY (KEY ISSUES):	No changes to the SFIs are proposed. The changes to the SoRD are: • Revised delegated limits following the changes to the restructure of operations. • Reinstatement of the £5,000 delegated limit. • Changes to professional services consultancy contracts to comply with NHS Improvement directives.	
RECOMMENDATION:	The Board of Directors is requested to approve the contents of 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	

1. PURPOSE

The Trust's Standings Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) are reviewed and revised at least bi-annually. The purpose of this report is to seek approval from the Board of Directors for proposed amendments following the latest review.

2. KEY ELEMENTS

The SFIs state the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with current law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The SoRD states how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of the Trust's policies and procedures.

A full review of the SFIs and SoRD was undertaken and approved by the Audit Committee in January 2017 with a review date of January 2019. There were some minor amendments to the SoRD approved by the Audit Committee in July 2017. In future the SFIs and SoRD will be reviewed and approved by the Board of Directors.

The policies have been reviewed and it is proposed to amend the SoRD to reflect the following:

- Changes in the restructure of Operations.
- Reinstatement of the £5,000 delegated limit (this delegated limit was removed in February 2016 but the proposal to reinstate was approved by the Audit Committee in April 2018).
- NHS Improvement guidance on the approval of expenditure for consultancy services.

Therefore the proposed delegated limits are summarised in the sections below.

Proposed delegated limits (excluding consultancy services)

Value	Delegated Authority
Over £250,000	Chief Executive / Deputy Chief Executive (in absence of Chief Executive) *
Up to £250,000	Executive Directors *
Up to £100,000	Deputy Chief Operating Officer *
Up to £50,000	Director of Medical Education * Deputy Directors * Associate Director of Estates and Facilities * Chief Pharmacist * Clinical Business Unit Managers
Up to £25,000	Associate Directors Board Secretary * Deputy Chief Pharmacist * Assistant/Deputy Clinical Business Unit Managers Heads of Service (or equivalent) *
Up to £10,000	Matron/Lead Nurse * Heads of Service/Departmental Mangers (or equivalent) *
Up to £5,000	Ward/Service/Theatre Managers (or equivalent) Divisional Administrators

* Indicates no change to delegated limits approved by Audit Committee in January 2017.

Proposed delegated limits - consultancy services

All Trusts and Foundation Trusts are required to seek approval from NHS Improvement for any professional services consultancy contracts above £50,000. This includes new contracts above £50,000 and extending or varying existing contracts that results in a contract exceeding £50,000.

For professional services consultancy contracts below £50,000 it is proposed that approval from an Executive Director is required.

3. RECOMMENDATIONS

The Board of Directors is requested to approve the contents of the report.

SCHEME OF RESERVATION AND DELEGATION

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 committee 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's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them will automatically transfer to the Deputy Chief Executive.

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 Director of Finance and Commercial Development, 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.

DUTIES AND RESPONSIBILITIES

Delegated Executive Lead

It is the responsibility of the Board of Directors to ensure systems and processes are in place to NHS Improvement and implement this procedural document.

Delegated Executive Lead

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 procedural document.

Delegated Executive Lead

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

Delegated Executive Lead

The Director of Finance and Commercial Development has been delegated by the Chief Executive to take the Executive ownership for this procedural document.

Senior Clinicians and Managers

Senior Clinicians and Managers are responsible for the provision of managerial and professional clinical advice to their teams on patient safety issues, and to ensure the provision of services and care is consistent and equitable care relating to this procedural

Senior Clinicians and Managers

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

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

Accountability

The Code of Conduct and Accountability which has been adopted by the Foundation Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters 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, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these;
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior 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 Remuneration and Terms of Employment Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

Matters Reserved unto the Board of Directors

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 of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.
- Suspend Standing Orders.
- Vary or amend the Standing Orders.
- Ratification of any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with the Standing Orders.

- Approval of a Scheme of Reservation and Delegation of powers from the Board of Directors to Committees.
- 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.
- Requiring and receiving the declaration of officers' interests which may conflict with those of the Foundation Trust.
- 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 modifications thereto.
- To receive reports from committees including those which the Foundation Trust is required by regulation to establish and to take appropriate action thereon.
- 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.
- Disciplining Board members or employees who are in breach of Statutory Requirements or Standing Orders.

Appointments/Dismissal

- The appointment of the Vice Chairman of the Board of Directors.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- The appointment, appraisal, 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 Remuneration Committee regarding the Chief Executive, Directors and senior employees.

Policy Determination

The approval of Foundation Trust management policies including:

- Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Approve procedure for declaration of hospitality and sponsorship.
- Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.

- Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.

Strategy and Business Plans and Budgets

- Definition of 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 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.
- Approve income and expenditure budgets.
- Approve annually Foundation Trust's proposed annual business plan / Service Development Strategy
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings
- Approve PFI proposals.
- Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 per annum or £2,000,000 in total if the period of the contract is longer than 1 year.
- 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 Director of Finance of Commercial Development.
- 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 regarding the appointment (and where necessary dismissal) of the internal and external auditors. Responsibility for the appointment or removal of the auditors is held by the Governors' Council.

The Board are required to:

- 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 and Annual Accounts prior to:
  - being laid before Parliament, which is prior to

- presentation to the Governors' Council at a Members' Meeting.
- Receipt and approval of the Annual Report and Accounts for funds held on trust (Charitable Funds).

Monitoring

- 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 affairs of the Foundation Trust by means of the provision to the Board of Directors as the Directors may require from directors, committees, and officers of the Foundation Trust as set out in management policy statements.
- Receive reports from the Director of Finance and Commercial Development on financial performance against the agreed annual financial plan.

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 in respect of these committees. In accordance with Standing Orders, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

Delegation to Officers

Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and Commercial Development and other directors.

The following responsibilities are defined through NHS Improvement's Foundation Trust Accounting Officer Memorandum.

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 the 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 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 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.

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	Chairman	Chairman
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 Director of Finance and Commercial Development (report to the Audit Committee)	All staff	All staff

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Audit Arrangements**		
a)	To make recommendations to the Governors' Council in respect of 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).	Director of Finance and Commercial Development
b)	Monitor and review the effectiveness of the internal audit function.	Audit Committee	Director of Finance and Commercial Development
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 cost-effective audit service	Audit Committee	Director of Finance and Commercial Development
f)	Implement recommendations	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects**	Chief Executive	Medical Director or Director of Medical Education
3.	**Authorisation of New Drugs**	Chief Executive	Drugs and Therapeutics Committee
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)	Director of Finance and Commercial Development	Head of Financial Services
	• Opening bank accounts	Director of Finance and Commercial Development	Director of Finance and Commercial Development
	• Authorisation of transfers between Foundation Trust bank accounts	Director of Finance and Commercial Development	To be completed in accordance with bank mandate/internal procedures
	• Approve and apply arrangements for the electronic transfer of funds	Director of Finance and Commercial Development	To be completed in accordance with bank mandate/internal procedures
	• Authorisation of: - GBS schedules - BACS schedules - Automated cheque schedules - Manual cheques	Director of Finance and Commercial Development	To be completed in accordance with bank mandate/internal procedures
b)	Investments:		
	• Investment of surplus funds in accordance with the Foundation Trusts Treasury policy	Director of Finance and Commercial Development	Head of Financial Services
	• Preparation of Treasury procedures	Director of Finance and Commercial Development	Head of Financial Services
c)	Petty Cash	Director of Finance and Commercial Development	Refer To Table B Delegated Limits
5.	**Capital Investment**		
a)	Programme:		
	• Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / Service Development Strategy	Chief Executive	Director of Finance and Commercial Development
	• Preparation of Capital Investment Programme	Chief Executive	Director of Finance and Commercial Development

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Preparation of a business case	Chief Executive	Executive Director / Associate Directors of Operations / Clinical Business Unit Managers / Heads of Department.
• Monitoring and reporting on all capital scheme expenditure including variations to contract	Director of Finance and Commercial Development	Head of Financial Services
• Authorisation of capital requisitions	Chief Executive	Refer to Table B Delegated Limits
• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	Director of Finance and Commercial Development	Head of Financial Services
• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Chief Executive	Director of Finance and Commercial Development
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	Director of Finance and Commercial Development
• Issue procedures to support: o capital investment o staged payments	Chief Executive	Director of Finance and Commercial Development
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Director of Finance and Commercial Development	Head of Financial Services
• 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	Director of Finance and Commercial Development
b) Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Director of Finance and Commercial Development
c) Leases (property and equipment)		
• Granting and termination of leases with Annual rent < £250k	Chief Executive	Director of Finance and Commercial Development
• Granting and termination of leases of > £250k should be reported to the Board of Directors	Board of Directors	Chief Executive
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 Trust Standards of Business Conduct.
8. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Director of Nursing
b) Responsibility for ensuring complaints relating to a division / department is investigated thoroughly.	Chief Executive	Heads of Department
c) Medico - Legal Complaints Coordination of their management.	Chief Executive	Director of Nursing

	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	Director of Finance and Commercial Development / Director Human Resources and Organisational Development / Director of Nursing.
	Freedom of Information Act compliance code	Chief Executive	Director of Finance and Commercial Development / Director of Human Resources and Organisational Development / Director of Information Management & Technology.
10.	**Data Protection Act**		
a)	Review of Foundation Trust's compliance	Chief Executive	Director of Information Management and Technology
11.	**Declaration of Interest**		
	• Maintaining a register of interests	Chief Executive	Director of Finance and Commercial Development
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Senior Managers / Consultants
12.	**Disposal and Condemnations**		
	• Items obsolete, redundant, irreparable or cannot be repaired cost effectively • Develop arrangements for the sale of assets	Director of Finance and Commercial Development	Associate Director of Estates and Facilities in accordance with agreed policy. Refer to Table B Delegated Limits
	• Disposal of Protected Property (as defined in the Terms of Authorisation)	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
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 / draw down Public Dividend Capital.	Director of Finance and Commercial Development	Head of Financial Services
b)	Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board	Chief Executive / Director of Finance and Commercial Development
c)	Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive / Director of Finance and Commercial Development	Director of Finance and Commercial Development
d)	Preparation of procedural instructions concerning applications for loans and overdrafts.	Director of Finance and Commercial Development	Head of Financial Services
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit budgets to the Trust Board	Director of Finance and Commercial Development	Director of Finance and Commercial Development
	• Submit to Board financial estimates and forecasts	Chief Executive	Director of Finance and Commercial Development
	▪ Compile and submit to the Board a business plan/Service Development Strategy (SDS) which takes into account financial targets and forecast limits of available resources. The Business Plan/SDS will contain: o a statement of the significant assumptions on which the plan is based; o details of major changes in workload,	Chief Executive	Director of Finance and Commercial Development

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
delivery of services or resources required to achieve the plan. o		
b) Monitor:		
o Devise and maintain systems of budgetary control.	Director of Finance and Commercial Development	Deputy Director of Finance
o Monitor performance against budget	Director of Finance and Commercial Development	Deputy Director of Finance
o Delegate budgets to budget holders	Chief Executive	Director of Finance and Commercial Development
o Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Director of Finance and Commercial Development	Deputy Director of Finance
o Submit returns in accordance with the Independent Regulator's requirements for financial NHS Improvementing.	Chief Executive	Deputy Director of Finance
o Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
Preparation of: • Annual Accounts	Director of Finance and Commercial Development	Deputy Director of Finance
• Annual Report	Chief Executive	Director of Community Relations
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.	Director of Finance and Commercial Development	Budget Holders
d) Authorisation of Redesignation: It is not possible for any officer to redesignate from non-recurring headings to recurring budgets or from capital to revenue / revenue to capital. 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 Foundation Trust Financial Procedures	Director of Finance and Commercial Development	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 and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems	Director of Finance and Commercial Development	Deputy Director of Finance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
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 Executive	Head of Financial Services
b)	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Director of Finance and Commercial Development	Associate Director of Estates and Facilities
c)	Calculate, account and pay capital charges in accordance with the requirements of the Independent Regulator	Director of Finance and Commercial Development	Head of Financial Services
c)	Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Director of Finance Commerical Development and reporting losses in accordance with Foundation Trust's procedures	Chief Executive	All staff
19.	**Fraud (See also 26, 36)**		
a)	Monitort and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive and Director of Finance and Commercial Development	Local Counter Fraud Specialist.
b)	Notify Counter Fraud and Security Management Service and External Audit of all suspected Frauds	Director of Finance and Commercial Development	Local Counter Fraud Specialist.
20.	**Funds Held on Trust (Charitable and Non Charitable Funds)**		
a)	Management: • Funds held on trust are managed appropriately.	Charitable Funds Committee	Head of Financial Services
b)	Maintenance of authorised signatory list of nominated fund holders.	Director of Finance and Commercial Development	Head of Financial Services
c)	Expenditure Limits	Director of Finance and Commercial Development	Refer To Table B Delegated Limits
d)	Developing systems for receiving donations	Director of Finance and Commercial Development	Head of Financial Services
e)	Dealing with legacies	Director of Finance and Commercial Development	Head of Financial Services
f)	Fundraising Appeals	Charitable Funds Committee	Charity Fundraising Manager / Head of Financial Services
	▪ Preparation and monitoring of budget	Director of Finance and Commercial Development	A nominated fund raising manager with advice from financial link.
	▪ Reporting progress and performance against budget.	Director of Finance and Commercial Development	A nominated fund raising manager with advice from financial link.
g)	Operation of Bank Accounts:		
	• Managing banking arrangements and operation of bank accounts	Director of Finance and Commercial Development	Head of Financial Services
	• Opening bank accounts	Director of Finance and Commercial Development	Director of Finance and Commercial Development

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
h)	Investments: • Nominating deposit taker	Charitable Funds Committee	Director of Finance and Commercial Development
	• Placing transactions	Director of Finance and Commercial Development	Director of Finance and Commercial Development / Investment Broker
i)	Regulation of funds with Charities Commission	Director of Finance and Commercial Development	Head of Financial Services
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	Director of Nursing
22.	**Hospitality/Gifts**		
a)	Keeping of hospitality register	Chief Executive	Director of Finance and Commercial Development
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	Director of Nursing
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.	Director of Finance and Commercial Development	Deputy Director of Finance
	• Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Finance and Commercial Development	Director of Information Management and Technology.
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Director of Finance and Commercial Development	Director of Information Management and Technology.
25.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors	Chief Executive	Director of Finance and Commercial Development / Board Secretary
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Executive Directors
d)	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)	Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Counter Fraud Management Services of frauds	Chief Executive	Director of Finance and Commercial Development

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Losses Losses of cash due to theft, fraud, overpayment & others. Fruitless payments (including abandoned Capital Schemes) Bad debts and claims abandoned. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson).		
	Reviewing appropriate requirement for insurance claims	Director of Finance and Commercial Development	Head of Financial Services
e)	A register of all of the payments should be maintained by the Finance Department and made available for inspection	Director of Finance and Commercial Development	Head of Financial Services
f)	A report of all of the above payments should be presented to the Audit Committee	Director of Finance and Commercial Development	Head of Financial Services
	Special Payments Compensation payments by Court Order	Chief Executive	Above Excess – NHSLA Below Excess – Chief Executive
	Ex gratia Payments:-		
	• To patients/staff for loss of personal effects		Director of Finance and Commercial Development
	• For clinical negligence after legal advice		Medical Director / Director of Finance and Commercial Development
	• For personal injury after legal advice		Medical Director / Director of Finance and Commercial Development
	• Other clinical negligence and personal injury		Medical Director / Director of Finance and Commercial Development
	• Other ex-gratia payments		Director of Finance and Commercial Development
27.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board	Chairman	Chairman
b)	Chair all Foundation Trust Board meetings and associated responsibilities	Chairman	Chairman
28.	**Medical**		
	• Clinical Governance arrangements	Medical Director / Director of Nursing	Medical Director / Director of Nursing
	• Medical Leadership	Medical Director	Medical Director
	• Programmes of medical education	Medical Director	Medical Director
	• Medical staffing plans	Medical Director	Medical Director
	• Medical Research	Medical Director	Medical Director / Director Finance and Commercial Development
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	Head of Procurement
b)	Obtain the best value for money when requisitioning goods / services	Chief Executive	Head of Procurement / Chief Operating Officer / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department
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.	Chief Executive	Director of Finance and Commercial Development

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	(Subject to the limits specified above in (a)		
d)	Develop systems for the payment of accounts	Director of Finance and Commercial Development	Head of Financial Services
e)	Prompt payment of accounts	Director of Finance and Commercial Development	Head of Financial Services
f)	Financial Limits for ordering / requisitioning goods and services	Director of Finance and Commercial Development	Refer To Table B Delegated Limits
g)	Approve prepayment arrangements	Director of Finance and Commercial Development	Director of Finance and Commercial Development
30.	**Nursing**		
	▪ Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice.	Director of Nursing	Deputy Director of Nursing
	▪ Matters involving individual professional competence of nursing staff.	Director of Nursing	Deputy Director of Nursing
	▪ Compliance with professional training a development of nursing staff.	Director of Nursing	Deputy Director of Nursing
	▪ Quality assurance of nursing processes.	Director of Nursing	Deputy Director of Nursing
31.	**Patient Services Agreements**		
a)	Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Director of Finance and Commercial Development
b)	Quantifying and monitoring out of area treatments	Director of Finance and Commercial Development	Deputy Director of Finance
c)	Reporting actual and forecast income	Chief Executive	Deputy Director of Finance
d)	Costing Foundation Trust Contract and Non Commercial Contracts	Director of Finance and Commercial Development	Deputy Director of Finance
e)	Reference costing / Payment by Results	Director of Finance and Commercial Development	Deputy Director of Finance
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Director of Finance and Commercial Development	Deputy Director of Finance
32.	**Patients' Property** (in conjunction with financial advice)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Director of Finance and Commercial Development / Heads of Department
b)	Prepare detailed written instructions for the administration of patients' property	Director of Finance and Commercial Development	Head of Financial Services
c)	Informing staff of their duties in respect of patients' property	Director of Finance and Commercial Development	Assocate Director of Operations / Clinical Business Unit Managers / Heads of Department
d)	Issuing property of deceased patients.	Director of Finance and Commercial Development	
	▪ <£4,999 in accordance with agreed Foundation Trust policies.		General / Cash Office Staff
	▪ >£5,000 only on production of a probate letter of administration		Director of Finance and Commercial Development
33.	**Personnel & Pay**		
a)	Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive / Executive Directors	Director of Human Resources and Organisational Development / 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.	Director of Governance and Workforce	Director of Human Resources and Organisational Development
c)	Authority to fill funded post on the establishment with permanent staff.	Director of Governance and Workforce	Executive Directors / Associate Directors of Operation / Clinical Business Unit

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
			Managers / Heads of Department in accordance with Trust policy
d)	The granting of additional increments to staff within budget	Chief Executive	Director of Human Resources and Organisational Development
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Director of Human Resources and Organisational Development	Associate Director of Human Resources
f)	Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance.	Director of Finance and Commercial Development	Deputy Director of Finance / Head of Management Accounts
	• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Director of Finance and Commercial Development
	• Self financing changes to an establishment	Director of Finance and Commercial Development	Deputy Director of Finance / 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	Director of Human Resources and Organisational Development	Associate Directors of Operation / Clinical Business Unit Managers
	• Authority to complete and authorise positive reporting forms (SVLs)	Director of Finance and Commercial Development	Associate Directors of Operation / Clinical Business Unit Managers
	• Authority to authorise overtime	Director of Human Resources and Organisational Development / Director of Finance and Commercial Development	Associate Directors of Operation / Clinical Business Unit Managers
	• Authority to authorise travel & subsistence expenses	Director of Human Resources and Organisational Development / Director of Finance and Commercial Development	Associate Directors of Operation / Clinical Business Unit Managers
h)	Leave *(Note entitlement may be taken in hours)*	Director of Human Resources and Organisational Development	*Refer to Annual Leave Policy*
	<u>Annual Leave</u>		
	- Approval of annual leave		Executive 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 / 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 / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department Medical Staff – Medical Director
	<u>Special Leave</u>	Director of Human Resources and Organisational Development	

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Compassionate leave		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave (to be applied in accordance with Foundation Trust Policy)		
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust Policy)		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Manager
• Leave without pay		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Manager
• Medical Staff Leave of Absence – paid and unpaid		Medical Director / Divisional Medical Directors
• Time off in lieu		Departmental / Line Managers
• Maternity Leave - paid and unpaid	Director of Human Resources and Organisational Development	Automatic approval with guidance
<u>Sick Leave</u>		
i) Extension of sick leave on pay	Director of Human Resources and Organisational Development	
ii) Return to work part-time on full pay to assist recovery		
<u>Study Leave</u>		
• Study leave outside the UK	Chief Executive	Executive Director
• Medical staff study leave (UK)	Medical Director	
- Consultant / Non Career Grade		Medical Director
- Career Grade		Post Graduate Tutor
• All other study leave (UK)	Director of Governance and Workforce	Executive Directors / Divisional Director of Operations / Heads of Department (in accordance with agreed Foundation Trust policy)
i) Removal Expenses, Excess Rent and House Purchases	Director of Human Resources and Organisational Development	Executive Director
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)		Refer to Table B Delegated Limits
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	Director of Human Resources and Organisational Development	As per procedure

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
k)	Authorised Car Users		
	• Leased cars (Business and personal)	Chief Executive	Director of Finance and Commercial Development
	• Regular user allowance	Director of Finance and Commercial Development	Executive Director / Assocate Director of Operations / Clinical Business Unit Managers / Heads of Department
l)	Mobile Phone / Messaging Services	Director of Finance and Commercial Development	Director of Finance and Commercial Development / Associate Director of Estates and Facilities
m)	Renewal of Fixed Term Contract	Director of Human Resources and Organisational Development	Heads of Department on advice from Human Resources and Divisional Accountants
n)	Staff Retirement Policy		
	▪ Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief Executive	Director of Human Resources and Organisational Development
	▪ Authorisation of return to work in part time capacity under the flexible retirement scheme.	Chief Executive	Director of Human Resources and Organisational Development
o)	Redundancy		
	• Approval to proceed	Chief Executive	Director of Human Resources and Organisational Development / Director of Finance and Commercial Development
	• Payments (including legal fees) below £50,000	Chief Executive	Director of Human Resources and Organisational Development / Director of Finance and Commercial Development
	• Payments (including legal fees) over £50,000	Nominations and Remuneration Committee	Director of Human Resources and Organisational Development / Director of Finance and Commercial Development
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Executive	Director of Human Resources and Organisational Development
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.	Director of Human Resources and Organisational Development	Associate Director of Human Resources
s)	Engagement of staff not on the establishment		
	• Management Consultants		Refer to Table B
	▪ Booking of bank staff		
	• nursing	Director of Nursing	Associate Directors of Operation / Divisional Heads of Nursing
	• other	Executive Directors	Associate Directors of Operation / Heads of Department / Line Managers
	▪ Booking of agency staff		
	• nursing	Director of Nursing	Associate Directors of Operation / Divisional Heads of Nursing

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• other	Executive 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	Director of Finance and Commercial Development / Head of Procurement / Associate Director of Estates and Facilities
	• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Associate Directors of Operation / Heads of Department
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	Head of Procurement
	• Receipt and custody of tenders prior to opening	Chief Executive	Director of Finance and Commercial Development
	• Opening Tenders	Chief Executive	Two officers from the approved list as authorised by the Audit Committee or release of electronic tenders on e contract management system by designated officer.
	• Decide if late tenders should be considered	Chief Executive	Director of Finance and Commercial Development
	• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Executive Director / Associate Directors of Operation / Heads of Department
c)	Quotations	Chief Executive	Refer To Table B Delegated Limits
d)	Waiving the requirement to request		
	• tenders - subject to Standing Orders (reporting to the Board)	Chief Executive	Refer To Table B Delegated Limits
	• quotes - subject to Standing Orders	Chief Executive or Director of Finance and Commercial Development	Director 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	Director of Finance and Commercial Development	Deputy Director of Finance
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	Manager On-call / Heads of Department / Associate Directors of Operation
b)	Where a fraud is involved (reporting to the Directorate of Counter Fraud Services)	Director of Finance and Commercial Development	Head of Internal Audit / Local Counter Fraud Officer
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Director of Finance and Commercial Development	Director of Finance and Commercial Development
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Director of Nursing

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• Developing systems for the management of risk.	Director of Nursing	Associate Director of Governance
	• Developing incident and accident reporting systems	Director of Nursing	Associate Director of Governance
	• Compliance with the reporting of incidents and accidents	Director of Nursing	All staff
38.	**Seal**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary
b)	Attestation of seal in accordance with Standing Orders	Chairman / Chief Executive	Chairman / Chief Executive (report to Board of Directors)
c)	Property transactions and any other legal requirement for the use of the seal.	Chairman / Chief Executive	Chairman 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 of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance and Commercial Development	Deputy Director of Finance
b)	Non patient care income	Director of Finance and Commercial Development	Deputy Director of Finance
c)	Informing the Director of Finance and Commercial Development of monies due to the Foundation Trust	Director of Finance and Commercial Development	All Staff
d)	Recovery of debt	Director of Finance and Commercial Development	Head of Financial Services
e)	Security of cash and other negotiable instruments	Director of Finance and Commercial Development	Head of Financial Services
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores and receipt of goods, issues and returns	Director of Finance and Commercial Development	Head of Procurement / Head of Pharmacy / Associate Director of Estates and Facilities and appropriate Heads of Department
b)	Stocktaking arrangements	Director of Finance and Commercial Development	Head of Financial Services
c)	Responsibility for controls of pharmaceutical stock.	Designated Pharmaceutical officer	

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.

	Proposed Financial Limits (Subject to funding available in budget**)**		**Includes:-**
1	**CHARITABLE FUNDS**		
	Charitable Funds Committee	Over £5,000	*Note: Manual system, paper based approval*
	Director of Finance and Commercial Development and Director of Nursing	£1,001 to £5,000	
	Head of Financial Services and Fundraising Manager	Up to £1,000	
2	**GIFTS AND HOSPITALITY**	£25	
3.	**LITIGATION CLAIMS**		Clinical Negligence Claims Clinical negligence claims are handled by the NHS Litigation Authority on behalf of the Trust under the CNST and ELS Schemes. Authorisation from the NHSLA is required before admissions may be made and monetary compensation offered. All payments will be made directly by the NHSLA. (*NHSLA – Clinical Negligence Reporting Guidelines, 5th Edition, October 2008).*
	Chief Executive / Director of Finance and Commercial Development	Excess payments: Over £15,000	Employers Liability and Public Liability Claims These claims are handled under the NHSLA RPST Scheme.
	Director of Nursing	Up to £15,000	
	Litigation & Risk Manager	PL claims: Payments within excess £3,000	
		EL claims: Payments within excess £10,000	
4.	**LOSSES AND SPECIAL PAYMENTS**		
	Losses Fruitless payments (including abandoned capital schemes)	£250,000 and above	Board of Directors
	Other Losses Losses of cash due to theft, fraud, overpayment and others	£5,000 up to £250,000	Chief Executive / Director of Finance and Commercial Development reported to the Audit Committee
		£5,000	Chief Executive / Director of Finance and Commercial Development
	Bad debts and claims abandoned		
	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson etc)		
5.	**PETTY CASH DISPURSEMENTS/ PATIENTS MONIES (authority to pay cash)**		
	Director of Finance and Commercial Development or Nominated Deputy	Over £50	Petty Cash / Sundry Exchequer Item
	Budget Manager	Up to £50	
	Director of Finance and Commercial Development	Over £5,000	Patient Monies (see patients property Table A Section 32)
	Deputy Director of Finance and Commercial Development / Head of Financial Services	£101 - £5,000	

	Proposed Financial Limits (Subject to funding available in budget**)** ℹ	**Includes:-**
	Cash / General Office Managers	Up to £100
6.	**REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS**	
6.1	**Revenue Expenditure – Delegated Authority (excluding consultancy services and removal expenses)**	

	Value	**Delegated Authority**
Level 1	Over £250,000	Chief Executive/ Medical Director*
Level 2	Up to £250,000	Executive Directors
Level 3	Up to £100,000	Deputy Chief Operating Officer
Level 4	Up to £50,000	Director of Medical Education Deputy Directors Associate Director of Estates and Facilities Chief Pharmacist Clinical Business Unit Managers
Level 5	Up to £25,000	Associate Directors Board Secretary Deputy Chief Pharmacist Assistant / Deputy Clinical Business Unit Managers Heads of Service (or equivalent)
Level 6	Up to £10,000	Matron/Lead Nurse Heads of Service/ Department Managers (or equivalent)
Level 7	Up to £5,000	Ward/Service/Theatre Managers Divisional Administrator (or equivalent)

* Delegated responsibility in absence of Chief Executive

6.1	**Consultancy Services**		
	Up to £50,000	Chief Executive / Executive Directors	
	Over £50,000	Requires approval from NHS Improvement	
6.3	**Capital Expenditure**		
	Annual Capital Programme and amendments to the Capital Programme approved by Board of Directors following recommendation by Capital Planning Group and Finance and Sustainability Committee.		
	Approval of orders for schemes within the approved capital programme in accordance with delegated authority per section 6.1.		
	Urgent schemes approved by Director of Finance and Commercial Development (or Deputy Director of Finance).	Up to £250,000	
	Chief Executive	£250,000 - £500,000	
	Board of Directors	Above £500,000	
6.4	**Removal Expenses:-**		
	Director of Human Resources and Organisational Development	Up to £8,000	
7.	**QUOTATIONS AND TENDERS**		
	Head of Procurement / Associate Director of Estates and Facilities / Chief Pharmacist	£10,000 to £60,000	Quotations: *Inviting* a **minimum of 3 written quotations** for goods/services.
	Head of Procurement / Associate Director of Estates / Chief Pharmacist	Over £60,000 (in compliance with EC Directives as appropriate)	Competitive Tenders: *Inviting* **a minimum of 3 written competitive tenders** for goods/services.

	Proposed Financial Limits (Subject to funding available in budget)		Includes:-
			EU Limits and subsequent changes to be provided under separate correspondence by Head of Procurement
8.	**BUSINESS CASE APPROVAL**		**Conditions:-**
	Board of Directors	Over £500,000	Capital and Revenue costs must be approved
	Executive Team	£100,000 - £500,000	
	Operations Group	Up to £100,000	
9.	**REDESIGNATION**		**Conditions:-**
	Trust Board	Over £250,000 pa	Trust must still meet Financial Targets
	Chief Executive	Up to £250,000 pa	Total Trust budget remains under spent
	Director of Finance and Commercial Development	Up to £100,000 pa	Total Trust budget remains under spent
	Deputy Director of Finance	Up to £25,000 pa	Total Divisional / Departmental Budget remains under spent

EQUALITY IMPACT ASSESSMENT

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

Title	
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	4
What are the changes to previous version?	
Publication Date	January 2017
Review Date	January 2019
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	Audit Committee
Approval Date	16th January 2017
Ratified by(Quality Committee and or Sub Committees)	Audit Committee
Ratification Date	16th January 2017
Author Contact	2208
Librarian	Linda Atkin
Division	Finance
Specialty (if local procedural document)	

Ward/Department (if local procedural document)	
Patient documentation included Y/N	
Date Approved at documentation group via Director of Communications and Engagement)	
Readership (Clinical Staff, all staff)	
Information Governance Class (Restricted or 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 Improvement 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 NHS Improvement .

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 Director of Finance and Commercial Development or delegated finance officer **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.

Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance and Commercial Development 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. The Director of Finance and Commercial Development must approve all financial procedures.

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 procedural document.

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 procedural document.

Executive Directors

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

Delegated Executive Lead

The Director of Finance and Commercial Development has been delegated by the Chief Executive to take the Executive ownership for this procedural document

Senior Clinicians and Managers

Senior Clinicians and Managers are responsible for the provision of managerial and professional clinical advice to their teams on patient safety issues, and to ensure the provision of services and care is consistent and equitable care relating to this procedural document.

All Staff

All staff are expected to comply with this procedural document. 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.

Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

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 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 (income and expenditure) for a specific area of the organisation.
The Chair	Means the Chairman 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, such person.
Chief Executive	Means the Chief Officer (and Accounting Officer) of the Foundation Trust
Committee	Means a committee appointed by the Board of Directors or Governors Council.
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 obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	Means a person appointed to the Board of Directors in accordance with the Trust's constitution and includes the

	Definition
	Chair.
Director of Finance and Commercial Development	Shall mean the chief finance officer of the Foundation Trust.
Executive Director	Means an Executive Director of the Trust.
External Auditor	Any external auditor other than the External Auditor appointed under the Constitution to review and report upon other aspects of the Foundation Trust's performance.
External Auditor	the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act;
Financial Year	a) The period beginning with the date on which the 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 Improvement	regulator of Foundation Trusts, NHS Trusts and Independent providers of NHS funder care (from 1st April 2016)
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.
Partner	In relation to another person, a member of the same household living together as a family unit;
Registered Dentist	A registered dentist within the meaning of the Dentists Act 1984.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters.

	Definition
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust.

Wherever the title Chief Executive, Director of Finance and Commercial Development, 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, including nursing and medical staff and consultants practising on the Foundation Trust premises and members of staff of the PFI contractor or Trust staff working for the contractor under retention of employment model.

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 budgets and 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 Governors Council 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 Director of Finance and Commercial Development 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 existing 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 Director of Finance and Commercial Development 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 separation 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 Director of Finance and Commercial Development include:

d) the provision of financial advice to other members of the Board of Directors, Governors Council 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, severally and collectively, 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 Director of Finance and Commercial Development.

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 function.

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 auditor at least once every five years.
- To make recommendations to the Governors Council, 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.
- To develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

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 chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Director of Finance and Commercial Development in the first instance).

It is the responsibility of the Director of Finance and Commercial Development to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the selection process when an audit service provider is changed.

The appointment of the External Auditor is the responsibility of the Governors Council.

Director of Finance and Commercial Development

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Governors Council 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 embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the 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 pecuniary nature, the Director of Finance and Commercial Development must be notified immediately.

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

The Head of Internal Audit shall be accountable to the Director of Finance and Commercial Development. The reporting system for internal audit shall be agreed between the Director of Finance and Commercial Development, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the 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 Head of Internal Audit shall have access to report direct to the Chairman 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 time-scales specified within the report. The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development. Changes implement 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 NHS Improvement 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 Governors Council following recommendation from the Audit Committee.

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

The Governors Council shall appoint or remove the External Auditor at a general meeting of the Governors Council

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 Governors Council.

Undertaking Work

NHS Improvement 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 if 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 function 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 Governors Council 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 NHS Improvement within 30 days (or such shorter period as NHS Improvement 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 Counter Fraud and Security Management Service (CFSMS). The Foundation Trust shall act in accordance with:

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

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

The Local Counter Fraud Specialist shall report to the Director of Finance and Commercial Development and shall work with the staff in the CFSMS in accordance with the Department of Health Fraud and Corruption Manual.

The Local Counter 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 CFSMS.

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 local security management 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 Local Security Management Specialist (LSMS).

BUSINESS PLANNING, FINANICAL PLANNING AND PERFORMANCE MONITORING

Preparation and approval of Business Plans / Service Development Strategy and budgets

The Chief Executive will compile and submit to the Board of Directors a Strategic Direction document that encompasses an annual business plan and takes into account financial targets and forecast limits of available resources. The Annual Business Plan / Service Development Strategy 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 Director of Finance and Commercial Development will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

a) be in accordance with the aims and objectives set out in the Foundation Trust's annual business plan / Service Development Strategy, and the commissioners' local delivery plans;

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development to enable budgets to be compiled.

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

The Director of Finance and Commercial Development 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 redesignation;

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 Director of Finance and Commercial Development.

Budgetary control and reporting

The Director of Finance and Commercial Development 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) balance sheet, including movements in working capital;

   iii) cash flow statement

   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 Director of Finance and Commercial Development'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 Director of Finance and Commercial Development 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 redesignation 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 redesignation; and

d) no permanent employees are appointed without the approval of the Chief Executive or Director of Finance and Commercial Development 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.

NHS Improvement returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS Improvement within the specified time-scales.

ANNUAL ACCOUNTS AND REPORTS

Accounts

The Foundation Trust shall keep accounts in such form as the NHS Improvement 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 NHS Improvement 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 NHS Improvement 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, any report of the External Auditor on them, and the annual report are to be presented to the Governors Council at a General Meeting.

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 NHS Improvement. 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 NHS Improvement requires.

The Foundation Trust is to comply with any decision NHS Improvement 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.

Annual Plans

The Foundation Trust shall give information as to its three year financial plan to NHS Improvement. The Foundation Trust must make clear which elements of the Annual Plan do not constitute forward planning information. The document containing this information is to be prepared by the Directors. In preparing the document, the Directors shall have regard to the views of the Governors Council. The Annual Plan must be approved by the Board of Directors.

The Foundation Trust is required to provide three types of in-year reports:

- regular reports, (quarterly basis), subject to review;
- exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards; and
- ad hoc reports, following up specific issues identified either in the Annual Plan or during the year.

BANK ACCOUNTS

General

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

Banking procedures

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

The Director of Finance and Commercial Development shall approve security procedures, including those arrangements with third party organisations, for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

Tendering and Review

The Director of Finance and Commercial Development will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Audit Committee and the Board of Directors. This review is not applicable under the Government Banking Services initiative.

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

Income systems

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development is also responsible for the prompt banking of all monies received.

Fees and charges other than Foundation Trust Contract.

The Director of Finance and Commercial Development 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 inform the Director of Finance and Commercial Development or delegated finance officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

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, NHS Improvement will be notified and an appropriate action plan developed to correct the non-compliance.

Debt recovery

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided

by the Counter Fraud and Security Management Service. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Foundation Trust's Losses and Compensations 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 Appointments 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.

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 Governors Council, 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 annual budget will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Director of Human Resources and Organisational Development 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 Divisional Accountant 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 commencing pay rates, condition of service, etc., for employees.

Processing of the payroll

The Director of Human Resources and Organisational Development in conjunction with the Director of Finance and Commercial Development 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 Director of Human Resources and Organisational Development 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 Director of Human Resources and Organisational Development

instructions and in the form prescribed by the Director of Human Resources and Organisational Development; 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 Director of Human Resources and Organisational Development must be informed immediately. In circumstances where fraud might be expected this must be reported to the Director of Finance and Commercial Development.

Regardless of the arrangements for providing the payroll service, the Director of Human Resources and Organisational Development in conjunction with the Director of Finance and Commercial Development 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 on an ongoing basis and annually by the Supplies Department; and

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 Audit Committee but where it is necessary to amend the financial limits for those managers below Executive Director status, these amendments require authorisation by the Chief Executive or Director of Finance and Commercial Development and ratification to the Audit Committee. Where it is necessary to amend the financial limits for Executive Directors, these amendments require authorisation by the Chief Executive and ratification to the Audit Committee.

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 Director of Finance and Commercial Development (and/or the Chief Executive) shall be consulted.

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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) a list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

   ii) certification that:

   - goods have been duly received, examined and are in accordance with specification and the prices are correct;
   - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where

applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; 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 Supplies 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development;

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 Director of Finance and Commercial Development and that:

a) all contracts other than for a simple purchase permitted within the Scheme of Reservation and Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and Commercial Development in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Chief Executive and Director of Finance and Commercial Development and the Department of Health ("The Procurement and Management of Consultants within the NHS");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 Director of Finance and Commercial Development on behalf of the Chief Executive;

e) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

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) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance and Commercial Development;

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

k) petty cash records are maintained in a form as determined by the Director of Finance and Commercial Development.

Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors, or in the case of contracts entered into using Procure 21 (P21) 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. Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development or a person with specific delegated powers from the Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 NHS Improvement as appropriate.

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

Capital investment

The Chief Executive:

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 NHS Improvement 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

The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development shall calculate and account for capital charges in accordance with the Foundation Trust Financial Reporting Manual, and other applicable guidance issued by NHS Improvement 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 Director of Finance and Commercial Development.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and Commercial Development. 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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development) 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 Director of Finance and Commercial Development for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance and Commercial Development. 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 Estates Manager.

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

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

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development.

The designated manager shall be responsible for a system approved by the Director of Finance and Commercial Development for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance and Commercial Development 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 Director of Finance and Commercial Development. 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 Director of Finance and Commercial Development.

DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Policy for the re-use, sale and disposal of obsolete equipment.

All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance and Commercial Development; and

b) recorded by the condemning officer in a form approved by the Director of Finance and Commercial Development 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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development who will take the appropriate action.

Losses and special payments

The Director of Finance and Commercial Development must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance and Commercial Development who will liaise with the Chief Executive.

Where a criminal offence is suspected, the Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Reservation and Delegation.

The Director of Finance and Commercial Development shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

For any loss, the Director of Finance and Commercial Development should consider whether any insurance claim can be made.

The Director of Finance and Commercial Development 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 Litigation Authority (NHSLA) 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 NHSLA 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 Director of Finance and Commercial Development

The Director of Finance and Commercial Development, 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 Director of Finance and Commercial Development 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 Finance and Commercial Development 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 Trust in the region wishes to sponsor jointly) all responsible directors and employees will send to the Director of Finance and Commercial Development:

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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) Director of Finance and Commercial Development staff have access to such data; and

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

Risk Assessment

The Director of Finance and Commercial Development 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 NHS Improvement 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 Finance and Commercial Development 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 Director of Finance and Commercial Development 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.

Where Department of Health instructions require the establishment and maintenance of separate accounts/ records for patients' monies; these shall be opened and operated under arrangements agreed by the Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development, 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 Finance and Commercial Development 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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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, inter alia, 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development.

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

In respect of Donations, the Director of Finance and Commercial Development 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 and Bequests, the Director of Finance and Commercial Development shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Director of Finance and Commercial Development 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 testator all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Director of Finance and

Commercial Development 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 and bequests.

In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

The Director of Finance and Commercial Development shall prepare annual accounts in the required manner, which shall be submitted, to the Charitable Funds Committee within agreed timescales.

The Director of Finance and Commercial Development 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

The Director of Finance and Commercial Development shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Director of Finance and Commercial Development.

The Director of Finance and Commercial Development shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them with all necessary information.

The Charitable Funds Committee shall be advised by the Director of Finance and Commercial Development on the outcome of the annual audit.

Taxation and Excise Duty

The Director of Finance and Commercial Development 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 (DoH) 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 Director of Finance and Commercial Development 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 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 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 Executive, 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) submitted in a plain sealed package or envelope bearing a pre-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) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) any tenders issued electronically via the e contract management system can be 'locked' until the due date at which point they can be 'released' 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.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

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 be endorsed on the tender envelope/package or recorded electronically on the e contract management system for tenders issued and received electronically.

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 opened by two senior officers/managers designated by the Chief Executive and not from the

originating department. Any tenders issued electronically via the e contract management system will be locked until the due date at which point they can be released by a designated officer.

(ii) Where paper copies are received a member of the Board of Directors (see also point v below) will be required to be one of the two approved persons present for the opening of tenders as per the Scheme of Reservation and Delegation. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Scheme of Reservation and Delegation.

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

(iv) The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Director of Finance and Commercial Development or any approved Senior Manager from the Finance Department from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Foundation Trust's Board Secretary will count as a Director for the purposes of opening tenders.

(vi) Where paper copies are received every tender received shall be marked with the date of opening and initialled by those present at the opening or where tenders are received and opened electronically the date will be recorded electronically recorded on the e contract management system.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender; and
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

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

(viii) 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 designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance and Commercial Development 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 and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or 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, recorded, and held in safe custody by the Chief Executive or their nominated officer.

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. Price will account for 50% of the overall score.

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.

Tender reports to the Board of Directors

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

The Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

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 either the Chief Executive or Director of Finance and Commercial Development.

Authorisation of Tenders and Competitive Quotations

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

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 Director of Finance and Commercial Development.

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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 NHS Litigation Authority 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 NHS Litigation Authority the Director of Finance and Commercial Development shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance and Commercial Development 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 NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 Director of Finance and Commercial Development 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 NHS Litigation Authority. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Director of Finance and Commercial Development 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 NHSLA, 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	V3
Publication Date	January 2017
Review Date	January 2019
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	Audit Committee
Approval Date	16th January 2017
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	16th January 2017
Author Contact	2208
Librarian	Linda Atkin
Division	Finance
Specialty (if local procedural document)	
Ward/Department (if local procedural document)	
Readership (Clinical Staff, all staff)	All Staff
Information Governance Class (Restricted or unrestricted)	